

Emerging alcohol policy innovation in the Northern Territory, Australia

1 | UNDERSTANDING THE HARMS OF ALCOHOL CONSUMPTION

The costs and harms of alcohol consumption in Australia are well documented.¹ While the National Health and Medical Research Council are currently reviewing the *Australian Guidelines to Reduce Health Risks from Drinking Alcohol*,² the latest global evidence suggests there is no safe level of alcohol consumption.³ The negative effects on the health and well-being of our society far outweigh its benefits.^{1,3-5} Harmful levels of alcohol consumption—both binge drinking and sustained high and moderate levels of drinking—increase the propensity for risk taking associated with violence, crime, drink-driving, unsafe sex, alcoholic poisoning, drinking while pregnant and a wide raft of anti-social behaviours.^{1,3-5} Alcohol's harm also extends beyond the drinker to those around the drinker and arguably the totality of this harm is more than that which accrues to the drinker. This harm includes family and domestic violence, child neglect, diminished industry productivity and other third-party harm.⁶

The Australian Institute of Health and Welfare reports that the proportion of people drinking in excess of the recommended Australian risk guidelines has been declining since 2010.¹ Generally speaking, this is good news. However, there is reason to be cautious⁷ with population demographics changing and the decline being marginal given current average per capita drinking level is more than double those in the 1930s.⁸ For example, we know that around one in three Australians continue to binge drink, and that alcohol also remains the most common principal drug of concern for which Australians seek treatment.¹ Also, we know that alcohol is an addictive drug. Dependence upon alcohol requires expensive therapeutic and treatment options to minimise harms to the individual, their family and the broader community.⁹ The chronic impact of alcohol consumption on population health in Australia is also well documented.^{1,10} That is, excessive alcohol consumption exacerbates health issues associated with chronic conditions such as diabetes, cardiovascular disease, mental illness and cancer.¹⁰ Furthermore, excessive alcohol consumption is positively associated with pathological gambling,^{11,12} spending more money while gambling¹³ and other psychiatric disorders.¹⁴ As such, it adds a layer of complexity to the way in which policy and program interventions are, and continue to be, designed.

The health promotion community has been active in the planning, implementation and evaluation of alcohol harm minimisation strategies for decades.¹⁵ These have often reflected a comprehensive approach to health promotion¹⁶ and have been supported by respective state and national alcohol harm minimisation strategies and policies.^{5,17} While this has contributed to strengthening the evidence base about what works and why, concern has also been raised about the policy rhetoric and lack of tangible action. When compared with other wicked public health problems, such as tobacco control, we have not yet seen an equivalent trajectory of health improvement.⁴ A notable area of difference between alcohol harm minimisation and tobacco control measures has been the relative emphasis placed on sustained policy and legislative reforms. In spite of a comprehensive evidence base,¹⁸ there remains significant room for improvement in this regard in Australia. In this editorial, we provide examples of two promising alcohol policy and legislative interventions currently being implemented in the Northern Territory (NT), Australia.

2 | PROMISING ALCOHOL POLICY DEVELOPMENTS IN THE NORTHERN TERRITORY

The NT has the highest reported rates of alcohol consumption in Australia, with corresponding high rates of alcohol-fuelled violence and crime.^{19,20} Meaning that the NT is a fertile ground for alcohol policy interventions. Historically, many government-led alcohol policy interventions in the NT have been implicitly targeted towards Aboriginal drinkers where public drunkenness, disorder and threats to urban amenity have been a primary focus.²¹ In particular, the "Living With Alcohol Program" introduced in the NT in the early 1990s, and implemented over the subsequent decade, proved to be one of Australia's most comprehensive and innovative policy and practice responses to curb the harms of alcohol at that time.^{22,23} In this editorial, we draw on the Northern Territory Government's (NTG) response to the recent independent review of alcohol policies and legislation in the NT released in October 2017.²⁴ The final report included 220 recommendations, with the NTG expressing its support in February 2018 for 187 recommendations, in-principle support for 32, and rejecting only one—a proposal to ban the trading of take-away alcohol on a Sunday.¹⁹ The NTG also swiftly released an *Alcohol Harm Minimisation Action Plan 2018-2019* in February

2018,²⁵ including the establishment of a new Liquor Commission Act 2018²⁶; and provisions to be the first jurisdiction in Australia to implement a Minimum Unit Price (MUP) on alcohol. In addition, the NTG had already (re)introduced the Banned Drinker Register (BDR) in September 2017. A snapshot of the intent of the BDR and MUP is provided below.

2.1 | Banned Drinker Register

The BDR is a policy initiative which aims to improve community health and safety by reducing alcohol-related harms²⁷ and is supported by the NT Harm Reduction Act 2017.²⁸ It is an explicit alcohol supply reduction measure that involves placing people who consume alcohol at harmful levels, to themselves or others, onto a register which prohibits the consumption, possession or purchase of alcohol. This response usually gets triggered through engagement with police, courts, the BDR registrar or other authorised officers, often as a result of public drunkenness or acts of violence. A self-referral pathway is also available. In its current format, the limitation of purchasing is enacted through the electronic scanning of personal identification at take-away alcohol outlets.²⁷ The length of time an individual is on the BDR can be 3, 6 or 12 months depending on the reason and severity of issues underpinning the referral.²⁷

The BDR was initially introduced in 2011–2012 under the former NT Labor Government, but was decommissioned swiftly by the incoming Country Liberal Party Government in late 2012 without any formal evaluation of the planning and implementation processes, or subsequent impacts or outcomes.²⁷ In the lead-up to the 2016 NT election, a key election commitment of the incoming Labor Government was to reintroduce the BDR.²⁷ There was a clear directive that the BDR would be reintroduced within the first 12 months of office and it was subsequently reintroduced on 1 September 2017.²⁷

A recent 6-month process evaluation revealed that the BDR was meeting its policy objectives.²⁷ The evaluation outlined seven key messages and made 23 recommendations. The NTG made a formal response to the evaluation supporting 14 recommendations and providing in-principle support for a further nine recommendations,²⁹ indicating its intent to drive further reforms in this space. While acknowledging that ongoing monitoring and evaluation of the BDR is required—particularly an impact evaluation and an exploration of its intersection with other policy initiatives—early signs are promising.

2.2 | Minimum Unit Price

In addition to the BDR, the NTG introduced an MUP on alcohol on 1 October 2018, legislated through the NT Liquor Act 2018.³⁰ The MUP involves setting a minimum cost on take-away alcohol—per standard drink—as an explicit supply reduction strategy. In the NT, the MUP was set at AUD\$1.30 per standard drink, despite the policy and legislation review recommending an MUP of AUD \$1.50 per standard drink.¹⁹

Nevertheless, the NT is the first jurisdiction in Australia to introduce legislation of this nature, building on similar initiatives implemented in Canada and Scotland. The intent of MUP is to reduce accessibility of cheap alcohol—primarily cheap wine, fortified alcohol and some low-cost beer. Despite having received significant public scrutiny in both popular and social media during its introduction, there is an emerging global evidence base showing that MUP can reduce alcohol consumption, particularly among people who drink alcohol at harmful levels, and among people from low socioeconomic status backgrounds.^{31–34} MUP is different from other price policy measures, such as a volumetric tax on alcohol, in that the retailer retains the increased revenue. In this sense, it is more palatable to the alcohol industry. However, it is also susceptible to minimally regulated price hikes of alcohol, for example, the cost of mid-range wine. The retention of extra revenue by the alcohol industry is something of a lost opportunity for public health. Indeed, a hypothecated volumetric tax arrangement, where income generated from alcohol taxes is deliberately reinvested into health promotion and prevention efforts are favoured and frequently regarded as a preferred option among the public health community.⁴ It is therefore critical that the NTG invests in the monitoring and evaluation of this new legislation. While common sense suggests it is most likely to be effective with parallel volumetric tax and secondary supply reduction measures, it is imperative to understand the short-, medium- and long-term impacts of MUP. It will be equally important to assess the effectiveness of the introduction of an MUP in the NT, where the social and cultural contexts may differ from those of Canada, where the evidence base is currently strongest.

3 | CONCLUSION

This editorial was not intended to be a comprehensive review of alcohol policy approaches in Australia. Rather, it was designed to provide a snapshot of two innovative alcohol policy and legislative developments, in a jurisdiction with the highest reported alcohol consumption in NT, Australia.^{19,20} We have provided two examples of changes underway to reduce alcohol consumption in the NT, Australia. We recognise that other promising policy interventions are being planned and implemented in other state, national and global contexts, such as moderate restrictions to alcohol trading hours and outlet numbers.^{17,18,35} We also note the importance of changing narratives about the culture of drinking, both in Australia and elsewhere across the world, if population health gains are to be realised.³⁶ As such, we advocate for scholarly reviews, original research and policy evaluations relating to innovative alcohol policy and legislative reforms across the Australasian region to be published in the *Health Promotion Journal of Australia*. We welcome alcohol interventions, which explicitly aim to reduce health inequities among the most vulnerable populations affected by the harmful consumption of alcohol.

Health promotion scholarship, existing alcohol harm minimisation strategies and emerging evaluations tell us that more comprehensive

approaches to reduce alcohol consumption in Australia are required.^{4,5,15–17,25,27} Ideally, these need to involve a suite of complementary strategies—including health education, social marketing, provision of health information and concurrent action on the social determinants of health—in parallel to policy and legislation innovation. To assess the efficacy and effectiveness of policy and legislation interventions, and the respective intersections with other health promotion strategies, the ongoing investment in robust impact and outcome evaluation is required. This will assist in providing an evidence base about what works best and why. In turn, this helps with the scalability and transferability of alcohol policy and legislative interventions that aim to reduce the harms of alcohol at a population level. We encourage all state, territory and federal governments and research funding bodies to prioritise evaluation work of this nature. Doing so will help to reduce the devastating impact of alcohol on the Australian community.

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