

# Process Evaluation of the Banned Drinker Register in the Northern Territory

Prepared by Professor James Smith & Dr Elizabeth Adamson

June 2018

## **Acknowledgements**

This evaluation report was prepared with the independent oversight of Professor James Smith and Dr Elizabeth Adamson from Menzies School of Health Research. This was undertaken on an in-kind basis.

A time-limited BDR Evaluation Working Group was established to provide advice and guidance on the development of the evaluation between March-June 2018. We acknowledge the time and input of all members of this group.

Representatives from the Northern Territory Government prepared the descriptive analysis presented in Section 3 of the report. This included input from:

- Carolyn Whyte, Department of the Attorney-General & Justice
- Cecelia Gore, Department of Health
- Chris Moon, Department of Health
- Andy Lai, Department of Health
- Alana Cook, Department of the Attorney-General & Justice
- Foster Lau, Department of the Attorney-General & Justice
- Kylie Williams, Department of the Attorney-General & Justice
- Yuejen Zhao, Department of Health

We thank them for preparing this component of the evaluation report.

The Alcohol Harm Minimisation Working Group and the Alcohol Review Implementation Team Steering Committee were both consulted during the drafting of this report. We thank them for their feedback.

We thank all the participants that took part on the key informant interviews that contributed to the data analysed in Section 5 of this report.

## **Suggested Citation**

Smith, J. & Adamson, E. (2018). *Process evaluation of the Banned Drinker Register in the Northern Territory*. Darwin, Menzies School of Health Research.

## Contents

Acknowledgements.....	1
Terminology.....	6
Table of Figures .....	9
List of Tables .....	15
Executive Summary .....	16
1 Recommendations.....	19
2 Alcohol harm minimisation in the Northern Territory and the BDR.....	21
2.1 Background .....	21
2.1.1 Alcohol context in the NT.....	21
2.1.2 Alcohol Harm Minimisation in the Northern Territory .....	22
2.1.3 What is the Banned Drinker Register?.....	23
2.1.4 Ministerial Commitment to Evaluation .....	27
2.2 Aim of the Evaluation .....	27
2.3 Process Evaluation Approach.....	28
3 Descriptive analysis of the BDR.....	29
3.1 Aims and methods of descriptive analysis .....	29
3.2 Takeaway Alcohol Transactions .....	29
3.2.1 Number of transactions.....	30
3.2.2 Percentage of transactions by a person on the BDR.....	31
3.2.3 Transactions by weekday .....	32
3.2.4 Transactions by time of day .....	33
3.3 Persons on the BDR .....	34
3.3.1 Number of people on the BDR over time by ban type .....	34

3.3.2	Demographics .....	36
3.3.3	Number of persons on police banned drinker orders .....	37
3.3.4	Completion of police bans .....	38
3.3.5	Secondary supply .....	39
3.3.6	BDR Registrar referrals and banned drinker orders .....	40
3.3.7	Banned drinkers in prison .....	41
3.3.8	Number of people ever on the BDR .....	43
3.3.9	Breaches of bans .....	43
3.3.10	BDR coverage by region.....	44
3.3.11	Profiles of banned drinkers .....	47
3.4	Banned Drinker Responses .....	55
3.4.1	Frequency of alcohol-related events while on the BDR .....	55
3.4.2	Alcohol and other drugs episodes of care in the non-government sector .....	65
3.4.3	Alcohol and other drugs episodes of care in the NT government sector .....	70
3.5	Associated Alcohol-Related Data .....	72
3.5.1	Alcohol-related assault offences .....	72
3.5.2	Domestic violence assault offences .....	73
3.5.3	Drink-driving offences.....	73
3.5.4	Liquor offences .....	75
3.5.5	BDR trigger events (apprehensions, infringements, protective custody) .....	76
3.5.6	Alcohol attributable presentations to NT emergency departments.....	79
3.5.7	Sobering-up shelter admissions .....	80
4	Desktop Audit .....	85
4.1	Aims & method of desktop review .....	85
4.2	Summary of planning process .....	86

4.2.1	Initiation of BDR planning .....	86
4.2.2	Project Management & Governance .....	87
4.2.3	Planning and development of BDR model .....	92
4.2.4	Timelines.....	95
5	Key Informant Interviews .....	97
5.1	Aims and methods of key informant interviews and focus groups .....	97
5.2	Methodology .....	97
5.2.1	Participant Demographics, Selection & Recruitment .....	97
5.2.2	Conducting Interviews .....	97
5.2.3	Transcription, Coding and Analysis .....	98
5.3	Key issues associated with the planning and early implementation of the BDR.....	98
5.3.1	Capacity to learn from BDR Version 1.....	98
5.3.2	Alignment with broader alcohol harm minimisation reforms in the NT .....	101
5.3.3	Working together within the context of a whole-of-government response .....	102
5.3.4	The effectiveness of communication .....	104
5.3.5	BDR referral pathways .....	111
5.3.6	The potential for BDR Phase 2 .....	117
5.3.7	Matters internal to the NTG.....	128
6	Evaluation Summary.....	129
6.1	Summary of descriptive analysis.....	129
6.2	Summary of desktop audit.....	132
6.3	Summary of key informant interviews.....	133
6.4	Overarching key messages .....	134
7	References .....	136
8	Appendices.....	138

8.1	Appendix A - Appendices associated with the descriptive analysis .....	138
8.1.1	Appendix 1: Regional Supporting Data.....	138
8.1.2	Appendix 2: Latent Class Analysis.....	166
8.2	Appendix B - BDR Individual Interview Schedule .....	169
8.3	Appendix C – RACI Matrix .....	170
8.4	Appendix D – Examples of Business Process Maps associated with the BDR .....	174

## Terminology

AOD(D)	Alcohol and Other Drugs (Directorate of the NT Department of Health)
Ban	A generic term for a Banned Drinker Order made by the NT Police or BDR Registrar, or a court order, or a condition imposed by the Parole Board, banning a person from purchasing, possessing, or consuming alcohol and placing the person on the Banned Drinker Register.
BDO	A Banned Drinker Order: an order made under the <i>Alcohol Harm Reduction Act 2017</i> , by the NT Police or the BDR Registrar, banning a person from purchasing, possessing, or consuming alcohol during the period for which the order is made.
BDR	Banned Drinker Register: the electronic identification system established under section 31A(2) of the <i>Liquor Act</i> , in which bans are registered. For the period covered by this report, identification of individuals wishing to purchase takeaway alcohol has been scanned and checked against the BDR to determine whether the individual is subject to a prohibition.
Cancelled ban	A ban that has been mistakenly issued (i.e. to the wrong person, or for circumstances that are not consistent with the <i>Alcohol Harm Reduction Act 2017</i> ). Cancelled bans are not valid and so are excluded in determining the count of individuals on the BDR. As cancellations may occur days or weeks after the ban is added, this has the effect of slightly reducing the number of individuals counted as on the BDR at a given point in time.
Episode of care	The period of contact, with defined dates of commencement and cessation, between a client and a treatment provider or team of providers in which there is no change in the main treatment type or the principal drug of concern, and there has not been a non-planned absence of contact for greater than 3 months.

Main treatment type Main treatment type for alcohol and other drugs is the main activity determined necessary at assessment by the treatment provider to treat the client's alcohol and/or drug problem for the principal drug of concern.

Options are:

*Withdrawal management (detoxification)* - any form of withdrawal management, including medicated and non-medicated, in any delivery setting.

*Counselling* - any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency.

*Rehabilitation* - an intensive treatment program that integrates a range of services and therapeutic activities that may include counselling, behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and tends towards a medium- to longer-term duration. Rehabilitation activities can occur in residential or non-residential settings.

*Support and case management* - when there is no treatment provided to the client other than support and case management (e.g. treatment provided through youth alcohol and drug outreach services).

*Information and education* - when there is no treatment provided to the client other than information and education.

*Assessment only* - when there is no treatment provided to the client other than assessment.

On the BDR For analysis purposes, a person is deemed to be “on the BDR” at a particular point in time if s/he is an adult whose details have been added to the electronic Banned Drinker Register, and is thereby prevented from



purchasing takeaway alcohol at that point in time. A person may be issued with a valid ban on an earlier date but is not considered to be on the BDR until the ban has been registered in the electronic system.

Counting of persons on the BDR is done as at the end of the day (i.e. the moment before midnight) and includes all persons on bans that are active at that point in time. Individuals are categorised according to their most recently issued ban. Bans that are either revoked or cancelled on the same day that they are added to the system are not counted as having been active.

Reason for cessation	The reason for ending the treatment episode from an alcohol and other drug treatment service.
Revoked ban	A ban that is revoked is valid and considered active until the revocation date. It is not counted as active on that date (as counting is based on bans that are still active at the very end of the day).
Statistical linkage key (SLK)	Statistical linkage key 581 (SLK-581) is a code consisting of elements of an individual's name, date of birth and gender. The SLK-581 allows for records belonging to the same client to be identified in a manner that protects the privacy of the individual.
Takeaway alcohol	Alcohol that is purchased at a licensed premises for consumption elsewhere (e.g. it is taken away from the premises for consumption).
Transaction	An electronic record of an attempt to purchase takeaway alcohol. All transactions are checked against the BDR. A transaction may result in a sale or no sale, and a transaction may involve a check against local alcohol restrictions as well as the BDR.

## Table of Figures

Figure 1. Key actions areas outlined in the NT Alcohol Harm Minimisation Action Plan .....	22
Figure 2. Authorised person referral pathway .....	24
Figure 3. BDR triggers and ban breaches .....	25
Figure 4. Number of BDR transactions by month and region .....	30
Figure 5. Monthly Northern Territory and regional transactions per head of adult population ..	31
Figure 6. Percentage of transactions resulting in no sale because the purchaser was on the BDR .....	32
Figure 7. Average daily transactions by region and weekday .....	33
Figure 8. Average hourly transactions by hour of day and day of week .....	34
Figure 9. Number of people on the BDR by date and most recently issued active ban .....	35
Figure 10. Number of people on the BDR by date, and percentage by gender and Aboriginal status .....	36
Figure 11. Percentage of banned drinkers who were female by date and referral pathway .....	37
Figure 12. Number of persons on first, second, subsequent, and court-varied police BDOs .....	38
Figure 13. Percentage of first police BDOs completed by gender and triggering event .....	39
Figure 14. Number of persons on the BDR for BDR Registrar BDOs by month.....	40
Figure 15. Number of people on the BDR by date and percentage by custodial status.....	42
Figure 16. Number of males and females on the BDR by date and percentage by custodial status .....	42
Figure 17. Number of people ever on the BDR by the end of the month, and monthly growth .	43
Figure 18. Percentage of persons on the BDR at the end of each month who breached one or more bans during the month .....	44
Figure 19. Percentage of adults apprehended for alcohol-related offences who were already on the BDR .....	45
Figure 20. Percentage of adults given alcohol-related infringements who were already on the BDR .....	46
Figure 21. Percentage of adults taken into protective custody who were already on the BDR...	47
Figure 22. Mean frequency of events for identified groups.....	48
Figure 23. Group 1 sample profile: moderate to high frequency non-criminal events with alcohol mandatory treatment.....	49

Figure 24. Group 2 sample profile: moderate to high frequency criminal and non-criminal events with time in prison .....	50
Figure 25. Group 3 sample profile: low frequency criminal and non-criminal events with time in prison .....	51
Figure 26. Group 4 sample profile: low to no criminal or non-criminal alcohol-related events, usually with time in prison.....	52
Figure 27. Group 5 sample profile: low to moderate frequency non-criminal events without AMT.....	53
Figure 28. Group 5 sample profile: very high frequency non-criminal events without AMT....	53
Figure 29. Group 6 sample profile: very low frequency criminal events without time in prison	54
Figure 30. Sociodemographic profiles of the six groups of banned drinkers, including mean age and standard deviation .....	55
Figure 31. Discontinued contact: significant period of time on BDR with no alcohol-related justice contact (Group 3).....	56
Figure 32. Discontinued contact: significant period of time on BDR with no alcohol-related justice contact (Group 3).....	57
Figure 33. Discontinued contact: significant period of time on BDR with no alcohol-related justice contact (Group 2).....	58
Figure 34. Reduced frequency response: decreasing frequency alcohol-related justice contact while on BDR (Group 2).....	59
Figure 35. Continued events response: continued high frequency contact with the justice system (Group 2).....	60
Figure 36. Continued events response: continued moderate frequency contact with the justice system (Group 1).....	60
Figure 37. Continued events response: continued low frequency contact with the justice system (Group 3).....	61
Figure 38. Nil events response: continued absence of alcohol-related contact with the justice system (Group 4).....	62
Figure 39. Combination response: continued high contact followed by discontinued contact (Group 2).....	63
Figure 40. Re-offending when ban finishes while in prison (Group 4) .....	64

Figure 41. No re-offending when ban finishes while in prison (Group 4) .....	64
Figure 42. Re-offending when ban extends after prison (Group 4) .....	65
Figure 44. Count of alcohol-related episodes of care in NGO agencies, January 2016 - February 2018.....	65
Figure 45. Relationships between episodes of care and BDR dates .....	66
Figure 46. Number of days in treatment (length of stay) for selected main treatment types.....	68
Figure 47. Number of episodes by BDR clients by pre-BDR involvement in NGO treatment...	70
Figure 47. Count of alcohol-related episodes of care in NTG agencies, January 2016 – February 2018.....	71
Figure 48. Monthly number of alcohol-related assault offences and 12-month rolling average.	72
Figure 49. Monthly domestic violence assault offences by alcohol involvement, and 12-month rolling averages .....	73
Figure 50. Monthly drink-driving offences and 12-month rolling average .....	74
Figure 51. Drink-driving offences by type, 12-month rolling averages .....	75
Figure 52. Monthly liquor consumption-related offences and 12-month rolling average .....	75
Figure 53. Monthly liquor licensing-related offences and 12-month rolling average .....	76
Figure 54. Monthly adult alcohol-related apprehensions and 12-month rolling average .....	77
Figure 55. Monthly alcohol-related infringement notices and 12-month rolling average .....	78
Figure 56. Monthly alcohol-related protective custody episodes and 12-month rolling average	78
Figure 57. Alcohol attributable presentations to NT emergency departments, January 2016-February 2018 .....	79
Figure 58. Count of admissions to NT sobering-up shelters by month and 12-month rolling average .....	80
Figure 59. Admissions to sobering-up shelters by region, January 2010 to February 2018, 12-month rolling average .....	81
Figure 60. Number of admissions to regional sobering-up shelters by source of referral, selected months.....	82
Figure 61. Admissions to NT sobering-up shelters by day of the week by selected months, % in day .....	83
Figure 62. Admissions to NT sobering-up shelters by hour of the day by selected months, % in hour .....	84

Figure 63. BDR Governance overview, Stage 1 .....	88
Figure 64. Governance and management structure post BDR implementation.....	91
Figure 65. Number of self-referrals onto the BDR by age, gender and Indigenous status .....	114
Figure 66. Average hourly transactions through the week, Darwin .....	138
Figure 67. Monthly alcohol-related assault offences, Darwin, and 12-month rolling average .	139
Figure 68. Monthly domestic violence assault offences by alcohol involvement, Darwin, and 12-month rolling averages.....	139
Figure 69. Monthly liquor consumption and licensing offences, Darwin, and 12-month rolling averages.....	140
Figure 70. Monthly drink-driving offences, Darwin, and 12-month rolling average .....	140
Figure 71. Drink-driving offences by type, Darwin, 12-month rolling averages .....	141
Figure 72. Monthly adult alcohol-related apprehensions, Darwin, and 12-month rolling average .....	141
Figure 73. Monthly alcohol-related protective custody episodes, Darwin, and 12-month rolling average .....	142
Figure 74. Average hourly transactions through the week, Palmerston .....	142
Figure 75. Monthly alcohol-related assault offences, Palmerston, and 12-month rolling average .....	143
Figure 76. Monthly domestic violence assault offences by alcohol involvement, Palmerston, and 12-month rolling averages .....	143
Figure 77. Monthly liquor consumption and licensing offences, Palmerston, and 12-month rolling averages .....	144
Figure 78. Monthly drink-driving offences, Palmerston, and 12-month rolling average .....	144
Figure 79. Drink-driving offences by type, Palmerston, 12-month rolling averages .....	145
Figure 80. Monthly adult alcohol-related apprehensions, Palmerston, and 12-month rolling average .....	145
Figure 81. Monthly alcohol-related protective custody episodes, Palmerston, and 12-month rolling average .....	146
Figure 82. Average hourly transactions by hour of day and day of week, Alice Springs .....	146
Figure 83. Monthly alcohol-related assault offences, Alice Springs, and 12-month rolling average .....	147

Figure 84. Monthly domestic violence assault offences by alcohol involvement, Alice Springs, and 12-month rolling averages.....	147
Figure 85. Monthly liquor consumption and licensing offences, Alice Springs, and 12-month rolling averages .....	148
Figure 86. Monthly drink-driving offences, Alice Springs, and 12-month rolling average .....	148
Figure 87. Drink-driving offences by type, Alice Springs, 12-month rolling averages .....	149
Figure 88. Monthly adult alcohol-related apprehensions, Alice Springs, and 12-month rolling average .....	149
Figure 89. Monthly alcohol-related protective custody episodes, Alice Springs, and 12-month rolling average .....	150
Figure 90. Average hourly transactions by hour of day and day of week, Katherine .....	150
Figure 91. Monthly alcohol-related assault offences, Katherine, and 12-month rolling average .....	151
Figure 92. Monthly domestic violence assault offences by alcohol involvement, Katherine, and 12-month rolling averages .....	151
Figure 93. Monthly liquor consumption and licensing offences, Katherine, and 12-month rolling averages.....	152
Figure 94. Monthly drink-driving offences, Katherine, and 12-month rolling average .....	152
Figure 95. Drink-driving offences by type, Katherine, 12-month rolling averages .....	153
Figure 96. Monthly adult alcohol-related apprehensions, Katherine, and 12-month rolling average .....	153
Figure 97. Monthly alcohol-related protective custody episodes, Katherine, and 12-month rolling average .....	154
Figure 98. Average hourly transactions by hour of day and day of week, Tennant Creek.....	154
Figure 99. Monthly alcohol-related assault offences, Tennant Creek, and 12-month rolling average .....	155
Figure 100. Monthly domestic violence assault offences by alcohol involvement, Tennant Creek, and 12-month rolling averages .....	155
Figure 101. Monthly liquor consumption and licensing offences, Tennant Creek, and 12-month rolling averages .....	156
Figure 102. Monthly drink-driving offences, Tennant Creek, and 12-month rolling average ..	156

Figure 103. Drink-driving offences by type, Tennant Creek, 12-month rolling averages.....	157
Figure 104. Monthly adult alcohol-related apprehensions, Tennant Creek, and 12-month rolling average .....	157
Figure 105. Monthly alcohol-related protective custody episodes, Tennant Creek, and 12-month rolling average .....	158
Figure 106. Monthly alcohol-related assault offences, Nhulunbuy, and 12-month rolling average .....	158
Figure 107. Monthly domestic violence assault offences by alcohol involvement, Nhulunbuy, and 12-month rolling averages.....	159
Figure 108. Monthly liquor consumption and licensing offences, Nhulunbuy, and 12-month rolling averages .....	159
Figure 109. Monthly drink-driving offences, Nhulunbuy, and 12-month rolling average .....	160
Figure 110. Drink-driving offences by type, Nhulunbuy, 12-month rolling averages .....	160
Figure 111. Monthly adult alcohol-related apprehensions, Nhulunbuy, and 12-month rolling average .....	161
Figure 112. Monthly alcohol-related protective custody episodes, Nhulunbuy, and 12-month rolling average .....	161
Figure 113. Average hourly transactions through the week, NT Balance .....	162
Figure 114. Monthly alcohol-related assault offences, the NT Balance, and 12-month rolling average .....	162
Figure 115. Monthly domestic violence assault offences by alcohol involvement, NT Balance, and 12-month rolling averages.....	163
Figure 116. Monthly liquor consumption and licensing offences, the NT Balance, and 12-month rolling averages .....	163
Figure 117. Monthly drink-driving offences, the NT Balance, and 12-month rolling average. ....	164
Figure 118. Drink-driving offences by type, NT Balance, 12-month rolling averages .....	164
Figure 119. Monthly adult alcohol-related apprehensions, the NT Balance, and 12-month rolling average .....	165
Figure 120. Monthly alcohol-related protective custody episodes, the NT Balance, and 12-month rolling average .....	165

## List of Tables

Table 1. Count of episodes and relationship between episode and BDR dates .....	66
Table 2. Summary of episode characteristics .....	67
Table 3. Summary of age, Aboriginal status and gender .....	68
Table 4. Frequency of pre-BDR commencement episodes .....	69
Table 5. Count of assessment and treatment clients commenced who self-identify as on the BDR in NTG services .....	71
Table 6. Alcohol attributable presentations to NT emergency departments, selected months .....	79
Table 7. Admissions to NT sobering-up shelters by source of referral, selected months.....	82
Table 8. Admissions to NT sobering-up shelters, selected months, summary demographic characteristics.....	84
Table 9. Frequency distribution for alcohol-related event indicators .....	167
Table 10. Comparison of baseline models.....	167
Table 11. Item response probabilities for the six-group model .....	168



## Executive Summary

The harmful use of alcohol in the Northern Territory is a public health concern. This has recently been emphasised through the findings of the *Alcohol Policies and Legislation Review Final Report* resulting in an explicit policy commitment by the Northern Territory Government (NTG) to invest in an *Alcohol Harm Minimisation Action Plan* (AHMAP). One of the strategies emphasised in the AHMAP is the reintroduction of the Banned Drinker Register (BDR).

The BDR is a policy initiative which aims to improve community health and safety by reducing alcohol-related harms. It is an explicit alcohol supply reduction measure that involves placing people that consume alcohol at harmful levels, to themselves or others, onto a register which prohibits the consumption, possession or purchase of alcohol. In its current format, the limitation of purchasing is enacted through take-away alcohol outlets. The length of time an individual is on the BDR may differ from three, six or 12 months. Participation in voluntary therapeutic services aimed at reducing the harms of alcohol consumption can reduce the length of time an individual is on the BDR.

The BDR was officially reintroduced in the NT on 1 September 2017. The Minister for Health made a commitment that the BDR implementation process would be evaluated by June 2018 with independent oversight. Menzies School of Health Research was approached to assist with this task in March 2018. This report responds to the Minister's evaluation commitment.

There are three overarching questions that have guided the evaluation process. These include:

- Was the policy implemented as intended?
- Is the BDR meeting its intended objectives?
- What improvements or changes are required?

To respond to these questions, a mixed-methods approach was adopted involving multiple elements. These elements included:

- *Descriptive analysis of administrative data* relating to pathways onto the BDR, increased access to treatment and support services, the activity of the BDR Registrar and assessment clinicians, compliance in take away outlets, and the characteristics of people who have been issued BDOs

- *A desktop audit* of the planning processes used across different agencies, including the effectiveness of the roll out of technology, and utilisation of the program funding
- *Key informant interviews* with policy-makers, frontline staff and industry representatives involved in the planning and/or early implementation of the BDR.

Drawing on the combined findings of these three elements, we discuss key issues that have either supported or hindered the planning and early implementation of the BDR. These issues relate to capacity to learn from BDR Version 1; alignment with broader alcohol harm minimisation reforms in the NT; working together within the context of a whole-of-government response; effectiveness of communication; BDR referral pathways; the potential for BDR Phase 2; and matters internal to NTG.

There are seven key messages that can be gleaned from this evaluation. These include:

1. BDR is one of many alcohol harm minimisation policy initiatives, it does not work in isolation. It forms part of the contribution in achieving a healthier and safer community by reducing alcohol related harms.
2. The influences, impacts and outcomes of the BDR need to be understood in the context of other alcohol harm minimisation policy reforms and initiatives underway in the NT (such as those outlined in the *Alcohol Harm Minimisation Action Plan 2018-19*).
3. The BDR is working effectively in identifying a sub-set of people who misuse alcohol and are engaged in anti-social behaviour and the justice system.
4. The BDR is changing some people's behaviours around alcohol use – but there are still people on the BDR accessing alcohol and engaging in behaviour that brings them into contact with the justice system. Secondary supply and grog running are not stopped by the BDR.
5. The self-referral option offered through the BDR is showing encouraging signs of uptake. This voluntary pathway could be promoted further.
6. The BDR provides a unique opportunity to engage in assertive health promotion outreach activities. This element can be strengthened through engagement of the community based alcohol and other drugs workforce.
7. The uptake of therapeutic services among people on the BDR has been low. The promotion of these services and the respective referral pathways could be enhanced.

These messages have been incorporated into the final recommendations presented below. The recommendations aim to guide future enhancements and to increase the policy integrity of the BDR.

# 1 Recommendations

The Northern Territory Government should:

1. Continue to monitor trends associated with takeaway liquor transactions, persons on the BDR, and associated alcohol related data, as per the descriptive analysis included in this report.
2. Consider removing the current discretionary approach to alcohol related domestic violence offences, and making them an automatic trigger for a 3 month BDO.
3. Consider including BDR status information as a standard part of a person's health record in hospital and primary health care clinical settings.
4. Investigate appearances of people on the BDR in Sobering-Up Shelters to assist with targeted health interventions for these clients.
5. Upgrade IJIS to support enhanced integration with other NTG IT systems.
6. Develop a more robust community education campaign about the aim and purpose of the BDR to increase public understanding of the BDR. There is an opportunity to use success stories from people on the BDR to inform a campaign of this nature.
7. Implement a standard referral template for health assessments.
8. Consider mandating courts to notify the BDR Registrar if they vary or revoke a person's BDO.
9. Promote the BDR self-referral pathway more actively to people with patterns of risky drinking behaviours. This requires tailored social marketing efforts to different sub-sets of people who misuse alcohol.
10. Develop strategies to better promote the array of therapeutic services available to assist people placed on the BDR.
11. Develop assertive health promotion outreach strategies and resources (particularly health education, the provision of health information, and more detailed information about therapeutic services) for people issued with a BDO.
12. Prioritise implementation of practical levers and strategies to increase the voluntary uptake of therapeutic services among people on the BDR. A targeted and culturally responsive approach will be required to reach different sub-sets of people on the BDR. Potential options could include:
  - a. Police referring people on a police initiated BDO to the BDR Registrar for referral for therapeutic support and/or consideration of income management order, with a rationale as to why this option would be beneficial.
  - b. Courts referring people with a Court Order with alcohol prohibition conditions to the BDR Registrar for therapeutic support.
  - c. Assertive follow-up and coordinated therapeutic support options discussed with people on a BDO by locally-based alcohol treatment services.
13. Consider trialing BDR scanners at on-premises venues in Alice Springs, Katherine and Tennant Creek where Police Auxiliary Liquor Inspectors (PALIs) are deployed.

14. Implement policy responses that address the secondary supply of alcohol and grog running, in tandem with investments in the BDR. It is proposed that such responses are targeted at high risk population groups, such as the recent announcement of an additional 12 police officers and 3 prosecutors with a specific focus on secondary supply.
15. Substantially increase health promotion efforts across the NT community to reduce the risks and harms of alcohol consumption, with the intent of reducing BDOs issued over the longer term. This requires investment in a workforce with specific expertise and skill-sets in community development and health promotion; and should align with the NT Strategic Health Promotion Framework.
16. Develop more sophisticated ways to more accurately identify place of residence and event location for people on the BDR to assist with the tailoring of location-specific alcohol harm minimisation policy and program responses.
17. Investigate ways to record volume of alcohol sales as part of the BDR. This could be linked to work currently underway within Licensing NT to examine existing data collection requirements from licensees.
18. Investigate ways to record the name and contact details of individuals on the BDR who attempt to purchase alcohol (i.e. those considered by law to have breached) to assist in strengths-based and assertive health promotion outreach activities.
19. Over the longer-term, invest in the digitisation of photo identification (such as Driver's Licenses and Australia Post KeyPass card) used for the BDR. This could also provide a solution for other public policy responses requiring photo identification.
20. Resolve data quality issues through integrated information technology solutions that address errors due to multiple entries (i.e. alias or date of birth) of people placed on the BDR. Expanding the BDR to additional settings (e.g. on premises, or late-night venues) may also require the implementation of alternative technology solutions.
21. Consider providing the BDR Registrar access to the Motor Vehicle Registry records to help streamline processes associated with the legislative requirement for the BDR Registrar to be satisfied with a person's identity.
22. Expand the list of persons authorised to refer to the BDR Registrar, including Level 4 counsellors registered with the Australian Counselling Association.
23. Invest in an independent longer-term comprehensive impact and outcome evaluation of the BDR.

## **2 Alcohol harm minimisation in the Northern Territory and the BDR**

### **2.1 Background**

#### **2.1.1 Alcohol context in the NT**

The Northern Territory (NT) population has a unique association with alcohol. Most people living in the NT drink alcohol at levels that cause few adverse effects, and do so as a means of enjoying the unique cultural and social environment that the NT has to offer (Riley 2017). However, a substantial proportion of people continue to drink at levels that increase the risk of alcohol-related harm, ultimately causing ill health and hardship (Whetton et al 2009; Symons et al 2012; Riley 2017). It is well established that the NT has the highest per capita consumption of alcohol in Australia; the highest rate of risky alcohol consumption in Australia; the nation's highest rates of alcohol-related hospitalisations; and high rates of road trauma and mortality involving illegal blood alcohol concentration levels (Whetton et al 2009; Symons et al 2012; Riley 2017). This creates significant costs for the NT economy. As highlighted in the recent NT Alcohol Policies and Legislation Review Final Report,

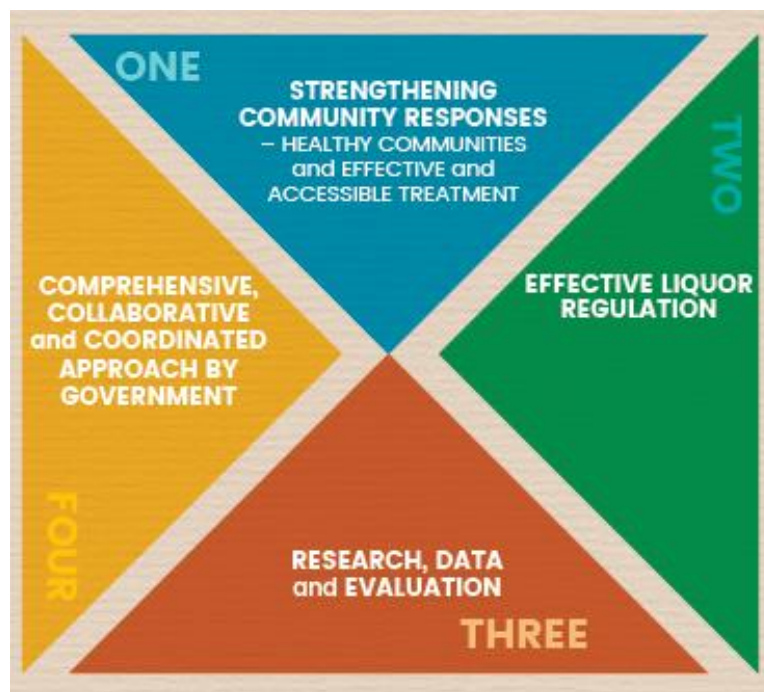
There can be no doubt the people of the Northern Territory of Australia have a problem with alcohol. Whilst it can be readily accepted that many people in the Northern Territory do not drink alcohol at all and most of those who do drink alcohol do so responsibly, the fact remains that we have a strong, entrenched and harmful drinking culture. We have a problem that must be addressed (Riley 2017, p1)

The need to change the NT's relationship with alcohol is evident and urgent action is required. In March 2017, the NT Government (NTG) commissioned the abovementioned independent review into alcohol policies and legislation in the NT. The review process involved community and key stakeholder consultation and resulted in 220 recommendations being presented back to the NTG on 19 October 2017. The NTG responded to the recommendations on 27 February 2018, indicating its support for 186 recommendations and in-principle support for a further 33 recommendations (NTG 2018a). Only one recommendation was not supported (NTG 2018a). This has marked a significant change in responding to the harms of alcohol experienced in the NT.

### 2.1.2 Alcohol Harm Minimisation in the Northern Territory

The response to the *NT Alcohol Policies and Legislation Review* was accompanied by the release of the *Alcohol Harm Minimisation Action Plan 2018-2019* (NTG 2018b). The aim of the action plan is to significantly reduce alcohol-related harms for Territorians. The action plan acknowledges that harm minimisation is a term which underpins effective action consistent with national and international drug policy (NTG 2018b). It includes reducing the demand for alcohol; reducing the supply of alcohol; and reducing the harm caused to individuals, families and the community from alcohol (NTG 2018b). It is a sensible balance of responses across these three pillars that is required. To achieve this focus the NTG has identified four key action areas in its action plan. These are depicted in Figure 1 below.

*Figure 1. Key actions areas outlined in the NT Alcohol Harm Minimisation Action Plan*



Source: NTG 2018b, p3

A key element of action area two, which relates to effective liquor regulation, clearly highlights that the establishment and enforcement of the BDR is a key priority of the NTG. The Department of Health (DoH) has been tasked with leading this policy initiative.

### **2.1.3 What is the Banned Drinker Register?**

The BDR is a major alcohol harm reduction initiative for the NT. As outlined above, the BDR is one of a number of initiatives included in the *Alcohol Harm Minimisation Action Plan (AHMAP)* that are collectively intended to improve community health and safety through reducing the harm caused by risky drinking behavior in the NT.

The BDR had initially been introduced in 2011-2012 under the former Labor Government. It was decommissioned swiftly by the incoming Country Liberal Party Government shortly thereafter, without any formal evaluation of the planning and implementation processes, or subsequent impacts or outcomes. It was replaced with a new policy measure known as the Alcohol Mandatory Treatment (AMT) program.

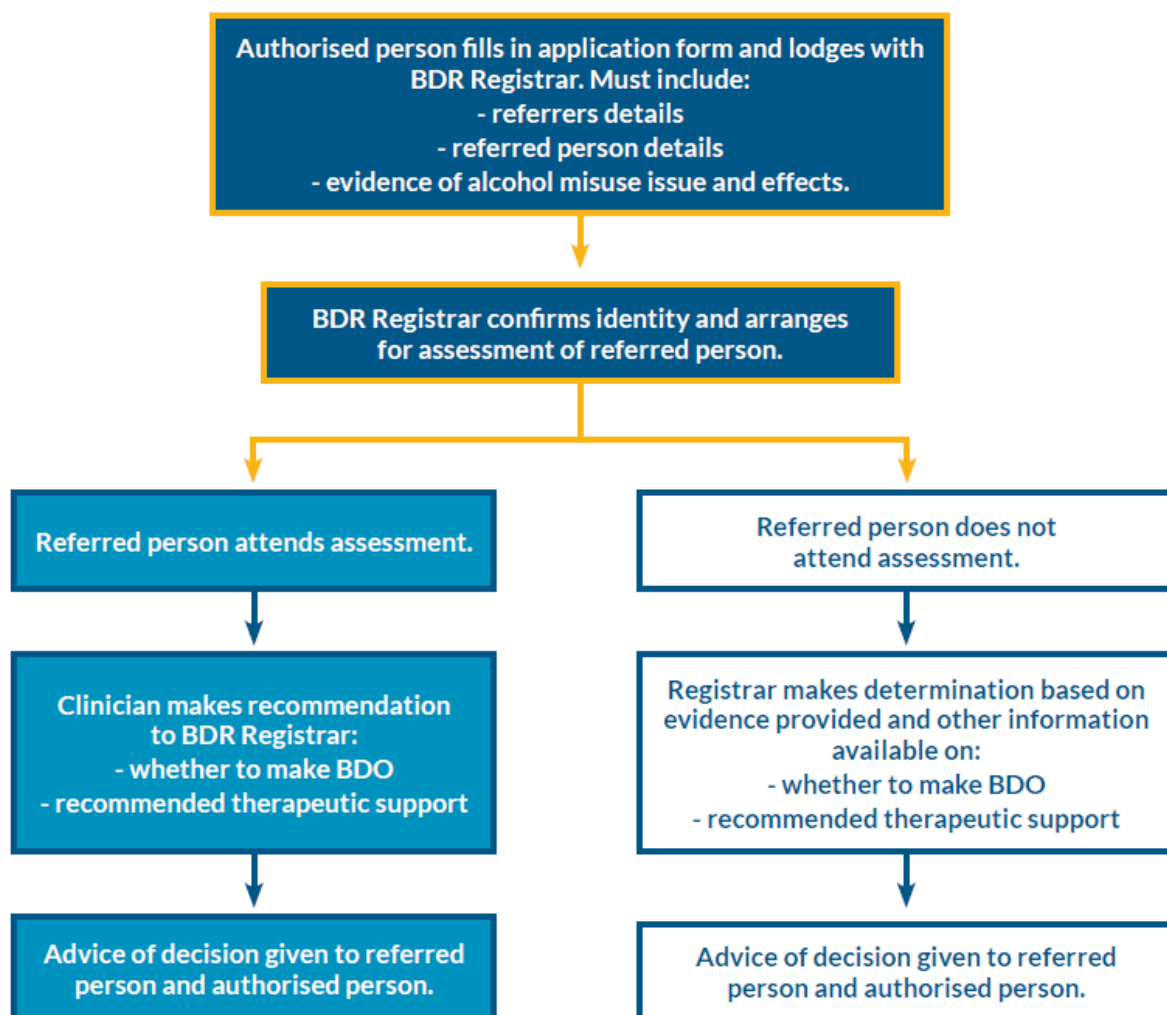
In the lead-up to the 2016 NTG election, a key election commitment of the incoming Labor Government was to reintroduce the BDR. There was a clear directive that the BDR would be reintroduced within the first 12 months of office. The BDR was subsequently reintroduced on 1<sup>st</sup> September 2017. Its reintroduction occurred mid-way through the Alcohol Policies and Legislation Review, and also preceded the release of the AHMAP by nearly six months.

The BDR is an explicit alcohol supply reduction measure that involves placing people that consume alcohol at harmful levels to themselves or others onto a register which prohibits the purchase of alcohol from take-away alcohol outlets. This involves all consumers having photo ID scanned at point of purchase. Those that are not on the BDR can purchase alcohol. Those that are on the BDR cannot.

There are multiple triggers and orders that result in someone becoming a banned drinker. It can involve prohibitions initiated by authorised officers that work in a range of different sectors, including police, justice, courts, child protection and health settings, which result in a person being placed on the BDR. The authorised person referral pathway is depicted below (see Figure 2).



Figure 2. Authorised person referral pathway

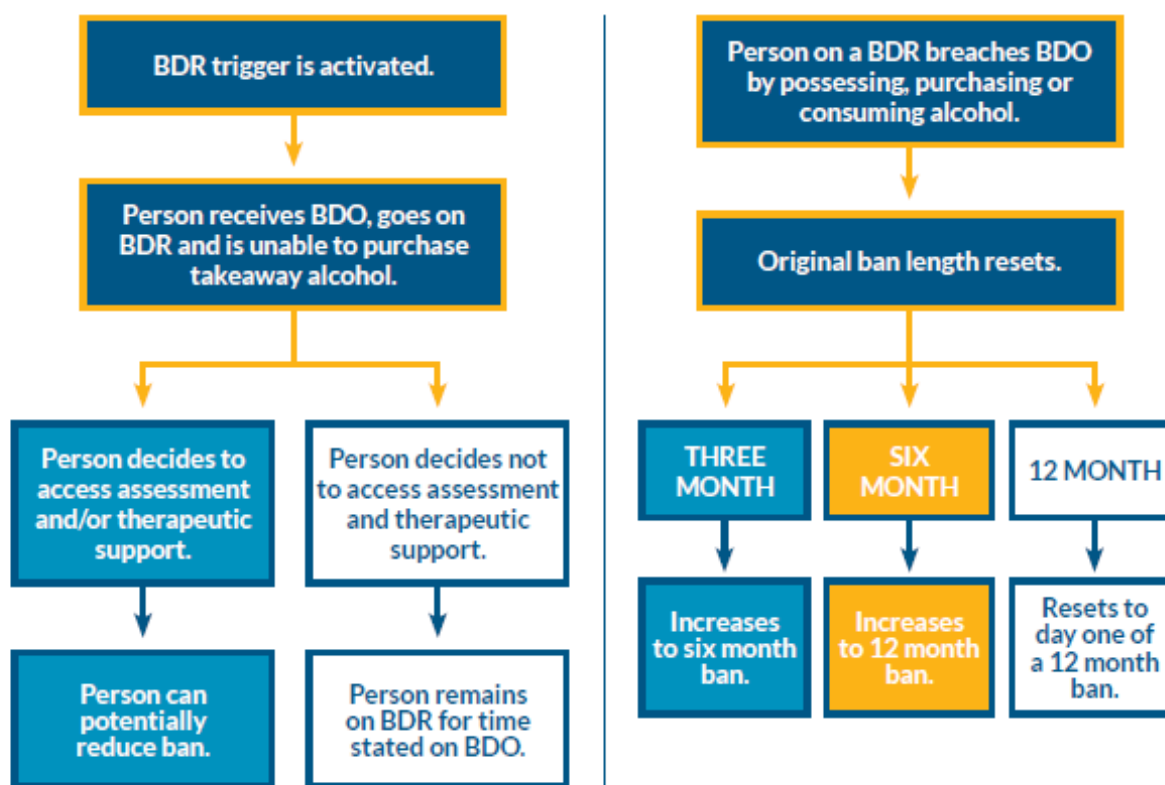


Source: NTG, 2017, 'Authorised Person Referral Pathway' (Fact Sheet)

Individuals can also opt to self-refer onto the BDR if they wish. These individuals may also choose to self-refer off the BDR at their discretion.

The length of time an individual is on the BDR may differ from three, six or 12 months. Participation in voluntary therapeutic services aimed at reducing the harms of alcohol consumption can reduce the length of time an individual is on the BDR. These triggers and associated durations on the BDR are depicted below (see Figure 3).

Figure 3. BDR triggers and ban breaches



Source: NTG, 2017, 'BDR Triggers and Bans' (Fact Sheet)

The overarching goal of the current BDR is **to improve community health and safety by reducing alcohol-related harms.**

The current objectives include:

1. To reduce the supply of alcohol to people who misuse alcohol;
2. To reduce alcohol-related offending and domestic violence;
3. To reduce the frequency and/or severity of alcohol-related health conditions;
4. To increase the uptake of therapeutic support by people misusing alcohol;
5. To ensure the Alcohol and Other Drug workforce is culturally competent and skilled in the assessment and care of Aboriginal clients;

6. To ensure that ongoing, evidence-based therapeutic support is available in a timely, effective and accessible manner; and
7. To ensure that Territorians, visitors and licensees understand that the BDR is a health-based intervention to make communities safer and healthier, and comply with the new photo ID system requirement.

Importantly, the BDR system is a project within a broader DoH-led program to establish a health-centric, alcohol harm reduction policy framework (DAGJ, 2017).

In line with this, the following benefits were identified by the NTG in relation to the reintroduction of the BDR:

- An increase in community awareness of risky drinking behaviour;
- Improved amenity around takeaway liquor outlets;
- A reduction in the number of hospital emergency department presentations of people suffering alcohol-related injuries and harms;
- A reduction in alcohol-related offending and domestic violence incidents; and
- An increase in the number of people accessing alcohol withdrawal and therapeutic support services.

There are a number of differences between the types of prohibitions that result in a person being placed on the BDR from the system in place during 2011-2012 and the way the system currently operates (Department of Health, 2017). Under the current BDR, a person may be placed on the BDR through the mechanisms outlined in the *Alcohol Harm Reduction Act 2017*:

- Being apprehended for an alcohol-related offence;
- Being named as the defendant on a Police domestic violence order where the officer believes that the defendant was affected by alcohol at the time of engaging in the conduct to which the order relates;
- Receiving any combination of three alcohol-related protective custody episodes or alcohol infringement notices in two years;
- Having an alcohol prohibition condition (purchase, possess or consume conditions) on a court order (including child protection and bail orders) or parole orders;
- By decision of the BDR Registrar after being referred by an authorised person or a family member or carer; or
- Self-referral for any reason.

In relation to the operation of the BDR, the most significant change is the decision-making function to make bans. This was previously held by a Tribunal and is now undertaken by a BDR Registrar. The Registrar is a “clinical decision maker that evaluates the evidence and the outcomes of any assessment and makes a determination about a ban” (Department of Health, 2017, p8). Appeals are now heard at the Northern Territory Civil and Administrative Tribunal (NTCAT). The redesign of the system was developed by senior officers from within Government who were involved in the original implementation and operation of the BDR. This included representatives from Police, Health, Justice and Treasury (Department of Health, 2017a, p9).

The BDR system is implemented across the NT in licensed takeaway venues. Prior to implementation, it was expected that the system would be rolled out in 192 outlets, which included 138 in Darwin and Palmerston, 24 in Katherine, 13 in Tenant Creek and surrounding area, 27 in Alice Springs and surrounding areas, 8 in Gove, Groote Eylandt and Milikapiti, and 4 in outlets that were under construction (DAGJ, 2017, p25).

#### **2.1.4 Ministerial Commitment to Evaluation**

In August 2017, the Minister for Health made a public commitment that the BDR implementation process would be evaluated by June 2018 with independent oversight. This evaluation report responds to this commitment.

## **2.2 Aim of the Evaluation**

There are three key questions that underpin the evaluation of the planning and early implementation process associated with the BDR:

- Was the policy implemented as intended?
- Is the BDR meeting its objectives?
- What improvements or changes are required?

To respond to these questions, a mixed-methods approach was adopted involving multiple elements. The process evaluation approach adopted is outlined further below.

### 2.3 Process Evaluation Approach

The three key elements of the evaluation approach include:

- *A descriptive analysis of administrative data* relating to pathways onto the BDR, increased access to treatment and support services, the activity of the BDR Registrar and assessment clinicians, compliance in take away outlets, and the characteristics of people who have been issued bans;
- *A desktop audit* of the planning processes used across different agencies, including the effectiveness of the roll out of technology, and utilisation of the program funding; and
- *Key informant interviews* with policy-makers, frontline staff and industry representatives involved in the planning and/or early implementation of the BDR.

This evaluation project was approved by the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (2018-3079).

### **3 Descriptive analysis of the BDR**

#### **3.1 Aims and methods of descriptive analysis**

This section presents a summary of the BDR-related information observed in the first six months of operation, from September 2017 through February 2018<sup>1</sup>. This includes patterns in the number of liquor transactions, persons on the BDR, and episodes of care. Also included is an analysis of alcohol-related contact with the justice system by banned drinkers in the year prior to the BDR and since going on the BDR, which describes how banned drinkers are responding to the program. This section concludes with supplementary charts showing patterns in various alcohol-related data series from both the justice and health sectors, such as alcohol-related assaults and drink driving, alcohol-attributable emergency department presentations, and sobering-up shelter admissions.

This section does not attempt to determine whether the intended outcomes of the BDR are being achieved: it is still too early for significant behavioural change to be measured as a result of the BDR. The supplementary charts indicate the type of evidence that will be considered in future impact and outcome-oriented evaluations, and provide an indication of the historical baseline patterns from which change as a result of the BDR and other alcohol-related initiatives can be measured.

#### **3.2 Takeaway Alcohol Transactions**

Since 1 September 2017, the purchase of takeaway alcohol has required the purchaser's identification to be checked against the BDR (in Nhulunbuy the permit system ensures that individuals on the BDR cannot purchase alcohol). Each transaction results in either a sale or no sale, and in some areas local liquor restrictions apply. In such areas, a transaction may result in no sale because a person is on the BDR, or because a person not on the BDR is attempting to purchase liquor in excess of the local restriction. Only the transaction result and type of check is recorded, not the details of the purchaser or products purchased. For this reason, transactions may not reflect patterns in the quantity of alcohol purchased or consumed, nor indicate the number of banned

---

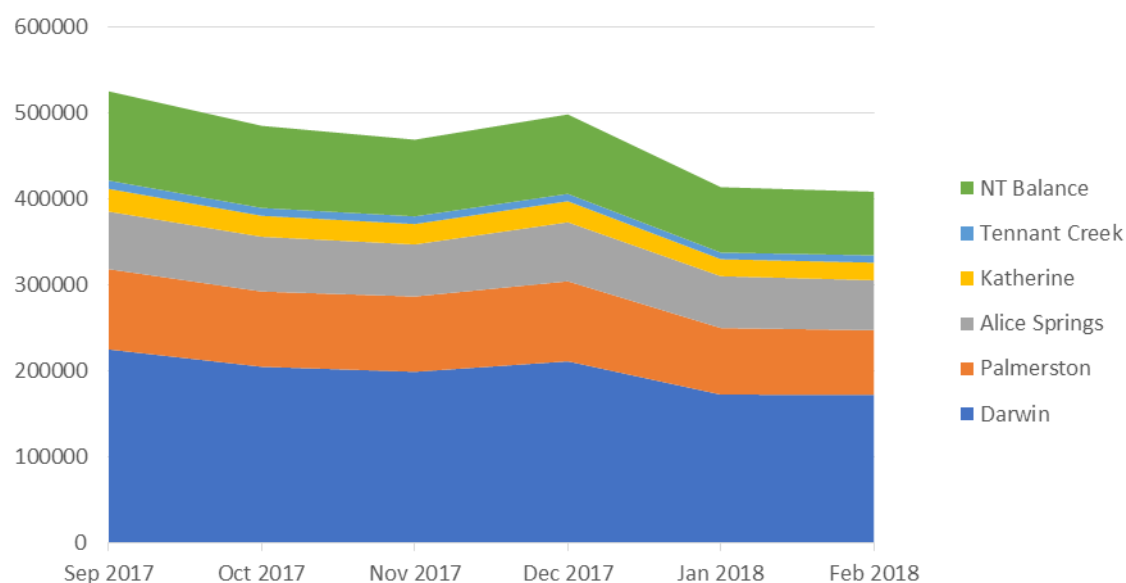
<sup>1</sup> Data are as extracted for the April 2018 BDR report, as these were the most recent data available at the time of analysis; only the first six months of operation were included for this report, apart from the analysis of banned drinker profiles in Section 3.3.11 and banned drinker responses in Section 3.4.1.

individuals attempting to purchase alcohol or the frequency with which any single individual attempts to purchase alcohol.

### 3.2.1 Number of transactions

Over 2.8 million takeaway alcohol transactions were recorded from 1 September 2017 through to 28 February 2018. The monthly number of transactions was greatest during September 2017, decreasing 22% by February 2018 (Figure 4). Darwin accounted for 42% of transactions over the period, followed by the NT Balance (19%), Palmerston (18%), Alice Springs (14%), Katherine (5%) and Tennant Creek (2%).

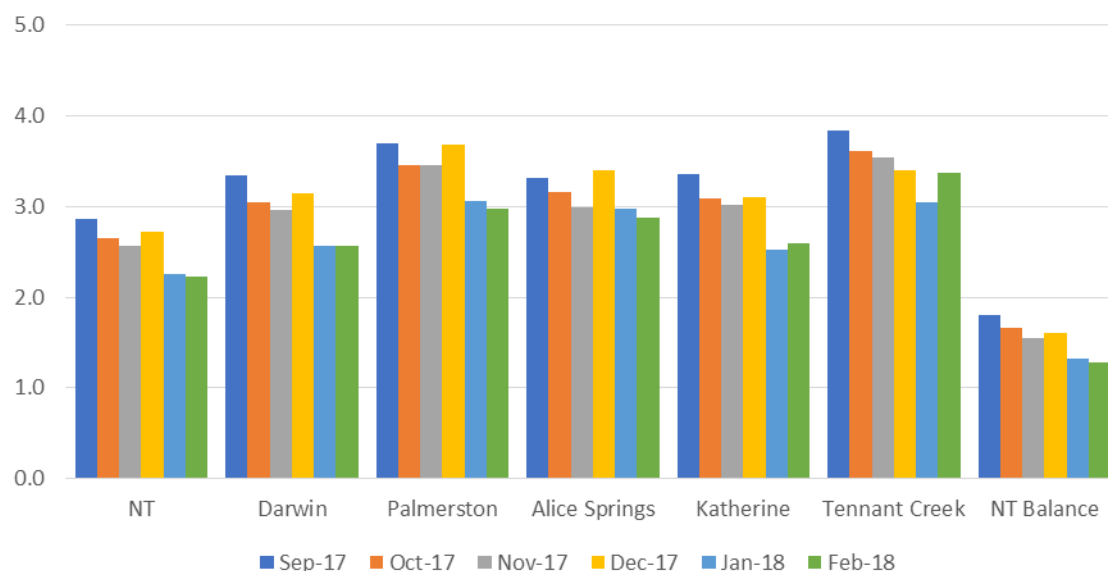
*Figure 4. Number of BDR transactions by month and region*



Across the Northern Territory, the number of transactions averaged approximately 2.5 transactions per month per head of adult population<sup>2</sup> (Figure 5). Darwin, Alice Springs and Katherine had similar transaction rates, ranging from 2.9 to 3.1 per adult per month, with 3.4 per adult per month in Palmerston. The NT Balance, where many communities are dry, had the lowest transaction rate at 1.5 per adult per month, and Tennant Creek had the highest at 3.5 per adult per month.

<sup>2</sup> The population used was the NT Estimated Resident Population for September 2017 (Australian Bureau of Statistics, 2018), with regional splits derived from the population distribution as at 30 June 2016 (Australian Bureau of Statistics, 2017) and the proportion aged 18 and over derived from additional data provided to NT Treasury by the Australian Bureau of Statistics.

Figure 5. Monthly Northern Territory and regional transactions per head of adult population



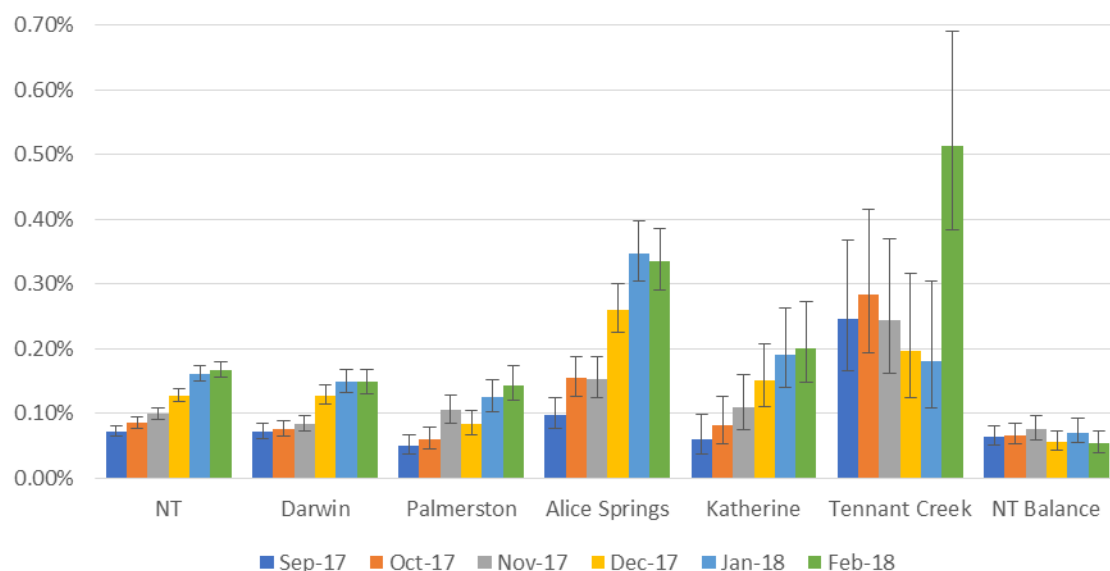
### 3.2.2 Percentage of transactions by a person on the BDR

Of the 2.8 million alcohol transactions recorded in the Northern Territory between September 2017 and February 2018, 3,255 (0.12%) resulted in no sale due to the purchaser being identified as on the BDR. The percentage increased from 0.07% of transactions in September 2017 to 0.17% of transactions in February 2018.

Tennant Creek had the highest percentage of transactions for the period resulting in no sale due to the purchaser being on the BDR (0.28%), followed by Alice Springs (0.22%), Katherine (0.13%), Darwin (0.11%), Palmerston (0.09%) and the NT Balance (0.06%). Figure 6 shows the percentage of transactions in each month and region resulting in no sale due to the purchaser being on the BDR. The 95% confidence limits for the percentages are shown by error bars: where the error bars overlap to a material degree, the differences among months are not statistically significant.



Figure 6. Percentage of transactions resulting in no sale because the purchaser was on the BDR

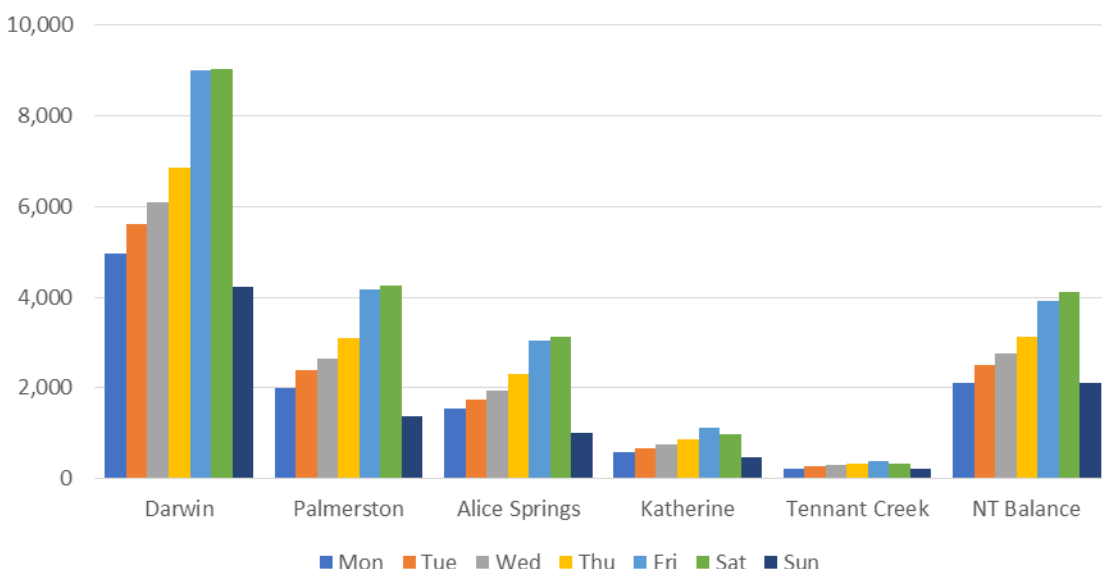


Compared with previous months, Tennant Creek had a significantly larger percentage of transactions resulting in no sale in February 2018.

### 3.2.3 Transactions by weekday

All regions showed a pattern of gradual increases in transactions from Monday to Thursday, followed by a peak on Friday and Saturday night (in smaller regions such as Katherine and Tennant Creek, the peak was less pronounced than in Darwin and Palmerston). In Katherine and Tennant Creek transactions reached a peak on Fridays, while in Darwin, Palmerston, Alice Springs, and the NT Balance, Saturdays had the highest number of transactions. The number of transactions in all regions was substantially lower on Sundays. Figure 7 shows the average daily transactions in each region by day of the week between September 2017 and February 2018.

Figure 7. Average daily transactions by region and weekday

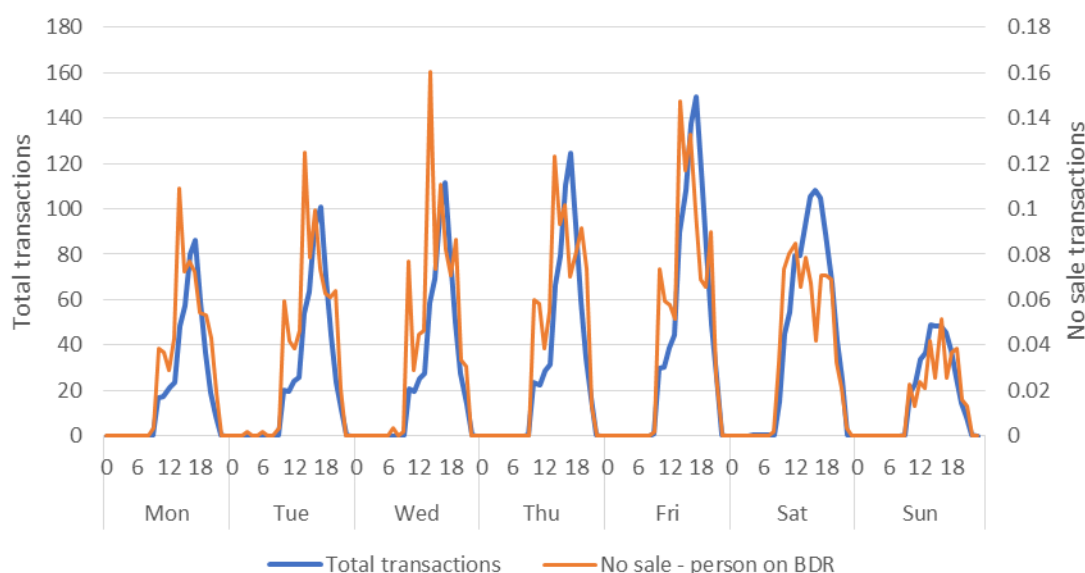


### 3.2.4 Transactions by time of day

Between Monday and Friday, the peak transaction time in the Territory was 5:00 to 6:00 pm, accounting for 18% of weekday transactions Territory-wide. Weekday transactions resulting in no sale due to the purchaser being on the BDR generally showed small, early peaks from 10:00 to 11:00 am, and 13% of these transactions occurred prior to noon. This was followed by the main peak from 2:00 to 3:00 pm, with another peak from 4:00 to 5:00 pm. Only 7% of total transactions and 10% of the no-sale transactions occurred from 8:00 pm onwards.

On the weekends, the peaks in total transactions were broader as purchasing hours were not impacted by working hours. The Saturday peak occurred from 3:00 to 6:00 pm, and the Sunday peak occurred slightly earlier, from 2:00 to 5:00 pm. The no-sale transactions were similarly spread over a wider time period on the weekends. Twelve per cent (12%) of total transactions and 20% of the no-sale transactions occurred prior to noon on weekends, and 7% of the total transactions and 8% of the no-sale transactions occurred after 8:00 pm. Figure 8 shows the average hourly transactions by hour of the day and day of the week across the Territory from September 2017 to February 2018. Total transactions are shown on the left axis and transactions resulting in no sale due to the person being on the BDR are shown on to the right axis, which is one one-thousandth the scale of the left axis. This has the effect of showing the no-sale transactions at 1,000 times their scale, relative to total transactions.

Figure 8. Average hourly transactions by hour of day and day of week



Note: the no-sale transactions are shown at 1,000 times their size relative to total transactions, so that patterns may be compared.

Additional charts of hourly transactions by region are provided in Section 8.1.

#### Recommendation:

*1. The NTG should continue to monitor trends associated with takeaway liquor transactions, persons on the BDR, and associated alcohol related data, as per the descriptive analysis included in this report.*

### 3.3 Persons on the BDR

#### 3.3.1 Number of people on the BDR over time by ban type

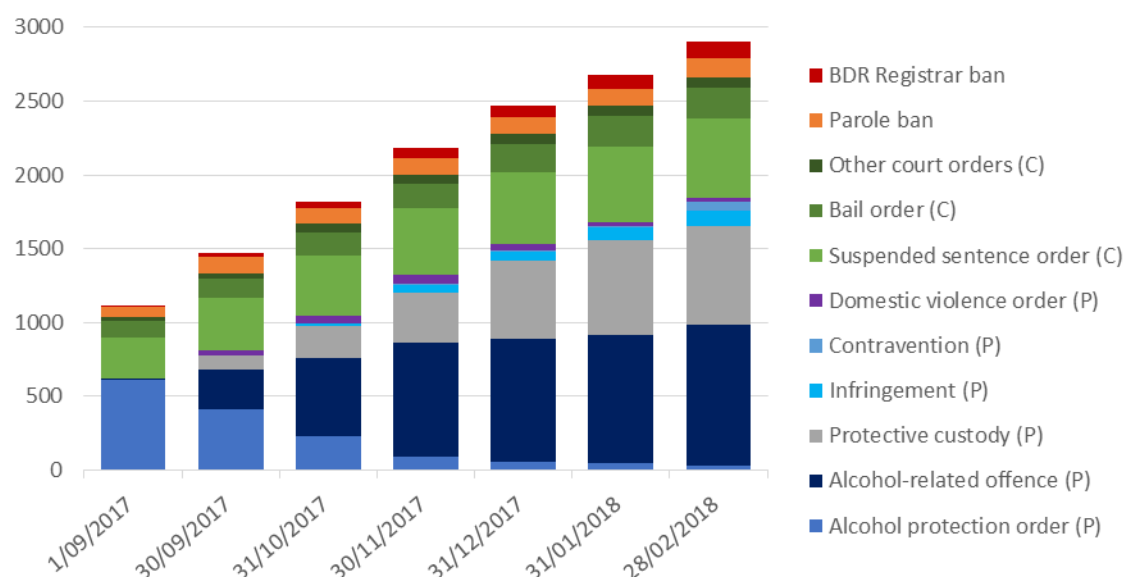
There were 1,257 individuals whose details were pre-loaded into the BDR in advance of full implementation. This included 663 individuals with alcohol protection orders that had been converted to police bans, 572 individuals with court ordered bans, 108 individuals with parole bans, and three individuals with self-referral bans (some individuals had more than one pre-loaded ban). Some of the pre-loaded court bans finished on or before the first day of full implementation and other bans began on a future date, so not all of these people were on the BDR as at the beginning of September.

At the end of the first day of full operation on 1 September 2017, the BDR had 1,114 individuals on it with active bans, including 419 (38%) with court bans, 70 (6%) with parole bans, three (0.3%)

with self-referral bans, 608 (55%) with bans from converted alcohol protection orders, and 14 (1%) on other types of police bans.

By the end of February 2018, there were 2,905 individuals on the BDR. Of those, 64% were on for a police ban, 28% were on for a court ban, 4% were on for a parole ban, and 4% were on for a BDR Registrar ban. Figure 9 shows the number of people on the BDR with valid, active bans by month, by the most recently issued type of ban (P indicates police bans and C indicates court bans).

*Figure 9. Number of people on the BDR by date and most recently issued active ban*



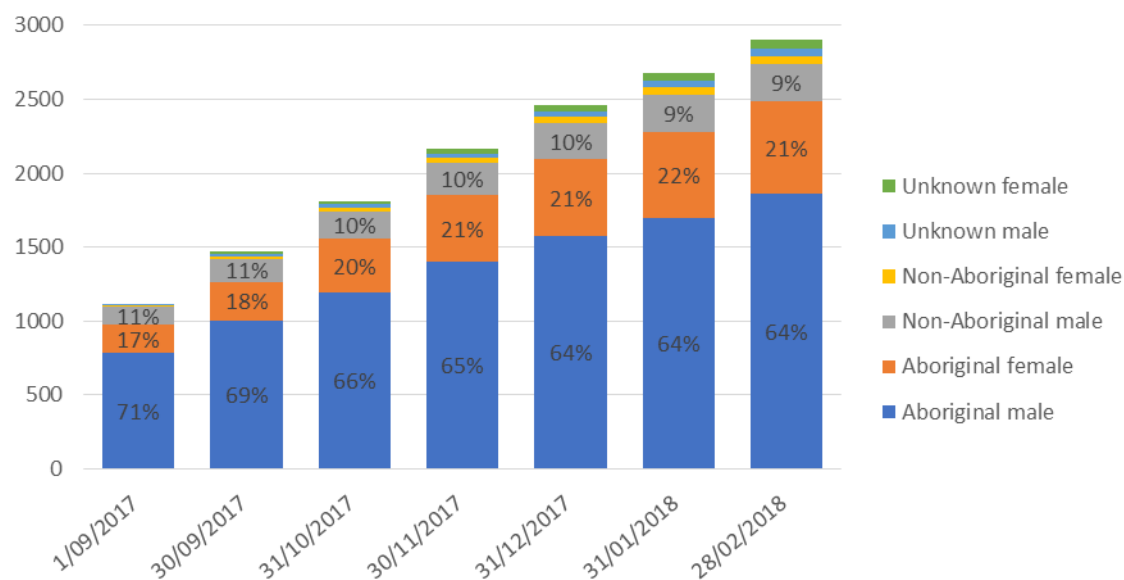
Apprehensions for alcohol-related offences have become the most frequent reason for people being on the BDR, followed by protective custody episodes and suspended sentence orders. By the end of November 2017, 98% of those who had started with an alcohol protection order ban had either moved to another type of ban (44%) or completed their ban and gone off the BDR (53%). Although domestic violence orders accounted for only 1% of individuals on the BDR on 28 February 2018, 48% of those on the BDR for alcohol-related offence bans on this date and 54% of those on court bans were defendants in domestic violence cases.

The category “Contravention” refers to bans given when a police officer discovers a known banned person possessing, consuming, or having recently consumed alcohol, where the person is not apprehended, infringed or taken into protective custody.

### 3.3.2 Demographics

On 1 September 2017, 87% of individuals on the BDR were Aboriginal. This percentage dropped to 86% by the end of February 2018, but this may be due to the increase in individuals placed on a BDR Registrar ban, for whom Aboriginal status was not recorded in the BDR. The percentage of banned drinkers who were male declined from 82% on 1 September 2017 to 73% on 28 February 2018. Figure 10 shows the number of people on the BDR each month by gender and Aboriginal status.

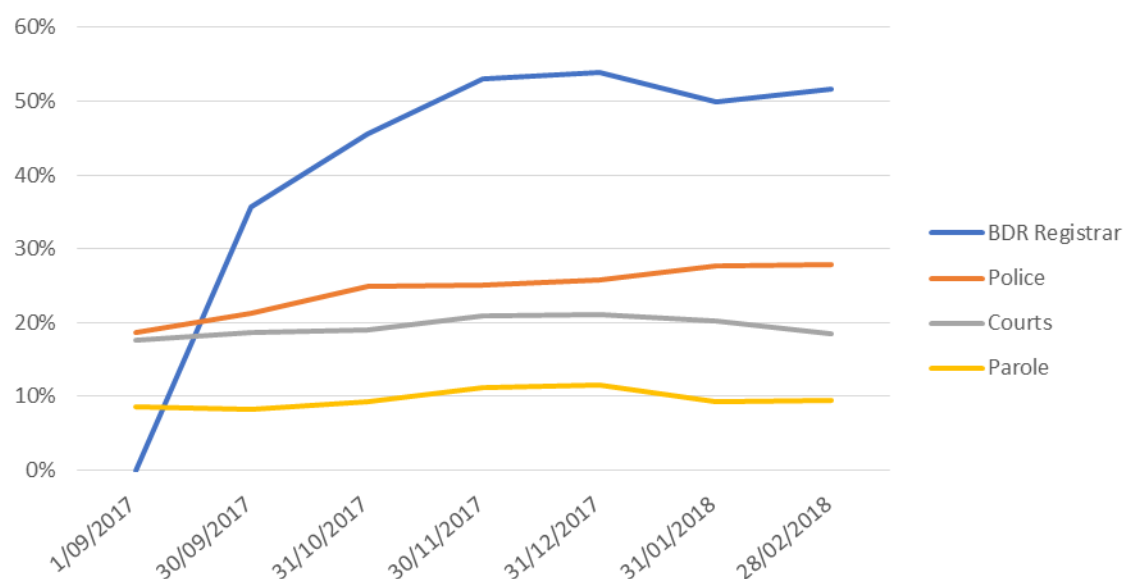
*Figure 10. Number of people on the BDR by date, and percentage<sup>3</sup> by gender and Aboriginal status*



As shown in Figure 11, the percentage of banned drinkers who are female varied considerably among referral pathways. On 28 February 2018, over half of those on a BDR Registrar ban were female, compared with 28% of those on a police ban, 18% of those on a court ban and 10% of those on a parole ban.

<sup>3</sup> The chart percentages have been rounded and may not sum to the exact values mentioned in the text.

Figure 11. Percentage of banned drinkers who were female by date and referral pathway<sup>4</sup>

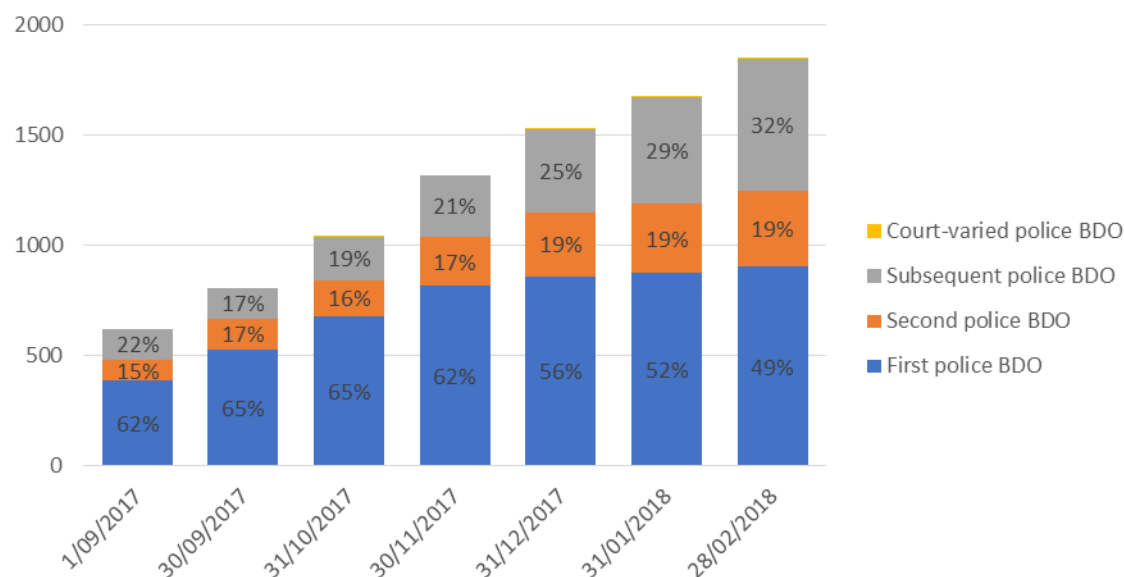


### 3.3.3 Number of persons on police banned drinker orders

When the NT Police issue a BDO to a person who does not already have an active police ban, the BDO is recorded as a first BDO with a duration of three months. If that BDO is breached, a second BDO that lasts for six months is issued, and if a second BDO is breached, a subsequent BDO that lasts for 12 months is issued. Another subsequent BDO is issued for a breach of a subsequent BDO. A police BDO may also be varied in duration by order of the court (distinct from a court ordered ban). Figure 12 shows the number of individuals on first, second, subsequent, and court-varied police BDOs by month.

<sup>4</sup> Only three individuals were banned via the BDR Registrar on 1 September 2017, none of whom were female.

Figure 12. Number of persons on first, second, subsequent, and court-varied police BDOs



The number of banned drinkers on first BDOs is fairly stable, the number on second BDOs is increasing slowly (though the proportion of the total is steady), and the number on subsequent BDOs is increasing rapidly. The steady numbers in the first BDO category indicate that the rate at which new first BDOs are issued is similar to the rate at which individuals move out of the first BDO category, whether because they receive a second BDO or a court ban, or because they complete their ban and go off the BDR. The rapid increase of the subsequent BDO category and the fact that individuals on subsequent BDOs outnumber those on second BDOs suggest that most individuals who receive a second BDO move to a subsequent BDO. This is discussed further in the next section.

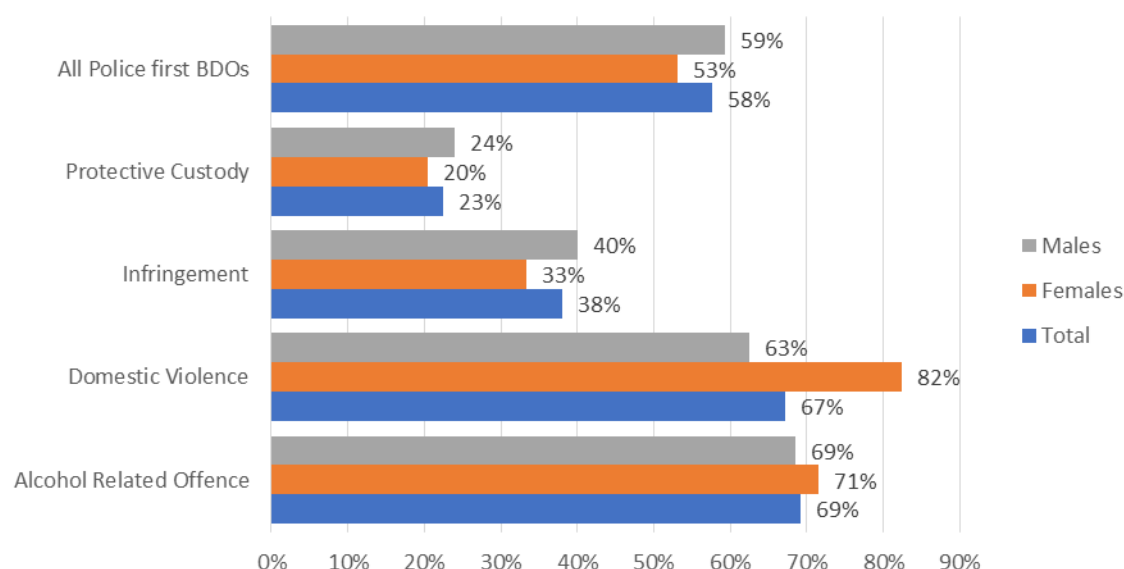
### 3.3.4 Completion of police bans

There were 1,202 first police BDOs issued at least three months prior to 28 February 2018, giving time for the bans to be completed. Of these bans, 693 (58%) were completed without being breached by another police ban. The remaining 42% were breached. Completion was least likely for first BDOs issued for protective custody, where only 23% were completed before being breached by another police ban (either another protective custody ban or some other type of police ban). Completion was most likely for first BDOs issued to those apprehended for an alcohol-related offence, of which 69% were completed, closely followed by first BDOs issued for domestic violence orders (67%). As a number of individuals receiving an alcohol-related offence ban would

have served some or all of the ban in prison, it is not surprising that this group was more likely to complete a first BDO than individuals on protective custody or infringement bans.

Males were more likely than females to complete a first police BDO overall, though females were more likely to complete a domestic violence BDO and slightly more likely to complete a BDO issued for an alcohol-related offence. Figure 13 shows the percentage of first BDOs completed by gender and triggering event.

*Figure 13. Percentage of first police BDOs completed by gender and triggering event*



The completion of second and subsequent BDOs will be reviewed at a later time.

### 3.3.5 Secondary supply

Section 42 of the *Alcohol Harm Reduction Act* makes it an offence to supply alcohol to a person subject to a prohibition under section 31A(2) of the *Liquor Act*. Between 1 September 2017 and 28 February 2018, three bans were issued for individuals charged with such offences: one for an offence in Katherine, and two for offences in Tennant Creek. In this time, the NT Police also issued manual bans to at least four other individuals where the comments recorded indicated the individual was observed purchasing alcohol for, or supplying alcohol to, a person on the BDR, where a charge was not recorded. The locations of the individuals when they received these bans



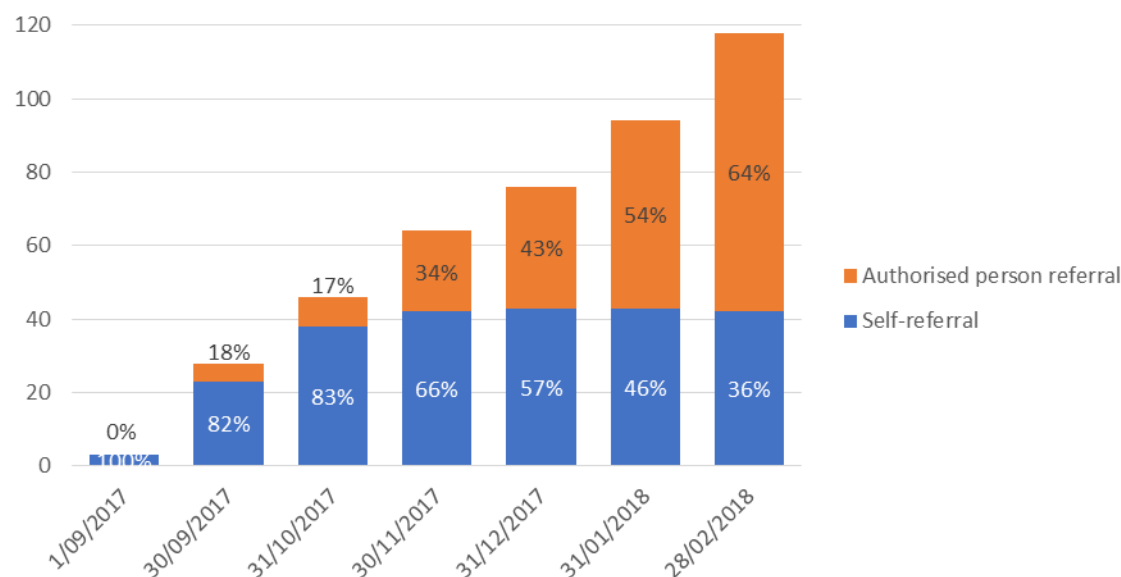
were not recorded. It was noted that there are substantial difficulties in finding effective methods to stop people privately supplying alcohol to banned drinkers.

### 3.3.6 BDR Registrar referrals and banned drinker orders

The BDR Registrar may add individuals to the BDR at the individual's request (self-referral) or as a result of a referral from an authorised person or a family member or carer, following the process outlined in Divisions 3 and 4 of the *Alcohol Harm Reduction Act 2017*. Between 1 September 2017 and 28 February 2018, the BDR Registrar had received 84 self-referrals, 108 authorised person referrals and 4 family/carer referrals. Not all referrals result in a BDO being issued: a person who is already banned through another pathway cannot be given a self-referral BDO, and persons referred by others generally require assessment before a BDO is issued.

At the end of February 2018, 118 individuals were on the BDR for self-referral and authorised person referral BDOs issued by the BDR Registrar (Figure 14). While four referral applications were received from families or carers in the first six months of the BDR, no BDOs had been issued for these referrals in this period.

Figure 14. Number of persons on the BDR for BDR Registrar BDOs by month



Individuals who self-refer to the BDR may request bans of three, six, or 12 months, and they may later apply to have their self-referral ban revoked if they no longer wish to be banned. If such an individual has incurred a ban through another pathway in the meantime, however, the revocation

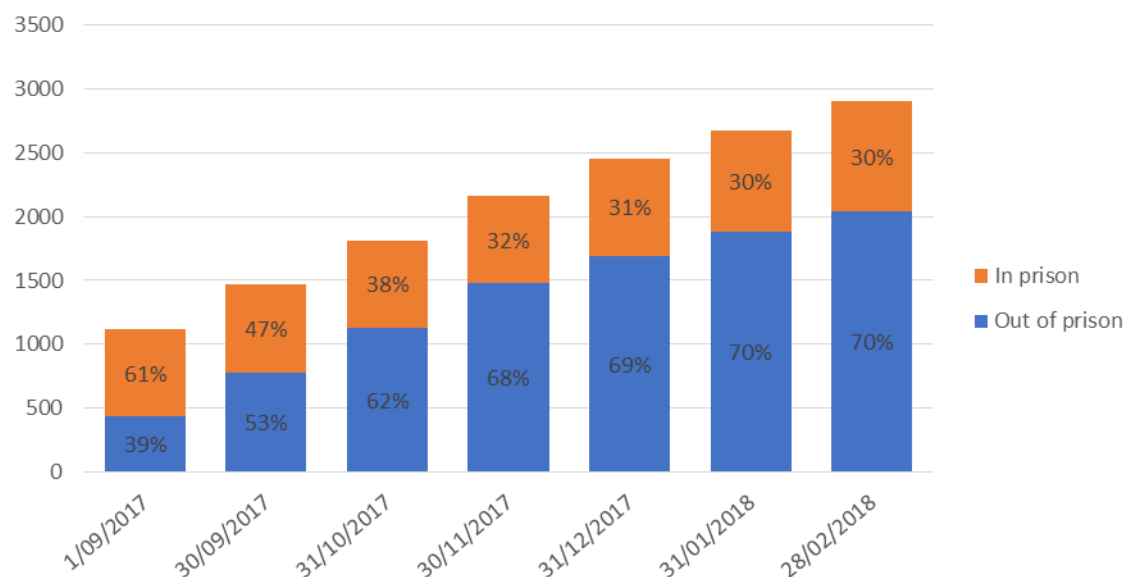
of their self-referral ban will not remove them from the BDR. The number of individuals on self-referral bans remained at 42-43 from the end of November 2017 to the end of February 2018. The growth in BDR Registrar bans since this time has been due to the increase in referrals from authorised persons. This does not mean that individuals are no longer self-referring, but that the rate at which self-referrals occur is similar to the rate at which these individuals move to another ban or go off the BDR (either by finishing their banned period or by requesting removal from the BDR).

Between September 2017 and February 2018, 80 BDOs were made for individuals who self-referred. Some of these BDOs were made for the same individual who self-referred again after requesting revocation of the initial ban. Of the 80 BDOs, 29% were made for three months, 15% were made for six months, and 56% were made for 12 months. During the reporting period, 24 self-referral BDOs were revoked. A few people asked for their bans to be revoked within a few days, or even on the same day, of being issued, while other individuals served a significant portion of their ban before requesting revocation (e.g. 52 days of a three-month ban; 76 days of a six-month ban).

### **3.3.7 Banned drinkers in prison**

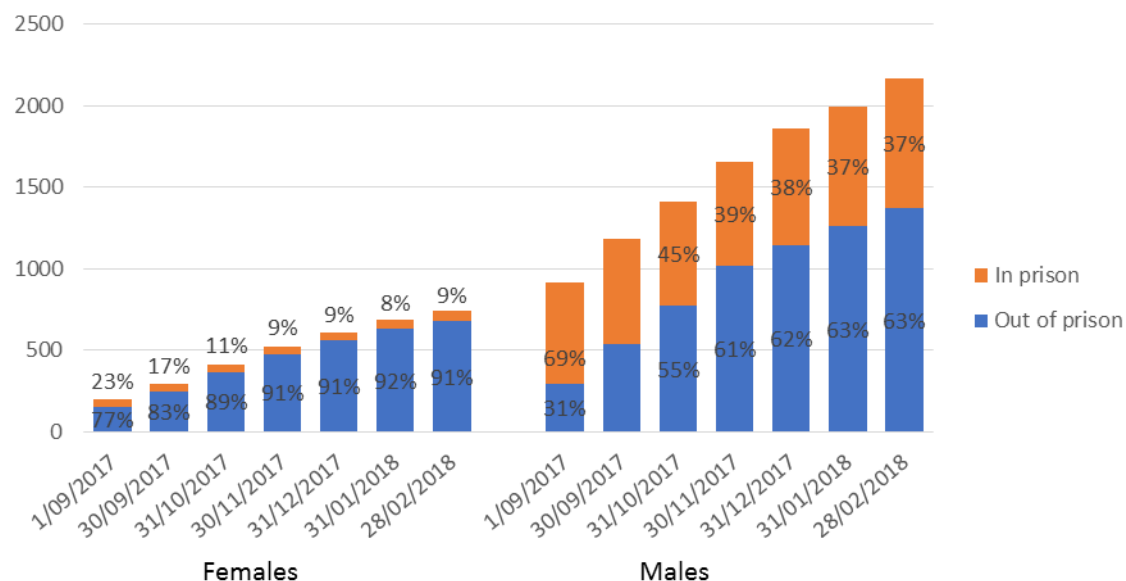
A significant proportion of banned drinkers were in custody, ranging from a high of 61% on 1 September 2017 (due to pre-loading individuals with suspended sentence and parole bans prior to their release from prison) to 30% by the end of February 2018. Figure 15 shows the number of people on the BDR at the end of each month by custodial status.

Figure 15. Number of people on the BDR by date and percentage by custodial status



The percentage of female banned drinkers who were in prison was much less than the percentage of male banned drinkers in prison, as shown in Figure 16.

Figure 16. Number of males and females on the BDR by date and percentage by custodial status

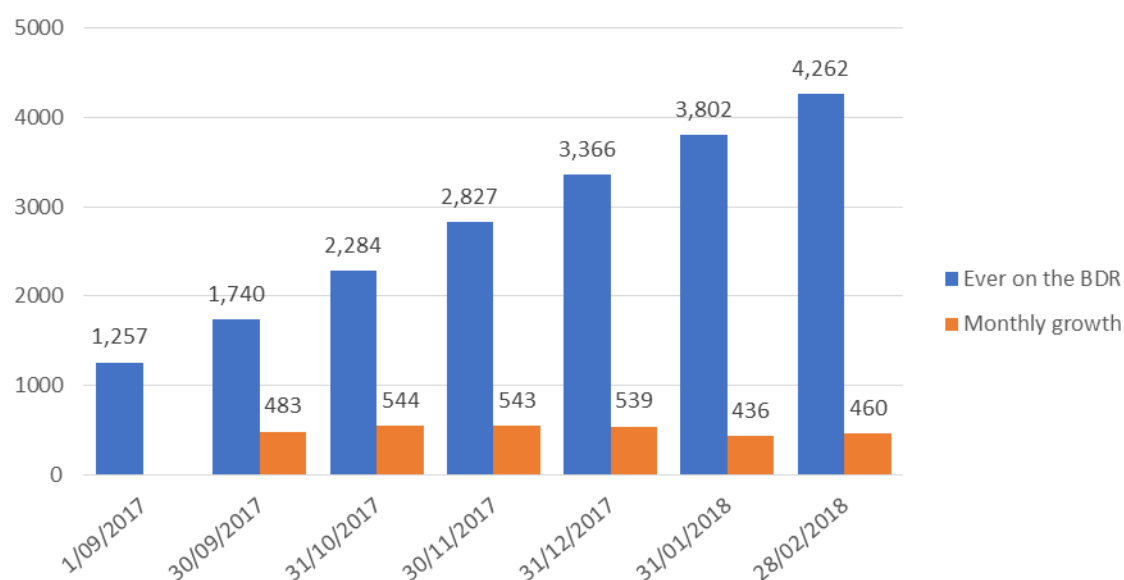


The percentages of Aboriginal and non-Aboriginal banned drinkers in prison were nearly identical on 28 February 2018: 31% of Aboriginal banned drinkers were in prison on that date, along with 30% of non-Aboriginal banned drinkers.

### 3.3.8 Number of people ever on the BDR

By the end of February 2018, a total of 4,262 individuals had received one or more valid bans that had been active for at least one day (bans that are issued and revoked on the same day are not considered to have been active, and some bans issued will become active on a future date). The rate of growth averaged 501 new individuals per month in the first six months of the BDR, excluding the pre-loaded individuals, but is gradually slowing. Figure 17 shows the number of people who had ever been on the BDR by the end of each month, and the growth during the month.

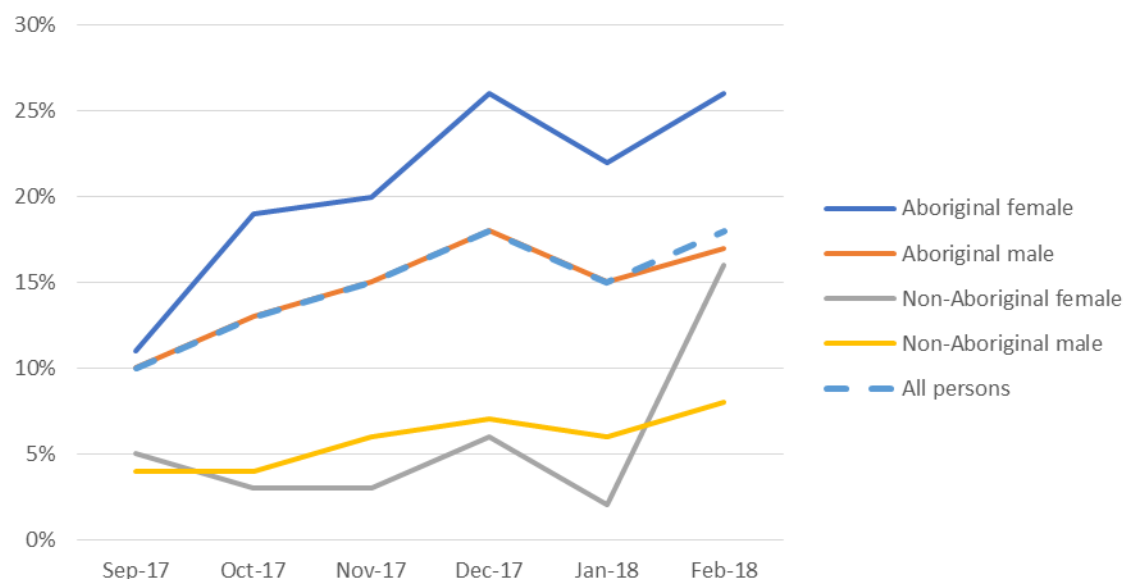
*Figure 17. Number of people ever on the BDR by the end of the month, and monthly growth*



### 3.3.9 Breaches of bans

A ban is breached when the NT Police record a banned person purchasing, possessing, or consuming alcohol, or having recently done so. This could be by way of an alcohol-related apprehension, infringement, protective custody episode, or a contravention of an existing ban. An individual on the BDR may breach multiple bans with a single event: for instance, a person with an active police ban and an active court ban may receive an alcohol-related infringement ban that breaches both existing bans. For this reason, breaches are not expressed in terms of bans breached, but as the percentage of individuals on the BDR at the end of the month who breach one or more bans during a month. Figure 18 shows the percentage of persons on the BDR each month who breached one or more bans.

*Figure 18. Percentage of persons on the BDR at the end of each month who breached one or more bans during the month*



Females were more likely than males to breach their bans, perhaps because a higher percentage of banned males are in prison where they are unable to breach bans (see Figure 18), and Aboriginal people were more likely to breach their bans than non-Aboriginal people. Overall, 10% of people on the BDR at the end of September 2017 breached a ban in that month. This increased to 18% for people on the BDR at the end of February 2018.

### **3.3.10 BDR coverage by region**

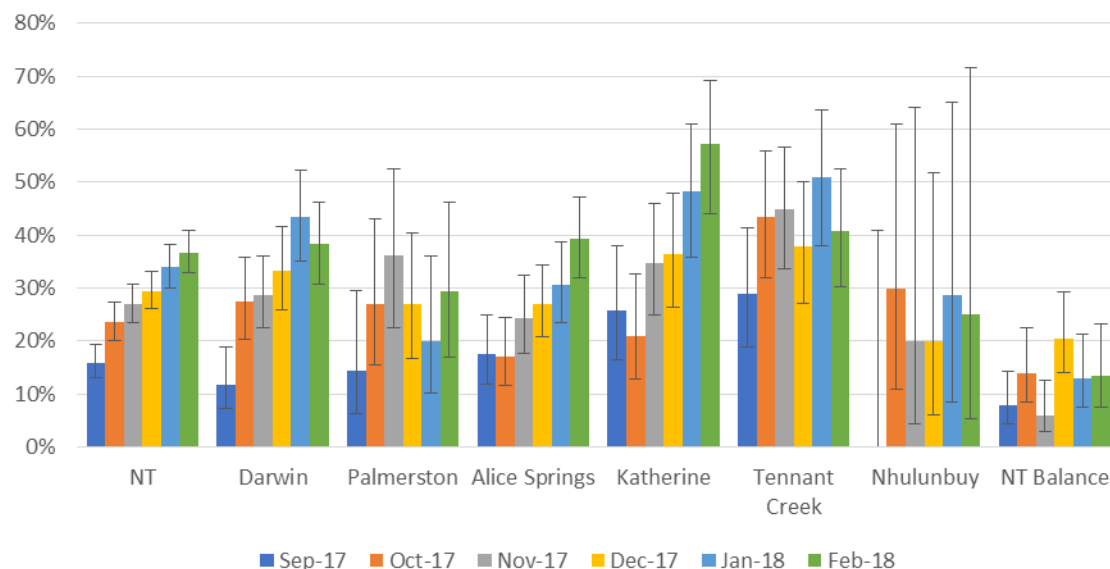
As noted above, a significant and growing proportion of individuals on the BDR breached one or more bans. Over time, the percentage of the targeted populations (those who are apprehended for alcohol-related offences, receive alcohol-related infringements or are taken into protective custody) who are already on the BDR should increase as the BDR reaches more people whose alcohol-influenced behaviour is bringing them into contact with the justice system. This section does not consider how a person went onto the BDR, but whether they are on the BDR (for any reason) when they enter the justice system for an alcohol-related offence, infringement, or protective custody episode.

### 3.3.10.1 Alcohol-related offences

Across the Northern Territory, the percentage of adults apprehended for an alcohol-related offence<sup>5</sup> who were already on the BDR increased from 16% in September 2017 to 37% in February 2018. Similar increases were seen in most regions, although percentages were more variable in smaller regions. The degree of overlap in the error bars, which represent 95% confidence intervals for the percentages, provide an indication of whether the percentages in different months are significantly different—little to no overlap indicates a significant difference, while a high level of overlap indicates no difference.

In February 2018, 37% of adults apprehended for alcohol-related offences were already on the BDR at the time of apprehension (Figure 19). Aside from Nhulunbuy, where numbers of alcohol-related apprehensions are very low, the NT Balance had the lowest percentage of apprehended adults on the BDR in February 2018, at 14%, while Katherine had the highest, at 57%.

*Figure 19. Percentage of adults apprehended for alcohol-related offences who were already on the BDR*



### 3.3.10.2 Alcohol-related infringements

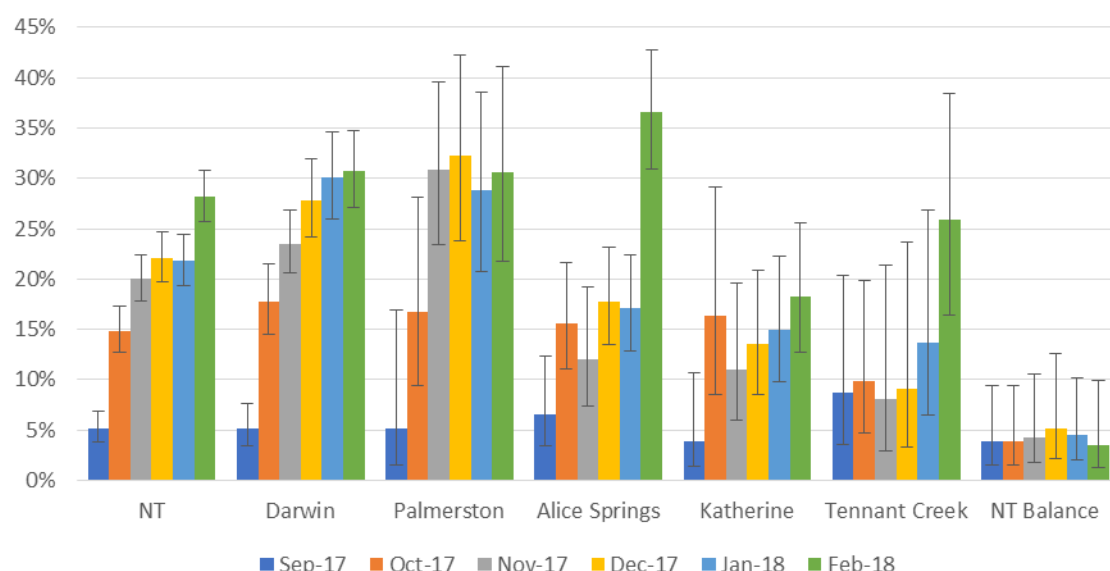
The percentage of NT adults given an alcohol-related infringement<sup>6</sup> who were already on the BDR ranged from 5% in September 2017 to 28% in February 2018 (Figure 20). Again excluding

<sup>5</sup> An individual is counted once for each date apprehended.

<sup>6</sup> Alcohol-related infringements are as defined in the *Alcohol Harm Reduction Act 2017*. An individual is counted once for each date infringed.

Nhulunbuy, where only one of the 78 adults who received an infringement during the period was on the BDR, the proportion of adults infringed in February 2018 who were on the BDR at the time ranged from 4% in the NT Balance to 37% in Alice Springs.

*Figure 20. Percentage of adults given alcohol-related infringements who were already on the BDR*

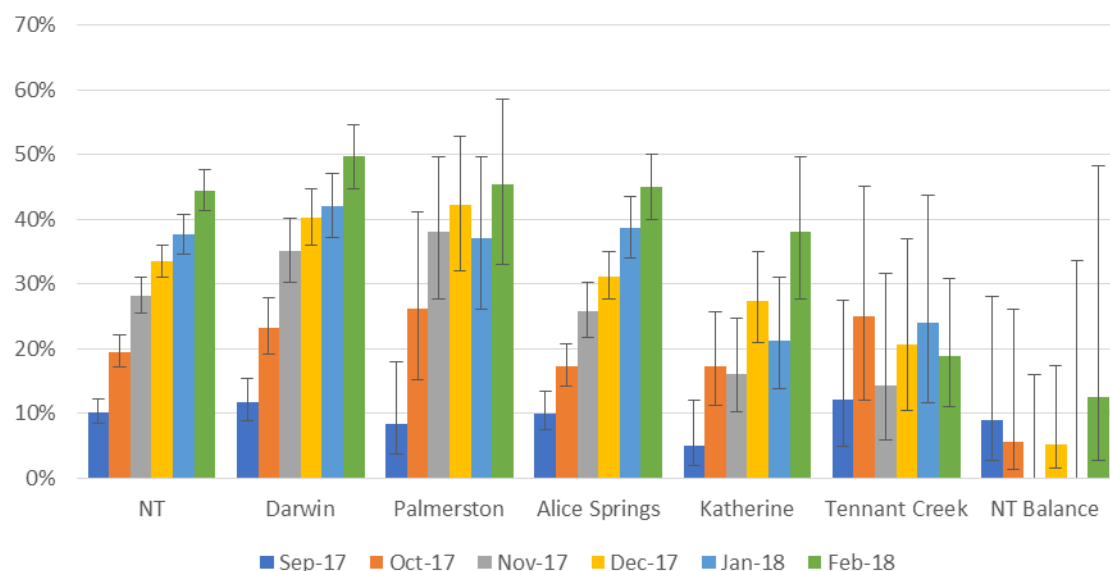


In Alice Springs and Tennant Creek, the February 2018 percentages were much larger than the values recorded from September to December 2017. The larger percentages may be associated with additional police activity associated with Operation Haven.

### ***3.3.10.3 Protective custody episodes***

In September 2017, 10% of adults taken into protective custody were already on the BDR at the time of the episode. This increased to 45% by February 2018. In February 2018, 13% of those taken into protective custody in the NT Balance were on the BDR, compared with 50% of those taken into protective custody in Darwin. Figure 21 shows the percentage of adults taken into protective custody in each region who were already on the BDR at the time. Nhulunbuy is not shown as only eight individuals were taken into protective custody in Nhulunbuy between September 2017 and February 2018, none of whom were on the BDR.

Figure 21. Percentage of adults taken into protective custody who were already on the BDR



At the Territory level, it appears that the BDR is still expanding its coverage of the trigger events populations (those taken into protective custody, given an alcohol-related infringement, or apprehended for an alcohol-related offence). The percentage of individuals in these pathways who are already on the BDR is not expected to fully reach 100%: in the infringement and protective custody pathways, recruitment onto the BDR requires three of these events in a two-year period, and in the alcohol-related apprehension pathway, many individuals will complete their bans before they are intercepted for a new trigger event. New individuals (e.g. those who reach their 18<sup>th</sup> birthday, as well as migrants to the Territory) will also continue to appear in the base populations for each pathway.

### 3.3.11 Profiles of banned drinkers

A statistical analysis was undertaken to identify groups of banned drinkers with similar patterns of alcohol-related contact with the justice system in the year prior to going on the BDR. The sample consisted of 4,934 individuals who had received one or more valid justice system bans (bans issued by the NT Police, courts, or Parole Board<sup>7</sup>) by 30 April 2018. Five indicators of justice system contact (alcohol-related protective custody episodes, infringements, and apprehensions, time in

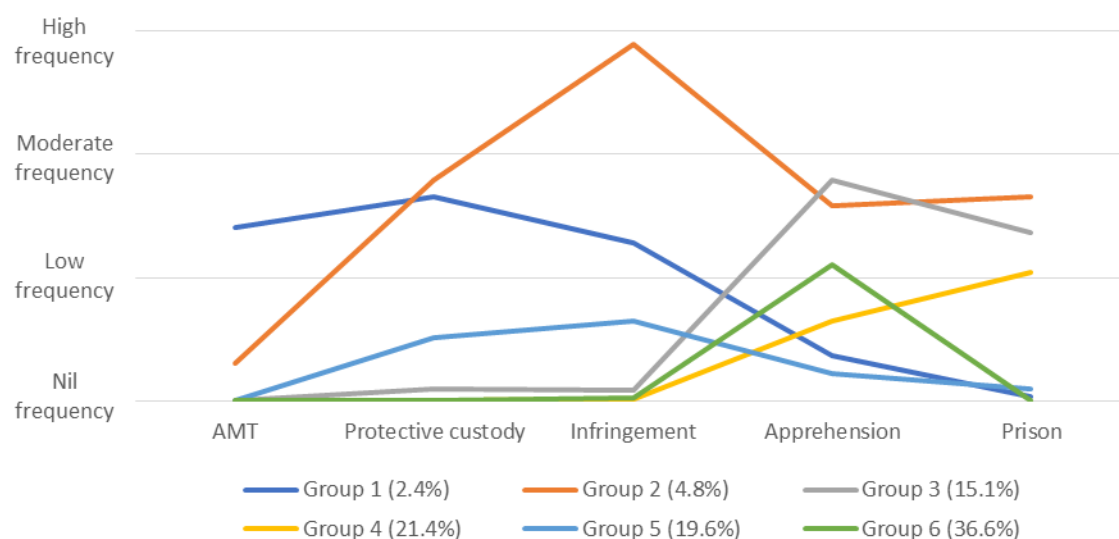
<sup>7</sup> See *bans* in the Terminology section. Banned drinkers on a BDR Registrar ban who received no additional valid police, court, or parole bans were excluded from this analysis.



prison, and time on a residential order for alcohol mandatory treatment) were included in the analyses. More information on the analysis is given in Section 8.1.2.

The analysis identified six groups from the data. Figure 22 presents the mean frequency of events for each of these groups and shows that each group is characterised by a distinct pattern in prior year alcohol-related events.

*Figure 22. Mean frequency of events for identified groups*



The mean frequencies give an indication of the types of events that are important for each group. For instance, three groups (3, 4, and 6) average a very low frequency of non-criminal events (alcohol mandatory treatment, protective custody and infringement), and low to moderate frequency apprehensions. Groups 3 and 4 tend to have some involvement with prison, while Group 6 does not.

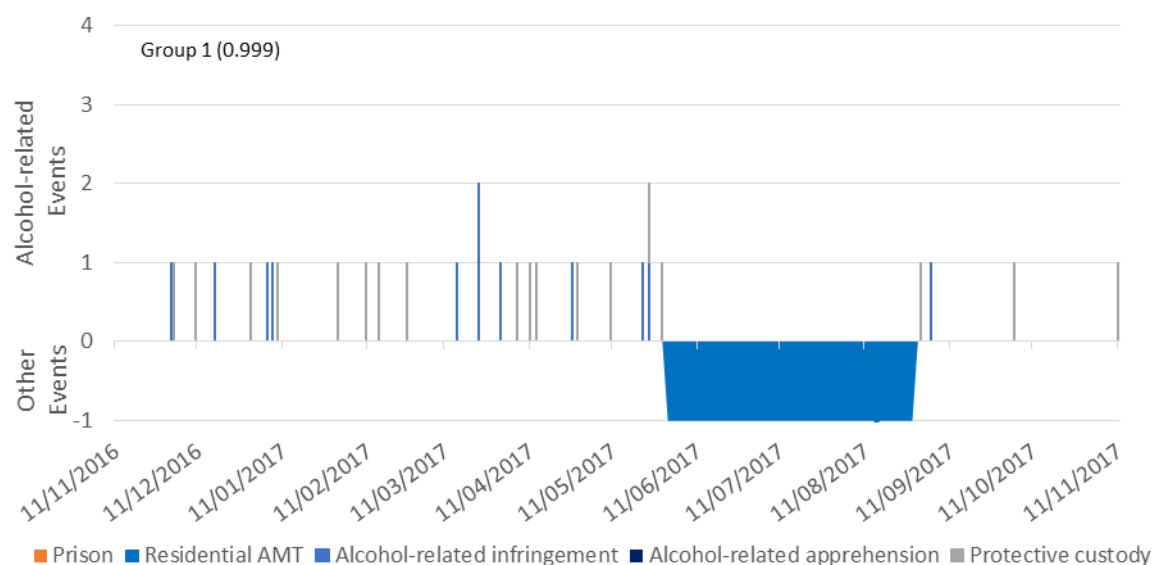
Groups were described based on the criminal or non-criminal nature of the previous year's alcohol-related events as this was where the most distinctive differences among groups were found. Infringements (given for minor offences such as consuming liquor in a regulated place, which do not require an appearance in court) were included in the non-criminal category rather than the criminal category (which involved more serious offences).

Group 1 was characterised by a high probability of both protective custody episodes and infringements, with a majority participating in alcohol mandatory treatment (AMT). This group

represented 2.5% of banned drinkers, a result of the relatively small number of individuals in the overall sample who had engaged in AMT in the previous year. Banned drinkers within this group had strong associations with non-criminal events and weak associations with criminal events<sup>8</sup> (apprehension and prison).

Figure 23 shows a sample profile for a banned drinker belonging to Group 1. The value of 0.999 indicates the probability that the individual belongs to the class, ranging from 0 to 1: this this case, the individual is a nearly perfect fit). The profile shows the justice system events in the year before this person went on the BDR. Alcohol-related events (alcohol-related apprehensions, protective custody episodes and infringements) appear as vertical lines above the axis, and other events (residential alcohol mandatory treatment or prison) appear below the axis.

*Figure 23. Group 1 sample profile: moderate to high frequency non-criminal events with alcohol mandatory treatment*



Group 2, representing 4.8% of banned drinkers, was characterised by a moderate to high frequency of both criminal and non-criminal alcohol-related events with the addition of time spent in prison. The variety in prior year alcohol-related events among this group of banned drinkers is reflected

<sup>8</sup> The AMT program was designed for people who had been taken into protective custody three or more times over a two-month period but excluded those who committed a crime under the influence of alcohol. Group 1 reflects the association between a moderate to high level of non-criminal events, nil to low level criminal events and AMT.

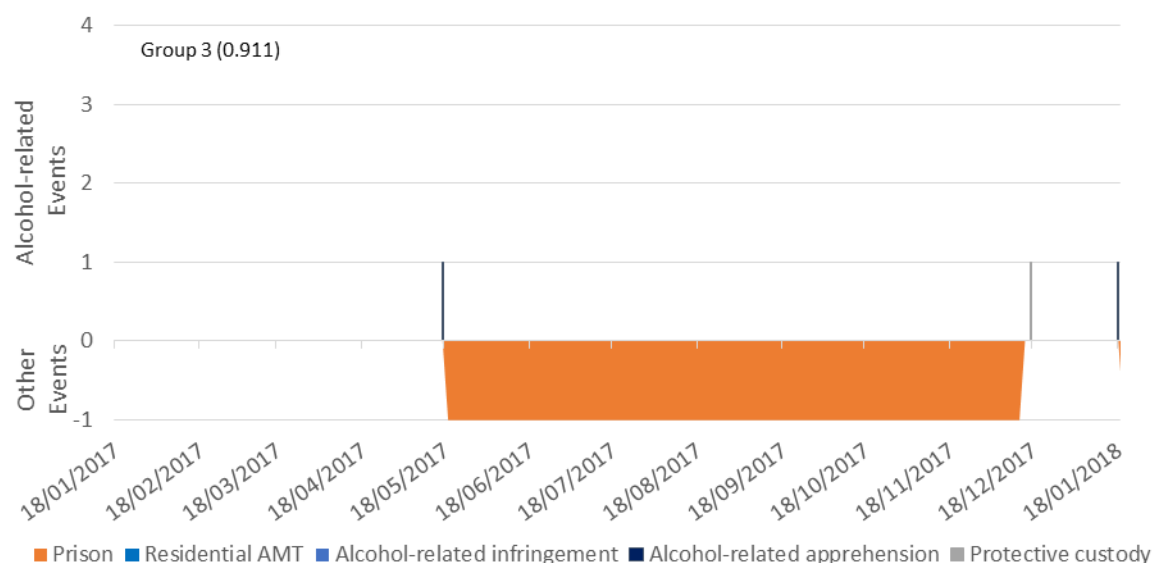
in Figure 24, with the profile showing several periods of time in custody and frequent criminal and non-criminal alcohol-related events occurring between custodial periods.

*Figure 24. Group 2 sample profile: moderate to high frequency criminal and non-criminal events with time in prison*



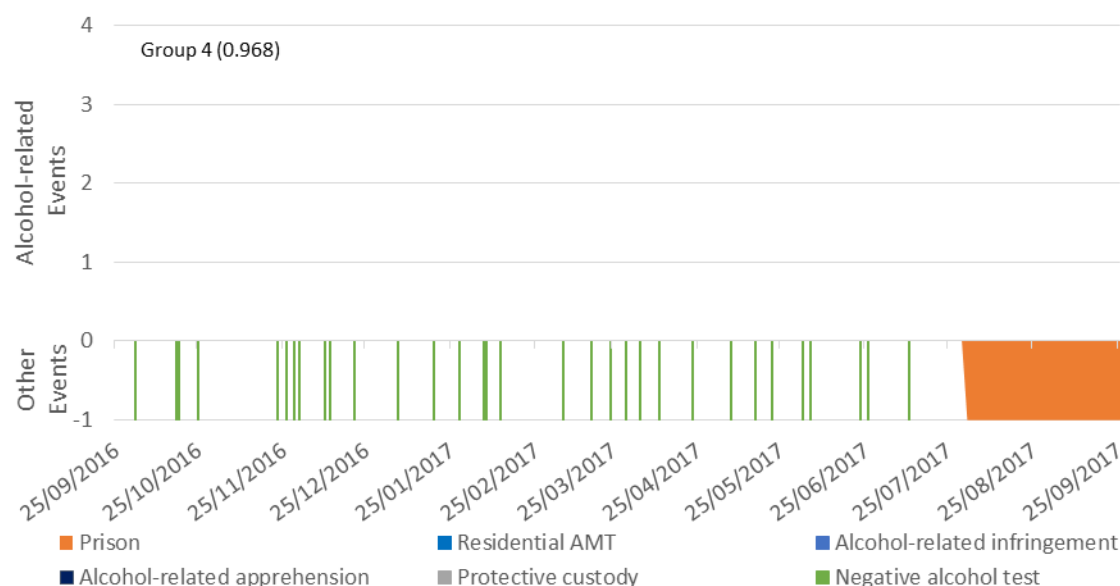
Group 3 had a larger membership (15.0%) than the previous two and was characterised by a low frequency of non-criminal events and a higher frequency of alcohol-related apprehensions, with the addition of a high probability of spending some time in prison (0.85). Figure 25 shows a sample profile for Group 3: note the lower frequency of events compared with Group 2.

Figure 25. Group 3 sample profile: low frequency criminal and non-criminal events with time in prison



Group 4, which consisted of 21.4% of the sample, had very high probabilities of no infringement and protective custody events and a high probability of nil or one apprehension. In the year prior to going on the BDR, most of these individuals spent time in prison: many individuals in this group are on parole or court bans, often for alcohol-related offending that happened more than a year prior to the implementation of the BDR. Figure 26 shows the profile of a banned drinker on parole in Group 4 (the green lines indicate negative-outcome alcohol tests performed by NT Community Corrections—note that this individual had no positive-outcome alcohol tests in the period shown).

Figure 26. Group 4 sample profile: low to no criminal or non-criminal alcohol-related events, usually with time in prison



Group 5, which comprised 19.7% of the sample, exhibited similar alcohol-related event probabilities to Group 1, with a moderate probability of low to moderate frequency infringements and a high probability of low to moderate frequency protective custody episodes. Banned drinkers in this group also had a high probability of having no alcohol-related apprehensions, and a high probability of spending the prior year in the community rather than prison. This dominance of non-criminal events, compared to criminal apprehensions, is apparent in the profiles shown in Figure 27 and Figure 28. The key difference between Group 1 and Group 5 is the absence of alcohol mandatory treatment for Group 5<sup>9</sup>. Group 5 included the banned drinker with the highest frequency of alcohol-related events in the year prior to going on the BDR (one event every 4.9 days, as shown in Figure 28).

Group 6 made up 36.6% of the sample and showed extremely low probabilities of infringement and protective custody events, and a high probability of having a single alcohol-related apprehension. This group also had near a zero probability of spending time in prison or alcohol mandatory treatment during the year prior to going on the BDR. The key difference between Group 6 and Group 3 is the absence of periods in custody for banned drinkers in Group 6. As depicted in the profile shown in Figure 29, many individuals within Group 6 had only a single

<sup>9</sup> This analysis only considered events in the year prior to going on the BDR: it is likely that some of the individuals in Group 5 participated in alcohol mandatory treatment at an earlier time.

alcohol-related apprehension in the year before going on the BDR (this being the event that put them on the BDR).

*Figure 27. Group 5 sample profile: low to moderate frequency non-criminal events without AMT*



*Figure 28. Group 5 sample profile: very high frequency non-criminal events without AMT*

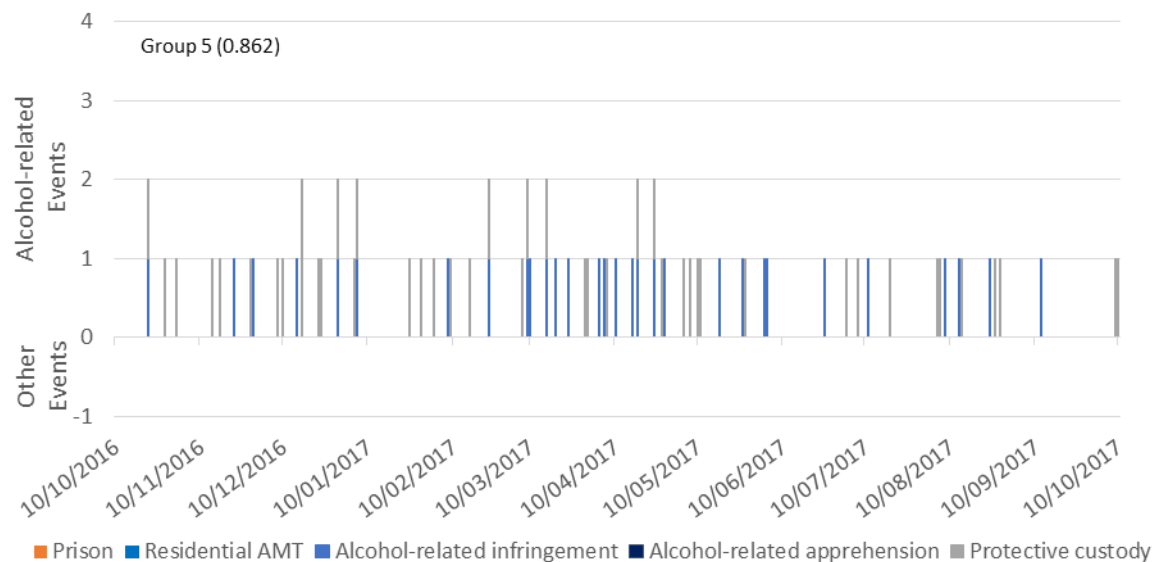
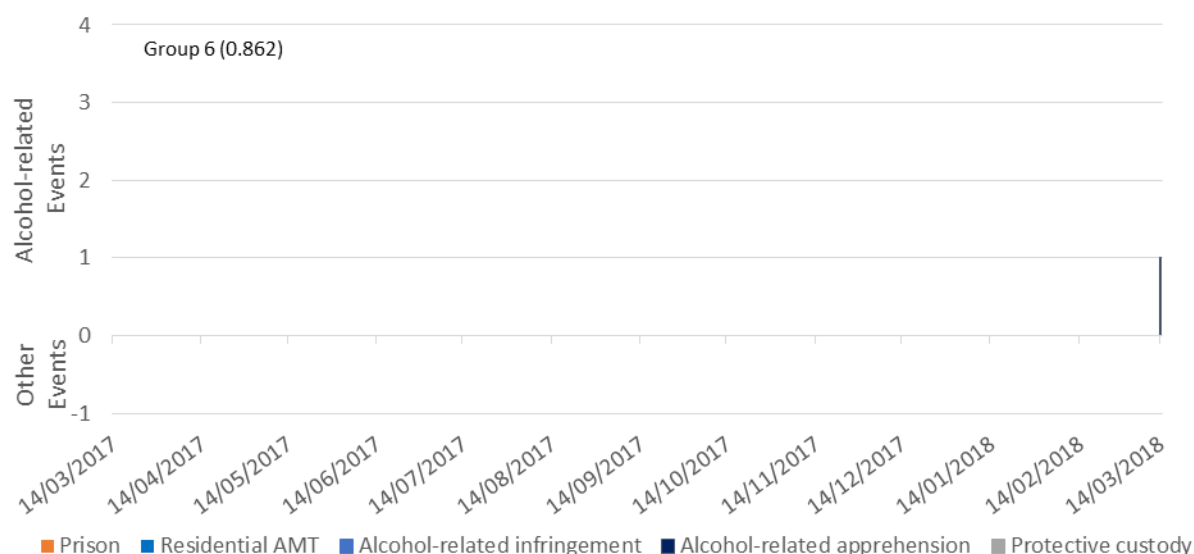


Figure 29. Group 6 sample profile: very low frequency criminal events without time in prison

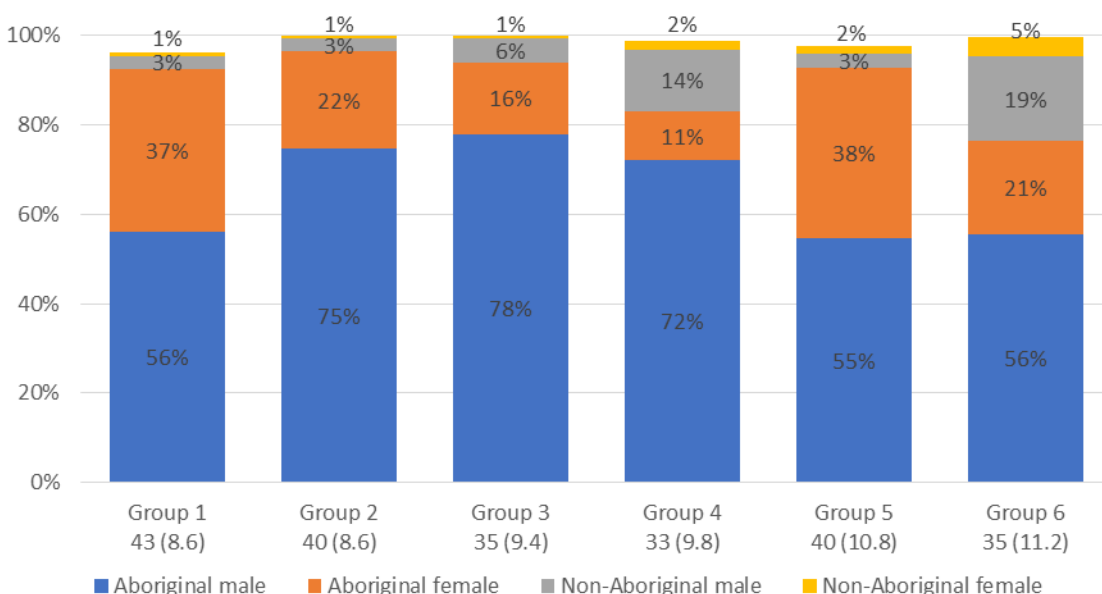


### 3.3.11.1 Group Demographics

The Aboriginal status, gender, and age of individuals in the six groups were analysed to determine how the groups varied based on sociodemographic factors. The mean age of banned drinkers varied from 33 years ( $SD = 9.8$ ) in Group 4 (rare to no alcohol-related contacts in previous year, usually with the addition of time spent in prison) to 43 years ( $SD = 8.6$ ) in Group 1 (high frequency of non-criminal events with time in alcohol mandatory treatment). Group 3 (low frequency of criminal and non-criminal alcohol-related appearances with the addition of time spent in prison) and Group 6 (rare criminal alcohol-related events) also showed relatively young mean ages with banned drinkers in these groups being approximately 35 years old.

In terms of Aboriginal status and gender, Group 6 (rare criminal events) had the highest proportion of non-Aboriginal people (23.5%) and Groups 1 and 5 (predominantly non-criminal events) had the highest proportions of females (40.2% and 41.6% respectively). The membership of all other groups was composed predominantly of Aboriginal males. Figure 30 shows the sociodemographic profiles of the six groups. The mean age and standard deviation (in brackets) for each group are shown below the group label.

Figure 30. Sociodemographic profiles of the six groups of banned drinkers, including mean age and standard deviation



Note: Aboriginal status and/or gender was unknown or not recorded for a few individuals: bars for these individuals are not included in the chart. Percentages have also been rounded and may not sum exactly to 100%.

### 3.4 Banned Drinker Responses

This section provides an initial look at the types of responses being shown to date by banned drinkers, and describes banned drinkers' participation in treatment.

#### 3.4.1 Frequency of alcohol-related events while on the BDR

Preliminary qualitative analysis was undertaken to look for emerging response patterns in the frequency of justice system events recorded for banned drinkers after going on the BDR. Changes in either the positive or negative direction were identified based on the relative frequency and criminal/non-criminal categorisation of a banned drinker's prior year justice system events compared to events occurring during and/or after going on the BDR. It is important to note that the following analyses are only *potential* indications of how banned drinkers may be responding: the relatively short time elapsed since implementation means that behaviour patterns are likely still changing and that it is too early to expect conclusive results. The early response patterns of all individuals in the analysis had not yet been assessed at the time of this report; hence, no information on the frequency of such responses is presented here.



The first, most encouraging, response pattern identified was termed *discontinued contact*. This response was characterised by a significant period on the BDR without alcohol-related contact with the justice system. For some individuals, evidence of alcohol desistance, provided by negative alcohol tests administered by NT Community Corrections as part of a court or parole order, was also available. These tests indicate that the individual is still in the Northern Territory and testing negative for alcohol consumption. The profiles presented in Figure 31 and Figure 32 illustrate this type of response. Each chart shows the events in the year prior to going on the BDR and events in the year to date following their addition to the BDR. The purple vertical line indicates 30 April 2018 (the date of this analysis).

*Figure 31. Discontinued contact: significant period of time on BDR with no alcohol-related justice contact (Group 3)*

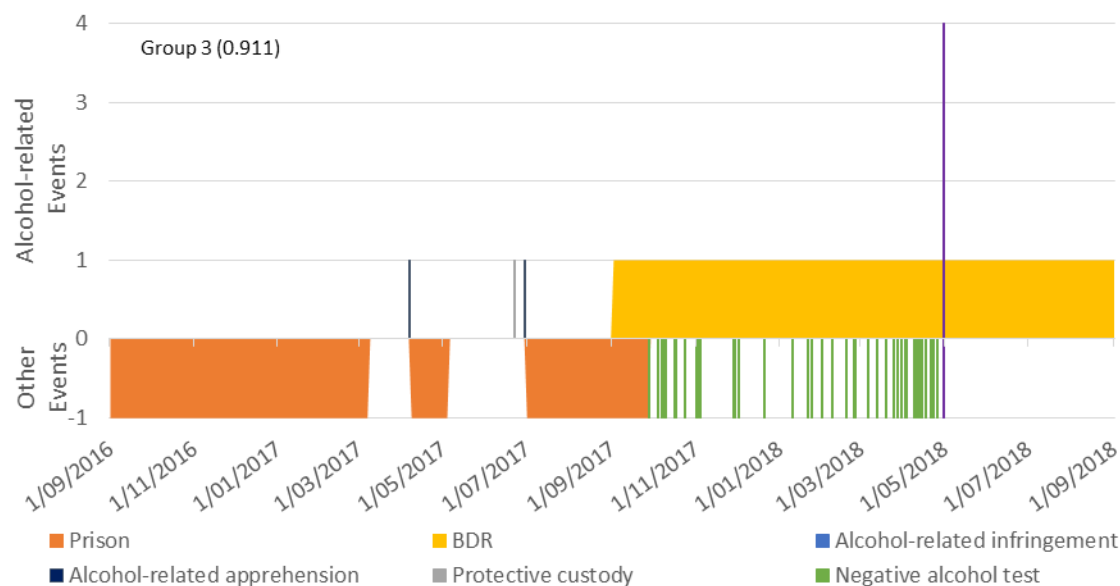
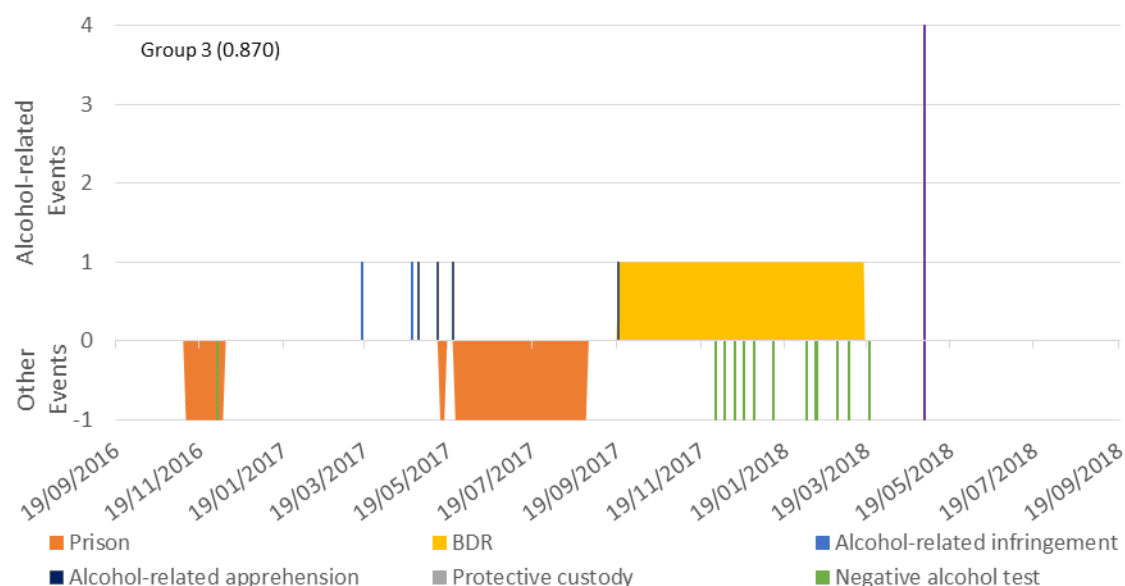


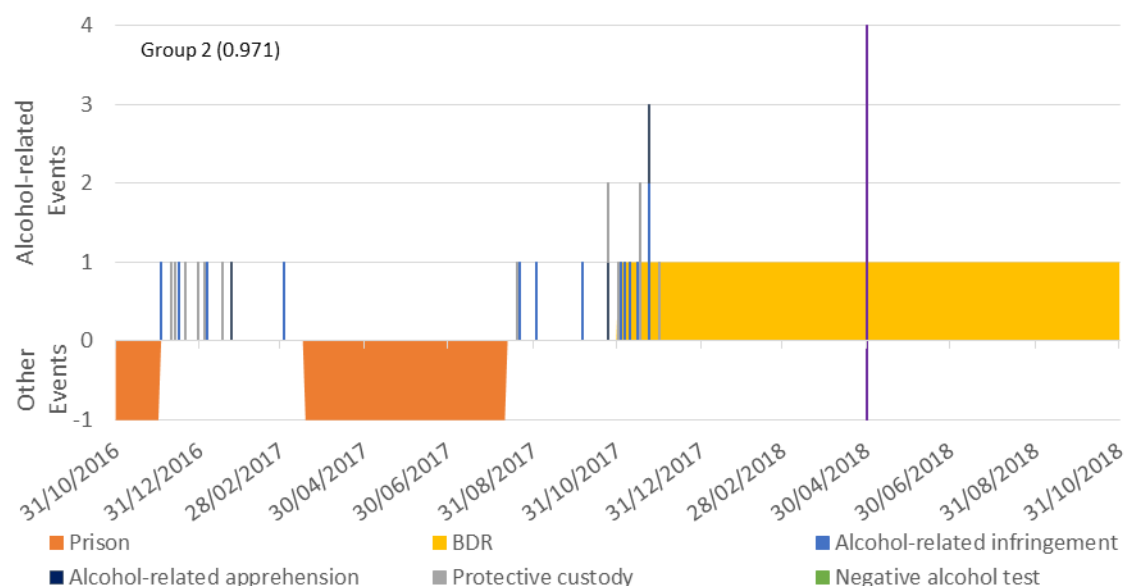
Figure 32. Discontinued contact: significant period of time on BDR with no alcohol-related justice contact (Group 3)



In their year prior to the BDR, both of these individuals had a small number of criminal and non-criminal events culminating in alcohol-related apprehensions for which they spent time in custody. This is consistent with their membership in Group 3. Since being placed on the BDR, neither individual has had any alcohol-related events recorded in the justice system, nor any positive alcohol tests. The individual in Figure 32 has gone off the BDR, with no further alcohol-related contact recorded.

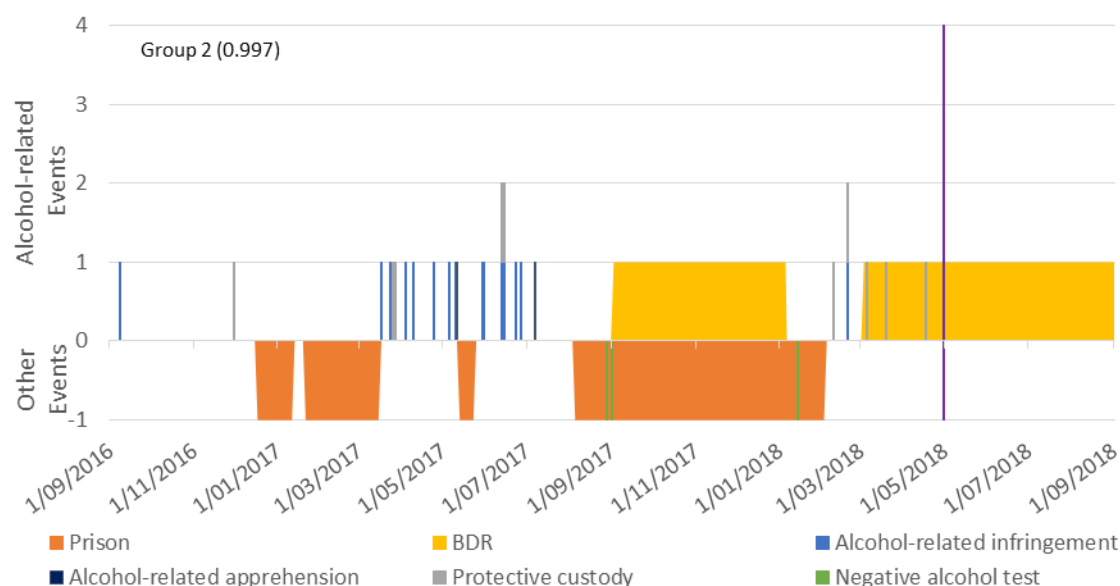
The individual in Figure 33 also shows discontinued contact, after a period of high frequency events when first on the BDR, but this time without the evidence provided by negative alcohol tests. This individual is in Group 2 (high frequency of alcohol-related events plus prison). The individual's last appearance in the justice system was in November 2017, and it is not possible to determine from the available data whether the individual is still in the Northern Territory.

Figure 33. Discontinued contact: significant period of time on BDR with no alcohol-related justice contact (Group 2)



A second type of response observed was termed *reduced frequency*. Similar to the first response, this is suggestive of a positive outcome. Although the individual may not be desisting entirely, the frequency of alcohol-related contact with the justice system has reduced while on the BDR, with the potential for further reduction in the longer term. Individuals showing this response were mainly in Groups 1, 2 and 5, as these individuals had frequent enough events in the year before going on the BDR to show a reduced frequency while on the BDR. This response differed from potential desistance in that individuals did not show a significant period of time (relative to their previous year) in the community without alcohol-related events.

Figure 34. Reduced frequency response: decreasing frequency alcohol-related justice contact while on BDR (Group 2)



A third observed response was termed *continued events*. This was characterised by individuals showing a similar or increased frequency of events while on the BDR relative to the year prior to the BDR. Continued frequency responses included high (Figure 35), moderate (Figure 36), and low (Figure 37) frequency. For this group, the BDR does not appear to have yet resulted in noticeable reduction of contact with the justice system, with some individuals breaching their first bans within a day or two of them coming into effect, and even accumulating two bans from different pathways in the same day. This shows that some banned drinkers are still gaining regular access to alcohol. Individuals showing continued low frequency responses may have alcohol-related contact at a low enough frequency to complete their bans and come off the BDR.

Figure 35. Continued events response: continued high frequency contact with the justice system (Group 2)

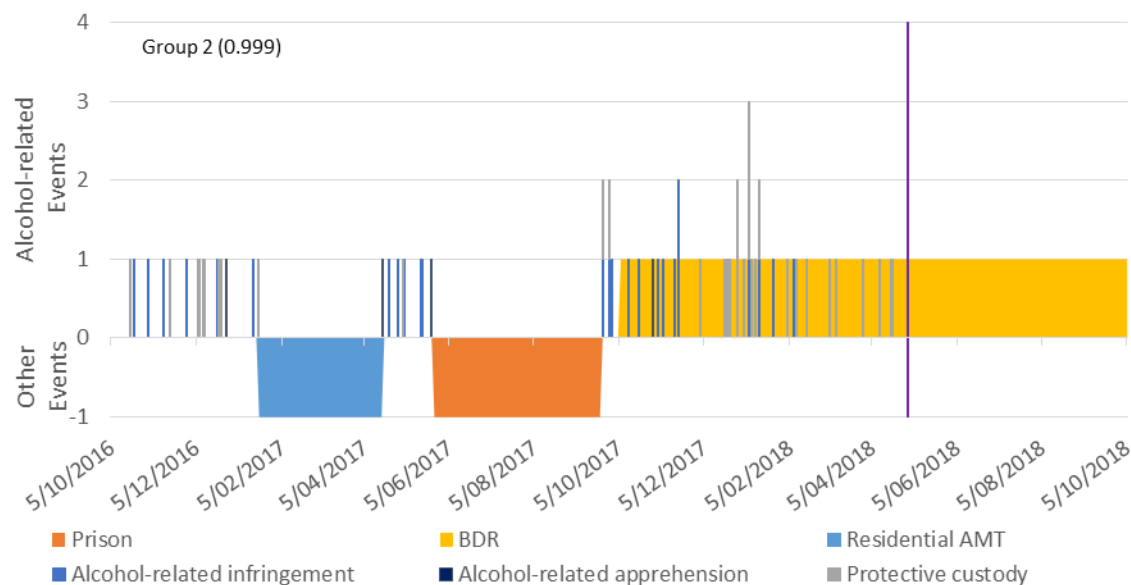


Figure 36. Continued events response: continued moderate frequency contact with the justice system (Group 1)

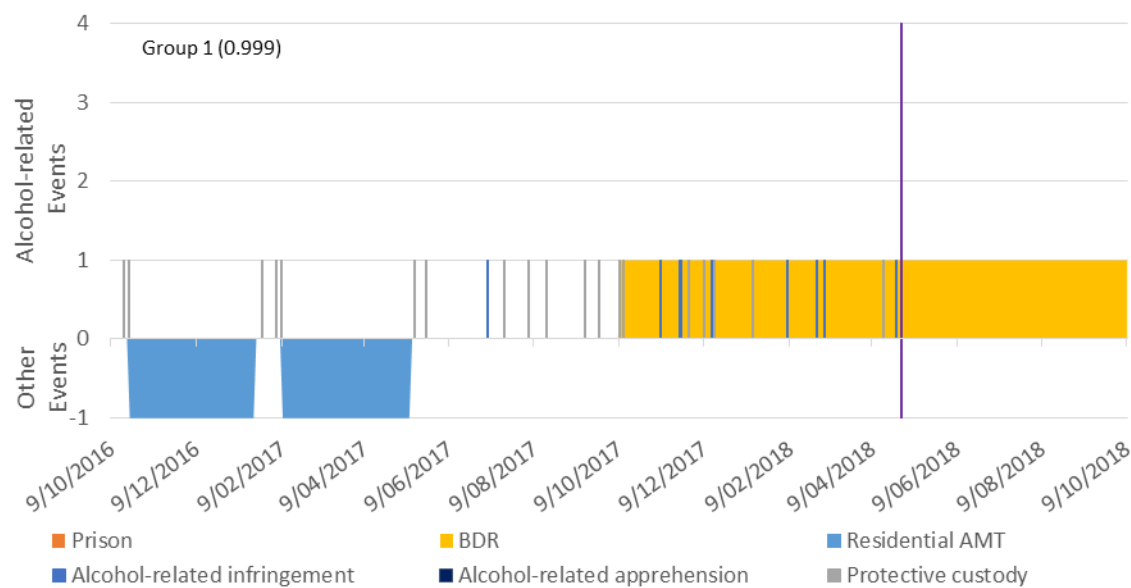
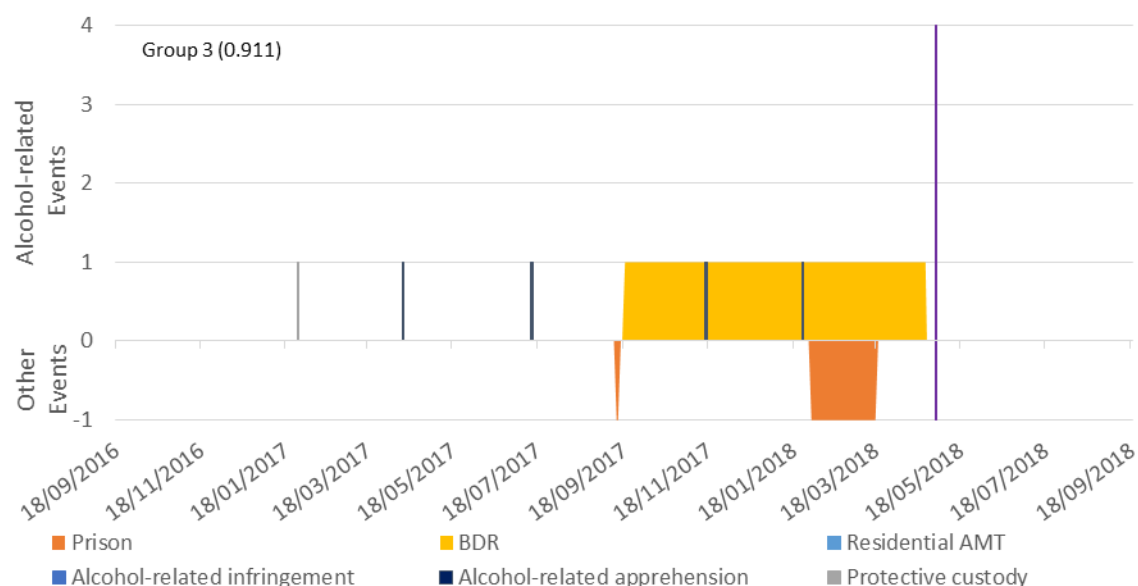
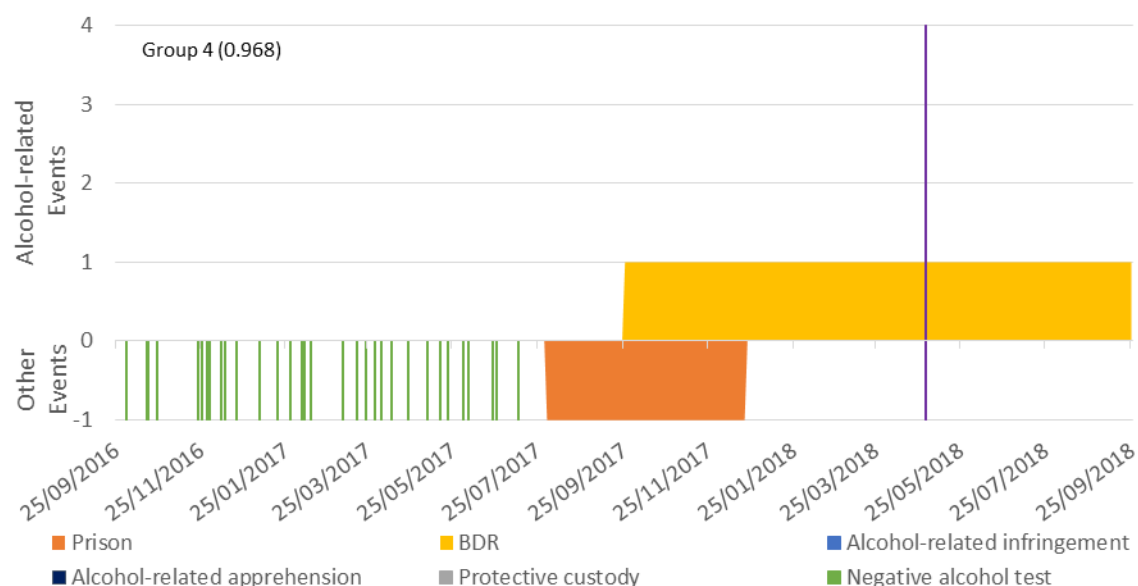


Figure 37. Continued events response: continued low frequency contact with the justice system (Group 3)



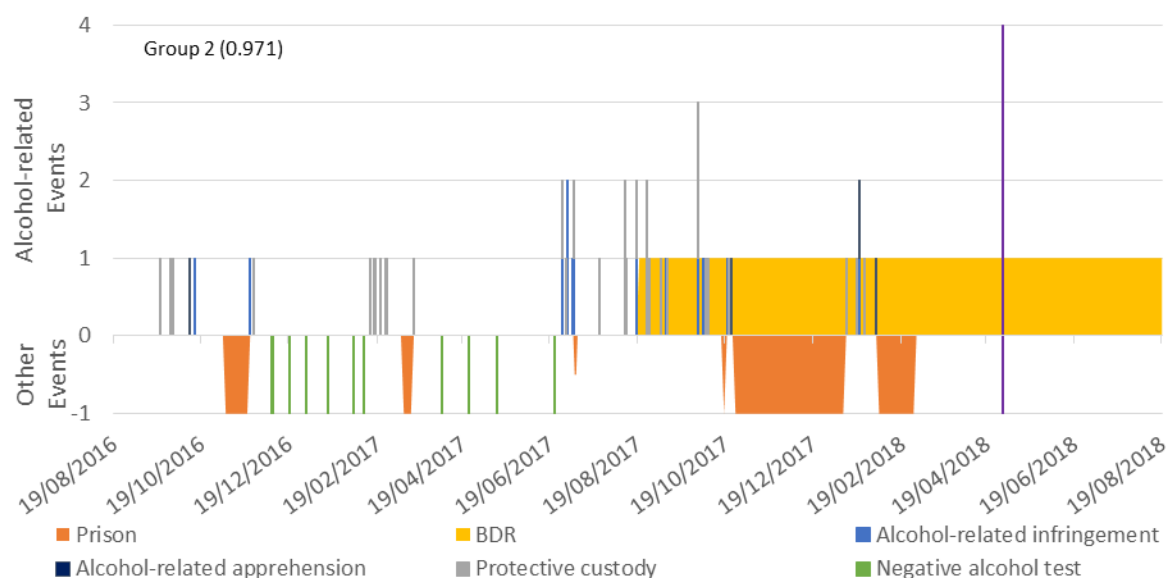
A fourth response, which could be considered a special category of the continued events response, was termed *nil events*—individuals who had no alcohol-related contact with the justice system in either the year prior to or since going on the BDR, as shown in Figure 38. Most of these individuals were in Group 4. While such individuals have engaged in some level of alcohol misuse in the past (evidenced through them being placed on the BDR), it seems unlikely that they were alcohol dependent at the time of their ban. Hence, it is not surprising that these individuals maintain a negative alcohol status while on the BDR.

Figure 38. Nil events response: continued absence of alcohol-related contact with the justice system (Group 4)



Many individuals showed combinations of response patterns: for instance, the individual in Figure 39 initially showed a continued high frequency of events when out of prison, followed by discontinued contact after the last period in prison. As the individual was not subject to alcohol testing during this period, it is not possible to determine from this information whether the individual is residing in the Territory and not coming into contact with the justice system, or living outside the Territory.

Figure 39. Combination response: continued high contact followed by discontinued contact (Group 2)

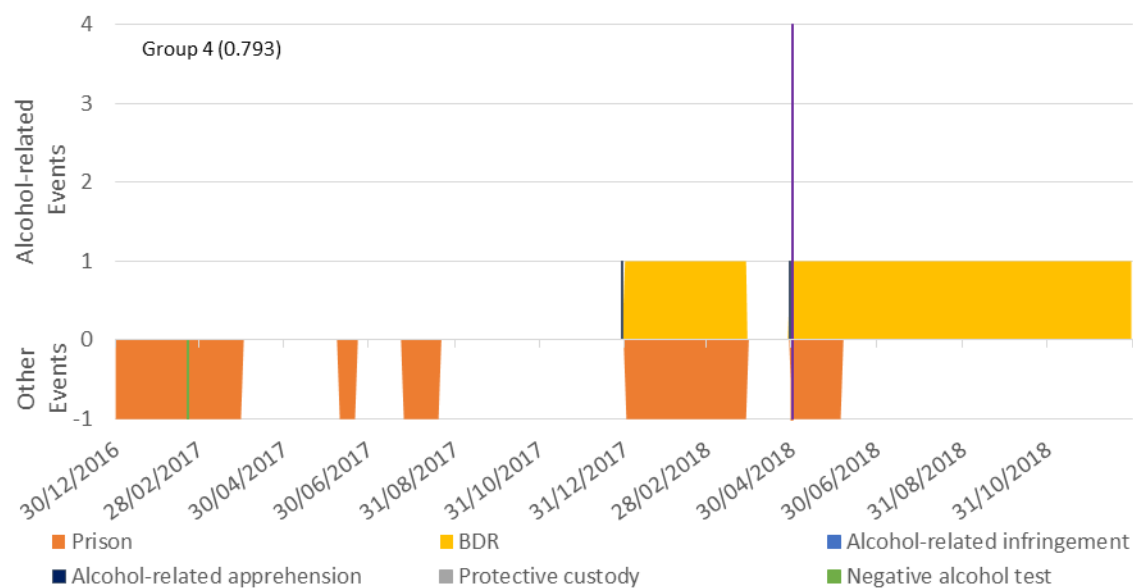


It is important to note that not all individuals in a particular group showed the same type of response. The groups of banned drinkers are based on similarity of alcohol-related contact with the justice system in the year *prior* to going on the BDR. The fact that individuals in a particular group may show a variety of responses indicates that prior behaviour is not the sole predictor of how a person responds to being on the BDR. The question of how, and/or if, people transition from one group in the year before to a different group in the year after will be more thoroughly addressed at a later date.

The final category observed, although not technically a response, is illustrative of what can happen when the length of a ban corresponds with the length of a subsequent prison term. As shown in Figure 40, the individual served the duration of the first period on the BDR entirely in custody. At the time of release from prison, the ban was no longer active meaning there was nothing to prevent the individual from purchasing alcohol. Within a month, the individual was apprehended for a new alcohol-related offence and returned to the BDR (and to prison). In this situation, the individual's prior year's history of rare alcohol-related events and/or type of sentence (fixed term, without community corrections supervision after release) may not provide justification for extending the ban after prison.



Figure 40. Re-offending when ban finishes while in prison (Group 4)



It is important to note that there are also individuals who have so far not reappeared in the data for a new alcohol-related offence in such circumstances (Figure 41), as well as those who quickly reoffend after leaving prison even though they remain on the BDR (Figure 42).

Figure 41. No re-offending when ban finishes while in prison (Group 4)

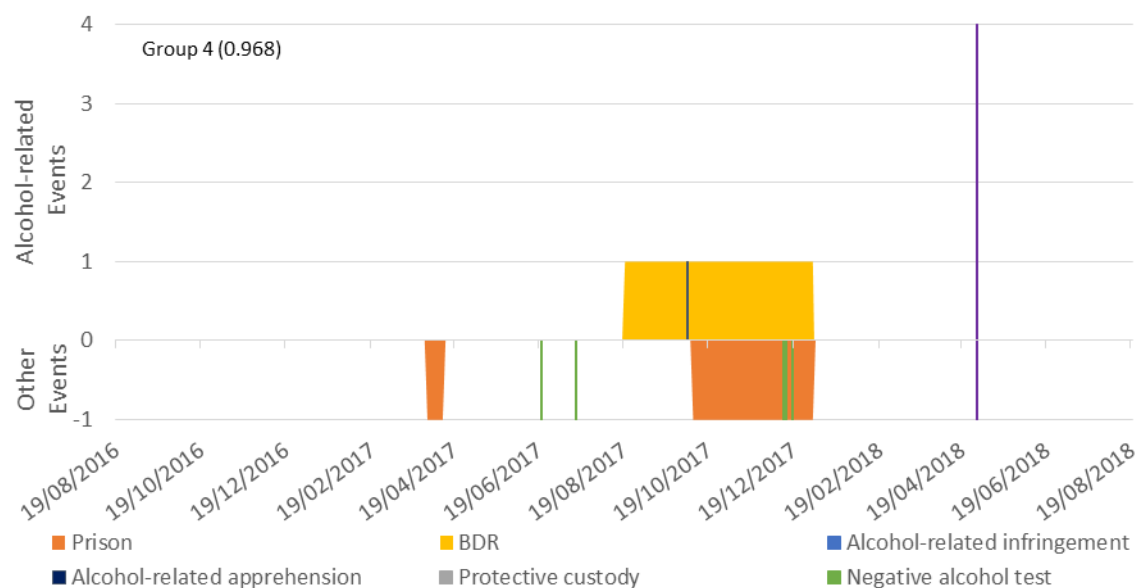
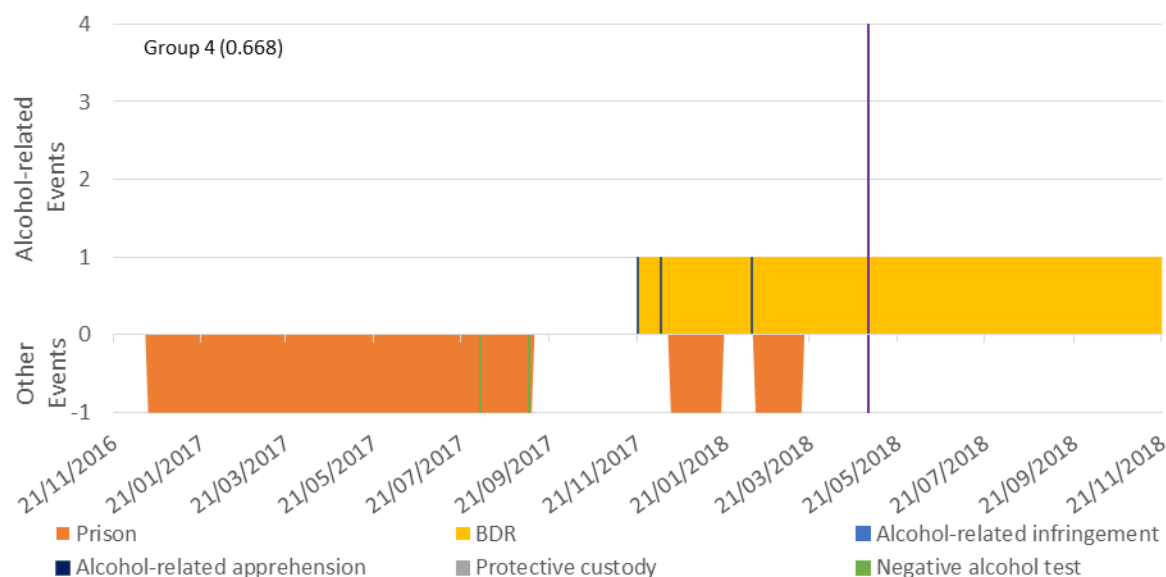


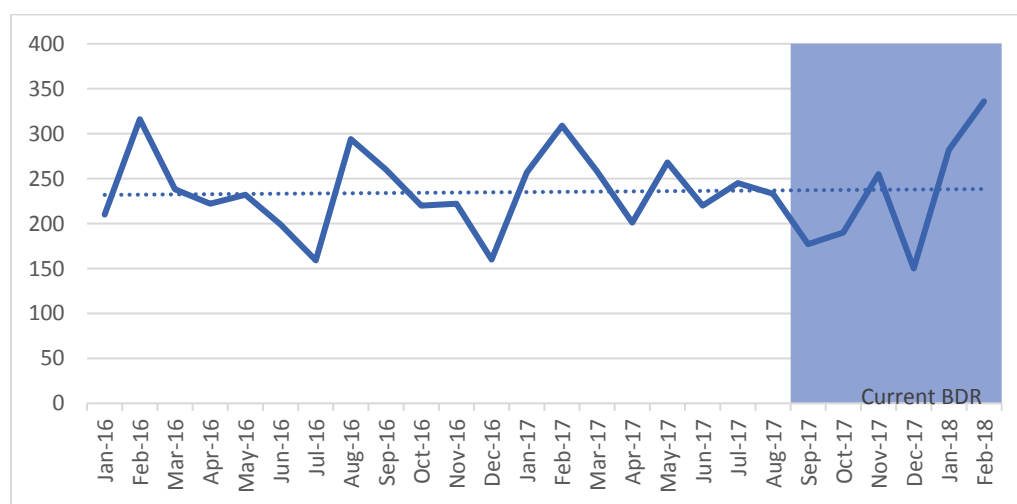
Figure 42. Re-offending when ban extends after prison (Group 4)



### 3.4.2 Alcohol and other drugs episodes of care in the non-government sector

The number episodes of care where alcohol is the main drug of concern commenced in specialist AOD non-government organisation (NGO) treatment providers since January 2016 has fluctuated around an average of 233 per month with no apparent trend (Figure 43).

Figure 43. Count of alcohol-related episodes of care in NGO agencies, January 2016 - February 2018

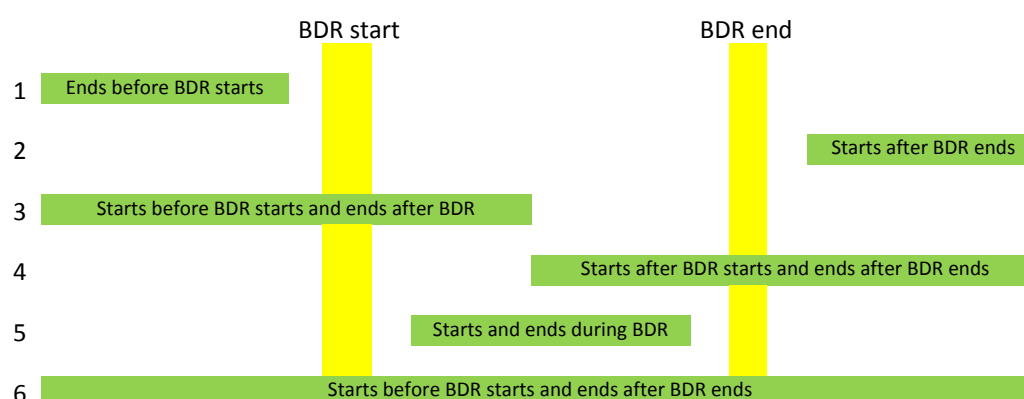


There is no mandatory recording of treatment activity for people who are on the BDR. Clients who enter treatment can self-identify as being on the BDR; those who do self-identify can provide their

BDR registration number to treatment agency staff. This number is recorded on the AODD External Service Provider Client System along with the person's BDR start and end dates. This system of self-identification means that the counts provided here are likely to be an underestimate.

Figure 44 shows the potential relationships between episodes of care and periods on the BDR.

*Figure 44. Relationships between episodes of care and BDR dates*



Between September 2017 and February 2018, 81 individuals self-identified as being on the BDR when commencing a treatment episode, accounting for 99 episodes in total. Record matching using a statistical linkage key (SLK) found a further 196 episodes for these 81 individuals (Table 1), some of which occurred before their BDR involvement and some after.

*Table 1. Count of episodes and relationship between episode and BDR dates*

	Self-identified during episode as on BDR		
	No	Yes	Total
<b>1 Episode ends before BDR start date</b>	112	5	117
<b>2 Episode starts after BDR end date</b>	3	0	3
<b>3 Episode starts before BDR and ends during BDR</b>	4	3	7
<b>4 Episode starts during BDR and ends after BDR</b>	7	11	18
<b>5 Episode starts and ends within BDR dates</b>	69	80	149
<b>6 Episode starts before and ends after BDR dates</b>	1	0	1
<b>Total</b>	196	99	295

The 81 individuals show 178 episodes where treatment and BDR dates overlap in some way, comprised of 170 episodes that started on, between or after the dates that the person was on the BDR (Categories 2, 4 and 5 in Figure 42 and Table 1), seven episodes that started before BDR

involvement and ended during (Category 3) and one that started before and ended after BDR involvement (Category 6).

Of the 178 episodes possibly related to BDR involvement, 30% recorded a main treatment type of 'Assessment only', 49% had a more substantive form of treatment – withdrawal, counselling or rehabilitation – and 20% had some other form of treatment. Table 2 summarises the number, completion rate and mean length of stay of episodes undertaken by individuals identified as being on, or having been on, the BDR at the time the episode commenced.

*Table 2. Summary of episode characteristics*

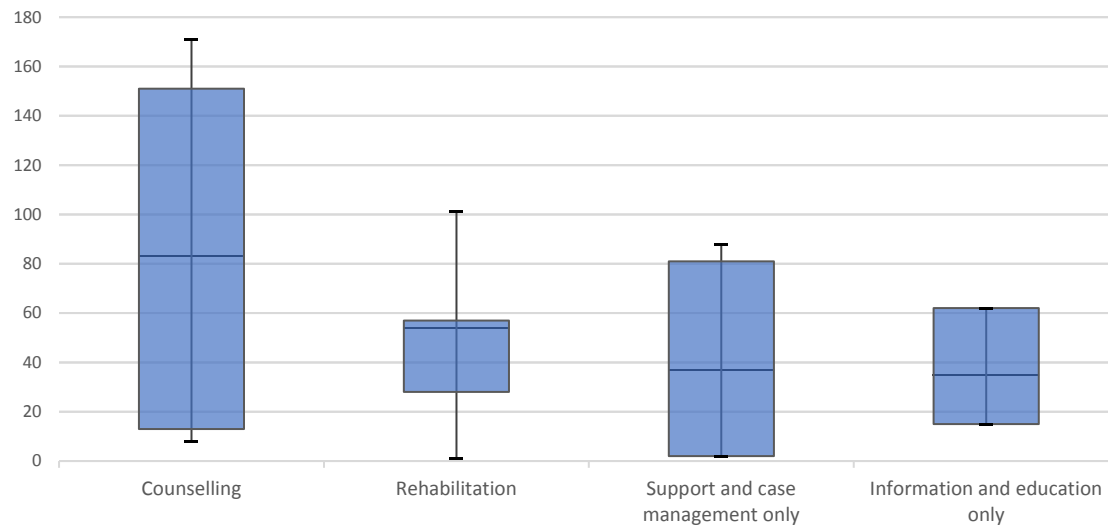
Main treatment	Count	%	Treatment completed (%)	Mean LOS (days)
Withdrawal management	1	0.6	0.0	1.0
Counselling	13	7.3	75.0	92.3
Rehabilitation	74	41.6	55.4	50.4
Support and case management only	16	9.0	66.7	40.8
Information and education only	18	10.1	50.0	40.3
Assessment only	54	30.3	94.3	1.2
Other	2	1.1	50.0	63.0
<b>Total</b>	<b>178</b>	<b>100.0</b>	<b>70.1</b>	<b>33.2</b>

Forty-five episodes were still open at the time of reporting and so have not recorded a reason for cessation or length of stay. Overall, 70% of the episodes in Table 2 recorded 'treatment completed' as the reason for cessation. This proportion varied by main treatment type, with 94% of assessment only episodes, 75% of counselling episodes and 55% of residential rehabilitation episodes being completed.

Of the substantive treatment types, counselling episodes recorded the longest average length of stay of 13 weeks (92 days) and the largest range. Residential rehabilitation episodes lasted an

average of just over seven weeks (50 days) within a narrower range. Figure 45 shows the distribution<sup>10</sup> of length of stay for selected treatment types.

*Figure 45. Number of days in treatment (length of stay) for selected main treatment types*



The 81 clients were mainly male (65%) and Aboriginal (91%). The average age at the commencement of the episode was 34 years, with non-Aboriginal clients being slightly older than Aboriginal clients and males slightly older than females (Table 3).

*Table 3. Summary of age, Aboriginal status and gender*

Characteristic	
% Male (n=81)	65.4
% Aboriginal (n=81)	90.6
Average age in years at episode start (n=295)	34
Male (n=190)	34
Female (n=105)	33
Aboriginal (n=256)	33
Non-Aboriginal (n=39)	35

<sup>10</sup> For each treatment type, the “whiskers” show the maximum and minimum lengths of stay (excluding outliers), the horizontal line in the middle of the box is the median length of stay, and the box shows the range of lengths of stay for the middle half of all episodes.

Most clients (69%, n=56) nominated either Darwin (19%), Alice Springs (26%), or Tennant Creek (25%) as their usual town or community. The balance (n=25) nominated a range of rural and remote communities.

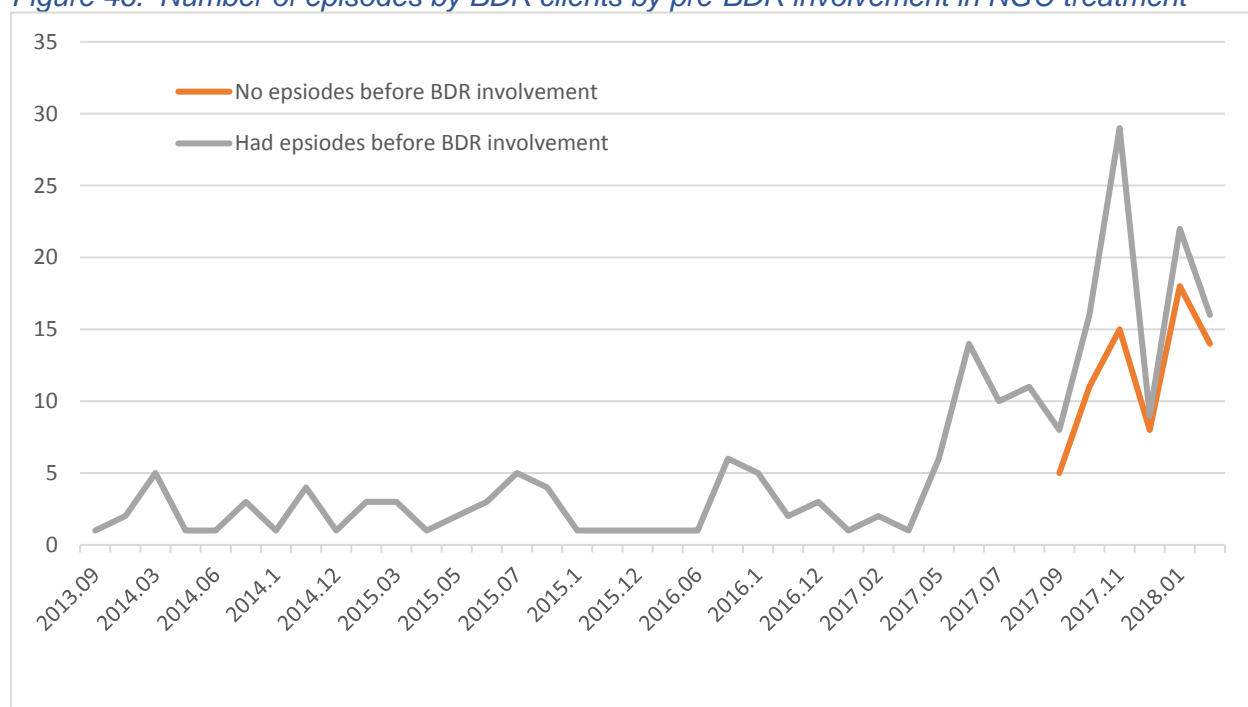
Forty-two individuals (52%) recorded episodes that started and ended before their BDR start date, with 33% having one previous episode and 36% having had two or three, for an average of three episodes, ranging from one to eight. Thirty-nine clients (48%) had no episodes before their BDR involvement (Table 4)

*Table 4. Frequency of pre-BDR commencement episodes*

Number of episodes	Count	Percent
1	14	33.9
2	9	21.4
3	6	14.3
4	7	16.7
5	1	2.4
6	2	4.8
7	2	2.8
8	1	2.4
<b>Total</b>	<b>42</b>	<b>100.0</b>

Figure 46 shows the count of episodes before and after the commencement of the BDR for the two groups described above, that is, those clients who were involved with the NGO treatment sector before the BDR commenced and those who are new to the sector, by month.

*Figure 46. Number of episodes by BDR clients by pre-BDR involvement in NGO treatment*

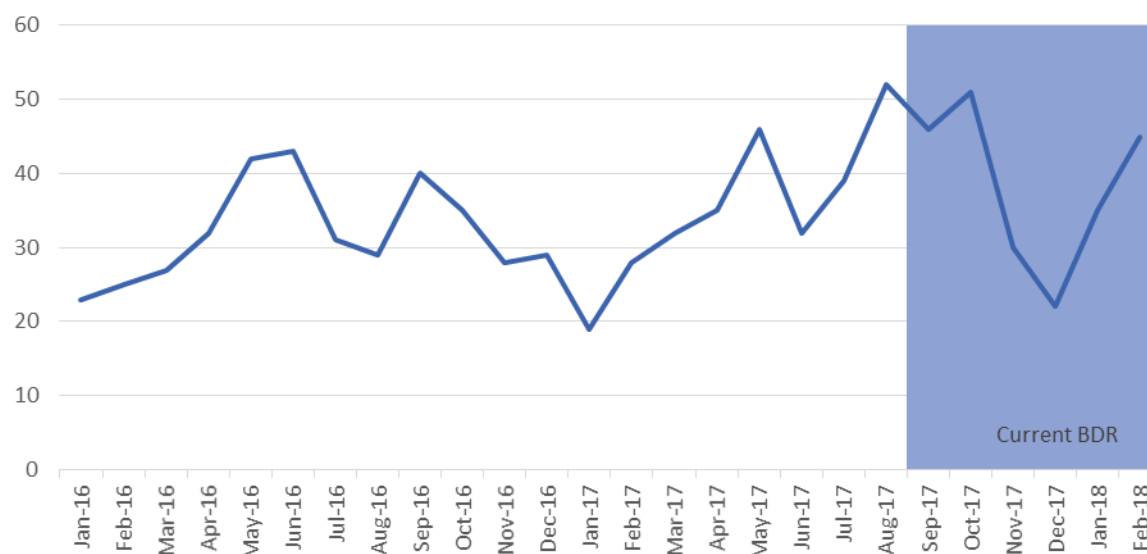


Between September 2017 and February 2018, 40% of treatment episodes commenced by BDR clients were commenced by new clients—individuals who had no prior treatment episodes in the NGO sector – with an average of 12 commencements in each month. Those who had engaged with the sector before the BDR commenced recorded an average of 3 commencements per month (over 32 months) compared to an average of 17 commencements per month since September 2017. Note that while this information was based on clients that self-identified as being on the BDR, the substantial increase in number of episodes, both for existing and new clients, is encouraging.

### **3.4.3 Alcohol and other drugs episodes of care in the NT government sector**

The number of episodes of care where alcohol is the main drug of concern commenced in each month in NTG agencies since January 2016 has fluctuated around an average of 34 with no apparent trend (Figure 47).

Figure 47. Count of alcohol-related episodes of care in NTG agencies, January 2016 – February 2018



There is no mandatory recording of treatment activity for people who are on the BDR. Clients self-identify to NTG assessment and treatment staff, who keep a simple tally of these clients. The tally is provided to AODD monthly and a summary is shown in Table 5.

Table 5. Count of assessment and treatment clients commenced who self-identify as on the BDR in NTG services

	Number of assessments completed where the person was on the BDR or was referred to the BDR	Number of therapeutic support cases where the person was on the BDR on or after commencement.
Sep-17	1	1
Oct-17	9	6
Nov-17	9	5
Dec-17	6	0
Jan-18	2	2
Feb-18	3	3
Total	30	17



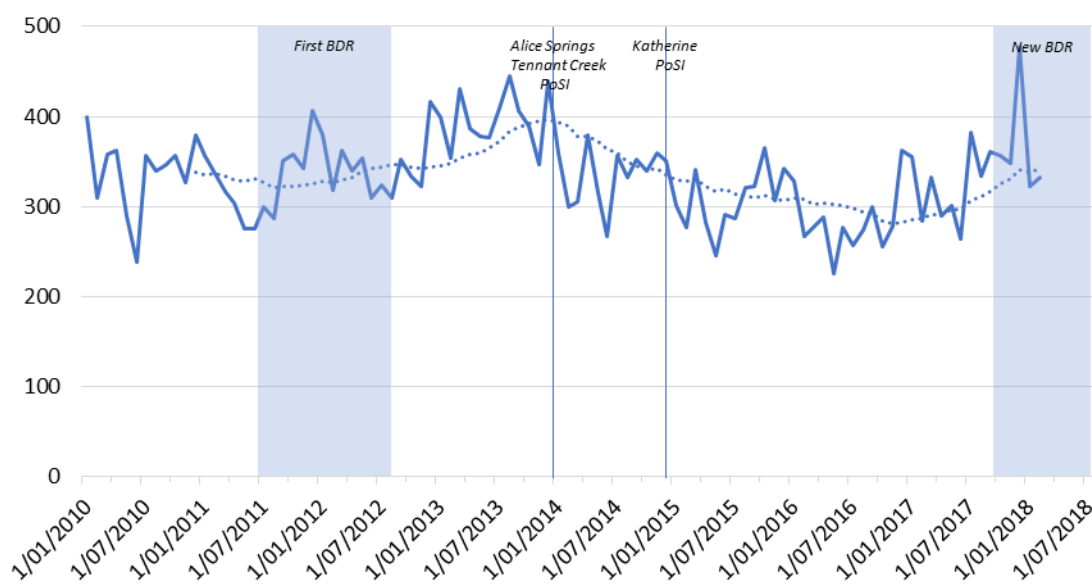
### 3.5 Associated Alcohol-Related Data

The following charts show patterns in Northern Territory alcohol-related events in the justice system (offences, infringements, apprehensions, and protective custody episodes) and health system (sobering up shelters and emergency department presentations) from January 2010 through February 2018. The protective custody data structure changed in July 2011 when the previous BDR was implemented, so protective custody episodes are only shown since that point. All charts show monthly values (solid line) and the 12-month rolling average (dotted line). Some events are strongly seasonal and may show a cyclical pattern of highs and lows; the 12-month rolling average counters for seasonality. Charts also show the period of operation of the first BDR (July 2011 through August 2012), the implementation of full-time point of sale interventions by NT Police in Alice Springs and Tennant Creek (early 2014) and Katherine (December 2014), and the period of operation of the new BDR (from September 2017). Charts showing the pattern of events in different regions can be found in Section 8.1.1.

#### 3.5.1 Alcohol-related assault offences

The 12-month rolling average for alcohol-related assault offences began to decline in early 2014, at about the time that full-time point of sale interventions commenced in Alice Springs and Tennant Creek. The decline continued until the end of 2016, after which these offences have increased. Figure 48 shows the number of alcohol-related assault offences per month.

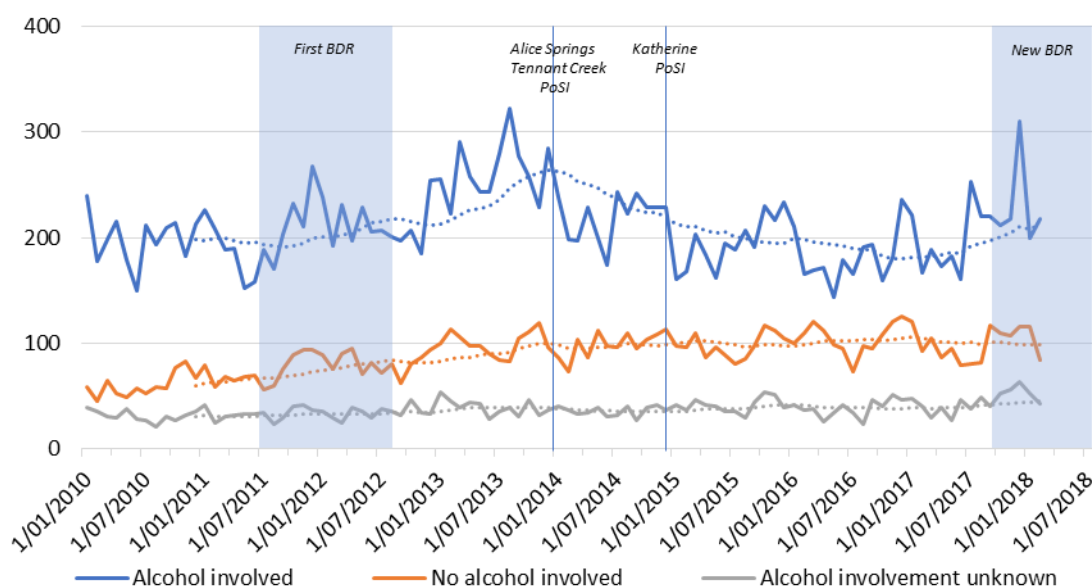
*Figure 48. Monthly number of alcohol-related assault offences and 12-month rolling average*



### 3.5.2 Domestic violence assault offences

Domestic violence assault offences involving alcohol show a similar pattern to the total number of alcohol-related assaults. Figure 49 shows the number of domestic violence assault offences per month by alcohol involvement. From January 2010 through February 2018, alcohol has been involved in 62% of domestic violence assaults. While alcohol-related domestic violence assaults are currently increasing, this pattern began prior to the reintroduction of the BDR.

*Figure 49. Monthly domestic violence assault offences by alcohol involvement, and 12-month rolling averages*



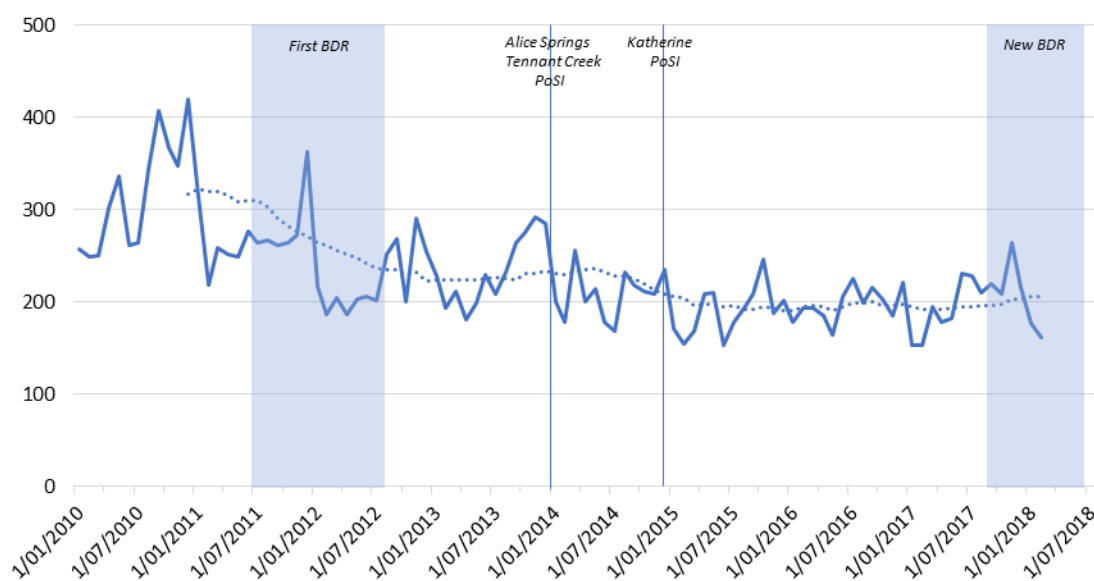
#### Recommendation:

2. Consider removing the current discretionary approach to alcohol related domestic violence offences, and making them an automatic trigger for a 3 month BDO.

### 3.5.3 Drink-driving offences

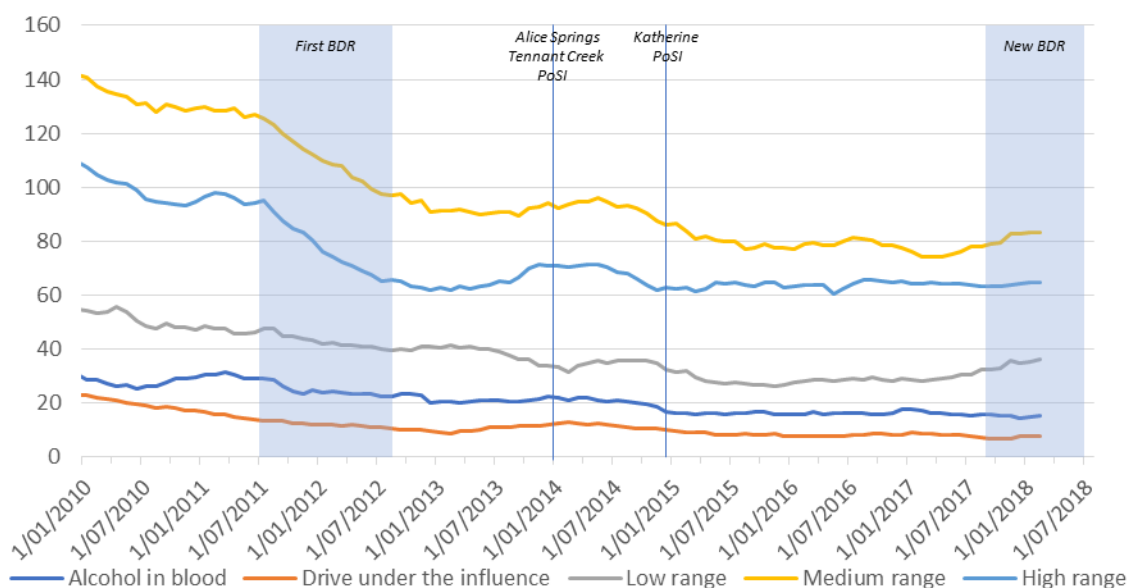
Drink-driving offences include both driving under the influence of alcohol (based on an assessment made by a police officer) and exceeding the prescribed blood alcohol content level (based on a breath test). The offence of failing to provide a breath sample for analysis is not included here because numbers are insignificant in comparison with the other two groups of offences. Drug-related driving offences are also excluded. Figure 50 shows the number of drink-driving offences per month.

Figure 50. Monthly drink-driving offences and 12-month rolling average



The patterns in the five types of drink-driving offences are shown in Figure 51. “Alcohol in blood” refers to offences involving the detection of alcohol in the blood of drivers where a zero blood alcohol limit is required by law. Medium-range drink driving has been the most frequent type of drink-driving offence since prior to 2010, accounting for 40% of these offences in the 12 months ending February 2018. All types of drink-driving offences have shown a reduction in frequency since 2010, with the average medium- and low-range drink-driving offences per month showing a slight increase since early 2017 and appearing to level out in recent months.

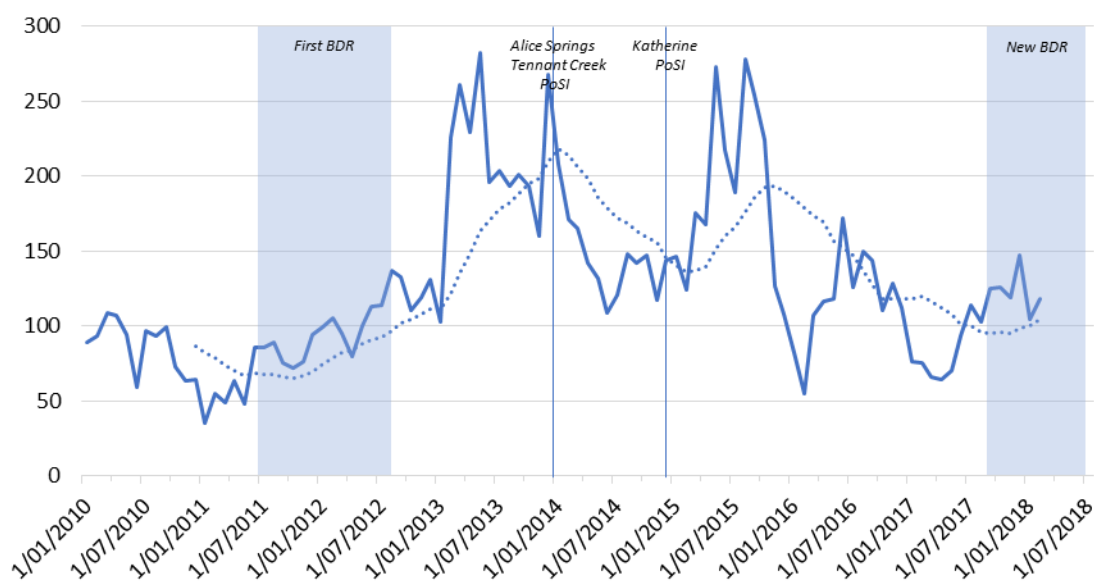
Figure 51. Drink-driving offences by type, 12-month rolling averages



### 3.5.4 Liquor offences

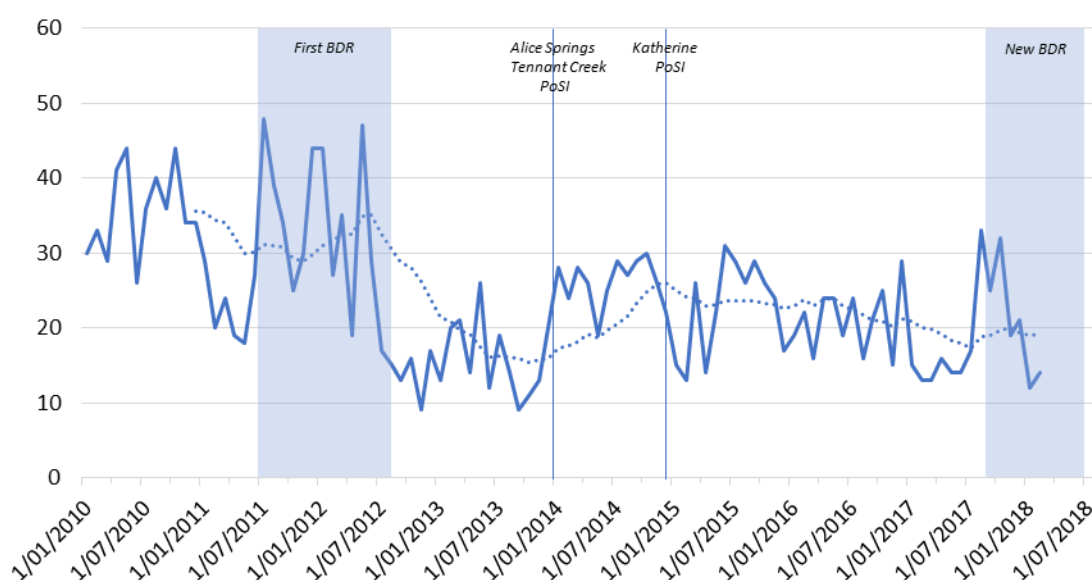
Liquor offences fall into two main categories: those involving the consumption of legal substances in regulated spaces, and those involving liquor licensing offences. Figure 52 shows the number of liquor consumption-related offences per month. These show a substantial decline in the first year that the full-time point of sale interventions were in place in Alice Springs and Tennant Creek, though offences rose again in late 2015.

Figure 52. Monthly liquor consumption-related offences and 12-month rolling average



Liquor licensing offences include the offence of selling liquor without a license, as well as serving alcohol to minors and other contraventions of liquor license restrictions. Selling liquor without a license (black market sales) might be expected to increase following the introduction of the BDR as profiteers on-sell alcohol to those who are unable to purchase takeaway alcohol. The numbers of such offences recorded, however, are very few: only seven such offences were recorded between September 2017 and February 2018, and 85 in total since January 2010. Figure 53 shows the number of liquor licensing-related offences per month.

*Figure 53. Monthly liquor licensing-related offences and 12-month rolling average*

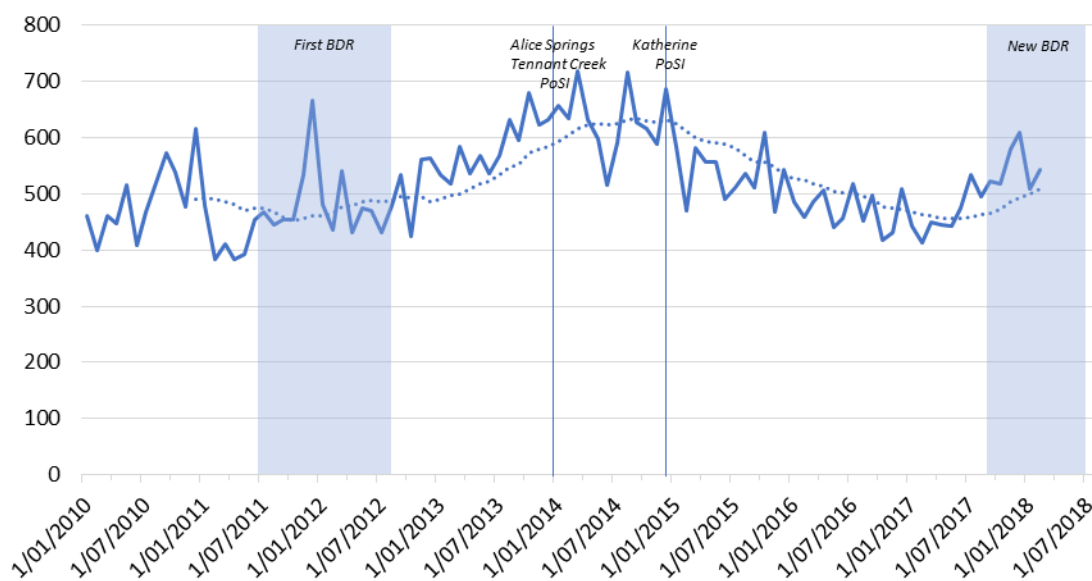


### 3.5.5 BDR trigger events (apprehensions, infringements, protective custody)

Apprehensions of adults for alcohol-related offences<sup>11</sup> reached a peak during 2014, followed by a decline until mid-2017. The average number of apprehensions in a 12-month period began to increase at or shortly before the time the BDR was implemented.

<sup>11</sup> Alcohol-related offences for this purpose include offences on apprehension reports where the NT Police have flagged that alcohol was involved; and offences mentioning liquor or alcohol in the description (and not tobacco, smoking, or drugs).

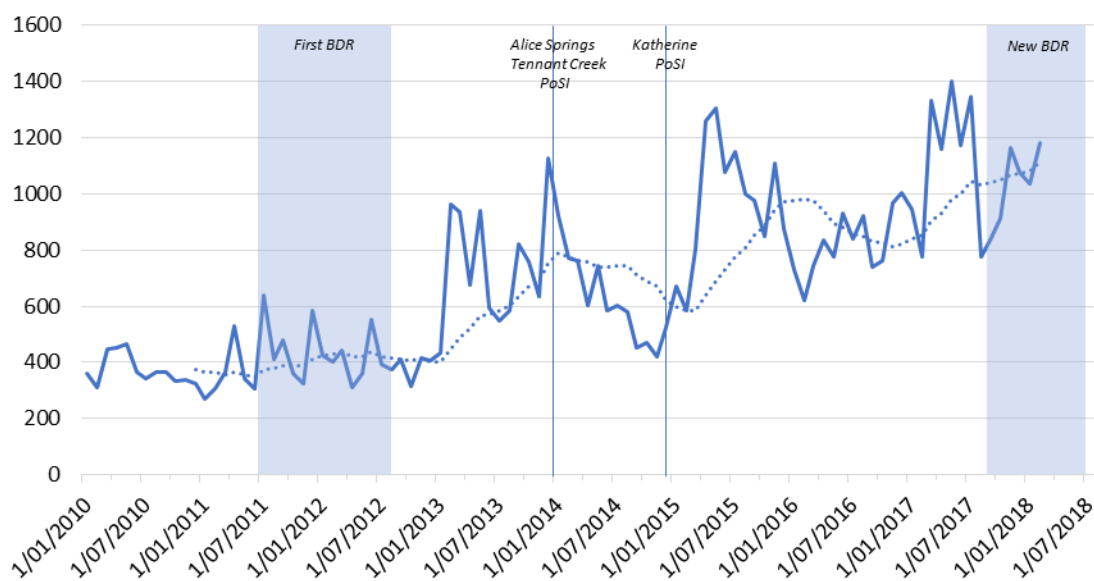
Figure 54. Monthly adult alcohol-related apprehensions and 12-month rolling average



The monthly average number of alcohol-related infringement notices<sup>12</sup> issued doubled between the end of the previous BDR and January 2014. Following this, the monthly average continued a pattern of alternating declines and increases with an overall increasing pattern (Figure 55).

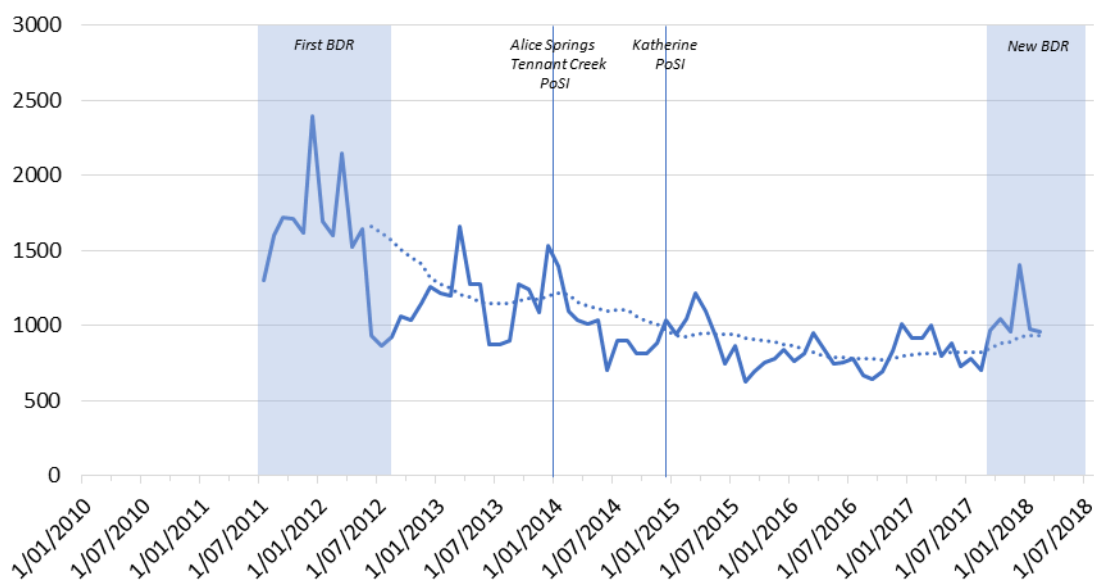
<sup>12</sup> Alcohol-related infringement notices are those that count as a trigger for a Banned Drinker Order according to the *Alcohol Harm Reduction Act*: section 75(1) or (1B), 101AE(1), 101L(1), 101V(1), 101W(1), 101ZE(4), 120N(1), 120P(3), 120T(1), 120U(3), 121(2) or 121A(1) of the *Liquor Act*; or section 25(3) or 26(1) of the *Traffic Act*; or section 47 or 53(1)(a) or (7) of the *Summary Offences Act*, if the police officer giving the infringement notice believes on reasonable grounds that the alleged offender is, at that time, affected by alcohol.

Figure 55. Monthly alcohol-related infringement notices and 12-month rolling average



The use of protective custody in the police watch houses has dropped substantially since the previous BDR due to operational and policy changes (Figure 56). Protective custody is only shown since July 2011, when the identity of individuals taken into custody was first recorded.

Figure 56. Monthly alcohol-related protective custody episodes and 12-month rolling average



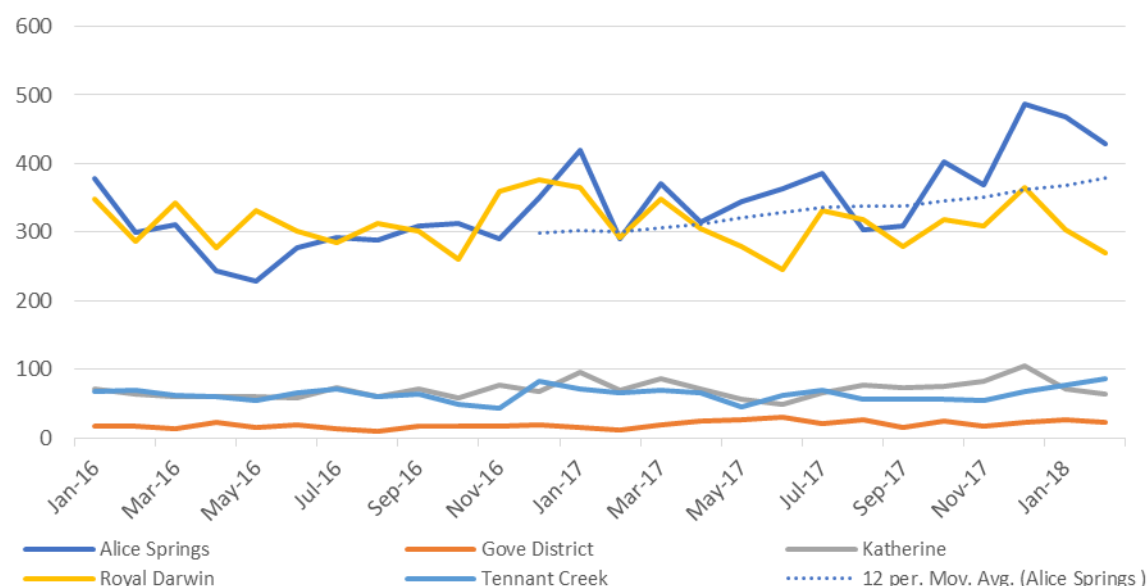
Protective custody is now generally considered an alternative of last resort. More individuals are now taken to hospitals, to sobering-up shelters, to their homes, or left in the care of a responsible

person, than they were several years ago. Protective custody episodes showed a small increase in the monthly average following the implementation of the new BDR.

### 3.5.6 Alcohol attributable presentations to NT emergency departments

Alcohol-attributable presentations to Northern Territory hospitals are shown in Figure 57. Presentations to Alice Springs Hospital have increased since September 2017, at least partially explained by a pre-existing upward trend (the 12-month rolling average, shown by the dotted line).

*Figure 57. Alcohol attributable presentations to NT emergency departments, January 2016-February 2018*



Average monthly presentations between September 2017 and February 2018 have increased compared to the same months in the previous year for Alice Springs, Gove District and Katherine and Tennant Creek hospitals, with presentations lower at Royal Darwin.

*Table 6. Alcohol attributable presentations to NT emergency departments, selected months*

Hospital	Sep 2016 to Feb 2017	Sep 2017 to Feb 2018
Alice Springs	329	411
Gove District	17	22
Katherine	73	79
Royal Darwin	326	308
Tennant Creek	63	66
NT Total	807	886



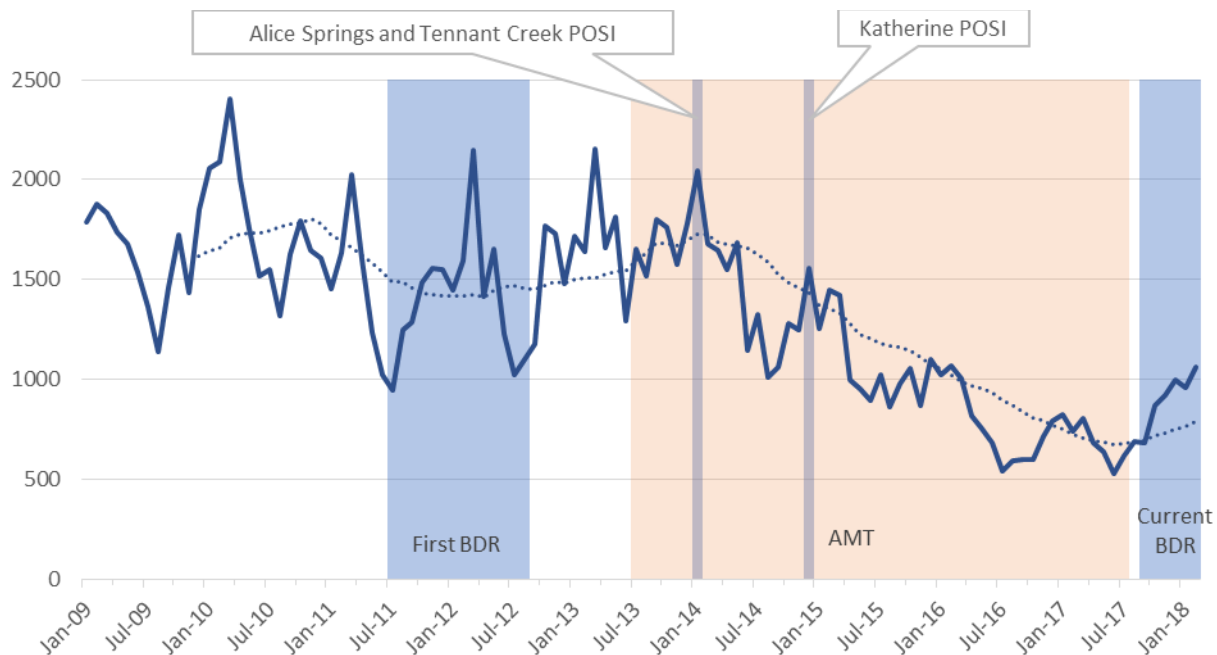
### Recommendation:

3. Consider including BDR status information as a standard part of a person's health record in hospital and primary health care clinical settings.

### **3.5.7 Sobering-up shelter admissions**

Admissions to NT sobering-up shelters since January 2009 (Figure 58) show seasonal variation and fluctuations by month. The 12-month rolling average shows a decline commencing around January 2014, continuing until June 2017, and reversing around August 2017.

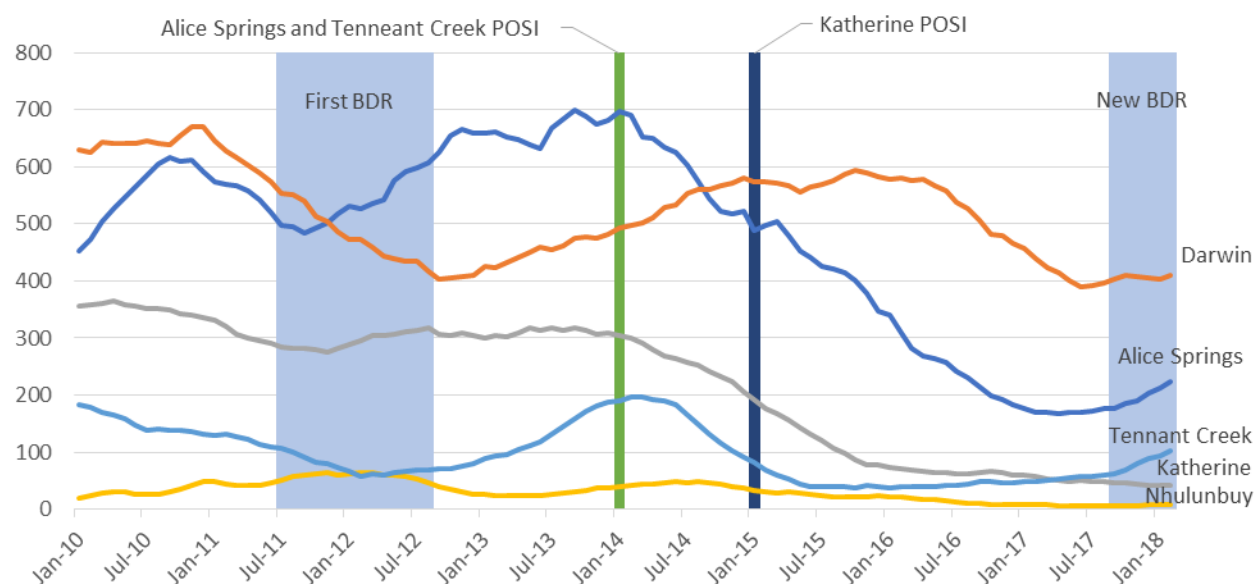
*Figure 58. Count of admissions to NT sobering-up shelters by month and 12-month rolling average*



#### **3.5.7.1 Regional sobering-up shelter admissions**

Admissions to sobering-up shelters show different patterns over time by region (Figure 59).

*Figure 59. Admissions to sobering-up shelters by region, January 2010 to February 2018, 12-month rolling average*



Alice Springs admissions account for the majority of the decline from January 2014 seen in the NT total, with a less rapid decline seen in Katherine and a decline in Tennant Creek commencing a few months later. Admissions in both Alice Springs and Tennant Creek show increases since the reintroduction of the BDR in September 2017. Darwin admissions show an increase commencing around December 2012, a period of relative stability from January 2015 to May 2016, and a subsequent decline. The average monthly number of admissions in Darwin shows a slight increase since June 2017.

### **3.5.7.2 Admission characteristics from September 2017 to February 2018**

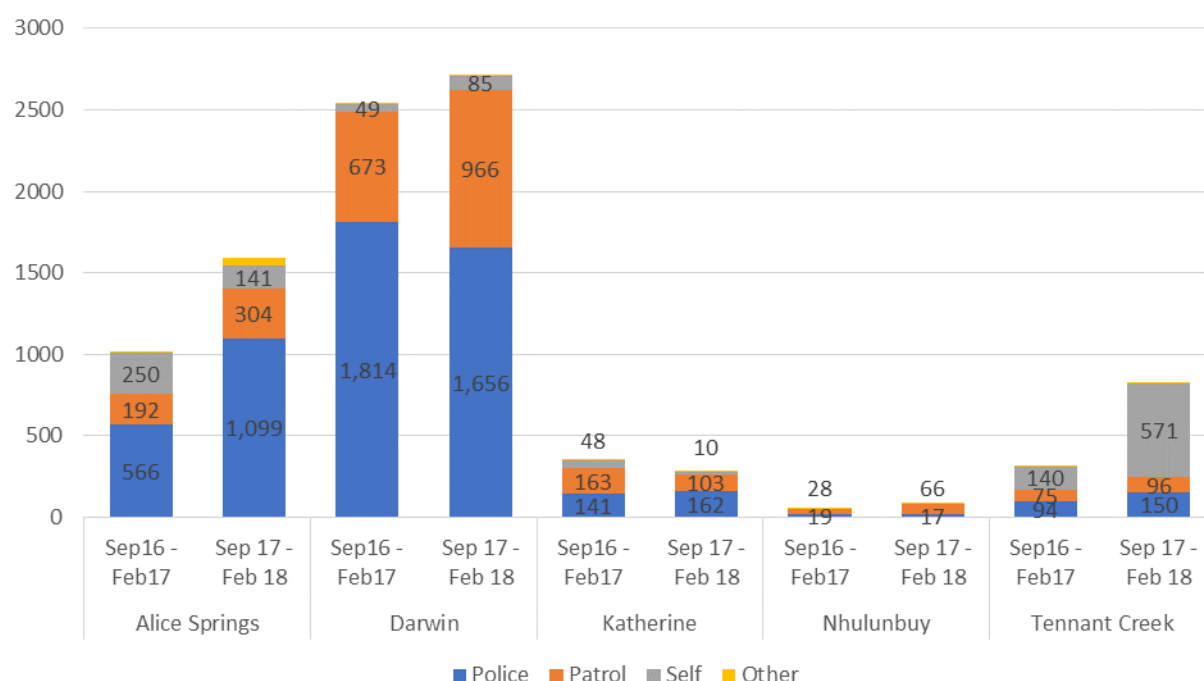
Individuals may be referred to sobering-up shelters by the NT Police, local community patrols, or other sources, and they may also self-refer. From September 2017 to February 2018, over half (56%) of referrals came from the NT Police. Community patrols accounted for 28%, self-referrals, 15%, and other sources, 1%. There were 28% more referrals during the months of the BDR's operation than during the same months the previous year. Police referrals increased by 17%, community patrol referrals increased by 36%, self-referrals increased by 66%, and referrals from other sources increased by 159% (numbers for this group were very small). Table 7 shows the number of admissions to NT shelters by referral source for the months of September 2016 to February 2017 and September 2017 to February 2018.

Table 7. Admissions to NT sobering-up shelters by source of referral, selected months

Source	Count			Percentage by source	
	Sep 16 - Feb 17	Sep 17 - Feb 18	% change	Sep 16 - Feb 17	Sep 17 - Feb 18
<b>Police</b>	2634	3084	17%	61.6%	56.2%
<b>Patrol</b>	1131	1535	36%	26.5%	28.0%
<b>Self</b>	487	807	66%	11.4%	14.7%
<b>Other</b>	22	57	159%	0.5%	1.0%
<b>Total</b>	4274	5483	28%	100.0%	100.0%

The source of referral varied substantially among regions, with some marked changes between the two periods (Figure 60).

Figure 60. Number of admissions to regional sobering-up shelters by source of referral, selected months



Darwin had 6% more admissions during the period of the current BDR compared with the same period the previous year. Police referrals dropped by 9%, while community patrol referrals increased by 44% and self-referrals increased by 73% from a low base.

Alice Springs had 56% more admissions during the period of the BDR compared with the same months of the previous year. Referrals by the NT Police almost doubled (an increase of 94%)

between the two periods, while community patrol referrals increased by 58% and self-referrals dropped by 44%.

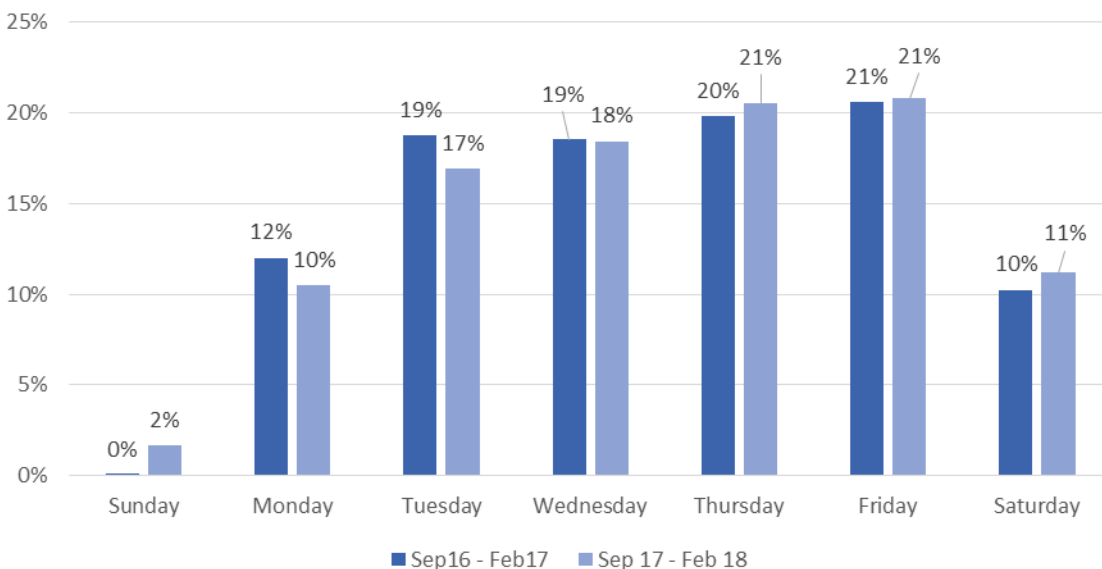
There were 22% fewer admissions in Katherine during the operation of the BDR, compared with the same period in the previous year, with a 15% increase in referrals from the NT Police, 37% fewer referrals from community patrols, and 79% fewer self-referrals.

In Tennant Creek, there were 166% more admissions to sobering-up shelters during the operation of the BDR than in the same months of the previous year, with the majority of the increase being made up of self-referrals. The number of self-referrals quadrupled (an increase of 308%), while police referrals increased by 60%, and community patrol referrals increased by 28%.

Nhulunbuy admissions increased by 77% between the two periods; there were more than twice as many community patrol referrals during the operation of the BDR as in the previous year

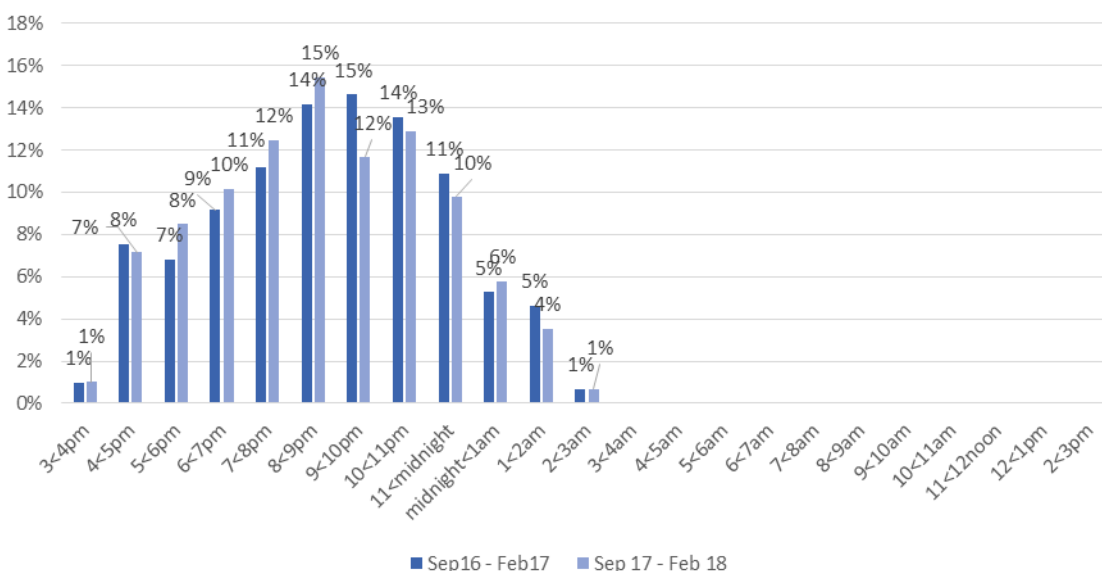
For the period of the current BDR, 42% of admissions occurred on a Thursday or Friday and 35% on a Tuesday or Wednesday (Figure 61). This pattern shows little variation across regions and when compared to the same period in the previous year.

*Figure 61. Admissions to NT sobering-up shelters by day of the week by selected months, % in day*



Since September 2017, admissions to the sobering-up shelters were more likely to occur before 9pm (55%) than was the case for the same months in the previous year (50%) (Figure 62).

*Figure 62. Admissions to NT sobering-up shelters by hour of the day by selected months, % in hour*



Admissions to NT sobering-up shelters from September 2017 to February 2018 were mainly male (57%), nearly all Aboriginal (99%), and averaged 46 years of age (Table 8). These characteristics show only small variations when compared to the same months in the previous year.

*Table 8. Admissions to NT sobering-up shelters, selected months, summary demographic characteristics*

Characteristic	September 2016 - Feb 2017	September 2017 - Feb 2018
% Male	56.9	56.9
% Aboriginal	99.1	99.1
Average age	44.4	45.8
Age percentiles		
25 <sup>th</sup>	38.0	39.7
50 <sup>th</sup>	44.9	45.9
75 <sup>th</sup>	51.0	52.4

#### Recommendation:

4. Investigate appearances of people on the BDR in Sobering-Up Shelters to assist with targeted health interventions for these clients.

## **4 Desktop Audit**

### **4.1 Aims & method of desktop review**

Part 4 reports on the desktop audit and analysis component of the implementation evaluation. This part of the evaluation aimed to understand the processes, timelines and involvement from various agencies in the planning and early implementation of the BDR. The analysis therefore drew on formal documentation provided by the BDR team - namely the Department of Health (DoH) - which tracked the planning and implementation of the program. The key sources for analysis included<sup>13</sup>:

- BDR Steering Committee meeting minutes
- Working Group meeting minutes
- Media briefings
- Costing estimates
- Progress reports
- Debate notes of the Alcohol Harm Reduction Bill 2017

These documents covered the time period from November 2016 (when the re-implementation of the BDR was announced by NTG) to February 2018 (following commencement of the BDR).

The evaluation team did not undertake an independent search of other publicly available documents that may have been relevant to the evaluation, with the exception of documents that were specifically recommended by stakeholders who were interviewed in the third stage of the evaluation process (see Part 5 for further information about the stakeholder interviews).

All documents received by the DoH were reviewed, and each document was analysed to varying degrees dependent on the type of document, depth and scope of information included in the document, and whether or not the information was cross-referenced in other documents. In total, 73 documents were included in a preliminary analysis, where the key points were noted and systematically reviewed by recording key details and further issues for inquiry in an Excel spreadsheet. This allowed the evaluation team to return to the spreadsheet to follow up key points and quickly identify relevant documents and information. Analysis of the documents was guided

---

<sup>13</sup> The evaluation team was not granted access to the Cabinet Submission documentation to review.

by the following research questions, developed by the evaluation team in consultation with the BDR Evaluation Committee:

- What did the planning process look like?
- How did the program unfold in relation to planned timeframes?
- Did it unfold in accordance with program aims, implementation plans, and deliverables?
- How did intergovernmental agencies work together through the planning process?

The remainder of this section presents findings from the review in relation to these questions. This stage of the evaluation was used to inform the development of the selected interviewees and interview schedule. The desktop review provides a foundation for understanding the key processes, and identifying issues for further investigation during the stakeholder interviews. It therefore provided valuable information that could be cross-checked or detailed further during the interviews. It does not, on its own, provide sufficient information to develop a comprehensive evaluation of the planning, development and early implementation of the BDR.

## **4.2 Summary of planning process**

This section summarises findings from the desktop review, in relation to identifiable themes in the implementation process: planning and implementation of the program.

### **4.2.1 Initiation of BDR planning**

The early stages of planning for the BDR commenced with workshops in November and December 2016. The BDR Project team was established in DoH prior to these workshops and met with the Department of Attorney-General and Justice to discuss the legislative requirements and to talk through referral pathways. Practical issues, such as the need to photo ID options were also identified at these meetings.

Under this approach, it was proposed that Stage 1 would operate similarly to the previous BDR (Version 1), with political/criminal justice pathways, scanning of ID and the provision of treatment services. Stage 2 would include consideration of additional referral pathways to “ensure that the

BDR is accessible to all people accessing community and health care services who could benefit from treatment”, and was intended to be implemented following the introduction of Stage 1 in September 2017 and further consultation with affected stakeholders. Follow up review with key stakeholders indicates that there is an intention to make improvements to the BDR, including developments identified as components of Stage 2, among key policy stakeholders. There is insufficient information available to make an assessment of these developments from the desktop audit. However, potential changes are discussed further in Section 5.

#### **4.2.2 Project Management & Governance**

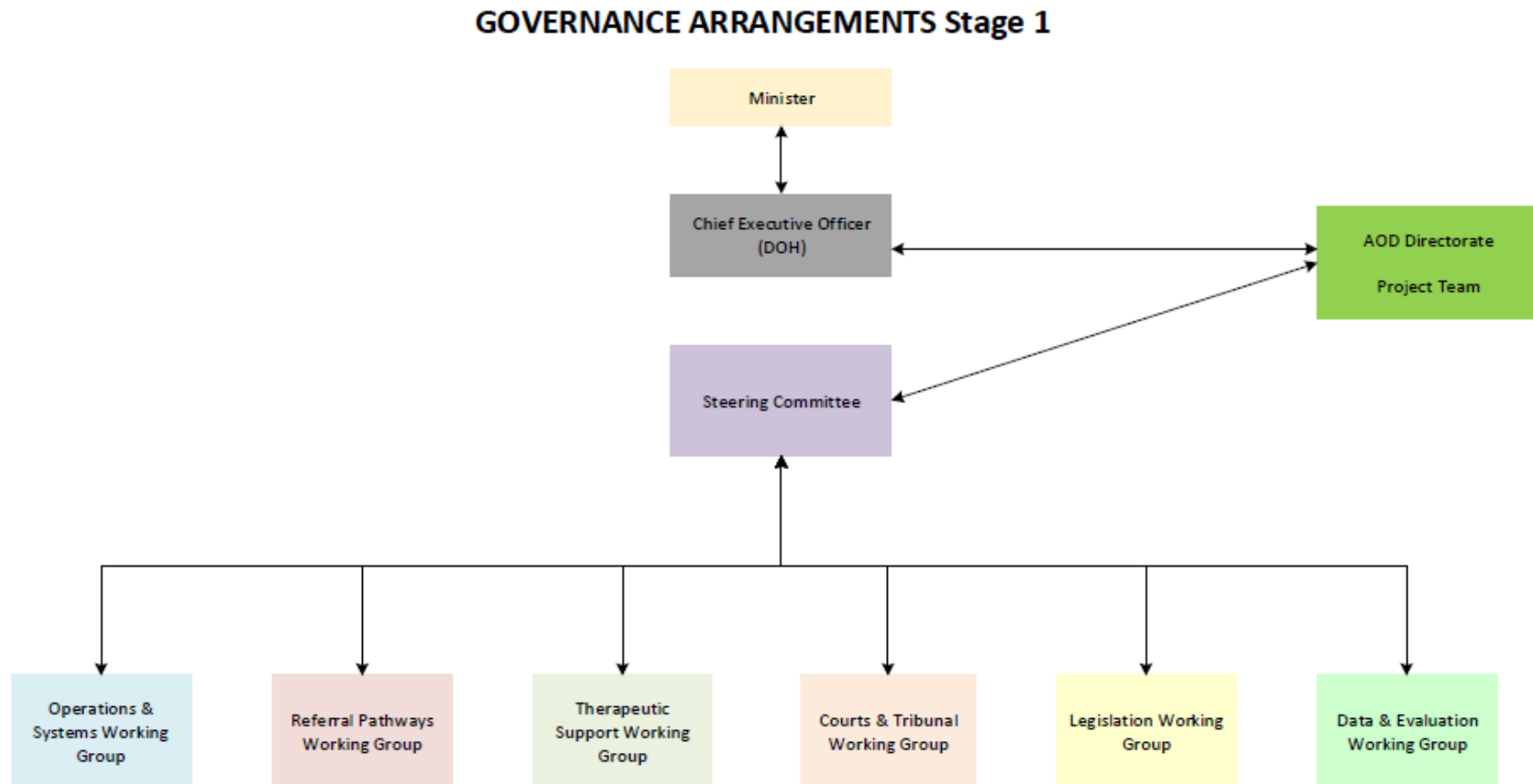
The DoH is the lead agency for the BDR. This change from the previous model (which was held by DAGJ) is intended to reflect the shift to a health-centric and therapeutic approach to the BDR. In the early stages of program planning, a team was established within the Alcohol and Other Drugs Directorate (AOD) within the Department of Health (DoE), with responsibility for:

- Project planning;
- Policy formulation;
- Communications/Community Engagement Strategies; and
- Project and Steering Committee support.

The governance structure established to deliver the BDR system by 1 September is depicted in Figure 63.



Figure 63. BDR Governance overview, Stage 1



Source: NTG, BDR Governance Overview, 20 December 2016 (Shared by DoH for purpose of Implementation Evaluation)

The DAGJ maintains responsibility for the scanning equipment and the education of licensees and outlet staff, as well as the provision of data and research with support from the DoH.

From the initial planning meeting (November 2016) and workshops (November and December 2016), interagency input was established as central to the planning and implementation of the BDR. The overall project management structure identifies the roles, responsibilities and membership of the various project management teams. These are:

- (i) **Steering Committee** – Provides strategic oversight of the BDR reintroduction. Includes members at Executive Director/Deputy Chief Executive level from a broad range of Agencies which are either directly involved in the BDR reintroduction (e.g. DoH, AGD, NTPFES) or which may be affected in the future (DoHCD). Chaired by General Manager Strategic Projects, DoH
- (ii) **BDR Project Management Team** – Provides information, support and coordination to the various BDR Working Groups. Manages the two-way passage of information between the Steering Committee and the BDR Working Groups, ensuring consistency of approach at a whole-of-Project level. Responsible for collectively coordinating the various BDR Working Groups to deliver the project deliverable – that is, reintroduction of the BDR as part of a health-centric alcohol harm reduction policy and legislative framework. Led by Director, Alcohol and Other Drugs Directorate, DoH
- (iii) **BDR Working Groups** – Under the guidance of the Steering Committee and BDR Project Management Team, conduct the detailed planning and implementation activities necessary to produce the project deliverable. The BDR Working Groups are Legislation, Data and Evaluation, Courts and Tribunals, Therapeutic Support, Referral Pathways and Operations and Systems.
- (iv) **Operations and Systems Working Group** – Responsible for all technology and system-related activities necessary to reintroduce the BDR by 1 September 2017, including development of system documentation and technology-related communications material. Led by Project Director, DAGJ

- (v) **NTG ICT Governance Board (IGB)** – As with all ICT investments made by NT Government, the IGB will have an ongoing role ensuring that appropriate governance measures are in place in the project. This involvement is consistent with the ICT Governance Framework, will involve Stage Gate reviews at the Business Case Stage, and prior to ‘Go Live’ of the system.

Reference: DAGJ, 2017, p11

Planning for implementation of the BDR began in November 2016 with a meeting in preparation for workshops. This initial meeting was attended by representatives from Health, Justice, Housing, Transport, and Territory Families. As noted, interagency workshops were held in November and December 2016. Agencies involved in the multi-agency workshops included (DAGJ, 2017, p16):

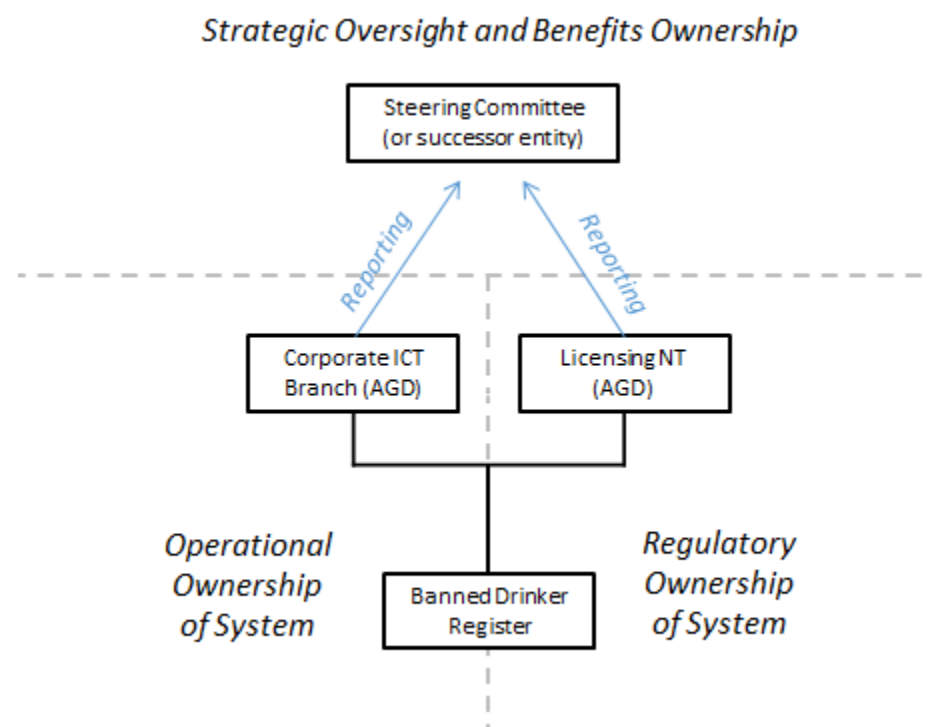
- DAGJ – Corrections
- DAGJ – Licensing NT
- DAGJ – Solicitor for the NT
- DAGJ – Courts
- DAGJ – Corporate ICT Branch
- DoH
- NT Police, Fire and Emergency Services
- Territory Families

This was followed by the establishment of the BDR Steering Committee in January 2017. The Steering Committee comprised of Chief Executive level officers from a range of NTG agencies. In addition to Steering Committee representation, informal consultation occurred with industry and representative associations. In many cases knowledge within these agencies about the previous BDR system informed the implementation and “were used as a starting point for workshop discussions” (DAGJ, 2017, p17)

The Steering Committee met regularly, approximately once per month, from the time of its establishment in January 2017 until after the commencement of the BDR. Following the implementation of the BDR, the Steering Committee was renamed as the Alcohol Harm Minimisation Working Group, and continues to provide strategic advice in relation to the BDR

and a suite of other alcohol policy initiatives being introduced across the NT. Figure 64 depicts the governance and management structure following the BDR's implementation in September 2017, with the 'successor entity' being the Alcohol Harm Minimisation Working Group.

*Figure 64. Governance and management structure post BDR implementation*



Source: DAGJ, 2017, p36

Another key component of the BDR Governance structure proposed by the DoH, as identified in the documents, was the role of Working Groups. At a December 2016 meeting, Terms of Reference and membership was detailed for each group.

**Operations and Systems** - Concerned with the physical BDR set up (infrastructure, scanning technology), forms of ID, IJIS interactions, ban lengths and compliance tracking. Meeting monthly or more often as required.

**Referral Pathways** - Concerned with the details of the referral pathways and how they will operate. Meeting monthly or more often as required.

**Courts & Tribunals** - Concerned with the operation of NTCAT in relation to the BDR and potential changes to the Sentencing Act and any relevant Practice Directions.

**Legislation** - Concerned with the legislation required for the BDR to operate. Meeting monthly or more often as required.

**Data & Evaluation** - Concerned with data collection and an evaluation framework. Meeting monthly or more often as required.

**Therapeutic Support** - Concerned with the clinical assessments and therapeutic supports that will be offered, how these are resourced, and involved in the formation of the Clinical Guidelines that support these.

The Working Groups had intermittent activity, with some Working Groups meeting regularly, while others were less active and essentially dissolved shortly after implementation (Steering Committee Meeting Minutes, 13 April 2017). A review of the documentation suggests only the Data & Evaluation, and Therapeutic Support, Working Groups were to continue meeting in the near future. The other groups, namely Legislation; Courts and Tribunals; Operations and Systems; and Referrals, only had one or two meetings in the first quarter of 2017. The Steering Committee meeting minutes in July 2017 states that “Working groups have not needed to meet – work continues within agencies.” (Steering Committee Meeting Minutes, 20 July 2017).

#### **4.2.3 Planning and development of BDR model**

The development of the BDR model was expedited by the existing infrastructure and processes that were in place from the former BDR between 2011 and 2012. The former program was used as a foundation for assessing infrastructure needs and estimating costs. This is explicitly stated throughout the documentation, particularly in the Business Case (DAGJ, 2017).

##### **4.2.3.1 *Shift to health-centric approach***

The key differences between the former program and the current BDR relate to the shift toward a health-focused approach that is reflected by the establishment of a Registrar having decision-making responsibility assessing referrals to the BDR, which previously was the responsibility of a Tribunal. There are a number of differences between the types of prohibitions that result in a person being placed on the BDR from the system in place during 2011-2012 and the way the system operated (Department of Health, 2017).

The Debate Notes from the Alcohol Harm Reduction Bill 2017 (DoH, 2017) outline the process and reasons for changes made to the BDR, compared with the previous policy. In addition to

involving senior officers involved in the original implementation and operation of the BDR, recommendations from the Alcohol Mandatory Treatment (AMT) Evaluation were also taken into consideration for the therapeutic pathways of the BDR (DoH, 2017).

#### ***4.2.3.2 Costs and infrastructure considerations***

The assessment of project costs and the business case for the BDR were largely based on the infrastructure and Information Technology (IT) costs, and the necessary upgrades from the previous system (discussed further below). The Business Case outlines that a decision was made to implement a BDR system “substantially similar to the 2011 version, utilising existing technology, equipment and infrastructure wherever feasible” (DAGJ, 2017, p20). This option was chosen over two other options put forward by the Department of Health:

- Procure a new BDR system, which incorporates best-of-breed, modern features such as facial recognition and mobile technology (*Not Recommended*); and
- Re-design and upgrade the 2011 version of the BDR, to incorporate best-of-breed, modern features such as facial recognition and mobile technology (*Not Recommended*).

Option 1 was preferred based on assessment of time constraints, risk and effectiveness: it had the highest likelihood of achieving implementation by 1 September 2017; it would deliver the best value; had the lowest risk due to the ability to “reuse existing documentary collateral and corporate knowledge”, and it was determined that it would be most effective in terms of the practicalities surrounding the technological features.

The Business Case relied heavily on the Communications & Technology Investment. However, a review of the documentation also identifies a number of other considerations due to the shift to a health-focused approach, compared with the former BDR. This includes the policy framework, broader change, communications plan and cross-agency governance considerations (DAGJ, 2017a). Other identified costs associated with the program are the costs associated with establishing the BDR Registrar Office (including appointment of Registrar and Support Officer); and the Communications Plan (internal and external).

In relation to the infrastructure costs, the Project team visited licensees and undertook an audit of all hardware remaining from the previous implementation of the BDR. Overall, the project cost

estimate (as of April 2017) was \$24.728 million with a \$5.970 contingency included (25%). These costs consisted of

- \$1.54 million on personnel costs
- \$23.2 million on operational costs
  - \$5.15 million in project costs/system implementation
  - \$18 million in ongoing costs

Drawing on the experience of the former BDR implementation, it was decided that any new hardware requirements for the BDR system would use whole-of-government equipment leasing arrangements, managed by the DCIS (Department of Corporate and Information Services) (DAGJ, 2017). It was decided this approach would “ensure greater consistency in support standards and contractual coverage of items procured by the project, including ongoing warranty and insurance provisions” (DAGJ, 2017).

Other decisions to maximise cost effectiveness of the system included

*...a preference to use older infrastructure in Darwin/Palmerston, rather than regional/remote areas, to minimise support costs and turnaround times should equipment faults or failures occur. New hardware infrastructure that is procured will be deployed to regional and remote locations in the first instance, to ensure those locations have less chance of operational problems. (DAGJ, 2017a, p25)*

The Business Case presented a high risk profile for the implementation of the BDR. Tight timelines, the use of older technology, reliance on external resources, and an increased number of pathways onto the BDR system that increased the stakeholders and complexity of identity verification were all identified as high risk factors for implementing the BDR. To balance out these high risk factors, high levels of corporate knowledge and existing infrastructure and documentation were identified as key factors that reduced the risk of the project (DAGJ, 2017, p11). Findings from the key stakeholder interviews and focus groups were consistent with this risk profile and management approach, with most stakeholders agreeing that knowledge of key personnel and the use of existing infrastructure were central factors in the capacity to implement the BDR within the tight timeline, by 1 September 2017.

The implementation of the BDR program relied on the success of prior stages, which were presented in the Business Case (DAGJ, 2017, p10). The ability to assess the scope and progress against these activities is feasible to varying extents from the documents available for review. Minutes from Steering Committee meetings and Project Deliverable timelines illustrate that project planning and schedule creation were carried out successfully and documentation shows that almost all tasks and deliverables in the project planning stage were achieved within the planned timeframes. The most notable items for long-term procurement (activity 2) identified were the outsourcing of the Communications Plan and the procurement of infrastructure and IT servicing. This relates directly to activity 3, the audit of existing infrastructure at licensee premises. Overall, one of the key themes identified through the documentation were the time constraints required to meet the 1 September 2017 implementation date.

#### **4.2.4 Timelines**

A review of documentation demonstrates that the implementation of the BDR kept to its timelines. Both major outputs (i.e. commencement date of 1 September 2017) and progress milestones (such as internal communication and actions) were achieved. However, it is also clear that major decisions about the BDR model were restricted by these time constraints. In particular, as noted above, ‘Option 1’, which relied heavily on previous systems and infrastructure, was chosen because it was viewed as the only feasible option within the timeframe.

It is evident from the documentation that the agencies and committees responsible for planning and implementation were committed to achieving key milestones to achieve the Government’s policy within the timeframe. Where there were concerns about delays in IT and infrastructure, resources and key personnel were directed to the issues to ensure implementation was achieved. This is evident in the Progress Reports through July and August 2017, which kept clear and detailed information to ensure key milestones were achieved.

The necessity to adopt an iterative approach is evident in various documentation. It identifies the challenges of progressing one area of the program prior to other key tasks. In particular, there were challenges in developing the infrastructure and IT requirements prior to decisions being made related to the referral pathways and triggers. A palpable example of the iterative approach to policy development is the fact that the legislation was not passed until August 2017, following audits and



testing of infrastructure across sites. This issue, and a number of the anomalies in this approach to program development and implementation are also noted in the Business Case Stage Gate Review 1 (Ernst & Young 2017). This was a requirement of DCIS and undertaken in May 2017. This review occurred after legislation was introduced to Parliament in April 2017. The report identifies that “various workstreams are undertaking their work with the necessary urgency to deliver to the timelines, however there is adhoc coordination across the whole project to effectively manage dependencies, and a detailed project plan has not been presented for review” (NT DCIS, 2017, p8).

The key issues identified throughout the desktop review are highly consistent with those raised by Ernst and Young (2017) and during the key informant interviews. As such, discussion about these issues has been incorporated into the qualitative analysis presented in Part 5.

## **5 Key Informant Interviews**

### **5.1 Aims and methods of key informant interviews and focus groups**

Part 5 of the evaluation involved undertaking individual interviews and focus groups with key informants involved in the planning or early implementation of the BDR.

### **5.2 Methodology**

#### **5.2.1 Participant Demographics, Selection & Recruitment**

Key informants from different stakeholder categories were invited to participate in the study. This included policy-makers, frontline staff, and key industry representatives. In the context of this study a policy-maker was defined as someone who was working (or who had worked) in the Northern Territory Government (NTG) and was directly involved in the planning or early implementation process of the BDR. This included representatives from multiple government agencies within NTG. A frontline staff member was someone involved in implementing operational elements of the BDR, for example, voluntary therapeutic services. An industry representative was a nominated licensee legislated to implement the BDR within an alcohol take-away context. Thirteen policy-makers and five frontline staff participated in individual interviews. In addition, three separate focus groups were conducted – two with policy-makers; and one with industry representatives. A total of 16 policy makers participated in the first focus group, and 16 in the second focus group. A total of three people participated in the industry focus group. Some participants were involved in both an individual interview and focus group. All participants were recruited to this study using a purposive sampling method. This was facilitated through the BDR Evaluation Working Group. Participants have each been allocated a number that has been used in the presentation of the analysis below. This is to preserve the identity of participants.

#### **5.2.2 Conducting Interviews**

A semi-structured interview format was used during individual interviews (see Appendix C) and more directed questioning was used during focus groups based on emerging themes from the individual interviews. A total of 16 interviews and three focus groups were conducted by Professor Smith and/or Dr Adamson during this part of the evaluation process. Sixteen individual interviews were conducted face-to-face (including two interviews each involving two participants from the same agency) and three were conducted via phone. All interviews were audio-recorded (with the

exception of two requests from one policy-maker and one frontline staff member for the interview not to be recorded). All interviews were conducted during May-June 2018. Individual interviews with policy makers typically lasted between 60 minutes to 1 ½ hours. Whereas, focus groups lasted between 30 minutes to 1 ¾ hours.

### **5.2.3 Transcription, Coding and Analysis**

All interviews were transcribed by a professional transcription service. Professor Smith & Dr Adamson compared written field notes with transcripts for accuracy prior to coding. Where time permitted, participants also had the opportunity to review their transcripts prior to coding. Coding and analysis occurred in parallel to the interview process.

The analysis process initially involved a workshop between Professor Smith and Dr Adamson to identify and compare emerging themes based on a repeated review of transcripts. This involved an inductive approach whereby codes emerged out of the data. Initial themes were discussed at a BDR Evaluation Working Group meeting in early June 2018. This was used as a timely feedback mechanism to validate the reliability and trustworthiness of the data and themes presented.

## **5.3 Key issues associated with the planning and early implementation of the BDR**

### **5.3.1 Capacity to learn from BDR Version 1**

As discussed earlier in this evaluation report, the BDR had been implemented previously in 2011-2012. Therefore this was considered to be a reintroduction of a former policy initiative of the NTG. This meant that there were opportunities to learn from the successes and challenges from the implementation of the previous version (referred to here as Version 1). However, there was no formal evaluation of the BDR Version 1. This meant that it was difficult for stakeholders involved in Version 2 to refer to lessons learned, perhaps with the exception of people that had been involved in the planning and/or implementation of both versions. As one participant claimed,

There is in fact, I think, a comparison table that someone did about what BDR Mark 1 looked like and what BDR Mark 2 would look like, and there certainly were people in the office with corporate lived experience of what it had been like the first time around and what could be different this time. (Participant 2)

Key differences between the two versions of the BDR were relatively easily identifiable. In particular, areas where key lessons had been learned related to:

- Project Management;
- Information Technology (IT) and Infrastructure;
- Legislation;
- Tribunal; and
- Governance.

In terms of project management, one interviewee commented,

I know the first thing we did was went and pulled out the physical paper, trimmed [NTG document system] archive boxes of stuff from the previous one. I know that we used previous work plans and schedules and budget papers and things like that to inform what we spent last time ... it was a big group thing where everybody who might have had an interest ... sat there and made comment and assessment on each of the line items going, "Yes, we'll need to do that again or we won't need that. Last time we didn't allow any money for whatever and so we'll put that in this time." So all of the work plans and schedules and all that sort of thing were certainly relied on and tweaked from last time. (Participant 10)

Whilst some participants were skeptical of the usefulness of past planning documents, others indicated that the planning for Version 2 was much easier, 'the second time around, many knew it was coming, and knew what they were in store for' (Participant 16). One area where past experience appeared to be valuable was that relating to IT and infrastructure requirements. For example,

I think certainly there were a lot of the learnings from [the] previous [BDR], in terms of the system and with the rollout and with the IT side of things, because a lot of the IT products were still on the ground. So there was work done by IT people to identify which retailers still had the scanners and the equipment, and then they were able to make an assessment about whether or not they were still current or whether we needed. (Participant 9)

This was reaffirmed by another participant,

I think the IT team certainly would have done their own [analysis about] what worked what didn't work, what went well what didn't work well, what can we learn? So they would have had their own IT learnings from last time that were available ... it is such a major project from the IT side of things they would have certainly had outcomes and things “oh we learned this last time” kind of thing, and so they were able to hit the ground running this time. (Participant 3)

A participant closely involved in the IT aspects of both BDR versions clearly stated,

What we had to do when we started this project, the first thing I had to do, was do a complete audit and find 320 devices that had been deployed, and to see what state they were in so that I could then work out whether or not I could reuse that technology in the outlets. So, we had to do an audit of all the liquor outlets in the Northern Territory.... So, while we were doing all of the back-end application stuff, we also were retrofitting and refurbishing the technology components within the liquor outlets across the Northern Territory ... I guess, it was helpful that I, kind of, knew where we failed last time when we were rushing it out the door. So, you know, like some of the technology advancements, and stuff like that... For example, we didn't have any remote management on the devices, and things like that. We have got a very sound technology architecture now. (Participant 6)

One of the key changes from Version 1 to Version 2 of the BDR was a decision not to include a smart court and tribunal in the reintroduced version. This change was reinforced by multiple participants,

There were a lot of differences – one of which was no smart court, and no tribunal. We were told we didn't have the money for the smart court. And the tribunal was ineffective. So we ditched those ... we took on what we could take on. You know, things like the tribunal didn't work. You know, this thing didn't work. (Participant 8)

So this time, there's no tribunal, the focus is that it's a health clinical problem, and I think the thinking is that this [the decision about a BDO] is a clinical role, to decide

whether people have an alcohol misuse problem, and what therapeutic – and to try and encourage people into therapeutic support programmes. (Participant 1)

Another consideration that surfaced during the BDR reintroduction process included governance, with a general view that the previous governance structure had worked well. As one participant stated,

So again with the previous one there was working groups, like with the legislation, with IT, with communication, so there were those various working groups. So they were able to use those as a basis for, "Okay well what do we need in terms of working groups to move this forward, and who would be the relevant people from the agencies to be involved?" (Participant 9)

### **5.3.2 Alignment with broader alcohol harm minimisation reforms in the NT**

A recurring theme throughout the analysis was that the BDR formed part of a broader alcohol policy agenda being implemented by the NTG. As one participant succinctly stated, ‘the wicked problem that it is, can really only be tackled through a harm minimisation lens’ (Participant 4). This concept was reaffirmed repeatedly,

The BDR’s not a standalone thing. There are all these other government alcohol policies wrapped around it. It’s supportive of the banned drinker register, the Riley Review, and having the ARIT [Alcohol Review Implementation Team] team working on the recommendations. (Participant 1)

The alcohol policy and legislation review came sweeping over the top of it ... it’s [the BDR] certainly a contentious area of policy, and it’s both seen as a magic bullet and also just one thing in a suite of things. (Participant 2)

It's not just the BDR, it's the BDR and a lot of other measures. One measure you're going to find a way around it but then if that one is blocked too and that one is blocked then you're going to start thinking crikey it would just be easier if you quit drinking. (Participant 3)

A joined-up whole-of-government policy response to alcohol harm minimisation was generally deemed to be of high importance,

It's – like there's no magic wands in there, but altogether, I think they will make a difference. It's a pretty vital part of those initiatives, if you like, yeah. When we get all those things in place, I think it will make a difference. I'm hoping it will. (Participant 16)

In this sense, there was a recognition that the BDR and the alcohol harm minimisation approach of which it is a part, dovetail closely with other broader social policy issues. For example, one participant claimed,

[There are] linkages with other strategies and the social policy issues. Housing, education, health, domestic and family violence. The linkages between all of those focus points, the Government strategies, the NGO service delivery ... The 'chicken/egg' argument around mental health, alcohol addiction, and then your DV [domestic violence], your homeless, your gambling. All of these facets are so intertwined, and which one came first, and which one caused what, you could get lost forever. (Participant 4)

### **5.3.3 Working together within the context of a whole-of-government response**

Participants frequently spoke about the BDR planning process as an opportunity to work together across multiple agencies. The overwhelming majority of participants indicated that the 'the cross-government collaboration was good' (Participant 6) and that most stakeholders worked together effectively.

The people who've formed those working relationships to get it done, it was a good example of government working together on something, from what I can see and feel. (Participant 2)

So all of that was probably managed well, considering that it was something that every agency and people involved had an opinion on, and how it would be managed. (Participant 4)

The Licensing guys, they were great. We would say, “I need five or 15, or 20, inspectors to go out with these technicians,” because we have no authority to enter a private premise or a liquor outlet, “To do this, this, this and this.” They made them available. Between Licensing and my team, we worked extremely collaboratively together. We were very much a collegiate and cooperative team. You know, we were tight as water. (Participant 6)

It was generally well recognised that there was an expectation within government, and subsequently throughout the BDR planning process, to work together collaboratively. The following participants explained this well,

When I go to the meeting, I should be there wearing my ‘agency hat’, but equally my Government’s intent means that we are to work together as best as we can. So, we’re not all on the same team, but towards the end we’re supposed to be! And balancing our own expectations, at times, as well. (Participant 4)

I guess it just required a lot of collaboration working together and keeping communication channels open and things like that. So it seemed to work okay and it was just more, when it gets to the pointy end when you've got Cabinet submissions and things like that ... it gets a bit murky with that governmental process. (Participant 9)

Not surprisingly, some participants also highlighted tensions of working together that emerged throughout the planning process. For example, ‘there was lots of conflict and disparity in discussion between key stakeholders, both internally within our agency, and with other agencies’ (Participant 5). Such tensions were usually expressed in relation to the division of tasks (particularly differences in policy and operational considerations) between the DoH and DAGJ.

Everyone did play fair and nice, but there was half the time, the fact that the responsibility was split was really difficult. Why are you playing in our patch? Or why



are you not playing in our patch? Before when it was the minister for – the first time when it was the Minister for Alcohol Reform – I think that’s what she was called at the time – it was one agency doing everything. Whereas this was two agencies [DoH and DAGJ] doing two separate things with help from other groups and yeah, that got quite difficult to manage. (Participant 8)

It was this department [DAGJ] that had done the initial BDR and so we knew what work was behind it to get it going. And I think the Department of Health, perhaps in the initial stages, wasn't quite cognisant of what work needed to happen and so it did require a little bit of assistance, or quite a lot of assistance, from this agency, from various areas in this agency, to get the project moving and to get it on track. And then once that happened then things moved along. (Participant 9)

It appeared that technology implications, including those associated with data ownership, were key issues, where tensions in working together were considered to be more pronounced. As one participant suggested,

Data ownership is such a wicked problem. Each agency is responsible for coordinating different aspects, which makes it really difficult to know who owns what, at what stage of the BDR, or BDO, process. (Participant 5)

Issues associated with the integration of IT systems across agencies was also identified as a significant issue, particularly the integration of the Integrated Justice Information System (IJIS) with other systems, such as the BDR.

#### Recommendation:

5. *Upgrade IJIS to support enhanced integration with other NTG IT systems.*

### **5.3.4 The effectiveness of communication**

Communication was identified regularly as integral to the planning and development of the BDR. Communication covered a range of issues, both internal and external. The Business Case (DAGJ, 2017) discussed in the desktop review outlined the types of activities to be included in the internal communications strategy, including interagency representation on committees and working

groups, and adopting a ‘shared resource’ approach to ensure relevant skills and expertise are shared across agencies. External communication included strategies and documentation and information for dissemination to the broader public. A separate, but related, theme was that of the media and the portrayal of the BDR.

It is important to note that internal and external communication were key issues identified through the desktop audit. As noted in the desktop audit, the BDR Project Team within the AOD Branch was responsible for communication, which consisted of both internal and external strategies. Communications crossed over with a number of other issues, for example Governance and Roles and Responsibilities (internal communications), as well as Referral Pathways (internal and external communication). Information on internal communication issues has been excluded from this report due to the sensitive nature of discussions, and potential to identify participants based on the information they have provided. This information will, however, be shared with NTG for internal quality improvement purposes.

#### ***5.3.4.1 External Communication***

As identified through the desktop audit, responsibility for the external communications activities was shared between Licensing NT and the AOD Branch. It was identified that communication was needed around the change in referral pathways and options after the individual had been placed on the BDR. Licensing NT was given responsibility to “manage communications and stakeholder relations with takeaway alcohol licensees, including providing training materials and responding to inquiries. DAGJ will use its existing relationships with licensees to provide clear direction and education in relation to the BDR requirements, processes, and technical operation of the system” (DAGJ, 2017a Section 8). Responsibilities for communication were divided between Health (AOD) and AGD (Licensing NT) (DAGJ, 2017a, Section 8.2). The external communication strategy indicates the need for a “clear, structured plan to communicate with external stakeholders” so that the BDR system is “accepted by the NT community and is able to effectively achieve its strategic objectives”. Some of the communications issues identified in the desktop audit were consistent with participants’ comments. This included concerns about the communication strategy surrounding the early rollout of the BDR, particularly in the regional and remote areas (noted in the SC Meeting Minutes, 19 August 2017). This was also noted by one of the participants:

The other thing which is a bit tricky is that the first round of comms didn't hit remote communities at all, really. It was very much a Darwin-centric thing so we're trying to rectify that now. (Participant 2)

In the interviews, there was considerable variation in views about the effectiveness and success of external communication. One participant was very positive about the communication, attributing much of this success to the Minister:

From my perspective I think the communications strategy was good in terms of public facing, The Minister launched the rollout, there was Facebook, the whatever, I think that that really did work well. (Participant 2)

A number of participants suggested external communication was less of an issue because the general public was familiar with Version 1 of the BDR. For example,

My sense is that there's a lot better acceptance of it this time around simply because it was held up as if we get into power we're going to implement this. So there were no surprises, people had done it before so it wasn't this great unknown [...] So I think there were a lot more concerns last time about how it was going to work, about who it was targeting or whether it was targeting people unfairly. (Participant 3)

However, others considered that the differences between Version 1 and the new BDR were not necessarily well understood by the general public,

Everyone who heard that it was going to be replacing the AMT [Alcohol Mandatory Treatment] and they were going to go back to the old system. That's what everyone thought, the scanning and that sort of thing but not understand fully some of the differences. As far as the public are aware I think it's just around, "I need my photo ID to go and get alcohol." (Participant 11)

A participant who visited all the Shows to disseminate information to the public stated,

people would come up and go, either, "fantastic, great that you can switch it back on again", or, "tell me how this works". I didn't have a single negative

comment from anybody, but it was very much a, “we had it before, you just turn on a switch and it’ll be on again”, which in no way reflected the amount of work that was actually required to stand it up. (Participant 2)

Another participant made similar observations about the need to have a better framework to ensure the correct messages are being communicated to the public and relevant stakeholders on the ground,

I think there needed to be much more of a developing a collective understanding of what actually BDR is. Simple things like consistent communication, consistent marketing, [...] They needed to actually do an advertising campaign that actually promoted the benefits of BDR. (Participant 13)

Similarly, one participant talked about the importance of having a consistent framework that all frontline agencies and staff understood, to ensure that the BDR is communicated effectively and consistently to the public. The participant used an example to explain this,

If a person is being asked about their ID at the point of sale and there is a police officer standing there, the person being asked, if they don’t trust what the bartender is telling them - or the employee – will automatically go to the police member for the, “Tell me, is this true?” So the communication strategy also needs to be that secondary component of, “How will others relay that message?” And then at the end of all of that communication is ‘the why’. So, a big component of alcohol reform and repairing our relationship with alcohol is the cultural change. We facilitate that through the conversation. (Participant 4)

Another issue identified was the lack of educational documents for frontline staff and agencies. While the documentation and guidelines appeared to be very effective for some stakeholders, there was also some evidence that the guidelines were not disseminated widely enough prior to implementation. A number of participants said that agencies and organisations developed their own guidelines because they were not aware that guidelines produced by DoH were available online.

Communication issues were raised in relation to the dissemination of information to other key agencies involved in the implementation, particularly the courts and medical professionals authorised to make referrals,

Yes, it's about raising awareness amongst authorised applicants about what they can do. 60 presentations have been given since the BDR started. And still not everyone is aware. (Participant 1)

Another participant also commented

I believe probably during the implementation stage there could have been some work done in setting up a training package or an awareness package. [...] and also for other areas as well, for promoting the BDR because there's also - people can self-refer on to the BDR as well. Even communicating what the BDR was to the drug and rehab services around and NGOs. What is the BDR? What's our role? If a client is on an order what does that mean? That sort of thing. (Participant 11)

And another participant commented there was:

[a] bit of a delay in getting documents up on website. Would have been helpful to have them earlier. Clinicians felt that training information day would have been useful. Some of the medical officers uncertain about who can refer (Participant 12)

There was some frustration that the legal aspects of the BDR were not fully understood by those using the system and making referrals. For example, from a licensee perspective,

So, the education was pretty poor – very poor. The guides that were developed were pretty poor. We still have anomalies, in relation to bush orders. We haven't had a definite guide on that. (FG3)

Some participants believed there also needed to be better communication about the different referral pathways to the public. In particular, there was a sense that that there was not enough information communicated to the public about how the referral pathways differed from Version 1.

Similarly, there was limited information about the potential for family members and carers to make referrals. For example,

I think even some television advertising, newspaper advertising that sort of thing about what it is. How can you put a family member, apply to have a family member put on it, those sort of things. I know some [...] people that have said, “Hey, we’ve got a guy that drinks all the time. Where do I go to get someone to put on it?” That sort of thing. (Participant 11)

The need for communication in different languages, particularly Indigenous languages, was also identified by a couple of participants,

[...] One thing would have been enormously helpful that wasn’t in place, and is still ongoing is resources in Aboriginal languages. (Participant 1)

One participant talked about the need for these resources for the public, as well as to support the staff on the ground,

Did we go out and survey the target risk population? Did we produce materials explaining BDR in the right language? All that. Did we do that? I don’t know. From my perspective from implementing it in this context we didn’t. And I know that because the staff I’ve got didn’t understand it. (Participant 13)

It was suggested by some participants that these documents are now in the process of being developed.

#### Recommendation:

6. *Develop a more robust community education campaign about the aim and purpose of the BDR to increase public understanding of the BDR. There is an opportunity to use success stories from people on the BDR to inform a campaign of this nature.*

#### **5.3.4.2 Communication in the Media**

Participants were also asked about the role of the media in the planning and implementation of the BDR. There were mixed responses to these questions, with many participants not having much to say on this issue. A couple of participants specifically spoke about the role of the *NT News*,

Since it's been in operation, I think that the media itself is quite supportive ... Certainly mainstream media I think's been – I think the *NT News* is more supportive than ABC Radio presenters. There's a couple of ABC Radio presenters who are really anti-BDR but they're talk show hosts and that's okay, they're not news reporting. So, yeah, overall, I think it's been a supportive environment. (Participant 2)

Another participant commented:

Last time the *NT News* initially, like they need to get headlines, seemed much more antagonistic towards it whereas although once - after the first couple of months then the *NT News* last time was oh this looks like it's working so that's a good thing. There wasn't much in the way of negative publicity we don't want this sort of thing, this going to be a real imposition. I think just because people were familiar with what it was going to be like. And from the public facing side of things it's not much different, if any different, you show your licence you get your alcohol. (Participant 3)

Another respondent indicated that the media also plays a critical role in holding government to account,

The media is critical in conveying the appropriate message, and the media is critical so that when you get things wrong, you can be held to account on it. And when things are being delivered on public purse, that's very important. So, if the deployment of however-many-hundred devices we did this time – I think it was 180 – if we had have got that wrong, we should be on the front page of the paper with, “What a stuff up,” and “tax dollars,” etcetera, etcetera. “Please explain.” That is appropriate. (Participant 4)

In summary, there appeared to be less interest in the BDR by popular media in the reintroduction of the BDR than there had been during the introduction of Version 1.

### 5.3.5 BDR referral pathways

There was substantial discussion throughout the interviews about referral pathways. This related to referral pathways onto the BDR, including self-referrals; and referral pathways from the BDR into alcohol treatment and therapeutic services. In terms of referral pathways onto the BDR there was a general sense that pathways onto the BDR worked well. As two participants advocated throughout the planning process,

“Let’s draw up a business process map around that. Let’s draw up a business process map on alcohol related offences. What does that mean in relation to domestic violence, court orders? What court orders are we referring to? Let’s draw up a business process map.” We did it, so that everybody can understand what this is all about. (Participant 6 & 7)

It appears this was largely due to the planning that went into the development of sixteen different business process maps associated with referral pathways on and off the BDR (see Appendix E for examples of business process maps). It seems that the promotion of referral pathways by the BDR Registrar among authorised officers has also complemented these processes. As one participant claimed,

She’s [BDR Registrar] done a whole heap of legal and court sessions and – you know, just that trying to brief everybody up, get engagement, and looking for improvements. (Participant 2)

Nevertheless, a few participants considered that some referral pathways onto the BDR could be further improved. For example,

Emergency department medical staff aren’t referring them on to the BDR Registrar, [those people] that are coming for alcohol related injuries or issues, or whichever. (Participant 6)

Similarly, multiple participants mentioned that referral pathways from the courts could also be improved. This was also identified in the desktop review whereby a brief from December 2017 (Doc #21) reads “Courts: In terms of court use of Banned Drinker Orders and referrals to assessments, the judiciary has been briefed on numerous occasions about the new BDR model and



its operation. The Director of Courts and the Local Court Registrar were instrumental in the development of the model and the portal system, and engaging with the Judges through the working groups. Legal Aid groups have also been engaged and briefed on the model, with the BDR Registrar regularly fielding queries from legal practitioners. A publicly available fact sheet was created to assist these practitioners with their queries. The Department of Health will continue to engage with the relevant officers to ensure the BDR remains a focus of the legal system.”

Recommendations:

7. *Implement a standard referral template for health assessments.*
8. *Consider mandating courts to notify the BDR Registrar if they vary or revoke a person’s BDO.*

One operational issue that has emerged in relation to the referral pathway onto the BDR has been the process of notifying people that they have been placed on the BDR. This was identified as being particularly problematic for those people considered to be itinerants or homeless. One interviewee mentioned,

I think one of the biggest difficulties I’ve had with the whole process is how the person gets notified of being put on an order. I think that’s been the biggest challenge ... often people don’t have phone numbers or the phone number is not connected or something like that so therefore, it’s very hard to notify someone of an order or notify of someone that has been referred ... some of them again would ring up and say, “hey, I tried to buy some grog. I can’t because apparently I’m on an order.” ... no one was able to contact them to let them know. A letter might have been sent but the person might be homeless, that sort of thing. That’s one of the real difficulties especially around homeless and itinerant people. (Participant 11)

Another hot topic of discussion was the option of a self-referral pathway in this version of the BDR. This is a new provision where people can voluntarily nominate themselves to be placed on the BDR. As one participant noted,

[The] first time we put it in [Version 1 of the BDR], you couldn't refer yourself, you had to get assessed to go on it, and I got a heap of calls about people saying, “hang on, I've got real problems, I want to put myself on,” and they couldn't do that, and ended up having to change things. So things like that we did straight off the bat, where you can self-refer straight away. (Participant 16)

The mechanism for self-referral is premised on self-determination and individual readiness to address their misuse of alcohol. This was exemplified by feedback from a self-referral onto the BDR that was provided to the evaluation team by the BDR Registrar: “Going on BDR was the best thing I ever did. AOD staff helped me self-refer and put me through withdrawal then I went to rehab for 12 weeks ... even though I was in rehab and wasn't drinking being on the BDR helped me be strong and now I don't feel the need to drink so I feel I can come off BDR. I know I can go back on if I need to. I feel so healthy now, I didn't realise how sick grog was making me ... I've done five detoxes before but always relapsed straight away. This time I did rehab and I feel it has worked ... now I have a job.” It appears that the self-referral pathway is a positive option at a range of levels. As such, it would be beneficial to play closer attention to the up-take of this pathway over the longer-term. As one interviewee commented,

[The] self-referral pathway has actually had a higher-than-we-anticipated uptake, I think we're up to about 50 out of about 3,000. So it's not an overwhelming percentage, but it's encouraging to think that people have actually taken that up 'cause it's not been a big part of the advertising ... what is good for those people is if you self-refer you can self-refer yourself back off. Whereas if you have an order made against you, then you're stuck with the three months or the six months or the whatever, and I think that there were some people who were taking that option which is great. (Participant 2)

When participants were queried about who was perceived to be using the self-referral pathway, there were different opinions noted. For example,

It's really been very broad. Men, women, 18, 70. Just wanting – a bit of a problem with binge drinking, or affecting relationships, dependent, been to rehab many, many times. Probably not many – hardly any indigenous people. Professional people. Very broad. (Participant 1)

It's interesting though when you look at self-referral ... the number of white men aged sort of 20 to 45 who put themselves on was incredible. It was weird almost. I was like "[what] the hell?" and it was almost like that was the exact group of people who were complaining the loudest about it. But they were secretly like put me on the BDR, because I can't be trusted. Or my wife's going to leave me next week if I don't sort my shit out. Please put me on. (Participant 8)

In addition, there were also other participants that suggested "older Indigenous women" were self-referring to avoid 'humbug' from families members known to misuse alcohol; and "middle-aged white women" that knew they consumed alcohol at risky levels. Information retrieved from the BDR Registrar's Office (see Figure 65 below) did not reveal any discernible pattern or distinct characteristics about the people self-referring.

*Figure 65. Number of self-referrals onto the BDR by age, gender and Indigenous status*

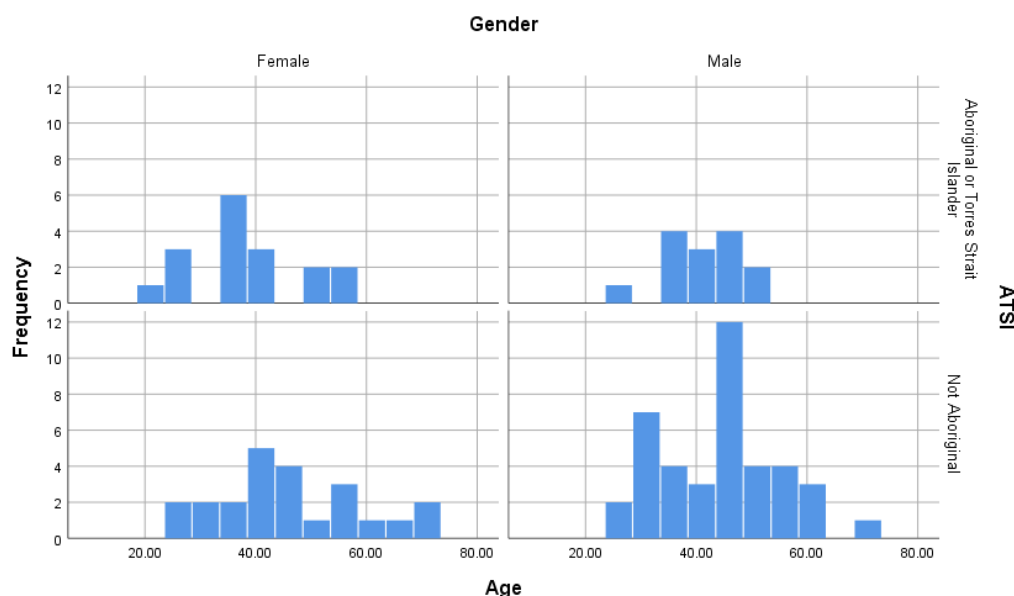


Figure 655 shows the characteristics of self-referrals since the commencement of the BDR, with a relatively even distribution of ages, a clustering between the ages of 35-50 year and a relatively even distribution by gender. Thirty percent of people identify as Aboriginal and Torres Strait Islander, which reflects population parity.

Recommendation:

9. *Promote the BDR self-referral pathway more actively to people with patterns of risky drinking behaviours. This requires tailored social marketing efforts to different sub-sets of people who misuse alcohol.*

Whilst referral pathways onto the BDR were described relatively positively, concerns were repeatedly raised about pathways from the BDR into treatment and therapeutic services. Stakeholders knew about these pathway options, for example, one participant commented, ‘I note that there are therapeutic options available to persons on the BDR, the BDR membership. And that there is still that therapeutic component’ (Participant 4). Participants also noted that there had been significant additional investment in therapeutic services during the reintroduction of the BDR,

Health was successful in getting a lot of money out of Government ... a lot of what had been funded before, had dissipated into the rest of the organisation. So we managed to get quite significant funding, and converting Stringybark into a voluntary residential treatment centre, putting the Sobering-Up Shelter there was a really important part of that, I think and so on. But they’ve had few clients. (Participant 14)

However, the primary issue raised was the uptake of the referral pathway into treatment services. As one participant stated,

A really substantial part of the investment was around, “we’re trying to get people into treatment”, the people didn’t read that memo so most of them who are on the BDR are not then, of course, accessing treatment services. The Minister says, “well why not? Why can’t they and why can’t you make them”; well, ‘cause their actual motivations for change haven’t changed, people will do it when they’re ready, when there’s other things, and the BDR’s not really a big stick or a carrot ... no-one has opted to do a treatment course to shorten their BDO cause that’s a pathway. So if you get an order of six months or more, you can attend a treatment program and have your order shortened or apply to have it shortened. No-one’s taken that option up. (Participant 2)

Despite the opportunity for people on the BDR to reduce the length of their order by participating in alcohol treatment services, it appears few people have taken up this option. As another participant claimed,

There haven't been a lot of referrals. For a few reasons, I suppose. People – they're not interested, they don't see they've got a problem. They'll just write – whatever – put me on the banned drinker register, I'll do the time. I'm not interested in trying to reduce it or trying to address my problem. (Participant 1)

In addition to a perceived lack of motivation and/or readiness of people on the BDR to access alcohol treatment services, the *voluntary* nature of participating in treatment services was also identified as a barrier for using such services. As one respondent commented,

There was shifting the old [AMT] from an involuntary model to a voluntary model and then a new model of practice. That's an issue we're still working through ... what that model should actually look like. (Participant 13)

#### Recommendations:

10. *Develop strategies to better promote the array of therapeutic services available to assist people placed on the BDR.*
11. *Develop assertive health promotion outreach strategies and resources (particularly health education, the provision of health information, and more detailed information about therapeutic services) for people issued with a BDO.*
12. *Prioritize implementation of practical levers and strategies to increase the voluntary uptake of therapeutic services among people on the BDR. A targeted and culturally responsive approach will be required to reach different sub-sets of people on the BDR. Potential options could include:*
  - *Police referring people on a police initiated BDO to the BDR Registrar for referral for therapeutic support and/or consideration of income management order, with a rationale as to why this option would be beneficial.*
  - *Courts referring people with a Court Order with alcohol prohibition conditions to the BDR Registrar for therapeutic support.*
  - *Assertive follow-up and coordinated therapeutic support options discussed with people on a BDO by locally-based alcohol treatment services.*

### 5.3.6 The potential for BDR Phase 2

Throughout both the desktop review, and the interviews and focus groups, there was often discussion about BDR Phase 2. As one participant noted,

Once September 1 [2018] was achieved, people's enthusiasm waned somewhat. Because it – was like the job was done, really ... some of the “what should have happened next, what do we think when we went Mark II”, that kind of bit got lost ... the story that people tell is they started with a really big wish list and then as the timeframes and the resources got tighter and tighter and tighter, things started to be, “what can we do by September 1 and what do we need to think about after that”, and I'm concerned that some of the “what do we need to think about after that” has been lost. (Participant 2)

After confirmation at a focus group with policy-makers, it became clear that there is no project plan or dedicated resources to articulate what Phase 2 (of Version 2) of the BDR might constitute. That is, Phase 2 is a somewhat nebulous concept and was referred to in a hypothetical sense of ‘what could be’ post early implementation. This was reaffirmed by one participant who claimed, ‘many suggestions, and potential innovations, were side-lined for stage 2 because of the tight timeframe’ (Participant 5). Nevertheless, potential areas for action, suggestions for change, or opportunities for quality improvement that were raised in this component of the study, often managed to capture ideas that had been ‘parked’ during the planning and early implementation of Phase 1. This section outlines a brief summary of these ideas, which span:

- Expansion of the BDR to on-premises drinking
- Secondary supply of alcohol
- Targeted, and culturally responsive, alcohol harm minimisation measures for Aboriginal people
- Greater investment in community development and health promotion strategies aligned with the BDR
- Acknowledging and responding to displacement influenced by the BDR and other alcohol harm minimisation policy initiatives
- Matching of the personal information of banned drinkers with the location of no sale data
- Digitisation of Drivers' Licenses

#### **5.3.6.1 Expansion of the BDR to on-premises drinking**

The expansion of the BDR to on-premises drinking was discussed by a few participants.

It [the BDR] could potentially be expanded to on-premises drinking. So in terms of a bigger picture and having a broader focus of being able to enforce prohibitions on particular individuals from accessing alcohol. (Participant 9)

You could probably look at expanding the BDR into other areas, like on-premise and stuff like that. I'm not sure it is as effective as last time from my observations. People seem to have it worked out better, secondary supply, and getting access to alcohol. (Participant 16)

There was evidence that some licensed premises were already exploring ways to expand key concepts adopted through the BDR into other contexts. This was confirmed in the industry focus group, where participants indicated,

So, the mobile device could certainly be something they'd be looking at, in relation to the nightclub – late-night trading scenario ... there's some [industry] interest in having multi-venue exclusions in that [Darwin nightclub] entertainment precinct. They're pretty early on, in terms of discussion ... so, there's certainly been discussions, in relation to how the BDR is – so, how can the BDR be best used? But, currently, the BDR is limited, in the sense of privacy. (Focus Group 3)

#### **Recommendation:**

13. *Consider trialing BDR scanners at on-premises venues in Alice Springs, Katherine and Tennant Creek where Police Auxiliary Liquor Inspectors (PALIs) are deployed.*

#### **5.3.6.2 Secondary supply of alcohol**

Many people discussed access to a secondary supply of alcohol among people on the BDR as a significant issue currently not being addressed. Access to a secondary supply of alcohol was also highlighted in the descriptive analysis. As one industry representative discussed,

My bottle shop guy said to me that, when the thing [BDR] started last year, we had a lot of knock-backs, initially. But, we haven't had any for a long time. So, they've cottoned on to the fact that they're on the register. They're coming in and either getting someone else to purchase it for them, which – I can't substantiate that, but you'd imagine. So, we've had very few – and, I'm not only talking about my premises here – very few knock-backs in last few months, which is an interesting statistic, I guess.

(Focus Group 3)

This observation was echoed by other participants who asserted that parallel measures to 'address secondary supply' issues, in concert with the implementation of the BDR, were urgently needed. Noteworthy is that the NTG Alcohol Review Implementation Team circulated a brief on 20 June 2018 outlining that the NT Police are "minimising the impacts of sly-grog and the secondary supply of alcohol to those on the Banned Drinker Register in regional and remote communities." It was also announced that "the NT Departments of Health and Attorney-General and Justice are jointly conducting a campaign aimed at raising awareness across regional and remote communities about the secondary supply of alcohol." This indicates NTG is already responding to this perceived policy and practice gap.

#### Recommendation:

14. *Implement policy responses that address the secondary supply of alcohol and grog running, in tandem with investments in the BDR. It is proposed that such responses are targeted at high risk population groups, such as the recent announcement of an additional 12 police officers and 3 prosecutors with a specific focus on secondary supply.*

#### **5.3.6.3 Targeted, and culturally responsive, alcohol harm minimisation measures for Aboriginal people**

Many participants mentioned that more targeted, and culturally responsive, alcohol harm minimisation measures for Aboriginal people, were required. The descriptive analysis revealed that 85-87% of people on the BDR identify as Aboriginal (with the exception of those BDOs issued by the registrar where Indigeneity is not currently documented). As one participant commented,

I'd probably suggest to Health that they put a record of whether their clients are Indigenous or not. I think it's almost not racist but it's naïve in some ways not to because we have such different justice outcomes for Aboriginal and non-Aboriginal



people to say that we're not going to record that information. So everything we do in the justice system we know whether people are Aboriginal, non-Aboriginal so you can say well yes they are having similar outcomes or no they're not, and that's really important to be able to say whereas in this case it wasn't something that was recorded for the BDR Registrar people. (Participant 3)

Given that approximately 30% of the NT population identify as Aboriginal, it is evident that Aboriginal people are extremely over-represented on the BDR from a population viewpoint. Whilst the BDR is a generic population level intervention, this finding indicates the value in adopting culturally responsive policy and program responses that parallel the BDR. This was reinforced by many participants. One participant commented that an 'Indigenous contact/liaison would be helpful' (Participant 12) for engaging Aboriginal people on the BDR. Another participant claimed, 'I think that I would have outreach staff to be able to go and find people who are referred, and Indigenous outreach staff' (Participant 1). The same participant also highlighted that 'one thing would have been enormously helpful that wasn't in place, and is still an ongoing issue, is resources in Aboriginal languages'.

#### ***5.3.6.4 Greater investment in community development and health promotion strategies aligned with the BDR***

There was a consistent theme that emerged throughout the interviews that a greater investment in community development and health promotion strategies aligned with the BDR was needed. This is consistent with recommendations in the Riley Review to increase community education about the harms of alcohol. This was aptly summarised by one participant,

Focus on some more consumer materials that accompany the website so it's not just a law-and-order thing but it's about, "if you're seeking help, here's some places", "this is what a standard drink is", so a little bit more of that health promotion thing which was absent altogether. (Participant 2)

Another respondent claimed,

I think there's some real opportunity to rescope some of the community development team that we have to add on that piece ... in terms of actually people – that health promotion kind of thing, it's been such a lost opportunity because we went too fast.  
(Participant 13)

The suggestion of assertive health promotion outreach targeted towards people on the BDR or at risk of being placed on the BDR was a solution offered by some policy-makers throughout interviews. The intent would be to deliver brief interventions, health education and provide health information consistent with the *NT Strategic Health Promotion Framework* and *NT Chronic Conditions Prevention and Management Strategy*. Such assertive outreach, could also assist in promoting therapeutic services and respective referral pathway options.

**Recommendation:**

15. *Substantially increase health promotion efforts across the NT community to reduce the risks and harms of alcohol consumption, with the intent of reducing BDOs issued over the longer term. This requires investment in a workforce with specific expertise and skill-sets in community development and health promotion; and should align with the NT Strategic Health Promotion Framework.*

**5.3.6.5 Acknowledging and responding to displacement influenced by the BDR and other alcohol harm minimisation policy initiatives**

Participants frequently discussed the importance of acknowledging and responding to displacement influenced by the BDR and other alcohol harm minimisation policy initiatives being introduced across the NT. The need to collect better quality data about event location in relation to the issuing of BDO, and the place of residence of people placed on the BDR, was deemed to be particularly important. An industry representative stated,

That is the biggest problem with it, is the displacement. I mean, it just – you know, they've got buses running up [to Darwin]. People are running people up from the communities – from Katherine, Tennant Creek – charging them money. Putting them in a bus so they can come up here and drink. (Focus Group 2)

Whilst it was acknowledged that the BDR is NT-wide, the perceived ability to access a secondary supply of alcohol in Darwin more easily was considered to influence displacement among those who misuse alcohol. As industry representatives commented,

We have this huge displacement issue, you know? We've seen it up here. Obviously, we've seen Ali Curung people move up to Rapid Creek. We've seen a lot, obviously, move to Tennant Creek. We've seen people moving to Mount Isa. So, every time we come up with a localised restriction that's not really connected to the BDR, it just pushes it out ... But, when you come to Darwin, there's no limit. So, Darwin becomes an alcohol destination for them. We think that's something that – it's not much to tweak the BDR, in terms of having it as restricted sales, rather than complete bans. In many cases, the restricted sales might be a better way to deal with it ... the concept of restricting the sales, so you actually keep people in a particular area, might be a better outcome than having a ban and either forcing them to get a second supply, or not having the choice to put them onto light beers, or mid-strength beers, which they [already] do in Nhulunbuy. So, that range of options (Focus Group 2)

I mean, the Central Australia guys are a little bit different because, for the last period of time, they've had the temporary beat locations or the POSIs, which is, effectively, a police BDR. They've had that in place for a period of time. So, there's been a fair bit of screening go on ... some of the issues that have come out – they're not so much about the BDR, but this is how the BDR could cure things if it was more uniform – have a uniform approach. (Focus Group 2)

An underpinning issue linked to displacement was community safety, a key aspect of the overarching goal of the BDR,

The ongoing effects of displacement is the natural progression to violence and break-ins and robbery, and that's where it's starting to skyrocket in Alice Springs, and it's starting to grow in Darwin, and it's causing major problems. If we don't address that displacement issue, it's just going to keep on growing. (Focus Group 2)

As such, there were calls for a more sophisticated effort in recording event location,

We have a modification that IT have got on their list to make, that's in terms of recording the event location. Again that wasn't something that was identified upfront mainly because we've quite a lot of work like for the evaluation we would have looked at that anyway. For reporting it on a regular basis we thought well that's going into some of that detail that we're not going to focus on this time, so we hadn't identified that as an issue that we needed ... yeah they'll be making that change for us in time. (Participant 3)

Recommendation:

16. *Develop more sophisticated ways to more accurately identify place of residence and event location for people on the BDR to assist with the tailoring of location-specific alcohol harm minimisation policy and program responses.*

**5.3.6.6 Matching of the personal information of banned drinkers with the location of no sale data**

In addition, to place of residence and event location, the matching of the personal information of banned drinkers with the location of no sale data (i.e. a breach), could provide important information to assist with the implementation of parallel health, police and justice interventions. As one participant summarised,

When we have a transaction that says it resulted in no sale because the person was on the BDR, ideally, we would like to know who that person on the BDR was. Now we don't, because that information isn't recorded. That was a big thing that happened in the first BDR, the government promised no we won't keep people's details. So the transaction data are just simply transactions and there's no person data ... we don't know if it's one person trying 3000 times or 3000 people trying once to purchase, that sort of thing. In other words, the reason that wasn't done wasn't a technical issue and it wasn't because we didn't identify it. (Participant 3)

The industry group was particularly supportive of collecting additional data on banned drinkers to assist with proactive responses,

I think that type of data is great. I don't know whether it's something the venues should get involved in. But, certainly, from the NT Police point of view – they're frustrated with a system where they can't get that type of data out of that system, so that they can track where somebody's purchasing a cask here, and then going around and buying another cask at another venue. They find that frustrating. (Focus Group 2)

Recommendation:

17. *Investigate ways to record volume of alcohol sales as part of the BDR. This could be linked to work currently underway within Licensing NT to examine existing data collection requirements from Licensees.*

The privacy implications of recording personal information about no sale data through BDR transactions was, however, a contested topic. Another participant stated,

Ensuring that it's not a record somewhere saying that, "Joe scanned and he was good," or, "Joe scanned and he was bad." I don't think that that would be appropriate under the privacy settings for every person, for a lawful commodity. Maybe in future, but I think we need a few more increments of change before we're at that threshold ... There has been argument – sorry, 'animated discussion' - internally here around, "but if we knew that it was Joe Bloggs trying to scan and 'being refused', we could offer him help." (Participant 4)

Some participants also suggested that collecting more detailed information about the volume of alcohol purchased, or implementing more uniform alcohol restrictions, across the NT would be beneficial,

One would assume that you purchase alcohol to consume [it]. So ... targeting the bulk of alcohol consumption through [restricting] takeaway alcohol [makes sense]. And trying to find some way to limit people's access. (Participant 9)

This concept was reiterated in a focus group with policy-makers,

That volume would assist us in identifying, in our view, secondary purchase, or secondary sale, which we have got a new allocation from government to pursue that,

with 12 positions. To pursue secondary supply, and part of that, that information will provide us with great leverage in informing that. (Focus Group 3)

**Recommendation:**

18. *Investigate ways to record the name and contact details of individuals on the BDR who attempt to purchase alcohol (i.e. those considered by law to have breached) to assist in strengths-based and assertive health promotion outreach activities.*

### **5.3.6.7 Digitisation of drivers' licenses**

The digitisation of drivers' licenses was proposed as a means to get more accurate personal information about proof of identity. As simply stated in a focus group discussion 'we need to address digitisation and identity ... and, discrepancies – or differences, in dates of birth between the Justice system and the Health system.' (Focus Group 3). Digitisation of drivers' licenses was one solution put forward,

I think we have a lot of work to do now with digitisation of driver's licences. Some jurisdictions are digitising their driver's licences so we are going to have to revisit our technology. (Participant 6)

Although, there was also a broader message conveyed that the IT infrastructure needed to be upgraded, in order to address issues related to the identity of people placed on the BDR. This was particularly relevant for minimising the possibility of duplicate entries across different agencies. As one respondent explained,

I think the BDR, the portal – have the functionality to look for not only name and date of birth, but aliases that are attached as well. Because what's put into the BDR is what's looked for when a person provides their ID. And if you don't have it right, exactly as is on their photo ID, and if you don't get a copy of their photo ID when you're making the order, there's room for error there. (Participant 1)

**Recommendations:**

19. *Over the longer-term, invest in the digitisation of photo identification (such as Driver's Licenses and Australia Post KeyPass card) used for the BDR. This could also provide a solution for other public policy responses requiring photo identification.*
20. *Resolve data quality issues through integrated information technology solutions that address errors due to multiple entries (i.e. alias or date of birth) of people placed on the BDR. Expanding the BDR to additional settings (e.g. on premises, or late-night venues) may also require the implementation of alternative technology solutions.*

A focus group with industry indicated that addressing identification issues could offer different alternatives to the BDR, such as a hybrid BDR/Permit system linked directly to your drivers' license. This was perceived as a way to strengthen the intent of the BDR,

One thing we talk about is a hybrid permit system. So, I don't know if you're familiar with what goes on in Nhulunbuy, but the permits there and Groote Eylandt – so, they've got the overlap of a permit system with a BDR. What we're looking at is in relation to the BDR – because it's attached to your ID – if you, for example, come from a particular community – we have communities that have agreements with licensed premises – the Devil's Marbles Hotel. Pine Creek Hotel is another one. So, if you come from those communities, there's a restriction. So, a restriction made from your ID. (Focus Group 2)

Another industry member, during the same focus group discussion, also advocated for existing systems within licensed venues where club membership is already a requirement, to be linked more purposefully with the BDR system,

We were hoping, initially, that – if we could get – because it's quite easy to get a photo of a customer onto our system. So, if we could swipe the member's card, to verify if they were on the BDR. So, in other words, our membership system talked to the NTG BDR system. Just one less device that's on the counter, or process that we need to go through, but that seemed to be too hard, at that point in time. At the moment, everybody's handing over three cards, and eyes are rolling all the time. If there was an opportunity to streamline that process, that would be great. (Focus Group 2)

In the interim, to resolve issues associated with identification of potential banned drinkers, a suggestion was made to at least allow the BDR Registrar to,

Have access to motor vehicle registry records to check what ID people may have, because with 99.9% of applications received, they don't provide ID for the person. And although the legislation doesn't say they have to, the legislation says that the registrar has to be satisfied as to the adult's identity, before making a banned drinker order. So the most effective way to do that is to get photo ID of the person. (Participant 1)

Recommendation:

21. *Consider providing the BDR Registrar access to the Motor Vehicle Registry records to help streamline processes associated with the legislative requirement for the BDR Registrar to be satisfied with a person's identity.*

Other recommendations to assist the BDR Registrar with operational elements associated with the issuing of a BDO, and the ongoing monitoring of the effectiveness of the BDR, were also highlighted. For example,

I think it would be useful if there was a banned drinker register online training that all people who were authorised applicants under the Act had to undertake at least once. Because there must be many, many more people who meet the criteria, authorised applicants like nurses and doctors and social workers and so on, in hospitals, come across, and they don't make the applications. And possibly some work on – what are the barriers to authorised applicants making applications? There must be something. (Participant 1)

Recommendation:

22. *Expand the list of persons authorised to refer to the BDR Registrar, including Level 4 counsellors registered with the Australian Counselling Association.*



### **5.3.7 Matters internal to the NTG**

A number of issues surfaced throughout the interviews that are best described as matters internal to the NTG. Given the sensitive nature of, and potential for individual participants to be identified based on the description of information they have provided, the evaluation team has decided to provide this information for internal use by NTG to assist with quality improvement processes. It is important to note that despite the identification of these issues during the development of the BDR, it was still implemented on time and under budget.

## 6 Evaluation Summary

As outlined in the executive summary, there are three overarching questions that have guided the evaluation process. These include:

- Was the policy implemented as intended?
- Is the BDR meeting its intended objectives?
- What improvements or changes are required?

To respond to these questions, a mixed-methods approach was adopted involving three interconnecting elements. These elements included:

- *A descriptive analysis of administrative data*
- *A desktop audit*
- *Key informant interviews*

These were presented as three separate sections 3-5 in this evaluation report. In an effort to answer the overarching evaluation questions, we now present key observations associated with the each of the three sections. We conclude this section with some overarching key messages that have merged out of the evaluation process.

### 6.1 Summary of descriptive analysis

The descriptive analysis presented in Section 3 demonstrated that:

- Banned drinkers are not prevented from obtaining alcohol through all pathways, although banning takeaway purchases makes obtaining alcohol more difficult.
- The percentages of individuals apprehended, infringed, or taken into protective custody who are already on the BDR are still growing.
- Some individuals appear to reduce or discontinue alcohol-related contact with the justice system, but others are maintaining their frequency of alcohol-related events while on the BDR.

- Banned drinkers with a low frequency of alcohol-related events may complete their bans without further alcohol-related contact with the justice system, as this requires relatively little behaviour change.
- Banned drinkers who have had high-frequency contacts with the justice system in the year prior to the BDR are likely to remain on the BDR for a significant period of time: effective desistance for these individuals may require multiple periods of treatment. Seeking treatment for alcohol misuse is voluntary, and requires the individual to be ready to make a change. For those who have not previously undertaken treatment, it is too early to expect to see a significant reduction in alcohol-related events as a result of being on the BDR.
- The number of treatment episodes commenced by individuals on the BDR appears to have increased substantially since the introduction of the BDR, both for clients who have undertaken prior treatment and those on their first treatment episode.

Section 3 of the report also identified the characteristics of people on the BDR. This showed:

- On 28 February 2018, 86% of those on the BDR were Aboriginal, and 73% were male. The percentage of bans issued to females over time has been relatively constant for bans issued by the BDR Registrar, Parole Board and courts, but is growing for bans issued by the NT Police. Females are more likely to be associated with non-criminal, rather than criminal, alcohol-related events, and the percentage of female banned drinkers in prison (9%) is much less than for male banned drinkers (37%). Female banned drinkers are more likely to breach their bans than males, perhaps because a lower percentage of females are in prison.
- Analysis of banned drinkers' prior contact with the justice system identified six groups of individuals that differ in terms of the frequency and criminality of their justice system contact in the year before the BDR. Groups 1, 2 and 5 show higher frequency alcohol-related contact with the justice system and make up 27% of individuals who have been on the BDR for a justice-related ban.
- Groups 3, 4 and 6 are characterised by low to very low frequency of alcohol-related appearances in the justice system, with or without time in prison, and account for 73% of individuals who have been on the BDR for a justice-related ban.

Potential areas for further investigation:

- While individuals on the BDR are prohibited from purchasing takeaway alcohol, they are not restricted from obtaining alcohol through other pathways, such as drinking on-site at licensed premises. This may lead to displacement of drinking from private premises or public spaces that offer privacy to licensed premises.
- This may in turn increase the frequency of alcohol-related violence in and/or near licensed premises. The issue of spatial displacement, and whether the profile of alcohol-related assaults in the NT regions has changed since the implementation of the BDR, would help to inform the feasibility of extending the BDR to licensed premises.
- The addition of health information, where available, to the banned drinker group analysis would allow a more holistic examination of the patterns in alcohol-related events and treatment before and after individuals go on the BDR. This might include banned drinker appearances in sobering-up shelters.
- The sobering-up shelter data could also enable an assessment of whether individuals are using this as a means of avoiding protective custody and the BDR. Analysis of this data together with justice system data would help inform whether adding sobering up shelter episodes as a further trigger would significantly widen the number of individuals added to the BDR, or whether these individuals are already largely on the BDR.
- An analysis of low-range drink driving offences, which are not currently automatic triggers for the BDR, would provide information on whether individuals with such offences progress to higher-range drink driving or other alcohol-related offences, or if apprehension for low-range drink driving has a preventative effect on further alcohol-related appearances in the justice system.
- Consider modelling the frequency of non-criminal events (infringements, protective custody episodes and possibly sobering-up shelter appearances) together.
- Further analysis might look at whether information about alcohol dependency is available for individuals on the BDR. The low-frequency contact cohort may require a different type of alcohol-related intervention than those in the high frequency cohort.
- Continued work on quantifying different types of responses shown by banned drinkers, and transition from prior-year event groups to different response groups.

- The results from the NT Police Last Drinks Survey, though not included in this document, will be available as part of future BDR evaluation processes.

## **6.2 Summary of desktop audit**

The desktop audit was primarily interested in the policy processes involved in implementing the BDR. The overarching analysis revealed that the BDR was implemented on time and within budget. Issues relating to both internal and external communication were identified during the desktop analysis and resurfaced throughout the key informant interviews. Internal communication was complex and related to interagency collaboration and cooperation. Notably, the implementation of the BDR was achieved in the set timeframe. The external communication strategy indicated the need for a “clear, structured plan to communicate with external stakeholders” so that the BDR system is “accepted by the NT community and is able to effectively achieve its strategic objectives”. Responsibility for the external communications activities was shared between Licensing NT and the AOD. Planned communication was achieved, although communication to licensees was delayed, particularly in regional areas. The inclusion of additional external communication strategies was emphasised as a potential opportunity during subsequent key informant interviews.

The desktop audit also highlighted that concerns were raised in relation to the quality of data and respective reporting expectations. Limitations associated with data generated through IJIS and its capability of integrating with the BDR were noted, particularly in relation to missing fields of information (e.g. name and date of birth) and multiple aliases. These issues persist and point toward the need for enhanced information technology systems to support data integration. Reporting also surfaced as an issue, particularly in relation to the functionality of automated reporting. It appears significant enhancements have been made to improve reporting capability since the initial implementation of the BDR. There are, however, ongoing concerns about data ownership. The subsequent development of a RACI matrix (Appendix D) by DAGJ has assisted in clarifying this issue.

The desktop review identified a number of queries and divergences among agencies in relation to the proposed referral pathways. In particular there was an identified need to seek feedback from various agencies, including Police, Territory Families, and Medical Officers. Feedback during the interviews indicated there was limited consultation with frontline staff about the referral pathways. There is potential to enhance these pathways through a deeper level of consultation with these staff moving forward. This is particularly relevant for therapeutic pathways from the BDR in treatment services.

### **6.3 Summary of key informant interviews**

A number of themes emerged out of the key informant interviews. These included:

- Capacity to learn from BDR Version 1
- Alignment with broader alcohol harm minimisation reforms in the NT
- Effectiveness of communication
- Working together within the context of a whole-of-government response
- BDR referral pathways
- The potential for BDR Phase 2

In an effort to address the overarching evaluation questions, particularly in relation to what improvements or changes are required, focused attention was paid to the discussion about BDR Phase 2 Options. Expanded discussion on these topics was perceived by the evaluation team and NTG stakeholders to provide the most useful information for informing continuous quality improvement. Key topics included the:

- Expansion of the BDR to on-premises drinking
- Secondary supply of alcohol
- Targeted, and culturally responsive, alcohol harm minimisation measures for Aboriginal people
- Greater investment in community development and health promotion strategies aligned with the BDR
- Acknowledging and responding to displacement influenced by the BDR and other alcohol harm minimisation policy initiatives

- Matching of the personal information of banned drinkers with the location of no sale data
- Digitisation of Drivers' Licenses

These issues have been explicitly embedded into the recommendations arising from this evaluation. In addition, a number of issues surfaced throughout the interviews that are best described as matters internal to the NTG. The evaluation team will provide this information for internal use by NTG.

Ongoing monitoring of the impact and outcomes associated with the BDR is critical to understanding its effectiveness and efficacy over the longer-term.

#### Recommendation:

23. *The NTG should invest in an independent longer-term comprehensive impact and outcome evaluation of the BDR.*

## **6.4 Overarching key messages**

Combining the observations described above, there are seven key messages that can be gleaned from this evaluation. These include:

1. BDR is one of many alcohol harm minimisation policy initiatives, it does not work in isolation. It forms part of the contribution in achieving a healthier and safer community by reducing alcohol related harms.
2. The influences, impacts and outcomes of the BDR need to be understood in the context of other alcohol harm minimisation policy reforms and initiatives underway in the NT (such as those outlined in the *Alcohol Harm Minimisation Action Plan*).
3. The BDR is working effectively in identifying a sub-set of people who misuse alcohol and are engaged in anti-social behaviour and the justice system.
4. The BDR is changing some people's behaviours around alcohol use – but there are still people on the BDR accessing alcohol and engaging in behaviour that brings them into contact with the justice system. Secondary supply and grog running are not stopped by the BDR.

5. The self-referral option offered through the BDR is showing encouraging signs of uptake. This voluntary pathway could be promoted further.
6. The BDR provides a unique opportunity to engage in assertive health promotion outreach activities. This element can be strengthened through engagement of the community based alcohol and other drugs workforce.
7. The uptake of therapeutic services among people on the BDR has been low. The promotion of these services and the respective referral pathways could be enhanced.

These messages have been incorporated into the final recommendations presented at the beginning, and throughout, the report.



## 7 References

- Akaike, H. (1974). A new look at the statistical model identification. *IEEE Transactions on Automatic Control*, 19 (6), 716-723.
- Australian Bureau of Statistics. (2018). Australian Demographic Statistics, Sep 2017 (cat. no. 3101.0). Released 22 March 2018.
- Australian Bureau of Statistics. (2017). Regional Population Growth, Australia, 2016 (cat. no. 3218.0). Released 28 July 2017.
- Chief Executive Brief, 9 December 2016
- Department of the Attorney-General and Justice (2017), Business Case: Reintroduction of a system to support the Banned Drinker Register, Version 1.0 (20 April 2017). NT Government: Darwin.
- Department of Health (2017), Debate Notes, Minister for Health. Alcohol Harm Reduction Bill.
- Ernst & Young (2017). A System to Support Reintroduction of the Banned Drinker Register: Business Case Review DRAFT. Prepared for DCIS, May 2017.
- Lanza, S. T., Collins, L. M., Lemmon, D. R., & Schafer, J. L. (2007). PROC LCA: A SAS procedure for latent class analysis. *Structural Equation Modelling*, 14 (4), 671-694.
- Northern Territory Government. (2016). *BDR Governance Overview*, 20 December 2016
- Northern Territory Government. (2017). *Banned Drinker Register: Banned Drinker Overview*.
- Northern Territory Government. (2018a). *Northern Territory Government response to the alcohol policies and legislation review Final Report*. Darwin, Northern Territory Government.
- Northern Territory Government (2018b). *Alcohol Harm Minimisation Action Plan 2018-2019*. Darwin, Northern Territory Government.
- Riley, T. (2017). *Alcohol Policies and Legislation Review: Final Report*. Darwin, Northern Territory Government.
- Schwarz, G. (1978). Estimating the dimension of a model. *The Annals of Statistics*, 6 (2), 461-464.
- Steering Committee Meeting Minutes, 13 April 2017.
- Steering Committee Meeting Minutes, 20 July 2017.

- Symons, M., Gray, D., Chikritzhs, T., Skov, S., Siggers, S., Boffa, J. & Low, J. (2012). *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.
- Whetton, S., Hancock, J., Chandler, N., Stephens, E. & Karmel, C. (2009). *Harms from and costs of alcohol consumption in the Northern Territory: Final report*. Report commissioned by Menzies School of Health Research. Adelaide, South Australian Centre for Economic Studies, Adelaide and Flinders Universities.

## 8 Appendices

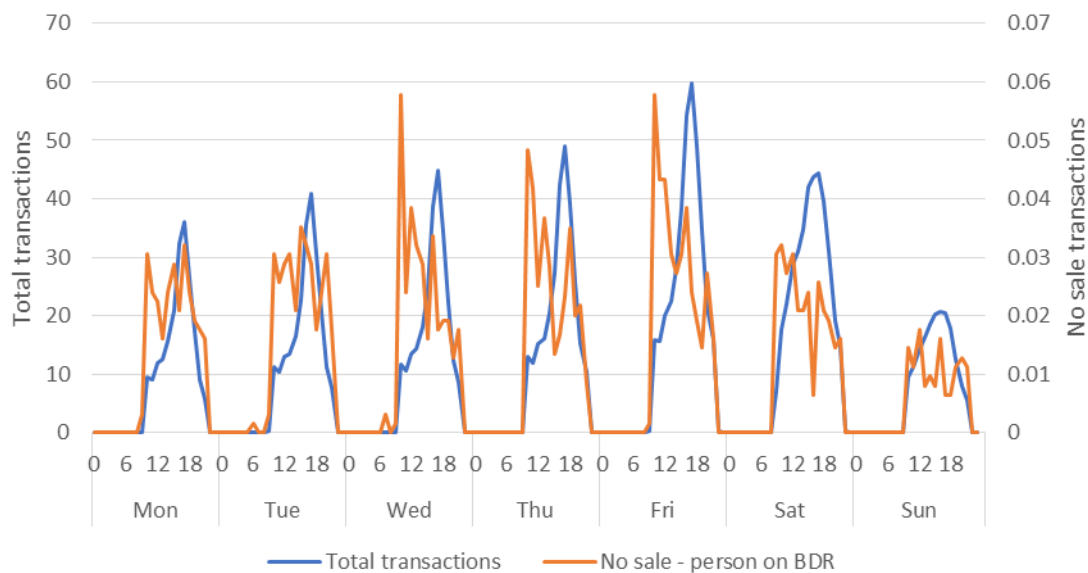
### 8.1 Appendix A - Appendices associated with the descriptive analysis

#### 8.1.1 Appendix 1: Regional Supporting Data

The following section provides charts showing patterns in regional alcohol transactions, as well as charts of regional alcohol-related data similar to those in Section 3.5.

##### 8.1.1.1 Darwin

*Figure 66. Average hourly transactions through the week, Darwin*



Note: the no-sale transactions are shown at 1,000 times their size relative to total transactions, so that patterns may be compared.

Figure 67. Monthly alcohol-related assault offences, Darwin, and 12-month rolling average

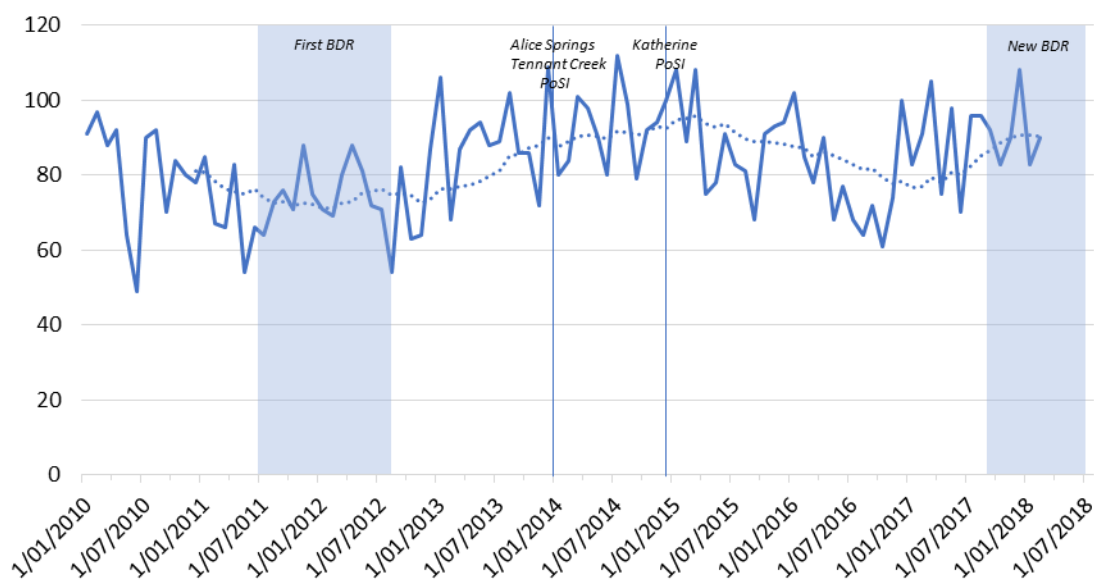


Figure 68. Monthly domestic violence assault offences by alcohol involvement, Darwin, and 12-month rolling averages

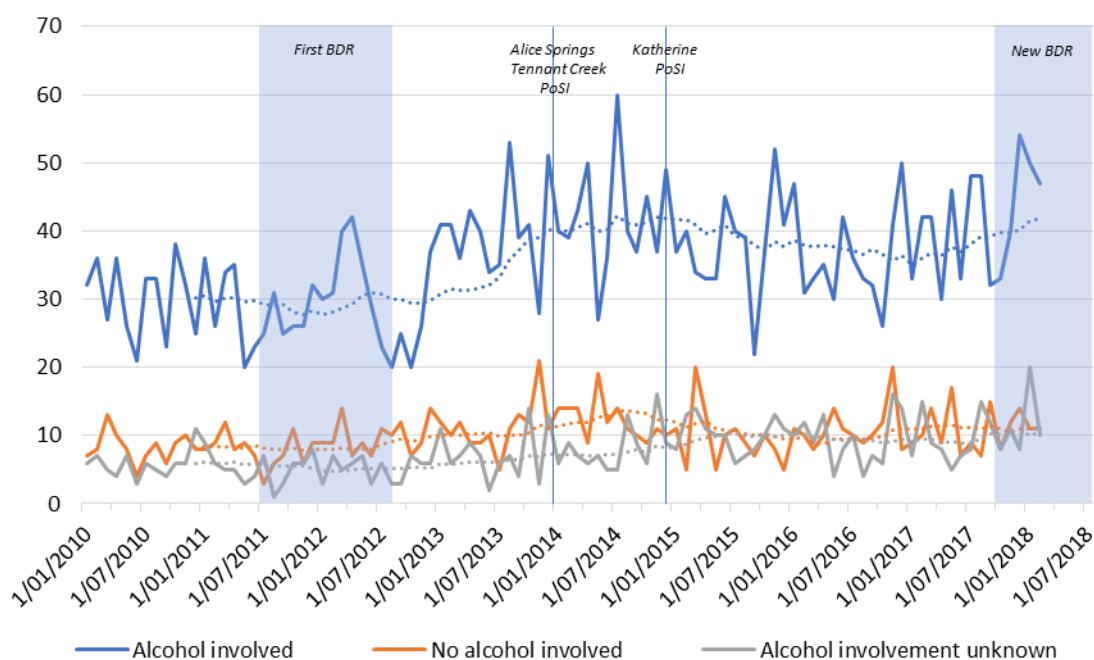


Figure 69. Monthly liquor consumption and licensing offences, Darwin, and 12-month rolling averages

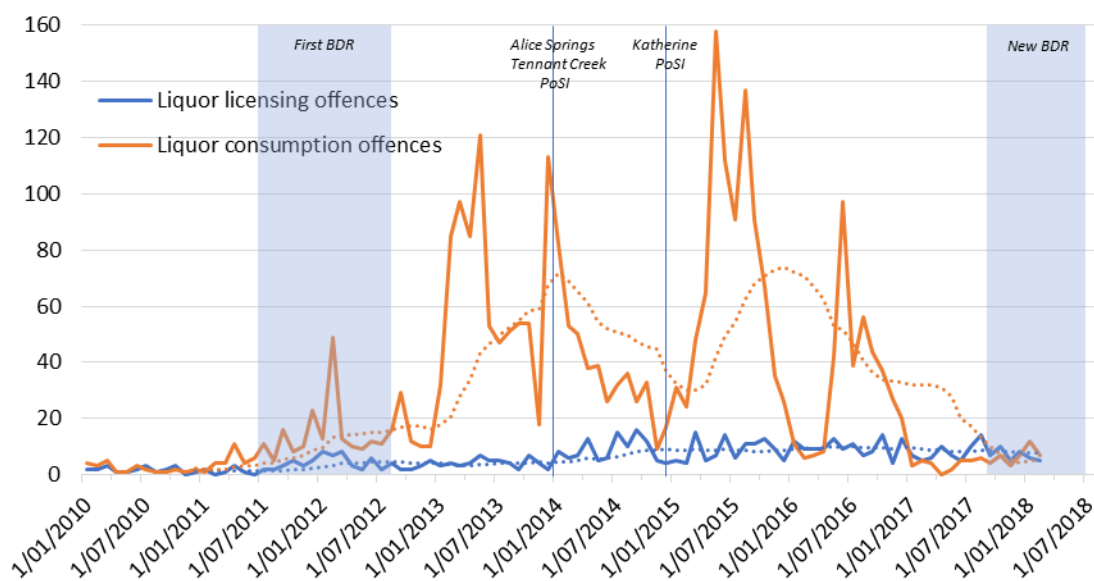


Figure 70. Monthly drink-driving offences, Darwin, and 12-month rolling average

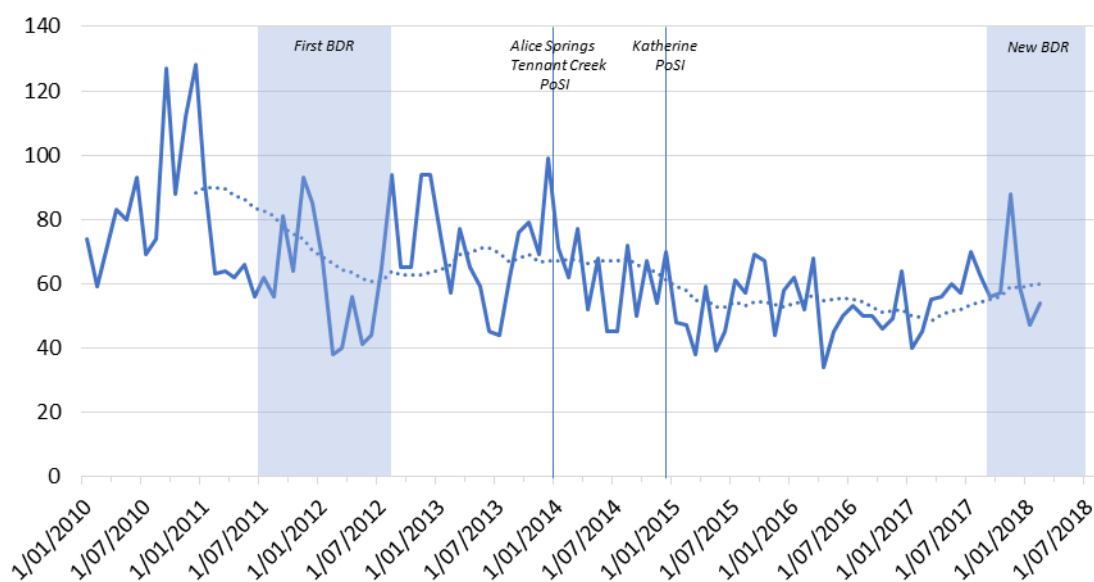


Figure 71. Drink-driving offences by type, Darwin, 12-month rolling averages

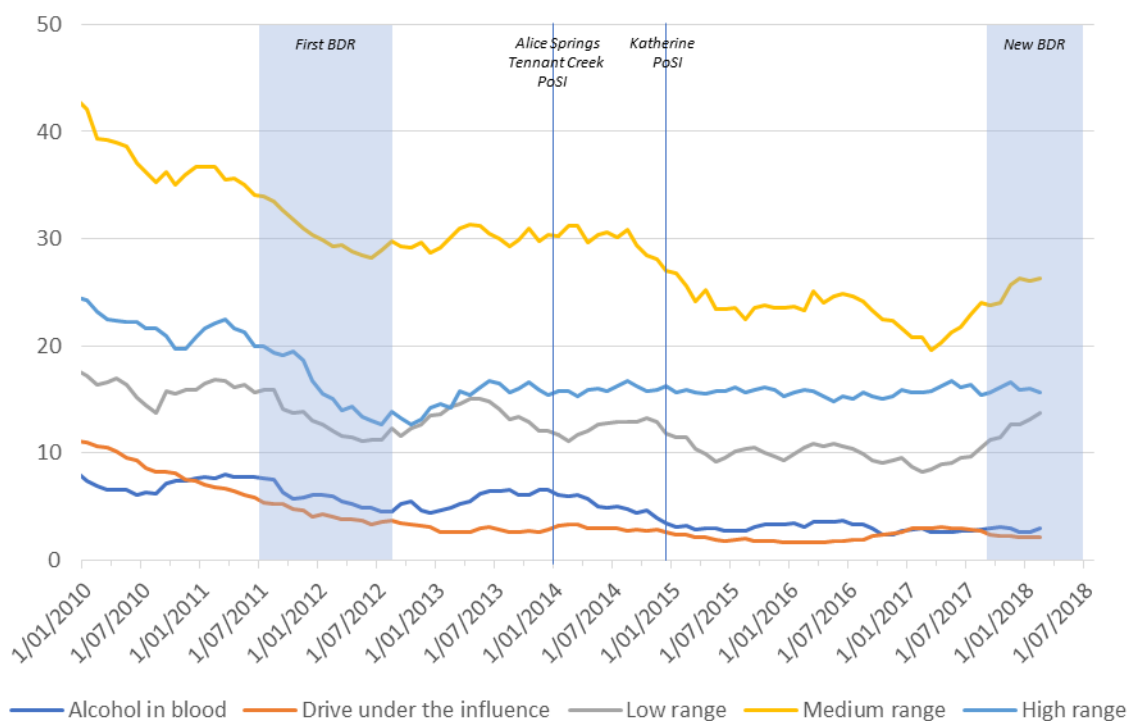


Figure 72. Monthly adult alcohol-related apprehensions, Darwin, and 12-month rolling average

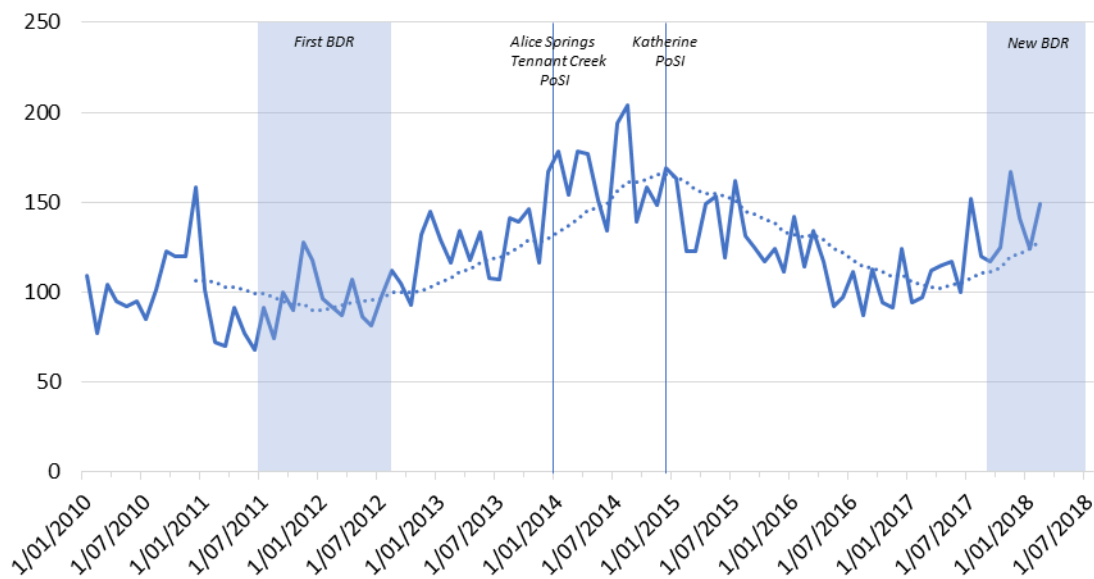
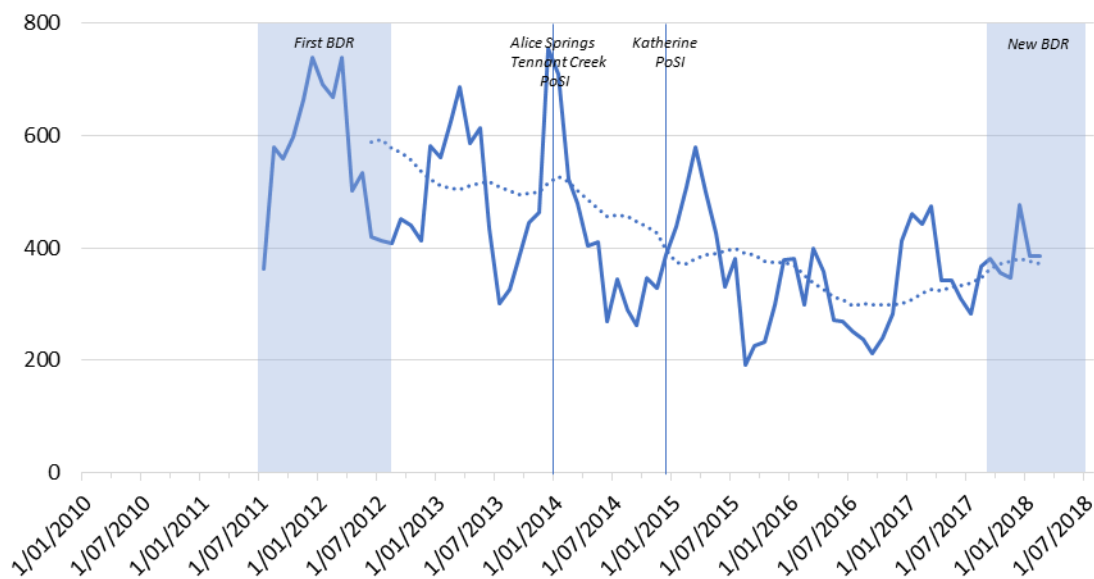
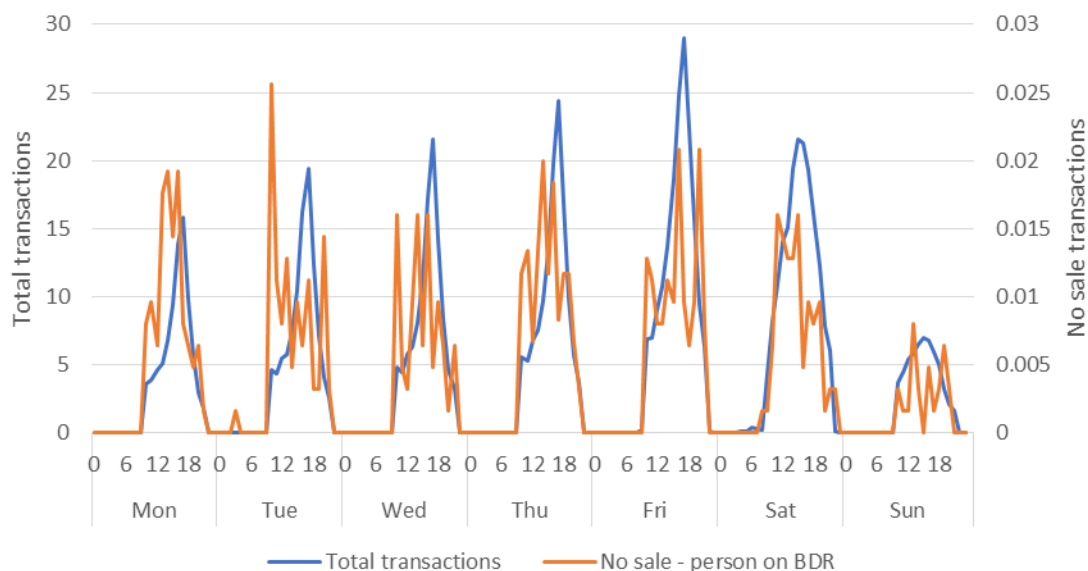


Figure 73. Monthly alcohol-related protective custody episodes, Darwin, and 12-month rolling average



### 8.1.1.2 Palmerston

Figure 74. Average hourly transactions through the week, Palmerston



Note: the no-sale transactions are shown at 1,000 times their size relative to total transactions, so that patterns may be compared.

Figure 75. Monthly alcohol-related assault offences, Palmerston, and 12-month rolling average

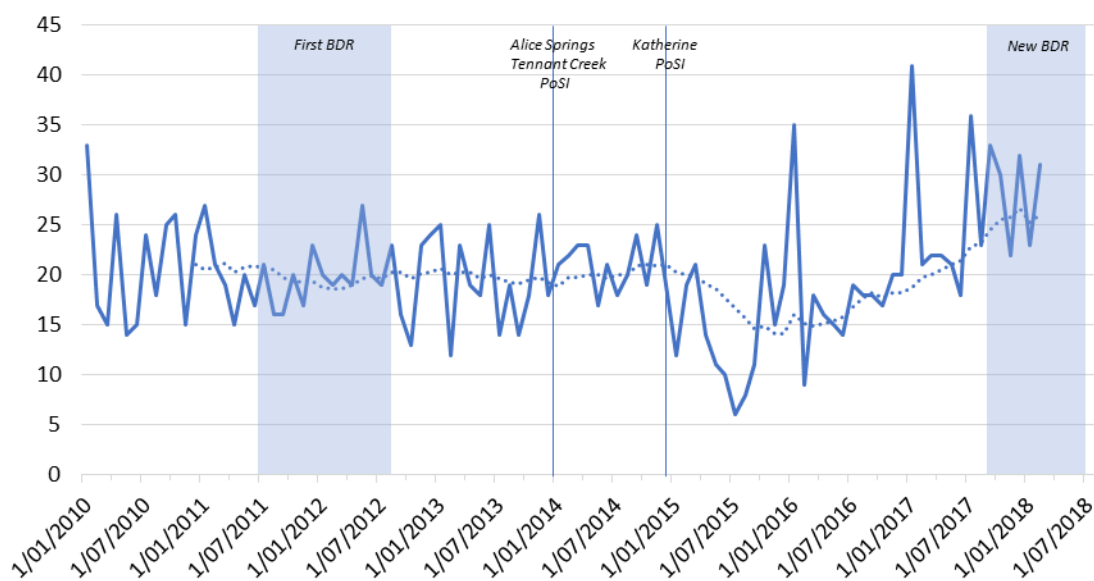


Figure 76. Monthly domestic violence assault offences by alcohol involvement, Palmerston, and 12-month rolling averages

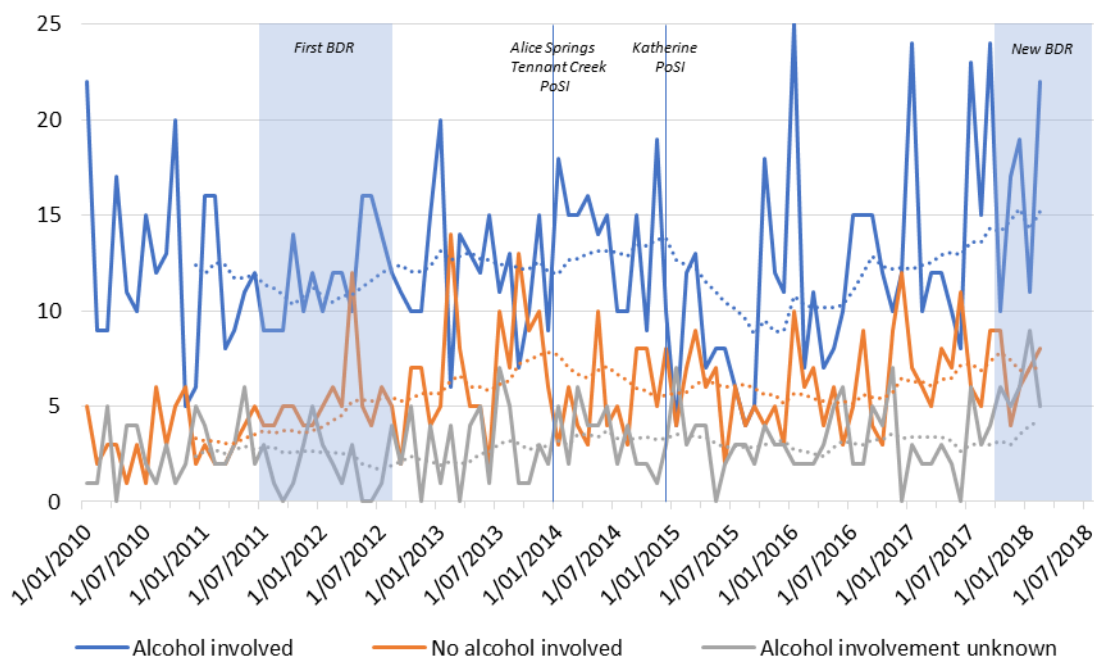




Figure 77. Monthly liquor consumption and licensing offences, Palmerston, and 12-month rolling averages

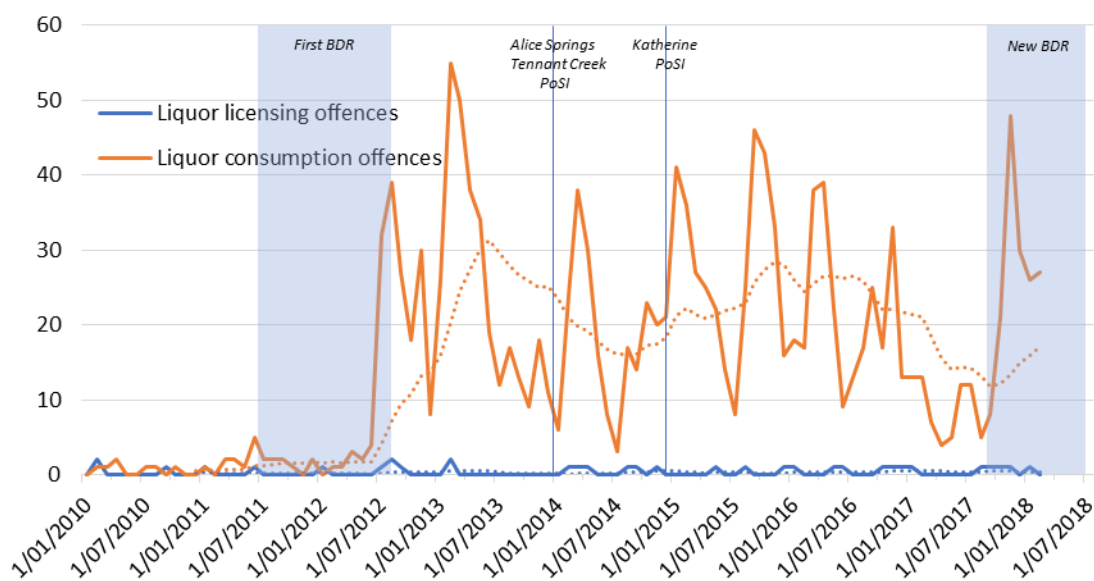


Figure 78. Monthly drink-driving offences, Palmerston, and 12-month rolling average

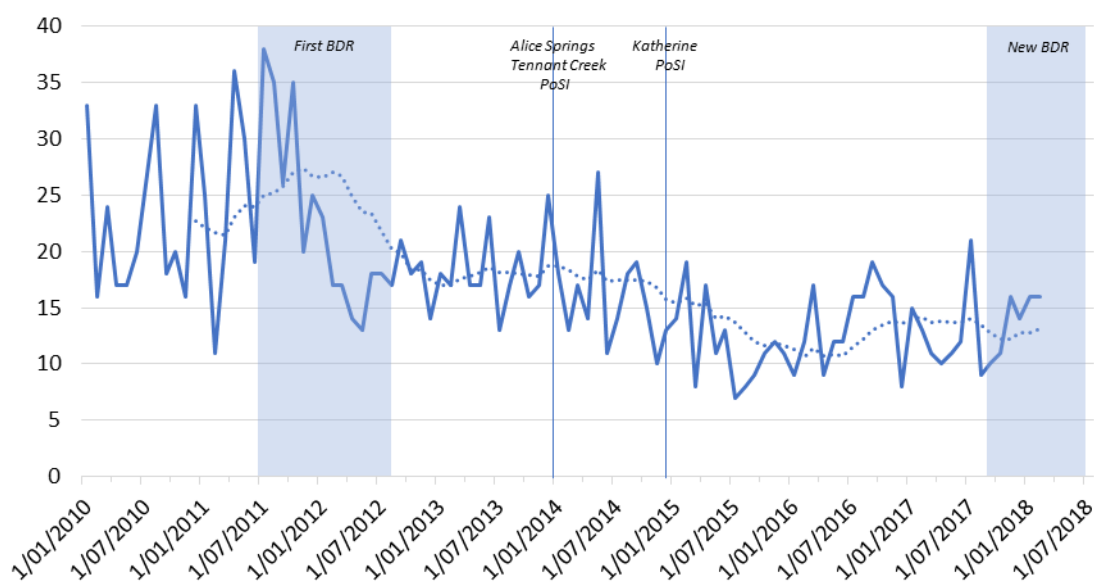


Figure 79. Drink-driving offences by type, Palmerston, 12-month rolling averages

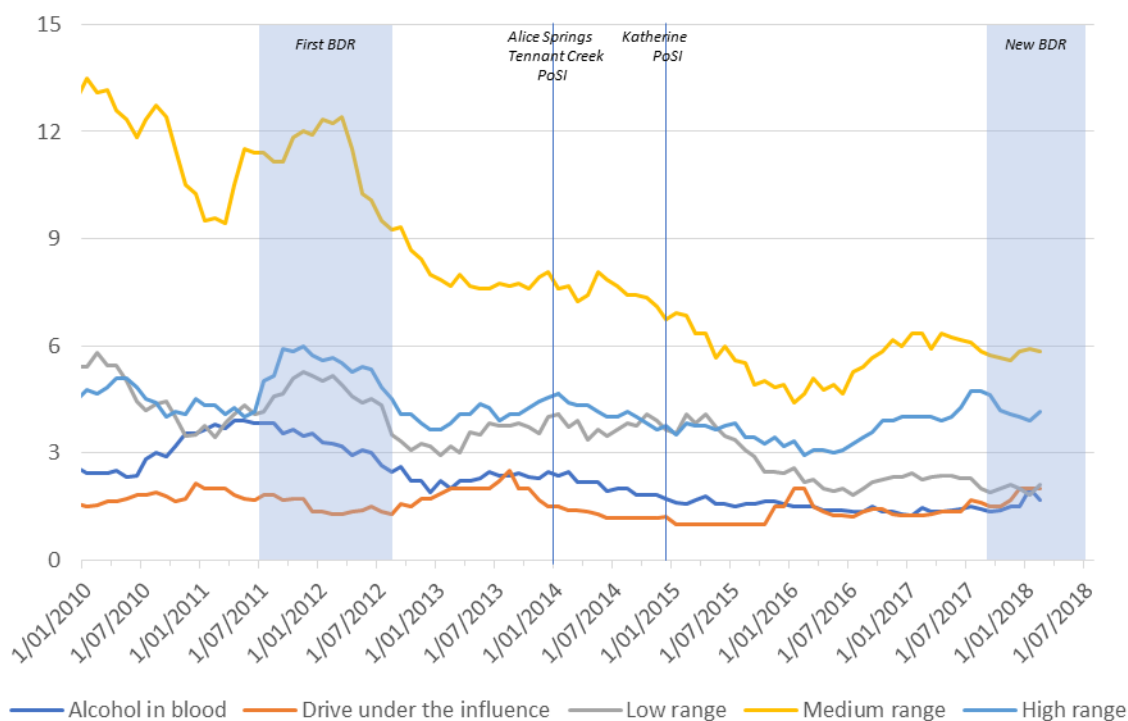


Figure 80. Monthly adult alcohol-related apprehensions, Palmerston, and 12-month rolling average

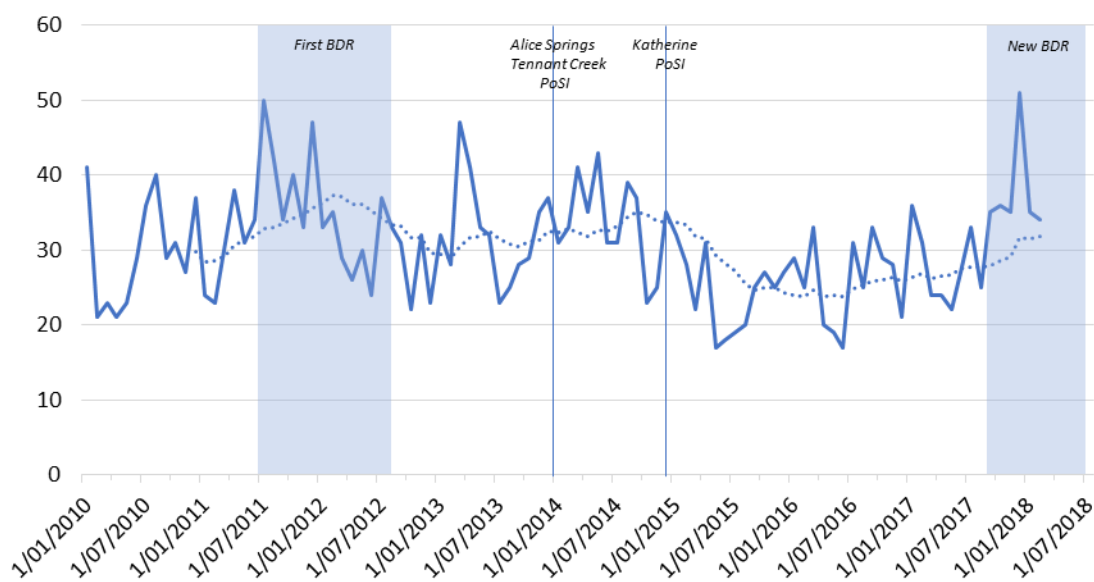
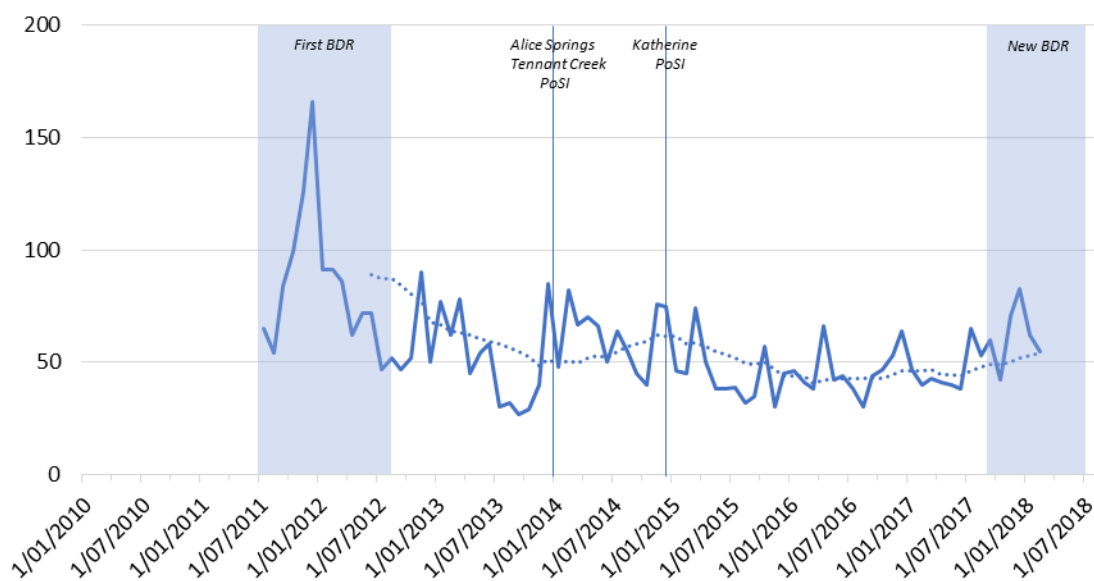
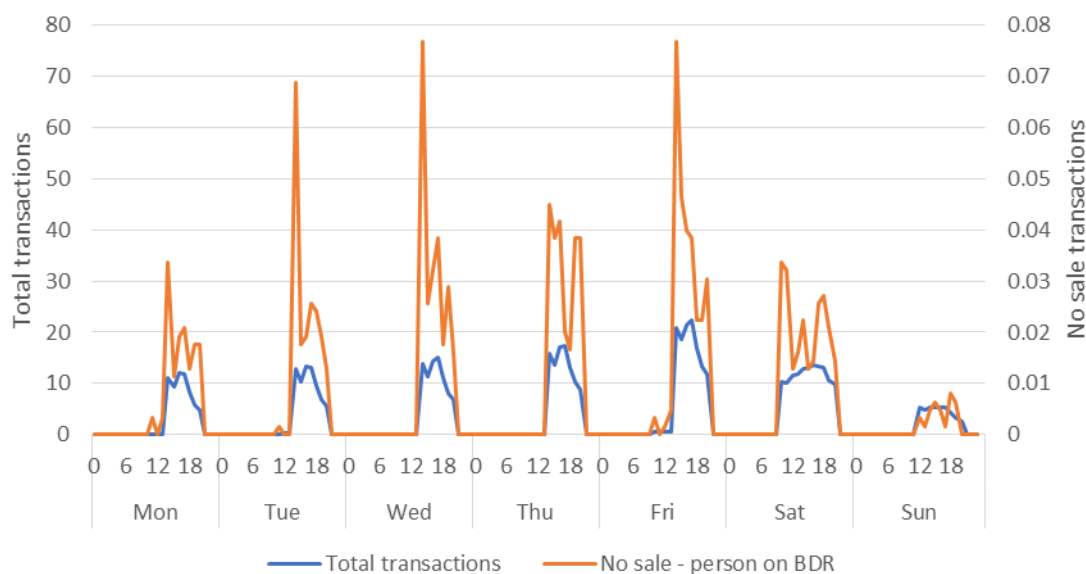


Figure 81. Monthly alcohol-related protective custody episodes, Palmerston, and 12-month rolling average



### 8.1.1.3 Alice Springs

Figure 82. Average hourly transactions by hour of day and day of week, Alice Springs



Note: the no-sale transactions are shown at 1,000 times their size relative to total transactions, so that patterns may be compared.

Figure 83. Monthly alcohol-related assault offences, Alice Springs, and 12-month rolling average

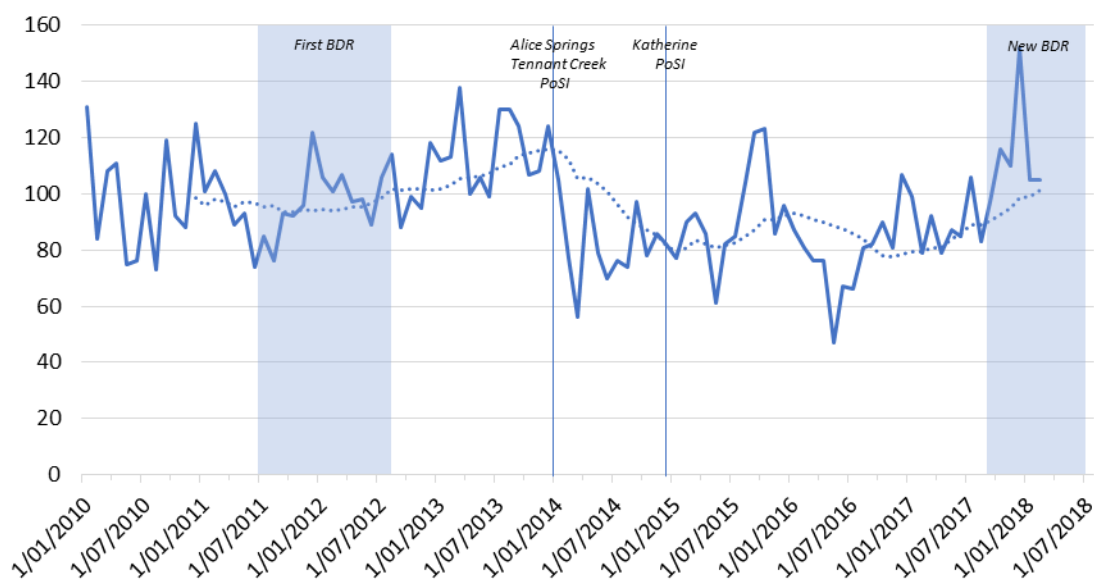


Figure 84. Monthly domestic violence assault offences by alcohol involvement, Alice Springs, and 12-month rolling averages

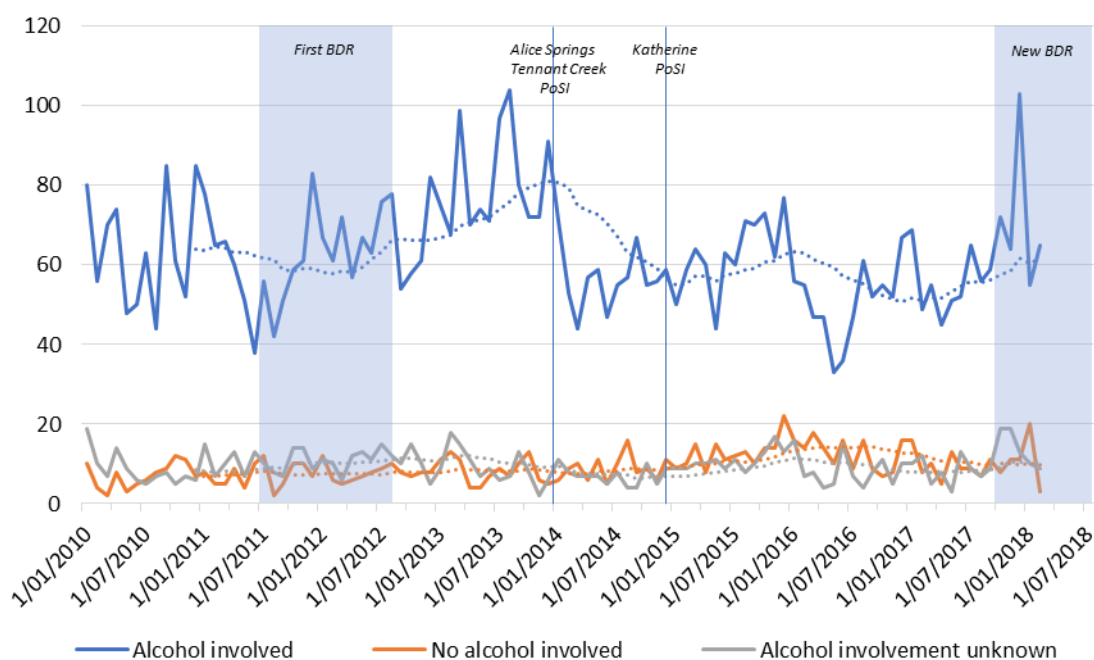


Figure 85. Monthly liquor consumption and licensing offences, Alice Springs, and 12-month rolling averages

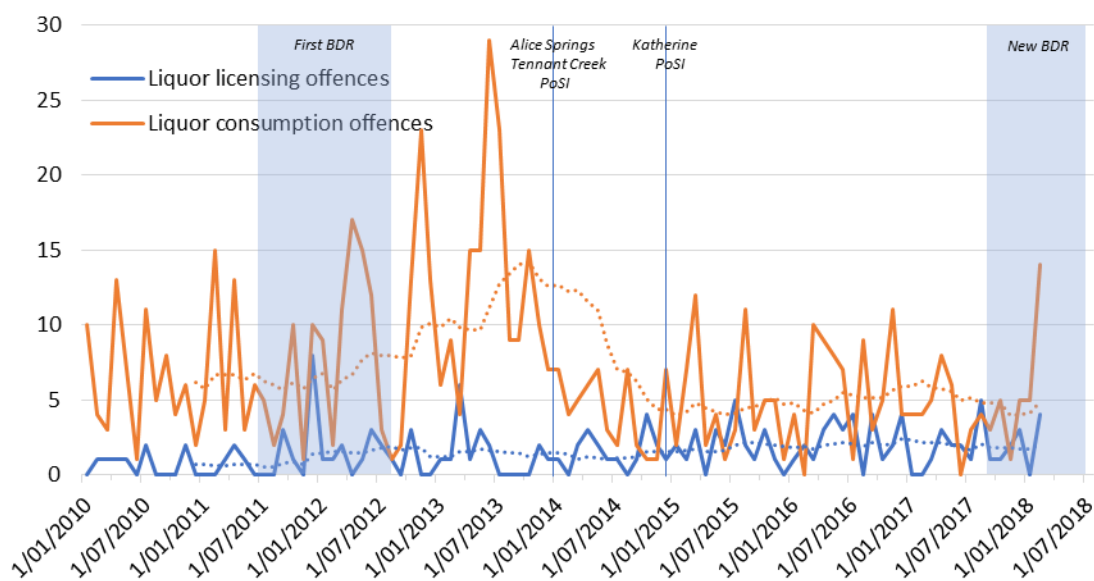


Figure 86. Monthly drink-driving offences, Alice Springs, and 12-month rolling average

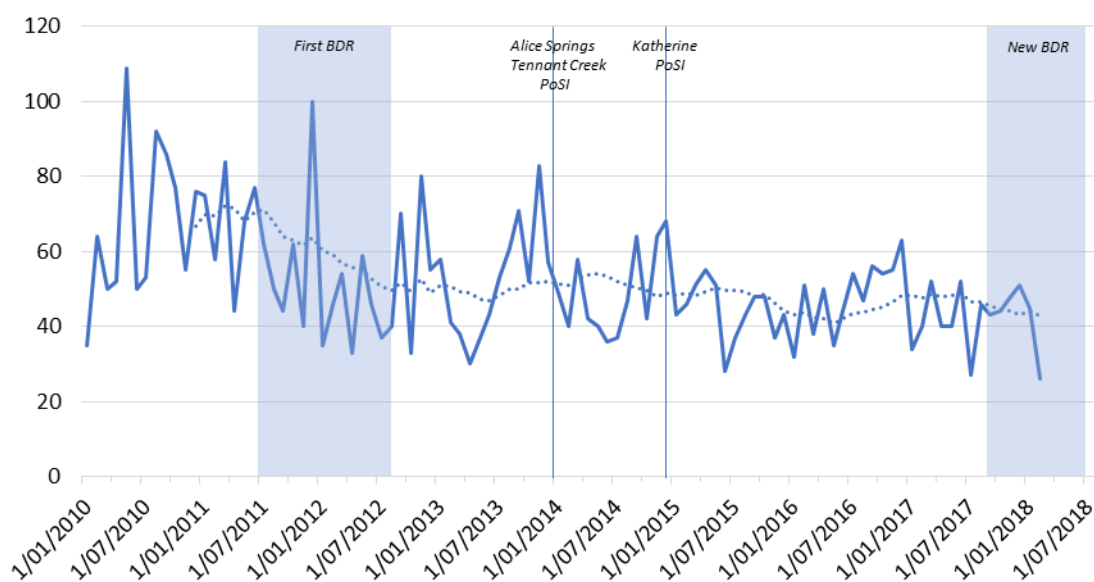


Figure 87. Drink-driving offences by type, Alice Springs, 12-month rolling averages

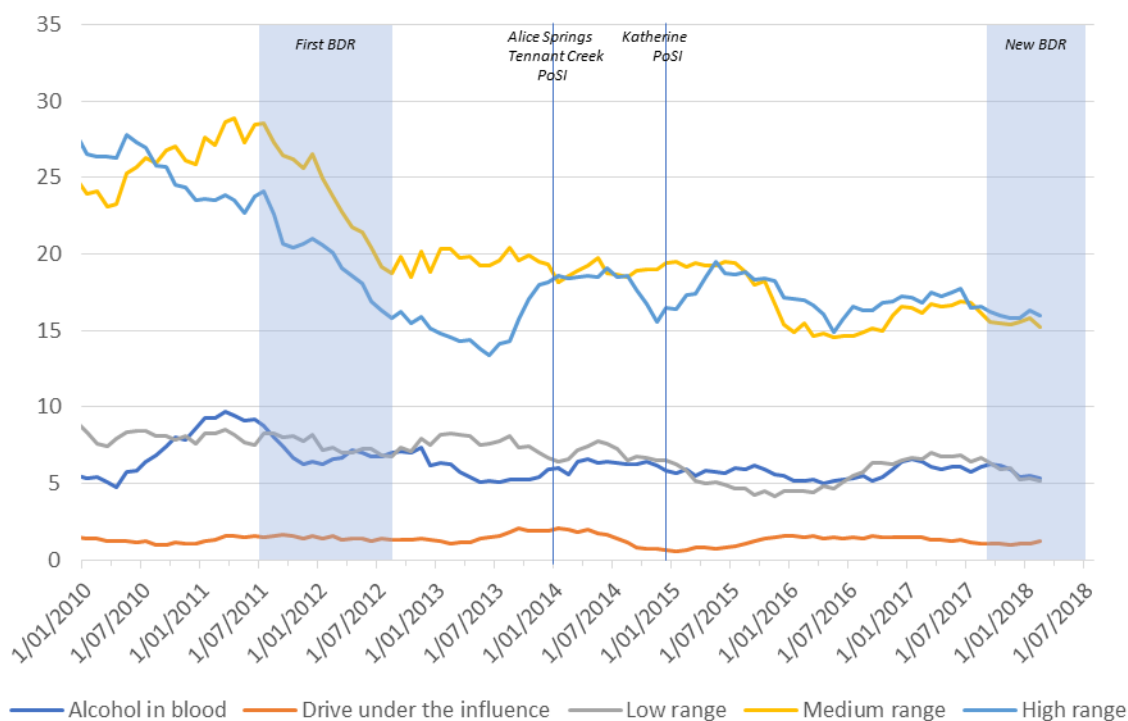


Figure 88. Monthly adult alcohol-related apprehensions, Alice Springs, and 12-month rolling average

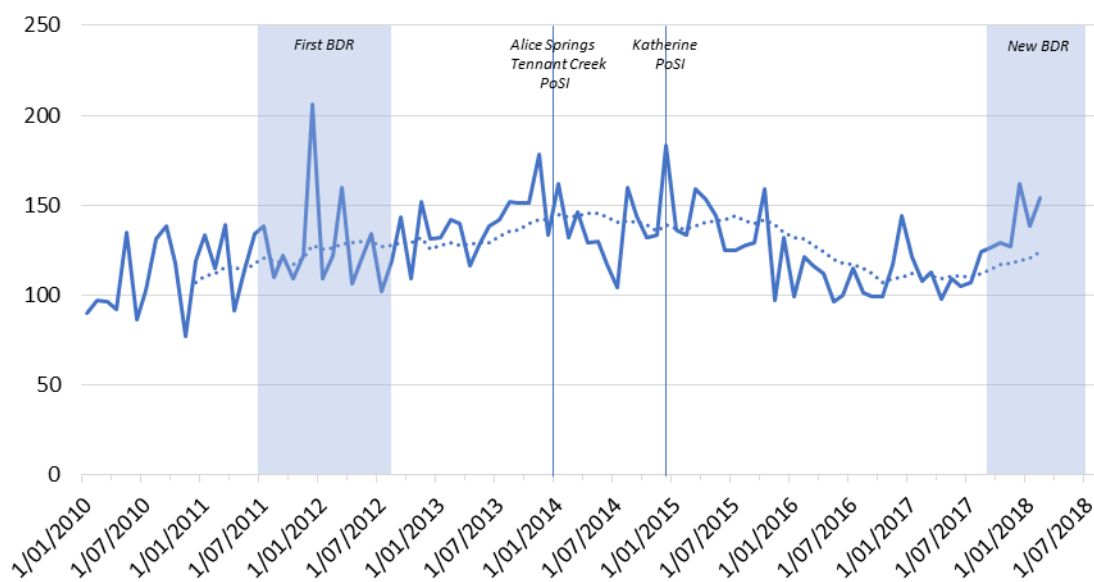
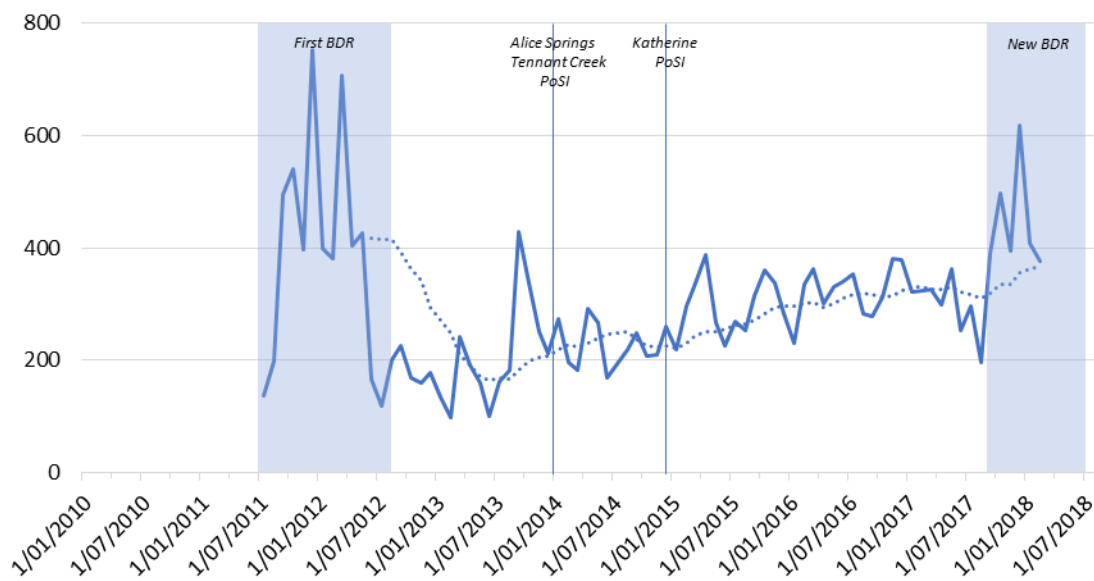
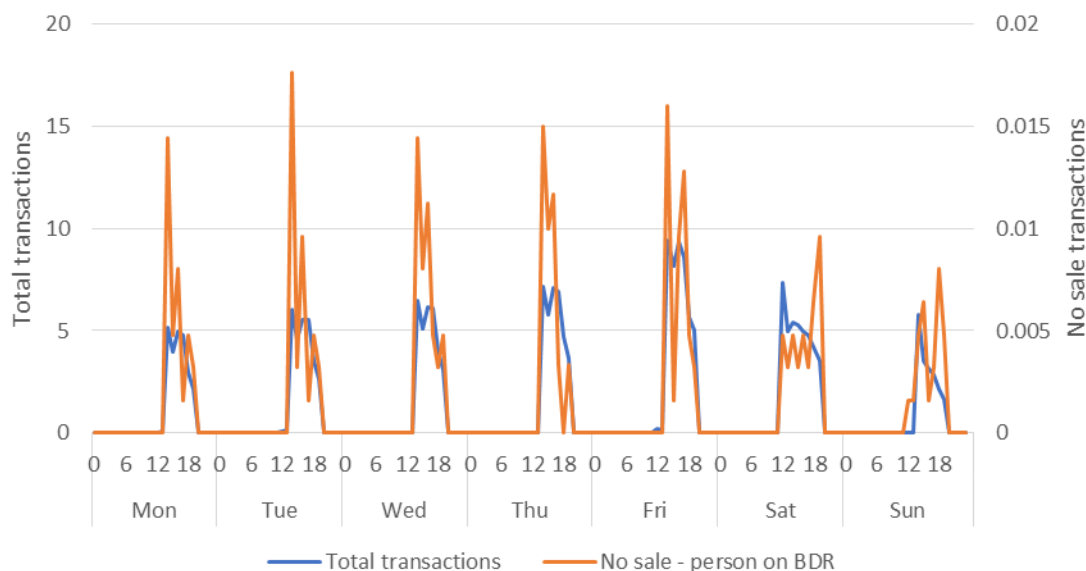


Figure 89. Monthly alcohol-related protective custody episodes, Alice Springs, and 12-month rolling average



#### 8.1.1.4 Katherine

Figure 90. Average hourly transactions by hour of day and day of week, Katherine



Note: the no-sale transactions are shown at 1,000 times their size relative to total transactions, so that patterns may be compared.

Figure 91. Monthly alcohol-related assault offences, Katherine, and 12-month rolling average

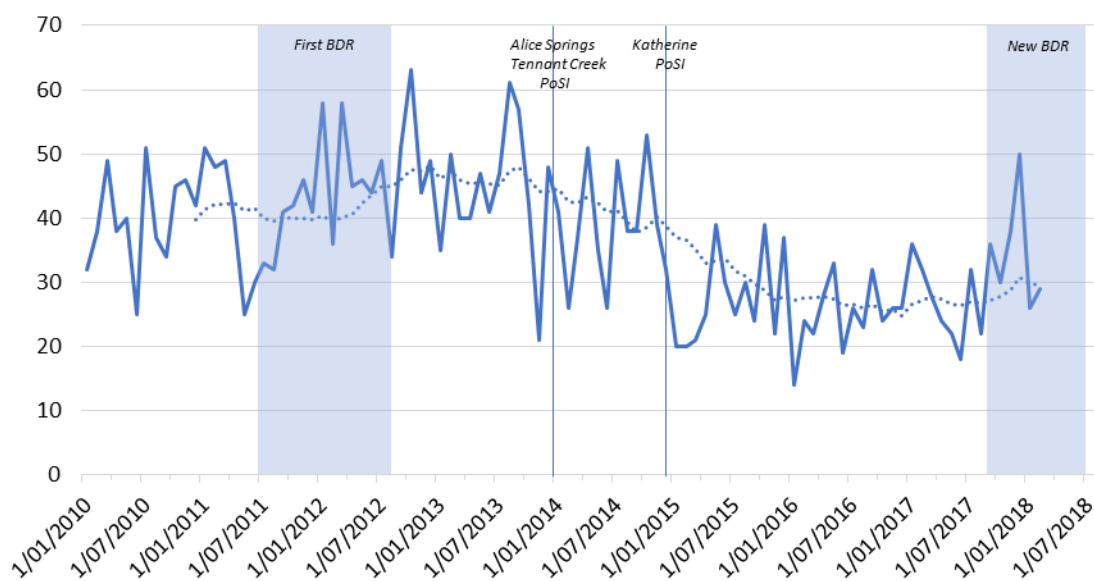


Figure 92. Monthly domestic violence assault offences by alcohol involvement, Katherine, and 12-month rolling averages

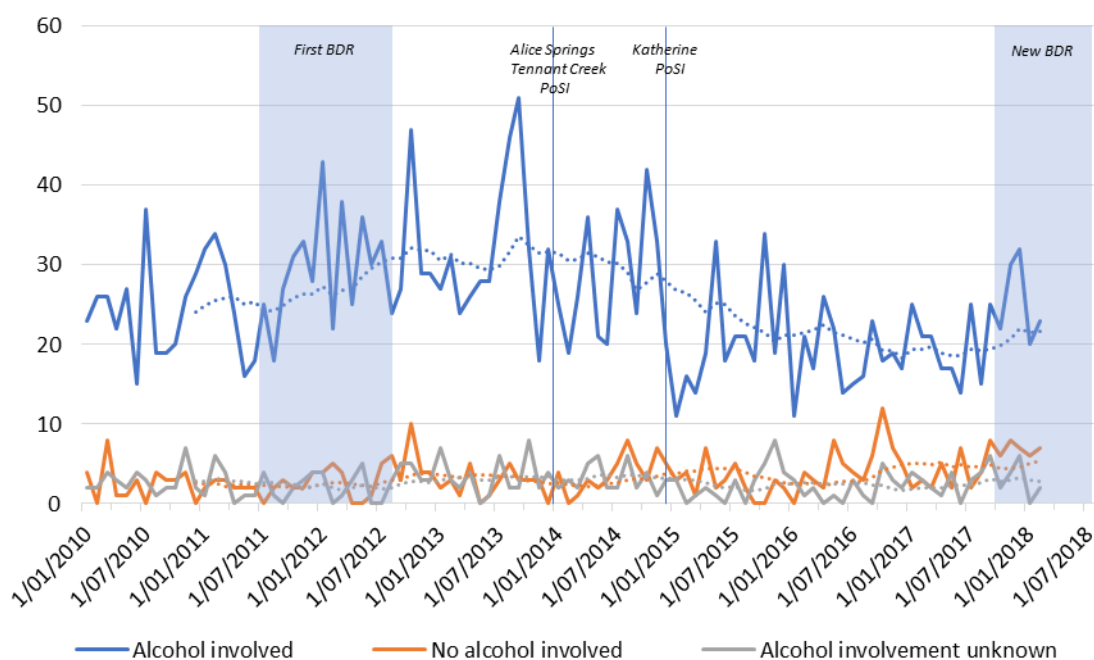




Figure 93. Monthly liquor consumption and licensing offences, Katherine, and 12-month rolling averages

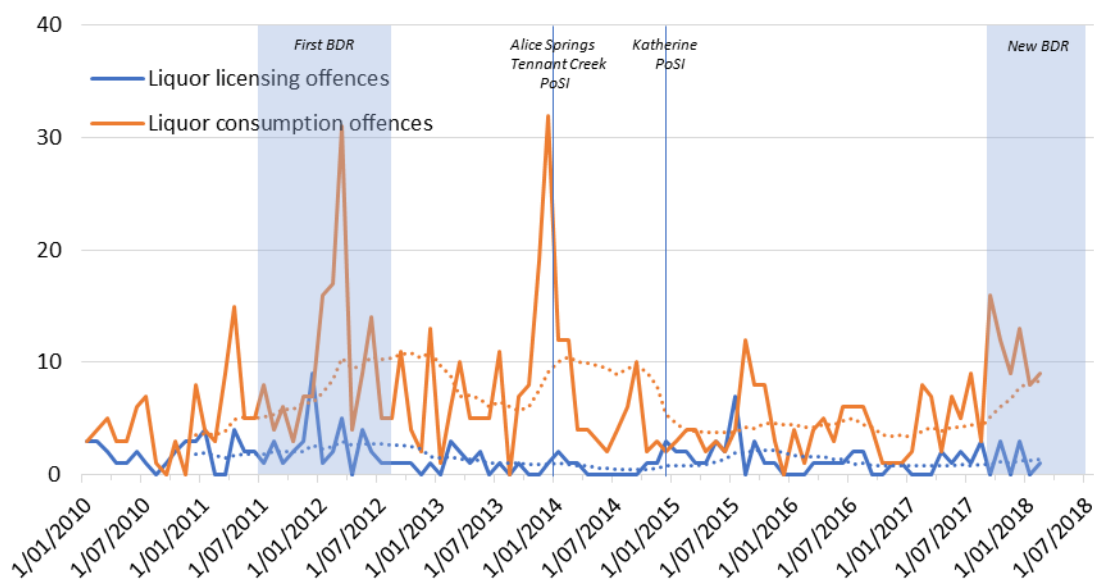


Figure 94. Monthly drink-driving offences, Katherine, and 12-month rolling average

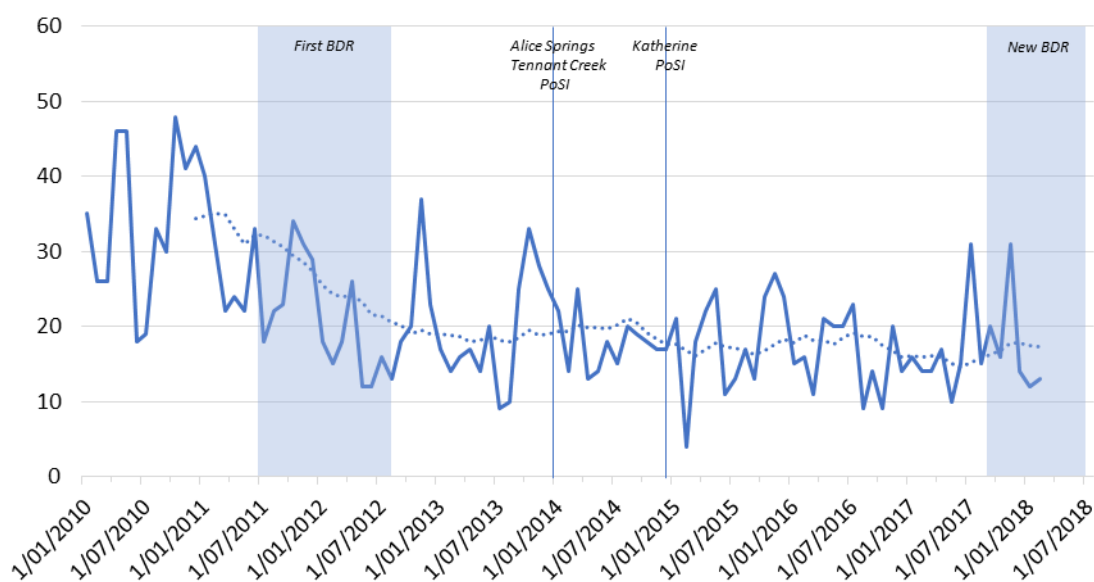


Figure 95. Drink-driving offences by type, Katherine, 12-month rolling averages

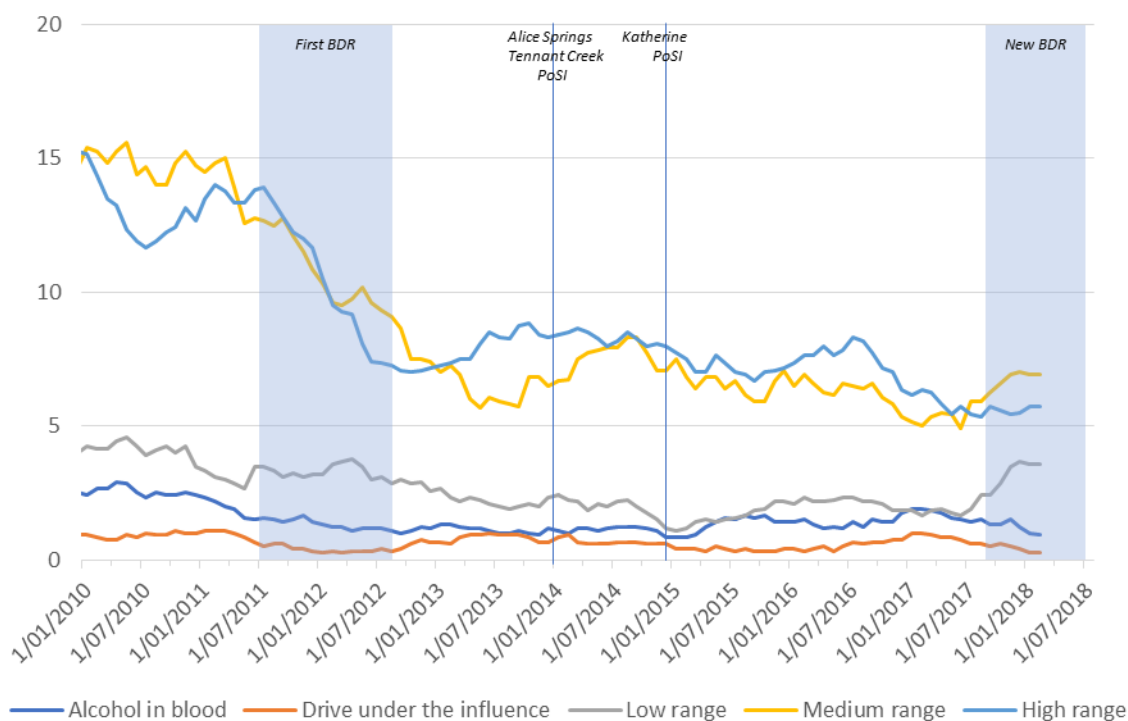


Figure 96. Monthly adult alcohol-related apprehensions, Katherine, and 12-month rolling average

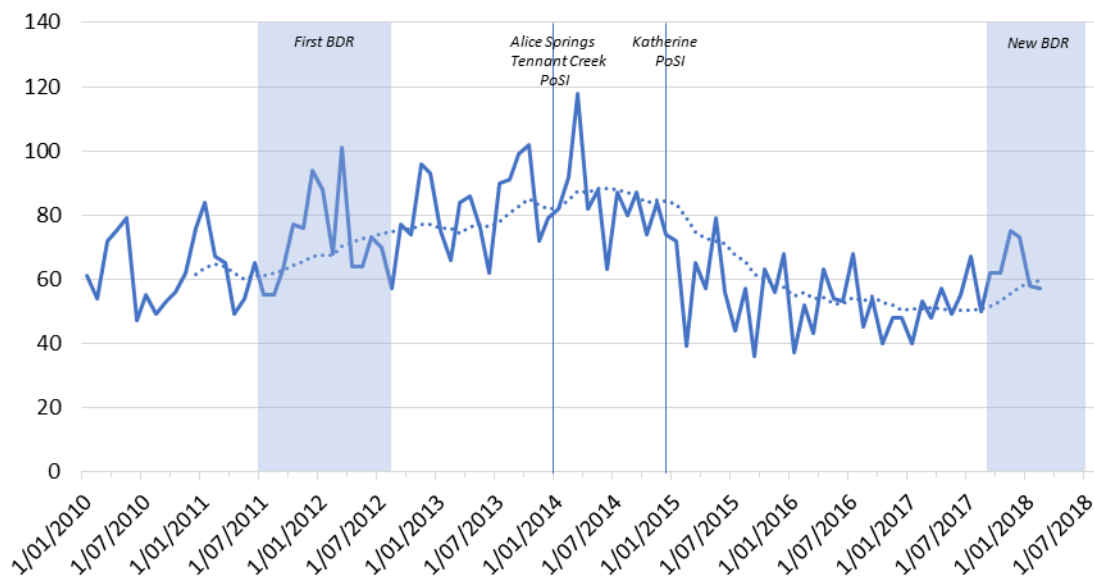
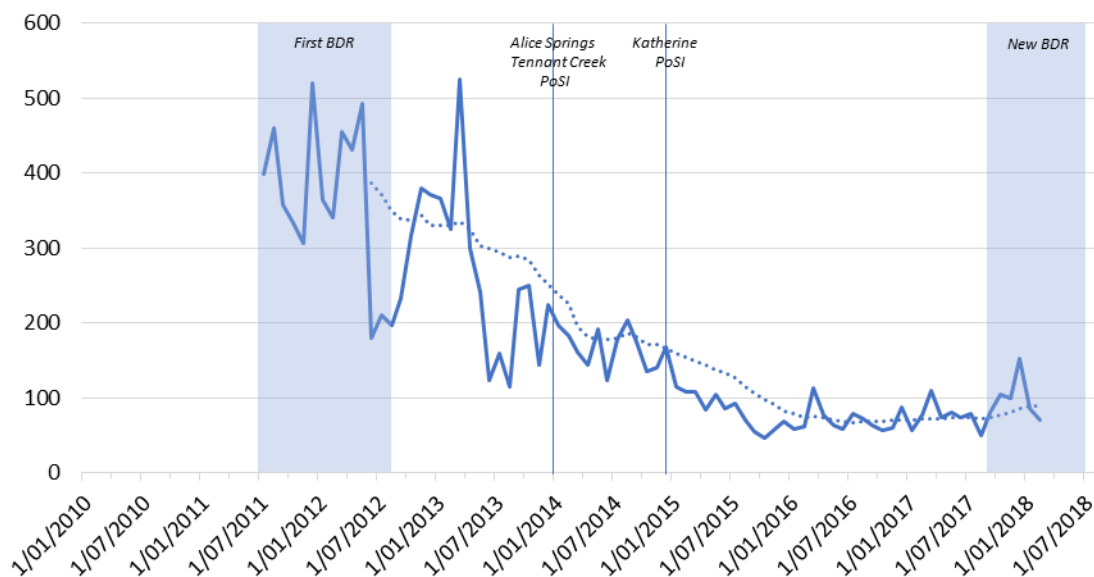
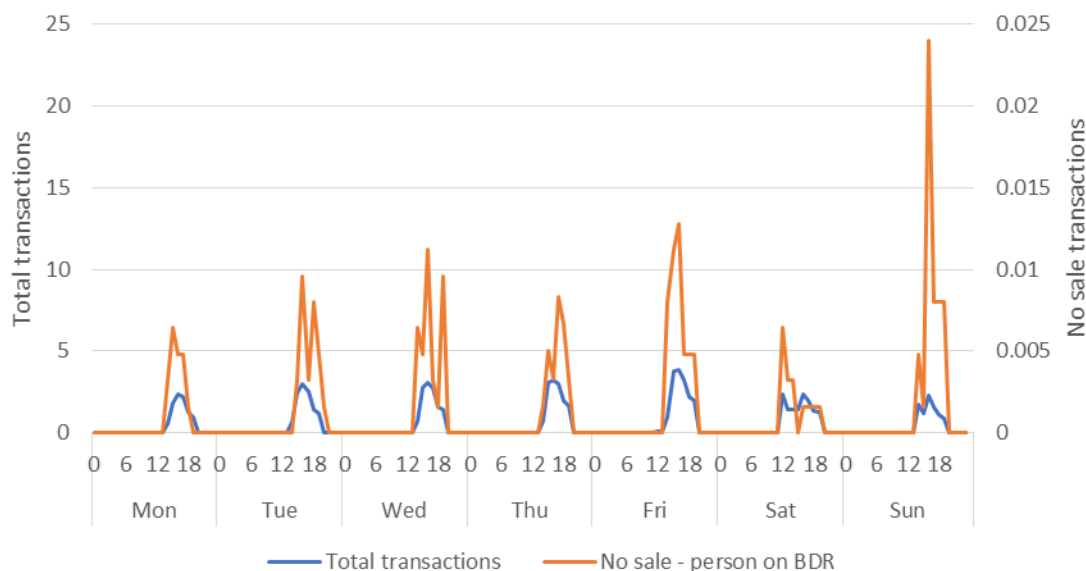


Figure 97. Monthly alcohol-related protective custody episodes, Katherine, and 12-month rolling average



#### 8.1.1.5 Tennant Creek

Figure 98. Average hourly transactions by hour of day and day of week, Tennant Creek



Note: the no-sale transactions are shown at 1,000 times their size relative to total transactions, so that patterns may be compared.

Figure 99. Monthly alcohol-related assault offences, Tennant Creek, and 12-month rolling average

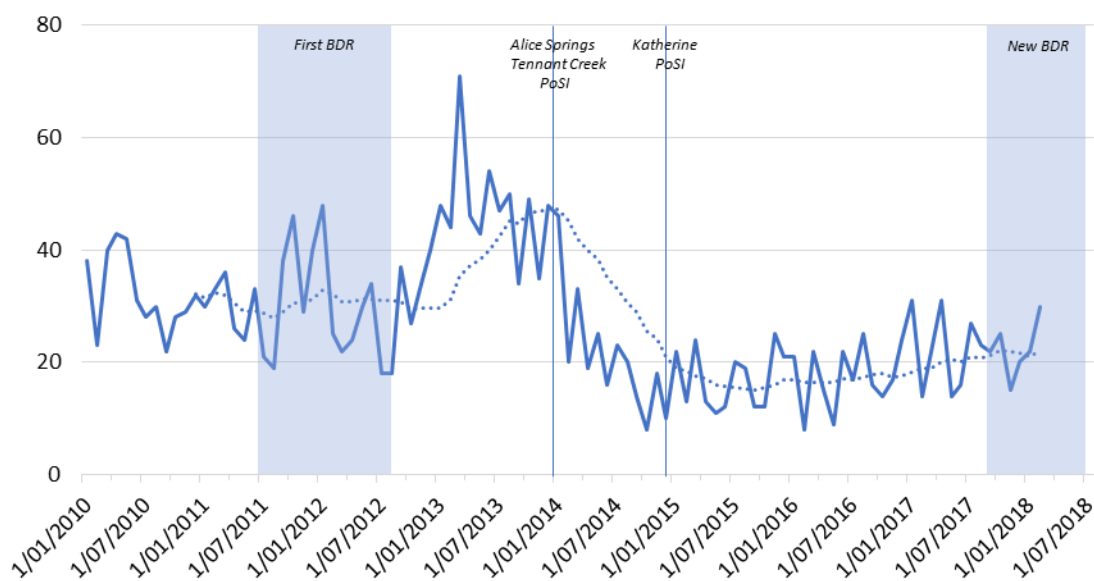


Figure 100. Monthly domestic violence assault offences by alcohol involvement, Tennant Creek, and 12-month rolling averages

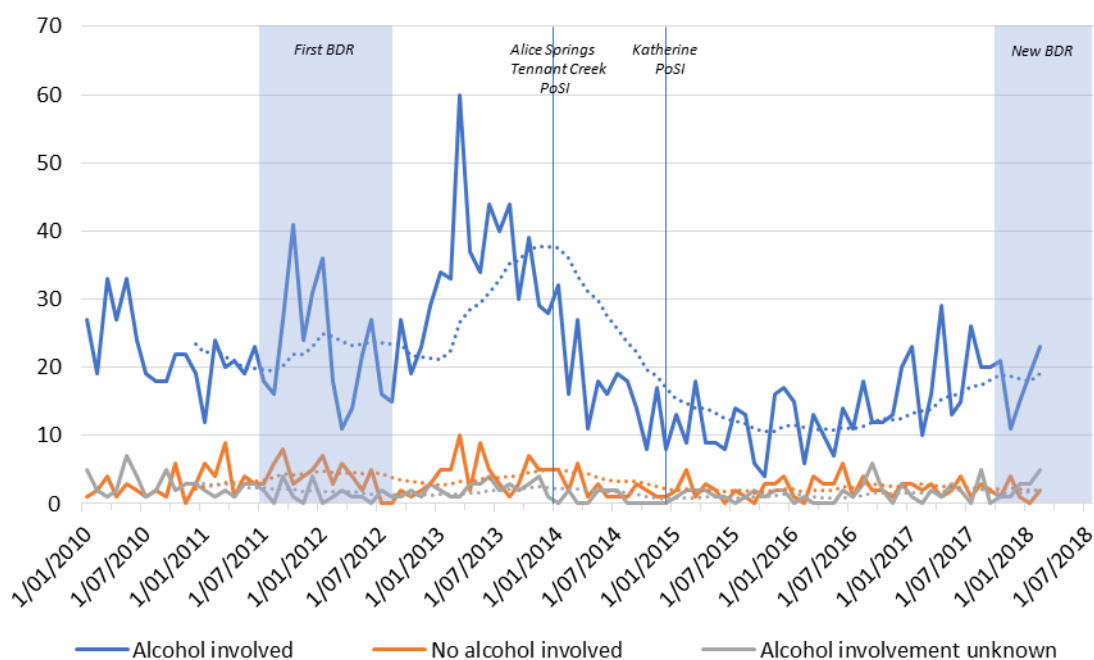


Figure 101. Monthly liquor consumption and licensing offences, Tennant Creek, and 12-month rolling averages

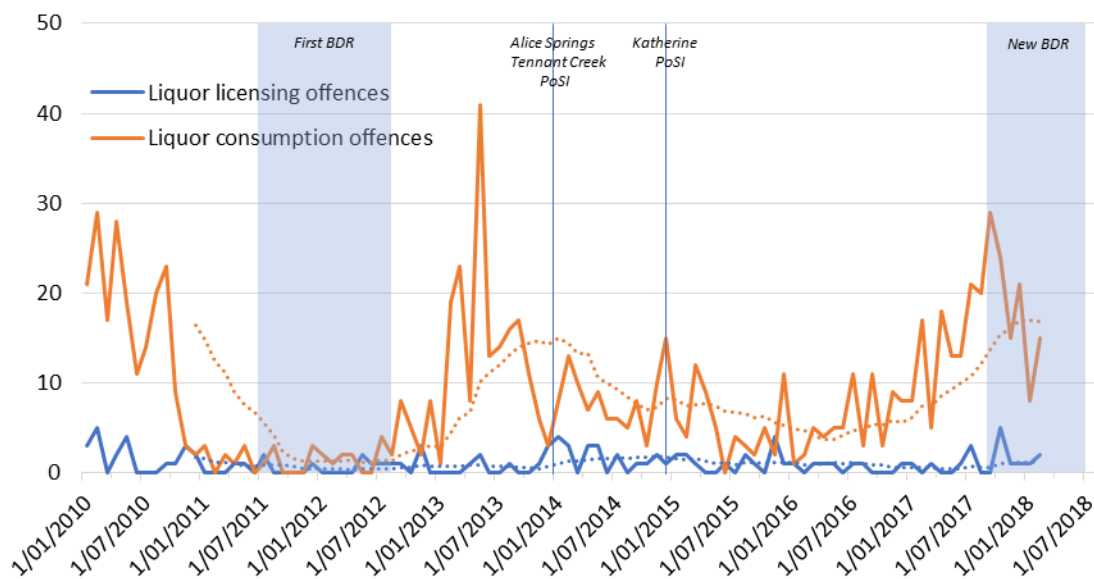


Figure 102. Monthly drink-driving offences, Tennant Creek, and 12-month rolling average

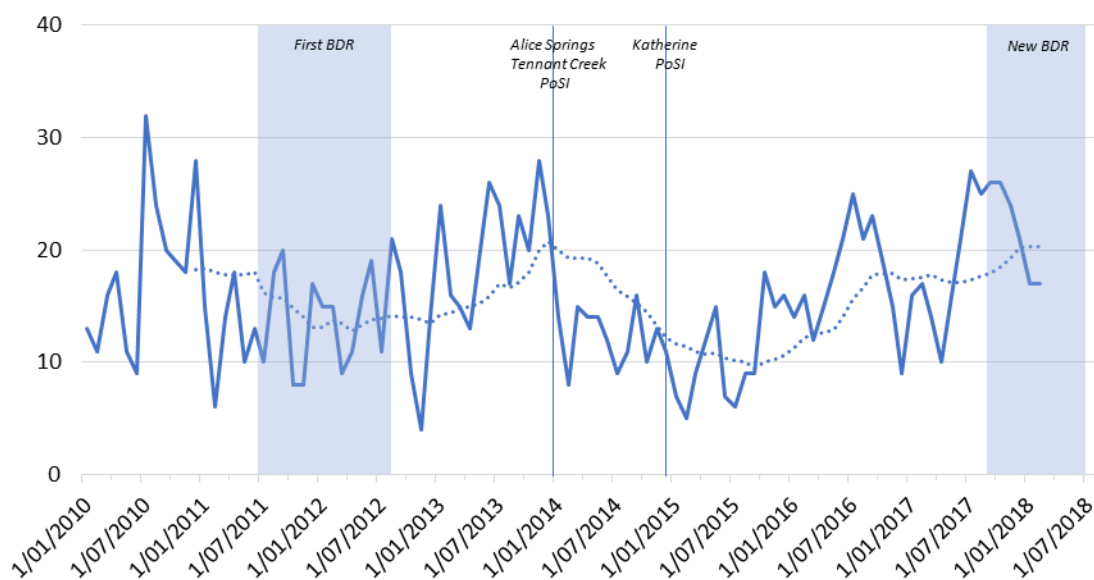


Figure 103. Drink-driving offences by type, Tennant Creek, 12-month rolling averages

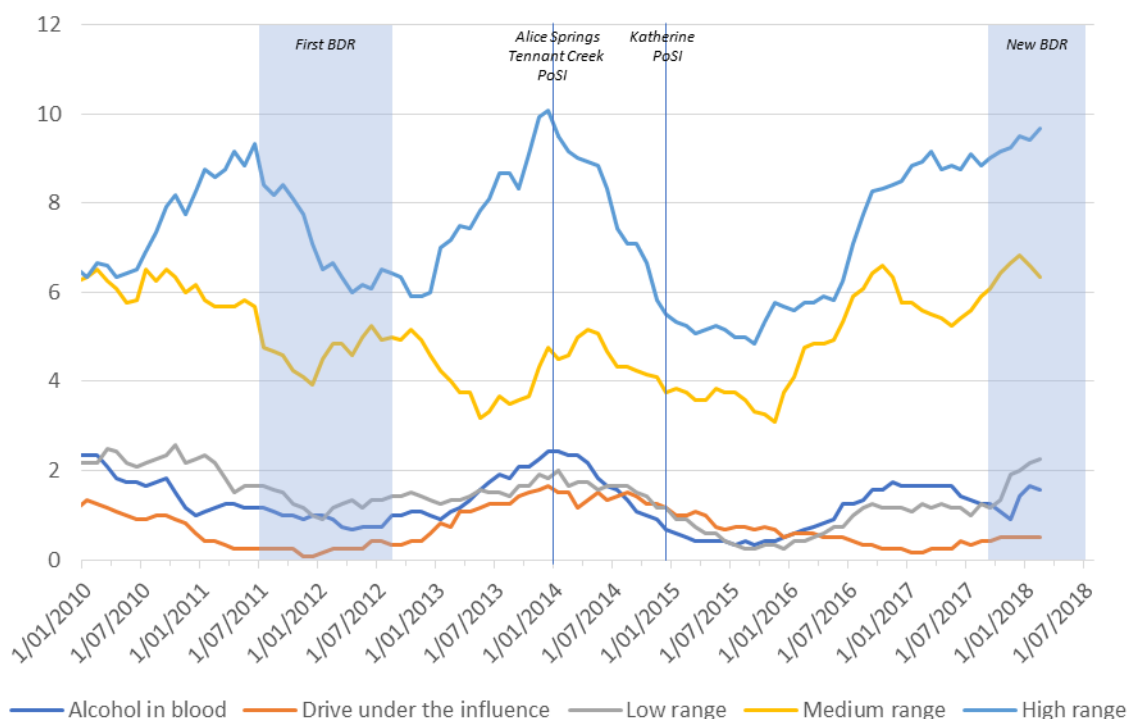


Figure 104. Monthly adult alcohol-related apprehensions, Tennant Creek, and 12-month rolling average

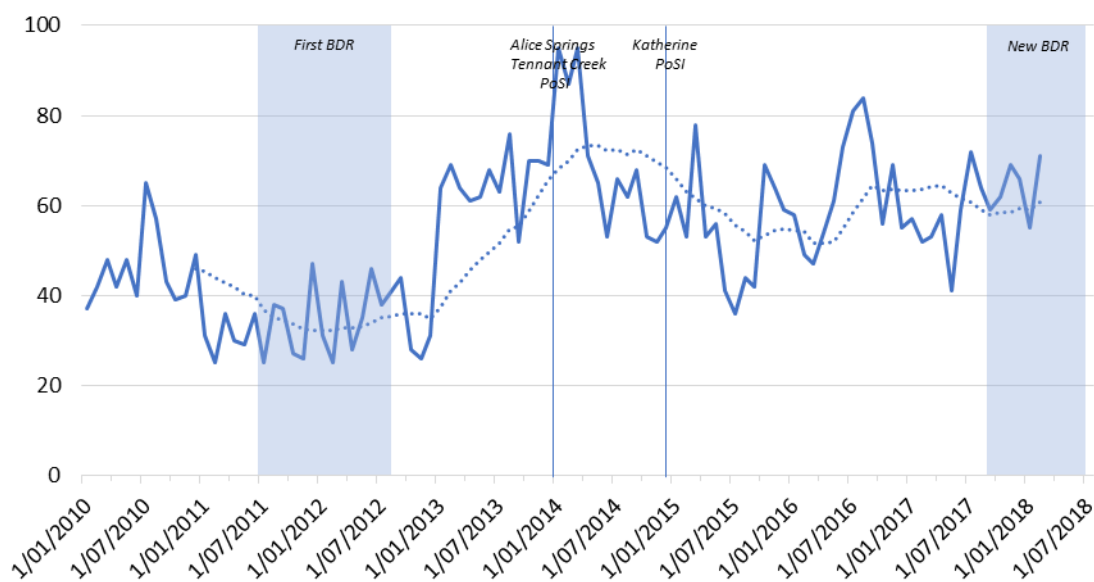
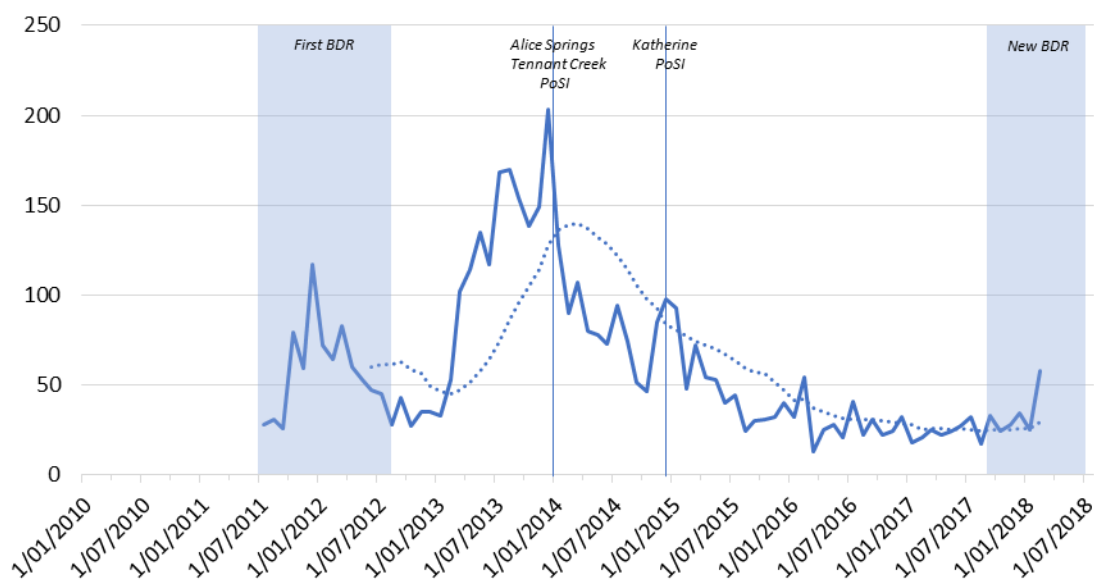


Figure 105. Monthly alcohol-related protective custody episodes, Tennant Creek, and 12-month rolling average



#### 8.1.1.6 Nhulunbuy

Figure 106. Monthly alcohol-related assault offences, Nhulunbuy, and 12-month rolling average

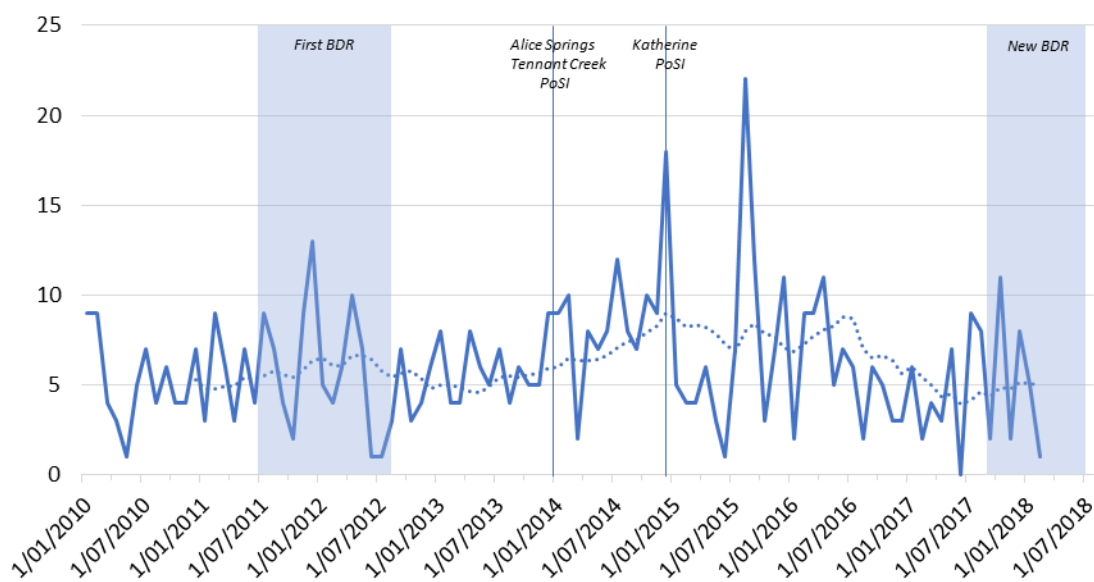


Figure 107. Monthly domestic violence assault offences by alcohol involvement, Nhulunbuy, and 12-month rolling averages

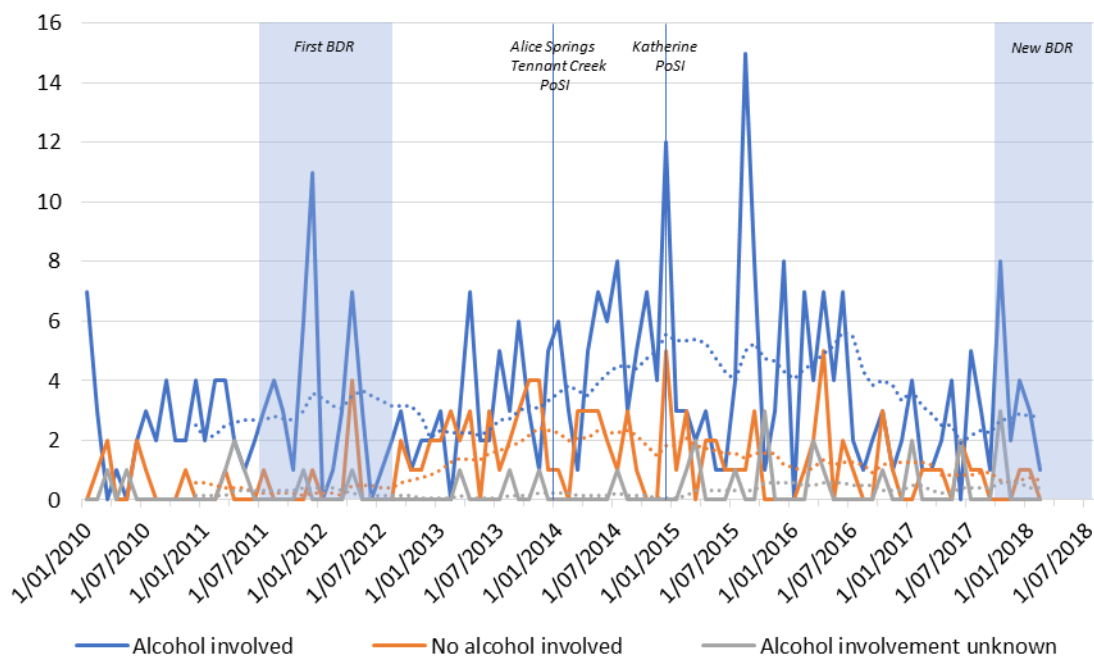


Figure 108. Monthly liquor consumption and licensing offences, Nhulunbuy, and 12-month rolling averages

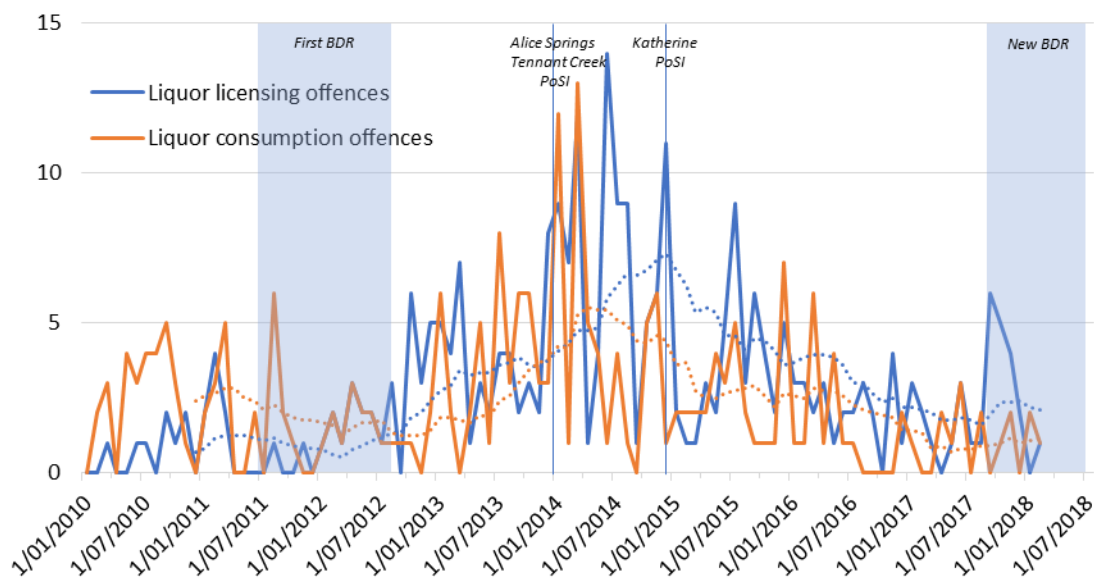




Figure 109. Monthly drink-driving offences, Nhulunbuy, and 12-month rolling average

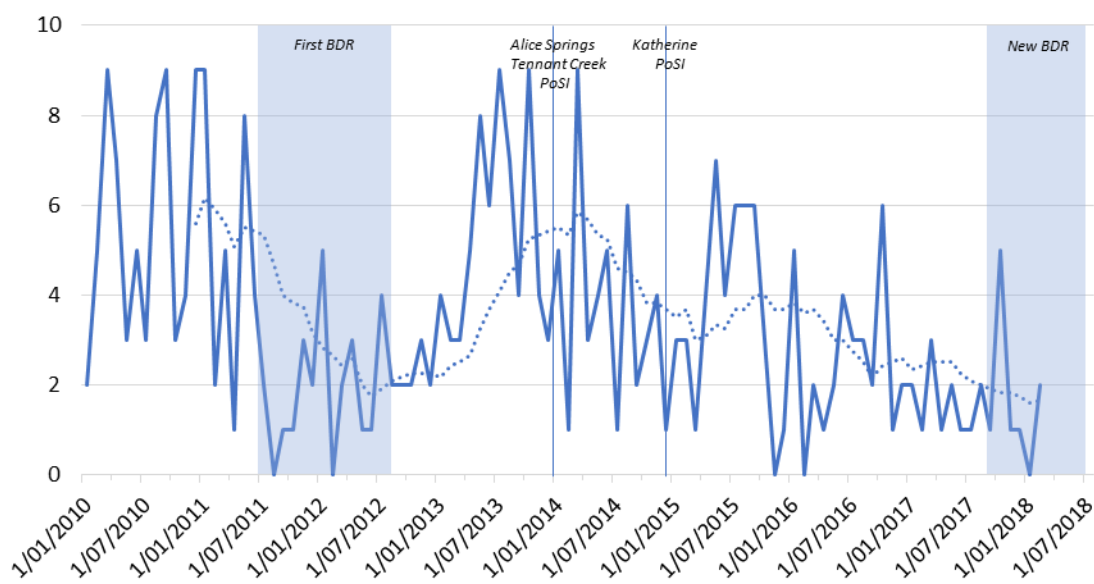


Figure 110. Drink-driving offences by type, Nhulunbuy, 12-month rolling averages

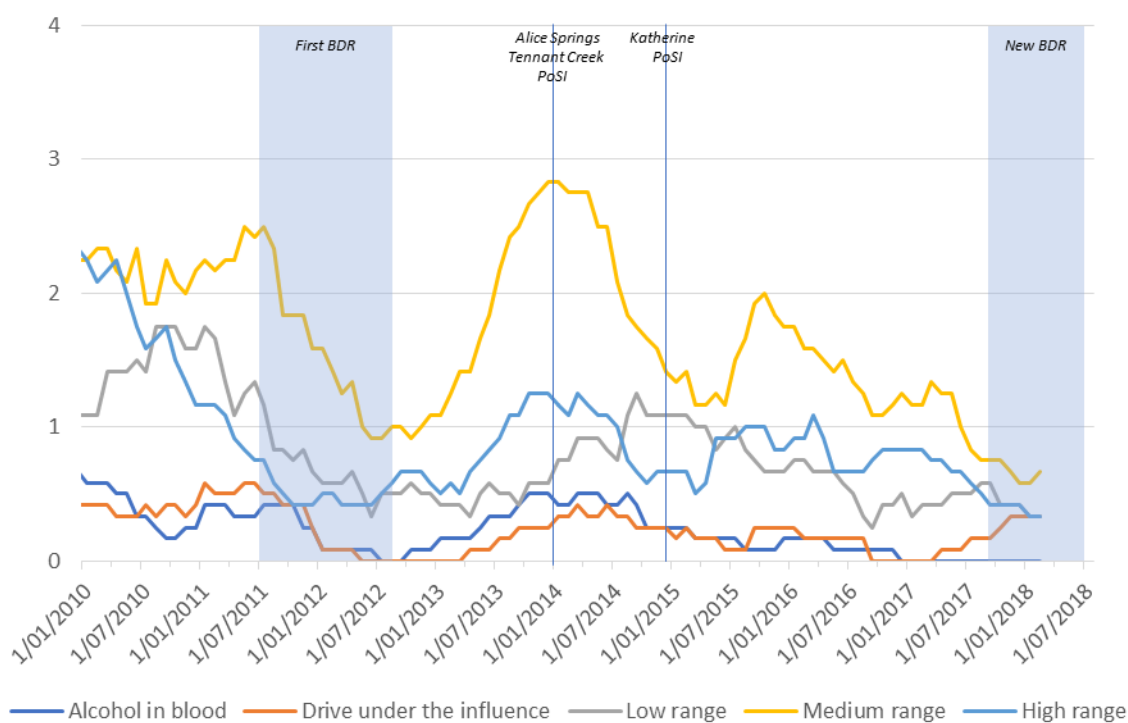


Figure 111. Monthly adult alcohol-related apprehensions, Nhulunbuy, and 12-month rolling average

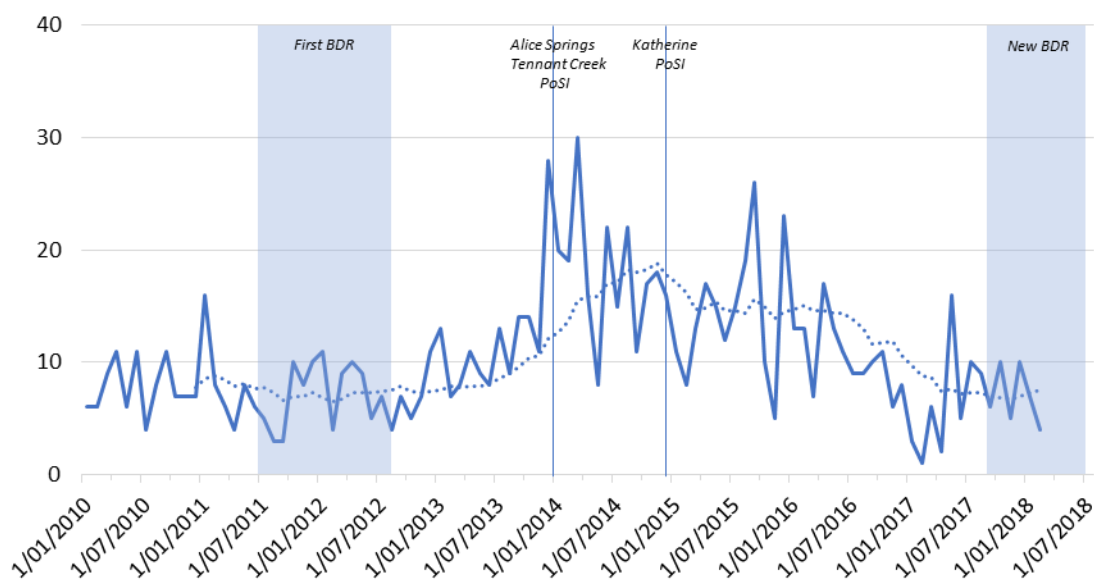
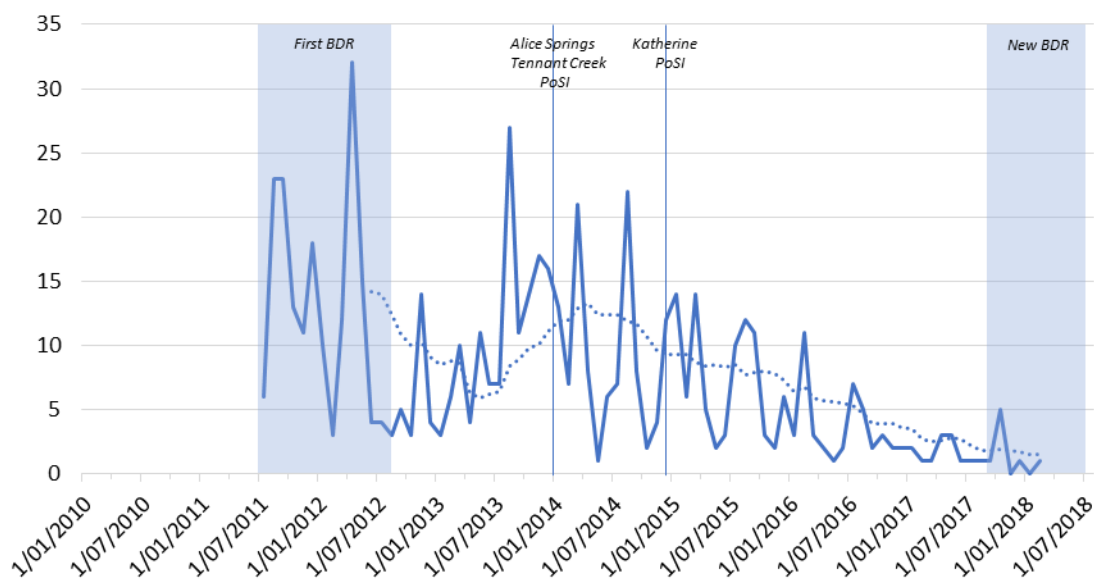
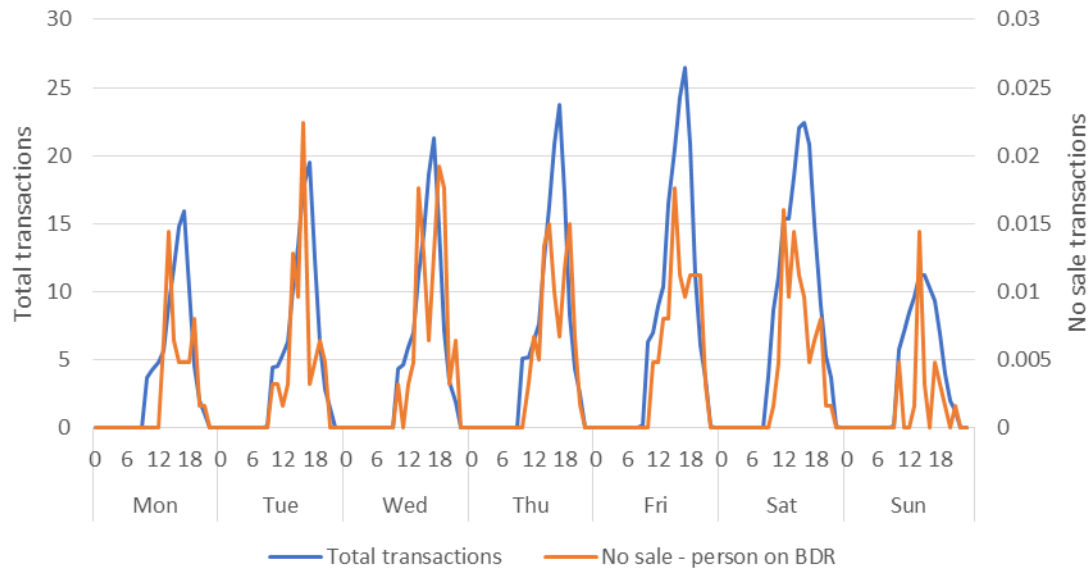


Figure 112. Monthly alcohol-related protective custody episodes, Nhulunbuy, and 12-month rolling average



### 8.1.1.7 NT Balance

Figure 113. Average hourly transactions through the week, NT Balance



Note: the no-sale transactions are shown at 1,000 times their size relative to total transactions, so that patterns may be compared.

Figure 114. Monthly alcohol-related assault offences, the NT Balance, and 12-month rolling average

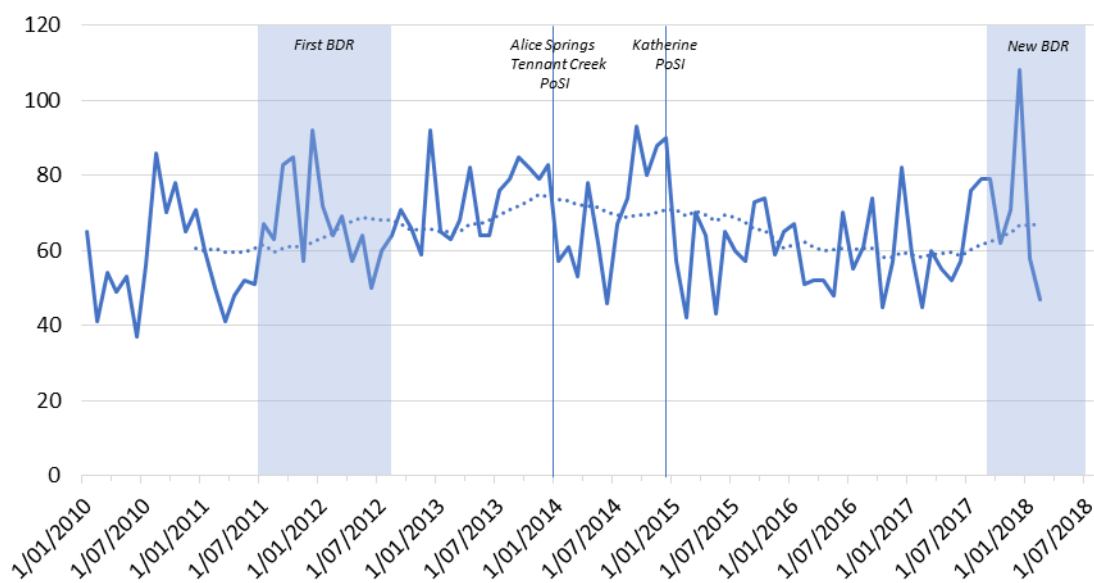


Figure 115. Monthly domestic violence assault offences by alcohol involvement, NT Balance, and 12-month rolling averages

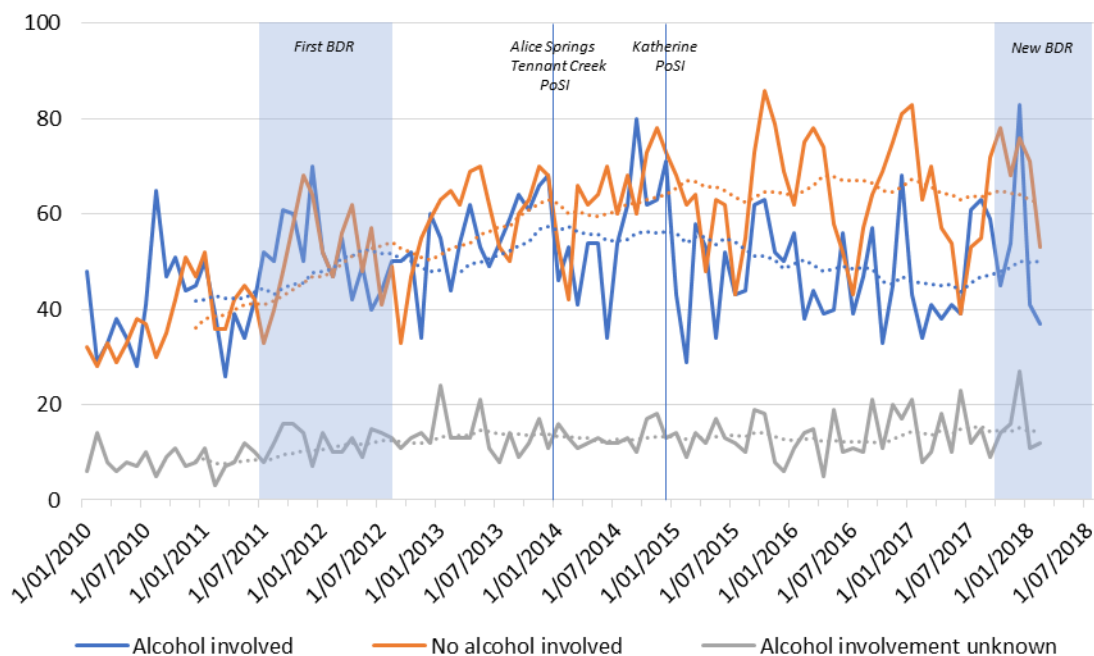


Figure 116. Monthly liquor consumption and licensing offences, the NT Balance, and 12-month rolling averages

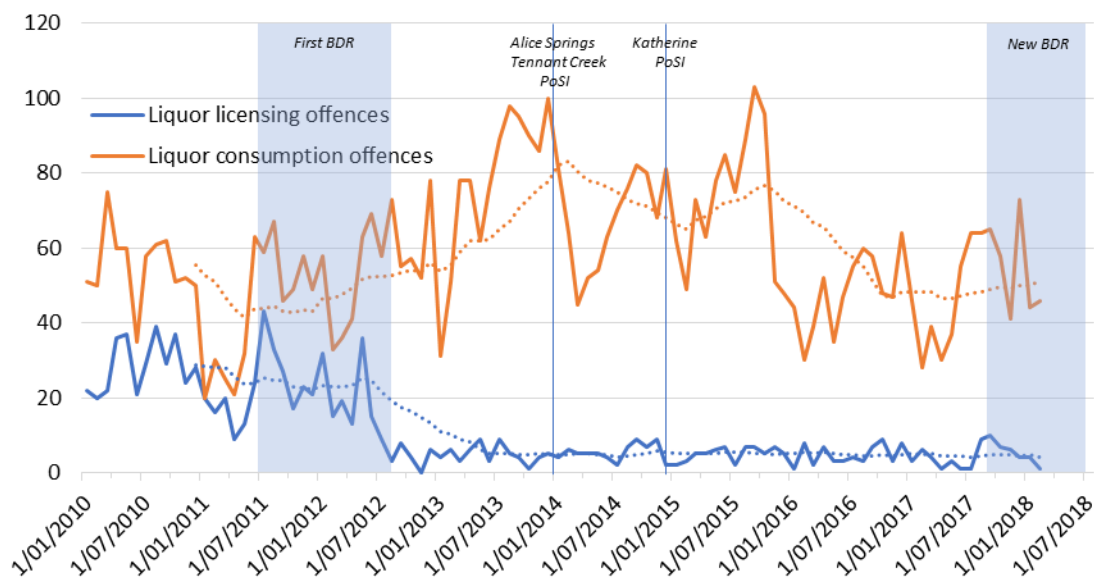


Figure 117. Monthly drink-driving offences, the NT Balance, and 12-month rolling average

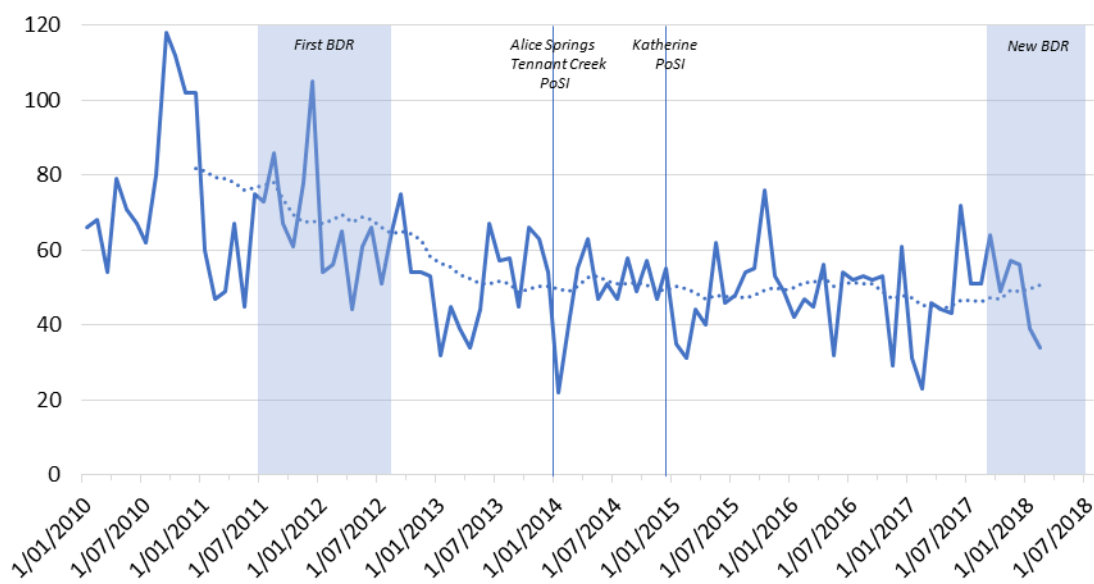


Figure 118. Drink-driving offences by type, NT Balance, 12-month rolling averages

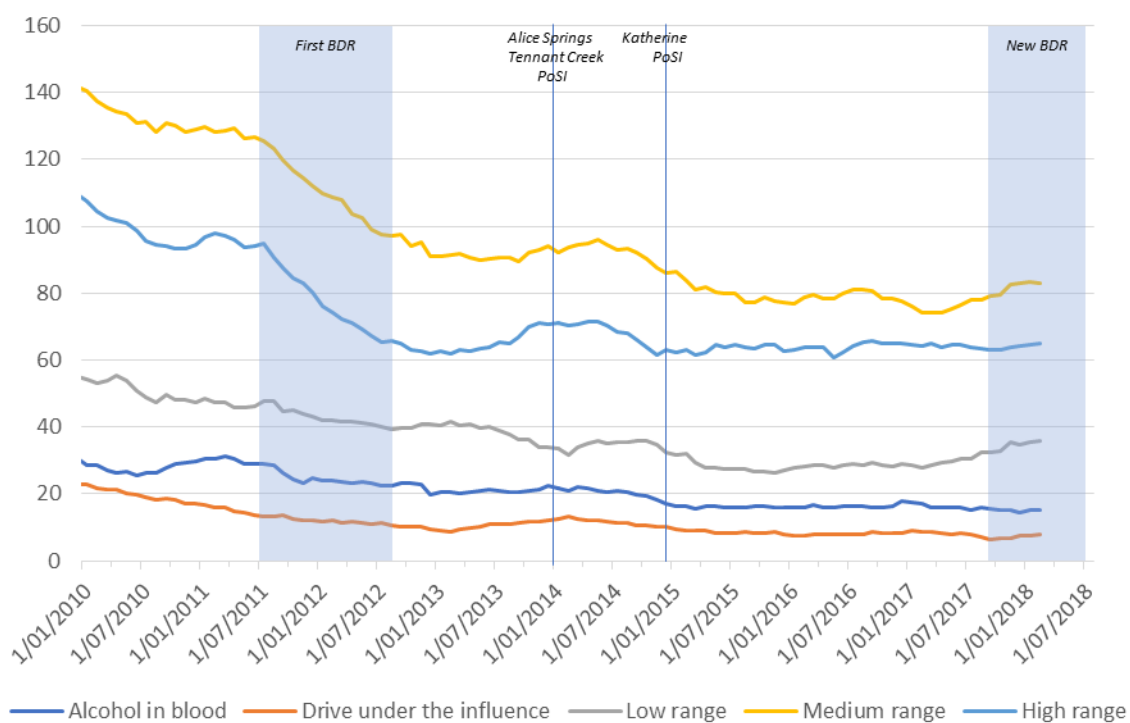


Figure 119. Monthly adult alcohol-related apprehensions, the NT Balance, and 12-month rolling average

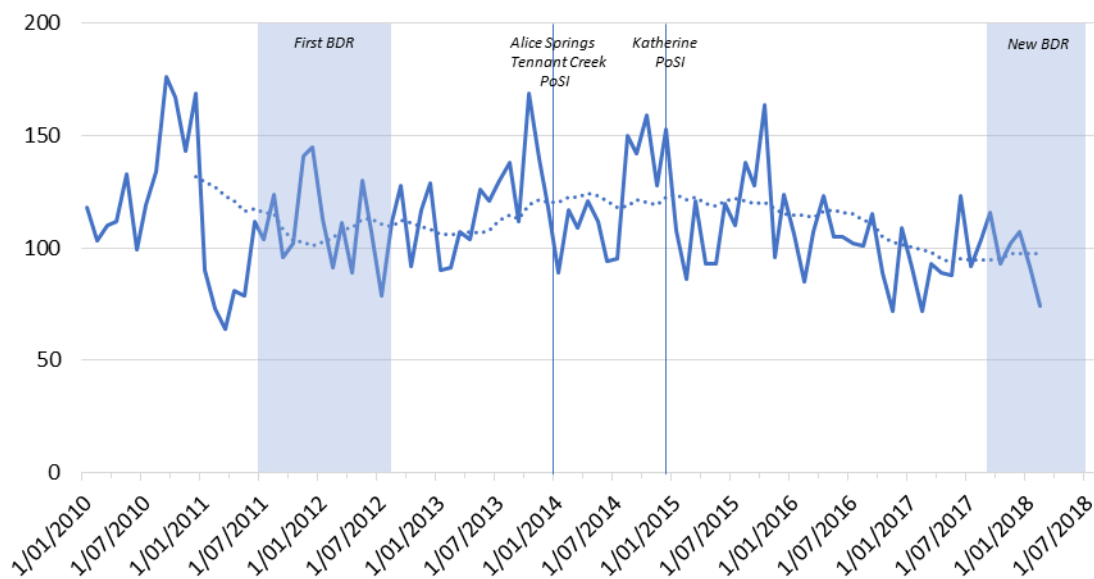
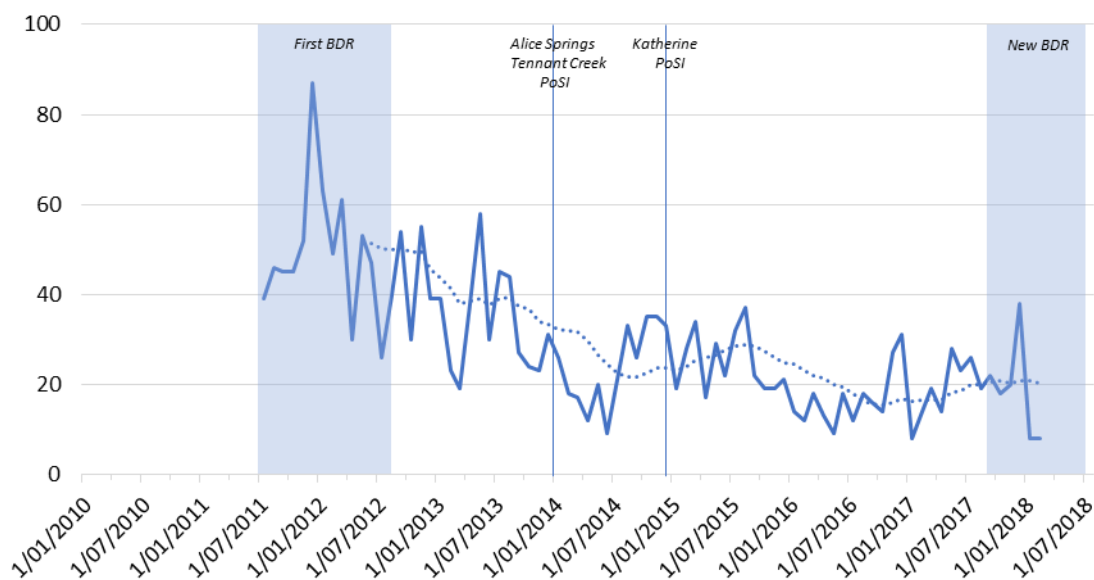


Figure 120. Monthly alcohol-related protective custody episodes, the NT Balance, and 12-month rolling average



### 8.1.2 Appendix 2: Latent Class Analysis

Latent class analysis (LCA) is a statistical method used to identify mutually independent subtypes of behaviour (latent classes) from a set of multivariate categorical indicators. As a model-based clustering method, LCA is able to capture the unobserved heterogeneity both among and within subgroups of individuals. By drawing from categorical data, LCA also has the advantage of making no assumptions about the distribution of the variables; the only assumption underpinning this technique is that of local independence which holds when there is zero correlation between the manifest (i.e. observable) variables within latent classes.

The analysis was performed using PROC LCA (Lanza et al., 2003), an add-on for SAS for Windows. Five indicators of justice system contact (alcohol-related protective custody episodes, infringements, and apprehensions, time in prison, and time on a residential order for alcohol mandatory treatment) were used in the analysis.

To account for variation in the frequency of protective custody, infringement, and apprehension events, these were recoded into three response categories: 1 = no occurrence of the event, 2 = low to moderate frequency of the event, 3 = high frequency of the event. For both alcohol-related infringements and protective custody events, low to moderate frequency was defined as the individual having at least one event, with any subsequent recorded events occurring on a sporadic basis. High frequency was assigned to individuals who had two or more infringements or two or more protective custody episodes in a seven-day period on at least two separate occasions during the prior year.

Apprehensions occur at a much lower frequency than protective custody and infringement events. In addition, a single alcohol-related apprehension is sufficient to put an individual on the BDR, compared to any combination of three alcohol related protective custodies or alcohol infringement notices in two years. In many instances an apprehension is also followed by a period in custody, which should theoretically introduce a normative break in behaviour and an opportunity for the individual to desist from further offending. For this reason, anything more than one alcohol-related apprehension in the year prior was coded as high frequency. The final two indicators, time in prison and time in alcohol mandatory treatment (AMT), were dichotomised due to the low number of individuals who had multiple prison or treatment events: 1 = no occurrence, 2 = one or more

occurrences. Table 9 shows the descriptive statistics for the individual indicators, and the way in which the frequencies of events were coded.

*Table 9. Frequency distribution for alcohol-related event indicators*

Indicator	Code	Label and number of events	Frequencies, % (n)
Infringement	1	None (0)	64.5 (3,181)
	2	Low-moderate (1 or more sporadic events)	29.9 (1,475)
	3	High (2 or more occasions with 2+ events in 7 days)	5.7 (278)
Protective Custody	1	None (0)	59.4 (2,929)
	2	Low-moderate (1 or more sporadic events)	36.9 (1,819)
	3	High (2 or more occasions with 2+ events in 7 days)	3.8 (186)
Apprehension	1	None (0)	33.0 (1,628)
	2	Low-moderate (1)	50.2 (2,477)
	3	High (2 or more)	16.8 (829)
Prison	1	No (0)	63.7 (3,145)
	2	Yes (1 or more occurrences)	36.3 (1,789)
Alcohol Mandatory	1	No (0)	97.0 (4,786)
Treatment	2	Yes (1 or more occurrences)	3.0 (148)

Using the Bayesian information criterion (BIC; Schwarz, 1978) and Akaike's information criterion (AIC; Akaike, 1974), a six-class solution was identified as providing the best overall fit to the data (see Table 10). The basis for this decision is that AIC and BIC are the most widely used evaluation criteria in LCA selection with smaller results for both criteria indicating a better fitting model. The increases in the AIC and BIC criteria beyond the six-class model show that the addition of further classes provided no improvement in model fit.

*Table 10. Comparison of baseline models*

No. of classes	Likelihood Ratio G <sup>2</sup>	Degrees of Freedom	AIC	BIC
2	1177.49	90	1211.5	1322.1
3	669.5	81	721.5	890.6
4	237.2	72	307.2	534.8
5	144.8	63	232.8	519.0
<b>6</b>	<b>62.4</b>	<b>54</b>	<b>168.4</b>	<b>513.1</b>
7	47.37	45	171.4	574.6

Note: bold type indicates the best fitting model

An assessment of membership probabilities (see Table 11) provided further confidence in the six-class model as each class was distinguishable from the others in terms of item-response



probabilities, and there was no class with a near-zero probability of membership (i.e. the latent classes were non-trivial in size). For each of the identified groups, Table 11 shows the probability of membership and conditional item-response probabilities for each type of alcohol-related event. Item-response probabilities range from 0.00 to 1.00, with probabilities closer to 1.00 indicating a higher probability of a ‘yes’ response for that item, conditional on membership in that group. For example, individuals in Group 2 had a relatively high (0.75) probability of low to moderate frequency protective custody events occurring in the prior year, and a very high (0.99) probability of spending some time in prison.

*Table 11. Item response probabilities for the six-group model*

		Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Group membership probabilities		2.5%	4.8%	15.0%	21.4%	19.7%	36.6%
<i>Item response probabilities</i>							
Non-criminal events	Frequency						
AMT	No	0.11	<b>0.84</b>	<b>1.00</b>	<b>1.00</b>	<b>1.00</b>	<b>0.99</b>
	Yes	<b>0.89</b>	0.16	0.00	0.00	0.00	0.01
Protective custody	None	0.00	0.01	0.36	<b>0.99</b>	0.04	<b>0.87</b>
	Low-moderate	<b>0.60</b>	<b>0.75</b>	<b>0.64</b>	0.01	<b>0.88</b>	0.13
	High	0.40	0.25	0.00	0.00	0.08	0.00
Infringement	None	0.10	0.13	<b>0.56</b>	<b>0.95</b>	0.24	<b>0.83</b>
	Low-moderate	<b>0.61</b>	0.44	0.43	0.05	<b>0.64</b>	0.17
	High	0.29	0.44	0.01	0.00	0.13	0.00
Criminal events	Frequency						
Apprehension	None	<b>0.70</b>	0.17	0.08	<b>0.51</b>	<b>0.77</b>	0.08
	Low-moderate	0.26	0.34	0.43	0.32	0.21	<b>0.83</b>
	High	0.04	<b>0.50</b>	0.48	0.16	0.02	0.09
Prison	No	<b>0.93</b>	0.01	0.15	0.24	<b>0.91</b>	<b>0.99</b>
	Yes	0.06	<b>0.99</b>	<b>0.85</b>	<b>0.76</b>	0.09	0.01

Note: probabilities in bold type indicate greater confidence in the presence of that frequency for the group

## 8.2 Appendix B - BDR Individual Interview Schedule

Q1. Please tell us a little bit about yourself and your work history. How long have you worked in your current role and setting?

Q2. Please explain what your role has been in the planning, development and/or early implementation of the BDR? Were you part of any committees or working groups? Which ones? Did you think they were effective in planning and implementing the BDR?

Q3. Did you use learnings from the previous BDR implementation (2011-2012) to assist with the second roll-out of the BDR (2017-ongoing)? If so, in what ways? If not, why not?

Q4. How important have project planning and communication documents and/or processes been in supporting your involvement in the early implementation of the BDR?

Q5. Please comment on the efficiency and time effectiveness of the BDR planning and implementation process? Are there particular aspects that have enabled or hindered this process?

Q6. In your opinion, what has worked well (e.g. enablers/opportunities) in relation to the planning, development and early implementation of the BDR and why?

Q7. In your opinion, what has not worked (e.g. barriers/challenges) well in relation to the planning, development and early implementation of the BDR and why?

Q8. If you were engaged in the planning, development and/or early implementation of the BDR again, what would you change and why?

Q9. The BDR has required input and co-ordination between various agencies and organisations throughout all stages of planning and early implementation. What has this looked like from your perspective?

Q10. What has the approach to governance and decision-making been throughout the planning, development and/or early implementation of the BDR? Has this impacted upon your work and if so in what ways?

Q11. What do you think the public perception of the planning and early implementation of the BDR has been and why?

Q12. What do you think of the media portrayal of the planning and implementation of the BDR? Do you think this is important and why?

Q13. In your view, exactly who is the BDR aimed at and why?

Q14. Is there anything else you would like to add?

### 8.3 Appendix C – RACI Matrix

Activity	Pol	DoH	BDR Sup	Crts	DCIS	L NT	AGD IJIS	AGD BDR	AGD IOMS	AGD NTCS	AGD ICT	AGD R&S	AGD Leg	ICT SP (NEC)
<b>Legislation</b>														
Alcohol Harm Reduction Act	C	A	I	C	I	C	R	R	C		I	C	R	
Liquor Act	C	C	I	C	I	A	R				I		R	
Serious Sex Offender Act	C	I	I	C		C	R		R	A	I		R	
<b>IJIS</b>														
IJIS System Outage	C	I	C	C	R		A	I	C		I	C		
IJIS Release Upgrade	C	I	C	C	R		A	I	C		I			
IJIS System Patch	C	I	C	C	R		A	I	C		I			
IJIS Data Quality – Police	A R	C	I				R	I			I	I		
IJIS Data Quality – Courts		C	I	A R			R	I			I			
IJIS Person Merge	A R	I	I					I	I					
IJIS Case Switch – Police	A R	C	I		R		R							
IJIS Case Switch – Courts		C	I	A	R		R	I						
IJIS Exception Report	C	C	R		R		A R	I						

Activity	Pol	DoH	BDR Sup	Crts	DCIS	L NT	AGD IJIS	AGD BDR	AGD IOMS	AGD NTCS	AGD ICT	AGD R&S	AGD Leg	ICT SP (NEC)
ELIN	A R				R		R	I						
IJIS Data Zap	C	C	R	C	R		A	I	C					
<b>BDR Application</b>														
BDR System Outage	C	C	R		I	I	C	A	C		C	C		
BDR Release Upgrade	C	C	R		C	I	C	A	C		C	C		
BDR System Patch	C		R		C	I	C	A	C		C			
BDR Mobile Application			R			I		A						
BDR Portal		A	R			I		C			I			
BDR APMS			R			A		C			I			
BDR Internet Sales			R			A		C			I			
BDR RFC Approval	C	C	R	C		I	C	R	C		A	C		
BDR Data Quality	C	A	R	C			C	C	C		C	C		
BDR Data Zap		A R	R				C	I	C			C		
<b>BDR Infrastructure</b>														
BDR Servers	I		C	I	R	I		A R						

Activity	Pol	DoH	BDR Sup	Crts	DCIS	L NT	AGD IJIS	AGD BDR	AGD IOMS	AGD NTCS	AGD ICT	AGD R&S	AGD Leg	ICT SP (NEC)
BDR POS Terminals	I		C			I		A R						R
BDR Mobile Terminals	I		C			I		A R						
<b>IOMS</b>														
IOMS Data Zap	I		C					I	R	A				
<b>NTG Infrastructure</b>														
NTG Servers						A R								
MQ Outage	I	I	C	I	A R		C	C	C			I		
MQ Upgrade			C		A R		C	C	C			I		
MQ Patch			C		A R		C	C	C			I		
Telstra Outage					A									R

#### R = Responsible (Blue)

##### ***“The Doer”***

The “doer” is the individual(s) who actually complete the task. The “doer” is responsible for action or implementation. Responsibility can be shared. The degree of responsibility is determined by the individual with the “A”.

##### **A = Accountable (Black)**

##### ***“The Buck Stops Here”***

The accountable person is the individual who is ultimately answerable for the activity or decision. This includes “yes” or “no” authority and veto power. **Only one “A” can be assigned to an action.**

C = Consulted (Green)

***“In the Loop”***

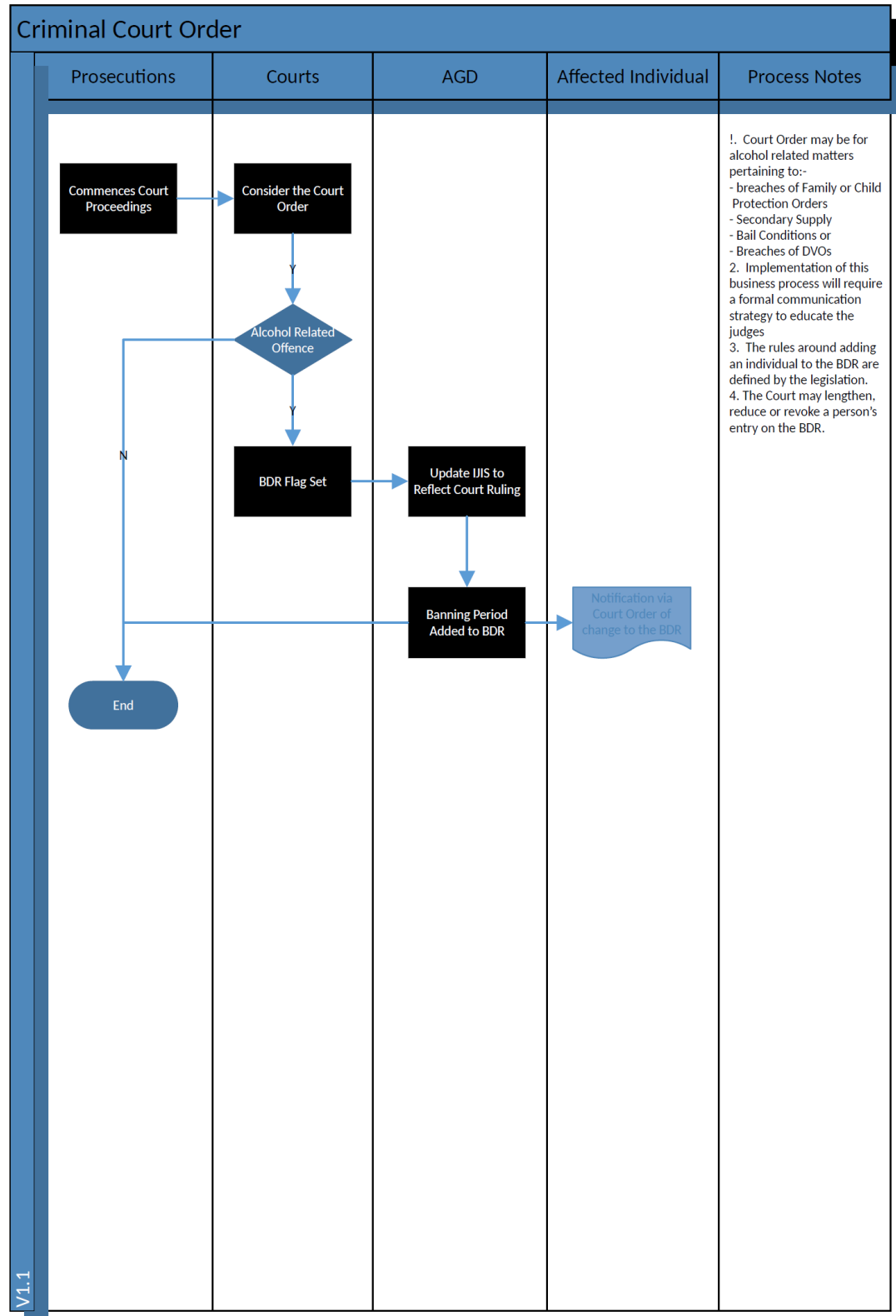
The consult role is the individual(s) (typically subject matter experts) to be consulted prior to a final decision or action. This is a predetermined need for two-way communication. Input from the designated position is required.

I = Informed (Orange)

***“Keep in the Picture”***

This is the individual (s) who needs to be informed *after a decision or action is taken*. They may be required to take action as a result of the outcome. It is a one-way communication.

## 8.4 Appendix D – Examples of Business Process Maps associated with the BDR



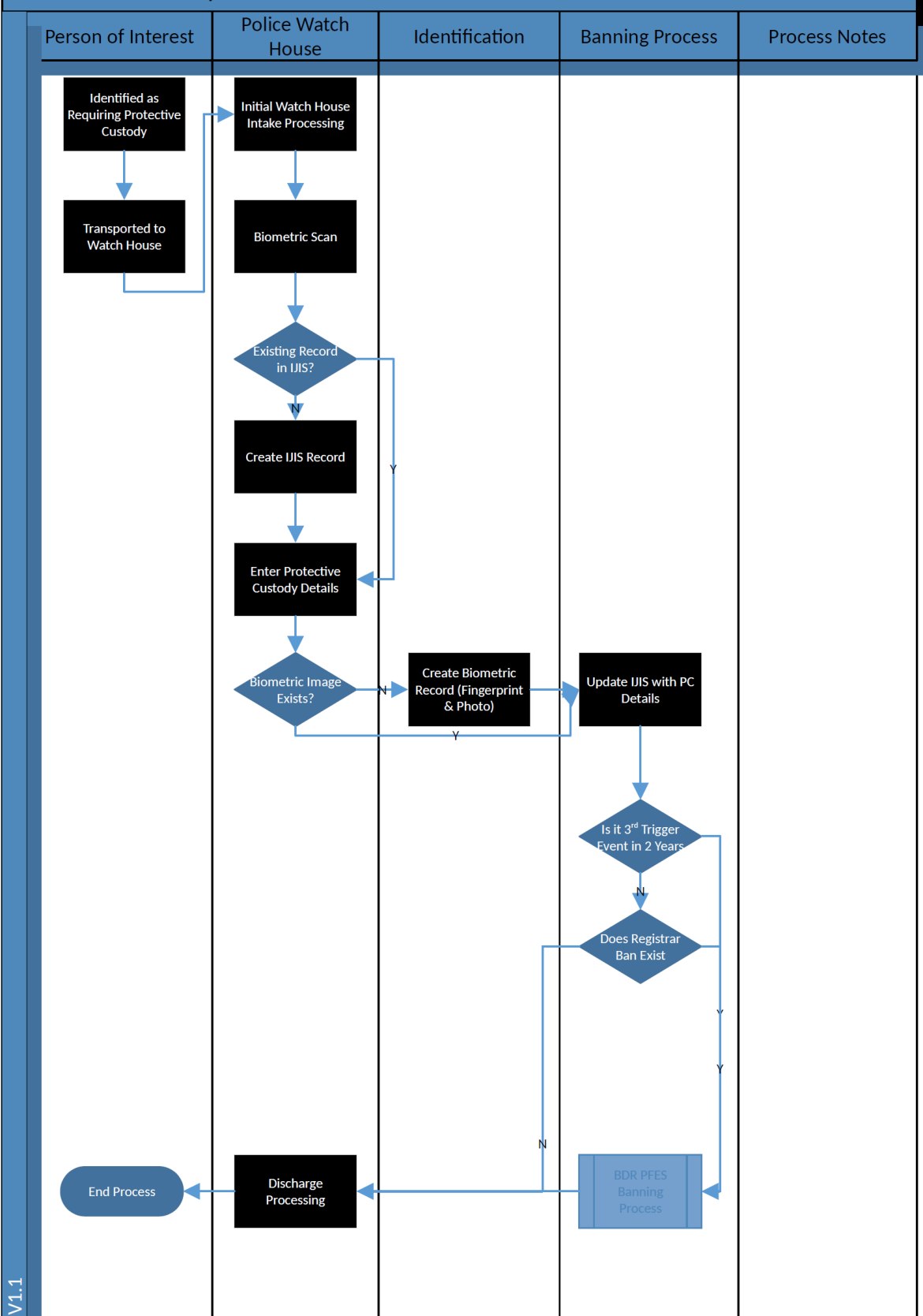
## BDR PFES Banning Process

BDR	Function	Function	Function
<pre> graph TD     Start([Start Banning Process]) --&gt; D1{Does Individual have a Registrar Ban?}     D1 -- Yes --&gt; F1[Extend the Registrar Ban]     D1 -- No --&gt; D2{Does Individual have a PFES Ban?}     D2 -- Yes --&gt; F2[Delete the Current Ban and Create a 2nd or Subsequent PFES Ban]     D2 -- No --&gt; F3[Create a PFES Ban]     F3 --&gt; D3{Is there a Self Referral Ban?}     D3 -- Yes --&gt; F4[Delete the Self Referral Ban]     F1 --&gt; F5[Print the BDO]     F4 --&gt; F5     F5 --&gt; End([End Banning Process])         </pre>			

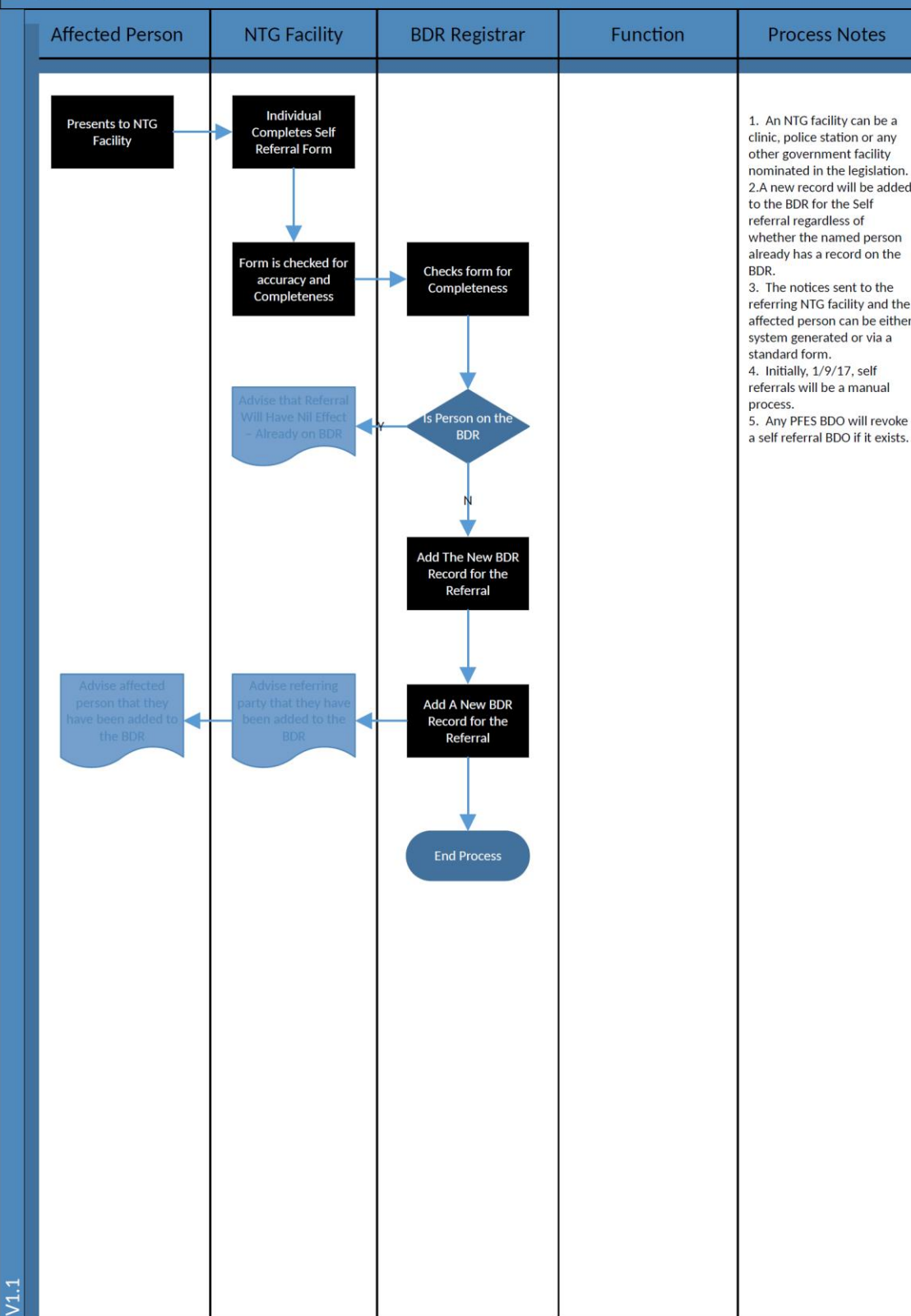
V1.2



# Protective Custody – Police Watch House



## Self Referral



V1.1

## Family/Carer Referral

