Central Australian
**Aboriginal Congress**
ABORIGINAL CORPORATION | ICN 7823

## Submission regarding the

# *Draft Northern Territory Alcohol Action Plan*

March 2023

**Final for submission**

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*Aboriginal health in Aboriginal hands.*

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# Recommendations

**Recommendation 1.** The Plan be updated to summarise the strategic context in which it is seeking to make a difference, including a description of the scale of alcohol-related harm in the Northern Territory and a summary of the policy settings and other events that have affected rates of alcohol-related harm.

**Recommendation 2.** Any revocation of an interim APA by the Director of Liquor Licensing under the new 'opt out' model should be provisional for a period of 12 months, while the effects are monitored through the Northern Territory Alcohol Data Monitoring Group. Should harms increase for that community, or in nearby communities due to access to alcohol in that community, the interim APA should be reimposed for a minimum of two years.

**Recommendation 3.** The Plan should detail the development of a clear and agreed process with service providers, police and community organisations for continuing to protect communities well in advance of the expiry of the interim APAs on 28 February 2027.

**Recommendation 4.** Aboriginal community-controlled organisations, especially Aboriginal community-controlled health services, should be recognised as preferred providers for government funded services to address alcohol-related harm, in recognition of their greater service effectiveness, their higher levels of employment of Aboriginal people, and their formal structures for involving Aboriginal communities in decision-making.

**Recommendation 5.** The Plan should provide explicit recognition of non-residential treatment as part of comprehensive primary health care for clients with alcohol problems, based on Congress' three streams of care (medical; psychological and socio-cultural support).

**Recommendation 6.** In order to address the shortage of an Aboriginal workforce to address alcohol, the Plan should (a) include support for the establishment of a national 'Aboriginal Health Worker' profession at Certificate II level to provide an entry point for community members to the health professions; and (b) support the establishment of a national scheme of scholarships, traineeships and cadetships directed especially through ACCHSs to support the training of Aboriginal psychologists and social workers.

**Recommendation 7.** In line with the strong international evidence that education campaigns have little effect on reducing alcohol-related harms by themselves, the Plan should make clear that development of such plans needs to be part of a broader campaign that includes action on availability, price, and treatment.

**Recommendation 8.** That the Plan should recommend the transfer of the Liquor Commission from the Department of Industry, Tourism and Trade to the Department of Health to reinforce the primacy of a public health perspective in all its decisions.

**Recommendation 9.** That the Plan explicitly recognises the role of two existing collaborative forums for alcohol-related policy advice and decision-making on funding of services, namely the Northern Territory Aboriginal Health Forum and the Northern Territory Executive Council on Closing The Gap / Aboriginal Affairs.

**Recommendation 10.** That the Plan explicitly recognises the role of the recently established Northern Territory Alcohol Data Monitoring Group (NTADMG) to monitor alcohol-related harm, through the regular examination of agreed datasets to inform

evidenced based discussions concerning data trends and emerging issues, and to provide a source of expert advice to the Northern Territory Liquor Commissioner in monitoring future effects of the revocation of interim APAs.

**Recommendation 11.** In recognition of the widely documented ineffectiveness of alcohol industry self-regulation, the Plan should contain an explicit rejection of voluntary self-regulation as a viable strategy for reducing alcohol-related harm.

**Recommendation 12.**That given the recent increases in alcohol-related harm in the Northern Territory, the Northern Territory Government commits to not relaxing any of the provisions of the Northern Territory Liquor Act 2019 through the current three-year review of that legislation. Instead the following legislative and regulatory actions should be taken:

**a)** **Transfer of liquor licences**: maintain the requirement under section 72(2) of the Act, that a new liquor licence application must be submitted if an existing licence is proposed to be transferred to a new owner; and amend section 72 such that the transfer of a licence can be objected to on the grounds that the new owner is not a 'fit and proper person';

**b)** **Secondary supply of alcohol**: that the Act be amended to distinguish between two types of secondary supply (for personal use or for monetary profit) with differing sanctions for each type of offence;

**c)** **Extension of moratorium of takeaway licences**: that the moratorium on new take away alcohol licences in the Northern Territory be extended for another five years;

**d)** **Risk Based Licensing**: that penalties for breaches under the risk-based licensing model be increases so as to act as a significant deterrent;

**e)** **Banned Drinker Register**: that the Act be amended such that licensed clubs and pubs are required to scan patrons identification on entry to confirm that they are not on the BDR, and for the supply of alcohol at a licensed pub or club to a patron who is on the BDR to be an offence;

**f)** **Grocery store sales**: amend Section 53 of the Liquor Act Regulations such that the gross value of the sales of liquor in grocery stores must not exceed 15% of the gross value of the sales of all products;

**g)** **Minimum Unit Price (MUP)**: amend the Liquor Act Regulations such that minimum unit price formula gives meaningful results; that the MUP is indexed annually on 1 July, based on a simple calculation using the Darwin CPI for the previous calendar year; and that the MUP from 1 July 2023 be set at $1.49 as per the intention of the Act

# Background

1. Central Australian Aboriginal Congress (Congress) is a large Aboriginal Community Controlled Health Service (ACCHS) based in Alice Springs. We are one of the most experienced organisations in the country in Aboriginal[1] health, a national leader in primary health care (PHC), and a strong advocate for the health of our people. Congress services over 17,000 Aboriginal people living in Alice Springs and remote communities in Central Australia including Ltyentye Apurte (Santa Teresa), Ntaria (Hermannsburg), Wallace Rockhole, Utju (Areyonga), Mutitjulu and Amoonguna.

2. Our submission is based on our experience of delivering comprehensive primary health care including multidisciplinary clinical care; health promotion and disease prevention programs; and action on the social, cultural, economic and political determinants of health and wellbeing. In particular, Congress has long been an advocate for effective population-level controls on the availability of alcohol.

3. Congress provides this response to the Draft Northern Territory Alcohol Action Plan (the Draft Plan) in two parts: first an overall response to the Draft Plan; and second responses to the specific initiatives and actions that it lists.

# Overall response to the Draft Plan

4. The Draft Plan should include the context and evidence-based analysis to provide a strategic rationale for action. There is now an internationally established evidence-base as to what works to reduce alcohol-related harm, as well as a great deal of data and experience specific to the Northern Territory. This evidence and the context are important guides for future action. In particular the draft Plan should include a description of the scale and direction of alcohol-related harm; and a review of the policy settings and other events that have affected rates of alcohol-related harm in the Northern Territory previously. Such strategic context-setting should take account of the following well-documented information.

## Including a strategic context for the Draft Plan

### High levels of harm persist

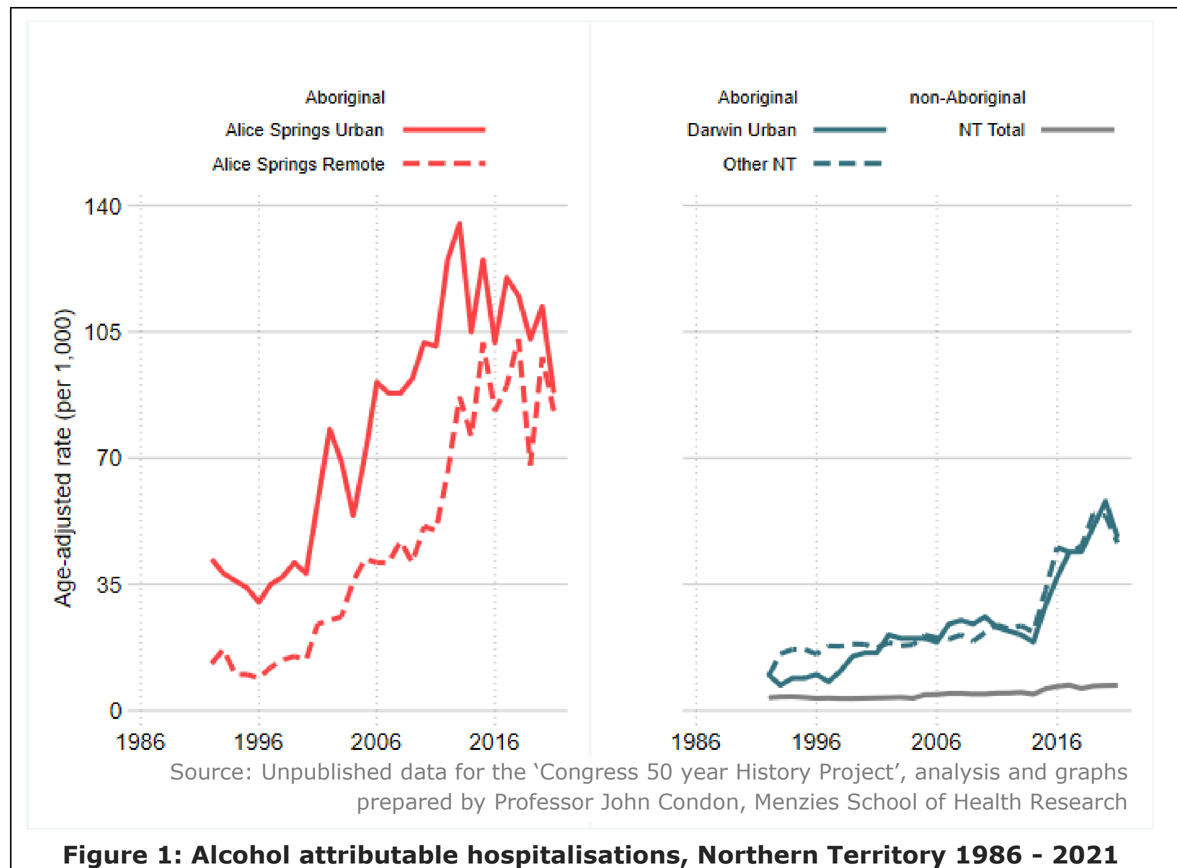
5. There is an exceptionally high level of alcohol consumption in the Northern Territory and it causes significant health and social harms. A few key statistics are required in the Draft Plan to give a sense of the scale of the problem, for example [1]:

   - the Northern Territory has highest per capita alcohol consumption in Australia;
   - alcohol-attributable deaths in the Northern Territory are 3.5 times the rate in Australia generally;
   - alcohol-attributable deaths for Aboriginal people in the Northern Territory are up to 10 times higher compared to non-Indigenous Territorians.

6. Alcohol-related harms are much higher still in some regions and for some populations. The 'Congress 50 year History Project' is being carried at the moment with Dr Jocelyn Davies coordinating the Congress team and partnerships with the Menzies School of Health Research and the Northern Territory Department of Health. Preliminary analysis

[1] In this document we use the term 'Aboriginal' as the most appropriate terms in the Central Australian context to refer to Australia's First Peoples.

carried out by the Menzies School of Health Research for the project indicates that in 2020, alcohol-attributable hospitalisations for Aboriginal people in Alice Springs were approximately 110 per 1,000 population (see *Figure 1*). This equates to around 11,000 alcohol-attributable hospitalisations per 100,000 population, around twenty times the national average of 510 alcohol-attributable hospitalisations per 100,000 [2].




Source: Unpublished data for the 'Congress 50 year History Project', analysis and graphs prepared by Professor John Condon, Menzies School of Health Research

**Figure 1: Alcohol attributable hospitalisations, Northern Territory 1986 - 2021**

7. Higher levels of harm within the Northern Territory justify the use of special measures to combat alcohol-related harm in some regions, *in addition* to an overall consistent approach across the Northern Territory.

### Healthy public policy makes a difference

8. Despite these shocking figures, we have exceptionally good evidence in the Northern Territory about how healthy public policy on alcohol can reduce alcohol-related harm. This is not anecdotal evidence, but high quality data based on publicly available datasets, that allow us to track and assess the impact of policy and legislative changes. A number of reviews have documented these in detail [3].

9. During the 2010s, the Northern Territory Government introduced a range of alcohol reforms to deal with the jurisdiction's long-standing issue with high levels of alcohol-related harm. This included [1, 4]:

   - Point of Sale Interventions (PoSIs, from 2018 called Police Auxiliary Liquor Inspectors or PALIs) at bottle shops in Alice Springs, Katherine and Tennant Creek (2014);
   - a Banned Drinkers Register (BDR) to reduce access to take-away alcohol by problem drinkers (2017);
   - a floor price to prevent the sale of cheap alcohol (2018);
   - a new *Liquor Act* that included risk-based licencing and greater monitoring of on-licence drinking (2019); and

- a commitment to high quality, ongoing independent evaluation.

10. These reforms were based on the evidence from around the world on what works to reduce alcohol related harm. Over their first full year of operation from 1 October 2018 they demonstrated significant reductions in sales of alcohol, which fell by 7% across the Northern Territory as a whole. Reductions in sales were greatest in those cheap types of alcohol associated with the greatest harms, with cask wine supply falling 51% and fortified wine sales down 37% following the introduction of the reforms [5].

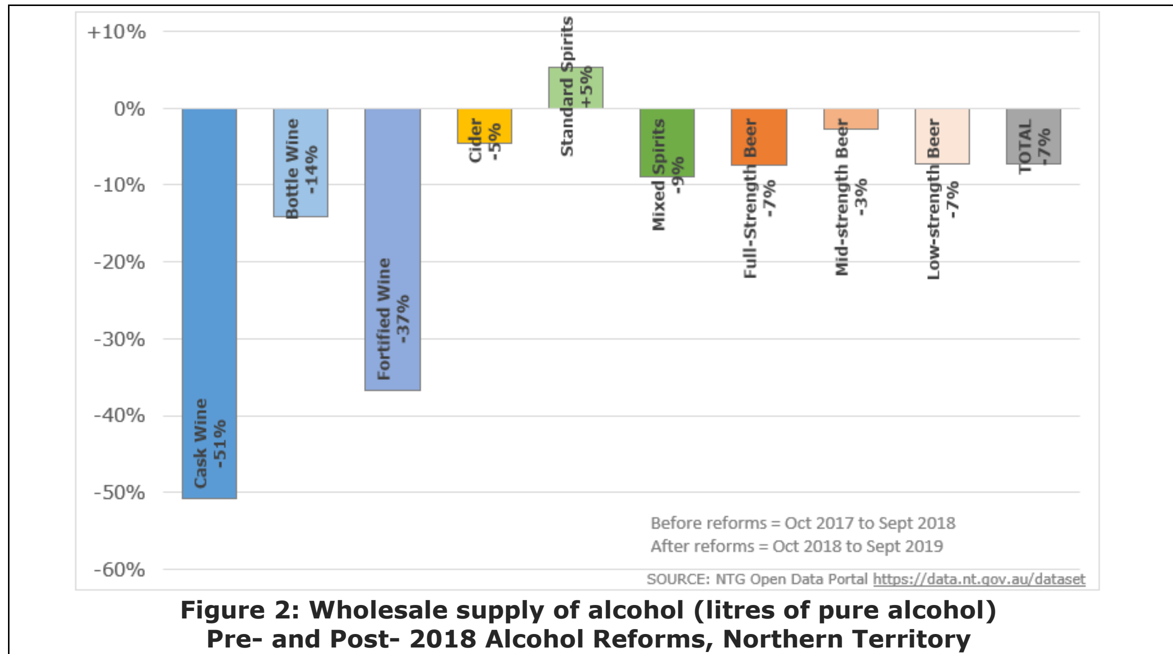



**Figure 2: Wholesale supply of alcohol (litres of pure alcohol) Pre- and Post- 2018 Alcohol Reforms, Northern Territory**

11. As a consequence, there were dramatic falls in alcohol-related harm across the Northern Territory. Domestic violence assaults fell by 11% (equivalent to around 460 fewer DV assaults) in the year following the introduction of the reforms. The effect in some areas was greater – for example, Alice Springs saw over 220 fewer DV assaults after the introduction of the reforms, a fall of 22% (*Figure 3*) [6, 7]. Unfortunately, the COVID-19 pandemic from March 2020 saw an increase in some forms of alcohol-related harm, with domestic violence assaults increasing markedly. While the reasons for this are yet to be examined for the Northern Territory, it is consistent with other Australian and international research showing that the COVID-19 pandemic was associated with both the onset and escalation of family violence [8].

12. The positive effect of the NT Government's Alcohol Reforms package was further undermined by the expiry of the *Stronger Futures in the Northern Territory Act 2012* (Alcohol Protected Areas) provisions in mid-July 2022. Under these provisions, introduced in the wake of the Northern Territory Emergency Response, 34 town camps, six *Aboriginal Land Rights Act* communities and 74 Community Living Areas were declared 'dry'. The provisions had a sunset clause, expiring on 17 July 2022.

13. Given the lack of any substantive consultation with Aboriginal communities, Congress advocated strongly for the Northern Territory Government to pass legislation to extend the provisions for two years. During this time proper consultations could be held which ensure that all voices in the community were heard. During this consultation period communities should be able to 'opt out' of the provisions if they wish with a formal indication that this is what they want to do. Congress, along with many other community organisations predicted that unless this action was taken, there would be a wave of alcohol fuelled violence, much of it directed at Aboriginal women.

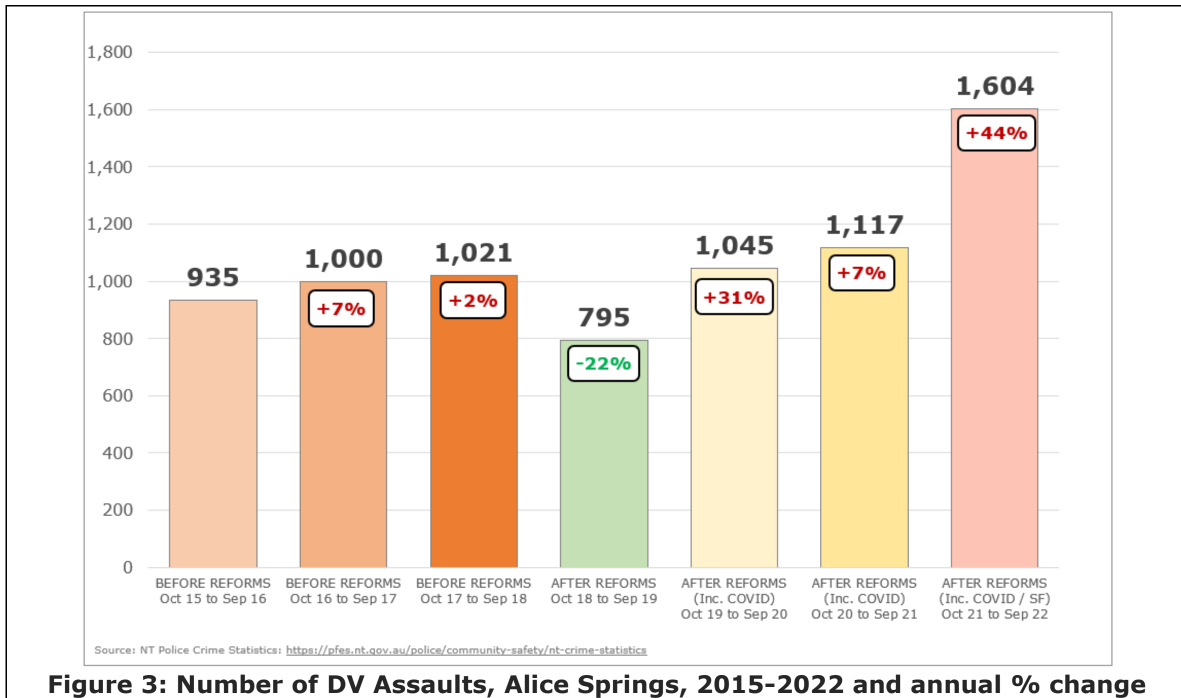



**Figure 3: Number of DV Assaults, Alice Springs, 2015-2022 and annual % change**

14. However, the NT Government did not act: many communities that wished to remain 'dry' had to 'opt in' to continue the restrictions and few . This led to an exponential increase in alcohol related harm, much of it suffered by Aboriginal women and children (see Attachment). This led to serious social disorder, and especially in Alice Springs, to mounting community concern and finally national media and political attention.

15. Fortunately the Northern Territory Government reversed its position and is once again supporting an evidence-based, public health approach to alcohol in the Northern Territory. Following a visit to Central Australia by the Prime Minister and senior Federal Ministers, on 25 January 2023 the Northern Territory Chief Minister announced immediate restrictions on take away alcohol availability in Alice Springs [9]:

- One sale per day per person, following industry guidance;
- Alcohol free days on Monday and Tuesday for takeaway purchases; and
- Limiting hours of alcohol being sold between 3pm-7pm, except for on Saturdays.

16. This was followed on 6 February 2023 by a joint statement by the Chief Minister and Prime Minister of a new 'opt out' model to apply to all communities previously subject to alcohol restrictions under the Stronger Futures legislation. Coming into effect on 16 February, this meant that all communities previously under the *Stronger Futures* provisions are subject to interim Alcohol Protection Area (APA) provisions, making them once again 'dry' areas;

17. The statement also announced a package of $250 million from the Australian Government to address the underlying drivers of alcohol abuse and violence, including for improved community safety and cohesion; job creation; better services; addressing Foetal Alcohol Spectrum Disorders; investing in families; and on Country learning.

18. While it is early days, as expected the restrictions on take away alcohol and declaration of interim APAs is already having a significant effect on the levels of alcohol-related harm in Alice Springs (*Figures 4 and 5*).

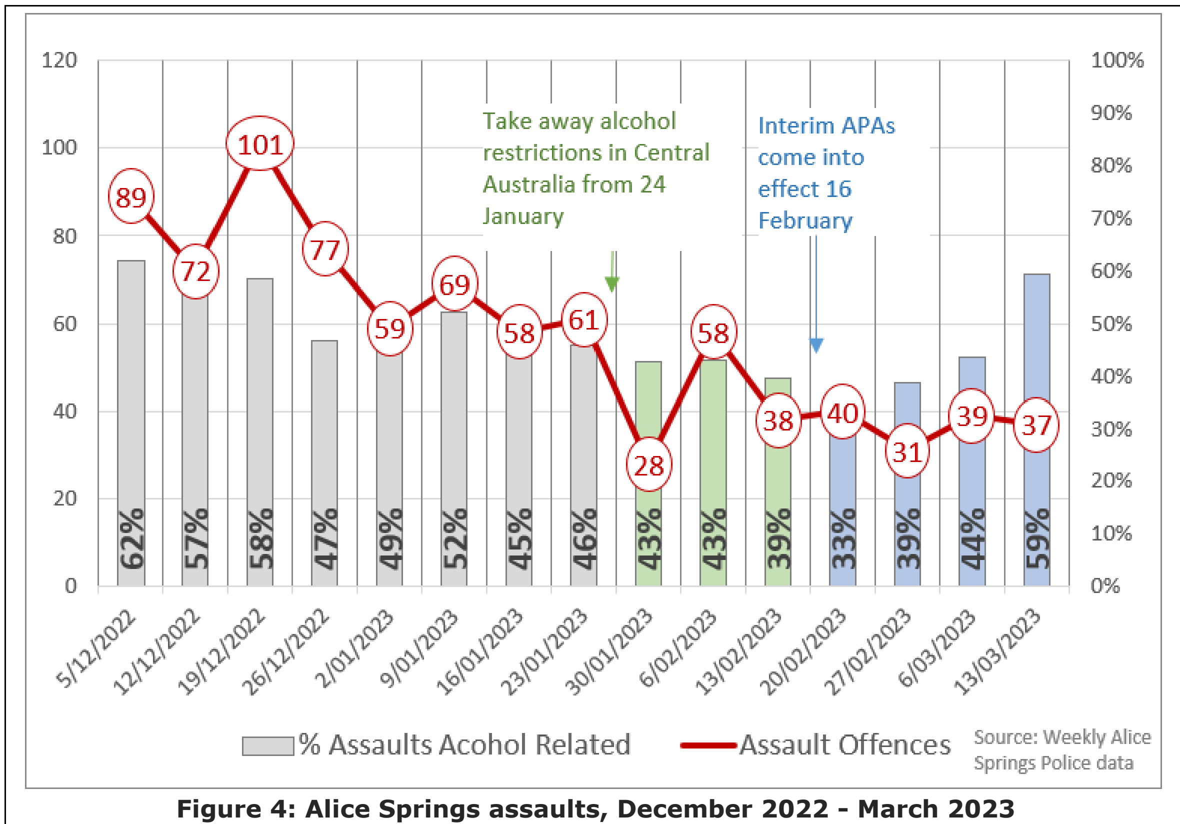



**Figure 4: Alice Springs assaults, December 2022 - March 2023**

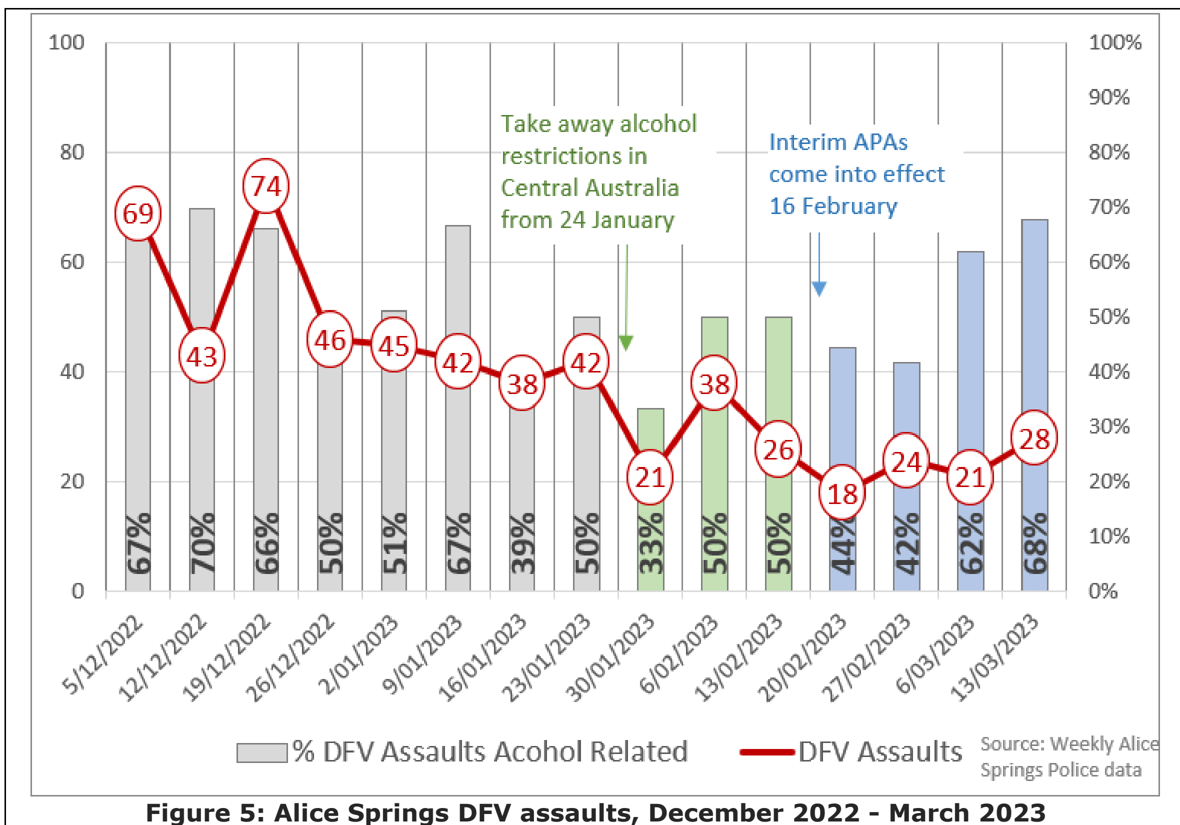



**Figure 5: Alice Springs DFV assaults, December 2022 - March 2023**

**Recommendation 1.** The Plan be updated to summarise the strategic context in which it is seeking to make a difference, including a description of the scale of alcohol-related harm in the Northern Territory and a summary of the policy settings and other events that have affected rates of alcohol-related harm.

# Response to specific areas of the Draft Plan

## 1. Strengthen and support community responses

### Interim Alcohol Protection Areas

19. This section of the draft Plan will need substantial revision in the light of the 'opt out' model for interim APAs introduced on 16 February. Congress supports the new model, noting that a community's interim APA may be revoked if:

- the community has a satisfactory community alcohol plan;
- at least 60% of adults who reside in the community support the community alcohol plan;
- the application contains the signed consent of the registered owner/s of the land; and
- the Director of Liquor Licensing is satisfied that the revocation will not have significant adverse impacts on the community.

20. However, we believe that any revocation of an interim APA should be provisional only, for a period of 12 months, while the effects are monitored through the Northern Territory Alcohol Data Monitoring Group (NTADMG: see below) using a discrete set of KPIs agreed by the NTADMG. Should harms increase then the interim APA should be reimposed for a minimum of two years.

21. We also note that the amendments to the Act reinstating the APAs are time-limited and set to repeal on 28 February 2027. Unless there is a clear and agreed process ahead of that date, the Northern Territory will once again find itself in the position it found itself with the expiry of the *Stronger Futures* provisions; a similar failure to act well ahead of February 2027 risks leading once more a wave of alcohol fuelled violence and property crime.

**Recommendation 2.** Any revocation of an interim APA by the Director of Liquor Licensing under the new 'opt out' model should be provisional for a period of 12 months, while the effects are monitored through the Northern Territory Alcohol Data Monitoring Group. Should harms increase for that community, or in nearby communities due to access to alcohol in that community, the interim APA should be reimposed for a minimum of two years.

**Recommendation 3.** The Plan should detail the development of a clear and agreed process with service providers, police and community organisations for continuing to protect communities well in advance of the expiry of the interim APAs on 28 February 2027.

### Treatment services

22. We support the draft Plan's aim to

> *Support individuals to obtain help and systems to respond – ensure our alcohol and other drug (AoD) treatment services and options are culturally safe and fit for purpose (Action #3).*

23. To this end, the plan should note that Aboriginal community controlled health services (ACCHSs) have a range of inter-linked structural advantages in delivering such services and hence improved outcomes compared to non-Indigenous services (government or private). These structural advantages include:

    a) *a holistic approach to service delivery*, including through addressing the social determinants of child and family wellbeing, based on a lived understanding of the Aboriginal conception of health;

    b) *culturally responsive services*: Aboriginal community-controlled health services are able to provide their care within a culturally responsive setting, based on local knowledge, an Aboriginal governance structure and workforce, and strong relationships with the communities that they serve;

    c) *better access, based on community engagement and trust*: a strong practice of community engagement founded on strong relationships with the community, in turn based on a sense of ownership and history. Aboriginal people consistently prefer to use Aboriginal organisations such as ACCHSs over mainstream services giving them a strong advantage in addressing access issues, particularly when dealing with culturally sensitive issues relating to sexuality, pregnancy, childbirth and addiction;

    d) *Aboriginal governance*: individuals and communities are encouraged and enabled to participate in decisions on service delivery, including though formal governing Boards, including a high proportion of Aboriginal women in governance positions;

    e) *an Aboriginal workforce*: community-controlled services are significantly better at attracting, training and retaining Aboriginal staff leading to greater cultural appropriateness of services as well as benefits through providing employment and capacity building in the Aboriginal community, especially for Aboriginal women;

    f) *high levels of accountability*: Aboriginal community-controlled health services are highly accountable to their funders for the services they provide through robust data collection and a reporting regime which is above the requirements of mainstream health and wellbeing services.

24. Such advantages were recognised by a Senate Inquiry which recommended that [10]:

    > *… future selection criteria and funding guidelines should give weighting to the contribution and effectiveness of Aboriginal and Torres Strait Islander organisations to provide to their community beyond the service they are directly contracted to provide.*

**Recommendation 4.** Aboriginal community-controlled organisations, especially Aboriginal community-controlled health services, should be recognised as preferred providers for government funded services to address alcohol-related harm, in recognition of their greater service effectiveness, their higher levels of employment of Aboriginal people, and their formal structures for involving Aboriginal communities in decision-making.

25. Congress has developed a comprehensive model of primary health care (PHC), founded on both addressing the determinants of health and wellbeing at a population level as well as treating poor health and wellbeing as it is expressed in the lives of individual Aboriginal community members. This comprehensive approach is mirrored in the organisation's approach to AOD issues (*Figure 6*).

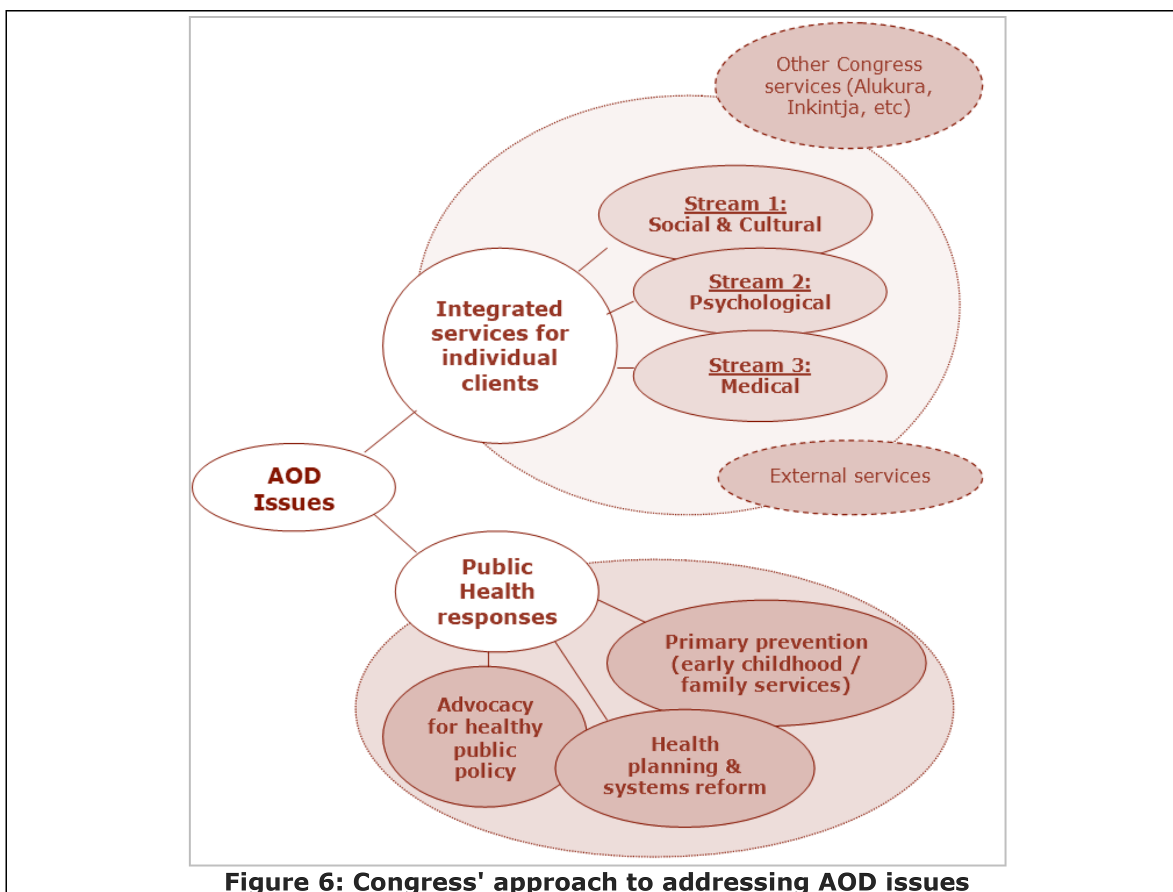



**Figure 6: Congress' approach to addressing AOD issues**

26. Our approach includes:

a) Public health responses to the health threats caused by alcohol and other drugs, such as:

   i. *Primary prevention* through a suite of early childhood development and family services

   ii. *Advocacy for evidence-based healthy public policy* including increasing the price of alcohol; reducing the supply of alcohol; and targeting the heaviest drinkers through programs such as the Northern Territory's Banned Drinkers register

   iii. *Health planning and systems reform* to reorient health systems meet the needs of Aboriginal communities through a number of key principles, including a holistic definition of health; using a social determinants approach; comprehensive primary health care; and Aboriginal community control

b) An integrated model of care for individual clients based on three streams of care (*Figure 7)*:

   i. *Social and Cultural Support* delivered by a team of Aboriginal workers with cultural knowledge, language skills and an in-depth knowledge of the Aboriginal community, alongside qualified social workers, this stream provides a wide range of assistance to clients such as individual advocacy; social support; cultural support; access to medical care; case management; AOD counselling and brief interventions.

ii. *Psychological therapy* carried out by qualified therapists and social workers, usually at the SEWB Service offices although sessions with clients in community settings are also available

iii. *Medical support* provided by Congress General Practitioners and other members of the PHC team including and pharmacotherapies to manage addiction / withdrawal where indicated.

| Stream | Provided by | Support provided |
|---|---|---|
| **Social and Cultural Support** | Within SEWB Service by:<br>• Aboriginal Care Management Workers (ACMWs)<br>• Aboriginal Cultural Integration Practice Advisor<br>• Social workers | • Client advocacy<br>• Cultural support<br>• Social support<br>• Access to medical care<br>• AOD counselling, brief interventions<br>• Case management |
| **Psychological Stream** | Within SEWB Service by:<br>• Psychologists<br>• Mental Health Accredited Social Workers | • CBT and related therapies including Motivational Interviewing, Schema Therapy, Mindfulness Therapies<br>• Brief Interventions<br>• Neuropsychological assessment |
| **Medical Stream** | From Congress clinics and outreach:<br>• Congress General Practitioners<br>• Registered Nurses<br>• Aboriginal Health Practitioners | • Pharmacotherapies<br>• Chronic disease management |

**Figure 7: Summary of Congress three streams of care in the treatment of alcohol-related disorders in primary health care**

**Recommendation 5.** The Plan should provide explicit recognition of non-residential treatment as part of comprehensive primary health care for clients with alcohol problems, based on Congress' three streams of care (medical; psychological and socio-cultural support).

### Supporting an Aboriginal alcohol workforce

27. It is well known that Australia is facing a crisis in the health workforce, exacerbated by the COVID-19 pandemic. However, the crisis for formally qualified Aboriginal health professionals has been in evidence for many years. For example, the number of Aboriginal Health Practitioners registered in the NT has fallen over the last 10 years: in 2012-13 there were 228 Aboriginal and Torres Strait Islander Health Practitioners registered in the Northern Territory, in 2020-21 there were 205 [11].

28. The reasons for this are complex but include the practice, regulatory and community demands on these positions. Many of the same factors are in play in terms of recruiting, training and retailing other qualified Aboriginal staff such as AOD workers, especially in remote areas.

29. Congress proposes that addressing this situation requires action on the social determinants especially through reducing poverty and inequality; a focus on early childhood development; substantially increased investment in public school education;

mass-campaign adult literacy programs such as that run by the Literacy for Life Foundation; and improved housing.

30. In addition, we need to lay down a pathway for community members who want to serve their communities, and provide a stepping-stone for entry level Aboriginal staff to start along that pathway. This means returning to an 'Aboriginal Health Worker' profession founded on 'basic skills' at Certificate II level. This role will have some basic health promotion and clinical skills, but will also bring their incredibly important cultural, language and community knowledge to the primary health care team. Some of these workers may be content to remain at this level. But others, once they gather confidence and skills, will then more easily progress to becoming 'Aboriginal and Torres Strait Islander Health Practitioners', or to AOD and youth workers.

31. However, we need to also address the shortage of Aboriginal psychologists and social workers – these positions are critical in providing culturally responsive leadership in AOD services, and encouraging and supporting more junior Aboriginal staff. This requires a national scheme of traineeships, scholarships and cadetships directed especially through ACCHSs to encourage and support Aboriginal community members to obtain these qualifications.

**Recommendation 6.** In order to address the shortage of an Aboriginal workforce to address alcohol, the Plan should (a) include support for the establishment of a national 'Aboriginal Health Worker' profession at Certificate II level to provide an entry point for community members to the health professions; and (b) support the establishment of a national scheme of scholarships, traineeships and cadetships directed especially through ACCHSs to support the training of Aboriginal psychologists and social workers.

### Education campaigns

32. We note the draft Plan's intention to:

> *Develop targeted education campaigns for specific cohorts with the goal of improving drinking culture and minimizing harm in the community (Action #7)*

33. However, the international evidence is clear that education and persuasion strategies, including school-based education, media campaigns and social marketing, cannot be relied upon as an effective approach *by themselves* [12]. They should only be considered as part of a broader campaign that includes action on availability, price, and treatment.

**Recommendation 7.** In line with the strong international evidence that education campaigns have little effect on reducing alcohol-related harms by themselves, the Plan should make clear that development of such plans needs to be part of a broader campaign that includes action on availability, price, and treatment.

## 2. Comprehensive, collaborative and coordinated government approach

34. In addition to the transfer of responsibility for alcohol policy and coordination to the Department of Chief Minister and Cabinet proposed in the Draft Framework, the Liquor Commission should be transferred from the Department of Industry, Tourism and Trade to the Department of Health.

35. This is important to reinforce the fact that all decisions regarding the regulation of liquor licences and in hearing and determining complaints under the Liquor Act are made primarily from a public health rather than a business or industry perspective.

36. The newly established Northern Territory Alcohol Data Monitoring Group is the key forum for progressing a coordinated approach to data and monitoring of alcohol related harm. However, for policy advice and decision-making on funding of services, there are two other forums which need explicit recognition in the Action Plan. These are:

    a) *The Northern Territory Aboriginal Health Forum,* a peak-level partnership with considerable public health expertise and a long history of successful collaboration between the Northern Territory and Australian Departments of Health, the National Indigenous Australians Agency (NIAAA) and Aboriginal Medical Services Alliance Northern Territory (AMSANT). The NTAHF provides strategic guidance and makes decisions about key policy issues to improve Aboriginal health and wellbeing, and supports health organisations across the NT to plan, share information and coordinate their programs and activities.

    b) *The Northern Territory Executive Council on Closing The Gap / Aboriginal Affairs*[2]*.* The Council has membership from NT Chief Minister and Cabinet, the NIAA, the Local Government Association of the Northern Territory (LGANT) and the Aboriginal Peak Organisations Northern Territory (APONT). Its role is to oversee the Northern Territory coordination and implementation of the National Agreement on Closing the Gap. Given the high impact of alcohol on a number of the Closing the Gap targets, and the large amount of funding announced by the Australian Government to address the underlying determinants of alcohol related harm, the involvement of the Executive Council needs to be made explicit in the draft Action Plan.

**Recommendation 8.** That the Plan should recommend the transfer of the Liquor Commission from the Department of Industry, Tourism and Trade to the Department of Health to reinforce the primacy of a public health perspective in all its decisions.

**Recommendation 9.** That the Plan explicitly recognises the role of two existing collaborative forums for alcohol-related policy advice and decision-making on funding of services, namely the Northern Territory Aboriginal Health Forum and the Northern Territory Executive Council on Closing The Gap / Aboriginal Affairs.

## 3. Research, data and evaluation

37. We welcome the commitment to monitor progress through a public data portal that includes figures updated as they become available. The current statistics published on the *Alcohol Policy in the Northern Territory* data page[3] are essential and should be maintained; any 'refresh' should build on this excellent data source and not remove any detail it currently contains. In particular data should be made available (a) in a timely way, (b) on a regional basis, and (c) consistently over a long period of time to allow measurement of trends.

38. To monitor the data and recommend appropriate responses to government, we support the recent establishment of the Northern Territory Alcohol Data Monitoring

[2] https://aboriginalaffairs.nt.gov.au/__data/assets/pdf_file/0008/1039814/closing-the-gap-implementation-plan-web.pdf

[3] https://alcoholpolicy.nt.gov.au/data-and-evaluation

Group (NTADMG). The role of the Group should be explicitly recognised in the Plan. It should also be seen as the primary source of expert advice to the Northern Territory Liquor Commission in monitoring future effects of the revocation of interim APAs.

39. The list of indicators on page 12 of the draft Plan are appropriate, but need to be made consistent with the terms of reference of the Northern Territory Alcohol Data Monitoring Group, noting that:

- the rate of alcohol *attributable* deaths per 100,000 people (not alcohol-*induced* deaths) is the standard internationally accepted measure of alcohol-related harm
- current monthly crime statistics published by the Northern Territory Police are essential and should be continued;
- hospital data, including ED presentations need to be published in a timely manner;
- wholesale alcohol supply data[4] should continue to be made easily publicly available by alcohol type and regions as in previous years, and not published as a summary only.

**Recommendation 10.** That the Plan explicitly recognises the role of the recently established Northern Territory Alcohol Data Monitoring Group (NTADMG) to monitor alcohol-related harm, through the regular examination of agreed datasets to inform evidenced based discussions concerning data trends and emerging issues, and to provide a source of expert advice to the Northern Territory Liquor Commissioner in monitoring future effects of the revocation of interim APAs.

## 4. Effective liquor regulation and compliance

### Ineffectiveness of industry self-regulation

40. The recent crisis of escalating alcohol-related harms and antisocial behaviour in Alice Springs was initially met by the Northern Territory Government with calls to alcohol retailers to self-regulate by voluntarily limiting alcohol sales [13]. However, there is substantial evidence that alcohol industry self-regulation (for example through responsible service agreements, and marketing codes and labelling) have been shown to be ineffective at reducing alcohol-related harm, particularly because they are resource-intensive to enforce and often contain vague language that allows their intent to be subverted [14-16].

**Recommendation 11.** In recognition of the widely documented ineffectiveness of alcohol industry self-regulation, the Plan should contain an explicit rejection of voluntary self-regulation as a viable strategy for reducing alcohol-related harm.

### Review of Northern Territory Liquor Act 2019

41. Congress has made a separate submission to the Three-Year Review of the *Northern Territory Liquor Act 2019*, and our response here largely follows that submission. We believe that the *Northern Territory Liquor Act* has been a major contributor to protecting Territorians from alcohol-related harm. Given this, and the increase in alcohol-related harms in recent months due to the effect of COVID-19 and the expiry

[4] https://industry.nt.gov.au/economic-data-and-statistics/business/wholesale-alcohol-supply/wholesale-alcohol-supply-data

of the Stronger Futures alcohol provisions, Congress argues very strongly against any relaxing of the Act's provisions at this time. To do so on the back of the of the wave of violence and property crime we have just experienced would be, in our view, reckless and irresponsible and would lead inevitably to the renewing of community and political concern within and beyond the Northern Territory.

42. The following paragraphs set out our position relating to the review of the *Northern Territory Liquor Act 2019*.

### Transfer of liquor licences

43. The transfer of a liquor licence from one owner to another provides an important opportunity for community and expert feedback on how the licence has been operating to date, and for the new licensees to document and be held accountable for their plans to address any issues. A public process that re-examines the licence's operations and requires the submission of a new licence application is therefore entirely appropriate and should not be relaxed.

44. We support amending section 72 such that the transfer of a licence can be objected to on the grounds that the new owner is not a 'fit and proper person'. This would ensure consistency with the provisions relating to the issue of a new licence (section 61) which allow this as a grounds for objection.

### Secondary supply of alcohol

45. The secondary supply of alcohol is a serious problem that has the potential to undermine key policy interventions such as the Banned Drinkers Register (BDR) and dry areas provisions. However, we think it is important that the legislation clearly distinguishes between two types of secondary supply:

    a) where a person buys a relatively small amount of alcohol to share with family or other community members, and where there is no attempt to profit monetarily from the supply. In this case, we believe that this offence should not be criminalised, and that an appropriate sanction is that the supplier is themselves placed on the BDR;

    b) where a person seeks to supply alcohol to others for monetary profit, whether this is in a remote community or in an urban centre. This should be a criminal offence and the appropriate sanctions should be increased as suggested in the Discussion Paper supporting the review of the Act.

### Extension of moratorium of takeaway licences

46. The five year moratorium on new takeaway licences was a recognition of the particular harms associated with these types of alcohol outlets. Numerous studies5 have shown that decreasing the physical availability of take-away alcohol decreases per capita consumption and reduces violence and property damage. Further, the consumption of take-away alcohol in home or community settings, rather than on licensed premises, is associated with domestic violence [17].

47. Accordingly, Congress strongly supports extending the moratorium on new take away alcohol licences in the Northern Territory for another five years. To end the

[5] For example Sherk A et al *Alcohol Consumption and the Physical Availability of Take-Away Alcohol: Systematic Reviews and Meta-Analyses of the Days and Hours of Sale and Outlet Density*. J Stud Alcohol Drugs. 2018 Jan;79(1):58-67. PMID: 29227232;

moratorium in 2023, after the traumatic events of the second half of 2022 would be both counter to the evidence and a matter of national public concern.

### Risk Based Licensing model

48. The Risk-Based Licensing model is an excellent example of legislative best-practice in preventing alcohol-related harm. However, to be fully effective, it requires penalties that are significant enough to act as a deterrent. Congress therefore supports the position that penalties for breaches should attract tougher penalties.

### 5.8. Banned Drinker Register

The key gaps in the application of the BDR provisions are secondary supply (see 5.4 above) and the fact that those on the BDR continue to drink alcohol at on-license venues. We suggest that, in line with Section 7 of the *Alcohol Harm Reduction Act 2017* which says that someone on the BDR *"is prohibited from purchasing, possessing or consuming alcohol during the period for which the order is in force",* licensed pubs and clubs should be required to scan patrons identification on entry to confirm that they are not on the BDR. This who are on the BDR should be refused access to the premises. The supply of alcohol at a licensed pub or club to a patron who is on the BDR should be an offence. Note that many pubs and clubs already require patrons to sign in and provide identification, either electronically or on paper.

### Other Issues (1): Grocery store sales

Section 53 of the *Liquor Act* Regulations (*Grocery store authority ancillary operations*) specifies "the gross value of the sales of liquor by the licensee on the licensed premises must not exceed 25% of the gross value of the sales of all products by the licensee, during each quarter". We suggest amending this reduce the gross value of alcohol sales to 15% of that of all products, as originally recommend by the Riley Review (Recommendation 2.5.19, page 55).

### Other Issues (2): Minimum Unit Price

Section 121 of the *Liquor Act (*Minimum sale price) specifies that alcohol may not be sold for less than $1.30 per standard drink. This amount is to be indexed from 1 July 2019, with the new price to take effect on 1 July of each year. However, the minimum sale price has apparently remained at $1.30[6], in contravention of the law.

We also note an apparent error in the drafting of the Regulations (Section 107) regarding the calculation of the indexation of the minimum unit price. It appears to us that if followed, the calculation method in the Regulations gives meaningless results.

Accordingly, we advocate:

- amending the *Liquor Act Regulations* Section 107 such that the $1.30 minimum unit price is indexed annually on 1 July, based on a simple calculation using the Darwin CPI for the previous calendar year;
- increasing the minimum unit price from 1 July 2023 using an amount indexed by Darwin CPI for the period 1 July 2019 to 31 December 2022, as was clearly originally intended in the legislation. We calculate the new minimum sale price to be $1.49 per standard drink as at the end of the December quarter 2022.

[6] Northern Territory Government (2022) *Alcohol minimum floor price*. Available: https://industry.nt.gov.au/publications/business/policies/floor-price

**Recommendation 12.** That given the recent increases in alcohol-related harm in the Northern Territory, the Northern Territory Government commits to not relaxing any of the provisions of the Northern Territory Liquor Act 2019 through the current three-year review of that legislation. Instead the following legislative and regulatory actions should be taken:

**(a) Transfer of liquor licences**: maintain the requirement under section 72(2) of the Act, that a new liquor licence application must be submitted if an existing licence is proposed to be transferred to a new owner; and amend section 72 such that the transfer of a licence can be objected to on the grounds that the new owner is not a 'fit and proper person';

**(b) Secondary supply of alcohol**: that the Act be amended to distinguish between two types of secondary supply (for personal use or for monetary profit) with differing sanctions for each type of offence;

**(c) Extension of moratorium of takeaway licences**: that the moratorium on new take away alcohol licences in the Northern Territory be extended for another five years;

**(d) Risk Based Licensing**: that penalties for breaches under the risk-based licensing model be increases so as to act as a significant deterrent;

**(e) Banned Drinker Register**: that the Act be amended such that licensed clubs and pubs are required to scan patrons identification on entry to confirm that they are not on the BDR, and for the supply of alcohol at a licensed pub or club to a patron who is on the BDR to be an offence;

**(f) Grocery store sales**: amend Section 53 of the Liquor Act Regulations such that the gross value of the sales of liquor in grocery stores must not exceed 15% of the gross value of the sales of all products;

**(g) Minimum Unit Price (MUP):** amend the Liquor Act Regulations such that minimum unit price formula gives meaningful results; that the MUP is indexed annually on 1 July, based on a simple calculation using the Darwin CPI for the previous calendar year; and that the MUP from 1 July 2023 be set at $1.49 as per the intention of the Act.

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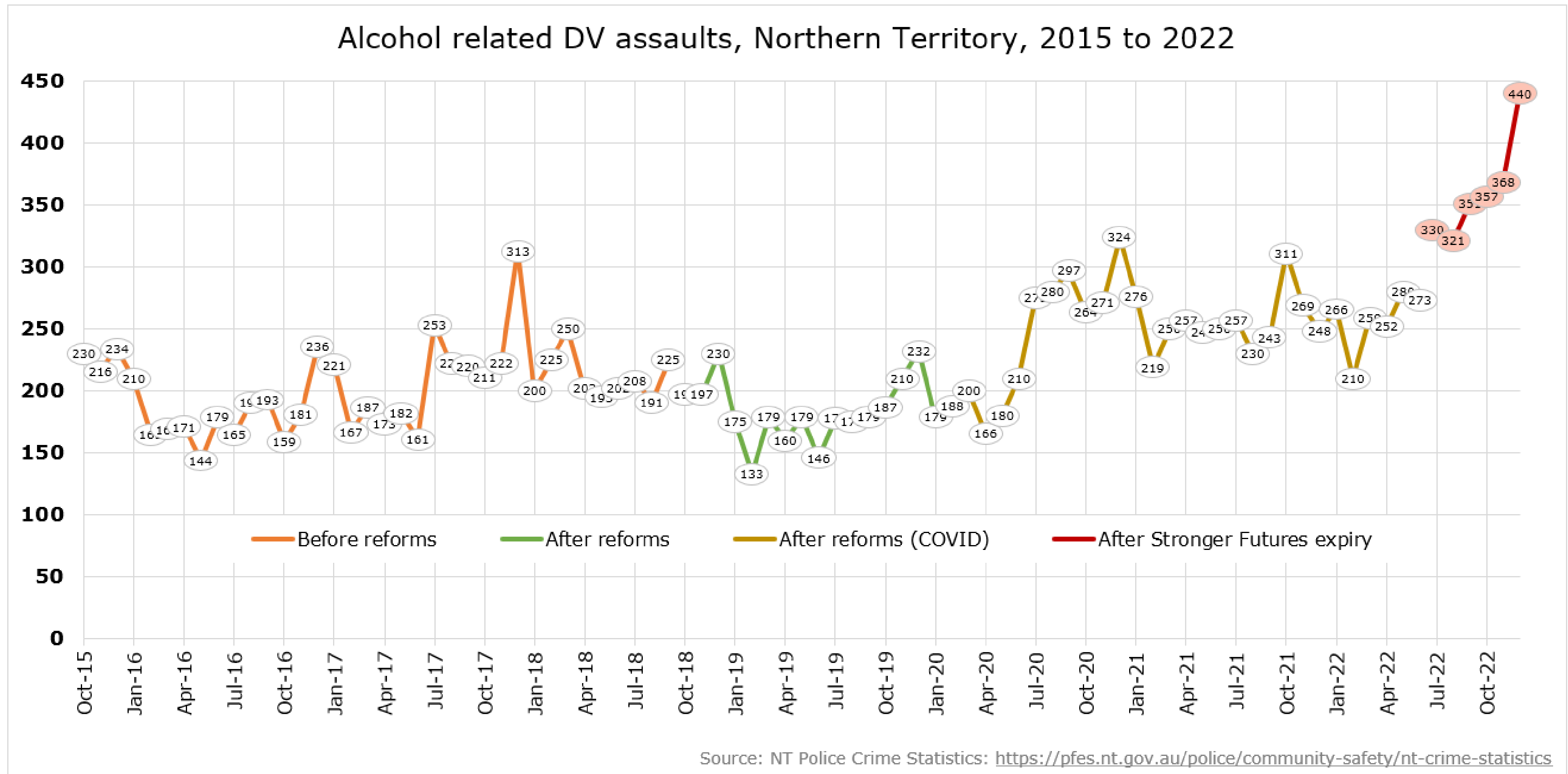
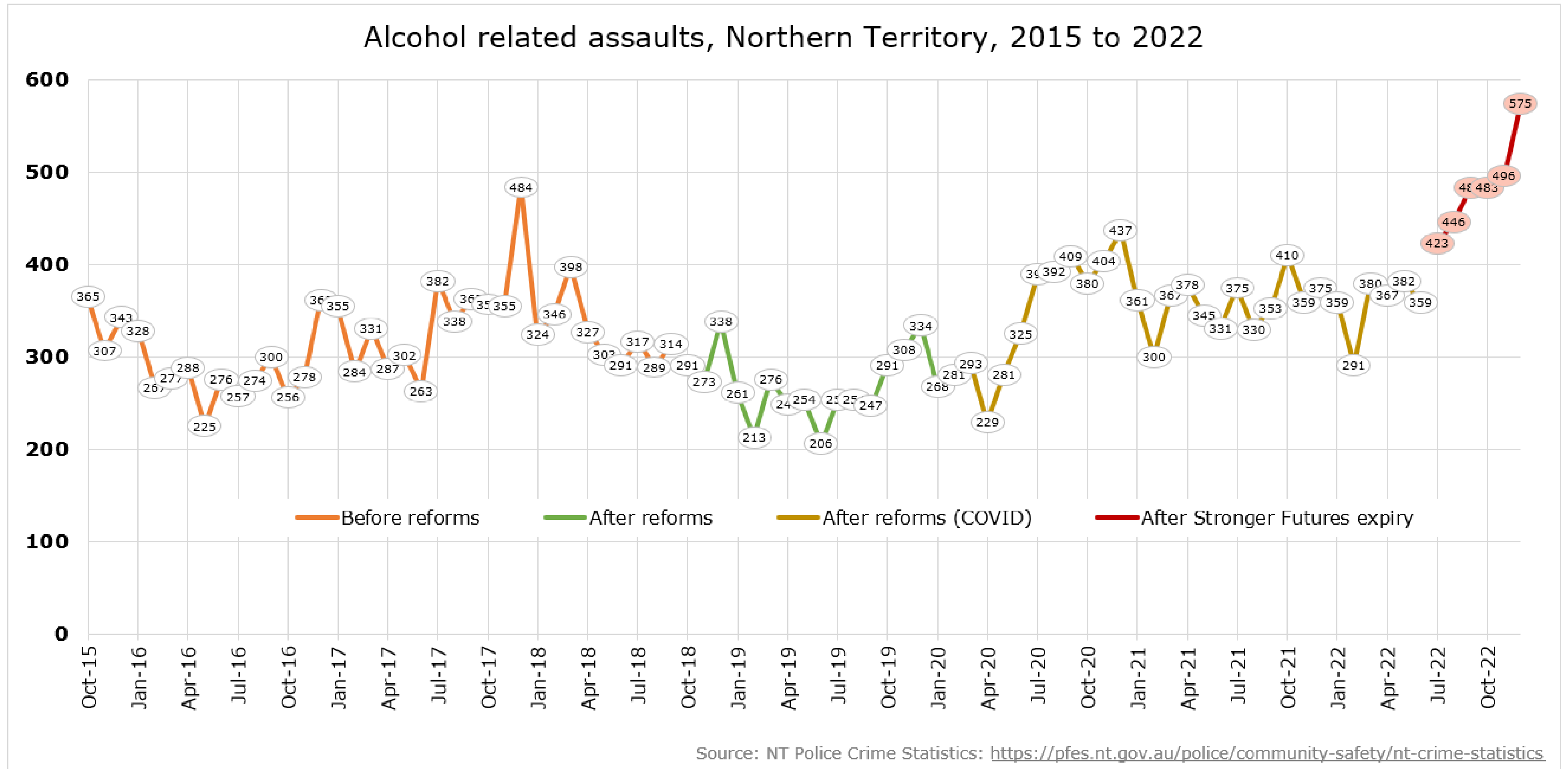
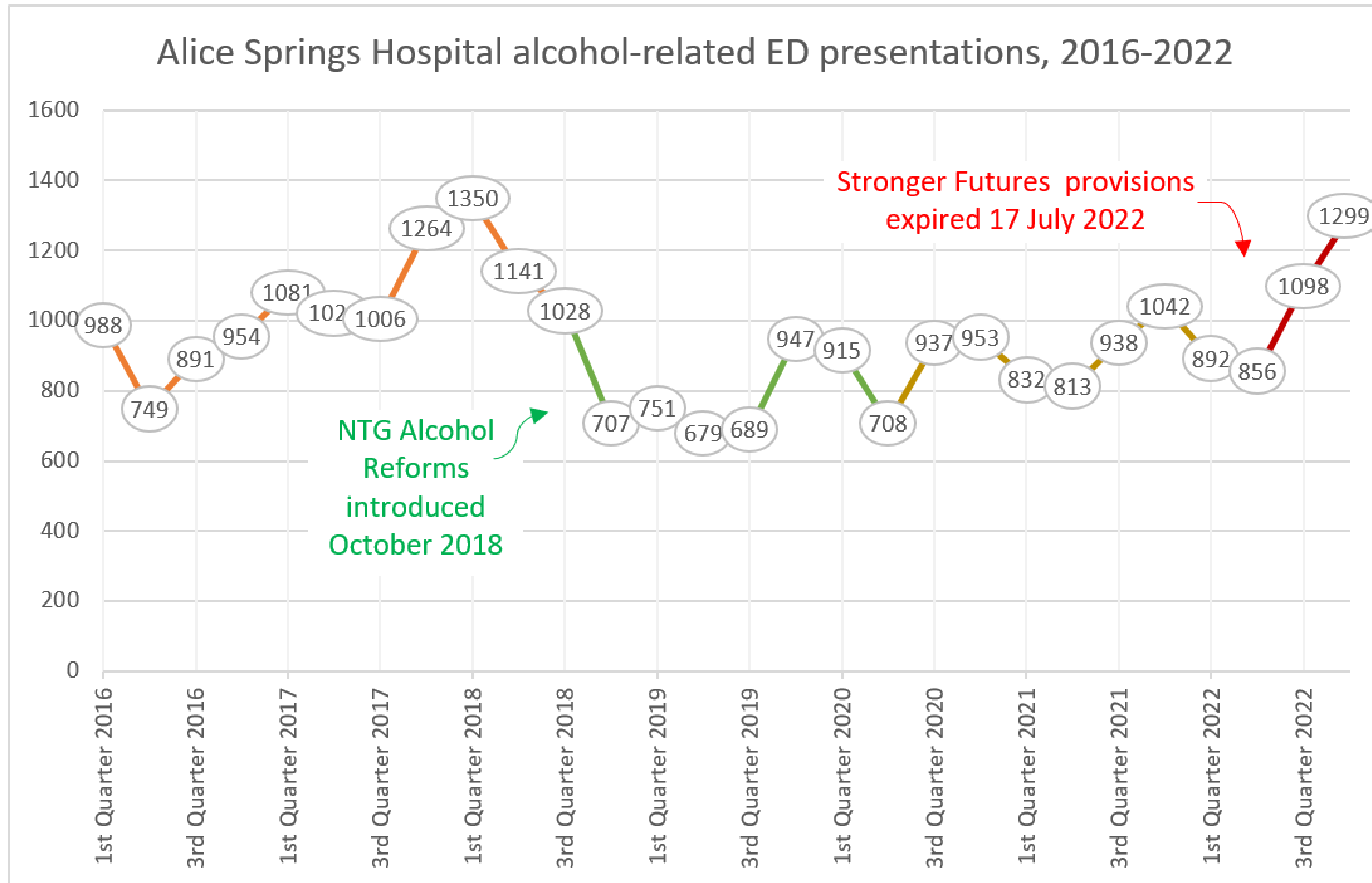
# ATTACHMENT A




Alcohol related assaults, Northern Territory, 2015 to 2022
Before reforms
After reforms
After reforms (COVID)
After Stronger Futures expiry
Source: NT Police Crime Statistics: https://pfes.nt.gov.au/police/community-safety/nt-crime-statistics


Alice Springs Hospital alcohol-related ED presentations, 2016-2022
Stronger Futures provisions expired 17 July 2022
NTG Alcohol Reforms introduced October 2018
1600
1400
1200
1000
800
600
400
200
0
988
749
891
954
1081
102
1006
1264
1350
1141
1028
707
751
679
689
947
915
708
937
953
832
813
938
1042
892
856
1098
1299
1st Quarter 2016
3rd Quarter 2016
1st Quarter 2017
3rd Quarter 2017
1st Quarter 2018
3rd Quarter 2018
1st Quarter 2019
3rd Quarter 2019
1st Quarter 2020
3rd Quarter 2020
1st Quarter 2021
3rd Quarter 2021
1st Quarter 2022
3rd Quarter 2022