

Executive Summary - Banned Drinker Register Process Evaluation

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 throughout the final report. The recommendations aim to guide future enhancements and to increase the policy integrity of the BDR.

For further information about the BDR Process Evaluation please contact Professor James Smith, Father Frank Flynn Fellow (Harm Minimisation) on (08) 8946 8685 or via email at james.smith@menzies.edu.au