8. Alcohol

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Summary

8.1 The Terms of Reference ask the ALRC to have regard to laws that may contribute to the rate of Aboriginal and Torres Strait Islander peoples offending including, for example, laws that regulate the availability of alcohol.

8.2 Liquor licensing laws fall within state and territory jurisdiction. In this chapter, the ALRC considers proposals to address harmful alcohol use and outlines previous recommendations by other inquiries and initiatives to address alcohol-related harms.

8.3 The Terms of Reference direct this Inquiry to consider laws regulating alcohol that may contribute to the rate of offending of Aboriginal and Torres Strait Islander peoples. However, the ALRC recognises that other substance abuse issues may also contribute, including the use and availability of illicit and non-illicit drugs, and the use of inhalants.

Alcohol and offending

8.4 A number of prior inquiries have identified widespread problems relating to the harmful use of alcohol and the links between alcohol and offending. For example, the 2013 National Drug Strategy Household Survey found that, while many drinkers in the Australian community consume alcohol responsibly, there is a substantial proportion of drinkers who consume alcohol at levels considered to increase the risk of alcohol-related harm.[1]

1 Australian Institute of Health and Welfare, *National Drug Strategy Household Survey Detailed Report* (2013) 40.

8.5 The National Drug Strategy 2010–2015, developed by the Ministerial Council on Drug Strategy, noted that 'excessive consumption of alcohol is a major cause of health and social harms' and that

> [s]hort episodes of heavy alcohol consumption are a major cause of road and other accidents, domestic and public violence, and crime. Long-term heavy drinking is a major risk factor for chronic disease, including liver disease and brain damage, and contributes to family breakdown and broader social dysfunction.[2]

8.6 With respect to Aboriginal and Torres Strait Islander peoples, the National Aboriginal and Torres Strait Islander Health Survey 2004–05 reported that, overall, fewer Aboriginal people drink alcohol than non-Indigenous people.[3] However, later inquiries have identified the harmful effects of alcohol in Aboriginal and Torres Strait Islander communities.[4]

8.7 In 2015, the House of Representatives Standing Committee on Indigenous Affairs conducted an inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities. The report made 33 recommendations concerning best practice strategies to minimise alcohol misuse and alcohol-related harm and best practice alcohol treatments and support.[5]

8.8 Submissions to the House of Representatives Inquiry spoke of the harm that alcohol abuse continues to cause Aboriginal communities and its connection to the over-representation of Aboriginal people in the criminal justice system.[6] For example, the Australian Crime Commission noted that alcohol was a factor in 78% of violent offences involving Aboriginal and Torres Strait Islander persons dealt with in the Alice Springs Supreme Court in 2010;[7] and the Northern Territory (NT) Police Association said that 60% of all assaults and 67% of reported domestic violence incidents in the NT involved alcohol.[8]

8.9 The Victorian Aboriginal Controlled Health Organisation (VACCHO) referred to research conducted through a partnership between the Victorian Department of Justice, Monash University and VACCHO, that showed the levels of alcohol and drug

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2 Ministerial Council on Drug Strategy, *National Drug Strategy 2010–2015: A Framework for Action on Alcohol, Tobacco and Other Drugs* (2011) 2.

3 Australian Bureau of Statistics, *National Aboriginal and Torres Strait Islander Health Survey, 2004–05, Cat No 4715.0* (2006) tables 6, 17; Australian Bureau of Statistics, *National Health Survey: Summary of Results, 2004–05, Cat No 4364.0* (2006) table 17.

4 House of Representatives Standing Committee on Indigenous Affairs, Parliament of Australia, *Alcohol, Hurting People and Harming Communities: Inquiry into the Harmful Use of Alcohol in Aboriginal and Torres Strait Islander Communities* (2015).

5 Ibid.

6 See, eg, Central Australian Aboriginal Legal Aid Service, Submission No 56 to Standing Committee on Indigenous Affairs, Parliament of Australia, *Inquiry into Harmful Use of Alcohol in Aboriginal and Torres Strait Islander Communities* (April 2014) 2.

7 Australian Crime Commission (ACC), Submission No 59 to Standing Committee on Indigenous Affairs, Parliament of Australia, *Inquiry into the Harmful Use of Alcohol in Aboriginal and Torres Strait Islander Communities: Alcohol, Hurting People and Harming Communities* (17 April 2014).

8 Northern Territory Police Association, Submission No 27 to Standing Committee on Indigenous Affairs, Parliament of Australia, *Inquiry into the Harmful Use of Alcohol in Aboriginal and Torres Strait Islander Communities: Alcohol, Hurting People and Harming Communities* (16 April 2014).

use in Victorian Aboriginal people in prison were higher than for non-Aboriginal prisoners, contributing to increasing rates of Aboriginal incarceration.[9]

8.10 A 2009 review of the Alice Springs Alcohol Management Plan has suggested that high levels of alcohol consumption are associated with high levels of alcohol-related harm and low consumption with low levels of harm. Drawing on the work of the National Drug Research Institute (2007), the review identified the most effective measures of reducing alcohol-related harm included:

- restrictions on the hours and days of sale on licensed premises;
- minimum legal drinking age enforcement for consumption and purchase;
- restrictions on high risk alcohol beverages (eg, cheap cask wine/fortified wine);
- outlet density;
- dry community declarations (when communities request declaration);
- mandatory packages of restrictions for remote and regional areas;
- restrictions on service to intoxicated people when enforced; and
- community-based interventions when enforced.[10]

8.11 While a connection between alcohol abuse and criminal conduct has been identified, criminalising alcohol consumption may not be an appropriate response. The National Congress of Australia's First Peoples (National Congress) has described such an approach as a 'failed strategy, merely adding to a cycle of escalating rates of incarceration. It hides specific problems in watch-houses, prisons and institutions and provides no remedy. This approach should play no future part in the alcohol policy'.[11]

8.12 The National Congress also argued that alcohol offences should not be seen as a criminal justice issue, but rather as a social and health problem:

> the way forward lies in a health and wellbeing approach based on community healing and personal rehabilitation, which addresses the historical and social factors which contribute to an unhealthy social environment and targets resources at those areas affected.[12]

Foetal Alcohol Spectrum Disorder

8.13 Alcohol consumed during pregnancy has been shown to cause defects in the developing foetus. The National Drug Strategy 2010–2015 pointed out that '[d]rinking during pregnancy can cause birth defects and disability, and there is increasing

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9 Victorian Alcohol & Drug Association, Submission No 29 to Standing Committee on Indigenous Affairs, Parliament of Australia, *Inquiry into Harmful Use of Alcohol in Aboriginal and Torres Strait Islander Communities* (April 2014).

10 Suzanne MacKeith, Dennis Gray and Tanya Chikritzhs, *Review of Moving Beyond the Restrictions: The Evaluation of the Alice Springs Alcohol Management Plan—A Report Prepared for the Alice Springs People's Alcohol Action Coalition* (2009) 12.

11 National Congress of Australia's First People, Submission No 97 to Standing Committee on Indigenous Affairs, Parliament of Australia, *Inquiry into Harmful Use of Alcohol in Aboriginal and Torres Strait Islander Communities* (2014) 2.

12 Ibid 3.

evidence that early onset of drinking during childhood and the teenage years can interrupt the normal development of the brain'.[13]

8.14 Foetal Alcohol Syndrome (FAS) and Foetal Alcohol Spectrum Disorders (FASD) describe a range of conditions that result from prenatal alcohol exposure during pregnancy. FAS and FASD can affect an unborn child exposed to alcohol in utero, with risk increasing as a multiple of the frequency and intensity of alcohol consumption. The effects of FAS and FASD on cognitive functioning and behaviour first noticed in children continue through to adulthood.[14]

8.15 Studies of the prevalence of FAS and FASD are limited. According to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG):

> FASD is a community wide problem with prevalence rates of Fetal Alcohol Syndrome (FAS) reported to be between 0.064 and 0.685 per 1,000 live births in Australia. Indigenous women are less likely to consume alcohol than non-Indigenous women but those who do are more likely to consume harmful amounts. FAS is up to 4 times higher in Indigenous Australians: 2.767 to 4.75 per 1,000 live births.[15]

8.16 RANZCOG describes the range of behavioural disabilities associated with FAS as 'behavioural disorders (eg, poor impulse control) and developmental delay (eg, impaired language and communication, social and emotional delays). These have lifelong implications such as impaired education, employment and imprisonment'.[16]

8.17 Some research points to FAS and FASD contributing to Aboriginal incarceration rates.[17] However, data on the relationship between imprisonment and FASD is scarce. One Canadian study found that youths with FASD are 19 times more likely to be incarcerated than youths without FASD in a given year.[18] There is limited statistical information in Australia about incarcerated persons with FASD:

> Limited research has investigated the relationship between FASD and contact with the criminal justice system in Australia. The limited Australian literature, complemented by international research, indicates that FASD should be considered at every stage of

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13 Ministerial Council on Drug Strategy, *National Drug Strategy 2010–2015: A Framework for Action on Alcohol, Tobacco and Other Drugs* (2011) 2.

14 House of Representatives Standing Committee on Indigenous Affairs, Parliament of Australia, *Alcohol, Hurting People and Harming Communities: Inquiry into the Harmful Use of Alcohol in Aboriginal and Torres Strait Islander Communities* (2015) 107.

15 Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Submission No 66 to Standing Committee on Indigenous Affairs, Parliament of Australia, *Inquiry into Harmful Use of Alcohol in Aboriginal and Torres Strait Islander Communities* (2014); House of Representatives Standing Committee on Indigenous Affairs, Parliament of Australia, *Alcohol, Hurting People and Harming Communities: Inquiry into the Harmful Use of Alcohol in Aboriginal and Torres Strait Islander Communities* (2015) 99.

16 Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Submission No 66 to Standing Committee on Indigenous Affairs, Parliament of Australia, *Inquiry into Harmful Use of Alcohol in Aboriginal and Torres Strait Islander Communities* (2014).

17 Harry Blagg, Tamara Tulich and Zoe Bush, 'Placing Country at the Centre: Decolonising Justice for Indigenous Young People with Foetal Alcohol Spectrum Disorders (FASD)' (2015) 19(2) *Australian Indigenous Law Review* 4.

18 Svetlana Popova et al, 'Fetal Alcohol Spectrum Disorder Prevalence Estimates in Correctional Systems: A Systematic Literature Review' (2011) 102(5) *Canadian Journal of Public Health* 336.

> the criminal justice system, from offending behaviour, through to court proceedings, as well as throughout incarceration and post-release. There is no Australian estimate of the number of offenders with FASD. Overseas studies of individuals with FASD, however, demonstrate high rates of contact with the criminal justice system.[19]

8.18 The National Indigenous Drug and Alcohol Committee made six specific recommendations directed at FAS and FASD, including: community information campaigns about the effects of consuming alcohol while pregnant; training of health practitioners to increase the earlier diagnosis and to assist in early identification and intervention; and other initiatives to address available support for people with FASD.[20] Funding Indigenous organisations to provide mentoring and family and support services as well as 'on-country' camps that aim to stabilise affected young people while attempting to heal families may also address the social effects of FAS and FASD more appropriately than a criminal justice response.[21]

8.19 A Commonwealth Action Plan to reduce the Impact of Foetal Alcohol Spectrum Disorders (FASD) 2013–14 to 2016–17 aims to improve outcomes for FASD affected infants as well as reducing its incidence in the population.[22]

A focus on harm reduction

8.20 As a response to harms associated with alcohol abuse and misuse, governments have prepared and implemented various strategies or plans. For example, the Intergovernmental Committee on Drugs developed the National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014–2019 (Drug Strategy).[23] The Drug Strategy provides a roadmap for work that might be done to minimise the negative effects of alcohol and other drugs (AOD), suggesting:

> In order to reduce high levels of harmful AOD use among some segments of the Aboriginal and Torres Strait Islander population it is necessary to: prevent or minimise the uptake of harmful use; provide safe acute care for those who are intoxicated; provide treatment for those who are dependent; support those whose harmful AOD use has left them disabled or cognitively impaired; and support those whose lives are affected by other's harmful AOD use.[24]

8.21 The Drug Strategy adopted a harm minimisation approach, identifying 'three pillars' of reduction focused on demand, supply and harm.[25]

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19 National Indigenous Drug and Alcohol Committee, *Addressing Fetal Alcohol Spectrum Disorder in Australia* (2012) 10.

20 National Indigenous Drug and Alcohol Committee, Submission No 94 to Standing Committee on Indigenous Affairs, Parliament of Australia, *Inquiry into Harmful Use of Alcohol in Aboriginal and Torres Strait Islander Communities* (2014) 18–9.

21 Harry Blagg, Tamara Tulich and Zoe Bush, above n 17.

22 Australian Government, *Responding to the Impact of Fetal Alcohol Spectrum Disorders in Australia: A Commonwealth Action Plan* (2013).

23 Intergovernmental Committee on Drugs, *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014–2019* (2015) 3. The Drug Strategy is a sub-strategy of the National Drug Strategy 2010–2015.

24 Ibid 10.

25 Ibid 5.

8.22 In an Aboriginal and Torres Strait Islander context such approaches were described as follows:

> Demand reduction strategies aim to reduce the appeal of alcohol, tobacco and other drugs, and drug taking. Prevention and early intervention are key elements of effective demand reduction strategies. Strategies that are effective in this context include preventative strategies such as early intervention, education and health promotion, provision of alternatives to AOD use; community-led initiatives leading to alcohol bans, permits and restrictions on hours of supply. For optimal treatment outcomes, a range of treatment options (provided in various settings) aimed at reducing individual demand, including screening and brief interventions, withdrawal management, pharmacotherapies, counselling, social support and ongoing support to reduce relapse rates need to be available.
>
> Supply reduction strategies aim to reduce the availability of alcohol, tobacco and other drugs, and control their use. Strategies that are effective in this context include indirect price controls by banning cheap high alcohol content beverages such as cask wine, restrictions on trading hours, fewer outlets, dry-community declarations and culturally sensitive enforcement of existing laws. A petrol sniffing strategy implemented by the Australian Government replacing unleaded petrol with a low aromatic alternative has led to significant reductions in petrol sniffing.
>
> Harm reduction strategies aim to reduce the negative effects of AOD use, without necessarily expecting people who use drugs to stop or reduce their use. Effective harm reduction strategies include: bans on the serving of alcohol in glass containers, night patrols, and sobering-up shelters.[26]

8.23 A range of responses have been recommended in combating alcohol abuse in Aboriginal and Torres Strait Islander communities. These include: dry communities; pricing controls; supply reduction strategies and reduction in trading hours; community controls and patrols; and other laws that restrict the sale of alcohol to intoxicated persons.[27] The 2015 House of Representatives Inquiry noted that Justice Reinvestment approaches also provided a 'promising strategy for reducing the number of Aboriginal and Torres Strait Islander people who are incarcerated for alcohol-related offences'.[28]

8.24 One review has suggested that the following alcohol reduction measures have not been successful at reducing harm, and, in some cases, have increased harm:

- staggered opening hours for licensed premises (which may increase violence);
- restrictions on service to intoxicated people when not enforced;
- liquor accords and community-based interventions when not enforced;
- local dry area alcohol bans (which do not decrease public disorder or hospitalisations, tends to elevate harms to Indigenous people, and often have the effect of being discriminatory);

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26 Ibid 12.

27 Dennis Gray and Edward Wilkes, 'Reducing Alcohol and Other Drug Related Harm' (2010) 3 *Closing the Gap Clearinghouse* 1.

28 House of Representatives Standing Committee on Indigenous Affairs, Parliament of Australia, *Alcohol, Hurting People and Harming Communities: Inquiry into the Harmful Use of Alcohol in Aboriginal and Torres Strait Islander Communities* (2015) 84. Justice reinvestment is discussed in detail in ch 13.

- wet canteens in Indigenous communities … community concerns relate to conflict between control of consumption and dependence on profits).[29]

Assessing solutions

Question 8–1 Noting the link between alcohol abuse and offending, how might state and territory governments facilitate Aboriginal and Torres Strait Islander communities, that wish to do so, to:

(a) develop and implement local liquor accords with liquor retailers and other stakeholders that specifically seek to minimise harm to Aboriginal and Torres Strait Islander communities, for example through such things as minimum pricing, trading hours and range restriction;

(b) develop plans to prevent the sale of full strength alcohol within their communities, such as the plan implemented within the Fitzroy Crossing community?

Question 8–2 In what ways do banned drinkers registers or alcohol mandatory treatment programs affect alcohol-related offending within Aboriginal and Torres Strait Islander communities? What negative impacts, if any, flow from such programs?

8.25 This section outlines a range of responses that have been trialled to address alcohol-related offending, including liquor accords, restrictions on the sale of alcohol, banned drinkers registers and mandatory treatment programs, and asks for submissions on their effectiveness.

Owning solutions

8.26 The Drug Strategy pointed out that, to achieve meaningful outcomes, there would need to be Aboriginal and Torres Strait Islander ownership of solutions, where 'development of actions to achieve each outcome should be led by local communities in collaboration with government and non-government sectors':[30]

> Aboriginal and Torres Strait Islander people should be meaningfully included and genuinely consulted regarding the development of solutions to harmful AOD use. Aboriginal and Torres Strait Islander ownership of solutions should occur from inception and planning, right through to implementation and provision, and monitoring and evaluation of any solutions.[31]

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29 Suzanne MacKeith, Dennis Gray and Tanya Chikritzhs, above n 10, 12–3, citations omitted.
30 Intergovernmental Committee on Drugs, above n 23, 18.
31 Ibid 4.

8.27 The Drug Strategy identified four priority areas:

> **Priority area one**
>
> Build capacity and capability of the AOD service system, particularly Aboriginal and Torres Strait Islander community-controlled services and its workforce, as part of a cross-sectoral approach with the mainstream AOD services to address harmful AOD use.
>
> **Priority area two**
>
> Increase access to a full range of culturally responsive and appropriate programs, including prevention and interventions aimed at the local needs of individuals, families and communities to address harmful AOD use.
>
> **Priority area three**
>
> Strengthen partnerships based on respect both within and between Aboriginal and Torres Strait Islander peoples, government and mainstream service providers, including in law enforcement and health organisations, at all levels of planning, delivery and evaluation.
>
> **Priority area four**
>
> Establish meaningful performance measures with effective data systems that support community-led monitoring and evaluation.[32]

8.28 The importance of ownership of solutions has been emphasised by Dennis Gray and Edward Wilkes, who argued that '[d]espite gaps in our knowledge, there is ample evidence to show what can be done to reduce AOD (Alcohol and other drug)-related harm. What is needed is the commitment to do it—with and not for Indigenous people'.[33]

Liquor accords

8.29 The liquor industry, comprised of off-licence packaged liquor retailers commonly referred to as 'bottle shops', and on-licence liquor providers, such as hotels and registered clubs, have in many instances sought to regulate the sale of liquor to reduce or minimise the harm of alcohol misuse or alcohol abuse.

8.30 Large liquor industry players, such as Wesfarmers (Coles), having a 33.5% share, and Woolworths, having a 40.2% share of the retail liquor market as of 2015,[34] have historically joined as members of accords across states and territories.

8.31 A liquor accord, as the NT chapter of the Australian Hoteliers Association (AHA (NT)) has explained, is

> a written agreement between licensed venues and other stakeholders, with the purpose of working together to support one another on issue/s of mutual concern. For

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32 Ibid 4–5.

33 Dennis Gray and Edward Wilkes, above n 27, 2. See also Alison Ritter et al, *New Horizons: The Review of Alcohol and Other Drug Treatment Services in Australia—Final Report* (UNSW, 2014).

34 Liquor Marketing Group, Submission to the South Australian Attorney-General *Liquor Licensing Discussion Paper* (February 2016) 3.

> example a liquor accord may be created to assist in the reduction of alcohol misuse and associated harms within a local community.
>
> Depending on the specific needs and characteristics of the region involved, most liquor accords include members from the local business community, local councils, local police, government departments and other community focused organisations. Voluntary participation by licensees in local area initiatives is allowed for when a stakeholder of a liquor accord and liquor related problems can be addressed with the introduction of practical solutions. Such teamwork aims to ensure that precincts and venues are safe and enjoyable places in which to meet and socialise which will ultimately enhance community life and enjoyment of the local area.[35]

8.32 The AHA (NT) assists in the development and implementation of Alcohol Management Plans and received funding from the Department of Business to assist industry to develop, maintain and promote liquor accords within the NT.

8.33 The AHA (NT) considered that liquor accords were 'extremely worthwhile', provided that

> all parties come to the table as equals and have a long-term view of the benefits which can flow from an effective liquor accord. This requires a strong commitment from all members (licensees, police, government) who must be able to work together to make change happen. It may also present an opportunity for local police and councils to improve their working relationships with industry on issues of common interest.[36]

8.34 Liquor accords may raise concerns relating to anti-competitive behaviours. With respect to this, the AHA (NT) said that these could be addressed

> by seeking immunity from the competition provisions of the Trade Practices Act through the 'authorization' process. There is a clear process to follow which will prevent any legal repercussions for members of an accord. The problem of alcohol abuse within local communities and the need for a range of strategies to address the problems are understood by the ACCC [Australian Competition and Consumer Commission]. Where the ACCC is satisfied that the public benefit from the arrangements between competitors will outweigh any public detriment, it can grant immunity from legal action.[37]

8.35 Liquor and Gaming New South Wales suggest that some liquor accords have reduced harmful effects of alcohol misuse and abuse:

> Successful liquor accord groups generate many benefits for licensees, patrons and the community:
>
> - Less alcohol-related assaults and anti-social behaviour
> - Local neighbourhoods that are safer and more welcoming
> - Better reputations for licensees
> - Improved business environment

35 Australian Hoteliers Association Northern Territory, *Liquor Accords* <www.ahant.com.au>.
36 Ibid.
37 Ibid.

- Constructive relationships between licensees, councils, patrons, residents and police
- Stronger compliance
- Less under-age drinking
- More awareness about responsible consumption of alcohol.[38]

8.36 The Norseman liquor accord is an example of an accord that has community support and is driven by community priorities:

> In the early 2000s members of the Indigenous community in Norseman in Western Australia became increasingly concerned that heavy alcohol consumption was the main cause of chronic health problems in their community. The community, in collaboration with local Health Department officers, worked with individuals and their families to prevent harmful drinking, but were not able to sustain a change to low risk drinking, and so decided that a different approach was needed … The Indigenous community in Norseman is not geographically discrete, rather it is distributed throughout the township. Consequently, the option used by many Indigenous communities, of declaring themselves dry was not available. However, there was clear recognition within the Indigenous community that certain beverages were particularly associated with heavy drinking. In an effort to reduce the amount of alcohol consumed, in particular the packaged liquor most linked to heavy drinking, the community proposed restricting the quantity and the hours of sale of these products.[39]

8.37 An evaluation of the Norseman liquor accord found that the accord had reduced alcohol-related harms:

> the Indigenous community was the driving force for introducing the restrictions, in response to the domestic violence, chronic disease and death that was associated with heavy drinking. The reasons given for not allowing sales, other than between midday and 6pm, was to limit the period of drinking so there was break for heavy drinkers to sober up. There was almost universal agreement that the behaviour of drinkers, the amount of alcohol consumed and alcohol-related harms had all changed for the better since the introduction of restrictions ... [and] the benefits for the Norseman community are clear. The restrictions are still in place, have increased social order, are still overwhelmingly supported by the community including the Licensee, and have remained effective in keeping in check those beverages identified from initial community discussions as problematic. These findings indicate that … an Accord, which is fashioned by key stakeholders, and supported by the whole community, can have a long-term impact on local alcohol problems.[40]

8.38 The ALRC invites comment on the effectiveness of liquor accords in addressing alcohol-related offending, and ways in which state and territory governments can facilitate the development and implementation of such accords in Aboriginal and Torres Strait Islander communities where there is community support for them.

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38 Liquor & Gaming NSW, *What Is a Liquor Accord?* Department of Industry NSW <www.liquorandgaming.nsw.gov.au>.

39 Richard Midford, John McKenzie and Rachel Mayhead, '"It Fits the Needs of the Community": Long Term Evaluation of the Norseman Voluntary Liquor Agreement' (Foundation for Alcohol Research, 2016) 9.

40 Ibid 22–7.

Fitzroy Crossing ban on full strength alcohol

8.39 In a 2010 report, the Australian Human Rights Commission detailed the implementation of alcohol restrictions in Fitzroy Crossing, noting its community-driven genesis:

> In 2007 … the senior women in the Fitzroy Valley decided to discuss the alcohol issue and look for solutions at their Annual Women's Bush Meeting. The Women's Bush Meeting is auspiced by Marninwarntikura; it is a forum for the women from the four language groups across the Valley. At the 2007 Bush Meeting, discussions about alcohol were led by June Oscar and Emily Carter from Marninwarntikura. The women in attendance agreed it was time to make a stand and take steps to tackle the problem of alcohol in the Fitzroy Valley. While the women did not represent the whole of the Valley, there was a significant section of the community in attendance. Their agreement to take action on alcohol was a starting point and it gave Marninwarntikura a mandate to launch a campaign to restrict the sale of alcohol from the take-away outlet in the Fitzroy Valley. The community-generated nature of this campaign has been fundamental to its ongoing success. The communities themself were ready for change.[41]

8.40 The Fitzroy Crossing initiative did not seek the complete prohibition on the sale of alcohol or to make Fitzroy Crossing a dry community. Instead, it sought to prevent the sale of full strength alcohol.

8.41 Speaking to SBS about her experiences implementing the ban on full strength alcohol in Fitzroy Crossing, June Oscar AO stated:

> We couldn't continue to live in a community that was just being decimated by alcohol. Every aspect of life. Every facet of life was being affected. And in 2005–6 we had 50 deaths in the valley. Many of them were alcohol-related deaths. Our right to a future was important. We had to fight for that future. So the women decided then in July of 2007 enough was enough. We want to pursue restrictions on the sale of full strength alcohol … Within the first 3 to 6 months we saw the presentations at hospital from 85% alcohol-related injuries drop to 25, 15%.[42]

8.42 The Fitzroy Crossing initiative allowed members of the Fitzroy Crossing community to design and implement strategies to reduce the prevalence of FASD in the community. The Australian Human Rights Commission noted:

> In October 2008, just over a year after the alcohol restrictions were brought into the Fitzroy Valley, members of the communities gathered to discuss FASD and other alcohol-related problems … In November 2008, a draft strategy was developed by the CEO of Marninwarntikura, June Oscar and Dr James Fitzpatrick, a paediatric trainee serving the communities. The strategy was called Overcoming Fetal Alcohol Spectrum Disorders (FASD) and Early Life Trauma (ELT) in the Fitzroy Valley: a community initiative. This strategy is now described locally as the Marulu Project. Marulu is a Bunuba word meaning 'precious, worth nurturing'.[43]

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41 Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2010* (2011) 71.

42 SBS, *Fitzroy Crossing—Meet June Oscar* <www.sbs.com.au/programs/first-contact>.

43 Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report 2010* (2011) 94.

8.43 In an evaluation of the effects of alcohol restrictions in Fitzroy Crossing two years following their implementation, a report by the University of Notre Dame (Australia) found 'continuing health and social benefits for the residents of Fitzroy Crossing and the Fitzroy Valley communities', including:

- reduced severity of domestic violence;
- reduced severity of wounding from general public violence;
- reduced street drinking;
- a quieter town;
- less litter;
- families purchasing more food and clothing;
- families being more aware of their health and being proactive in regard to their children's health;
- reduced humbug and anti-social behaviour;
- reduced stress for service providers;
- increased effectiveness of services already active in the valley;
- generally better care of children and increased recreational activities; and,
- a reduction in the amount of alcohol being consumed by Fitzroy and Fitzroy Valley residents.[44]

8.44 Another analysis also noted the benefits flowing from the experience in Fitzroy Crossing:

> In Fitzroy Crossing and Halls Creek, where the impetus for alcohol restrictions came from strong local women and where responsible serving of alcohol is now being enforced, there has been a noticeable decline (between 20% and 40%) in the number of alcohol-related crimes and alcohol-related admissions to hospitals.[45]

8.45 However, the same analysis also noted that, while

> stricter controls on alcohol has made these towns more pleasant places to live … the restrictions have not addressed the reasons why people are drinking in the first place. Controls on alcohol supply help mitigate the harms that alcohol causes, but they will not solve the alcohol problem.[46]

8.46 Kayla Calladine has also suggested that there are several limitations of alcohol restrictions, including the prevalence of unlawful sales of liquor at highly inflated prices to dry communities, otherwise known as 'sly grogging'. However, she concludes

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44 University of Notre Dame Australia, *Fitzroy Valley Alcohol Restriction Report: An Evaluation of the Effects of Alcohol Restrictions in Fitzroy Crossing Relating to Measurable Health and Social Outcomes, Community Perceptions and Alcohol Related Behaviours After Two Years* (2010) 10.

45 Sara Hudson, *Alcohol Restrictions in Indigenous Communities and Frontier Towns* (Centre for Independent Studies, 2011) 20.

46 Ibid.

that 'early evidence suggests *prima facie* improvement in living conditions, suggesting that voluntary prohibition regimes contribute to the aims of substantive equality'.[47]

8.47 Concerns also exist that prohibition of alcohol within dry communities has led to the substitution of illicit drugs for alcohol. The Healing Foundation has suggested that '[m]any dry communities now face the scourge of drugs as a substitute for grog, causing many of the same issues such as violence that alcohol did'.[48]

8.48 The ALRC invites stakeholder comment about the usefulness of initiatives, like that in Fitzroy Crossing, to prohibit the sale of full strength alcohol, and also about how state and territory governments might play a role in facilitating this where there is community support to do so.

Alcohol Mandatory Treatment and Banned Drinkers Register

8.49 During stakeholder consultations in the NT, the ALRC was made aware of mixed views about the appropriateness and success of the Alcohol Mandatory Treatment (AMT) Scheme operating in the NT and the possible reimplementation of a Banned Drinkers Register (BDR).

8.50 The Department of Health (NT) has described AMT as a 'mandatory treatment for adults who are taken into police custody for being intoxicated in public three or more times in two months':

> Individuals are clinically assessed and an independent tribunal then decides the best treatment options including:
>
> - up to three months in a secure residential treatment facility
> - up to three months in community residential treatment facility
> - another form of community management, such as income management.
>
> During their treatment clients are offered life skills and work readiness programs. On completion of their treatment, clients are provided with an aftercare program to support them when they return home.[49]

8.51 The proposed BDR identifies people who are banned from purchasing, consuming or possessing alcohol and prevents their purchase of alcohol at a takeaway outlet. A person can be placed on the BDR for reasons including:

- any combination of three alcohol-related protective custodies or alcohol infringement notices in two years
- two low-range drink driving offences or a single mid-range or high-range drink driving offence
- being the defendant on an alcohol-related domestic violence order

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47 Kayla Calladine, 'Liquor Restrictions in Western Australia' (2009) 7(11) *Indigenous Law Bulletin* 23, 27.

48 Healing Foundation, Submission No 42 to Standing Committee on Indigenous Affairs, Parliament of Australia, *Inquiry into Harmful Use of Alcohol in Aboriginal and Torres Strait Islander Communities* (2014) 5.

49 Northern Territory Department of Health, *Alcohol Mandatory Treatment (AMT)* <health.nt.gov.au/professionals/alcohol-and-other-drugs-health-professionals/alcohol-mandatory-treatment-amt>.

- having an alcohol prohibition condition on a court order (including child protection orders), bail or parole order
- by decision of the BDR Registrar after being referred by an authorised person such as a doctor, nurse or child protection worker, or a family member or carer
- self-referral for any reason.[50]

8.52 The House of Representatives Standing Committee on Indigenous Affairs Inquiry into alcohol use in Aboriginal and Torres Strait Islander communities noted that concerns have been expressed about AMT, including that it criminalised public drunkenness. It took into account the recommendations of the Royal Commission into Aboriginal Deaths in Custody for the abolition of offences around public drunkenness, and the submission of the Law Society of the NT raising concerns about a trend of criminalising addiction within the NT.[51]

8.53 An inquest into the death of Mr Murrungun, an NT Aboriginal man, heard that, while Mr Murrungun had been taken into police custody more than 60 times in 2014, he had only been referred for assessment under the AMT scheme on two occasions:

> In closing submissions at the inquest, counsel assisting the coroner Kelvin Currie described the scheme as 'illusory' and said police failed to document protective custody incidents.
>
> Mr Currie said almost 40 protective custody incidents were not recorded and counted towards the AMT scheme, despite laws requiring police to do this.[52]

8.54 The NT is not the only state or territory that provides for mandatory treatment of persons who abuse alcohol. Victorian laws in respect of mandatory treatment are found in the *Severe Substance Dependence Treatment Act 2010*, which allows for detention and treatment of a person experiencing severe substance dependence for up to 14 days. In New South Wales, the *Drug and Alcohol Treatment Act 2007* allows for initial detention of 'identified patients' for 28 days, with an option to extend treatment to three months.

8.55 In a 2017 study, PricewaterhouseCoopers Indigenous Consulting (PwC PIC) noted that, in 2012, the NT AMT replaced the BDR of some 2600 people without an evaluation into the effectiveness of that system.[53] In April 2017 it was announced that the NT Government is proposing a return of the BDR.[54]

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50 Northern Territory Government, *Banned Drinker Register Frequently Asked Questions* (2017).

51 House of Representatives Standing Committee on Indigenous Affairs, Parliament of Australia, *Alcohol, Hurting People and Harming Communities: Inquiry into the Harmful Use of Alcohol in Aboriginal and Torres Strait Islander Communities* (2015) 86.

52 Felicity James, *NT's Mandatory Alcohol Treatment Scheme 'Completely Dysfunctional'* (13 June 2016) ABC News <www.abc.net.au>.

53 PricewaterhouseCoopers Indigenous Consulting (PIC), *Evaluation of the Alcohol Mandatory Treatment Program* (2017) 5.

54 Sara Everingham, *Banned Drinker Register to Return to NT in September* ABC News <www.abc.net.au>.

8.56 Looking at issues relating to people who are not eligible for AMT, PwC PIC found that

> [a] significant number of people ‘leaked out’ of the AMT system and received no assessment or treatment. Sometimes this was expected—for example, people with outstanding warrants are not eligible for AMT and people with serious physical or mental health issues are immediately taken to hospital for treatment. This means a number of people who could potentially benefit from treatment were excluded from the process.[55]

8.57 There have been criticisms made of AMT. Fiona Lander, Dennis Gray and Edward Wilkes have argued that:

> there is little evidence of the scheme’s efficacy, and that the NT Government could adopt more cost-effective alternatives that would not involve the dubious application of a medical intervention to reduce public intoxication, with its concomitant legal and ethical issues.[56]

8.58 Despite criticism of AMT, the PwC PIC evaluation found that

> clients were consistently being supported to withdraw from alcohol safely and were being provided all the appropriate medical care during this time. Assessment staff also ensure any other pre-existing conditions are monitored during withdrawal to prevent complications arising. Once a client has safely withdrawn from the effects of alcohol they are provided with full time comprehensive health care and treatment for any existing conditions until transferred elsewhere as an outcome of the tribunal hearing. Assessment staff also ensure that clients learn about and understand their conditions, what their medications are for and the importance of complying with a treatment program. As per usual clinical guidelines, assessment staff request interpreters to help discuss medical issues with clients when it is appropriate.[57]

8.59 Commenting on evidence from case studies during the evaluation process, PwC PIC said that

> by the end of the assessment phase, after clients have had time to sober up and reflect, … they are more open to receiving treatment. For example, after completing the assessment process for the AMT program 75% of the case study group in this evaluation reported being highly or somewhat motivated to continue with the program, while 25% stated they were not very motivated or highly unmotivated/disinterested. Service providers reported that they believed most people were in the pre-contemplative stage after assessment but did agree that most people were compliant and willing to engage in treatment. However, the workers felt that many people may not be ready to make long-term changes in their drinking patterns and lifestyle, and that their experience was that most people would need more than one episode of treatment before changes would be seen. All case study participants

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55 PricewaterhouseCoopers Indigenous Consulting (PIC), *Evaluation of the Alcohol Mandatory Treatment Program* (2017) iii.

56 Fiona Lander, Dennis Gray and Edward Wilkes, ‘The Alcohol Mandatory Treatment Act: Evidence, Ethics and the Law’ (2015) 203(1) *The Medical Journal of Australia* 47, 47–9.

57 PricewaterhouseCoopers Indigenous Consulting (PIC), *Evaluation of the Alcohol Mandatory Treatment Program* (2017) 22.

> responded that they had been shown dignity and respect during the assessment process with one commenting ‘it’s a good place, they gave me clothes’.[58]

8.60 The ALRC is interested in hearing comment about the ways that BDRs and AMTs can reduce alcohol-related offending within Aboriginal and Torres Strait Islander communities, as well as any negative impacts that these approaches may have.

58 Ibid 22–3.