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29 June 2017

Mr Trevor Riley
Alcohol Policies and Legislation Review
c/- Department of Health
PO Box 40596
Casuarina NT 0811

Via Email: Alcohol.Review@nt.gov.au

Dear Mr Riley

RACP Submission to Northern Territory Alcohol Policies and Legislation Review Issues Paper

We write on behalf of The Royal Australasian College of Physicians (RACP) to provide a submission to the Northern Territory's Alcohol Policies and Legislation Review (the Review).

The RACP represents physicians across a diverse range of disciplines, including addiction medicine, oncology, gastroenterology, paediatrics, internal medicine, public health medicine, occupational and environmental medicine, rehabilitation medicine and sexual health medicine.

RACP members see first-hand the harms caused by alcohol, from their professional experience in Australia's addiction clinics, orthopaedic wards, rehabilitation centres, liver clinics, cancer wards, paediatric and child health clinics, and emergency departments. It is on the basis of this expertise and experience, as well as a comprehensive review of the evidence, that we welcome this opportunity to contribute to the Review.

However, we urge the Northern Territory government to undertake ongoing consultation with frontline practicing clinicians during this Review and during the development and implementation of policies that result. Their input into determining an effective suite of strategies and their engagement and support with their implementation will be vital.

Our comments and recommendations draw on the extensive evidence discussed and cited in our 2016 Alcohol Policy, developed jointly with the Royal Australian and New Zealand College of Psychiatrists (RANZCP).[1]

[1] This is available from https://www.racp.edu.au/docs/default-source/advocacy-library/pa-racp-ranzcp-alcohol-policy.pdf?sfvrsn=6

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Our submission focuses on the following questions highlighted in the Issues Paper:

- The role of local and regional alcohol management plans;
- Approaches to reducing demand for alcohol that should be considered in addition to those already adopted by the NT, and recommended approaches for changing the drinking culture. (These issues will be considered together given the relevant measures are complementary).
- The additional approaches needed to reduce alcohol-related harms through managing density restrictions on alcohol outlets.
- Any other approaches to reducing the harms of alcohol that should be considered in addition to those already adopted by the NT.

Local and regional alcohol management plans

The RACP supports a continuing role for local and regional alcohol management plans (AMPs).

A recent review of studies on the effectiveness of AMPs concluded that, while the evidence was still limited, if the AMPs were locally driven and owned the outcomes were stronger and more sustainable. The weaknesses of AMPs were most evident where their coverage had been narrowed to address primarily supply issues without complementary demand and harm-reduction measures; where there had been a lack of clarity in the roles and responsibilities of communities and governments; and where there was a lack of support in nurturing local community leadership.[2]

Effective AMPs are not those programs that simply restrict the sale of alcohol. AMPs in Aboriginal and Torres Strait Islander communities have succeeded when they have been:

- Voluntarily introduced, driven, and led by the community and Aboriginal and Torres Strait Islander agencies;
- Comprehensive, including a range of activities and resources to support individuals and communities in making changes and building community capacity; and,
- Fully implemented.

Subject to these important caveats the RACP believes that AMPs continue to have an important role in reducing alcohol related harms in communities.

Demand reduction measures and changing the ‘drinking’ culture

The RACP notes that the alcohol demand reduction measures currently in place in the Northern Territory include various forms of educational and counselling interventions (whether in schools, the criminal justice system or through the community), interventions targeted towards ‘at risk’ children via the NGO sector, and community-led initiatives implemented via AMPs.

[2] Smith K et al. Alcohol management plans and related alcohol reforms. Indigenous Justice Clearinghouse. Brief 16; October 2013.

All of these measures are of value and should continue. However the 'best buys' in public health interventions to reduce alcohol demand are pricing measures. There is a large body of evidence demonstrating the strong and direct relationship between alcohol price, consumption, and associated harms.[3]

The two forms these pricing-based measures can take (which are not mutually exclusive), are:

- moving to an underlying volumetric-based tax system for all alcoholic drinks, which would replace the existing Wine Equalisation Tax (WET) and abolish WET rebates; and
- legislating a minimum price per standard drink.

The RACP appreciates that the implementation of volumetric taxation is a matter for the Commonwealth Government. However the NT government should advocate for its introduction and work with the Commonwealth and other States and Territories on its design and implementation.

It is, however, within the capacity of the NT (and other State and Territory governments) to influence alcohol pricing through legislation for a minimum retail price per standard drink of alcohol. By setting a 'floor price' on alcoholic drinks, minimum pricing policies can have similar effects to volumetric taxation in reducing the availability of cheap alcohol and reducing alcohol consumption. This is particularly effective for hazardous drinkers who tend to buy the cheapest alcohol.

Minimum prices would also prevent the liquor industry from running promotions such as 'buy-one-get-one free' offers. While it has been argued that these minimum pricing policies are not well targeted and would also affect non-problem drinkers and low-income moderate drinkers, modelling suggests this policy would have little effect on these groups.[4] This policy would have greatest impact on high risk low-income drinkers, who are a group in need of intervention.[5]

The most extensively researched experience of minimum alcohol pricing is from British Columbia, Canada, where a 10 per cent increase in average minimum price for all alcoholic beverages was associated with reduced consumption of all alcoholic drinks by 3.4 per cent[6] and a reduction in wholly alcohol-attributable deaths by almost a third.[7]

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[3] Anderson P, Baumberg B 2006. Alcohol in Europe: a public health perspective. Report prepared for the European Commission. London: Institute for Alcohol Studies; Babor et al 2010. Alcohol: no ordinary commodity – Research and Public Policy, 2nd edn. Oxford: Oxford University Press; Cook PJ, Ostermann J, Sloan FA 2005, Are alcohol excise taxes good for us? Short- and long-term effects on mortality rates. Working Paper No. 11138. Cambridge MA: National Bureau of Economic Research; Grossman M et al. Effects of alcohol price policy on youth: a summary of economic research. J. Res. Adolesc 1994;4(2):347–364; Wagenaar AC, Salois MJ, Komro KA. Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. Addiction 1994;104(2):179–190.

[4] Holmes J et al. Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study. Lancet; 10 February 2014. http://dx.doi.org/10.1016/S0140-6736(13)62417-4.

[5] Holmes J et al. Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study. Lancet; 10 February 2014. http://dx.doi.org/10.1016/S0140-6736(13)62417-4.

[6] Stockwell T, Auld MC, Zhao Z, Martin G. Does minimum pricing reduce alcohol consumption? The experience of a Canadian province. Addiction 2012;107(5):912–920.

[7] Zhao J et al. The relationship between minimum alcohol prices, outlet densities and alcohol attributable deaths in British Columbia, 2002–09. Addiction 2013 Jun;108(6):1059–1069. doi:10.1111/add.12139. Epub 2013 Mar 21. Indirect evidence is also available from a study of Scotland's recent legislation which prohibits pricing promotions for alcoholic products. The legislation led to a 4 per cent decrease in wine sales and an 8.5 per cent drop in sales of pre-mixers compared to England and

The Review also seeks advice on promoting 'cultural change in relation to drinking behaviours'. Another strongly evidence based measure which simultaneously promotes cultural change while reducing demand for alcohol in the long term, is to raise the minimum purchase age for alcohol. There is substantial evidence that this can impact rates of long-term alcohol abuse and other psychological disorders related to drug and alcohol consumption.[8]

By implication, a higher minimum purchase age for alcohol is associated with later initiation into drinking and reduced frequency of heavy drinking.[9] The effects of early initiation into drinking persist well past young adulthood. Evidence suggests that exposure to a younger legal purchase age is associated with a more than 30 per cent increase in the risk of a past-year alcohol use disorder, even among respondents evaluated in their 40s and 50s, and an elevated risk for a past-year drug use disorder in middle adulthood.[10]

In other words, future generations that are initiated into drinking at an older age would be projected to have lower rates of alcohol use disorders. This would mean overall lower rates of demand for alcohol, as well as reduced magnitude of alcohol related harms, including harms from alcohol-fueled crime.

The RACP recommends that the NT Government also consider banning alcohol advertising on public transport. The harmful impact of alcohol advertising on young people is well-documented. Research has shown that exposure to alcohol marketing leads to children starting to drink at a younger age, regular young drinkers becoming prone to binge drinking, and established young drinkers consuming alcohol at harmful levels.[11] This ban is recommended by both the World Health Organization[12] and the Alcohol Advertising Review Board,[13] and is consistent with measures adopted in South Australia and the ACT.

Wales where the legislation did not apply. See NHS Health Scotland 2013. Monitoring and evaluating Scotland's Alcohol Strategy: the impact of the Alcohol Act on off-trade alcohol sales in Scotland.

[8] Plunk, AD, Cavazos-Rehg P, Bierut LJ, Crucza RA. The persistent effects of minimum legal drinking age laws on drinking patterns later in life. Alcohol Clin Exp Res. 2013 Mar;37(3):463–469; Cook PJ, Moore MJ, Environment and persistence in youthful drinking patterns. In J Gruber (ed.). Risky behavior among youths: an economic analysis. Chicago: University of Chicago Press; 2001, pp. 375–437; Dee TS. State alcohol policies, teen drinking, and traffic fatalities. Journal of Political Economics 1999;72(2):289–315; O'Malley P, Wagenaar A. Effects of minimum drinking age laws on alcohol use, related behavior and traffic crash involvement among American youth. J Stud Alcohol.1991;52:478–491; Norberg K. et al. Long term effects of minimum drinking age laws on past-year alcohol and drug use disorders. Alcohol Clin Exp Res. 2009 December;33(12):2180–2190; Birkmayer J, Hemenway D. Minimum-age drinking laws and youth suicide, 1970–1990. Am J Public Health 1999;89:1365–1368.

[9] Cook PJ, Moore MJ. Environment and persistence in youthful drinking patterns. In J Gruber (ed.). Risky behavior among youths: an economic analysis. Chicago: University of Chicago Press; 2001, pp.375–437; Dee TS. State alcohol policies, teen drinking, and traffic fatalities. Journal of Political Economics 1999;72(2):289–315; O'Malley P, Wagenaar A. Effects of minimum drinking age laws on alcohol use, related behaviour and traffic crash involvement among American youth. J Stud Alcohol 1991;52:478–491.

[10] Norberg K, Bierut LJ, Crucza RA. Long term effects of minimum drinking age laws on past-year alcohol and drug use disorders. Alcohol Clin Exp Res. 2009 Dec;33(12):2180–2190.

[11] Academy of Medical Sciences. Calling time: the nation's drinking as a major health issue. A report from the Academy of Medical Sciences. London; 2004.

[12] WHO Expert Committee on Problems Related to Alcohol Consumption, Second Report. WHO Technical Report Series 944, p47. Available at http://www.who.int/substance_abuse/expert_committee_alcohol/en/.

[13] Alcohol Advertising Review Board Content and Placement Code, available at http://www.alcoholadreview.com.au/resources/Alcohol-Advertising-Review-Board-Content-and-Placement-Code-July-2012.pdf.

Density and size restrictions on alcohol outlets

The RACP strongly supports changes to include the density of existing alcohol trading outlets as a key consideration in the decision making process for approving or denying an application for a new alcohol outlet.

A recent review of available studies concluded that 'regulation of alcohol outlet density may be a useful public health tool for the reduction of excessive alcohol consumption and related harms'.[14] There is a large body of evidence linking the density of outlets with the incidence of high risk drinking, including teenage binge drinking,[15] illegal underage purchasing of alcohol,[16] and secondary supply of alcohol to adolescents;[17] as well as various forms of alcohol-related harms.[18] These relationships apply to both on license and off license outlets. For example, a Victorian study has estimated that a 10 per cent increase in general license rates in one area increases assault rates by 0.6 per cent, while a 10 per cent increase in off-licence rates increases assault rates by 0.8 per cent.[19] One reason for this relationship is that outlet density means increased competition between outlets, including the discounting of alcohol products,[20] with prices lower in areas with a higher density of liquor outlets.[21]

Two main approaches for regulating outlet density have been adopted internationally. In the UK, local authorities can designate 'saturation zones' within licensing policies, meaning no new licensed premises are permitted in that area.[22] Alternatively, cluster controls can be established, which prohibit new liquor licences if they are within a given distance from licensed premises of the same category. This approach has been adopted in the UK, Paris and New York.[23]

The RACP urges the NT government to give serious consideration to these options being incorporated into the decision making for additional licence applications.

[14] Campbell CA et al. The effectiveness of limiting alcohol outlet density as a means of reducing excessive alcohol consumption and alcohol-related harms. *Am J Prev Med* 2009;37(6):556–569.
[15] Livingston AM, Laslett AM, Dietze P. Individual and community correlates of young people's high-risk drinking in Victoria, Australia. Drug Alcohol Depend. 2008 Dec;98(3):241–248; McKetin R, Livingston M, Chalmers J, Bright D. The role of off-licence outlets in binge drinking: a survey of drinking practices last Saturday night among young adults in Australia. Drug and Alcohol Review 2014;33(1):51–58. http://dx.doi.org/10.1111/dar.12073; Rowland B et al. Associations between alcohol outlet densities and adolescent alcohol consumption: a study in Australian students. Addictive Behaviors 2014;39(1):282–288. http://dx.doi.org/10.1016/j.addbeh.2013.10.001; Huckle T et al. Density of alcohol outlets and teenage drinking: living in an alcogenic environment is associated with higher consumption in a metropolitan setting. Addiction 2008 Oct;103(10):1614–1621
[16] Rowland B, Toumbourou JW, Livingston M. The association of alcohol outlet density with illegal underage adolescent purchasing of alcohol. Journal of Adolescent Health 2015;56(2):146–152. http://dx.doi.org/10.1016/j.jadohealth.2014.08.005.
[17] Rowland B, Toumbourou JW, Satyen L, Livingston M, Williams J. The relationship between the density of alcohol outlets and parental supply of alcohol to adolescents. Addictive Behaviors 2014;39(12):1898–1903. http://dx.doi.org/10.1016/j.addbeh.2014.07.025.
[18] Donnelley N et al. Liquor outlet concentrations and alcohol-related neighbourhood problems. Sydney: Bureau of Crime Statistics and Research, Sydney; 2006; Chikritzhs P, Catalano P, Pascal R, Henrickson N. Predicting alcohol-related harms from licensed density: a feasibility study. Hobart: National Drug Law Enforcement Research Fund: 2007, pp. x–xv; Gruenewald P. Ecological models of alcohol outlets and violent assaults: crime potentials and geospatial analysis. Addiction 2006;101(5):666–677
[19] Livingston M. A longitudinal analysis of alcohol outlet density and assault. Alcoholism: Clinical & Experimental Research 2008;32(6):1074–1079.
[20] New Zealand Law Commission. Alcohol in our lives: curbing the harm. Final report; 2010.
[21] Cameron M et al. The impacts of liquor outlets in Manukai City. Research Report No. 3. Wellington: Alcohol Advisory Council of New Zealand.
[22] Hadfield P, Measham F. A review of nightlife and crime in England and Wales. In P Hadfield (ed.). Nightlife and crime: social order and governance in international perspective. New York: Oxford University Press; 2009.
[23] Code de La Sante Publique Article L3335-1 and L3335-2.

Current NT harm reduction measures

Existing alcohol harm reduction measures in the Northern Territory highlighted in the Issues Paper include the implementation of a Banned Drinker Register, funding for sobering up shelters, funding for treatment services (including the development of a remote workforce program to support these services), development and implementation of plans to address foetal alcohol spectrum disorders (FASD) and various other measures aimed at domestic violence services and public housing safety.

Of these measures, the RACP's comments will focus on the proposals on the development and implementation of plans to address FASD, and to provide appropriate treatment programs and fund a workforce program to treat those in remote communities. The RACP holds that these are two of the most important areas in which to invest.

We welcome the NT Government's commitment to respond to the recommendations of the Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorder.

Available data indicates that parts of the NT have among the highest rates of FAS and FASD in Australia. For instance, a study in the Top End found a birth prevalence of FAS of 0.68 per 1,000 live births, with a higher rate in Aboriginal and Torres Strait Islander children (1.9 per 1,000 Indigenous live births).[24] Clinicians estimate that the prevalence of FAS may be as high as 15 per 1,000 children among Aboriginal and Torres Strait Islander communities in far north Queensland.[25]

Elements of an appropriate FASD prevention strategy would include the following:

- educating communities, particularly high-risk communities, on the harms of alcohol use in pregnancy;
- educating and supporting health professionals to provide primary care, specialised services for women, and antenatal care;
- establishing specialist multidisciplinary clinics;
- ensuring better dissemination of national NHMRC guidelines on alcohol use in pregnancy to health professionals and the general public, for instance through GP clinics; and
- providing routine screening and early interventions for pregnant women who misuse alcohol or have alcohol dependency.

Elements of an appropriate strategy to facilitate improvements in early diagnosis and management of FASD should include the following:

- providing all health professionals with information and training about the potential harms of alcohol use in pregnancy and the diagnosis and management of FASD;
- investing in the establishment and training of multidisciplinary teams of health professionals to run assessment and diagnostic clinics for FASD (incorporating a train-the-trainer component and information about specialist services); and
- investing in services for the diagnosis and management of FASD.

[24] Harris K, Bucens I. Prevalence of Fetal Alcohol Syndrome in the Top End of the Northern Territory. Journal of Paediatrics and Child Health 2003;39(7):528–533.
[25] Rothstein J, Heazlewood R, Fraser M. Health of Aboriginal and Torres Strait Islander children in remote Far North Queensland: findings of the Paediatric Outreach Service. Med J Aust 2007;186(10): 519–521.

The RACP also welcomes the NT Government's recognition of the importance of adequately funding treatment services and a workforce for delivering these services in remote areas, for instance through increased funding for programs such as the Remote Alcohol and Other Drugs Workforce program. This kind of targeting of services is strongly evidence based and we hope it will extend to other areas of likely under-treatment.

Studies suggest that drug and alcohol treatment services are scarce in rural Australia,[26] while staff of such services may not have appropriate training or support opportunities.[27] Australian treatment data shows that rates of utilisation of withdrawal management services are lowest in very remote (0.7 per cent) and remote areas (6 per cent) compared to those of major cities (17.7 per cent). [28] These low utilisation rates may be reflective of the current limited availability of alcohol and other drugs (AOD) treatment services, especially withdrawal management services, in rural areas. Thus a similar pattern of low rates of seeking treatment in the more remote areas of the NT would be expected.

Research has also identified a 'distance decay' effect whereby the number of consumers using healthcare services, including AOD services, decreases with increased distance from a service. [29] The underuse of withdrawal management services in these areas may reflect this. In addition to problems of distance and transport, concerns about social stigma, a culture of self-reliance and stoicism, and financial problems due to unemployment or low income may also hold back use of alcohol treatment services in these areas. [30]

There is also cumulative evidence of deficiencies in treatments available for Aboriginal and Torres Strait Islander people, which is particularly pertinent to the NT. For example, a recent survey of AOD centre staff found that 64 per cent of agency workers felt that Indigenous clients' needs were only partially met, and 9 per cent reported that such needs were not met at all. Workers in remote locations were significantly more likely to report a strong need for AOD services for Indigenous Australians. [31]

Another study of a mainstream health service found that outpatient treatment options for alcohol problems were rarely used by Aboriginal and Torres Strait Islander people, who instead tended to use emergency and inpatient services for advanced complications from

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[26] Brady M, Nicholls R, Henderson G, Byrne J. The role of a rural sobering-up centre in managing alcohol-related harm to Aboriginal people in South Australia. Drug Alcohol Rev. 2006;25(3):201–206.
[27] Australian Government Department of Health and Ageing. A national profile of Australian Government funded Aboriginal and Torres Strait Islander substance use specific services. Canberra: Australian Government, Department of Health and Ageing; 2006.
[28] Jackson H et al. Mental health problems in rural contexts: What are the barriers to seeking help from professional providers? Australian Psychologist 2007;42(2):147–160.
[29] Gamm LD. Mental health and substance abuse services among rural minorities. Journal of Rural Health 2004 Summer;20(3):206–209; Rosenblum A et al. Distance traveled and cross-state commuting to opioid treatment programs in the United States. Journal of Environmental and Public Health 2011:ID948789; Zulian G et al. How are caseload and service utilisation of psychiatric services influenced by distance? A geographical approach to the study of community-based mental health services. Social Psychiatry and Psychiatric Epidemiology 2011;46(9):881–891.
[30] Boyd C et al. Australian rural adolescents' experiences of accessing psychological help for a mental health problem. Australian Journal of Rural Health 2007;15(3):196–200; Judd FK, Humphreys JS. Mental health issues for rural and remote Australia. Australian Journal of Rural Health. 2001;9(5):254–258; Morley B et al. Improving access to and outcomes from mental health care in rural Australia. Australian Journal of Rural Health 2007;15(5):304–312; Turpin M, Bartlett H, Kavanagh D, Gallois C. Mental health issues and resources in rural and regional communities: an exploration of perceptions of service providers. Australian Journal of Rural Health 2007;15(2):131–136; Wallace C, Galloway T, McKetin R, Kelly E, Leary J. Methamphetamine use, dependence and treatment access in rural and regional North Coast of New South Wales, Australia. Drug Alcohol Rev. 2009;28(6):592–599.
[31] Roche A et al. The capacity of mainstream alcohol and drug treatment services to respond to the needs of Indigenous Australians. MJA 2009;190(10):582.

drinking or unplanned alcohol withdrawal.[32] It is argued that a lack of treatment uptake among Aboriginal and Torres Strait Islander people may be due to poor cultural appropriateness[33] and a lack of community awareness of the range of treatment services available.[34]

Better coordination and in particular geographic coordination of services can help enhance the effectiveness of AOD services. For instance, consideration should be given to co-locating AOD services with trusted, culturally appropriate medical services and other broader government services such as social services and sobering up shelters.

Aboriginal and Torres Strait Islander people across Australia are not routinely receiving access to the full range of treatment services available to mainstream populations – this is true in urban as well as rural/remote areas.[35] Thus we commend the NT government's attempt to identify opportunities for more targeted treatment services and recommend this be extended to other groups.

We look forward to continuing to contribute to this NT Government Review, and to engaging with the development and implementation of the resulting strategies. Do not hesitate to contact Senior Executive Office, Nell Sproule on Nell.Sproule@racp.edu.au or +61 8 8465 0972 if you would like to discuss any details in this submission or would like to organise further consultation.

Yours sincerely

Dr Catherine Yelland PSM
RACP President

Dr Robert Tait
RACP NT Committee Chair

[32] Teasdale KE et al. Improving services for prevention and treatment of substance misuse for Aboriginal communities in a Sydney Area Health Service. Drug Alcohol Rev. 2008;27(2):152–159.
[33] Ministerial Council on Drugs Strategy. National Drug Strategy: Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2006. Canberra: Commonwealth of Australia; 2003.
[34] Teasdale KE et al. Improving services for prevention and treatment of substance misuse for Aboriginal communities in a Sydney Area Health Service. Drug Alcohol Rev. 2008;27(2):152–159.
[35] Evans I et al. Brief intervention: increasing access to the full range of treatment services for alcohol problems for Aboriginal and Torres Strait Australians; 2008.