People's Alcohol Action Coalition[1]

Submission[2] to the

House of Representatives Standing Committee on Indigenous Affairs

Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities

[1] See **Appendix 1** for more details on the People's Alcohol Action Coalition

[2] PAAC would like to acknowledge the considerable assistance of Edward Tilton in writing this submission, and also to thank Professor Dennis Gray, Associate Professor Ted Wilkes and Research Associate Anna Stearne of the National Drug Research Institute for their very helpful data analysis and comments.

Executive Summary

Alcohol makes a significant contribution to the burden of sickness, injury and death in Aboriginal[3] communities. Alcohol misuse affects the health of individuals and their families, and undermines progress on many social and economic goals such as getting children into and through school, gaining employment and creating safer communities. Evidence-based policies and programs directed specifically at alcohol use in the Aboriginal community are central to closing the wide gap in disadvantage that still exists.

However, the harmful use of alcohol is not solely an Aboriginal problem: it is a major health and social issue for Australia, estimated to cost more than $15 billion each year. Many of the most effective ways of addressing these adverse effects of alcohol in Aboriginal communities are population-wide, that is, not targeted solely at Aboriginal people but applied to all Australian communities.

This submission examines both Aboriginal-specific and population-wide approaches to reducing alcohol-related harm. The key approaches, supported by substantial evidence from overseas and Australia, focus on reducing demand, reducing supply and minimising harm. In particular we recommend a sustained and holistic approach based on:

1. **Population-level supply reduction.** Reducing the supply of alcohol, especially to the heaviest or problem drinkers and to vulnerable groups (including young people) is the best way to reduce alcohol-related harm. In particular this means:

   a. **taking action on price** through a combined minimum per unit (or floor) price and a volumetric tax, to reduce the availability of cheap alcohol and raise funds to address alcohol-related harm

   b. **reducing trading hours**, including for take-away alcohol sales and for late night on-premises trading

   c. **reintroducing a form of the successful Banned Drinker Register with photo ID scanning at the point of sale** in the Northern Territory.

2. **Early childhood development programs** to break the inter-generational cycle of disadvantage and alcohol abuse that affects many Aboriginal families.

3. **Effective treatment for Aboriginal people,** focussed on sustained, quality treatments that we know work, adapted to be effective in the Aboriginal context.

To support these approaches, Australia needs **an agreed national data collection and reporting system** that will allow monitoring of the effectiveness of programs and policies, for both the Aboriginal and general Australian communities.

We argue that **the strong national and international evidence base should be the starting point** for any policy or legislative approach aimed at reducing the harm in Aboriginal communities. Innovative approaches which have a reasonable prospect of success may also be supported, although in such cases it is particularly important that long-term, rigorous evaluation is included.

[3] In this paper, we use the term 'Aboriginal' to refer to 'Aboriginal and Torres Strait Islander' and/or 'Indigenous' on the basis that this is the preferred term in the Northern Territory where PAAC is based.

Recommendations

1. *That Government invest in the data infrastructure that would allow for targeting of effort at areas of most need as well as ongoing, routine monitoring of the effect of programs and policies aimed at reducing alcohol-related harm in the Aboriginal and broader community. This should include:*

    a. *appropriate longitudinal datasets able to be analysed at a regional level containing agreed minimum data on (i) sales / consumption and (ii) alcohol-related harms with appropriate identification of Aboriginality; and*

    b. *either:*

        i. *conducting the 1994 special survey of alcohol and drug use among Aboriginal and Torres Strait Islander people on a regular basis; or*

        ii. *upgrading the relevant sections on alcohol consumption in the regular National Aboriginal and Torres Strait Islander Social Survey and the National Aboriginal and Torres Strait Health Survey.*

2. *Addressing the harmful use of alcohol in Aboriginal communities must be situated as part of a broader strategy to tackle the full range of the social determinants of ill-health including poverty, social exclusion and racism, and deficits in early childhood development, education and, employment.*

3. *Access to evidence-based early childhood development programs is a key strategy for the primary prevention of alcohol-related harms in the future and for breaking the intergenerational cycle of the harmful use of alcohol in the Aboriginal community. Sustained investment in such programs should be a foundation for addressing alcohol related harm in the Aboriginal community.*

4. *Given the association of the experience of racism with increased alcohol consumption, no program or policy designed to address the harmful use of alcohol in Aboriginal communities should be founded upon discrimination on the basis of race.*

5. *While Foetal Alcohol Syndrome (FAS) and Foetal Alcohol Spectrum Disorder (FASD) are not the only cause of alcohol-related cognitive impairment in the Aboriginal community, they should be recognised as disabilities and treatment and support offered accordingly.*

6. *More information is needed about alcohol-related cognitive impairment in Australia, including in the Aboriginal community. Research should be supported which aims to identify patterns of prevalence and incidence of these harms, whether caused in pregnancy through FAS/FASD, through poor parenting and neglect in early childhood, directly through the health effects of alcohol consumption, or otherwise indirectly through violence, accidents and injury.*

7. *The Aboriginal alcohol treatment system needs to be resourced to assess (in collaboration with the client, their carers and family as necessary) those with cognitive impairment to determine whether their needs are best met through alcohol treatment or disability services.*

8. *Criminalising any part of the treatment pathway is likely to have negative consequences. Criminal sanctions against women who drink while pregnant are unlikely to be effective, may actually be detrimental, and should be avoided.*

9. *There are a number of treatment and support options which have evidence of effectiveness. These should be the starting point for any public policy aimed at demand reduction and harm reduction in relation to alcohol consumption in Australia, including in the Aboriginal context. They include:*

    a. *well-resourced interventions from the primary health care setting delivered by trained staff, including brief interventions and community based treatment that includes medical treatment, evidence-based pyschological care, and social and cultural support.*

    b. *residential and community-based treatment programs which include social and cultural support for clients during and after treatment and adequate investment in infrastructure and training;*

    c. *bans on alcohol advertising and promotion; and*

    d. *Sobering Up Shelters and Night Patrols.*

10. *Ensuring the maximum effectiveness of treatment and support options for Aboriginal communities requires at least:*

    a. *addressing cultural safety;*

    b. *ensuring that a full range of treatment and support options is available for Aboriginal communities;*

    c. *investing in a Continuous Quality Improvement (CQI) approach; and*

    d. *providing adequate and secure resourcing (seven-year block funding) to support maximum service effectiveness.*

11. *Government should support the development of an "Aboriginal and Torres Strait Islander core functions of alcohol treatment framework", against which a regional-level needs-analysis is to be carried out to identify key service gaps. This will require a resource and investment fund to address those gaps identified.*

12. *Government should avoid investment in approaches for which there is no reasonable prospect of effectiveness or which discriminate against or further marginalise Aboriginal people. This includes:*

    a. *mandatory treatment linked to criminal sanctions; and*

    b. *education and persuasion strategies, including school-based education and media campaigns.*

13. *That the Federal Government, recognising that raising the price of alcohol is the most cost-effective way to reduce alcohol-related harm across Australia including in the Aboriginal and Torres Strait Islander community, introduces a national floor price for alcohol to be set at the retail price of a standard drink of full-strength beer (currently around $1.30). This should be combined with a volumetric tax to a national fund for the reduction of alcohol related harm, with access to this fund by jurisdictions to be determined on the basis of their actions to reduce alcohol-related harm across the whole population, including for the Aboriginal and Torres Strait Islander community.*

14. *That the Commonwealth encourage all jurisdictions to take action on reducing the availability of alcohol as a key measure to reduce alcohol related harm, including in the Aboriginal community. Minimum interventions would include:*

    a. *one take-away free day per week linked to Centrelink payments as a way to reduce total take away trading hours; and*

    b. *reduced and modified late night trading in accordance with the successful Newcastle trials.*

15. *That the Northern Territory Government reintroduce the effective photo ID scanning at the point of sale coupled with a Banned Drinkers Register, with resources for evaluation to be included from the start.*

16. *In addition to the population-wide supply reduction measures above, there may be additional measures, with community support, implemented through local Alcohol Management Plans for specific Aboriginal communities or living areas.*

17. *That the Federal Government support the adoption of consistent legislation across Australia that:*

    a. *establishes a licensees' liability for harm or damage resulting from irresponsible serving practices (especially serving alcohol to under-age or intoxicated people); and*

    b. *ensures greater enforcement of and penalties for irresponsible serving practices.*

18. *That all Australian jurisdictions report annually to the Commonwealth on alcohol consumption, alcohol related harms (including where appropriate by Aboriginality) and actions taken to address those harms (including actions taken to reduce supply and availability). Access to the national fund for the reduction of alcohol-related harm (see Recommendation 13) for each jurisdiction to be dependent on implementation of adequate reporting (see Recommendation 1) and evidence-based action taken to reduce alcohol-related harm for the whole population including the Aboriginal community.*

Response to the Inquiry's Terms of reference

1. Patterns of supply of, and demand for, alcohol in different Aboriginal and Torres Strait Islander communities, age groups and genders

Patterns of consumption

The data about consumption of alcohol in Aboriginal Australia is only broadly reliable and almost certainly underestimates the true scale of the problem. Key points include[4]:

- *Episodic heavy drinking (so-called 'binge drinking') is a particular problem for the Aboriginal community.* One in six (17%) Indigenous adults report long-term high risk alcohol consumption, which is similar to the non-Indigenous rate. However, episodic heavy drinking, which carries additional immediate short-term health risks, is estimated to be twice as prevalent amongst Indigenous people as amongst non-Indigenous people.

- *Australia's levels of alcohol consumption have been increasing, but at a faster rate in the Aboriginal community. C*onsumption rates are increasing for both Aboriginal and non-Indigenous Australians, and the gap in rates is widening: between 1994 and 2008 the prevalence of alcohol use among non-Indigenous Australians increased by 14%, but amongst Indigenous Australians by 24%[5].

- *Many Aboriginal people who abstain from alcohol are ex-drinkers who have given up alcohol.* While a higher proportion of Aboriginal Australians do not drink alcohol compared to non-Indigenous Australians, this includes many Aboriginal people who have been drinkers who have now given up alcohol, often because of serious health or other issues associated with their drinking. The proportion of those who never drank alcohol is similar for Aboriginal and non-Indigenous people.

- *There are significant regional variations in alcohol consumption patterns.* While direct data on alcohol consumption at a regional level is only inconsistently available, other data sources such as death rates and hospitalisations for alcohol-related conditions suggest there are significant regional variations in alcohol consumption patterns.

Data collection

Reliable, long-term datasets that can monitor patterns of alcohol consumption and harm in the Aboriginal community at a regional level are an essential tool for targeting effort

[4] The following points are drawn from Australian Health Ministers Advisory Council (2012). Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report. AHMAC. Canberra. Pp105-106; Gray D, Stearne A, et al. (2010). Indigenous-specific alcohol and other drug interventions. Australian National Council on Drugs research paper no. 20. Canberra, Australian National Council on Drugs. Pp15-21; Gray D and Wilkes E (2010). Reducing alcohol and other drug related harm. Resource sheet no. 3 produced for the Closing the Gap Clearinghouse. Canberra, AIHW (Australian Institute of Health and Welfare) / Australian Institute of Family Studies.

[5] The most recent data (see Australian Bureau of Statistics (ABS). (2014). "Apparent Consumption of Alcohol, Australia, 2012-13.") suggests that overall alcohol consumption may now be levelling off or even declining. However, as these are figures for Australia as a whole, no conclusion can be drawn from them about Aboriginal consumption patterns.

and monitoring the effect of programs and policies. Unfortunately, routine, consistent reporting on alcohol consumption patterns have not been the rule in Australia.

Sales data – which provide a proxy measure of consumption – are collected in four jurisdictions (the Northern Territory, Queensland, the Australian Capital Territory and Western Australia). They are an invaluable source, despite their inherent limitation in not being able to be disaggregated to provide data on consumption by population sub-groups, for example Aboriginal Australians.

Surveys are an important supplement to sales data but have limitations: they are infrequent, underestimate consumption, and unless specifically designed with this in mind risk, do not capture sufficient information from Aboriginal people to be useful. The most comprehensive survey of alcohol and other drug consumption among Aboriginal and Torres Strait Islander people was conducted in 1994[6] and has not been repeated. Questions on alcohol consumption in the National Aboriginal and Torres Strait Islander Social Survey (NATSISS) and the National Aboriginal and Torres Strait Health Survey (NATSIHS) are methodologically flawed and the results produced inadequate. Either the 1994 survey should be repeated on a regular basis or the questions on alcohol consumption in the NATSISS and the NATSIHS need to be upgraded to follow the methodology for such questions established by the World Health Organisation.

Better data collection is thus an essential tool to measure the effectiveness of interventions (see **Appendix 2** for a suggested minimum dataset).

Recommendations

1. ***That Government invest in the data infrastructure that would allow for targeting of effort at areas of most need as well as ongoing, routine monitoring of the effect of programs and policies aimed at reducing alcohol-related harm in the Aboriginal and broader community. This should include:***
    a. ***appropriate longitudinal datasets able to be analysed at a regional level containing agreed minimum datasets on (i) sales / consumption and (ii) alcohol-related harms with appropriate identification of Aboriginality; and***
    b. ***either:***
        i. ***conducting the 1994 special survey of alcohol and drug use among Aboriginal and Torres Strait Islander people on a regular basis; or***
        ii. ***upgrading the relevant sections on alcohol consumption in the regular National Aboriginal and Torres Strait Islander Social Survey and the National Aboriginal and Torres Strait Health Survey.***

[6] Commonwealth Department of Human Services and Health (1996). National Drug Strategy Household Survey: Urban Aboriginal and Torres Strait Islander Supplement 1994. Canberra, Australian Government Publishing Service.

2. The social and economic determinants of harmful alcohol use across Aboriginal and Torres Strait Islander communities

Explanations of illness based on exposure to individual risk-factors such as smoking, alcohol misuse, or being overweight have been the basis for many improvements in the health of populations, especially when it comes to chronic disease.

However, these risk factors are not evenly distributed in society. The evidence is now incontrovertible that beneath these individual risk factors lie deeper causative factors: the social determinants of health. A person's social and economic position in society, their early life, exposure to stress, educational attainment, access or lack of it to employment, access to health services, their exclusion from participation in society, and their access to food and transport: all exert a powerful influence on a person's health and their exposure to risk.

It has been extensively documented across the world alcohol that dependence is closely related to social and economic disadvantage (see **Figure 1**)[7].

It is in this context that Aboriginal and Torres Strait Islander alcohol consumption must be placed: higher levels of alcohol consumption and thus higher levels of alcohol-related harm is not a problem unique to Australia's First Peoples, but a pattern observed globally amongst poor and socially marginalised populations.

Accordingly, the harmful use of alcohol cannot be addressed in isolation from broader efforts to tackle disadvantage across the whole range of the social determinants of health in Aboriginal and Torres Strait Islander communities.

A number of the social determinants of health are of particular relevance to alcohol use in the Australian Indigenous context.

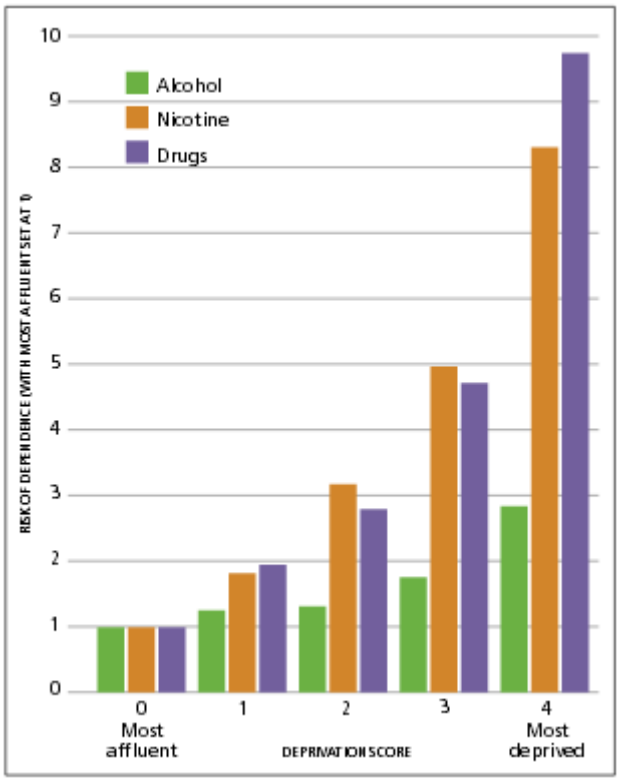

Figure 1: Socioeconomic deprivation and risk of dependence on alcohol, nicotine and drugs, Great Britain, 1993

Early childhood development

Early childhood is a key intervention point for the primary prevention of alcohol related harm. The experience of the child, including in the months before birth, is critical for building a platform for a healthy life and deficits at this time are powerfully linked to

[7] Wilkinson R and Marmot M, Eds. (2003). The Social Determinants of Health The Solid Facts, World Health Organization.

disadvantage and ill health later in life[8] including to an increased risk of unhealthy levels of alcohol consumption.

This suggests the existence of a dangerous 'feed-back loop' relating to harmful alcohol consumption amongst disadvantaged populations: harmful alcohol use by parents and carers is known to be associated with a lack of responsive care and stimulation in early childhood; children brought up in these environments are more likely to lack self-control and self-regulation as they grow to adulthood themselves, and will therefore be more susceptible to addictions, including to alcohol; they will be, in turn, less likely to provide their own children with the care and nurture they need. This cycle is reinforced by emerging evidence that every generation born to parents with an alcohol addiction is more genetically predisposed to an addiction[9].

Such an intergenerational feedback loop – mirroring and adding to the intergenerational exclusion and disadvantage suffered by many Aboriginal families in other areas of their lives – while not yet proven, is entirely consistent with the evidence, as well as with the experience of many Aboriginal community members and organisations.

Fortunately, there is very strong evidence on how to break such intergenerational cycles of disadvantage though the use of early childhood development programs. Sustained investment in evidence-based early childhood programs can offset early childhood disadvantage, and are a 'best buy' in terms of addressing health and social inequity and breaking the cycle of harmful alcohol use in the long-term. See **Appendix 3** for more detail.

Racism and the 'control factor'

The experience of racism is associated with increased alcohol consumption. Indigenous Australians commonly experience high levels of racism, from relatively minor incidents such as being called racist names, through verbal abuse, to serious assault[10]. The literature demonstrates a strong association between racism and poor mental health and alcohol misuse[11]. As well as addressing racism directly, this also points strongly to the need for interventions to tackle alcohol in Aboriginal communities to be non-racially discriminatory.

Lack of control over one's life is an important driver of ill-health and is associated with higher consumption of alcohol. There is good evidence based on biomedicine that the consistent exposure to stress associated with lack of ability to exercise control in life can

[8] Stanley F, Richardson S, et al. (2005). Children of the Lucky Country? How Australian society has turned its back on children and why children matter. Sydney, Macmillan.

[9] Nieratschker V, Batra A, et al. (2013). "Genetics and epigenetics of alcohol dependence." Journal of Molecular Psychiatry **1**: 11.

[10] Ferdinand A, Paradies Y, et al. (2012). Mental Health Impacts of Racial Discrimination in Victorian Aboriginal Communities: The Localities Embracing and Accepting Diversity (LEAD) Experiences of Racism Survey. Melbourne, The Lowitja Institute.

[11] Zubrick S, Silburn S, et al. (2005). The Western Australian Aboriginal Child Health Survey: The social and emotional wellbeing of Aboriginal children and young people. Perth, Curtin University of Technology and Telethon Institute for Child Health Research.; also see Paradies Y (2006). "A Systematic Review of Empirical Research on Self-reported Racism and Health." International Journal of Epidemiology **35**(4): 888-901.

profoundly undermine physical and mental health[12] Policy makers will thus need to be alert to the importance of empowerment approaches in addressing alcohol in the Aboriginal community.

Recommendations

2. ***Addressing the harmful use of alcohol in Aboriginal communities must be situated as part of a broader strategy to tackle the full range of the social determinants of ill-health including poverty, social exclusion and racism, and deficits in early childhood development, education and, employment.***

3. ***Access to evidence-based early childhood development programs is a key strategy for the primary prevention of alcohol-related harms in the future and for breaking the intergenerational cycle of the harmful use of alcohol in the Aboriginal community. Sustained investment in such programs should be a foundation for addressing alcohol related harm in the Aboriginal community.***

4. ***Given the association of the experience of racism with increased alcohol consumption, no program or policy designed to address the harmful use of alcohol in Aboriginal communities should be founded upon discrimination on the basis of race.***

3. Trends and prevalence of alcohol related harm, including alcohol-fuelled violence and impacts on newborns e.g. Foetal Alcohol Syndrome and Foetal Alcohol Spectrum Disorders

The harmful use of alcohol is a major health and social problem for Australia, estimated to cost the nation more than $15 billion each year in increased crime, health care, loss of productivity, and road accidents[13]. These costs are not distributed evenly across Australia. Such costs in the Northern Territory, for example, are estimated at $632 million, or well over four times the national average per adult[14].

Harmful alcohol consumption is associated with a wide range of health problems for the drinker (such as liver disease, high blood pressure, stroke, and some cancers), as well as more short-term health threats to both the drinker and those around them (including injuries from traffic accidents, assault and family violence, and self-harm). It also contributes to other social problems such as crime, violent anti-social behaviour,

[12] Syme S (2004). "Social determinants of health: The community as an empowered partner." Preventing Chronic Disease: Public Health Research, Practice, and Policy **1**(1): 1–5.; Tsey K, Whiteside M, et al. (2003). "Social determinants of health, the 'control factor' and the Family Wellbeing Empowerment Program." Australasian Psychiatry **11**(3 supp 1): 34–39.

[13] Collins D and L. H (2008). The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05. Canberra, Department of Health and Ageing.

[14] Whetton S, Hancock J, et al. (2009). Harms from and Costs of Alcohol Consumption in the Northern Territory, South Australian Centre for Economic Studies.

increased levels of incarceration, family breakdown, unemployment and impoverishment[15].

Drinking during pregnancy can lead to a number of harms to the unborn child (collectively referred to as Foetal Alcohol Spectrum Disorder), including low birth weight, heart defects, behavioural problems and intellectual disabilities. There is also a high co-occurrence of harmful alcohol consumption and mental health problems.

Patterns of alcohol-related harm

It against this background of the serious health and social problems caused by alcohol throughout Australian society that the harmful use of alcohol in Indigenous communities should be placed. Key points include:

- *Alcohol is associated with 5% of the burden of disease and injury borne by Indigenous Australians*, in particular through homicide, violence and suicide. For Aboriginal men in particular it is strongly associated with four of the top ten causes of premature mortality: suicide (9.1% of potential years of life lost), road traffic accidents (6.2%), alcohol dependence and harmful use (3.9%), and homicide and violence (2.8%)[16].

- *Indigenous Australians are hospitalised at much greater rates than non-Indigenous Australians for conditions to which alcohol makes a significant contribution*. For Indigenous males, the rates are between 1.2 and 6.2 times those of non-Indigenous males; for Indigenous females at rates between 1.3 and 33.0 times greater (the latter figure being for assault injuries) (see **Figure 2**). Once again, there are large regional variations – for example, Aboriginal women in the NT are 80 times more likely to be hospitalised as a result of assault[17].

Condition	Males	Females
Mental disorders due to psychoactive substance use (F10–F19)	4.5	3.3
Cerebrovascular disease (I60–I69)	2.4	2.5
Hypertensive disease (I10–I15)	4.2	5.6
Transport accidents (V01–V99)	1.2	1.3
Intentional self-harm (X60–X84)	2.9	1.9
Assault (X85–Y09)	6.2	33.0

Figure 2: Indigenous to non-Indigenous hospitalisation rate ratios for conditions in which alcohol is a significant contributing factor, 2005-06[18]

[15] National Preventative Health Taskforce 2008, *Preventing alcohol-related harm in Australia: a window of opportunity*. Technical Report No 3, prepared for the National Preventative Health Taskforce by the Alcohol Working Group, Commonwealth of Australia.
Available: http://www.health.gov.au/internet/preventativehealth/publishing.nsf/Content/tech-alcohol

[16] Vos T, Barker B, Stanley L, Lopez AD. 2007. *The burden of disease and injury in Aboriginal and Torres Strait Islander peoples*. Brisbane: School of Population Health, The University of Queensland.

[17] AIHW, National Hospital Morbidity Database, 2011/12

[18] Gray D, Stearne A, Wilson M & Doyle M 2010. *Indigenous-specific alcohol and other drug interventions.* Australian National Council on Drugs research paper no. 20. Canberra: Australian National Council on Drugs

- *Alcohol related mortality for non-Indigenous Australians is 5 to 19 times greater than among non-Indigenous people*[19]*.* The rates of alcohol related deaths of Aboriginal people vary widely across Australia, ranging from a low of 0.8 per 10,000 Indigenous residents in Tasmania to a high of 14.6 in Central Australia (see **Figure 3**).

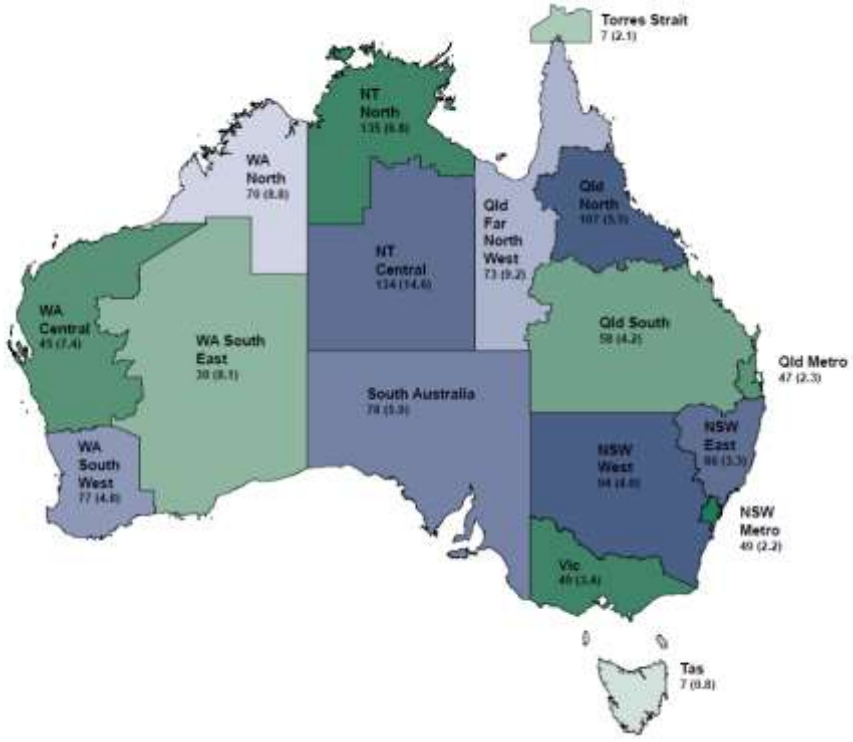

Figure 3: Estimated numbers and crude population rates (per 10 000 Indigenous residents) of alcohol-attributable deaths by (former) ATSIC zones, 2000–04[20]

- *Foetal Alcohol Spectrum Disorders (FASD) are a particular cause for concern in the Indigenous community*, being estimated at between 3 and 7 times as common as in the non-Indigenous population[21].

- *There is a high co-occurrence of harmful alcohol use with mental health and behavioural problems in the Aboriginal community*, with Indigenous Australians more than twice as likely as non-Indigenous Australians to report psychological distress and more likely to drink at harmful levels[22].

[19] Steering Committee for the Review of Government Service Provision (SCRGSP) (2009). Overcoming Indigenous disadvantage: key indicators 2009. Canberra, Commonwealth of Australia.

[20] Chikritzhs T, Pascal R, et al. (2007). Trends in alcohol-attributable deaths among Indigenous Australians, 1998–2004. National Alcohol Indicators, Bulletin no. 11. Perth, Curtin University of Technology / National Drug Research Institute

[21] Gray D, Saggers S, et al. (2008). Substance misuse. Aboriginal Primary Health Care: An Evidence Based Approach R. M. S. Couzos. Melbourne, Oxford University Press.

[22] Gray D and Wilkes E (2010). Reducing alcohol and other drug related harm. Resource sheet no. 3 produced for the Closing the Gap Clearinghouse. Canberra, AIHW (Australian Institute of Health and Welfare) / Australian Institute of Family Studies.

Data collection

As with levels of alcohol consumption, regular and routine reporting of alcohol related harms on a regional basis is a key tool for targeting programs and policies to areas of need and evaluating their effect. Unfortunately, as with consumption data, this information is not consistently available for governments, researchers, health services and policy makers. Key data to be collected on harms is detailed in **Appendix 2.**

4. The implications of Foetal Alcohol Syndrome and Foetal Alcohol Spectrum Disorders being declared disabilities

Heavy drinking during pregnancy has long been recognised as the leading non-genetic cause of intellectual disability in the broader community. However, until recently there has been a lack of more specific data in the Australian or Aboriginal context. Now however, some initial estimates show that 15.6% of avoidable intellectual disability in Aboriginal children is attributable to maternal alcohol use – twelve times the rate for non-Aboriginal children[23]. More research is needed, but the following points can be made:

- *FAS and FASD are not the only cause of alcohol-related cognitive impairment in the Indigenous community* – others include the direct toxic effects of harmful alcohol consumption, as well as indirect effects such as alcohol-related violence, accidents, poor nutrition and especially effects on early childhood development (see next point). The real incidence of alcohol-related intellectual or cognitive disability in the Aboriginal and Torres Strait Islander community is therefore certain to be considerably higher than that caused by FAS / FASD alone.

- *Harmful alcohol consumption in the family can have life-long negative effects on a child, irrespective of the presence of diagnosed FAS / FASD.* Lack of parental care and nurture after birth can have profound and permanent effects on brain chemistry and development[24]. An overly narrow emphasis on the damage done to development in utero – for example, through concentrating solely on the diagnosis of FAS/FASD – will not address those serious developmental deficits incurred after birth. As recommended above (and see **Appendix 3**), evidence-based early childhood programs are the most effective way of addressing developmental issues.

- *Those whose harmful alcohol use has left them disabled or cognitively impaired require specialised disability support*. The alcohol treatment system is not appropriate for people whose cognitive impairment is such that they are unlikely to benefit. An important part of the treatment stream is therefore the ability to assess potential clients for cognitive impairment, and to determine if they require alcohol treatment or disability services. Such assessments involving family and carers are

[23] O'Leary C, Leonard H, et al. (2013). "Intellectual disability: population-based estimates of the proportion attributable to maternal alcohol use disorder during pregnancy." Developmental Medicine & Child Neurology **55**(3): 271-277.

[24] See section on early child hood development above and in **Appendix 3**, and also Mustard J F (2006). Early Child Development and Experience-based Brain Development: The Scientific Underpinnings of the Importance of Early Child Development in a Globalized World. The World Bank Symposium on Early Child Development.

complex, time-consuming and require trained and skilled staff, with consequent cost implications for the treatment system.

- *There is no evidence to support criminalising women who drink during pregnancy.* Over a third of women who report drink at risky levels (especially 'binge drinking') continue to do so into pregnancy[25]. While this poses a threat to the health of the unborn child, criminal sanctions applied to women who drink during pregnancy may have negative consequences, for example through deterring them from seeking antenatal care or assistance with their drinking. Instead, the evidence suggests that approaches focusing on reducing alcohol consumption *before* pregnancy, and which are non-stigmatising and broad-based (focusing on wellbeing, nutrition, and enhancing the woman's living status) are most effective[26].

Recommendations

5. ***While Foetal Alcohol Syndrome (FAS) and Foetal Alcohol Spectrum Disorder (FASD) are not the only cause of alcohol-related cognitive impairment in the Aboriginal community, they should be recognised as disabilities and treatment and support offered accordingly.***

6. ***More information is needed about alcohol-related cognitive impairment in Australia, including in the Aboriginal community. Research should be supported which aims to identify patterns of prevalence and incidence of these harms, whether caused in pregnancy through FAS/FASD, through poor parenting and neglect in early childhood , directly through the health effects of alcohol consumption, or otherwise indirectly through violence, accidents and injury.***

7. ***The Aboriginal alcohol treatment system needs to be resourced to assess (in collaboration with the client, their carers and family as necessary) those with cognitive impairment to determine whether their needs are best met through alcohol treatment or disability services.***

8. ***Criminalising any part of the treatment pathway is likely to have negative consequences. Criminal sanctions against women who drink while pregnant are unlikely to be effective, may actually be detrimental, and should be avoided.***

[25] Anderson A E, Hure A J, et al. (2014). "Risky Drinking Patterns Are Being Continued into Pregnancy: A Prospective Cohort Study." PLoS ONE **9(7)**(7).

[26] Anderson et al 2014 ibid.; Burd L, Cotsonas-Hassler T, et al. (2003). "Recognition and management of fetal alcohol syndrome." Neurotoxicology and Teratology **25**: 681–688.

5. Best practice treatments and support for minimising alcohol misuse and alcohol-related harm

Australia's National Drug Strategy[27] establishes three agreed 'pillars' for tackling alcohol-related harm. These are demand reduction, supply reduction and harm reduction. Under this term of reference, we will consider the first and third of these approaches.

Demand reduction focuses on preventing uptake, delaying use, reducing misuse, and supporting people in recovery from alcohol use. In the Aboriginal context this commonly includes interventions from primary health care (Aboriginal community controlled health services and/or general practice) and alcohol treatment programs (residential or community-based). Demand reduction also includes restrictions on advertising and promotion of alcohol.

Harm reduction aims to keep people from harming themselves or others after they have been drinking and commonly includes Sobering Up Shelters and Night Patrols.

Best practice treatments and supports for individuals

It is a common view that alcohol treatment 'doesn't work.' However, this view is not supported by the international literature that overall demonstrates that treatment can be effective[28]. However, it is important to note that 'effectiveness' should not just be measured by the number of clients who abstain completely from alcohol after treatment – reduced alcohol consumption and improved social functioning (including within families) are also important measures of success.

- *Interventions from the primary health care setting* are known to be effective in other populations[29], and there is some evidence of effectiveness in the Aboriginal context[30]. Well-structured interventions for Aboriginal clients should provide three inter-related streams of care:
    - *the medical stream* uses medicines like Acamprosate, Naltrexone and other pharmacotherapies to address the balance of chemicals in the brain and increase the effectiveness of treatment;
    - *the psychological stream* includes structured therapies such as Cognitive Behaviour Therapy (CBT). These approaches are more than counselling, and require an ongoing relationship with psychologist or skilled therapist over many sessions;

[27] Ministerial Council on Drug Strategy (MCDS) (2011). National Drug Strategy. Canberra, Australian Government.

[28] Gray D and Wilkes E (2010). Reducing alcohol and other drug related harm. Resource sheet no. 3 produced for the Closing the Gap Clearinghouse. Canberra, AIHW (Australian Institute of Health and Welfare) / Australian Institute of Family Studies.

[29] Babor et al. 2010 Babor T, Caetano R, et al. (2010). Alcohol: no ordinary commodity. Oxford, Oxford University Press.

[30] Ministerial Council on Drug Strategy (MCDS) (2006). National Drug Strategy: Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009. Canberra, Australian Government.

- *the social and cultural support stream* helps the client change the social context which is part of the reason that addiction occurs and is maintained. This may include assistance with education and training, finding employment, accommodation, Centrelink, strengthening relationships with kin and country, enhanced cultural identity, group work and many other services.

To be effective in the face of the high acute care demand primary health care services face, they require specific resourcing to deliver such interventions which goes beyond the provision of materials (e.g. to support brief interventions) to include training for staff and provision of in-service public health expertise to maintain a focus on non-acute services such as those related to reduction in alcohol related harm.

- *Residential and community-based treatment programs*, most of them under local Aboriginal community control and run on an abstinence model, are amongst the most common alcohol interventions for Aboriginal communities. Few have been evaluated so it is therefore not known what percentage of clients who undergo treatment achieve either abstinence or reduced alcohol consumption after treatment, although mainstream literature suggests that in the best programs this figure should be around 20%[31]. From this literature, it appears that residential treatment may be appropriate for many Aboriginal drinkers given their health status, and social and economic environment[32]. In all cases, social and cultural support for clients during and after treatment (such as assistance with accommodation, education, training and employment) is likely to increase effectiveness[33].

- *Bans on alcohol advertising and promotion.* Exposure to marketing by the alcohol industry leads to young people beginning to drink earlier in their lives, and to drinkers consuming more alcohol[34]. Incomplete bans on alcohol advertising and promotion maybe ineffective as the industry shifts its effort to non-restricted forms of promotion. However, a major international study reviewing the evidence concludes that 'extensive restriction of marketing would have an impact'[35].

- *Sobering Up Shelters and Night Patrols* aim to prevent harm to people who have been drinking (including the risk of arrest and incarceration) and those around them (including through violence and accidents). While there are few evaluations of such programs, they provide opportunities for other treatment (e.g. brief interventions) and may encourage further community-based action to tackle alcohol abuse[36].

[31] Anton RF, Moak DH, et al. (1999). "Naltrexone and cognitive behavioural therapy for the treatment of outpatient alcoholics: results of a placebo controlled trial." American Journal of Psychiatry **156** 1758 - 1764.

[32] Babor T, Caetano R, et al. (2010). Alcohol: no ordinary commodity. Oxford, Oxford University Press.

[33] Sarrazin M V and Hall J A (2004). "Impact of Iowa case management on provisions of social support for substance abuse clients." Care Management Journals **5**: 3-11.; McLellan A T, Hagan T A, et al. (1998). "Supplemental social services improve outcomes in public addiction treatment." Addiction **93**: 1489-1499.

[34] Australian Medical Association (2012). Alcohol marketing and young people : time for a new policy agenda.

[35] Babor T, Caetano R, et al. (2010). Alcohol: no ordinary commodity. Oxford, Oxford University Press.

[36] Gray D and Wilkes E (2010). Reducing alcohol and other drug related harm. Resource sheet no. 3 produced for the Closing the Gap Clearinghouse. Canberra, AIHW (Australian Institute of Health and Welfare) / Australian Institute of Family Studies.

Conditions for success

There are a number of conditions for the successful implementation of treatment to reduce alcohol-related harm in Aboriginal communities. These include:

- *Addressing issues of cultural safety.* Interventions that are adapted to the particular cultural needs of the community they serve are significantly more effective than those which are not[37]. Developing genuine partnerships with Aboriginal communities to deliver treatment and support services, and respect and support for community controlled services are essential pathways to developing culturally safe services[38].

- *Providing a full range of treatment and support options.* Just as in any community, not all interventions are appropriate or relevant for all those whose use of alcohol puts them and those around them at risk of harm. While some may benefit from pharmacotherapy to address dependency, for others brief interventions or motivational interviewing may be required, and for others again residential treatment. The Aboriginal community in a particular region needs access to the full range of services. The development of a set of 'core services' for alcohol treatment, followed by a region-by-region needs-analysis to document key gaps, and a resource and investment program to meet those needs should be a priority.

- *Investing in a Continuous Quality Improvement (CQI) approach.* Many Aboriginal alcohol treatment services (especially those outside the primary health care sector) face continual activity or outcome evaluation demands from funding organisations. In many cases client numbers are too small to provide statistically significant results, and the services (many of which are substantially and historically underfunded) face a large reporting 'overburden'. The focus should move towards a CQI approach based on appropriate indicators and IT systems which seeks to identify areas for improvement (e.g. staff training, infrastructure[39]) and invests in addressing such barriers to effective service provision. An effective CQI approach should also include resources for monitoring and reporting on key performance indicators such as the level of alcohol consumption 12 months after treatment.

- *Providing adequate and secure resourcing to allow for actions to be refined and developed over time***.** Developing effective programs and partnerships in complex cross-cultural environments often marked by significant under-resourcing and fragile physical and organisational infrastructure takes time. Short-term funding can undermine community commitment, weaken consistent implementation of quality treatment, and destabilise services through loss of experienced staff and continual

[37] Smith T B, Rodríguez M D, et al. (2011). "Culture." Journal of Clinical Psychology **67**: 166-175.

[38] Taylor K, Thompson S, et al. (2010). "Delivering culturally appropriate residential rehabilitation for urban Indigenous Australians: a review of the challenges and opportunities." Australian and New Zealand Journal of Public Health **34** (S1): S36-S40.

[39] Gray D, Saggers S, et al. (2000). "What works?: a review of evaluated alcohol misuse interventions among Aboriginal Australians." Addiction **95**(1): 11-22.; Ministerial Council on Drug Strategy (MCDS) (2006). National Drug Strategy: Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009. Canberra, Australian Government.

diversion of resources into cycles of recruitment and training[40]. Seven year funding blocks should be the standard requirement for effective implementation.

Harm reduction approaches with little evidence of success

The best practice treatments and supports listed above, combined with the conditions for success, provide an evidence-based pathway to effectively reducing the harm done by alcohol in Aboriginal communities. Notwithstanding the need for well-structured, rigorously evaluated innovation under some circumstances, there are some approaches which have little evidence of success. These include:

- *mandatory treatment linked to criminal sanctions has very little evidence of success*. It appears to work least well for young people, can add to the disadvantage experienced by marginalised groups, and may displace voluntary clients from limited treatment spaces[41]. Note that this does not include short-term mandatory commitment for the purpose of assessment and care of people who may be at risk of harming themselves or others; and

- *education and persuasion strategies, including school-based education and media campaigns, have at best a minimal, short-term effect* and as a substantial review of the international literature notes, 'cannot be relied upon as an effective approach'[42].

[40] See for example d'Abbs P, Togni S, et al. (2013). "The Grog Mob: lessons from an evaluation of a multidisciplinary alcohol intervention for Aboriginal clients." Australian and New Zealand Journal of Public Health **37**(5): 450-456.

[41] Pritchard E, Mugavin J, et al. (2007). Compulsory treatment in Australia: a discussion paper on the compulsory treatment of individuals dependent on alcohol and/or other drugs. A report prepared for ANCD by Turning Point Alcohol and Drug Centre, Australian National Council on Drugs.

[42] Babor T, Caetano R, et al. (2010). Alcohol: no ordinary commodity. Oxford, Oxford University Press.

Recommendations

9. ***There are a number of treatment and support options which have evidence of effectiveness. These should be the starting point for any public policy aimed at demand reduction and harm reduction in relation to alcohol consumption in Australia, including in the Aboriginal context. They include:***
    a. ***well-resourced interventions from the primary health care setting, delivered by trained staff, including brief interventions and community based treatment that includes medical treatment, evidence-based pyschological care, and social and cultural support.***
    b. ***residential and community-based treatment programs which include social and cultural support for clients during and after treatment and adequate investment in infrastructure and training;***
    c. ***bans on alcohol advertising and promotion; and***
    d. ***Sobering Up Shelters and Night Patrols.***
10. ***Ensuring the maximum effectiveness of treatment and support options for Aboriginal communities requires at least:***
    a. ***addressing cultural safety;***
    b. ***ensuring that a full range of treatment and support options is available for Aboriginal communities;***
    c. ***investing in a Continuous Quality Improvement (CQI) approach; and***
    d. ***providing adequate and secure resourcing (seven-year block funding) to support maximum service effectiveness.***
11. ***Government should support the development of an "Aboriginal core functions of alcohol treatment framework", against which a regional-level needs-analysis is to be carried out to identify key service gaps. This will require a resource and investment fund to address those gaps identified.***
12. ***Government should avoid investment in approaches for which there is no reasonable prospect of effectiveness or which discriminate against or further marginalise Aboriginal people. This includes:***
    a. ***mandatory treatment linked to criminal sanctions; and***
    b. ***education and persuasion strategies, including school-based education and media campaigns.***

6. Best practice strategies to minimise alcohol misuse & alcohol-related harm

Under this term of reference we examine the 'third 'pillar' of the National Drug Strategy for tackling alcohol related harm in Australia: supply reduction, which is aimed at controlling, managing and regulating the supply of alcohol.

There is extensive evidence from the Aboriginal context, from Australia as a whole, and from numerous international settings that the most effective way to reduce alcohol-related harm is to control and manage the supply of alcohol at a whole-of-population level. There are numerous ways to do this – see **Appendix 4** for a summary. The best evidenced are as follows.

Pricing of alcohol: a 'best buy' for reducing alcohol-related harm

There is incontrovertible evidence that increasing the price of alcohol reduces consumption and alcohol related harm; it is also a highly cost effective intervention[43]. The World Health Organisation (WHO) has concluded:

> *There is indisputable evidence that the price of alcohol matters. If the price of alcohol goes up, alcohol-related harm goes down. Younger drinkers are affected by price, and heavy drinkers are more affected than light drinkers; in fact, if a minimum price were established per gram of alcohol, light drinkers would hardly be affected at all.*[44]

And the Australian National Preventative Health Taskforce has noted:

> *Policies that raise the price of alcoholic beverages are an effective means of reducing alcohol consumption. In addition, studies have shown that price increases reduce problems due to alcohol, including binge drinking and a variety of alcohol-related harms (for example, motor vehicle accidents, cirrhosis mortality and violence).*[45]

The three main policy approaches to supply reduction based on price are:

- a volumetric tax (taxing all or some alcohol products according to their alcohol content);
- a floor price (imposing a lower limit on price per unit of alcohol, preventing the sale and discounting of cheap alcohol); or
- local level agreements to remove cheap alcohol from sale.

[43] Godfrey C (1997). Can tax be used to minimise harm? A health economist's perspective. Alcohol Minimising the Harm What works? Plant M, Single E and Stockwell T. London, Free Association Books**:** 29-42.; Babor T, Caetano R, et al. (2010). Alcohol: no ordinary commodity. Oxford, Oxford University Press.

[44] World Health Organisation (WHO) (2009). Evidence for the effectiveness and cost–effectiveness of interventions to reduce alcohol-related harm Copenhagen, WHO Regional Office for Europe.

[45] National Preventative Health Taskforce (NHPT) (2009). Australia: The Healthiest Country by 2020. National Preventative Health Strategy - the roadmap for action. Canberra, Commonwealth of Australia.

The *volumetric tax approach* has the advantage of generating tax income, a proportion of which could be set aside for treatment programs or other approaches to reduce alcohol-related harms.

The *floor price approach* is more selective, likely to reduce alcohol consumption and related harms most amongst disadvantaged populations and young people, and not significantly affecting the price of relatively more expensive products that the majority of responsible drinkers purchase. There is particularly strong evidence for the effectiveness of a floor-price from Canada, where a 10% increase in the minimum price of alcohol reduced its consumption by over 16%[46].

Local level agreements have been successful in the Aboriginal context[47] however have proved difficult to enforce and to sustain.

Note that volumetric and floor price approaches can be combined and such approaches may utilise the advantages of each, for example as recommended in the Henry Tax Review[48].

One argument advanced to oppose pricing as a method for reducing alcohol related harm in the Aboriginal context is that the demand for alcohol in such communities is not responsive to price and that increased prices will simply lead to people spending more on alcohol with consequently less expenditure on necessities such as food. The data of a commonly cited study[49] to support this view has, however, recently been re-examined, and it is now clear that 'the study does not support the assertion ... that population-based price control measures are likely to be ineffective in reducing consumption in Indigenous communities'[50].

There have also been concerns expressed that minimum pricing would increase profits to the alcohol industry. While this may be the case, it should be noted both that the public good would still justify such a move on the one hand, and that governments may act to increase taxation on any such profits should they so wish[51].

Last, it should be noted that following a High Court ruling in 1997 related to the Northern Territory's 'Living With Alcohol' program (an attempt to introduce a levy on alcohol,

[46] Stockwell T, Auld C M, et al. (2012). "Does minimum pricing reduce alcohol consumption? The experience of a Canadian province." Addiction **107**(5): 912-920.

[47] For example see Gray D, Saggers S, et al. (2000). "Beating the grog: an evaluation of the Tennant Creek liquor licensing restrictions." Aust N Z J Public Health **24**(1): 39-44; Hogan E, Boffa J, et al. (2006). "What price do we pay to prevent alcohol-related harms in Aboriginal communities? The Alice Springs trial of liquor licensing restrictions." Drug and Alcohol Review **25**: 1 - 6.

[48] Henry K, Harmer J, et al. (2010). Australia's future tax system: report to the Treasurer, part two – detailed analysis. Canberra, Commonwealth of Australia, .

[49] Martin D F (1998). The Supply of alcohol in remote Aboriginal communities: potential policy directions from Cape York. Discussion Paper No. 162. Canberra, Centre for Aboriginal Economic Policy Research, Australian National University.

[50] Gray D (2012). "Is the demand for alcohol in Indigenous Australian communities 'price inelastic'?" Drug Alcohol Rev **31**: 818-822.

[51] Stockwell T. (2014). "Minimum alcohol pricing: Canada's accidental public health strategy." The Conversation, from http://theconversation.com/minimum-alcohol-pricing-canadas-accidental-public-health-strategy-25185.

found by the High Court to be a tax and therefore invalid), it has been established that only the Commonwealth Government has the constitutional authority to tax alcohol.

Reducing availability of alcohol

Reduced trading hours, including restrictions on take-away alcohol and late-night on-premise trading. After price, the most important determinant of alcohol consumption is its availability, and in the Aboriginal context in particular, take-away trading hours[52]. Such restrictions, in many different forms, have intermittently been applied in a number of places in the Northern Territory over the last twenty years, the most sustained and effective example being the ban on take-away sales on Thursdays in Tennant Creek which were trialled in 1995 and in effect from 1996 to 2006[53]. Although the effectiveness of the restrictions diminished over time (particularly because new Centrelink provisions meant that from 1999 recipients of benefits would not automatically receive their payments on Thursdays), they were associated a 20% reduction in the consumption of pure alcohol, and consequent declines in alcohol-related harm and alcohol-related offences[54].

There is also good evidence that restrictions on late-night on-premises trading reduces the amount of alcohol related harm, particularly relating to alcohol-related assaults. For example, the Newcastle trial, which involved the imposition of eleven restrictions on fourteen premises, shows that shutting late-night venues earlier reduces harm. In the trial, for example, the number of assaults after dark fell by 29%.[55]

Photo ID at point of sale linked to Banned Drinkers Register

In July 2011 the then Northern Territory Labor Government introduced a package of reforms to address alcohol-related harm: the *Enough is Enough* reforms. A key component of the *Alcohol Reform (Prevention of Alcohol-Related Crime and Substance Misuse) Act* was the introduction of banning notices and a Banned Drinkers Register (BDR). Banning and Treatment order (BAT) notices could be issued to those who were:

- taken into protective custody three times during a three-month period;
- issued with three alcohol-related infringement notices within a 12-month period;
- given two infringement notices for low range drink-driving within the previous three years;

[52] Edwards G (1994). Alcohol Policy and the Public Good. Oxford, Oxford University Press; Babor T, Caetano R, et al. (2010). Alcohol: no ordinary commodity. Oxford, Oxford University Press; Chikritzhs T, Gray D, et al. (2007). Restrictions on the sale and supply of alcohol: evidence and outcomes. Perth, National Drug Research Institute, Curtin University of Technology.

[53] D'Abbs P (2010). Managing alcohol in Tennant Creek, Northern Territory: an evaluation of the Tennant Creek Alcohol Management Plan and related measures to reduce alcohol-related problems. A report prepared for the NT Department of Justice. Darwin, Menzies School of Health Research.

[54] Gray D and Sputore B (1998). The effective and culturally appropriate evaluation of Aboriginal community alcohol intervention projects. Drug trials and tribulations: lessons for Australian policy: Proceedings of an International Symposium. T. Stockwell. Perth, National Centre for Research into Drug Abuse, Curtin University of Technology.

[55] Jones C, Kypri K, et al. (2009). Impact of Restricted Alcohol Availability on Alcohol-Related Violence in Newcastle, NSW. Sydney, New South Wales Bureau of Crime Statistics and Research.

- charged or summonsed in relation to an alcohol-related offence; or
- a defendant of a domestic violence order if the person was believed by police to be affected by alcohol at the time the conduct occurred.

The BAT notices prohibited the individual from the purchase of take-away alcohol[56] and the possession or consumption of alcohol, for a period of three months, or six or twelve months if breached. (A three-month notice could be reduced to one month if the person agreed to undergo voluntary alcohol treatment.)

An essential part of the BDR was the use of electronic identification scanners linked to the Register at all take-away outlets, with ID scanned for every customer, and banned drinkers barred from buying alcohol at the point of sale.

The BDR was in operation from July 2011 to August 2012, when the incoming NT Chief Minister, Terry Mills repealed the legislation, arguing that the measure had failed as problem drinkers were finding ways to purchase alcohol despite being listed on the register[57]. The decision met with a substantial amount of criticism.

To our knowledge, no formal evaluation of the BDR has yet been conducted. However, data recently obtained by PAAC on alcohol-caused admissions to the Alice Springs Hospital, and alcohol-related presentations to that hospital's Emergency Department has now been analysed by the National Drug Research Institute (NDRI). The full analysis is included at **Appendix 5**.

This analysis concludes that '*taken together, these indicators strongly suggest that the BDR was effective in reducing alcohol-related harms to health in Alice Springs'*. In particular, the figures show that the *removal* of the BDR led to a significant *increase* in harms:

- alcohol-caused hospital admissions doubled from around 40 per month to about 80 per month which equates to nearly 500 additional alcohol-caused hospital admissions per year;
- alcohol-related presentations to the Emergency Department also doubled from about 140 per month to about 280 per month.

Some commentary[58] has concluded that the BDR failed because it did not stop the long-term increasing trend in alcohol-related emergency presentations upon its introduction. While we do not yet have access to the full data, PAAC suggests that it is possible that the apparent failure of the BDR to show a *reduction* in presentation in presentations to emergency departments may be because:

[56] And on-premises drinking in two specified Alice Springs bars at each of the Todd Tavern and Gapview Hotels under a voluntary trial with the relevant licensees.

[57] Erikson S (2012). "Enough alcohol…is enough." Alternative Law Journal **37**(4).

[58] See for example http://www.abc.net.au/news/2014-03-19/did-the-northern-territorys-banned-drinker-register-work/5315286

- in its first few months of operation, there were relatively few people on the Banned Drinkers Register as it took some time for the population of heavy drinkers most at risk of harm be placed on the Register; and
- following the Briscoe death in custody in January 2012, Alice Springs police began taking all people on protective custody apprehensions to the emergency department for medical assessment, greatly boosting the numbers of alcohol related presentations (and noting that Alice Springs Hospital contributes the great bulk of such presentations in the Northern Territory).

Given this, it is clear that photo-licensing at the point of sale coupled with a BDR is an important and effective part of an overall, comprehensive approach to address the harm caused by alcohol misuse. It is a population-wide approach that effectively targets the heaviest drinker and applied more widely it is likely to make a major contribution to reducing alcohol caused harms in both the Aboriginal and non-Aboriginal communities.

Police Presence at take-away outlets or 'TBLs' in the Northern Territory

Since May 2012, police have been stationed outside Alice Springs take-away liquor outlets checking customer ID, and similar operations have also been undertaken in Katherine and Tennant Creek. In Alice Springs, police are sometimes stationed at all outlets during all opening hours – for example during a recent six-week block ending in early April 2014, or during major weekend sporting events – and at other times have covered outlets less regularly, as their resources permit. This practice is now known as 'Temporary Beat Locations' or TBLs.

The way in which TBLs work is that police ask customers to show ID as a way of establishing where they plan to consume take-away alcohol that they have bought or which they intend to purchase. It is our understanding that police apply a number of provisions of the *NT Liquor Act*[59] which pertain to restricted areas, restricted premises and regulated places. Alice Springs is a 'dry' town in which drinking in public is prohibited. Town camps are also 'dry,' being alcohol protected areas under Commonwealth law to which the *NT Liquor Act* also applies[60]. Some residences are also 'dry' because tenants have sought and obtained a restricted notice of their own volition. Police may seize liquor if they form a reasonable belief that an offence is being, or is likely to be, committed and may tip out the liquor.

The TBL operations in practice largely affect Aboriginal people as many live in areas such as town camps, remote communities or 'dry' houses where it is an offence to take or consume liquor, or they drink in public places such as river beds and parks. The practice has clearly offended at least some Aboriginal residents of Alice Springs, as was demonstrated at a recent protest[61].

[59] ss 95, 101AB, 101M, 101AN and 101Y

[60] *Stronger Futures in the Northern Territory Act* 2012 (Cth.)

[61] See http://www.ntnews.com.au/news/centralian-advocate/protest-against-racial-profiling-in-alice-springs/story-fnk4wgm8-1226867313878

Many prospective purchasers are undoubtedly deterred from buying by the likelihood of the liquor being seized, and the NT Government's Department of Business figures[62] show that alcohol supply in Alice Springs in 2012-13, for example, was 7% lower than in 2011-12.

There are questions about the legality (for example, whether people obliged to tell police where they reside in these circumstances) and the desirability (for example, in relation to further marginalising an already disadvantaged population) of targeting customers on this basis. However, the drop in supply is significant and may well explain the drop in hospital admissions from May 2013 as shown in **Appendix 5**.

PAAC has sought information in order to analyse the apparent effectiveness of the TBLs, including an examination of any differing effects due to complete or partial coverage of outlets by police. Following a meeting with senior police, we wrote to Chief Minster Adam Giles on 26th March asking that he consent as a matter of urgency to police providing the following information:

- records of police attendance outside take-away outlets since commencement of these operations in May 2012 or other date if applicable, including opening hours during which police were in attendance by date and details of which outlets were attended by dates of attendance;
- Protective custody numbers for the period in question corresponding to dates of attendance and dates of non-attendance, by where taken (watch-house, sobering-up shelter, hospital ED or other);
- Assault matters dealt with during the period concerned, by dates of attendance and non-attendance for comparison;
- Domestic assault matters dealt with during the period concerned, by dates of attendance and non-attendance for comparison;
- Cost of police attendance at take-away outlets during the period in question;
- Other relevant information relating to these operations that police are able to supply.

Unfortunately we have not to date received either an acknowledgment of our request or any substantive response. The key questions therefore remain open on whether the 'TBL' approach is sustainable (for example in terms of police resources), whether it is legal, and whether it has long-term negative consequences through perceptions of discrimination by Aboriginal people and consequently their further marginalisation when such marginalisation is already known to be a driver of addiction.

Dry community bans / Alcohol Management Plans

There is evidence that Aboriginal communities declaring themselves 'dry', prohibiting the consumption of alcohol within their boundaries, has some effect in reducing alcohol

[62] http://www.dob.nt.gov.au/gambling-licensing/liquor/Documents/wholesale_alcohol_supply_201306.pdf

related harm[63]. It is important that there is independent evidence that the decision to declare a community 'dry' or to amend or lift its 'dry' status is one that involves the whole community, including in particular women, non-drinkers and service providers such as police, education and health agencies.

Blanket bans on remote communities that do not involve local community action and decision, such as those introduced under the Northern Territory Emergency Response (NTER) may be viewed as discriminatory and paternalistic by many Aboriginal people, undermining their effectiveness as well as undermining the sense of life-control which is an important social determinant of health (see section on *The social and economic determinants* of harmful alcohol use across Aboriginal and Torres Strait Islander communities*above*).

Local dry area bans within towns or cities – for example the Northern Territory legislation prohibiting the public consumption of alcohol within 2 kilometres of licensed premises – often simply shift drinking to other, often more risky, adjacent areas and is not well-evidenced[64].

Dram shop liability

'Dram shop liability' means that premises which serve alcohol to under-age drinkers or to those who are already drunk can be held liable for any harm or damage caused by that person, and is relatively common in the United States where the relevant laws are administered by numerous States[65]. Canadian courts have long recognised commercial, or licensees' liability[66]. Where such liability exists, it has been shown to significantly improve age-checking and responsible serving practices by licensees and to consequently reduce alcohol-related harm, particularly traffic accidents[67].

In contrast to the USA and Canadian approaches, the Australian High Court has declined to date to accept that licensees owe a relevant duty of care to an intoxicated customer[68]. Legislation will therefore be needed under Australian law to establish this liability[69]. Note that serving under-age or intoxicated people is already illegal under State and Territory licensing laws, but that these laws are rarely enforced with sufficient penalties to effectively deter the irresponsible serving of alcohol[70].

[63] Chikritzhs T, Gray D, et al. (2007). Restrictions on the sale and supply of alcohol: evidence and outcomes. Perth, National Drug Research Institute, Curtin University of Technology.

[64] Ibid.

[65] http://www.thecommunityguide.org/library/Dram%20Shop_Overservice%20evidence%20review.pdf

[66] Stewart v. Pettie, 1995 CanLII 147 (SCC), [1995] 1 SCR 131;

[67] Babor T, Caetano R, et al. (2010). Alcohol: no ordinary commodity. Oxford, Oxford University Press.

[68] C.A.L. No 14 Pty Ltd v Motor Accidents Insurance Board; C.A.L. No 14 Pty Ltd v Scott [2009] HCA 47

[69] Shakeshaft A, Love S, et al. (2011). Alcohol Related Crime in City of Sydney Local Government Area: An Analysis for the Council of the City of Sydney. NDARC Monograph No. 63. Sydney, National Drug and Alcohol Research Centre (NDARC).

[70] Shoebridge A (1990). Tackling Excessive Drinking Or Excessive Supply. Alcohol and Crime, Canberra Australian Institute of Criminology.

Recommendations

13. ***That the Federal Government, recognising that raising the price of alcohol is the most cost-effective way to reduce alcohol-related harm across Australia including in the Aboriginal and Torres Strait Islander community, introduces a national floor price for alcohol to be set at the retail price of a standard drink of full-strength beer (currently around $1.30[71]). This should be combined with a volumetric tax to a national fund for the reduction of alcohol related harm, with access to this fund by jurisdictions to be determined on the basis of their actions to reduce alcohol-related harm across the whole population, including for the Aboriginal and Torres Strait Islander community.***

14. ***That the Commonwealth encourage all jurisdictions to take action on reducing the availability of alcohol as a key measure to reduce alcohol related harm, including in the Aboriginal community. Minimum interventions would include:***

    a. ***one take-away free day per week linked to Centrelink payments as a way to reduce total take away trading hours; and***

    b. ***reduced and modified late night trading in accordance with the successful Newcastle trials.***

15. ***That the Northern Territory Government reintroduce the effective photo ID scanning at the point of sale coupled with a Banned Drinkers Register, with resources for evaluation to be included from the start.***

16. ***In addition to the population-wide supply reduction measures above, there may be additional measures, with community support, implemented through local Alcohol Management Plans for specific Aboriginal communities or living areas.***

17. ***That the Federal Government support the adoption of consistent legislation across Australia that:***

    a. ***establish a licensees' liability for harm or damage resulting from irresponsible serving practices (especially serving alcohol to under-age or intoxicated people); and***

    b. ***ensures greater enforcement of and penalties for irresponsible serving practices.***

18. ***That all Australian jurisdictions report annually to the Commonwealth on alcohol consumption, alcohol related harms (including where appropriate by Aboriginality) and actions taken to address those harms (including actions taken to reduce supply and availability). Access to the national fund for the reduction of alcohol-related harm (see Recommendation 13) for each jurisdiction to be dependent on implementation of adequate reporting (see Recommendation 1) and evidence-based action taken to reduce alcohol-related harm for the whole population including the Aboriginal community .***

[71] Whatever the actual price, the aim is to ensure that (less harmful) beer is the cheapest drink, as the evidence shows that problem drinkers gravitate to cheaper products to get the most value for their money.

7. Best practice identification to include international and domestic comparisons

While rigorous evaluations of interventions in Aboriginal and Torres Strait Islander Australia are still relatively rare, nationally and internationally there is a great deal of strong evidence about 'what works' to reduce alcohol-related harm.

This evidence, much of which is cited in the body of this submission, should be the starting point for any policy or legislative approach to reducing the harm in Aboriginal and Torres Strait Islander communities. Thoughtful, informed and principled adaptation of what we know works to the Aboriginal context may be required, taking into account the positive role of culture in Aboriginal life, the social determinants of health, and the need to adopt solutions that are non-discriminatory and which do not perpetuate Aboriginal disadvantage and exclusion.

Given the scale and complexity of the issue, innovative approaches which can be expected to have a reasonable prospect of success may also be supported, although in such cases it is particularly important that long-term, rigorous evaluation is resourced from the beginning.

None of this should be taken as an excuse for governments to implement, in the first instance, policies or programs which have been reliably shown to be ineffective.

Appendix 1: About the People's Alcohol Action Coalition

The People's Alcohol Action Coalition's (PAAC) aim is to advocate for reduced alcohol-related harm, including through the following strategies:

- constructive reforms to the sale of alcohol;
- controls on public consumption;
- responsible service of alcohol; and
- promoting healthy lifestyles.

PAAC originated as the People's Alcohol Action Group (PAAG), a community-based response to growing awareness of excessive alcohol use and associated harm in the Central Australian region. PAAG began in November 1995 following a public rally called in Alice Springs by the late Aboriginal activist and Australian and Torres Strait Islander Commission (ATSIC) Central Zone Commissioner, Dr Charles Perkins.

Initially, PAAG received funding from the Northern Territory Government to employ a project officer to support the group, However, as PAAG decided to focus more of its effort on evidence-based alcohol supply reduction the group became more at odds with the NTG and its funding ceased in 1998. Without a project officer providing secretariat support, the group became less organised and less active than it had been; although it still continued to meet regularly, the level of communication amongst its members declined during this period.

In September 2000 another public meeting was called to debate strategies for a campaign aiming to reduce alcohol-related harm. At this meeting it was decided to re-activate the group as the People's Alcohol Action Coalition or PAAC - an unincorporated association of organisations and individuals with a history of dealing with the deleterious effects of alcohol. PAAC was able to attract sufficient funding and donations to again be able to employ its own project officer from 2009.

Members include lawyers, social workers, medical practitioners, Aboriginal organisations, trade unions, churches, social service organisation and individuals. Collaborating organisations include Central Australian Aboriginal Congress, Central Land Council, the Aboriginal Medical Service Alliance Northern Territory, Northern Territory Council of Social Services, Central Australian Youth Link Up Service , Ngaanyatjarra, Pitjantjatjara Yankunytjatjara Women's Council, the Uniting Church, the Public Health Association of Australia NT and the Mental Health Association of Central Australia.

Appendix 2: Suggested minimum dataset on alcohol consumption and alcohol-related harm[72]

Main indicators

- Apparent per capita consumption
- Hospital separations for selected acute and chronic alcohol-related conditions
- Alcohol-related deaths
- Confirmed assaults
- Serious road injuries (fatalities or injuries requiring hospitalisation)
- Proportion of alcohol consumed at risky and high-risk levels
- Proportion of the population drinking at risky and high-risk levels
- Estimated acute and chronic hospital separations attributed to risky and high-risk drinking

Additional Measures

- Alcohol-related admissions to treatment agencies
- Ambulance callouts
- Admissions to sobering up shelters
- Apprehensions without arrest/ protective custodies
- Night patrol encounters
- Confirmed public order incidents
- Alcohol-related prison reception

[72] Renouf G, Townsend J, et al. (2004). Northern Territory Alcohol Framework: Final Report. Darwin, NT Government Printer.

Appendix 3: Early Childhood Development

There is an abundance of strong evidence that well-designed early childhood development programs are a key, cost-effective intervention to address intergenerational disadvantage.

There are critical periods in early brain development where if a child is not provided with appropriate care and parenting, then significant brain potential is permanently lost. Children who are not exposed to rich conversational language, read to daily, encouraged much more often than they are discouraged, who do not get sufficient regular sleep, and who come to expect and demand immediate gratification, are unlikely to develop brain potential in key areas such as language and cognitive and emotional development.

Parental alcohol is frequently associated with antisocial behaviour and neglect of children during their critical early years, causing key deficits in development which many Aboriginal children carry into their school years and beyond.

The Australian Early Development Index (AEDI)[73] involved a 2009 snapshot of 261,147 children (97.5 per cent of the estimated five-year-old population) in their first year of full-time school across Australia. It found that almost 30% of Aboriginal children are vulnerable on two or more developmental areas such as physical health and well-being, social competence, emotional maturity, language and cognitive skills, communication skills and general knowledge. In some regions, the figures are much worse: for example, 46.8% of Aboriginal children in the Northern Territory have vulnerabilities on two or more areas compared to 8% of all Australian children.

The link between poor development in the early years and the subsequent development of addictions and other life-long problems has been demonstrated by many studies, including a recent major longitudinal study from Dunedin in New Zealand, which followed a cohort of more than one thousand children from birth to age thirty-two[74]. It found that the lower the self-control or emotional development in early childhood, the greater the risk of developing substance dependence in **Figure 4**)

[73] Centre for Community Child Health and Telethon Institute for Child Health Research (2009). A Snapshot of Early Childhood Development in Australia – AEDI National Report. Canberra, Australian Government.

[74] Moffitt T E, Arseneault L, et al. (2011). "A gradient of childhood self-control predicts health, wealth, and public safety." Proceedings of the National Academy of Sciences.

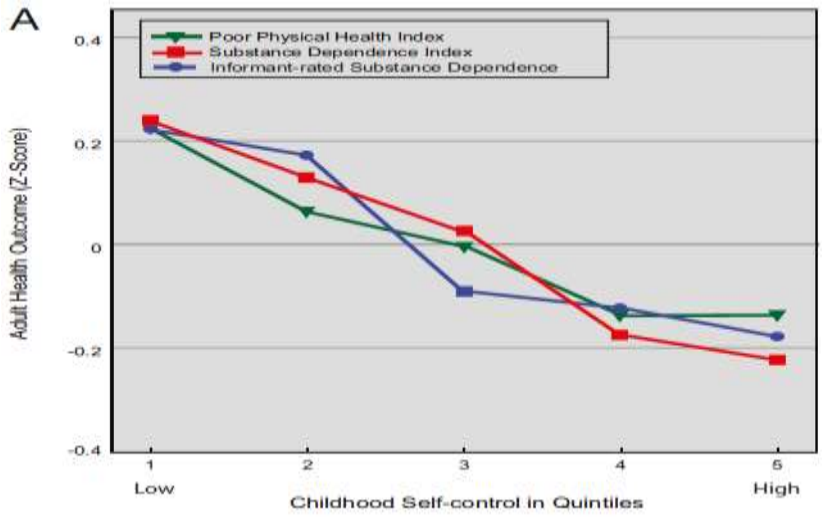

Figure 4: Relationship between childhood emotional development and adult health outcomes, including substance dependence

This demonstrates the extent of the challenge. The AEDI has revealed the disadvantage that Aboriginal children have in the two key language and cognitive domains and emotional domains when they first enter school. The next generation is likely to include disproportionate numbers of children who are likely to be impulsive and lack self-control (key aspects of the emotional development domain); have poor over-all brain development leading to poor school performance; have a greater propensity to develop alcohol and other drug addictions; to be on the streets and incarcerated.

Once this pattern of development and behaviour is established, youth interventions, while necessary, are far more costly and less effective. There is ample evidence that it is much more effective – and efficient in terms of resources – to invest in early childhood development programs which aim to prevent the development of this pattern of behaviours.

Examples of such preventative programs include the Nurse Family Partnership (NFP) Program Home Visitation and the Abecedarian model of Educational Day care.

These programs work with children before developmental problems arise. Approaches support children to access the stimulation, quality relationship and access to services needed for healthy development. While NFP uses an outreach based model with emphasis on home visits and contact with mothers, the Abecedarian Educational day care has a focus on daily contact with the child at a centre where children experience enriched care. These models are also sometimes referred to as 'preventative intervention', however will be referred to hear in this document as 'Preventative Programs' or 'Primary Prevention' to avoid confusion with ' early intervention' programs which provide support after a difficulty has been identified for treatment.

Such early childhood programs can:

- reduce the use of alcohol and other substances by young adults[75] including reducing the number of young women who start drinking before the age of 17[76];
- more than double school retention rates[77]; and
- dramatically reduce the youth incarceration rates[78];

Early childhood development programs are an essential contributor to raising children who are resilient and thus better equipped to avoid developing substance addictions and other problems in adolescence. Early childhood education and support are thus an essential part of the answer to reducing alcohol-related harm in the Aboriginal and broader communities.

[75] Olds D L, Eckenrode J, et al. (1997). "Long-term effects of home visitation on maternal life course and child abuse and neglect. Fifteen-year follow-up of a randomized trial." JAMA **278**(8): 637-643.

[76] Campbell F, Conti G, et al. (2014). "Early Childhood Investments Substantially Boost Adult Health." Science (forthcoming) - See www.heckmanequation.org.

[77] Campbell, F. A., B. H. Wasik, et al. (2008). "Young adult outcomes of the Abecedarian and CARE early childhood educational interventions." Early Childhood Research Quarterly **23**(4): 452-466.

[78] Tremblay R E, Gervais J, et al. (2008). Early childhood learning prevents youth violence. Montreal, Quebec, Centre of Excellence for Early Childhood Development.

Appendix 4: Supply reduction approaches to minimising alcohol related harm[79]

Type of restriction	Target population (s)	Comment	Efficacy: level of confidence for positive outcomes				Long-term viability	Administrative level for implementation	Level of reliance on enforcement for effective application	Viability for large cities	Viability for rural/remote communities with substantial Indigenous populations
			Uncertain ?	*Low* ✗	Good ✓	High ✓✓					
Price/taxation	General population/ high risk populations	High order supply reduction strategy				✓✓	High – if adjusted to reflect changes in disposable income	Federal, possible at state	Low	High	High
Trading hours	General population/ individual licensed premises	Reliable and consistent Australian evidence				✓✓	High	State/local	Low	High	High
Access to high risk beverages	General population/ high risk populations and situations (e.g. special events)	Best when rigorously enforced			✓		Moderate Reliant on on-going enforcement	State/local	High	High short-term, Low (long-term	High
Outlet density	General population	Requires a working model to inform policy			✓		High	State	Low	High	High
Government monopoly	General population	No Australian evidence			✓		Low	Federal/ possible at state	Low	High	N.A.
Lockouts	Individual licensed premises/ patrons	Relatively new to Australia with limited evidence for outcomes	?				?	Local	Moderate	High	High
Minimum drinking/purchase age	Licensed premises/ young people	Best when rigorously enforced				✓✓	High	State	High	High	Moderate: dependent on availability of enforcement to facilitate deterrence
Responsible Bars Service training	Licensed premises/ servers of alcohol	Needs to be mandatory and effectively enforced		✗	✓		Low	State/local	High	High	High
Evidence-based comprehensive community programs	Licensed premises / general population/ young people	Must be based on evidence and strongly enforced. Evidence for success in Australia is limited			✓		?	Local	High	High	Not known: theoretically viable; would need substantial resources and infrastructure in most cases
Voluntary community agreements (e.g. accords)	Licensed premises	Ineffective due to lack of emphasis on enforcement		✗			Low	N.A.	N.A.	N.A.	N.A.
Dry community declarations	High risk populations	Enforcement important for reaching potential			✓		High – with community support Low – without community support	State/local	Moderate: more likely to reach potential when effectively enforced but otherwise effective	Low	High
Local area alcohol bans	General population in high risk areas. Potentially discriminative	May reduce local disorder by displacing drinkers. Not shown to reduce overall consumption or harm.		✗			Moderate	Local	Moderate: subject to individual circumstances	High: subject to enforcement	Moderate: subject to effective enforcement and local community support

[79] From Chikritzhs T, Gray D, et al. (2007). Restrictions on the sale and supply of alcohol: evidence and outcomes. Perth, National Drug Research Institute, Curtin University of Technology.

Appendix 5:
The Northern Territory's Banned Drinkers Register[80]

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Alcohol Control Measures:
Central Australia and Alice Springs

This paper presents evidence for the effectiveness in Alice Springs of two alcohol control measures:

- indirect price control through the banning of table wine in containers of >2 litres and fortified wine in containers of >1 litre; and,
- the Northern Territory Banned Drinkers Register.

Price and consumption: the Alice Springs Liquor Supply Plan

The National Drug Research Institute conducted *A longitudinal study of the influences on alcohol consumption and related harm in Central Australia: with a particular emphasis on the role of price.*[81] The material in this section is based upon that report. In the 2nd quarter 2002, following a lengthy period of debate, Trial Liquor Licensing Restrictions were introduced in Alice Springs. A key element of these restrictions was a ban on the sale of table wine in containers >2 litres. This ban was lifted as part of amended restrictions in the 3rd quarter 2003 and along with a ban on fortified wine in containers of >1 litre was reintroduced in the 4th quarter 2006.

Over the period from the 3rd quarter 2000 to the 4th quarter 2010, there was an overall decline in per capita consumption of pure alcohol (based wholesale sales data – the most accurate estimate of consumption) from about four to about 3.5 litres per quarter by persons aged ≥15 years. The level of consumption of most beverage types remained stable and the largest changes took place in relation to cask table wine, fortified wine, and full-strength beer. Changes in consumption of these beverages is shown in Figure 1.

[80] Produced by Professor Dennis Gray and the National Drug Research Institute for PAAC.

[81] Symons M, Gray D, Chikritzhs T, Skov S, Saggers S, Boffa J, Low, J. A *Longitudinal Study of Influences on Alcohol Consumption and Related Harm in Central Australia: With a Particular Emphasis on the Role of Price.* Perth: National Drug Research Institute, Curtin University, 2012.

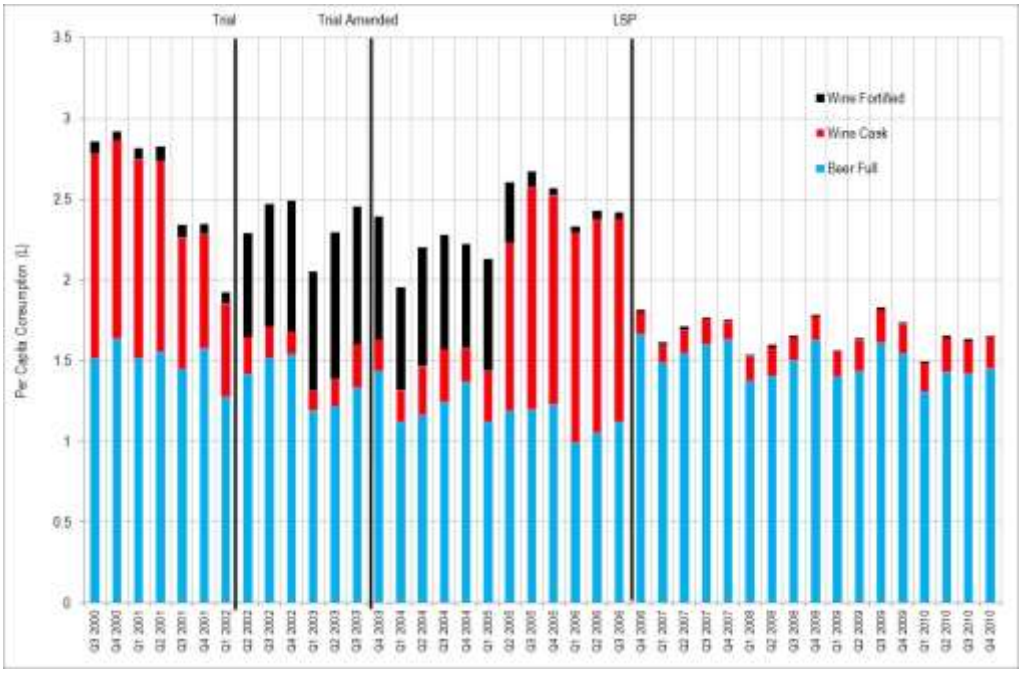

Figure 1: Impact of restrictions on estimated consumption of cask wine, fortified wine and full strength beer (in litres of pure alcohol) per person aged ≥15 years by quarter, Central Australia, July 2000 – December 2010

Over several quarters, in anticipation of the imminent introduction of the restriction on sale of table wine in containers >2 litres, it appears that retailers reduced their purchases of this beverage type (red bars in Figure 1) so as not to be caught with stock that they could not sell. Following the introduction of the Trial Restrictions, retailers began selling fortified wine (black bars in Figure 1) in casks of two litres as a cheap alternative to the larger casks of table wine. The result of this was that estimated consumption remained largely unchanged during the Trial period.

In the 3rd quarter 2003, amendments were made to the Trial Restrictions to again allow the sale of table wine in casks >2 litres. The result of this was that wholesale sales remained level but, over the ensuing 12 quarters, there was a shift back from consumption of fortified wine to table wine. Subsequently in the 3rd quarter 2006, sales of both table wine in containers of >2 litres and fortified wine in containers of >1 litre were prohibited, thus removing from the market the two cheapest forms of alcoholic beverage. As is evident from Figure 1, there was then a switch to the consumption of full-strength beer (blue bars). However, the increase in consumption of this higher priced beverage did not match the decline in consumption of cask table and fortified wine. (Consumption of cask table wine and fortified wine after this time was in smaller more expensive containers.)

Figure 2 illustrates the change in the mean (average) wholesale price per standard drink (a drink containing 12ml of pure alcohol) from the 3rd quarter 2000 to the 4th quarter 2010. As table wine in casks was withdrawn prior to the trial restrictions, the price rose from about $0.80 to about $0.95 per standard drink. With the introduction of two litre casks of fortified wine, which substituted for the larger containers of cask table wine, the mean priced fell back to about $0.80. With the introduction of the Alice Springs Liquor Supply Plan and the banning of both table wine in containers >2 litres and fortified wine

in containers of >1 litre, the mean price rose to about $1.10. This increase was primarily achieved by a doubling of the minimum unit price (MUP) from about $0.25 cents per standard drink to $0.50 per standard drink. This was the actual effect of removing the super-cheap four and five litre cask table wine and two-litre cask port from sale which left two-litre cask wine sold by the big supermarkets as the cheapest alcoholic beverage which sold for $0.50 per standard drink. This demonstrates the effectiveness of using a minimum unit pricing approach to achieve a planned substitution to more expensive, less harmful forms of alcohol.

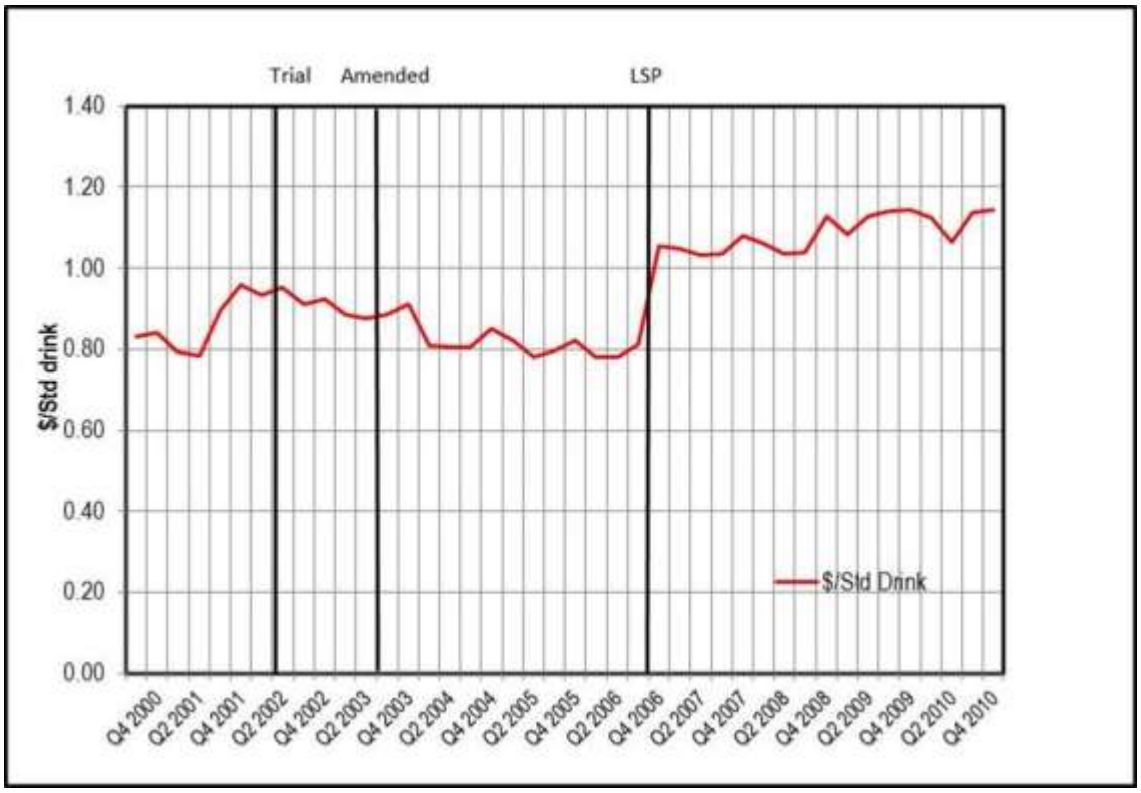

Figure 2: Impact of restrictions on mean wholesale price per standard drink (12ml alcohol) by quarter, Central Australia, July 2000 – December 2010

The impact of the changes in mean price per standard drink upon consumption is evident in Figure 3. With the increase in price from about $0.80 to about $0.95 in the lead-up to the trial restrictions, mean consumption among persons aged ≥15 year fell from about 25 standard drinks to about 20 per week. During the Trial Restrictions period when two litre casks of fortified wine were introduced, price declined to about $0.80 and consumption rose to about 24 standard drinks per person per week. With the increase in price to about $1.10 following the introduction of the Liquor Supply Plan mean weekly consumption declined to about 20 standard drinks.

It is important to note that other restrictions – such as reductions in takeaway trading hours made a contribution to the observed decline in consumption. Nevertheless, the correlation between mean price per standard drink and mean weekly consumption was 0.56 (R^2 = 0.56 p <0.01). This indicates that price accounted for 56% of the observed reduction in consumption and that the probability of such a relationship occurring by chance was less than one in 1,000. *This demonstrates that this indirect price control*

measure (i.e. removal of the cheapest priced beverages) led to a significant reduction in alcohol consumption in Alice Springs and Central Australia.

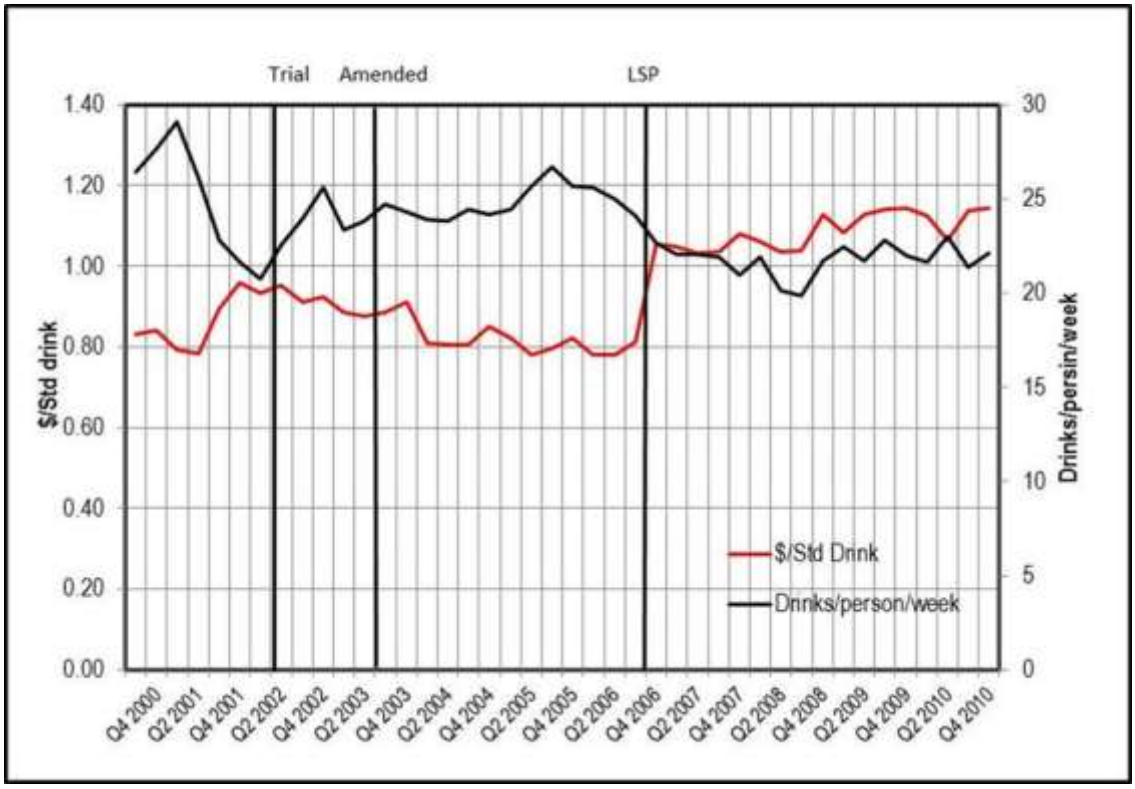

Figure 3: Impact of restrictions on mean wholesale price per standard drink (12ml alcohol) and mean weekly consumption of alcohol (standard drinks) per person ≥15 years by quarter, Central Australia, July 2000 – December 2010

As evidenced by predictive time series analysis,[82] the reduction in per capita alcohol consumption led to a significant reduction on alcohol-related harm – this is indicated by a reduced rate of admissions to Alice Springs Hospital for alcohol-attributable conditions (Figure 4). The red line in Figure 4 represents the rate of hospital admissions per thousand persons aged ≥15 years per quarter. This rose from about six in the 3rd quarter 2003 to about eight in the 2nd quarter 2006, prior to introduction of the Alice Springs Liquor Supply Plan. Based on the underlying trend in this rate of increase, statistical forecasting indicates that this would have continued to rise to about 13 admissions (95% confidence limits 12 – 13) by the 4th quarter 2010 (the blue line in Figure 4). The upper and lower confidence limits (UCL and LCL – represented by the broken mauve lines) indicate that, allowing for error one can be 95% confident that by that quarter the forecast rate would have been between 12 and 14 admissions per 1000 persons per quarter. However – as represented by the continuing red line from the 2nd quarter 2006 to the 4th quarter 2010 – admissions for alcohol-attributable conditions continued to rise albeit at decreased rate. That this observed rate was outside the lower confidence interval indicates that it is 95% likely that the decrease is attributable to the introduction of the Liquor Supply Plan – a major impact of which was the increase in mean price per standard drink and the associated decrease in consumption.

[82] IBM SPSS. *SPSS Forecasting 20.* Chicago: IBM SPSS, 2011

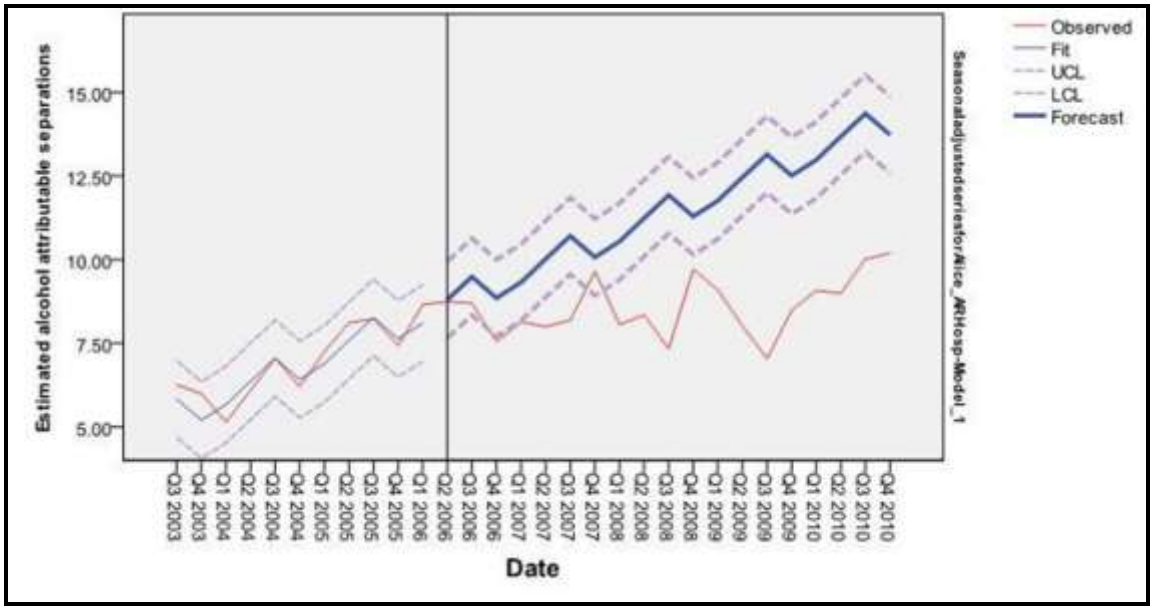

Figure 4: Impact of the Alice Springs Liquor Supply Plan on Alice Springs Hospital admission rates for alcohol-attributable conditions, observed and forecast values post-Q1 2006

The Banned Drinkers Register and Emergency Department presentations and Alice Springs Hospital admissions

In July 2011 the then Northern Territory Government introduced a number of legislated reforms to address alcohol-related harm: the *Enough is Enough* reforms. A key component of the relevant legislation, the *Alcohol Reform (Prevention of Alcohol-Related Crime and Substance Misuse) Act,* was the introduction of a banning notices and a Banned Drinkers Register (BDR). Banning and Treatment order (BAT) notices could be issued to those who were:

- taken into protective custody three times during a three-month period;
- issued with three alcohol-related infringement notices within a 12-month period;
- given two infringement notices for low range drink-driving within the previous three years;
- charged or summonsed in relation to an alcohol-related offence; or
- a defendant of a domestic violence order if the person was believed by police to be affected by alcohol at the time the conduct occurred.

The BAT notices prohibited the purchase of take-away alcohol[83], and the possession or consumption of alcohol, for a period of three months, or six or twelve months if breached. A three-month notice could be reduced to one month if the person agreed to undergo voluntary alcohol treatment.

[83] And on-premises drinking in two specified Alice Springs bars at each of the Todd Tavern and Gapview Hotels under a voluntary trial with the relevant licensees.

An essential part of the BDR was the use of electronic identification scanners linked to the Register at all take-away outlets, with ID scanned for every customer, and banned drinkers barred from buying alcohol at the point of sale.

The BDR was in operation from July 2011 to August 2012, when the incoming NT Chief Minister, Terry Mills, repealed the legislation, arguing that the measure had failed as problem drinkers were finding ways to purchase alcohol despite being listed on the register[84][76]. The decision met with a substantial amount of criticism. To date however, no formal evaluation of the BDR has been completed to our knowledge, and none has been published.

Under the provisions of the NT *Information Act*, PAAC obtained data from the Northern Territory Health Department on monthly presentations at the Alice Springs Hospital (ASH) Emergency Department (ED) and admissions to the ASH for conditions attributable to alcohol. The data on ED presentations covered the period July 2005 to October 2013 and the admissions data the period January 2011 to June 2013. PAAC provided these data to the National Drug Research Institute and requested that they be analysed to ascertain whether or not the introduction of the Banned Drinkers Register (BDR) in July 2011 or its subsequent abolition in August 2012 had any impact upon them. The data were subjected to the same predictive time series analysis as the ASH admissions data in the previous section.

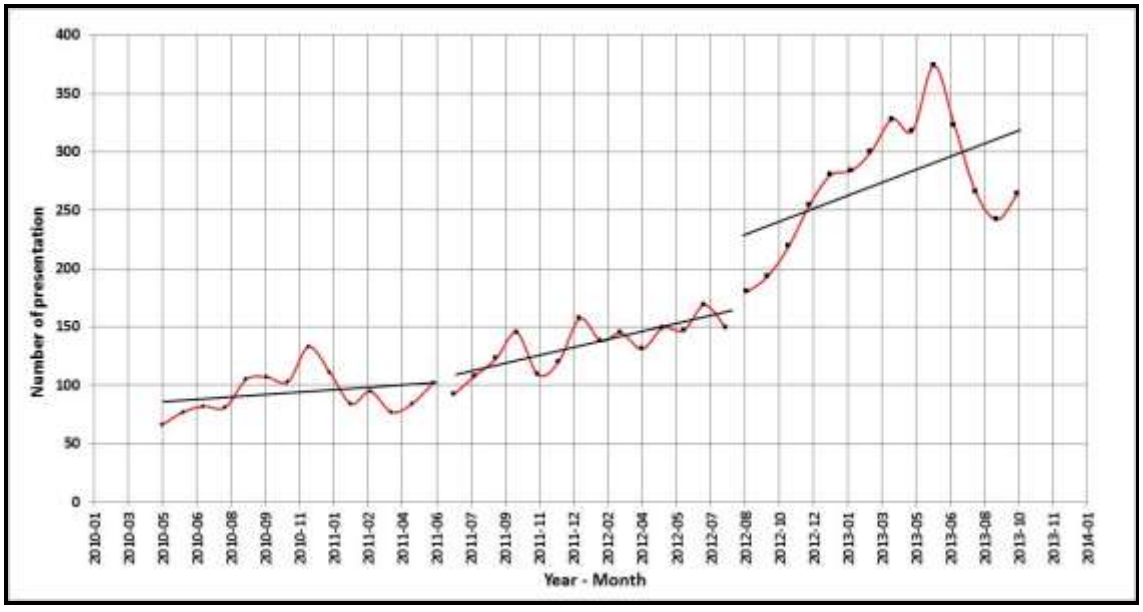

Figure 5: Alice Springs Hospital Emergency Department presentations for conditions wholly attributable to alcohol pre (May 2010–June 2011), during (July 2011–August 2012) and post (September 2012–October 2013) operation of the NT Banned Drinkers Register

[84] S Erikson, Enough alcohol…is enough, *Alternative Law Journal*, vol. 37, no. 4, 2012

Figure 5 presents monthly ED presentations wholly attributable to alcohol, and the underlying trends, for the 14 month periods pre-, during, and post operation of the BDR. Figure 6 shows that in the period prior to the introduction of the BDR, the number of presentations increased from about 75 per month to about 100 (red line). Based on this trend, it was forecast that presentations should have continued to rise to about 125 per month by August 2012 (blue line). In fact, however, presentations increased from about 100 to 150 per month (continuing red line) – an increase that statistically was significantly higher than that forecast. This increase is unlikely to be explained by the introduction of the BDR itself, as even its critics argue that it was ineffective rather than having had a negative impact.

While we do not have the data to explain this increase, it is widely known and reported in newspapers that following the Briscoe death in custody in January 2012[85], the police began taking all people on protective custody apprehensions to ED for medical assessment. This practice is very likely to account for the apparent contradiction to the effectiveness of the BDR due to this new policy which added substantially to alcohol caused ED presentations. This could be verified if police data was available but are best estimate is that this would have amounted to enough of an increase to solely account for the increase in alcohol caused ED presentations in this period and probably, without this change in policy, there would have been a decrease in presentations. This is an important point that requires further analysis of the actual data.

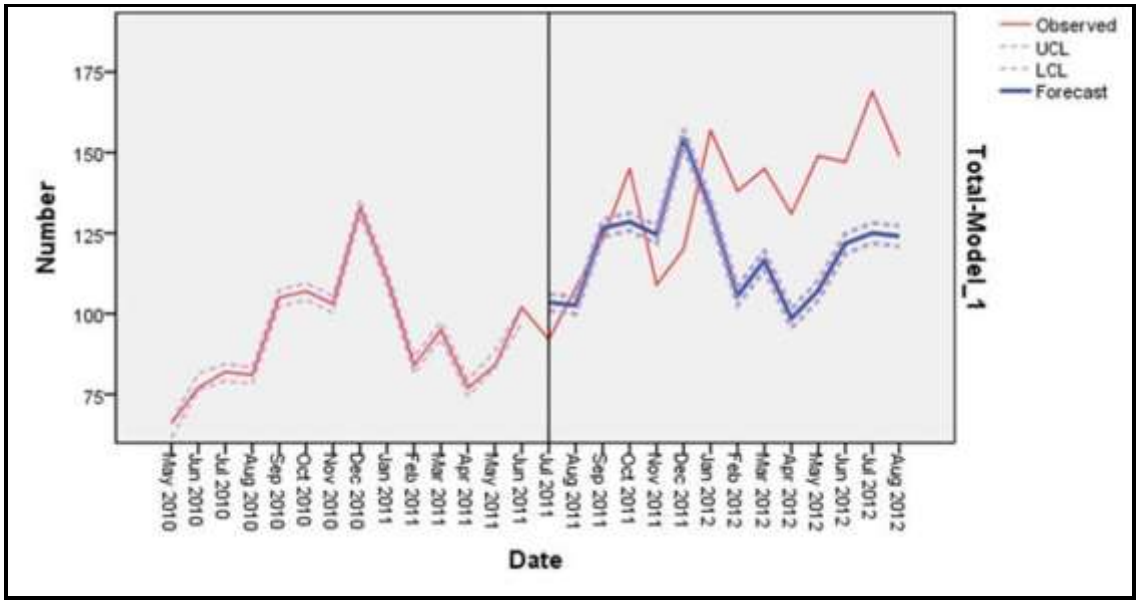

Figure 6: Alice Springs Hospital Emergency Department presentations for conditions wholly attributable to alcohol May 2010 to August 2012 and forecast numbers of admissions during operation of the NT Banned Drinkers Register (based on the series May 2010 to June 2011)

[77] Cavanagh G (Coroner). *Inquest into the death of Terence Daniel Briscoe* [2012] NTMC 032.

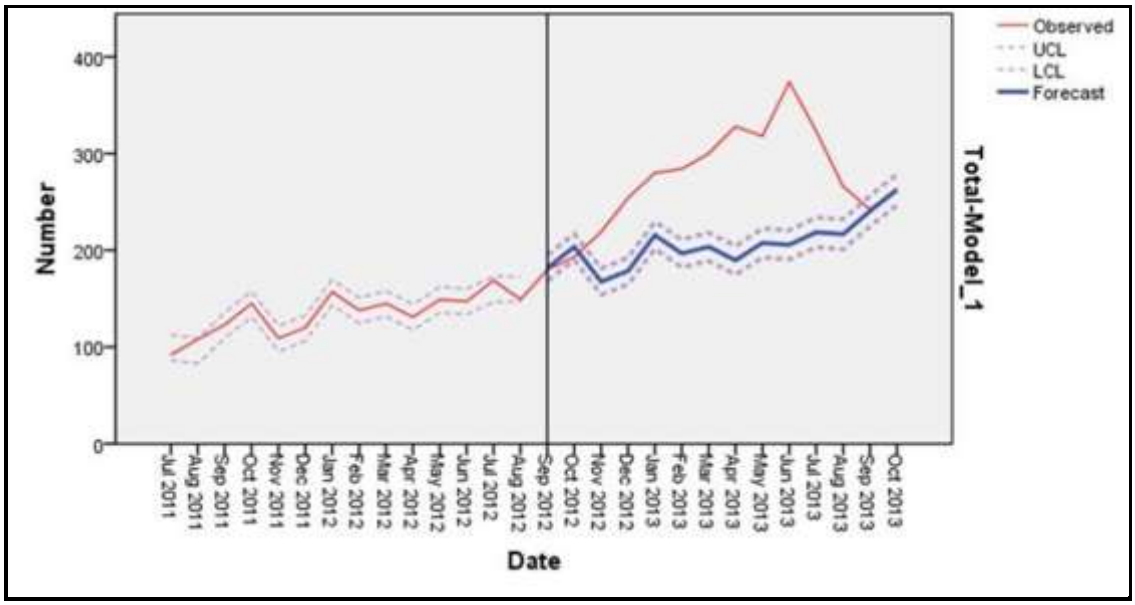

Figure 7: Alice Springs Hospital Emergency Department number of presentations for conditions wholly attributable to alcohol July 2011 to October 2013 and forecast numbers of admissions post-abolition of the NT Banned Drinkers Register (based on the series July 2011 August 2012)

Figure 7 illustrates the trend in ED presentations in the period subsequent to abolition of the BDR. As also shown in Figures 5 and 6, during the period that the BDR was in place the number of presentations rose from about 100 to 150 per month. Based on this trend (red line in Figure 7) it was forecast that over the period September 2012 to October 2013 this should have continued to rise to about 250 per month. However, for most months after abolition of the BDR there was a statistically significant rise (continuing red line) far in excess of that forecast (blue line).

Data were provided to PAAC on admissions to ASH for conditions wholly attributable to alcohol, conditions with an alcohol attributable ætiologic fraction of >0.4 (i.e. conditions for which it is known that at least 40% of cases are caused by alcohol), and assaults. As these data dated only from July 2011 to June 2013, it was not possible to examine any changes that might, or might not, have occurred following introduction to the BDR, but Figures 8 to 10 present the results of predictive time series analyses of the changes occurring in the 14 month periods during which it was in operation and subsequent to its abolition. These Figures show that there was a statistically significant increase in each of these indicators in the post-operation period (continuing red lines) over those forecast (blue line) on the basis of the trends in the period the BDR was in place (red line on the left of the Figures).

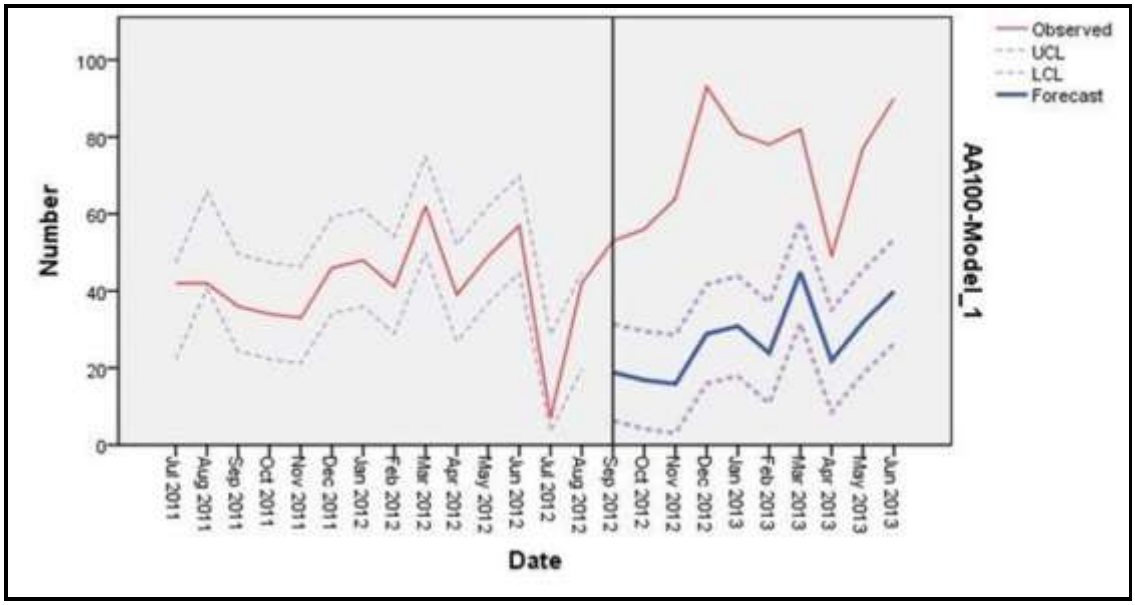

Figure 8: Alice Springs Hospital, number of admissions for conditions wholly attributable to alcohol July 2011 to June 2013 and forecast numbers of admissions post-abolition of the NT Banned Drinkers Register (based on the series July 2011 to August 2012)

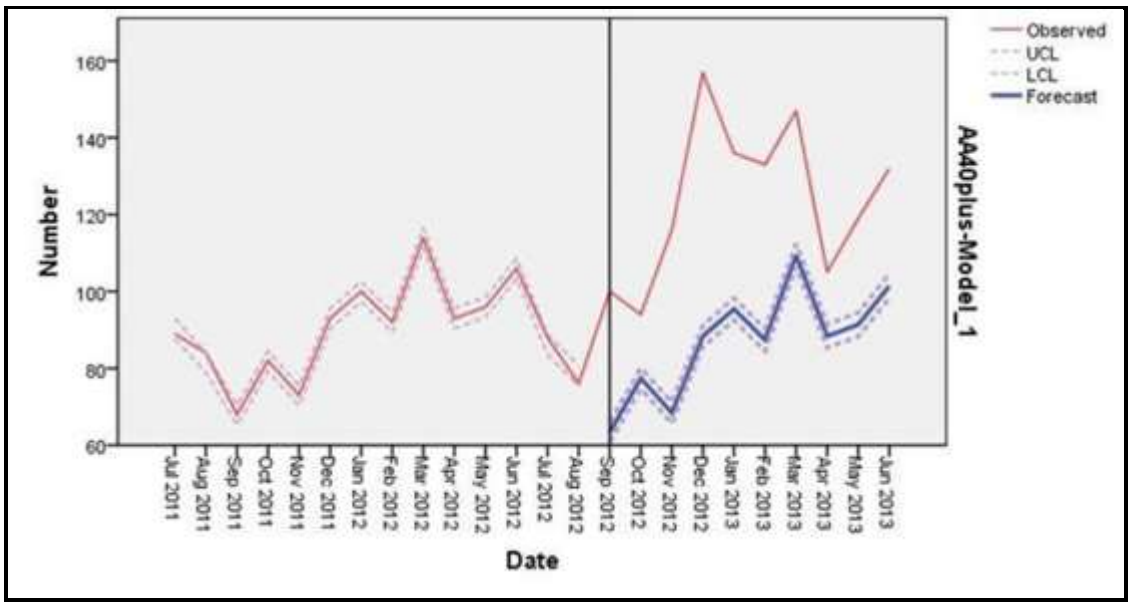

Figure 9: Alice Springs Hospital number of admissions for conditions with an alcohol-attributable aetiologic fraction >0.4, July 2011 to June 2013 and forecast numbers of admissions post-abolition of the NT Banned Drinkers Register (based on the series July 2011 to August 2012)

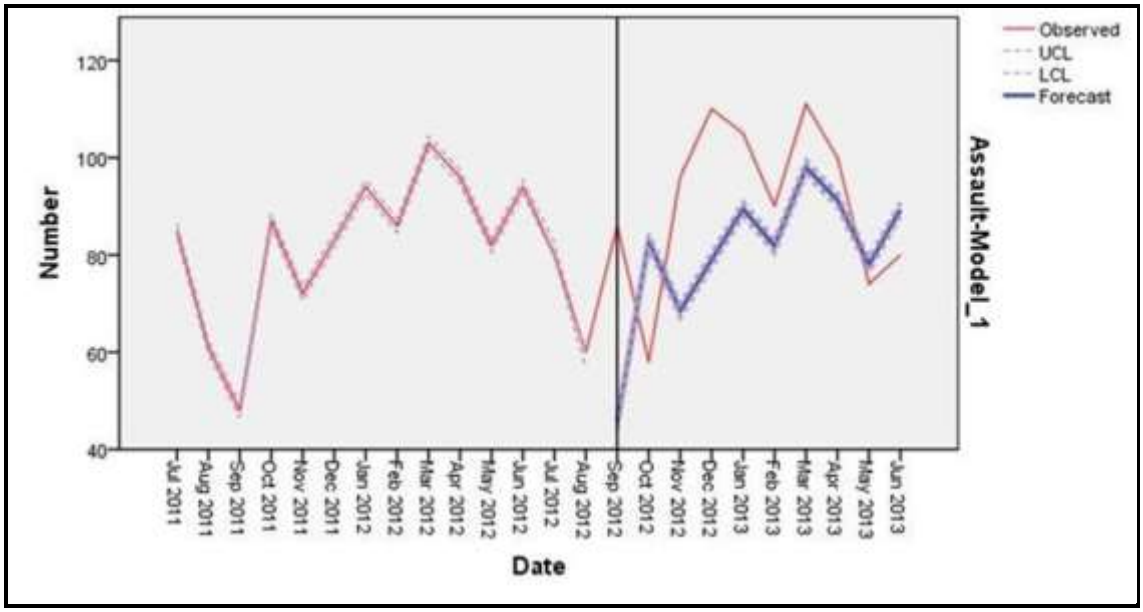

Figure 10: Alice Springs Hospital, number of admissions for assault injuries July 2011 to June 2013 and forecast numbers of admissions post-abolition of the NT Banned Drinkers Register (based on the series July 2011 to August 2012)

As indicated above, although there was an increase in ASH ED presentations for wholly alcohol attributable conditions following the introduction of the BDR, this is unlikely to have been a result of the BDR itself, as even its critics say only that the BDR was ineffective rather than negative in its impact. However, after abolition of the BDR, for each of the indicators examined – ED presentations for wholly alcohol attributable conditions, and ASH admissions for wholly alcohol attributable conditions, conditions with an alcohol-attributable fraction of 0.4, and assaults – there were increases that statistically were significantly higher than those predicted on the basis of trends during the period in which the BDR was in place. *Taken together, these indicators strongly suggest that the BDR was effective in reducing alcohol-related harms to health in Alice Springs.*

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Submitted on behalf of PAAC

Dr. John Boffa
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From: Vicki Gillick
To: Committee, Indigenous Affairs (REPS)
Subject: PAAC submission 24.4.14
Date: Thursday, 24 April 2014 8:54:58 AM
Attachments: PAAC Submission to HoR Alcohol Inquiry 24 4 14 FINAL signed.pdf

Dear Secretary,

Please find attached submission from the People's Alcohol Action Coalition (PAAC) to the
House of Representatives Standing Committee on Indigenous Affairs
Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities

Please contact me if you have any questions.

Regards,

Vicki

Vicki Gillick
Policy Co-ordinator (part-time)
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