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Evaluation of Harm Minimisation Measures in Banned Drinkers Areas

Final Evaluation Report

Department of Local Government, Sport and Cultural Industries

July 2025

Deloitte Access Economics

Limitation of our work

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Acknowledgement

The evaluation team would like to sincerely thank all stakeholders who volunteered their time to contribute to the evaluation.

Glossary

Acronym	Full name
AIHW	Australian Institute of Health and Welfare
BDA	Banned Drinker Area
BDO	Banned Drinker Order
BDR	Banned Drinkers Register
CAD	Computer Aided Dispatch
CSIs	Child Safety Investigations
Deloitte	Deloitte Access Economics
DASSOG	Drug and Alcohol Strategic Senior Officers' Group
DB	Disruptive Behaviour
DFSV	Domestic, Family and Sexual Violence
DLL	Director of Liquor Licensing
ED	Emergency Department
FASD	Fetal Alcohol Spectrum Disorder
FIFO	Fly In, Fly Out
FVRO	Family Violence Restraining Order
ID	Identification
KEQ	Key Evaluation Question
LGA	Local Government Area
LRPs	Liquor Restricted Premises
NT	Northern Territory
PLM	Program Logic Model
RSA	Responsible Service of Alcohol
TAMS	Takeaway Alcohol Management System
The Act	The *Liquor Control Act 1988*
The Department	Department of Local Government, Sport and Cultural Industries
WA	Western Australia
WAPOL	Western Australia Police Force

Executive summary

Policy context

The *Liquor Control Act 1988* (the Act) provides the legislative framework for the liquor licensing authority to regulate the sale, supply, and consumption of Liquor in Western Australia (WA). The primary objects of the Act are to:

- regulate the sale, supply and consumption of liquor;
- minimise harm or ill-health caused to people, or any group of people, due to the use of liquor; and
- cater for the requirements of consumers for liquor and related services, with regard to the proper development of the liquor industry, the tourism industry and other hospitality industries in the State.

The provisions of the Act therefore play an important role in addressing alcohol issues present in the State including minimising the harm caused by the misuse of alcohol. The Drug and Alcohol Strategic Senior Officers' Group (DASSOG) provides a whole-of-government approach to addressing these issues and is partially formed from the Western Australian Department of Local Government, Sport and Cultural Industries (the Department) alongside other government representatives including but not limited to the Department of Communities, Department of Education, Department of Health, and the Department of Justice.

Noting the severe impact of alcohol misuse in WA, the DASSOG, in consultation with key stakeholders and the community, developed the Western Australian Alcohol and Drug Interagency Strategy 2018-2022 (the Strategy)[1]. This strategy was created to provide a guide for government and non-government organisations, as well as the wider community, to prevent and reduce the adverse impacts of alcohol and other drug use in WA. The Strategy is aligned to the National Drug Strategy 2017-2026 and adopts an overarching harm minimisation approach aligned to the three pillars of:

- Supply reduction: preventing, stopping, disrupting or otherwise reducing the production and supply of illegal drugs and controlling, managing and regulating the availability of legal drugs.
- Demand reduction: preventing the uptake and/or delaying the onset of alcohol and other drug use, reducing alcohol and other drug use in the community and supporting people with evidence-informed treatment(s).
- Harm reduction: reducing the adverse health, social and economic consequences of the use of alcohol and other drugs, for individuals, families and others in the community.

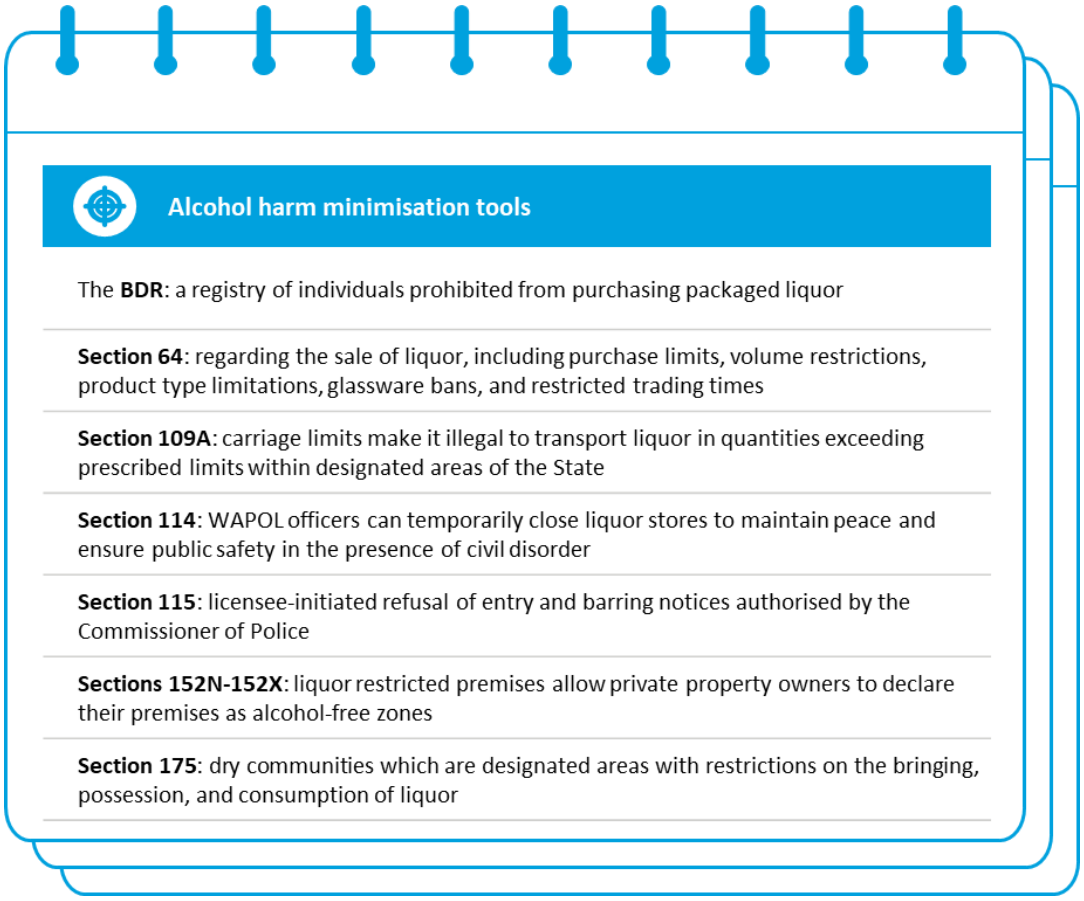
In response to both the objects of the Act, and the harm minimisation pillar of the Strategy, the Department has implemented a series of tools (delivered under the Act) targeted at alcohol harm minimisation across WA, including within banned drinker areas (BDAs). Further detail on these tools is provided below.

Alcohol harm minimisation tools (the tools)

BDAs are currently in place in the Kimberley, Pilbara, Goldfields, and Carnarvon and Gascoyne Junction, and are defined by the areas where the Banned Drinkers Register (BDR) is utilised. In addition to the BDR, a range of other tools are used within BDAs to mitigate alcohol-related harm on communities and individuals. Tools implemented, and therefore restrictions placed on takeaway alcohol, differ across BDAs. A summary of each tool is provided in Figure i below.

[1] Mental Health Commission (WA), *The Western Australian Alcohol and Drug Interagency Strategy 2018-2022* (2018) <https://www.mhc.wa.gov.au/media/2831/western-australian-alcohol-and-drug-interagency-strategy-2018-2022.pdf>

Figure i: The alcohol harm minimisation tools explored in the evaluation



Source: Deloitte Access Economics (2025).

Evaluation of the tools in BDAs

Deloitte Access Economics (Deloitte) was contracted by the Department to undertake an independent evaluation of the effectiveness of the tools delivered under the *Liquor Control Act 1988* in BDAs in WA. More specifically, the evaluation aimed to identify and assess the outcomes and impact of the BDR, giving consideration to the impact of the other tools (such as daily takeaway liquor limits) in reducing alcohol-related harm in BDAs. This involved:

- An outcome evaluation focused on the early impact of the tools, measuring changes in a range of quantitative and qualitative indicators relating to health, criminal justice, government and community services and youth engagement.
- A mixed-methods approach, integrating quantitative with qualitative data; through primary and secondary data collection and analysis.
- Triangulation of findings from multiple sources, including the voice of different stakeholders, assessment of the tools through their documentation, as well as consideration of the outcomes.

The evaluation was undertaken in accordance with the evaluation framework agreed by the Department in November 2024. The evaluation framework comprised a program logic, key evaluation questions and a data plan.

Evaluation framework

The evaluation framework set out the key lines of inquiry to pursue as part of the evaluation across the following three domains:

- Effectiveness. This domain seeks to understand the tools' progress towards stated objectives and expected outcomes.

- **Equity**. This domain seeks to understand what, if any, differences in outcomes observed exist across communities and/or regional contexts.
- **Sustainability**. This domain seeks to demonstrate the extent to which the tools are sustainable and what factors support sustainability.

The key evaluation questions (KEQs) answered by this report are detailed in Table i.

Table i: Abridged evaluation framework for the evaluation of the tools in BDAs

Domain	KEQ
Effectiveness	**KEQ1.1** Have the tools delivered short (<1 year)* or contributed to long-term (>1 year) outcomes sought for **individuals** on or previously on the BDR and/or impacted by other tools? Which tools have been more effective in delivering these outcomes?
	KEQ1.2 Have the tools delivered the short (<1 year) or contributed to long-term (>1 year) outcomes sought for **society** more broadly? Which tools have been more effective in delivering these outcomes?
	KEQ1.3 What are the key barriers and enablers to outcomes being realised? How have challenges been addressed?
	KEQ1.4 Have any unintended consequences (either positive or negative) of the tools been identified?
Equity	**KEQ2.1** How have the outcomes of the tools differed across communities and regional contexts?
Sustainability	**KEQ3.1** What conditions are required to support the ongoing success of the tools, and to what extent are the outcomes and features of the alcohol restrictions likely to be sustained?

Source: Deloitte (2024).

Note. *Time horizons refer to any outcomes since the BDR legislative amendments came into effect.

Analysis and findings development

The evaluation adopted a mixed methods approach that relied on both qualitative and quantitative data to answer the KEQs. Overall, the evaluation broadly satisfied set goals relating to breadth of data and perspectives captured. Further detail summarising the data collected, along with any limitations, is provided in the sections which follow.

Data collected included:

- **Stakeholder consultations.** A total of 46 interviews were conducted across all BDAs. The majority of consultations were conducted face to face in each BDA by members of the evaluation team. This included 11 consultations in the Pilbara, 11 consultations in the Goldfields, 14 consultations in the Kimberley, 4 consultations in Carnarvon and the Gascoyne Junction. See **Error! Reference source not found.** for further detail.
- **Two electronic surveys**.
  - **Licensee survey.** An online survey was distributed to all licensees across BDAs, including those with and without BDR terminals. The licensee survey was distributed to 335 licensees across BDAs, with a response rate of 20 per cent.

  - Community health and/or support service provider survey. Another online survey was distributed to community health and support services across the BDAs. The community health and support services survey was distributed to 128 service providers, with a response rate of 15 per cent.

- Secondary data. In addition to stakeholder interviews and surveys, the evaluation is supported by findings established through secondary data, including:
  - A brief literature scan. A review of broader research and literature was conducted to support the understanding of the current landscape of alcohol-related harm minimisation programs and initiatives that exist across Australian jurisdictions, as well as overseas.
  - Program documentation. Analysis of documentation supported preliminary understandings of the tools, their scope and the roll-out timeline.
  - Data from the Department and other government agencies. This included data from the Department, St John WA, WA Department of Justice, WA Department of Communities and WA Police Force (WAPOL) Health. Error! Reference source not found. details the secondary data utilised in this report.

The findings in this evaluation report were informed by the following analytical approaches:

- Data review. This stage involved reviewing the data for completeness, checking for and correcting for any errors or inconsistencies noted.
- Qualitative coding and theming. Free-text survey responses and consultation transcripts were systematically reviewed, with responses categorised into patterns and themes.
- Quantitative analysis. Survey responses and programmatic data were analysed using descriptive statistical techniques (including means, standard deviation, counts, frequencies, percentages) to glean patterns and trends present. Secondary data provided by government agencies was analysed using econometric techniques, where appropriate, to glean understanding of the effects of the tools over time.
- Data triangulation. Qualitative and quantitative data were combined to identify common themes and patterns, along with differences and reasons why, to derive meaningful insights.
- Findings development. Triangulated themes and patterns were tested for validity, evidence strength and completeness and translated into robust insights.

Evaluation limitations

The mixed-methods approach facilitated a solid evidence base for this evaluation, with data collected broadly satisfying set goals relating to breadth of data and perspectives captured. However, there are several limitations which are important to consider, as detailed in Table ii.

Table ii: Evaluation limitations

Limitation	Description
Difficulty in attributing changes in outcomes observed to the implementation of the BDR, and other tools.	To overcome this limitation, the evaluation has conducted a rigorous analysis that considers multiple data sources and takes into account potential confounding factors. By triangulating different data sets, the evaluation aims to provide a more comprehensive understanding of the relationship between the tools and the observed outcomes.
Timing allowed for focus predominantly on short-term outcomes	Some outcomes may not be immediately observable, but rather manifest over a longer time period. For example, changes in health system utilisation may take time to become apparent. To address the potential for delayed outcomes, the evaluation has taken a time-series approach, considering the impact of the tools over a longer time period. For those outcomes which are currently unobservable and require a long timeframe, the evaluation notes areas for future research and data capture.

Limitation	Description
Differing stakeholder perspectives	Stakeholder perceptions, and experiences, influence their contribution to evaluation activities. To address this, the analysis focuses on capturing a range of stakeholder views and identifying both common and divergent perspectives. By considering the various viewpoints and potential biases, the evaluation aims to provide a balanced and comprehensive view.
Stakeholder understanding of the remit of the tools	Many stakeholders refer to the Takeaway Alcohol Management System (TAMS) as a harm minimisation tool and often conflate it with the BDR. In cases where stakeholders conflate the two, the analysis has been careful to differentiate between the BDR and TAMS, ensuring accurate representation of their perspectives and the feedback received.
Data availability of information regarding the timing of implementation of some tools.	Tools such as the BDR and daily takeaway liquor limits monitored by the TAMS, have distinct start dates and therefore their implementation dates can be identified in datasets and carried through in econometric analysis which seeks to understand differences in outcomes over time, to isolate their effects. Contrastively, identifying the implementation dates of tools such as restrictions put in place under s.115 is often not possible and as such econometric analysis techniques are not able to determine the effects of these tools over time. Where appropriate, anecdotal reports have been drawn upon to further understand the influence of these tools on any observed trends in outcomes.

Summary of key findings

The evaluation revealed that stakeholders across BDAs and organisations (including licensees, WAPOL, health, community health and/or other support services) agree on the role of alcohol harm minimisation tools such as the BDR, daily takeaway liquor limits, and other tools, and were largely in favour of the BDR's permanency.

As mentioned, a program logic model (PLM) developed in collaboration with the Department informed the identification of the intended outcomes explored in this evaluation report (considering outcomes both in the short-term and longer term).

Current evidence on the effectiveness of the tools in reducing alcohol-related harm with respect to these outcomes (which include health service utilisation, anti-social behaviours and community safety, alcohol-related police offences, contact with the justice system, support service demand, disruptive housing behaviour and alcohol-attributed child protection cases) indicates mixed effectiveness and there is likely insufficient data and time lapsed to conclude outcome achievement. However, analysis of government agency (including Department of Communities, Department of Justice, St John Ambulance WA, WAPOL) secondary data in combination with stakeholder consultation outputs and evaluation survey results revealed the following overarching outcome trends:

- Health service utilisation: There has been limited change in the number of monthly alcohol-related ambulance callouts across BDAs, with a small statistically significant reduction in weekday callouts in the Goldfields BDA. This suggests a potential impact on reducing demand on ambulance services on weekdays.
- Anti-social behaviours and community safety: Anecdotal reports suggest a reduction in anti-social behaviour in some BDAs, such as a drop in youth crime and property offending in Derby. However, there have also been instances of increased aggressive behaviour towards licensees and theft of alcohol in response to the restrictions. As such, the impact of the tools on community safety has been varied.
- Alcohol-related police offences and contact with the justice system: There is not sufficient evidence to conclude that the BDR legislation has reduced alcohol-related police offence rates over time. While some BDAs showed decreases in alcohol-related offences over time following the legislative change, this was mirrored by a decrease in non-alcohol-related offences rates, suggesting that this result may stem from changes in police activity.

- Support service demand: Across BDAs, the majority of community health organisations consulted with, and that completed the survey, felt that there had not been an increase in the usage of community health and support services since the implementation of the BDR and other tools. While this does not imply that the tools are not effective, limited change in support service demand was seen by stakeholders as a hindrance in addressing alcohol-related harm in the community, based on a belief that behaviour was unlikely to change without adequate support systems in place.
- Disruptive housing behaviour: There is currently limited evidence to suggest that the tools have contributed to reductions in disruptive housing behaviour.
- Alcohol-attributed child protection cases: The analysis showed mixed results, with negative effects on substantiated investigations in the Pilbara and Kimberley BDAs following BDR implementation. The Carnarvon/Gascoyne BDA saw a significant effect before the legislation change, while the Goldfields BDA did not show statistical significance. However, this may be due to the time taken between a child safety investigation being commenced, and being substantiated leading to lower numbers of substantiated cases in more recent months.

One of the key barriers facing the BDR, reported by stakeholders through both consultations and surveys, is the fear of persistent secondary supply of takeaway alcohol. Stakeholders asserted that individuals find ways to circumvent the measures in place to limit purchasing of takeaway packaged liquor through purchases by friends or family members, or through black market supply. Stakeholders from WAPOL have reported experiencing barriers in enforcing restrictions and addressing black market supply. These barriers undermine the efficacy of the tools.

The success of the BDR, and alcohol harm minimisation tools generally, is also likely influenced by the availability and perception within communities of accompanying support services which target behaviour remediation through rehabilitation. Many individuals perceive these services as either inaccessible or inadequate, which can deter them from seeking necessary help. Such perceptions are often rooted in barriers like stigma, limited-service provision, and lack of cultural sensitivity, particularly in diverse or remote communities. If treatment services are perceived negatively, or are simply not available at the required scale, the BDR's potential to facilitate recovery and behavioural change diminishes. Without behaviour change, sustained long term harm reduction is unlikely to be realised.

The BDR and other tools considered in this evaluation report, such as daily takeaway liquor limits monitored by the TAMS in some towns are only likely to impact a small portion of the population – as shown by only 1 per cent of the population in BDAs being on the BDR. As such, any changes in outcomes which rely on a behaviour change, such as alcohol-related ambulance callouts, may not be detectable in aggregated data. Additionally, some data currently collected by government agencies has limited ability to specifically attribute alcohol use as the driver of a particular behaviour/issue, significantly impacting the ability to draw definitive conclusions around the tool's effectiveness. For example, Department of Communities data does not separate alcohol-related disruptive behaviour complaints from non-alcohol-related ones. This would obscure the effect of alcohol restrictions on the frequency of disruptive behaviour complaints because non-alcohol-related complaints would be expected to continue at the same rate.

While the BDR and daily packaged liquor purchase limits have existed in trial form for multiple years, the legislative change in December 2023 has established a more powerful legal framework which may be more likely to drive behaviour change. As such, the impact of these changes may be possible to examine over a longer time period. It would be beneficial to examine longitudinal outcomes for individuals on the BDR to detect more targeted outcomes - for example, linkage between BDR status and health records. As such, a longer-term analysis may be required to more accurately examine the impact of the BDR, and other tools on alcohol harm reduction at the community and system levels.

To strengthen the effectiveness of the tools, the following improvement opportunities can be considered:

- Implementing enhancements to improve the functionality of the BDR system and related software and hardware.
- Enhancing the enforcement power and allocation of resources for WAPOL.
- Streamlining the process for medically issued BDOs.
- Increasing the availability of wraparound support services and adopting a comprehensive, holistic approach to support individuals through a whole-of-government approach.
- Increased education and awareness campaigns to enhance knowledge and understanding of the BDR.

- Clearly communicating the BDR and other tools' objectives through accessible and culturally appropriate messaging.
- Maximising the visibility of support services to ensure accessibility for those affected by the BDR.

An overview of the headline findings under each of the evaluation domains is summarised in Table iii. The key findings are visually represented in the infographic which follows.

Table iii: Summary of key evaluation findings, by domain

Evaluation domain	Key evaluation findings
Effectiveness and Equity	Key Finding 1: The evidence around the impact of the tools on alcohol-related harm is mixed. Overall, there is insufficient data to conclude the level of impact, and more time is required to see the effect. Key Finding 2: Overall, the implementation of the BDR and daily takeaway liquor limits monitored by TAMS has not significantly influenced the trend of alcohol-related ambulance callouts in BDAs. This holds true even after the introduction of the BDR legislation in December 2023, while accounting for factors such as population, seasonality, and the effects of COVID-19. Key Finding 3: Stakeholders consulted from community health organisations across all BDAs reported that demand for these services has not risen since the introduction of the BDR. The utilisation of this pathway of support may be limited by a few factors – largely, there is a perceived shortage/absence of treatment and support centres, limiting opportunities for engagement. Further, engagement with these services tends to be self-motivated, meaning that while mandating support service attendance alongside a BDO would increase demand, it may not be effective in creating meaningful engagement on its own. Key Finding 4: Overall, the BDR trial and daily takeaway liquor limits have not demonstrated a statistically significant impact on the trend of alcohol-related police offences. Although there was a negative trend in offences across BDAs following commencement of the BDR legislation, it was not statistically significant. Following the legislative change, there were some statistically significant effects, but these tended to mirror broader trends in non-alcohol-related activity. Therefore, there is currently insufficient evidence to conclude that the BDR legislation has reduced offence rates and further time is required to establish the evidence base before additional analysis is conducted. Key Finding 5: While there appears to be a statistically significant effect of the tools on the number of child safety investigations substantiated where alcohol was a contributing factor. Further time is required to establish the evidence base before additional analysis examining the tools' impact on the number of alcohol-attributed child protection cases is conducted. Key Finding 6: There has generally been a good degree of public awareness about alcohol restrictions, however it tends to be lower for visitors. Stakeholders also reported uncertainty around where and when restrictions applied.
Sustainability	Key Finding 7: Almost 80 per cent of the 30 stakeholders consulted on this topic expressed some level of support for the BDR to become a permanent fixture in WA. Of those who expressed support, the majority indicated that their support was contingent on some reforms to the BDR legislation as well as technological improvements to the BDR system. Such updates and improvements, including enhancing software functionality and strengthening of legislation requirements to issue a BDO, are perceived to be necessary for ongoing long-term effectiveness. Key Finding 8: Increasing the availability of wraparound supports will likely improve the effectiveness of alcohol harm minimisation tools, including the BDR and daily takeaway liquor limits. Such efforts require a whole-of-government approach and should be led by appropriate agencies such as the Department of Health and the Mental Health Commission.

Evaluation domain	Key evaluation findings
	Key Finding 9: While unintended, alcohol harm minimisation tools are perceived as discriminatory by some state government and community stakeholders. Key Finding 10: Consultees and survey respondents acknowledged that enhancing education and awareness about the BDR and other alcohol-harm minimisation tools, particularly through targeted information campaigns, is essential for maximising their effectiveness and reducing alcohol-related harm.

Conclusion

The BDR demonstrates promise as a means for alcohol harm reduction. However, to fully realise its impact, addressing ongoing challenges such as secondary supply and the adequacy of enforcement power and support services remains crucial. Additionally, the importance of further data collection and ongoing analysis cannot be overstated. Continuous monitoring will be essential to continue to evaluate the BDR's effectiveness over time and adapt strategies in response to evolving community needs. By addressing identified limitations, it is possible for the BDR to evolve into a holistic strategy that not only limits access to takeaway alcohol but also promotes recovery and societal well-being. This multifaceted approach is vital for achieving sustainable reductions in alcohol-related harm and fostering healthier, safer communities.

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