Kimberley Aboriginal Health Planning Forum (KAHPF)

Submission to Alcohol restrictions in The Kimberley

Prepared by members of the Drug Alcohol and

Mental Health Subcommittee

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Introduction

The Kimberley Aboriginal Health Planning Forum (KAHPF) was established in 1998 and is represented by all key health stakeholders in the region. The KAHPF plays a crucial role in the ongoing advocacy, planning and development of regional health services within the Kimberley.

Our vision is "For Kimberley Aboriginal people, families and communities to lead strong, self-determining, well and healthy lives".

The KAHPF through it's Drug Alcohol & Mental Health (DAMH) sub-committee presents their views on the proposed Section-64 in the Kimberley, with an emphasis on increasing the evidence base around supply reduction, consideration of unintended consequences and ensuring that supply reduction initiatives draw on best practice, by coinciding with locally driven demand and harm reduction initiatives.

The current range of alcohol restrictions applied across the region are not sufficient to address the alcohol related harm in the Kimberley. Individual mobility across the region and the various liquor restrictions within towns add to the complexity. Anecdotal reports suggest that individuals will travel considerable distances to purchase full-strength alcohol in regional towns.

A region wide approach is needed to best address the complexity of alcohol related harms. The design and implementation of any initiative targeting alcohol-related harm requires a health-driven, interagency approach. This submission includes measures that can be implemented without compromising existing Kimberley-wide restrictions and restrictions within regional towns.

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1. Background

Consumption of alcohol is a function of both supply and demand and in all populations is a result of the interplay of the two factors. Supply reduction measures must be supported by demand reduction strategies to ensure effectiveness. It is also critical that supply reduction measures are supported by both the Aboriginal and Non-Aboriginal community.

It is of significant concern that Drug and Alcohol Prevention Services across the Kimberley are significantly lacking, with only 7000 hours of dedicated prevention activity and currently 0 hours for dedicated harm reduction services[20]. Supply reduction initiatives alone are not enough and will not succeed unless they are accompanied by appropriately resourced demand and harm reduction initiatives[21].

Action to address alcohol related harm should have three essential components:

- the underlying social determinants – including inequality, poverty, early-childhood development, education, environmental health, employment and housing
- the full-range of evidenced-based alcohol specific, demand reduction (e.g. education, media), supply and harm reduction (e.g. social infrastructure improvement; program development) strategies; and
- Aboriginal people and communities need to be adequately resourced and empowered to provide their own alcohol intervention services and strategies. Community capacity building and cross sector collaboration, along with engagement that is locally led, is critical to success[23].

2. Consumption and Harm

2.1. Alcohol Related Harm in the Kimberley

Effective interventions aimed at reducing alcohol related harm among Aboriginal people are dependent upon quality estimates of consumption. Unfortunately, we do not currently have such data. Having access to regular consumption data is required within the region to help assist in evaluating the effectiveness of AOD interventions.

In 2011-2012, the per capita consumption (pure alcohol/year) for the Kimberley population (15+ years) was 16.10 Lt compared to the rest of the state of 11.94 Lt.[1]. In the same year, Kimberley residents were the third highest consumers of alcohol in the state. The other two areas where consumption exceeded the Kimberley was Perth city followed by Fremantle.

Alcohol consumption within the Kimberley has been recorded to have been significantly higher than the state.

- 44% of Kimberley adults having consumed alcohol at a level which could contribute to long term harm[23] and

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- 22% of Kimberley adults identifying to have drank alcohol at short term risk between 2013-2016[25].

Kimberley residents experience the highest rates for alcohol related hospitalisations and deaths across the state[26].

- Alcohol related hospitalisation rates for Kimberley Aboriginal people are 7.1 times higher[25] and
- 3.6 times higher for alcohol related mortality compared to non-Aboriginal people[25].

Nationally alcohol use disorders account for 5.8% of the total burden of disease and injury within Aboriginal men and 2.3% of the disease burden experienced by Aboriginal women[28]. The disease burden due to alcohol experienced by Aboriginal people accounts towards 8.1% of the health gap[27]. It is recognised alcohol use has attributed to the burden of disease across 4 categories; injuries, cardiovascular disease, cancer and other linked disease (i.e. alcohol use disorder, liver disease, epilepsy, pancreatitis and lower respiratory infections)[27]

- Injuries and poisoning were a major causative for 9% (9, 505) of adult hospitalisations within the Kimberley between 2011-2015[25]
- Heart disease attributed to 4,491 (per 100,000 persons) Kimberley hospitalisation rates (age standardised rate) during 2011-2015[26].
- Kimberley residents also experienced a higher rate (1.3 times) of cancer mortality compared to the State[26].
- Convulsions and epilepsy attributed to 10% of 2011-2015 potentially preventable hospitalisations[25].

Harmful use of alcohol also contributes to the increased risk of violence, anti-social behaviour, accidents and mental illness[24]. The Kimberley experiences disproportionate levels of harm due to alcohol consumption compared to the rest of the state. In the period form 2009 – 2013 Alcohol-related domestic assaults were 78.4% compared to the rest of the state of 48%. Alcohol related non-domestic assaults were 60.1% compared to 37.9% for the rest of the state. In terms of health data, the Kimberley faces higher rates of alcohol related harm compared to the rest of the state as follows[2]:

- Treatment presentations (new episodes of care) where alcohol was the primary drug of concern were 25.6% higher than the state average
- Alcohol related hospitalisation rates were 3.7% higher than the state average
- Alcohol related mortality rate was 2.3% higher than the state average

Anecdotal reports from DAMH members indicate that alcohol is the primary drug of concern for a significantly high number of persons presenting to services. These include presentations across alcohol treatment and rehabilitation, homelessness, domestic and family violence and primary health services. The DAMH are particularly concerned with the association between alcohol related presentations and:

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- Rates of Foetal Alcohol Spectrum Disorder
- Diabetes and other chronic diseases
- Road accidents, particularly in remote areas
- Suicide and use of alcohol as a form of, or in combination with self-harm
- Domestic and family violence, assaults and sexual violence
- Incarceration rates
- Alcohol abuse
- Homelessness

2.1.1. Men's Outreach Service. Report from the "Change Em Ways men's behaviour change program"

19 men have been assessed as suitable for the current Change Em Ways workshop. Of these men:

- 10 reported daily, heavy and problematic alcohol consumption which appears to be linked to their violence (53%)
- 3 reported problematic or regular binge drinking (eg fortnightly) which appears to be linked to their violence (16%)
- 6 reported occasional or infrequent alcohol consumption which they did not consider problematic or linked to their violence (31%)
- 0 reported that they did not consume alcohol at all
- 13 men (69%) of the group reported that their alcohol consumption was linked to their violence.
- 160 men have undergone the intake and assessment process for the Change Em Ways program, since its inception. Program staff consider the current sample of 19 to be typical of the overall client group.

Note: a majority of the men reported other substance use (predominantly, cannabis or methylamphetamines) in association with their alcohol use.

2.2. Harm as a result of Supply reduction measures - Section 64 Restrictions, evidence base and unintended consequences

The DAMH/KAPHF does not seek to compromise restrictions in regional towns such as Fitzroy Crossing and Halls Creek, as all such initiatives should be led by local communities, however, it is important that 'lessons learned', from such initiatives are considered in terms of shaping future, evidence based strategies.

Section 64 Restrictions have been trialled in both Halls Creek and Fitzroy Crossing and initially, evaluations of the restrictions appeared promising, showing reduced hospital admissions between 2003 and 2013[9]. However, other research suggests that positive effects have been eroded over time [10, 11]. The KAPHF/DAMH are concerned about the lack of reliable longitudinal evaluation to show lasting change, and also the unintended consequences which may occur as a result of the introduction of section 64 alcohol

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restrictions across the Kimberley. A list of potential unintended consequences are outlined below.

2.2.1. Increased population mobility and displacement

Increased population mobility has been found to be a common impact of alcohol restrictions in other parts of Australia and around the world [10,11,12, 13,14,15]. If a section-64 is implemented, those unable to access full strength alcohol at a local level may travel greater distances, potentially outside of the Kimberley. This relocation can overstretch services, lead to overcrowding, homelessness, antisocial behaviour, road accidents and decreased school attendance. Such consequences carry the potential of negatively impacting communities by limiting resources to respond to crisis' and support for families.

2.2.2. Black market and secondary supply

Restrictions have been seen to incentivise an organised black market in alcohol and also lead to substitution with other substances such as illegal drugs or home brew. Exorbitant costs of 'illegal' alcohol, combined with the effects of money leaving the local communities, results in damage to individual wellbeing and to local economies. There have also been reports of increased use of other substances such as marijuana [10, 11] and increases in home brewing. Overall, regulated alcohol is much safer for consumers than an unregulated (home brewed) mix, which can be created in poor conditions, using harmful ingredients, with poor fermentation potentially leading too adverse health outcomes [16].

2.2.3. Increased criminalisation and discrimination

In the event that those engaged in the black market receive criminal convictions, (criminalisation) there is a major concern that this will result in increased harm. It is questionable as to whether increased criminalisation will result in any meaningful change and will likely have the alternative effect, leading to increased poverty, recidivism, barriers to gaining employment and an overburdening on law enforcement and the justice system. Discrimination has also been implied in restrictions, highlighting the importance of initiatives being locally driven by[17].

3. The Banned Drinkers Register (BDR)

After evaluation of the banned drinkers register in 2018, it is clear that further work and longitudinal evaluation is required to ensure that this initiative does not inadvertently cause further harm. In the Norther Territory, the majority of people placed on the banned drinkers register were Indigenous; leading some researchers to argue that it is discriminatory in nature[31]. Further, initial results showed that while there was some reduction in involvement in the criminal justice system (and breaches of bans), a significant proportion of people (60% in 2017 and 30% in 2018) on the BDR were in custody during the evaluation period. Where this is the case, breaches of bans and committing of further offences cannot occur, thus it is

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difficult to determine impacts of the BDR. The evaluation also pointed to the failure of the BDR to circumvent secondary supply of alcohol to those on the register. Among key messages from the BDR evaluation were:

- That it is only one measure among multiple harm minimisation initiatives
- Its impacts need to be considered in the context of broader reforms
- Longitudinal evidence is a requirement to determine effectiveness
- Support for those on the BDR should increase by looking at linkage to health and justice systems
- That self-referral pathways be strengthened and promoted [30]

Patron banning orders have been referred to as a form of 'exclusionary punitivism' that focus on defining and controlling an individual, rather than the wider elements which underpin alcohol related problems. Palmer and Warren note (2014) state:

"Any failure of individuals to adapt to greater levels of policing and surveillance will only increase the number of accumulated incivility demerit points and their exclusionary impacts (p.15).

*It has been consistently argued that individual controls are a poor substitute for population based strategies" (*room15).

4. The DAMH/KAHPF's preferred 'package of restrictions'

There is good evidence for the effectiveness of a range of supply reduction interventions but the three for which the evidence is strongest are: price and taxation; reducing or changing trading hours; and a minimum drinking or purchasing age. The KAHPF/DAMH supports strategies that target price and taxation and the regulation of trading hours as these two strategies have the greatest impact within Aboriginal communities[3].

Supply reduction strategies can result in rapid reductions in excessive consumption and harm. Demand reduction strategies take longer to have an impact, however, are necessary to support sustainable changes initiated by supply reduction measures. The KAHPF/DAMH proposes the consideration of a broader package of restrictions including price and taxation, reduced trading hours and reducing access to high risk beverages.

4.1. Price and taxation

Increasing price of alcohol is the most effective means of reducing consumption. There are three ways of achieving this; Increases in the taxation; imposing a minimum price per unit of alcohol in beverages below which they cannot be sold; and by banning the sale of low-priced beverages.

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Increased taxation is effective in reducing demand where this revenue is spent on increasing employment, sport and entertainment, creating harm reduction initiatives and assisting people to live more fulfilled lives[31]

Setting a minimum unit price (MUP) for alcohol is an efficient and cost-effective way to reduce alcohol consumption[4]. A minimum unit price (MUP) for alcohol was introduced in the Northern Territory in October 2018. This measure has shown to be effective in reducing alcohol-related harm[5]. A report assessing the impact of a minimum unit price one year after implementation found reductions in alcohol-related road crashes causing injury or fatality, assaults, ambulance attendances and emergency department presentations[5].

There have also been reductions in episodes of protective custody. The report found that the minimum unit price had no significant impact on tourism (pre-coronavirus period), or the number of liquor licences in the Norther Territory[5].

MUP is part of a suite of effective harm reduction measures and can be implemented alongside other measures such as the introduction of a volumetric tax on alcohol, implementing comprehensive demand reduction strategies and stricter policing of liquor outlets.

Taxation laws are the responsibility of the federal government, however, it is possible that state and territory governments can influence the price of alcoholic beverages by other means. For example, in Alice Springs, the Peoples Alcohol Action Coalition (PAAC) argued for the trial imposition by the Northern Territory Government of a MUP per standard drink. PAAC has argued that a MUP was not a form of taxation and as the benchmark applied to all beverages and licensees, it would not contravene the 'public interest' provisions of National Competition Policy[6]. In the Northern Territory, legislation makes the minimum unit price a condition of holding a liquor licence.

It has been proposed that using price as a strategy for reducing high levels of alcohol consumption and related harm will result in an adverse effect on Aboriginal people[7]. The basis of this argument is that among Aboriginal people, the demand for alcohol is 'price inelastic' (has a low elasticity value). That is, in response to increases in the unit price of alcoholic beverages, rather than reducing consumption, Aboriginal people will divert financial resources away from the purchase of essential items such as foodstuffs in order to maintain alcohol consumption levels.

In response to this, there is no evidence to support such a finding. Although elasticity values may vary, the literature demonstrates that alcohol consumption is inversely responsive to changes is price and that heavy drinkers and young people are more responsive than other population groups[3]. There is also limited evidence to suggest that increasing the unit price of alcohol will result in substitution (where alcohol is substituted for other drugs or volatile substances).

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The KAPHF strongly endorse trialling MUP across the Kimberley, provided there is robust, longitudinal evaluation is to coincide with its implementation. A comprehensive review of 517 studies assessing the effects of MUP, found that many had methodological flaws, although 33 studies showed considerable merit. From this, it was concluded that, *"it is highly probable, but not definite, that introducing MUP for alcohol would reduce alcohol consumption and alcohol-related harms".* Ongoing research to evaluate the effectiveness of such measures is critical to expand on the existing evidence base[19].

4.2. Reduced trading hours

Reductions in the hours of trading for licenced premises have demonstrated to be effective in reducing alcohol consumption and related harm in Aboriginal communities. This is also supported by international evidence.

In April 2002 restrictions on trading hours were trialled in Alice Springs. Takeaway liquor sales were restricted to between the hours of 2:00 pm and 9:00 pm on weekdays. In the 12-months prior to the introduction of the restrictions, the number of persons taken into police custody averaged 999 per month. In the trial restrictions period, there was a statistically significant decline of 34 per cent to an average of 659.This reduction was mostly attributable to the reduction of takeaway trading hours and the restrictions on front bar trading[8].

4.3. Reducing access to high risk beverages

Introduction of the Takeaway Alcohol Management System (TAMS) across the region where packaged liquor is sold. The TAMS must be supported by strict compliance by liquor outlets and rigorous enforcement by authorities.

We propose the following to daily restriction be implemented to support the TAMS.

- Daily purchase of 1 carton of Full-Strength beer, cider and pre-mixed drinks.
- No limit on mid strength and low alcohol beer.
- Daily purchase of 2 bottles of wine.
- Daily purchase of 750mL Spirits, 750mL fortified wine.

Special exemption for pre-ordering of bulk purchases of alcohol consistent with Kununurra and Wyndham. Larger quantities of alcohol will require a completed Broome Liquor Accord Form which can be obtained from one of the local takeaway alcohol outlets. The form will then be submitted to the local Police for approval. This needs to be completed at least 72 hours in advance.

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5. Summary and recommendations

The aim of alcohol policy is to reduce or minimise the impact of alcohol misuse on public health and safety. Alcohol-related problems are most likely to respond to changes in the physical and economic availability of alcohol.

Recommendation 1: The KAHPF/DAMH recommends that a "package of restrictions" be implemented across the region that consists of applying a minimum unit price to alcohol, reduction in trading hours where packaged liquor is sold, reducing access to high risk beverages and extending TAMS across the region. Such initiatives must coincide with well-funded health promotion campaigns.

Recommendation 2: Improved planning and investment into Prevention services, which enhances demand and harm reduction initiatives is required. Alcohol is a health and social issue that impacts the whole community. It is crucial that the implementation of supply reduction measures be supported with parallel demand and harm reduction interventions, as well as early intervention with general practitioners and other primary care settings. This would require an increased level of funding to support targeted community driven initiatives, research and data collection to evaluate the effectiveness of interventions across the region.

Recommendation 3: There is a requirement for improved access to data, including alcohol sales data and data relating to alcohol related harm. Meaningful change will draw on more reliable and accessible data over time.

Recommendation 4: Implementation of a banned drinkers register must be further evaluated, particularly the effects of further discrimination, social exclusion and punitivism toward people involved in the justice system. It must be implemented in a manner that considers linkage to health, justice and community services, particularly, with consideration to the availability of comprehensive domestic and family violence programs. It should not be considered as a substitute for population based strategies.

Recommendation 5: There is a need for improved longitudinal evaluation incorporating robust evaluation/research methodology. While some interventions may have seen initial, promising results, it is possible that results can erode over time. Long term change requires careful and robust evaluation.

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