

## **Executive Summary and Key Messages of the 12-Month Evaluation of the Banned Drinker Register in the Northern Territory**

The harmful use of alcohol in the Northern Territory is a public health concern. This was emphasised through the findings of the *Alcohol Policies and Legislation Review Final Report*, which resulted in the Northern Territory Government (NTG) developing and implementing the *Alcohol Harm Minimisation Action Plan 2018-2019* (AHMAP). The Banned Drinker Register (BDR) is one of the strategies outlined in the AHMAP. 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 would be evaluated regularly. A six-month evaluation report was released by Menzies School of Health Research (Menzies) in June 2018 (Smith & Adamson 2018). It outlined 23 recommendations and seven key messages, which have been incrementally addressed by the NTG since the release of the report.

A further six months has passed, and a 12-month evaluation of the BDR is now possible. Menzies School of Health Research has been engaged by NTG to provide independent oversight of the 12-month evaluation process. Four overarching evaluation questions have underpinned this approach:

1. What has happened in the first year of implementation of the BDR?
2. Does the BDR adequately target people misusing alcohol?
3. Has the BDR reduced the frequency of banned drinkers' contact with the justice system?
4. Has the use of specialist therapeutic services changed under the current BDR?

A phased two-part mixed-methods evaluation process has been negotiated between NTG and Menzies. Part 1 is quantitative and prepared by NTG. It involves a *descriptive analysis of relevant administrative data* held by the NTG. The quantitative analysis is the primary focus of this report. We provide information about:

- comparisons with the previous BDR (2011-2012);
- the characteristics of individuals and groups on the BDR;
- individual contacts with the justice system pre and post BDR;
- pathways onto the BDR – including alcohol-related offences and protective custody orders; and
- the use of sobering up shelters and other treatment services by those on the BDR.

This report provides an in-depth account of the intersection between the BDR and the justice system. This includes a latent class analysis examining shared characteristics noted among particular groups of people on the BDR in relation to their engagement with the justice system. Additionally, selected information is also provided about the intersection between the BDR and the health system, specifically alcohol-related emergency department presentations, and the use of sobering up shelters and alcohol treatment services. This evaluation has not looked at the intersections between health and justice data. It is proposed that future BDR evaluations examine these intersections in more detail.

Part 2 of the evaluation is qualitative. It will involve an independent analysis of key stakeholder perspectives - such as service providers, licensees, youth, tourists, and community members - about the impact of the BDR in the first 12 months of implementation. This work will be presented in a second report to be finalised for public release in June 2019.

We have made some initial recommendations and key messages based on the preliminary quantitative analysis presented in this report. However, a combined analysis of the quantitative and qualitative evaluation findings, from both Parts 1 and 2, will provide additional contextual information. This is likely to result in more pertinent recommendations for (a) improving the policy integrity and fidelity of the BDR over the mid to longer-term; and (b) informing the direction of future impact and outcome evaluations of the BDR.

### **Key Messages**

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 effectiveness of the BDR is best understood longitudinally. The results of this impact evaluation should be used as an initial baseline. Impacts on health behaviour change will become more evident once the 24-month evaluation is completed and throughout subsequent evaluation processes.
4. There is potential to strengthen support for people on the BDR by examining their parallel engagement with health and justice systems more closely. This will require increased investment in data-linkage capacity.
5. The BDR provides a unique opportunity to engage in more assertive alcohol-related community development health promotion activities at a population level.
6. An increased focus on both service provider and public perceptions of the effectiveness of BDR is warranted, and should be incorporated into Part 2 of the 12-month evaluation. This will provide additional context to tailor parallel alcohol intervention strategies.