3

Best practice strategies to minimise alcohol misuse and alcohol-related harm

Introduction

3.1 Much evidence received by the committee related to strategies to reduce the supply of alcohol. This included taxation regimes, liquor licencing and reducing alcohol–related marketing.

3.2 The committee heard that Aboriginal and Torres Strait Islander people have developed a variety of locally based strategies to reduce alcohol access in their communities. In many cases, these strategies have been established in cooperation with a range of stakeholders, including government agencies, licensees and police.

3.3 Attention was also drawn to the importance of community support in the development of measures to control the supply of alcohol. The importance of community consultation in the development and operation of alcohol supply reduction measures was stressed as key.[1]

Population-level supply reduction

3.4 The committee heard that reduction in supply showed reduction in alcohol–related harms across populations.[2] Population–level supply

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1 Australian Human Rights Commission (AHRC), *Submission 31*, p. 8; Aboriginal Peak Organisations of the Northern Territory (APO NT), *Submission 72*, p. 27.

2 The Lyndon Community, *Submission 16*, p. 1.

reduction is seen as critical to any program to reduce alcohol–related harm.[3]

3.5 Others argue it displaces the problem to somewhere else. Foundation for Alcohol Research and Education (FARE) notes that despite evidence of the wide range of alcohol–related harms, alcohol is more available than it has ever been before and is more affordable than it has been for three decades.[4]

3.6 FARE believes population–wide reduction strategies reduce the consumption levels across a population. Regulatory control of the access to and price of alcohol can be used to ensure alcohol–related harm is minimised.

3.7 A number of ways in which regulatory control can be used were raised during the inquiry, and ranged from the role of the alcohol industry, reducing alcohol advertising, eg during sport, to supply reduction measures such as strengthening liquor licencing regimes and changing alcohol taxation.

3.8 The Public Health Association of Australia (PHAA) gave evidence that while clinical services are essential, there is a great need for population-based responses to the harmful use of alcohol.[5]

Challenging the Alcohol Industry

3.9 In Australia, all alcoholic products made for commercial purposes are subject to various excise duties and taxes, and all state and territory jurisdictions have laws regulating the production, retail and consumption of alcohol. These regulations and laws balance the public interest with the interests of the alcohol industry.[6]

3.10 Concerns were raised that this balance is currently tipped too far in favour of the interests of the alcohol industry, which includes alcohol manufacturers, distributors, and retailers. It was argued that the primacy of the alcohol trade needs to be challenged, and that the alcohol industry takes more responsibility for reducing the harmful use of alcohol, particularly in Aboriginal and Torres Strait Islander communities.[7]

3.11 The Northern Territory Police Association (NTPA) asserts while 'society picks up the bill for the sustained disadvantage and misery which results

3 People's Alcohol Action Coalition (PAAC), *Submission 7.1*, p. 2.

4 Foundation for Alcohol Research and Education (FARE), *Submission 83*, p. 35;

5 Public Health Association of Australia (PHAA), *Submission 91*, p. 5.

6 National Drug Research Institute (NDRI), *Submission 47*, p. 14.

7 Mr Michael Thorn, Chief Executive, FARE, *Committee Hansard*, Canberra, 28 August 2014, p. 1.

from the excessive consumption of alcohol', the supply of alcohol remains unchanged.[8]

3.12 The NTPA comments:

> Such is the power and influence of alcohol manufacturers, distributors, and retail suppliers … the availability of alcohol goes unchecked, save as to age based restrictions and trading hours, by the legislature. The supply chain is kept open unabated. The profits of suppliers, from manufacturers and distributors, to pubs, clubs and stores, are relentlessly protected, guaranteed, and defended.[9]

3.13 Professor Peter d'Abbs from the Menzies School of Health Research says that alcohol misuse systems have been institutionally sustained by liquor licensees and their suppliers, as well as their political representatives.[10]

> In places where heavy episodic drinking has taken root over several generations, both the drinking itself and the activities that sustain it – such as grog runs – have not only become culturally normal, they are also institutionally sustained, both by institutions that benefit directly from the status quo – most obviously takeaway and on–premise liquor outlets and their suppliers, employees and political representatives – and by other institutions that have accommodated themselves to the status quo, if only for their own peace of mind, such as local workplaces and schools that tailor their expectations regarding attendance and absenteeism to the local income–bingeing cycle.[11]

3.14 The Lyndon Community notes that local groups wishing to make changes are not well-informed or well-resourced about how to reduce alcohol supply. The Lyndon Community believe that the alcohol industry is a major impediment to reducing the supply.[12]

Taxation on alcohol

3.15 There was strong support for the introduction of a volumetric tax as well as a minimum or floor price on alcohol in Australia.

3.16 The Royal Australasian College of Physicians (RACP) notes taxation of alcohol can be used to generate direct revenue to fund alcohol treatment

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8 Northern Territory Police Association (NTPA), *Submission 27*, p. 9.

9 NTPA, *Submission 27*, p. 8.

10 Professor Peter d'Abbs, Menzies School of Health Research, *Submission 99,* p. 20.

11 Professor Peter d'Abbs, Menzies School of Health Research, *Submission 99*, p. 20.

12 The Lyndon Community, *Submission 16*, p. 10.

services or prevention programs. They also note that volumetric tax based on evidence of harm associated with particular beverage types, can provide an additional element of flexibility in targeting.[13]

3.17 Volumetric taxation is placed on alcohol products based on their alcohol content. It was described as one of the most effective ways of reducing harmful alcohol use and related harm in both Aboriginal and Torres Strait Islander and non–Indigenous communities.[14]

3.18 A study in 2013 in the Medical Journal of Australia found that if the Wine Equalisation Tax was abolished and replaced with a volumetric tax on wine, taxation revenue would increase by $1.3 billion per year, alcohol consumption would be reduced by 1.3 per cent, and $820 million would be saved in health care costs and 59 000 disability-adjusted life-years would be averted.[15]

3.19 Dr John Boffa from the People's Alcohol Action Coalition (PAAC) drew the committee's attention to a study of the effectiveness of Canadian price-based harm minimisation policies.[16]

3.20 The study found that for every 10 percent increase in alcohol price, the number of alcohol-attributable deaths decreased by one third.[17] The results of this study support earlier research in Alaska and Florida, United States, which reported substantial reductions in mortality following tax increases on alcohol.[18]

3.21 The National Aboriginal and Torres Strait Islander Legal Services and the Human Rights Law Centre propose that a volumetric system would replace existing excises on alcohol with a common tax based on alcohol content. This would be across all forms of alcohol and would help to

13 Royal Australasian College of Physicians (RACP), *Submission 28*, p. 21.

14 See, for example: PAAC, *Submission 7.1*, p. 27; Professor Kate Conigrave, Dr Kylie Lee and Mr Peter Jack, University of Sydney, Discipline of Addiction Medicine, *Submission 38*, p. 11; NDRI, *Submission 47*, p. 17; Professor Dennis Gray, Member, National Indigenous Drug and Alcohol Committee (NIDAC), *Committee Hansard*, Canberra, 15 May 2014, p. 7l; Professor Marcia Langton, *Committee Hansard*, Melbourne, 30 May 2014, p. 32.

15 C Doran, L Coblac, B Vandenberg et. al., *Estimated impacts of alternative Australian alcohol taxation structures on consumption, public health and government revenues,* Medical Journal of Australia, 2013, 199(9), p. 619.

16 Dr John Boffa, Spokesperson, PAAC, *Committee Hansard,* Alice Springs, 31 March 2014, p. 6.

17 J. Zhao, T. Stockwell, G. Martin et. al., *The relationship between minimum alcohol prices, outlet densities and alcohol-attributable deaths in British Columbia*, 2002-09 Addiction, June 2013, Vol. 108(6), p. 1059.

18 M. Maldonado-Molina and A. Wagenaar, *Effects of alcohol taxes on alcohol-related mortality in Florida, time-series analyses from 1969 to 2004,* Alcoholism: Clinical and Experimental Research, 2010, 34(11), p. 1915; A. Wagenaar, M. Maldonado-Molina, and B. Wagenaar, *Effects of alcohol taxes on alcohol-related disease mortality in Alaska, time-series analyses from 1976 to 2004,* American Journal of Public Health, 2009, 99(8), p. 1464.

reduce alcohol-related harm by increasing the relative cost of drinking higher alcohol beverages and making lower alcohol beverages more affordable and attractive.[19]

3.22 FARE argues that Australia needs to address:

> … the inequitable alcohol taxation system that allows for alcohol to be purchased for as little as 25 cents per standard drink.[20]

3.23 The National Drug Research Institute (NDRI) supports a tiered volumetric tax on alcohol, similar to that which was proposed in the 2010 *Australia's Future Tax System* report:

> Under such a proposal, all beverage types (beer, table wine, fortified wine, spirits, etc.) would be taxed on the basis of alcohol content, with beverages in tiers (low, medium, and high alcohol content for example) being taxed at different rates with lower rates on low alcohol content beverages. The advantage of such a system is that it would apply on a national basis and be a disincentive to high levels of consumption among all drinkers.[21]

3.24 In addition to instituting volumetric taxation, there was strong support for a minimum or floor price on alcohol.[22] This sets a minimum price per standard drink or unit of alcohol at which alcoholic beverages must legally be sold.

3.25 Dr John Boffa said that it is the 'minimum price that makes the biggest difference to the heaviest drinkers'[23] and supported the introduction of a volumetric tax that incorporates a floor price:

> If a volumetric tax could be achieved, it is the gold standard and it should be done, but it has to be done in a way that implements a minimum price.[24]

3.26 Dr John Boffa notes that substitution is not a major issue in relation to alcohol interventions that are price based because alcohol is 'the drug of choice'.[25] Referring to evidence from Canada, Dr Boffa says that:

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19 National Aboriginal and Torres Strait Islander Legal Services and the Human Rights Law Centre, *Submission 58*, p. 18.

20 FARE, *Submission 83*, p. 37.

21 NDRI, *Submission 47*, p. 16; The Treasury, *Australia's Future Tax System*, Final Report: Part 2, 2010, pp. 431-443.

22 See, for example: FARE, *Submission 83*, p. 40; NDRI, *Submission 47*, p. 22; PAAC, *Submission 7.1*, p. 2; Central Land Council (CLC), *Submission 68*, p. 7; APO NT, *Submission 72*, p. 6; Criminal Lawyers Association of the Northern Territory (CLANT), *Submission 76*, p. 1; Central Australian Aboriginal Congress (CAAC), *Submission 84*, p. 4; PHAA, *Submission 91*, p. 7; Australian Drug Foundation (ADF), *Submission 92* , p.15.

23 Dr Boffa, PAAC, *Committee Hansard*, Alice Springs, 31 March 2014, p. 6.

24 Dr Boffa, PAAC, *Committee Hansard*, Alice Springs, 31 March 2014, p. 6.

> … alcohol is still readily available; it is just at a higher price. So you get very little substitution. It is not prohibition. If you had prohibition, you would get a lot of substitution, but we are only talking about regulation.[26]

Liquor licencing regimes

3.27 The retail and wholesale of alcohol requires a licence from the liquor licensing authority of the relevant state or territory.

3.28 FARE is concerned that alcohol is more accessible now than it has been previously:

> Alcohol is more readily available than it ever has been in Australia. The number and density of liquor licenses has consistently increased over the past 10 to 15 years. This is despite the fact that research overwhelmingly demonstrates that as alcohol becomes more available, consumption and alcohol-related problems increase, and that to reduce alcohol-related harms, a reduction in access and availability are effective measures.[27]

3.29 Internationally, research has shown that extended late night trading hours result in increased alcohol consumption and alcohol-related harm.[28] Similarly, research shows that as the density of liquor outlets increases, the incidence of alcohol–related harm increases.[29]

3.30 The committee heard that changes to liquor licencing laws, such as limiting the density of alcohol outlets and reducing trading hours could reduce the supply of, and harm caused by alcohol in Aboriginal and Torres Strait Islander communities.[30]

3.31 The NDRI reports that restrictions on trading hours have been effective in reducing alcohol consumption and alcohol–related harm in Aboriginal and Torres Strait Islander communities, and that this is supported by strong international evidence.[31]

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25 Dr Boffa, PAAC, *Committee Hansard*, Alice Springs, 31 March 2014, p. 6.

26 Dr Boffa, PAAC, *Committee Hansard*, Alice Springs, 31 March 2014, p. 6.

27 FARE, *Submission 83*, p. 12.

28 T Stockwell and T Chikritzhs, 'Do relaxed trading hours for bars and clubs mean more relaxed drinking? A review of international research on the impacts of changes to permitted hours of drinking', *Crime Prevention and Community Safety*, 2009, vol. 11, p. 153.

29 M Livingston, T Chikritzhs and R Room, 'Changing the density of alcohol outlets to reduce alcohol-related problems', *Drug and Alcohol Review*, 2007, vol. 26, p. 564.

30 See, for example: FARE, *Submission 83*, p. 14; NDRI, *Submission 47*, p. 23; The Alcohol & Drug Service, St Vincent's Hospital, Sydney, *Submission 63*, p. 13.

31 NDRI, *Submission 47*, pp. 23-24.

3.32 In addition to reducing trading hours and outlet density, there was strong support for strengthening existing liquor licencing regimes. For example, Aboriginal Peak Organisations of the Northern Territory (APO NT) stress the need for stronger enforcement of existing licensing laws,[32] while the NTPA calls for more work to be done on the legislative level to strengthen licencing requirements and reduce the availability of alcohol.[33]

3.33 The committee heard that several jurisdictions were moving towards a risk–based licencing system.[34] The New South Wales Government gave evidence that it has introduced stronger licensing provisions as part of its package of reforms to reduce alcohol-related violence and antisocial behaviour. The measures include a periodic, risk-based licencing scheme that imposes higher fees for venues and outlets that have later trading hours, poor compliance records or are located in high risk locations.[35]

3.34 FARE supports the expansion of a risk-based liquor licensing regime, where the fees that a licensee pays to operate are related to the risks of their operations.[36]

Reducing alcohol-related marketing

3.35 The pervasiveness of alcohol advertising in sport was highlighted as an example of where regulations need to change, particularly where children are frequently exposed to alcohol promotion.[37]

3.36 Professor Mike Daube from the McCusker Centre for Action on Alcohol and Youth comments that:

> Aboriginal children are as vulnerable as any others, and possibly more so, to the massive and cynical exposure of children to alcohol promotion, particularly through sports such as AFL, NRL and cricket. Aboriginal children are as aware as any others that the State of Origin game is not New South Wales against Queensland; it is VB against XXXX.[38]

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32 APO NT, *Submission 72*, p. 9.

33 NTPA, *Submission 27*, pp. 14-18.

34 Mr Thorn, FARE, *Committee Hansard*, Canberra, 28 August 2014, p. 7.

35 NSW Government, *Submission 62*, p. 9.

36 Mr Thorn, FARE, *Committee Hansard*, Canberra, 28 August 2014, p. 7.

37 Professor Mike Daube, Director, McCusker Centre for Action on Alcohol and Youth, *Committee Hansard*, Perth, 30 June 2014, p. 19; National Alliance for Action on Alcohol (NAAA), *Submission 54*, p. 1.

38 Professor Daube, McCusker Centre for Action on Alcohol and Youth, *Committee Hansard*, Perth, 30 June 2014, p. 19.

3.37 Currently, alcohol advertising in various media in Australia is self–regulated according to industry compliance with the Alcohol Beverages Advisory Code.[39]

3.38 Alcohol advertising on television is regulated by the Commercial Television Industry Code of Practice, which restricts the times where alcohol advertisements can be shown on television to M, MA and AV classification periods. Typically, alcohol advertising on commercial television is restricted to between 8.30pm and 5.00am; however an exemption allows advertisements to be shown during live sporting broadcasts at any time of the day.[40]

3.39 The National Alliance for Action on Alcohol (NAAA) asserts that, in order to protect children from alcohol marketing and promotions, the loophole that allows alcohol advertising during live sport needs to be closed.[41]

3.40 The McCusker Centre for Action on Alcohol and Youth says that current approaches to regulating alcohol advertising have failed and that a comprehensive regime needs to be established:

> Independent, legislated controls on the content, placement and volume of all forms of alcohol advertising and promotion are urgently needed. Such a system would include comprehensive codes and enforceable decisions with sanctions that genuinely act as a deterrent.[42]

3.41 While restrictions on alcohol advertising aim to limit the exposure of people, particularly children, to the promotion of alcohol products and drinking as desirable, the committee heard that such changes need to be part of a broader suite of measures to reduce access to alcohol.[43]

Conclusion

3.42 There is high availability of cheap alcohol across Australia. The committee considers that alcohol outlet trading hours are too long and have been shown to be not always in the best interests of the public.

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39 The Alcohol Beverages Advertising Code Scheme, *About the ABAC Scheme*, 2014, < http://www.abac.org.au/about/> viewed 20 April 2015.

40 Australian Communications and Media Authority, *Commercial Television Industry Code of Practice*, January 2010, p. 31.

41 NAAA, *Submission 54*, p. 1.

42 McCusker Centre for Action on Alcohol and Youth, *Submission 21*, p. 3.

43 Professor Elizabeth Elliott, Paediatrician, Westmead Children's Hospital and the University of Sydney, *Committee Hansard*, Sydney, 5 September 2014, p. 1; Lililwan Project Team, *Submission 90*, p. 4.

3.43 The committee believes that the taxation system is a very effective way to address reducing harms related to alcohol. The impact of a volumetric tax and a minimum floor price on the health of the Australian community needs greater investigation.

3.44 The committee notes that the findings of the 2010 *Australia's Future Tax System* report (Henry Tax review), indicate that a volumetric tax would better address alcohol-related harm than current taxation arrangements.

3.45 The committee considers that the way forward is the introduction of volumetric tax in conjunction with a minimum floor price. There would need to be an exploration of the system needed, for example, whether a tiered volumetric system would be the most appropriate.

Recommendation 4

3.46 **That the committee recommends:**

- **the introduction of a national minimum floor price on alcohol, and**
- **prompt consideration be given to the recommendations of the Henry Tax Review on volumetric tax.**

3.47 The states and territories are responsible for licencing laws in their jurisdiction and therefore have a key role in regulating the supply and access to alcohol.

3.48 The committee is concerned about statistics which highlight a correlation between the density of liquor outlets and an increase in domestic violence. The steps taken by the alcohol industry retailers to introduce liquor outlets closely clustered with other outlets and in total disregard of the views of the local community are of great concern.

3.49 Opening hours for liquor sales should be modified according to community wishes. If a community wants to take steps to reduce alcohol–related harm, they need to be supported in ensuring they can make the necessary changes.

3.50 The committee commends the introduction, in New South Wales, of risk based licences. These licences impose higher fees on venues and outlets that have later trading hours, poor compliance or are in high risk locations.

3.51 The committee wants risk-based licencing and licencing fees based on the possible harm caused given greater consideration by states and territories.

Recommendation 5

3.52 **That the states and territories conduct detailed analysis of any demand increase for liquor licences particularly in areas of high risk drinking, with a view to moving towards a risk-based licencing system similar to that of New South Wales.**

3.53 The committee notes that marketing of alcohol is a big business and one that the alcohol industry self-regulates through the Alcohol Beverages Advertising Code (ABAC) Scheme which includes the ABAC Responsible Alcohol Marketing Code.

3.54 Currently advertisements for alcoholic drinks may not be broadcast during times when children would typically be watching unless it is part of a live broadcast of a sporting event. This makes a mockery of the regulations, given the strong connection between Aboriginal and Torres Strait Islander children and sport.

3.55 Watching a sporting program should not involve a child being bombarded with advertisements for alcohol, both directly and indirectly through sponsorship badges and caps for example.

3.56 The committee heard evidence about how sport can give Aboriginal and Torres Strait Islander people many positive things but is worried that the advertising of alcohol in sport could provide mixed messages.

3.57 The committee feels that the welfare and future of children is certainly more important than the profits of either sporting teams or the alcohol industry and considers that there is much to be gained by stopping alcohol advertising on television before 8.30pm.

Recommendation 6

3.58 **That the Commonwealth takes steps to ensure a nationally consistent and coordinated approach to alcohol advertising, including:**

- **Banning alcohol advertising during times and in forms of the media which may influence children**
- **Banning alcohol sponsorship of sporting teams and sporting events, including but not limited to those in which children participate or may be involved, and**

- **That the Australian Communication and Media Authority change the Commercial Television Code of Practice to ensure that alcohol is not able to be advertised before 8.30pm and that no exemptions are given for alcohol promotion during sport broadcasting.**

Local supply reduction measures

3.59 Targeted strategies to reduce alcohol–related harm should be implemented in such a way as to ensure that the particular requirements of a community or a group of individuals are best met.

3.60 These strategies currently include supply reduction measures such as declaring communities as being dry, the development of alcohol management plans to control the way alcohol can be consumed in a particular community and 'alcohol accords'.

3.61 Across Australia there are many communities that have developed local supply reduction measures. For example, FARE observes that some remote communities, including Aurukun in Queensland and the Anangu Pitjantjatjara Yankunytjatjara (APY) lands in South Australia are 'dry', meaning that no alcohol is permitted in the community. Other communities, such as Tennant Creek in the Northern Territory, Ceduna in South Australia and Fitzroy Crossing and Karratha in Western Australia, have restrictions on when and what type of alcohol products can be purchased.[44]

Community led

3.62 The Australian Drug Foundation (ADF) believes that Aboriginal and Torres Strait Islander communities must be empowered to control or end the supply of alcohol if that is what they wish.

3.63 ADF also recognises the value of any support for communities including scope for monitoring and the evaluation of the strategies so that communities can learn from their own and from other communities' experience.[45]

3.64 The Central Land Council (CLC) states that community driven initiatives are the most common forms of treatment and support services in central

44 FARE, *Submission 83*, p. 13.

45 ADF, *Submission 92*, p. 4.

Australia for minimising alcohol related harm. However, the problem is too often short-term funding and lack of follow-up for the time it takes to remain sober. They state:

> These services effectively take people away from potentially dangerous situations reducing the risk of violence/accidents due to alcohol abuse and are mostly run by local people who have an in-depth understanding and knowledge of community dynamics. They also reduce the potential for arrests and people being taken into police custody.[46]

3.65 The Australian Society for Medical Research believes that fostering the creation of local, community-driven initiatives will result in flexible, tailored support, capable of meeting the demand of individual communities.[47]

3.66 The Healing Foundation notes that locally driven responses and leadership are critical to quality outcomes being realised.[48]

3.67 APO NT notes the importance of Aboriginal and Torres Strait Islander people being in control of their own actions and services and the need to engage Aboriginal and Torres Strait Islander people in the planning and development of strategies to address the misuse of alcohol.[49]

Community based Alcohol Management Plans

3.68 An Alcohol Management Plan (AMP) is a community agreement to tackle the harm caused by alcohol abuse. AMPs are developed in partnership with communities and with support from local organisations and governments.

3.69 A range of stakeholders were generally supportive of AMPs.[50]

3.70 Other stakeholders were critical of current arrangements around AMPs. In particular:

- few AMPs are actually in place, particularly in the Northern Territory[51] despite many having been prepared and submitted for approval

46 CLC, *Submission 68,* p. 4.

47 Australian Society for Medical Research, *Submission 75*, p. 6.

48 Healing Foundation, *Submission 42,* p. 6.

49 APO NT, *Submission 72*, p. 13.

50 AHRC, *Submission 31*, p. 10; APO NT, *Submission 72*, p. 15, pp.31-33; University of Melbourne, *Submission 44*, p. 9; Mr John Patterson, Executive Officer, Aboriginal Medical Services Alliance Northern Territory (AMSANT), *Committee Hansard*, Darwin, 3 April 2014, p. 21; ADF, *Submission 92*, p. 13; Aboriginal Health Council of Western Australia (AHCWA), *Submission 69*, p. 2; RACP, *Submission 28*, p. 24; FARE, *Submission 83*, p. 15.

- the CLC said that the benchmark criteria for Ministerial approval was too high[52]
- Dr Shelley Bielefeld was concerned that Ministerial approval was required[53] causing delays, and
- the Australian Crime Commission (ACC) said that AMPs are difficult to enforce.[54]

3.71 FARE comments that management plans designed to reduce alcohol harm that are not culturally appropriate will not be effective in Aboriginal and Torres Strait Islander communities, and the most effective approach requires AMPs to be driven and led by Aboriginal and Torres Strait Islander communities and agencies, with support from governments if needed to build the local capacity to develop the plans.[55]

3.72 Concern was raised during the inquiry that once a community has mobilised to develop an AMP, the lack of responsiveness from governments can mean that impetus and motivation is lost. Professor Langton notes that some AMPs with community endorsement had been waiting for approval for two years or longer.[56]

3.73 Other submitters called on the Government to make it a priority that once AMPs are finalised they are swiftly ratified by the Minister.[57]

3.74 The Northern Territory (NT) Government said that there was scope for better coordination of the AMP process between the NT Government and the Commonwealth.[58] IRAG expresses the following view:

> Aboriginal people can come up with their own solutions for their own problems, that's why we [Mt Nancy town camp] worked on our Alcohol Management Plan. This has never been supported by the NT government and it has never been supported by the federal government. Our time and effort has been wasted, money has been wasted to recreate the wheel. We know that there are social issues and we know that there is violence. We try very hard to do what we can to stop these.[59]

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51 Mr Patterson, AMSANT, *Committee Hansard*, Darwin, 3 April 2014, p. 20; Intervention Rollback Action Group (IRAG), *Submission 57*, p. 2.

52 CLC, *Submission 68*, p. 7.

53 Dr Shelley Bielefeld, *Submission 67*, p. 4.

54 Australian Crime Commission (ACC), *Submission 59,* p. 7.

55 FARE, *Submission 83*, p. 19.

56 Professor Marcia Langton, *Committee Hansard*, Melbourne, 30 May 2014, p. 29.

57 Dr David Cooper, Manager, Research Advocacy Policy, AMSANT, *Committee Hansard*, Darwin, 3 April 2014, p. 23; APO NT, *Submission 72*, p. 6.

58 Northern Territory (NT) Government, *Submission 60*, p. 25.

59 IRAG, *Submission 57*, p. 4.

Targeted supply restrictions

3.75 The committee heard that strategies to manage the supply of alcohol in Aboriginal and Torres Strait Islander communities were also in response to increases in harmful alcohol use at certain times of the year.

3.76 For example increases in visitors from remote communities to town camps in the Northern Territory during events such as football carnivals often alter drinking patterns in those locations.[60]

3.77 Mrs Brahim from the Julalikari Council Aboriginal Corporation in Tennant Creek observes that 'in the football season you will see a huge influx of people—families, as well as kids that are not going to school.'[61]

3.78 The Lyndon Community describes the strategies to reduce alcohol–related violence in Orange, NSW on specific days or occasions. They noted there was early closing on high risk days such as Christmas and Anzac Day and restrictions on the alcohol content of drinks served at races.[62]

3.79 The committee heard that local police played a key role in cooperating and managing alcohol supply during football carnivals in places such as Tennant Creek.[63]

Changes to liquor licencing laws Coober Pedy

3.80 The Coober Pedy Hospital and Health Services comment that, following changes to liquor licencing laws in Coober Pedy in September 2013, the overall number of accident and emergency presentations decreased by about 14 per cent.[64]

60 ACC, *Submission 59*, p. 6.

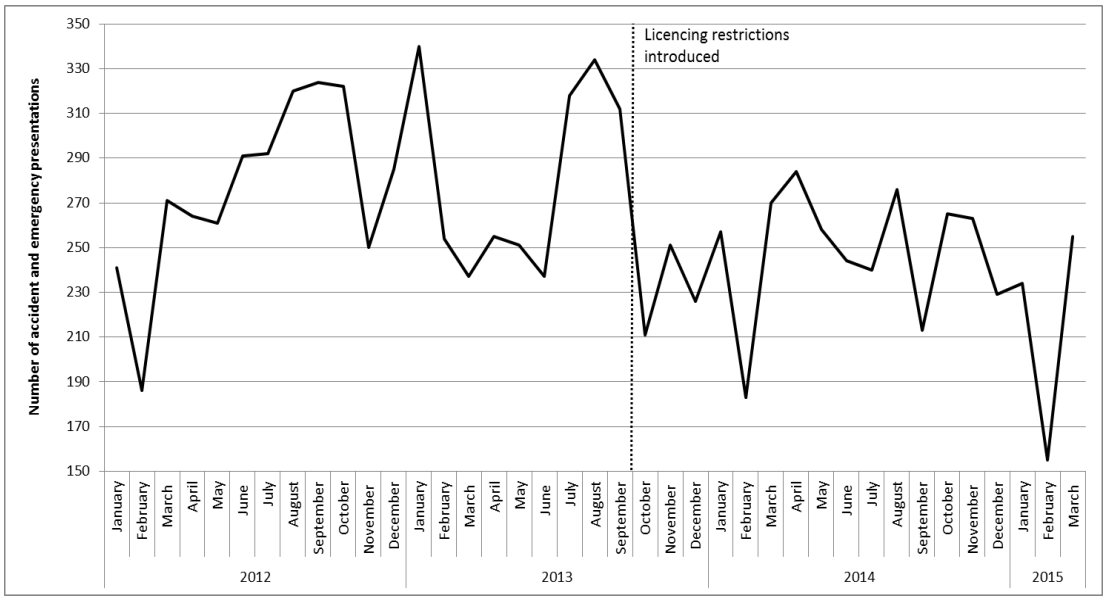
61 Mrs Patricia Brahim, Chief Executive Officer, Julalikari Council Aboriginal Corporation, *Committee Hansard*, Tennant Creek, 1 April 2014, p. 26.

62 The Lyndon Community, *Submission 16*, p. 9.

63 Mr Stewart Naylor, Member, Tennant Creek Alcohol Reference Group, *Committee Hansard*, Tennant Creek, 1 April 2014, p. 3.

64 Coober Pedy Hospital and Health Services, *Submission 131*, p. 3.

Figure 3.1 The impact of changes to liquor licencing laws on hospital presentations: Coober Pedy Hospital 2012–15



Source Coober Pedy Hospital and Health Services, Submission 131, p. 8.

3.81 Figure 3.1 illustrates that accident and emergency presentations at the Coober Pedy Hospital have trended downwards since September 2013, from a peak of 340 in January 2013 to a low of 155 in February 2015.[65] The number of accident and emergency presentations varies seasonally, with February recording the lowest number of presentations in each year.

3.82 The Coober Pedy Hospital reports that there have been substantial decreases in accident and emergency presentations for Aboriginal and Torres Strait Islander people experiencing a variety of conditions since the licencing changes, including:

- psychosocial presentations by 17 per cent
- lacerations by 34 per cent, and
- musculoskeletal problems by 33 per cent.[66]

3.83 In addition, inpatient admissions for Aboriginal and Torres Strait Islander people seeking treatment for alcohol issues increased by 30 per cent.[67]

65 Coober Pedy Hospital and Health Services, *Submission 131*, p. 8.

66 Coober Pedy Hospital and Health Services, *Submission 131*, p. 4.

67 Coober Pedy Hospital and Health Services, *Submission 131*, p. 6.

Alcohol Accords

3.84 An Alcohol Accord is a term used to describe a voluntary agreement between licensees and other stakeholders to limit the harm caused by alcohol in communities.

3.85 Government and alcohol industry stakeholders were supportive of the role of alcohol accords in reducing harm.[68] For example, the Australian Hotels Association (AHA) gave evidence that local liquor accords can be a valuable tool for reducing alcohol-related harm and ensuring local licensees work together to address community concerns.[69]

3.86 Similarly, the Queensland Government said that accords play a key role in harm minimisation and enable effective communication and problem solving between licensees and other stakeholders.[70]

3.87 Conversely, the NDRI observes that voluntary accords have limited effect.[71]

Canteens and licenced clubs

3.88 Some witnesses drew attention to the provision of 'wet' canteens and licenced clubs in some communities, owned and operated by Aboriginal and Torres Strait Islander community councils.

3.89 Dr Maggie Brady explains that community licenced clubs and canteens were introduced in many Aboriginal and Torres Strait Islander communities following the end of prohibition laws in the 1960s which were:

> … based on a very laudable idea that people could have limited amounts of alcohol and be eased into learning about drinking moderately.[72]

3.90 The idea that licenced clubs could teach people responsible drinking is supported by the Association of Alcohol and Other Drug Agencies NT.[73] The Association argues that:

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68 Australian Hotels Association (AHA), *Submission 45*, p. 5; NSW Government, *Submission 62*, p. 9; Mr Jordan Jenkins, Licensees Alcohol Accord Tennant Creek, *Committee Hansard*, Tennant Creek, 1 April 2014, pp. 8-13; NT Government, *Submission 60*, p. 8; Queensland Government, *Submission 98*, p. 20.

69 AHA, *Submission 45*, p. 5.

70 Queensland Government, *Submission 98*, p. 20.

71 NDRI, *Submission 47*, p. 31.

72 Dr Maggie Brady, *Committee Hansard*, Canberra, 23 October 2014, p. 1.

73 Association of Alcohol and Other Drug Agencies NT, *Submission 11*, p. 5.

> … without the opportunity to learn responsible drinking behaviour, young people are introduced to alcohol on the side of the road where the behaviour is anything but responsible.[74]

3.91 Associate Professor Alan Clough describes the management of canteens by Aboriginal and Torres Strait Islander councils as a conflict of interest:

> The conflict of interest was that these councils, which generally had few funds at that time to support community and social services, came to rely on the funds from the canteens to support a lot of the community activities. At the same, of course, they were essentially obliged to keep the peace and keep good order.[75]

3.92 Professor d'Abbs states of the small number of communities that established licensed clubs in the Northern Territory, most were shown to have significantly higher levels of alcohol consumption than in the Northern Territory as a whole.[76]

3.93 Dr Paul White, a specialist physician in psychiatry, asserts that the introduction and operation of licenced canteens in Cape York in Queensland had a damaging impact on communities:

> They have lost two or three generations of Indigenous folk on the Cape, and it was very much around the introduction of the canteens into the towns in the 1970s, and the movement of people from the outstations into those centres.[77]

Banned Drinkers Register

3.94 The Northern Territory's Banned Drinkers Register (BDR) was highlighted as an example of a successful, albeit short –lived, measure to reduce harmful alcohol use and alcohol related harm.[78] The BDR was designed to stop problem drinkers from purchasing alcohol, and included a central database that collected information on the identity of banned drinkers. The BDR was in operation in the Northern Territory from July 2011 to August 2012.[79]

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74 Association of Alcohol and Other Drug Agencies NT, *Submission 11*, p. 2.

75 Associate Professor Alan Clough, *Committee Hansard*, Cairns, 17 February 2015, p. 3.

76 Professor Peter d'Abbs, Menzies School of Health Research, *Submission 99*, p. 4.

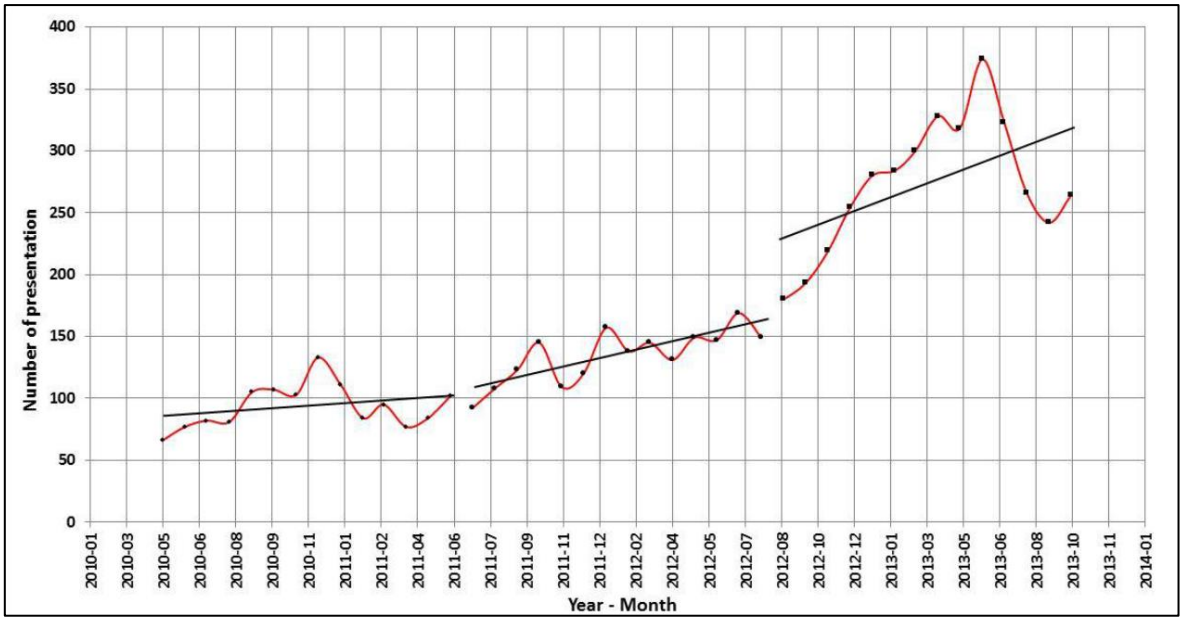
77 Dr Paul White, Specialist Physician, Synapse, *Committee Hansard*, Brisbane, 20 June 2014, p. 40.

78 See, for example: Mr Vince Kelly, President, NTPA, *Committee Hansard*, Canberra, 5 June 2014, p. 2; Dr John Boffa, Spokesperson, PAAC, *Committee Hansard*, Alice Springs, 31 March 2014, p. 3.

79 PAAC, *Submission 7.1*, p. 40.

3.95 It was emphasised that when the BDR was abolished, alcohol-related harms in the Northern Territory increased. The NTPA notes alcohol-related hospital emergency admissions rose by 80 per cent in the 14 months following the abolition of the BDR in the NT.[80]

Figure 3.2 Alice Springs Hospital Emergency Department presentations for conditions wholly attributable to alcohol before, during and after the operation of the Northern Territory Banned Drinkers Register



Source People's Alcohol Action Coalition, Submission 7.1, p. 39.

3.96 Figure 3.2 illustrates that when the BDR was removed in August 2012, alcohol–related admissions to the hospital's emergency department were approximately double the average monthly admissions when the BDR was in operation.[81]

3.97 The NTPA asserts that the BDR needed time to mature,[82] while a substantial number of witnesses called for the reintroduction of the BDR.[83]

3.98 Both FARE and the PAAC note that while no formal evaluation of the BDR was conducted by the NT Government, subsequent analysis by the NDRI has shown that there was a reduction in alcohol-related harms in Alice Springs as a result of the BDR.[84] This is in contrast to statements

80 NTPA, *Submission 27,* pp. 13-14.

81 For further analysis, see *Submission 7.1*, pp. 39-44.

82 NTPA, *Submission* 27, p. 11.

83 See, for example: Ms Andrea Mason, Coordinator, Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, *Committee Hansard*, Alice Springs, 31 March 2014, p. 5; PAAC, *Submission 7.1*, p.5; CLC, *Submission 68*, p. 7; CLANT, *Submission 76*, p. 1; FARE, *Submission 83*, p. 11.

84 FARE, *Submission 83*, p. 37; PAAC, *Submission 7.1*, p. 23.

made by the NT Government that the BDR was abolished because it was not working.[85]

Conclusion

3.99 A range of local supply reduction measures that communities are being used to meet the particular requirements of a community.

3.100 The change in a community when alcohol consumption is moderated or excluded can be dramatic, for example on Groote Eylandt or Fitzroy Crossing. The committee also heard about the positive effect of accords and targeted supply restrictions

3.101 The committee saw clear evidence of the benefit of steps being taken to change the availability of alcohol for the duration of a big event. This requires police and state or territory cooperation and planning with the community. The whole community can then feel safe and enjoy the event that is not marred by alcohol–related violence and associated harm.

3.102 The committee strongly believes that governments at all levels should support these local strategies, rather than hinder them through unnecessary restrictions, red tape or timeframes.

3.103 The committee notes with concern the lack of cooperation from the Northern Territory Government to this inquiry. The committee was prevented from obtaining any direct evidence from hospital staff and police in the Northern Territory on their experience of alcohol-related harm. Although the Northern Territory Government provided an aggregated submission, this did not address many of the concerns of those dealing with alcohol-related harm on a daily basis in the Territory.

3.104 The committee commends Coober Pedy for developing a whole-of-community solution to addressing the harmful use of alcohol, especially their willingness to adopt restrictions in the non-Indigenous and Aboriginal and Torres Strait Islander communities.

3.105 In relation to Alcohol Management Plans, the committee heard of completed plans sitting on minister's desks for years, with the goodwill and momentum of the community slowly dissipating. This needs to change.

3.106 Governments at all level must facilitate the efforts of a community to reduce alcohol-related harm in their community. This can involve

85 The Hon Robyn Lambley, Deputy Chief Minister, NT Government 'New alcohol statistics again show BDR was a useless tool', *Media Release 140228*, 28 February 2014.

flexibility around licencing conditions for events, quickly approving AMPs and being willing to listen to a community rather than dictating to them.

3.107 The committee considers it important that support for community driven initiatives to minimise alcohol misuse in Aboriginal and Torres Strait Islander people is prioritised and that communities are empowered and supported to drive these initiatives.

Recommendation 7

3.108 **That governments at all levels:**

- **prioritise Aboriginal and Torres Strait Islander community driven strategies to reduce the harmful effects of alcohol**
- **ensure that communities are empowered to develop the strategies that will work for their communities, and**
- **cooperate and facilitate any work in Aboriginal and Torres Strait Islander communities which aims to change the liquor trading hours in their community.**

Community Alcohol Management Plans and other community driven strategies need to be reviewed and processed within a maximum of a six month period, including where any alterations are recommended.

The current backlog of Community Alcohol Management Plans in the Department of Prime Minister and Cabinet need to be cleared by January 2016.

3.109 The evidence shows that the Northern Territory's BDR was working effectively to reduce the supply of alcohol to problem drinkers, and that its abolition was associated with increases in alcohol-related harm.

3.110 The committee is concerned that, despite evidence of its effectiveness and significant support from stakeholders, the BDR was abolished after one year of operation. The committee is of the view that the BDR needed more time to develop, and that a longer period of operation would have yielded better results.

3.111 The committee calls on the NT Government to immediately reinstate the BDR. While recognising that the abolition of the BDR was a decision for the NT Government, the committee asserts that it is the Northern Territory's responsibility to act in the best interests of Aboriginal and

Torres Strait Islander people in the Territory and reinstate a measure that has been shown to be effective.

Recommendation 8

3.112 **That the Northern Territory Government re-introduce the Banned Drinker's Register and set up a comprehensive data collection and evaluation program which monitors criminal justice, hospital and health data.**