



Moving Beyond the Restrictions: The Evaluation of the Alice Springs Alcohol Management Plan

Kate Senior, Menzies School of Health Research
Richard Chenhall, Menzies School of Health Research
Bill Ivory, Menzies School of Health Research
Christopher Stevenson, Monash University



MONASH University
Medicine, Nursing and Health Sciences

School of Public Health and Preventive Medicine



discovery for a healthy tomorrow

PO Box 41096, CASUARINA NT 0811 | John Mathews Building (Building 58), Royal Darwin Hospital Campus, Rocklands Drive, CASUARINA NT
0810 Phone: 08 8922 8196 | Facsimile: 08 8927 5187 | Web: www.menzies.edu.au | Email: info@menzies.edu.au



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List of acronyms

ABS – Australian Bureau of Statistics

AMP – Alcohol Management Plan

ARP – Alcohol Reference Panel

ASH – Alice Springs Hospital

AWG – Alcohol Working Group

CAAC – Central Australian Aboriginal Congress

CAAODS – Central Australian Alcohol and other Drugs Service

CAAPU – Central Australian Indigenous Alcohol Programs Unit

CDU – Charles Darwin University

DASA – Drug and Alcohol Services Association

ICD – International Classification of Diseases

MSHR – Menzies School of Health Research

NDRI – National Drug Research Institute

NTCOSS – Northern Territory Council of Social Service

NTERA – *Northern Territory Emergency Response Act 2007 (Cth)*

NTG – Northern Territory Government

NTHHA – Northern Territory Branch of the Australian Hotels and Hospitality Association

PAAC – People’s Action Against Alcohol Coalition

RCT - Randomised Controlled Trial

SMR – Standard Mortality Ratio

WHO – World Health Organisation



Executive summary

There have been a number of evaluations of alcohol management in the Alice Springs region. Interestingly, an evaluation in 1975 emphasised the need for government and other agencies to view the issues holistically and to address them accordingly. The outcomes of this evaluation point to a similar situation with comparable recommendations.

The situation in Alice Springs is unique in some respects but has parallel characteristics to other towns and communities in Australia. Alice Springs is an important regional supply, service-orientated, and tourism town. Its people have diverse backgrounds and appear as durable as the environment they live in. Associated with this is a hard drinking culture that permeates the community with a range of issues regardless of one's cultural background.

The research group found a community that in many ways is ruptured and fragmented when it comes to the ways and means of how such challenges can be confronted. This situation is exemplified by the perception that alcohol problems are confined to a minority of drinkers that seemingly pervades the dialogue surrounding drinking and its effects in the town.

Nevertheless, a positive outcome of such discourse is the fact that people *do care* about their community and are very keen to live in a town where there are more responsible attitudes toward drinking. There is some way to go; the first thing that everyone needs to accept is that it is a community problem. Non-Indigenous and Indigenous individuals, groups and organisations all have a responsibility therefore in addressing the challenges and working toward better solutions. Government have an important role of course, however the acceptance by the community that it is a community problem is paramount.

Some of the community and government initiatives are having a positive effect on drinking in the town. However, some of the initiatives, such as certain restrictions, can and should not be considered, on their own, as long-term solutions. Other processes need to be implemented, oversighted and managed in an effective manner. An important component of such processes is data that is well managed, available, and appropriate for those agencies involved.

Recommendations

At a superficial level it would appear that the alcohol restrictions in Alice Springs are unpopular and that further efforts in this direction are unlikely to be supported by the community. Further analysis, however, reveals that although many people consider the current restrictions to be inconvenient, the underlying cause of their discontent is their perception that restrictions have been imposed without adequate consultation.

Furthermore, there is strong cultural resistance among the non-Indigenous population in Alice Springs to acknowledge that alcohol is a problem which affects both Indigenous and non-Indigenous people in the community. This perception adversely affects the non-Indigenous community's willingness to engage in strategies to address the problem of alcohol in the community. On the basis of these findings, we recommend that the current alcohol restrictions be maintained in their current form and that extensive community consultation, education and social marketing be conducted before implementing any stronger measures. The current set of restrictions provide a good platform for the implementation of the broader range of measures associated with the Alcohol Management Plan (AMP), which must be implemented in wide consultation with the community.

Other specific initiatives which should be considered by the Northern Territory Government (NTG) are listed below:

Implementing a community development model for reform

Strategies need to be implemented to engage the community in discussion about alcohol and the problems of alcohol misuse in the community. A community development model is needed to bring together and coordinate the various community interests in this issue. The NTG needs to consider the creation of community development positions, one Indigenous and one non-Indigenous, whose responsibilities are to oversee an Alcohol Working Group (AWG), to coordinate community responses, to develop and maintain linkages between interest groups and alcohol services and to conduct the on-going evaluation of the Alcohol Management Plan. These people would also be responsible for developing relationships with the local media and ensuring the regular dissemination of information about the Alcohol Management Plan and associated activities to the media. This requires a long term commitment from government for at least five years.

Ideally these positions should be jointly funded by the Department of Justice and the Department of Health and Families; however, the individuals involved must be primarily driven by the needs and agendas of the community, not the funding bodies.

The community development officers and the Alcohol Working Group will require access to specialist support to assist with developing interventions and ensuring that these are established in a way that can be monitored and evaluated. We recommend that the Menzies School of Health Research is retained to provide such on-going advice and assistance.

The evidence from the literature (see Chapter 11) demonstrates that this is feasible and an effective approach. It not only facilitates community involvement, but also produces measurable changes in alcohol risk behaviours.

Changing the social climate around alcohol issues in Alice Springs

There needs to be a social marketing campaign, which highlights that alcohol misuse is a problem of both the Indigenous and non-Indigenous communities in Alice Springs and which encourages the community to consider ways to deal with the problem. The NTG needs to investigate innovative social marketing campaigns, which are designed to capture the attention of a broad range of community members.

Education was a widely suggested solution to the alcohol problem, and there is a role for continuing public health education which can be aimed at a variety of levels, including school based education and the provision of information at public events. Again this has to be sustainable and must be implemented in combination with the mass social marketing campaign.

Training packages which combine community development, drug and alcohol issues and effective networking and communication between services should be made available to all members of the Alcohol Working Group. This training is currently available through the community services package, at Certificate three and four levels offered by Charles Darwin University.

Ongoing communication about the Alcohol Management Plan and its components is essential to obtain public support. The NTG needs to develop and implement a more comprehensive public information and awareness process about the Alcohol Management Plan. This should be available through various medium to local residents in Alice Springs and also to visitors to the region. In addition, the Alcohol Management Plan and the relevant legislation should be adequately discussed with service providers, including police, night patrol, and the liquor industry.

Establishment of a new Alice Springs Alcohol Working Group

The Minister for Alcohol Policy should consider the establishment of a new Alcohol Working Group. The current body, the Alcohol Reference Panel (ARP), whilst it has provided advice to government since 2007, needs revisiting particularly in terms of community representation and how it operates. The Minister may wish to consider a new membership, not precluding consideration of some current members, which better covers the scope of community interests.

Meetings need to be timely, structured and informed by data that is up-to-date and accurate. There needs to be a set agenda, and actions flowing out of, each meeting.

Suitable arrangements should be made, and funded by the government, in order that members can personally attend each meeting. Phone link-ups are not suitable and several current members said that they felt “left out” at current meetings by not being present (sometimes because of budgetary issues).

The role of the Working Group needs to be clearly defined by the Minister. The current body does not appear to have a clearly defined and understood role, and there has been an obscuration of what they originally were to do and achieve. Clear reporting mechanisms to the Minister or appropriate body need to be clarified. The Working Group needs to develop a strategic plan with appropriate resources to achieve the agreed goals.

Importantly the wider community needs to be kept aware of the establishment of such a Working Group and its role.

Improving the resources and infrastructure to deal with the problems of alcohol misuse

The NTG needs to consider the wider implications and effects of alcohol misuse. Preventative initiatives, such as education and support should be implemented, particularly for those at high risk, at an early age. In particular, existing organisations that can proficiently provide programs, such as the Gap Youth Centre, Holyoake, Central Australian Indigenous Alcohol Programs Unit (CAAPU), Drug and Alcohol Services Association (DASA) and Central Australian Aboriginal Congress (CAAC) should be sustained through adequate funding and other support.

Other programs, such as night and day patrols were mentioned by residents, during the research, as being very effective mechanisms when operated properly. The NTG should consider reviewing the role and effectiveness of such services to ensure that they are sufficiently funded, adequately supported and proficiently operated. Again,

the provision of certificate level training to night patrols covering the areas of alcohol and other drugs, and effective communication and networking with other agencies should be considered.

Developing an effective framework for ongoing monitoring and evaluation

Monitoring and Evaluation of the AMP's should be conducted at the community level and be the responsibility of the community development officer and the Alcohol Working Group. Resources must be available to support this process, including expert advice when needed.

The development of a pragmatic, reliable and agreed upon minimum data set to inform evaluation is essential. This will require the cooperation and input of a range of government agencies. The provision of such information, will ensure that the Working Group is able to demonstrate progress and that this progress will not be disputed on the basis of the reliability of the data. It will also ensure that data is available in a timely fashion and that the focus of future evaluations is not on how to obtain the data, but how to use it to demonstrate change.

The collection of statistical data to demonstrate progress is essential, but the ongoing evaluation must also monitor the progress of the intervention in terms of the linkages, coordination of services, input from wide range of community organisations and the ongoing communication and dissemination of results. It is recommended that the Alcohol Working Group examine and consider using the range of tools that are available for such monitoring (examples are provided in appendix 3-5).

Developing a "plain-language" handbook for the evaluation of Alcohol Management Plans

A key resource to support the conduct of Monitoring and Evaluation of the AMP's at the community level would be a handbook for the evaluation of Alcohol Management Plans. Such a handbook should describe, in language accessible to community members and stakeholders, the major steps in planning and carrying out an evaluation. It should cover the identification of the key evaluation questions relating to the AMP goals and outcomes and the development, collection, analysis and reporting of the minimum evaluation data set and associated indicators. It should also describe the role and importance of qualitative information in an evaluation and describe its collection, analysis and reporting. Finally, the handbook should be designed to assist community members and stakeholders in accessing professional advice and support in those areas where it is appropriate. Such a handbook would be of major value in allowing communities to plan and implement AMP evaluations.

We recommend that the Menzies School of Health Research be commissioned to develop such a handbook.

Reassessing drinking in Indigenous communities

The inability to drink in public or in town camps has created a culture of resistance in Alice Springs among some Indigenous residents. This further serves to create a divide between Indigenous and non-Indigenous residents of Alice Springs. The NTG needs to engage in a more comprehensive negotiation process with town camp residents and organisations with regard to alcohol use on these leases and if necessary consider negotiating with the Federal Government to remove the “dry town camps law”. Consideration also needs to be given to a process whereby town camp residents can apply, through existing legislation, to have their premises declared “dry” if they so wish.

The NTG also needs to be aware and respond to the unintended consequences of the current restrictions, especially the needs of drinkers who move out of the town’s boundaries to drink. Consideration needs to be made of the harm reduction strategies that may be necessary to support this group of people and their families.

Numerous people interviewed, both Indigenous and non-Indigenous, spoke about the possibility of establishing “wet canteens” or clubs in communities. Whilst such initiatives are essentially a business concern, the NTG through its regional development arm may wish to consider how the most appropriate and responsible business climate can be established to possibly encourage such opportunities. This might possibly be initially instigated with an analysis of alternative community liquor alternatives. However, it appears that the public perception that problem drinkers are coming from outside the community may be overstated, with the sobering up data suggesting that there has been a decline in the contribution of communities outside of Alice Springs to the total numbers of people in sobering up shelters.

Licensed premises

The Alice Springs community has historically been serviced by an abundance of liquor outlets. A more rigorous and proactive program of “buy back” of licenses should be implemented by the NTG.

The NTG should commission a study which examines how a particular culture of drinking is perpetuated by the licensed premises that cater specifically for Indigenous people in Alice Springs. There are indications to suggest that practices such as “book up” for alcohol, which leave an individual indebted to a licensed premise are occurring, as well as variable pricing of some products. Whilst certain practices may

currently be legal, there is still a responsibility for citizens to be fully aware of their rights.

Responsible service of alcohol training is considered an important role in reducing alcohol related harm; however, with a highly transient workforce it is difficult to enforce such training in Alice Springs. Consideration should be made to the development of a training package which includes a cultural awareness component, which would assist the alcohol workforce as they move through the Northern Territory.

Review of alcohol treatment services

Currently some services, especially those designed specifically for Indigenous people appear to be operating in isolation from each other. Services in Alice Springs must be encouraged to communicate with each other and consider collaborative approaches to issues such as referral, effective treatment and case management.

The NTG should consider implementing a round of competitive funding for existing services, which would encourage them to develop collaborative projects to address the needs of Indigenous clients and develop effective and sustainable networks between services.

The NTG needs to consider an audit and mapping of the services provided in Alice Springs, to determine the types of service, that are being offered and to determine the linkages and potential for building further linkages between services.

There needs to be greater involvement of the services in a discussion about best practice when dealing with Indigenous clients and a consideration of the evidence base about effective and appropriate treatments.

Case management of Indigenous clients must be reviewed as a priority, with inter-agency discussion on how to best manage and refer clients through various services, including follow-up and after-care.

Consider the needs of elderly people

The evaluation team heard the issues that some elderly people have in purchasing alcohol at a suitable time. However, it is inappropriate that any special dispensation be made for their concerns. It will open the situation, and particularly for Indigenous elderly people, for exploitation by younger people and the negative outcomes outweigh the positives at this stage. Other mechanisms might be considered by the Alcohol Working Group, or other organisations in the future. At the present time, the

elderly will have to bear the burden of alcohol responsibilities as will the wider community, in what is, essentially, a community problem.

An investment in community change

None of the strategies listed above are “quick fixes”. They require extensive inter-governmental cooperation and an investment of resources and time. This evaluation has demonstrated that alcohol misuse in Alice Springs is a complex and enduring problem. We have reviewed evaluation reports and their recommendations for the last thirty years, which reiterate the same messages as this report. There needs to be a fundamentally different way to address alcohol issues in the community and this approach will require extensive community consultation and the embracing of a community development framework to enact change. There is a good evidence base that such interventions will be successful, both in terms of changing the community climate towards being more receptive and knowledgeable about the issues and in terms of demonstrating measurable change (see Chapter 11). If the Northern Territory Government is committed to developing a sustainable and community focused Alcohol Management Plan in Alice Springs (and elsewhere), these ground up interventions are necessary as the first step to move beyond the liquor restrictions.

Kate Senior



1. Introduction

The Northern Territory Government (NTG) commissioned the development of a NT Alcohol Framework in 2004. The Framework proposed the introduction of various initiatives in order to reduce the harm caused by alcohol to individuals and the community. Action under the Framework was to be guided by evidence based, coordinated and collaborative, and balanced approach principles. The Framework recommendations were formally adopted by the NTG in 2005. An initiative of the new approach was the establishment of the Office of Alcohol Policy and Coordination.

The then Chief Minister, the Honourable Claire Martin, MLA on 7 September 2006 announced a plan under the framework to address ongoing alcohol issues in Alice Springs. The Alice Springs Alcohol Management Plan (referred to as the AMP) was developed under the auspices of the Chief Minister's Alcohol Taskforce. The three key strategies of the AMP are:

- Reducing supply – restricting the availability and accessibility of alcohol;
- Reducing harm – influencing drinking choices and drinking environments and providing interventions that prevent further harm; and
- Reducing demand – changing individual attitudes to drinking and challenging community tolerance of harmful drinking patterns.

The new approach was to feature a Liquor Supply Plan to govern the sale of takeaways and the operation of licensed premises.

An Alice Springs Alcohol Reference Panel consisting of government, Alice Springs Town Council and various stakeholder representatives was established. An evaluation of the AMP, with community input, was to be conducted after 12 months.

Menzies School of Health Research (MSHR) was engaged in August 2008 to evaluate the AMP. The terms of reference included:

- What strategies from the AMP have been implemented?
- If a strategy has not been implemented, why, and what barriers are there?
- What has been the effect of such implementation?

The NTG also requested that the evaluation assess whether “Thirsty Thursday” initiatives trialled previously in Tennant Creek have relevance and possible application to Alice Springs.

The evaluation utilised quantitative and qualitative methods of data collection to inform the process. Qualitative data included written submissions following open invitations to the public by the media, targeted interviews with key stakeholder groups, and random sample of interviews with Alice Springs residents. Quantitative data included various statistical collections and an analysis of the surveys.

The evaluation environment

Government policies

Alice Springs has been the site of various Commonwealth and NTG interventions since 2006. These interventions primarily focus toward Indigenous individuals and groups; however, the wider community is affected in some form or another. Such interventions include:

- New Liquor Supply Plan (October 2006)
- Income quarantining (August 2007)
- Declaration of Public Restricted Areas (August 2007)
- Implementation of Alcohol Takeaway Identification cards (June 2008).

These interventions, and particularly the Commonwealth Intervention, have perceptibly affected behaviour beyond that directly associated with alcohol consumption, but ultimately affecting outcomes in some form.

For instance, income quarantining allegedly has influenced the movement of some Indigenous people to circulate beyond their “normal” patterns of community association. Similarly it was proposed to the evaluation team that the interventions have influenced drinking styles and patterns such as drinking outside the immediate Alice Springs town area and transporting alcohol back to communities. Consideration of these factors, particularly population trends have had to be taken into account.

Evaluating the Alice Springs AMP has had to be conducted within this complex milieu of government policy; all of which potentially impact on individual and group behaviour when it comes to alcohol consumption. Thus the evaluation of specific strategies and initiatives within this environment has been challenging.

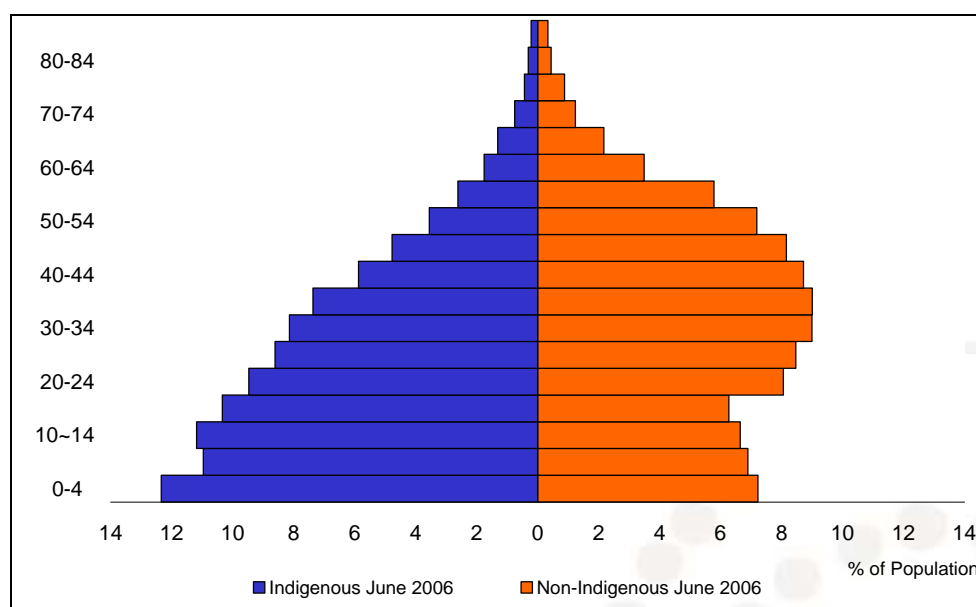
Demographic Profile of Central Australia and Alice Springs

The Central Australian region has a population of 39559, or 18.8% of the total Northern Territory population (ABS 2008). Indigenous people make up 41.1% of this population.

The town of Alice Springs has a distinct demographic composition. It is estimated that the population of Alice Springs at 30 June 2007 was 26194 (ABS 2009). In 1961 it was 4668.

The Indigenous component of this population is 5238 or 20.4%. These figures include the town camp population of Alice Springs. This compares with an Indigenous percentage of the total Australian population of 2.4% (or 5.3% if compared to the category of towns in the “outer regional” bracket) (ABS 2003).

Even more interesting in terms of policy implications is the “very young age composition” of the Indigenous population generally when compared to the “old age composition” of the Australian population (Taylor 2006: 6-7). This is illustrated in Figure 1.1. Taylor also points out that with this youthful age profile and “substantial room for improvement in life expectancy”; the Indigenous population is now poised to increase even further. This observation can also be applied to the Alice Springs situation with a further emerging young Indigenous population in the future. The Indigenous population in the Territory is projected to grow by 56% (or 1.9% per annum) from 2006 to 2036. Of the total Indigenous population of Alice Springs, 2911 or 55.5% are under 24 years of age.



(Source: Northern Territory Treasury, ABS Cat. No. 3201.0)

Figure 1.1: Age Distribution of Territory Indigenous and non-Indigenous populations, 2006

There is a common perception in Alice Springs that more Indigenous people have moved to Alice Springs from outlying communities since the Federal intervention of 2006. A report on the Australian Government Emergency Response in the NT analysed this perception of “urban drift”. It concluded that there was “no clear evidence of an overall net shift of population from one area to another” (Australian Government 2008). It did note, however, that people have been motivated to explore options beyond prescribed areas, for instance toward places such as Coober Pedy. Taylor (2008: 5) also explained that some of the evidence pointed toward Indigenous “heightened dislocation and inconvenience” particularly with regard to where they can spend their income. This appears, according to Taylor (2008: 5), to have led to “increased itinerancy in urban centres”.

An outcome of the NT Government alcohol restrictions has been the necessity for people purchasing alcohol to have suitable identification. Tangentyere Council provides a service issuing such cards to Indigenous clients. By November 2008 they had issued 2250 identification cards.¹ These cards were issued to male and female Indigenous people over 18 years of age. They estimate that 883 of these cards were issued to people resident in Alice Springs. The remainder 1344 were from “outside” Alice Springs including Central Australian communities, and people from Western Australia and South Australia. Thus whilst the core population of Alice Springs remains constant, there appears to be considerable movement of people to and from the town.

Nature and context of the problem

The nature of the drinking “problem” in Alice Springs is assumed by some to be confined to the Indigenous population. In effect, the consumption of alcohol and resultant negative outcomes must be assumed to affect all residents of Alice Springs in some form or another as the consumption of alcohol per person in the town is significantly higher than the national average.

Why is there such a high consumption of alcohol? It is necessary to gain a historical perspective of Alice Springs foundations. The town of Alice Springs is unique in many ways. It was originally established as a watering point for Afghan traders, explorers and travellers and still substantially operates as a service centre for visitors and outlying communities. The town supports a permanent population of 27000 people, however, there are a further 9000 people within the surrounding region. Its economy is reliant on the wider regional populations as well, not only for food and supplies, but also for alcohol. Whilst the adverse effects of alcohol are an issue, its sale and contributions to the local economy is important.

¹ Tangentyere Council, interview with M. Clerk, 30/11/08.

The “frontier” aspect of the town’s history perhaps plays a part in its drinking image today. Hard work and reward encompasses, particularly in the pastoral industry, a session, often lasting for days or weeks in the local pub. This pattern of drinking was associated with both Indigenous and non-Indigenous workers. The pastoral and associated industries changed its labour focus from the 1970s onwards, with a particular down-turn in Indigenous labour, but the drinking styles and patterns have remained.

Associated with the reward type representation and analysis in a hard working environment, is perspectives from the ethnographic literature on drinking that emphasise its convivial and sharing functions, its enhancement of group solidarity and its role in constructing social worlds (Brady 2004; Collman 1979; Horton 1943; Sansom 1980). This analysis, although focused on the Indigenous environment may also apply to the non-Indigenous context as far as the town of Alice Springs goes.

Indigenous drinking as a source of tension in the town

Alice Springs has always been a community with a large Indigenous population, it appears though that Indigenous people were increasingly conceptualised as a “problem” in the community after World War Two, due to population growth in the town and influx of new people and ideas from other parts of Australia (Donovan, 1988: 304). In 1964, the *Social Welfare Ordinance* (Cth) legalised Indigenous consumption of alcohol and with this right, the public perception of the “Indigenous problem” grew:

With little to do, because jobs were scarce, yet with welfare money readily available, many of the Aborigines took to the drink. Long considered lazy and aimless, the new freedom, specifically the ready access to liquor, meant that many became drunk, disorderly and abusive. The paradox was that while many whites condemned the drunkenness and disorderliness that resulted, others hastened to take advantage of it by delivering liquor to the camps and settlements at inflated prices (Donovan, 1988: 306).

These tensions continue to the present day. Alice Springs is a tourist town, which extensively promotes and markets Indigenous art and culture, but the town’s relationship with Indigenous people is fraught. The public highly visible nature of Indigenous drinking and disputes ensures that they are blamed for the social disorder in the town. At the same time, Indigenous drinking continues to be an important source of revenue for many of the town’s businesses.



(source NT Tourism)

Figure 1.2: Alice Springs Town

2. Methodology and type of evaluation

Terms of reference

The terms of reference for the evaluation of the Alice Springs Alcohol Management Plan were:

- What strategies from the AMP have been implemented?
- If a strategy has not been implemented, why and what barriers are there?
- What has been the effect of such implementation?
- How can the impact of the alcohol management plans be assessed?

Type of evaluation

Our immediate problem was to determine what sort of evaluation it was possible to carry out, and what methods and tools would be most appropriate to achieve this. There is a very rich evaluation literature (for example, see Owen 2005). Hawe et al. (1990) provide a very useable framework, and describe evaluation as being composed of three distinct types:

Process evaluation: is concerned with the processes or strategies that were used to implement a project, service or plan. It focuses on the planning and implementation processes used, the choice of strategies and interventions and their impact and reach. Process evaluations can include site visits, key informant interviews, surveys of participant, analysis of reports as minutes and direct observation. These tools support and enhance the planning process itself.

Impact evaluation: is concerned with evaluating the effect of an intervention, plan or project and is used to determine whether objectives have been met or not. Methods used to obtain data include surveys, focus groups, questionnaires, nominal group techniques and similar qualitative and quantitative strategies. Impact evaluation tells us about the results produced by the strategies or interventions.

Outcomes evaluation: is concerned with the long-term effects of an intervention, plan or project and can help identify whether goals have been achieved or not. Outcome evaluation is concerned with effectiveness and with identifying those outcomes that can be attributed to the intervention. It is often used to inform decision making about the continuation of projects or services. Methods used in outcome evaluation include analyses of qualitative and

quantitative data obtained from routine data collections, one-off studies, surveys, focus groups and nominal group techniques. (Hawe et al. 1990, cited in Eagar et al. 2004: 3-4).

Previous reports have attempted to describe the impact of various alcohol restrictions in Alice Springs (Crundall and Moon 2003). We argue, however, that it is too recent to focus on the impact of the Alcohol Management Plans, as many aspects of the plans were implemented less than one year ago, for example the ID system was introduced in June 2008. It is also clear that only some aspects of the Alcohol Management Plan have been fully implemented, these aspects concentrate on the reduction of supply. Some of the other components of the plan; demand reduction and harm reduction have not been implemented (see Chapter 6, table 6.1). Indeed there is minimal evidence to suggest that there has been consideration of what strategies could be utilised to implement these aspects of the Alcohol Management Plan. Furthermore, the situation is complicated by the range of interventions, including the Intervention, which has been implemented in Alice Springs during the last few years. Table 2.1 provides a timeline of the various initiatives which have been implemented in Alice Springs since 1999.

Table 2.1: Time Line of Government (NT and Federal Governments) Alcohol Related Initiatives and Interventions

Date	Government Initiative
2009	Operation RAID NT Police – December 08/ January 09
2008	Identification cards implemented – 23 June Special police antisocial behaviour operation – April CCTV surveillance – Todd Mall – 10 April
2007	Income quarantining by Federal Govt. commenced – 1 August Town camps declared “dry” from Dec 07 – Decision 1 August Public restricted area commenced (NTG) – 1 August Beer in long necks banned – June Dry Town Decision – 9 May “Moving Alice Ahead” project announced – 18 April
2006	Alcohol Reference Panel first meeting – 2 November Liquor Supply Plan amended – 1 October (to be monitored over 12 months) Broader Alcohol Management Plan (AMP) announced by Chief Minister Martin – 7 September Moratorium on new takeaway licenses for 12 months – June
2005	Operation Sharp Edge NT Police Minister for Racing, Gaming and Licensing delivers Alcohol Ministerial Statement to the Legislative Assembly which outlined the Government’s approach to addressing alcohol issues in the community. An initiative of the new approach was the establishment of the Office of Alcohol Policy and Coordination. Also identification of a Framework for Addressing Alcohol Issues in the Northern Territory – 11 October
2004	NT Alcohol Framework final report presented to NTG – July Interim NT Alcohol Report presented to NTG – February
2003	Removal of container size restrictions – July
2002	Takeaway hours reduced 2pm-9pm – April Light beer only before 11.30am Monday to Friday and other measures Liquor Trial – reducing grog related harm – 1 April commenced – 12 months

Instead of providing an impact or outcomes evaluation of the Alcohol Management Plans in Alice Springs we will provide a process evaluation, which explores the different components of the Alcohol Management Plan, and the processes involved in the implementation of the Plan. The object of this evaluation is to describe what aspects of the plan have been established, how the key stakeholders in the establishment of the Plan consider the implementation and its aims and what information is necessary to effectively report on these aims. In this way we can work towards providing recommendations of how to establish a framework whereby monitoring and impact evaluations of the Alice Springs Alcohol Management Plan can be developed and conducted.

Challenges for the evaluation

The evaluation of the Alice Springs Alcohol Management Plan was challenging for several reasons. One of the most important factors was the politically fraught arena which formed the background for the evaluation. There were many competing and disparate opinions surrounding the problem of alcohol misuse in the community and many highly vocal individuals and groups. This required the evaluation team to spend a significant amount of time in consultation and to ensure that no group or individual with an opinion on the problem was neglected. There were also significant difficulties in arranging access to some groups.

The Alcohol Management Plan was implemented in Alice Springs at the same time as the Commonwealth Intervention. This caused a number of difficulties. First it was often difficult for community members to distinguish between the Northern Territory Government and the Commonwealth Government initiatives and second it was very difficult to isolate the impacts of the Alcohol Management Plan.

Finally, there were a range of difficulties with obtaining and analysing the relevant quantitative data. Some of these problems were due to the difficulties of dealing with a range of Government agencies, but more importantly there was no agreement about a minimum data set to perform such evaluations and no streamlined way of obtaining the data.

The evaluation team found that data was being collected from a wide range of sources — by Alice Springs interest groups and the Alcohol Reference Group and that it was very difficult to make assessments about the reliability and quality of the data. Often discussions about the problem of alcohol misuse in Alice Springs (as evidenced by the minutes of the Alcohol Reference Group) turned into a debate about who had access to the best data, rather than focusing on strategies to address the problem.

Methods and data sources

The process evaluation has utilised the following methods and data sources:

- Key informant interviews, both to assess how the Alcohol Management Plans are perceived and accepted by the community, but also to determine how they have been promoted and managed by key stakeholders.
- Participation and observation of relevant meetings, such as the meeting of the Alice Springs Town Council, the Chamber of Commerce and the Alcohol Reference Panel.
- A description of services involved in alcohol misuse and a description of the linkages and communication between these services.
- An exploration of the governance structures maintaining the Alcohol Management Plans, and how decisions were made and implemented concerning the Alcohol Management Plans.
- A survey of community attitudes and receptivity to the Alcohol Management Plans (these were conducted in the community as a whole and separately in town camps).
- A call for submissions to the evaluation (received from individuals and organisations).
- A review of the media concerning alcohol and related problems and how the restrictions were interpreted and presented to the community.
- A review of the activities of alcohol related interest groups and how they presented their agendas to the community.
- A review of routinely collected data, with a focus on how accessible and relevant this data was and to describe any problems that arose in obtaining this data.

Ethics was granted for this project in December 2008 by the The Human Research Ethics Committee of the NT Department of Health and Families and Menzies School of Health Research (NEAF HREC No. EC00153).

3. The Alice Springs Environment

Alcohol misuse as a problem in Alice Springs

Alcohol misuse is a problem for the Northern Territory as a whole, with Territorians in 2005/2006 drinking 14.9 litres of absolute alcohol (Lal) per person by those aged 15 years and over (NT Dept of Justice 2009). In comparison, the apparent annual per

person consumption by those aged 15 years and over in Australia for the same period, was 9.8 litres (ABS 2006).

To put this in an international perspective, the World Health Organisation (WHO) reported a global average of 5.1 litres of pure alcohol per adult (15+ years) per year (WHO 2004). The apparent alcohol consumption levels of the Northern Territory are among the highest in the world, exceeding those of the countries who were rated as the highest consumers in the world in 2003, such as Ireland at 13.7 litres per year, and the Czech Republic at 13.0 litres per year (WHO 2008).

The figures for Alice Springs are exceptional. Alcohol consumption in 2005/2006 was 20.38 litres by those aged 15 years and over (NT Dept of Justice 2009).²

The impact of alcohol on health outcomes in Central Australia

The impact of alcohol consumption on health outcomes may be investigated by examining those causes of death which are directly due to alcohol abuse. Table 3.1 lists the main causes of death as classified by the WHO International Classification of Diseases (ICD) revision 10.

Table 3.1: Main disease categories directly associated with alcohol use

ICD 10 code	Condition
F10	Mental and behavioural disorders due to use of alcohol
I42.6	Alcoholic cardiomyopathy
K29.2	Alcoholic gastritis
K70	Alcoholic liver disease
K85.2	Alcohol-induced acute pancreatitis
K86.0	Alcohol-induced chronic pancreatitis
X45	Accidental poisoning by and exposure to alcohol

Note that the use of these conditions will understate the true alcohol mortality burden as alcohol increases the risk of a variety of other conditions and so contributes a proportion of their mortality burden. However, there is no way to identify specific

² Note that the collection methods of alcohol volumes in the ABS publication and NT Dept of Justice internal data are different together with the fact that NT includes tourist numbers in the population denominator thus rendering the comparisons as indicative.

cases of these other conditions caused by alcohol from the national deaths data so they have been excluded from our calculations.

Table 3.2 presents the actual number of deaths from these alcohol related conditions in Central Australia for the most recently available three years (2004 to 2006) for Indigenous and non-Indigenous people. It also presents an estimate of the number of deaths which would have been expected in these years if the national average death rates for all Australians for these conditions had applied to Central Australia. Finally, it presents the estimated Standardised Mortality Ratio (SMR)—which is calculated as the ratio of the actual deaths to the estimated expected deaths. The SMR is a measure of how much the mortality from these conditions observed in Central Northern Territory is greater than the national average.

Table 3. 2: Observed and estimated expected deaths from alcohol related conditions in Central Australia for the period 2004 to 2006

	Observed deaths	Estimated expected deaths	Estimated standardised mortality ratio with 95% confidence interval
Indigenous people	32	1.0	30.9 (21.2, 43.7)
Non-Indigenous people	4	2.9	1.4 (0.4, 3.5)

The SMR for Indigenous deaths is estimated to be 30.9 with a 95% confidence interval of 21.2 to 43.7. This means that the number of deaths directly related to alcohol among Indigenous people during the three years 2004 to 2006 was around 31 times higher than the national average during this period for all Australians—clearly demonstrating a major impact of alcohol consumption on Indigenous people in this region. The SMR for non-Indigenous deaths is estimated to be 1.4 with a 95% confidence interval of 0.4 to 3.5. Thus although the number of deaths directly related to alcohol among non-Indigenous people during this period was estimated to be 40% higher than the national average, this figure must be treated with caution. The very small number of alcohol related deaths both observed and expected among non-Indigenous people means that the SMR cannot be estimated with sufficient accuracy to identify any difference between non-Indigenous alcohol related mortality in Central Australia and the national Australian average.

Whose problem?

Alcohol misuse in Alice Springs is often presented as an Indigenous problem, this viewpoint is common in the media and promulgated by community groups such as the Responsible Drinkers Lobby, who characterise their own drinking as being

responsible and moderate in comparisons with the irresponsible drinking of a minority of primarily Indigenous people.

The presentation of alcohol misuse as an Indigenous problem is also influenced by the crisis driven view of the effects of Indigenous drinking. For example, research from the Alice Springs Hospital drew attention to the levels of stab injuries in the community, of which 99.99% were incurred by Indigenous people and 31% were associated with alcohol (Jacob et al. 2007). There is no disputing that alcohol has had a very serious effect on the Indigenous population of Alice Springs, but it is also possible that the largely hidden effects of non-Indigenous drinking are not being acknowledged. As Gray points out, the non-Indigenous level of drinking in Central Australia is also at an unacceptably high level:

If Indigenous drinking is factored out per capita, consumption by the non-Indigenous people in central Australia is still about 52 percent higher than the national average (Gray, 2000: 4)

The World Health Organisation points out that there are many levels of possible health effects of alcohol misuse from the acute problems, through to the cumulative effects of drinking at unsafe levels over a period of time, which influence a range of diseases:

The strongest drinking-related predictor of many chronic illnesses is the cumulated amount of alcohol consumed over a period of years (WHO 2008).

The Alice Springs focus on alcohol as a disruptive and dangerous social issue has obscured the public health effects of dangerous levels of consumption. These are largely hidden in the non-Indigenous population who do not greatly influence the acute alcohol related indicators such as assault rates and whose drinking is not in the public view.

Government policies

Alice Springs has been the site of various Commonwealth and NTG interventions particularly since 2006. These interventions primarily focus toward Indigenous individuals and groups; however, the wider community is affected in some form or another. Such interventions include:

- New Liquor Supply Plan (October 2006)
- Income quarantining (August 2007)
- Declaration of Public Restricted Areas (August 2007)
- Implementation of Alcohol Takeaway Identification cards (June 2008).

These interventions, and particularly the Commonwealth intervention, have perceivably affected behaviour beyond that directly associated with alcohol consumption, but ultimately affecting outcomes in some form.

For instance, income quarantining allegedly has influenced the movement of some Indigenous people to circulate beyond their “normal” patterns of community association. Similarly it was proposed to the evaluation team that the interventions have influenced drinking styles and patterns such as drinking outside the immediate Alice Springs town area and transporting alcohol back to communities. Consideration of these factors, particularly population trends have had to be taken into account.

Evaluating the Alice Springs AMP has had to be conducted within this complex milieu of government policy; all of which potentially impact on individual and group behaviour when it comes to alcohol consumption. Thus the evaluation of specific strategies and initiatives within this environment has been challenging.

Media

There are two newspaper outlets in Alice Springs, the *Centralian Advocate* published Tuesday and Friday, and the *Alice Springs News* which is printed once a week.

ABC radio broadcasts local content for 9 hours per day (with AM at 8.30 am). Other programs are broadcast from Darwin. Radio National, Classic FM and JJJ broadcast locally on the Northern Territory/Queensland schedule.

Four free to air television stations broadcast in Alice Springs. They are Impartja, Southern Cross Television, ABC Television and SBS. Imparja broadcast a local news service on weekdays. ABC has a NT specific news service which operates out of Darwin. There is an Alice Springs based journalist and camera person. There is little Alice Springs content on the other channels.

Four radio stations operate in the town including the Central Australian Aboriginal Media Association (CAAMA), 8CCC (a community radio station), 8HA (commercial music and talk station) and SunFM (commercial music and talk station).

Due to the relatively small size of the town, its character of local networks, and the opportunity for exchange due to the proliferation of hotels and clubs, it appears that opinion building on issues such as alcohol and crime are formed on a community basis. However the media, and it appears particularly through the *Centralian Advocate* and some of the radio stations, play an important role in further formulating, focusing, and broadcasting popular opinion. This is influential in agenda-setting amidst an overriding stance that sees Alice Springs as “south of the Berrimah line” (not particularly within the scope of the government’s concern).

The Role of the Media with Alcohol in Alice Springs

Research suggests that the mass media performs a key role in agenda-setting and shaping public opinion (McCombs and Shaw, 1972). The media, particularly newspapers, in Alice Springs appear to play a significant role in this process in the community. This is particularly prominent with regard to the issue of alcohol. The *Centralian Advocate*, for example, regularly has stories that feature alcohol linked with crime and youth. It might be argued that the media organise public understanding of the issue, perceptions and even the use of phrases associated with alcohol. There are several phrases for instance that the research team regularly encountered, such as “recidivist drinkers”. This term is variously used by journalists, commentators and letters from residents to describe the so-called 200-300 problem drinkers in the town. It identifies the problem area and labels this section of the community as requiring rehabilitation and treatment.

During the period of the Menzies research, September 2008 to April 2009, headlines that appeared in the *Centralian Advocate* and on *ABC Online* included:

- “Booze lobbys fight restrictions battle” – *Advocate* – 4 November 2008
- “Let’s get serious to deal with grog” – *Advocate* – 3 February 2009
- “Minister urged to make Alice alcohol policy a priority” – ABC Alice Springs – 5 February 2009
- “War on crime steps up” – *Advocate* – 20 February 2009
- “Only a real police presence will stop criminals: businessman” – *Advocate* – 20 February 2009
- “A battle with many fronts: schools, youth help, police beat” – *Advocate* – 20 February 2009.

Given the influence of the media on public opinion in Alice Springs, it appears imperative that they be utilised to address issues such as education on drinking and information about government alcohol initiatives. The evaluation, for example, has identified a significant issue with dissemination of information about the AMP and the opportunity exists for this necessary action to be done in a more professional and informative manner.

The national media also contributed to the environmental factors affecting the community’s response to the Alcohol Management Plans. For example, at the end of December 2008, *The Australian* examined alcohol related crime under the headline “Down like Alice: the meltdown of a tourist mecca” (Robinson, 2008). This story, which draws heavily on the opinions of politician Jodeen Carney MLA (CLP), warned tourists that: “it’s an alcohol-fuelled town that has the highest murder rate per

capita of any non-conflict region”. The fact that tourists were not the target of violence in Alice Springs was underplayed.

The comments of Alice Springs residents that they are embarrassed by this level of attention and concerned about the effects on local tourism are very real in the context of this kind of media attention.

Community groups with a focus on alcohol and related problems

Existing community groups can be an excellent resource for developing a community focused intervention. These groups have potentially strong existing networks into the community and are strongly grounded in community concerns. In Alice Springs, two quite disparate groups have emerged as a reaction to the problems caused by alcohol misuse in the community. These are the People’s Action Against Alcohol Coalition, which was formed in 1995, and the much more recently formed Responsible Drinkers Lobby.

People’s Action Against Alcohol Coalition (PAAC)

The People’s Action Against Alcohol Coalition (PAAC) was formed in 1995. It has membership from Congress, NTCOSS, Central Australian Legal Aid, the Uniting Church and the Central Australian Youth Linkup Service. It has high profile support in the community from Dr John Boffa, representing Congress.

PAAC has been active and vocal in its lobbying to reduce the availability of alcohol in Alice Springs and makes regular submission to the local and national media about alcohol issues. They have, throughout their existence, lobbied for strengthening of existing liquor restrictions, including the introduction of at least one, but preferably two days a week when takeaway alcohol is not available for sale.

PAAC made a detailed submission to the Evaluation which outlined their concerns with the availability and quality of data to demonstrate change as a result of alcohol restrictions. PAAC are represented on the current Alcohol Reference Panel which was established as part of the Alcohol Management Plan.

The Responsible Drinkers Lobby

The Responsible Drinkers Lobby was formed by high profile Alice Springs Alderman, Liz Martin, OAM, in response to the alcohol restrictions which were imposed upon Alice Springs. The group appears to have high profile support from the Alice Springs Town Council.

The Responsible Drinkers Lobby describes itself as “a group of community minded Alice Springs residents, desperately concerned about the failure of current alcohol restrictions to offer any real or significant impact on recidivist public drunkenness, family violence, criminal activity, binge drinking and anti-social behaviour in our streets, in our homes and businesses and in our public areas” (Martin, 2009: 3). Underlying this concern is the conviction that alcohol restrictions are an imposition on the majority of “responsible drinkers” in Alice Springs. By November 2008, there were 625 members of the group.

From October 2008 to December 2008, the Responsible Drinkers Lobby conducted a survey to elicit views of the Alice Springs community. This was done in an effort to ensure that: “The opinions of the broader community are accurately reflected in any position paper, review or strategy dealing with alcohol related harm to person and property in Alice Springs” (Martin, 2009: 3).

This survey which was intended to be representative of the views of the broader Alice Springs community had some serious methodological flaws; it was given to people who expressed an interest in the Responsible Drinkers Lobby and so can be expected to represent the views of people who responded to the agenda of the Lobby. The format of the questionnaire, which has a question followed by a range of possible answers, has the potential to guide respondents to answer in a particular way. For example Q27:

How does this current wave of antisocial behaviour make you feel?

The questionnaire then offers the respondent categories of: fearful for my life, fearful for my family, fearful for my property, all of the above, somewhat cautious, somewhat embarrassed, not fearful at all and other. It would be difficult to think of an “other” category given the range of emotive responses provided prior to it.

The total number of people who responded to the survey was 833, which reveals a high degree of motivation of this particular group of people to have their opinions heard. This is contrasted to the three responses from individuals (as opposed to organisations) that were received as a result of the call for public submissions that was put out by the evaluation team. It is evidence of an extraordinary commitment to furthering the cause of the responsible drinkers by Liz Martin.

The responses to the survey are collated in a report entitled “Enough is enough”. Surprisingly the report received minimal media attention, which appears to be confined to a fairly critical report in the *Alice Springs News* (Finnane, 12 Feb 2009). It also generated a series of letters to the editor including one entitled “the selfish Grog Lobby” which stated:

At a time when every state government, many local governments, supreme court judges plus the Federal Government are looking at strategies to curb the horrific human damage caused by alcohol abuse, these people are advocating a softening of restrictions that will return us to the awful days when people got their money early in the morning and went straight down the grog shop (Harries, 2009).

The report lists 26 recommendations, all of which are about governments implementing strategies to help the minority of problem drinkers or providing extra funding for existing services. Most of the 26 recommendations (see Table 3.3) involve a repositioning of the problem, from one that encompasses the whole community, to one that focuses on problem drinkers. Furthermore, all the strategies listed are things that should be done for Alice Springs by an outside authority, rather than strategies that can be developed within the community.

Table 3.3: Strategies proposed by the Responsible Drinkers Lobby

1. Northern Territory Government should work with Indigenous groups, service providers and other stakeholders to develop an integrated youth policy.
2. All levels of government work to develop a lock down facility for homeless and delinquent youth.
3. All levels of government develop a plan for the long term accommodated care facility for homeless recidivist drinkers, for whom rehabilitation is not an option.
4. Alice Springs Town Council and the Northern Territory Government investigate operating a night-time care and diversion program in Alice Springs that diverts delinquent, homeless and at risk children from the streets.
5. The Northern Territory Government in association with the Federal Government opens a fully integrated alcohol rehabilitation facility in Alice Springs, with mandatory attendance for third time offenders.
6. A Territory wide overarching strategy is formed to oversee coordinated treatments for the prevention of alcohol related harm in our community.
7. Northern Territory Police work with the Alice Springs Town Council to determine best practices for closed circuit television and lighting in Alice Springs.
8. Northern Territory Government to review and refine the Alcohol Court.
9. Increased funding for night and day patrols.
10. The Northern Territory Government re-consider mandatory sentencing for criminal offences.
11. Northern Territory Police work with the community to develop strategies to place police on the ground and the Todd Mall area.
12. The Northern Territory Government allows liquor outlets to open for takeaways from 10am until 10pm.
13. Northern Territory Government liaise with camp authorities to investigate the need for increased policing in town camps.
14. The Northern Territory Government research options for using early intervention of public drunkenness and drinking in public places as a preventative measure against antisocial behaviour.
15. Appointment of full time truancy officers.

16. Northern Territory Government and traditional owners explore the viability of opening an Indigenous social club with a focus on low alcohol, low risk, responsible drinking.
17. Northern Territory Government works to find a way to ensure financial restitution is made by the perpetrator to the victim.
18. Northern Territory Government works with Indigenous groups and other stakeholders to determine the best strategy for the implementation of wet canteens in Indigenous communities.
19. All levels of government continue to provide funding for broad educational initiatives, and a new priority be given to campaigns that target specific sub-groups, such as teens and pre-teens.
20. Northern Territory Government and Police work with traditional owners and town camp authorities in developing facilities for children within the camps.
21. Need to expose children to responsible drinking behaviours.
22. The Commonwealth and the Northern Territory Governments undertake further research into the need for halfway houses in communities.
23. The Federal and Northern Territory Governments take a geographical approach to spreading the allocation of takeaway licenses evenly across the community.
24. The Federal and Northern Territory Governments look at how to return at least a percentage of alcohol taxation revenue directly back to the communities where it was sold. These funds to be used for the development of treatment and to help meet the costs of cleaning up the community.
25. Governments should not ban advertising/sponsorship of sporting and community events but instead continue to promote responsible drinking behaviours.
26. That in their consideration of an alcohol free day for Alice Springs all levels of government consider both the “dire consequences” for the tourism industry as well as why this concept failed in Tennant Creek.

(Adapted from Martin 2009)

Liquor Outlet Density

Liquor outlet density is strongly related to drinking patterns and problems (Kypri et al. 2008). The availability of alcohol in an outlet dense environment is only one part of the equation in the calculation of alcohol related harm. Gruenwald (2008) argues that outlets in alcohol dense areas must also compete with each other and work to provide customers with an environment which is appropriate to their needs and in doing so may serve to reinforce a particular type of drinking behaviour in the community. Using the example of the perpetuation and conglomeration of violent bars, he comments that:

Once the demand for alcohol begins to be met by commercial establishments, these establishments culturally co-evolve with drinkers’ habits and cultural practices with respect to drinking are shaped and re-shaped as markets continuously restructure to meet demands (Gruenwald, 2008: 1586).

In 1999, Brady and Martin examined reducing alcohol density as a strategy to reduce alcohol consumption. They commented that Alice Springs had a “very high ratio of

liquor outlets per head of population and that this can be linked to high consumption levels” (1999: 6).

By 2008, the number of liquor outlets remained at the same level, but there was a reduction in the number of hotel licenses and one extra restaurant license. Brady and Martin had commented favourably on a proposal to maintain the number of licenses in Alice Springs, “but allow the development of licensed cafes with outdoor tables along the Todd Street Mall, selling alcohol with meals” (1999: 7).

Table: 3.4 Alice Springs liquor outlets

Category	June 1988*	June 1997*	September 2008
Hotel	17	22	16
Tavern	2	4	4
Restaurant	13	17	18
Other On-License	6	10	13
Store	14	11	10
Liquor Merchant	5	3	4
Licensed Club	13	13	12
Off licences	?	?	3
Total	70	80	80

* source Brady and Martin (1999: 7).

Table 3.5 Liquor Outlets where takeaway is available

Category	Number	Restricted membership/access
Club	11	Yes, must be a financial member
Hotel	2	Where takeaway is publicly available*
Tavern	1	No
Liquor Merchant	4	Yes, conditions apply
Store	11	No
Off license	3	Conditions apply

* Other hotels have conditions that permit a bona-fide lodger to remove alcohol from the premises under certain circumstances.

The important indicator in outlet density is the number of premises that sell take away liquor. On first investigation, there would appear to be a large number of these outlets in Alice Springs, however many of these sell alcohol subject to being a member of a club, or being a resident of a hotel or caravan park, and so do not cater for off the street trade. Alice Springs currently has twelve licensed premises that provide takeaway which is not restricted by membership rules, associated with being a member of a wine club, or a guest at a hotel.

Brady and Martin comment that there is “widespread anecdotal evidence that there are three or four problem liquor outlets that contribute disproportionately to the Indigenous drinking problems, all situated along the Todd River and most near Town Camps” (1999: 7). As can be seen, from Figure 3.1, this situation remains the same, with clusters of easily accessible outlets which are within walking distance from each other. Following Grunewald’s argument, the clustering of these outlets not only provides ready access to alcohol but may also serve to reinforce a particular kind of drinking culture. The process by which this drinking culture is being developed and reinforced by these establishments is an important subject of future research.



Figure 3.1: Location of Key* Takeaway Outlets in Alice Springs

* There are other takeaway outlets, however most of these have some form of restriction, such as the need to be a financial member of a club.

Note: Yellow dots signify the approximate location of the outlet

4. Best Practice in addressing alcohol related problems

The policy options available to address alcohol misuse and their efficacy have been extensively reviewed (Edwards et al, 1997). For a recent example see d'Abbs et al. (2008). Stockwell (2006: 270), provides a useful definition of the three main conceptual pathways for addressing alcohol related problems:

1. *Harm reduction*: Strategies that reduce the likelihood of harm to health or safety without necessarily requiring a change in pattern or level of substance abuse. These work principally by making the substance use environment safer (for example, better lighting, well trained security staff) and/or the means of administering the drug less risky (for example, using clean needles, safer glassware).
2. *Demand reduction*: Strategies which succeed by motivating users to consume less over all and/or less per occasion (for example, controlled drinking and brief intervention programmes, abstinence-orientated treatment programmes) or by affecting population groups (for example, raising taxes on tobacco or alcohol).
3. *Supply reduction*: strategies that are intended to achieve social, health and safety benefits by reducing the physical availability of a particular substance (for example, creating legal prohibition, reducing hours and days of sale for legal drugs).

Stockwell argues that supply reduction and demand reduction remain the most effective strategies, because they focus on reducing the amount and availability of alcohol. He argues that harm reduction strategies in their purest form (which acknowledge that risky drinking practices are taking place and which attempt to minimise associated harms) are quite rare — some examples would be exchanging plastic for glass bottles, or the innovative public health approach being carried out in Tennant Creek which looks at providing water and firewood for people at drinking camps. Nevertheless, harm reduction strategies remain an important part of the alcohol policy tool kit.

Population based approaches or targeted interventions for problem drinkers?

There is a prominent popular discourse that alcohol problems are related to a relatively small group of problematic drinkers and that it is these people who should be target of any alcohol related interventions. As Casswell (1993: 459) points out, the

popular discourse about moderate drinking and associated public resistance to community focused interventions, is now also related to the understanding of some protective health effects of moderate alcohol consumption.

The debate around interventions which target populations as a whole or so called “high risk” segments of the population is influenced by how the alcohol is conceived of as a problem and how this is measured. Policy makers could, for example, be influenced by any of the following factors:

- The difference between absolute level of consumption and occasional high levels of consumption (binge drinking) within those people who usually drink within a moderate range.
- The difference between acute effects of alcohol intoxication and cumulative effects on chronic disease over a lifetime.
- The difference between social order effects of alcohol use and public health effects.

Research, however, continues to demonstrate that risks associated with alcohol apply to the entire population of drinkers, and not just those who drink at high levels. Therefore the most appropriate interventions are universal ones (such as taxation on alcohol, limiting access to alcohol etc.) supplemented by interventions which target the high risk group (Stockwell, 2009; Skog, 2006).

Restrictions on the supply of alcohol

Restricting the supply and availability of alcohol is a universal approach, which can be unpopular with people who do not consider that they warrant such intervention (Room, 2001). Such strategies, however, remain the most effective (Stockwell, 2009). Some possible restrictions on the supply of alcohol may include:

- Price based – for example, taxation.
- High risk beverages – formal or informal arrangements to totally or partially restrict sale of beverages which are considered to be high risk, for example, spirits, fortified wine and cask wine.
- Area based restrictions – arrangements to ban the possession of alcohol in certain areas, such as individual residences, town camps or communities.
- People based restrictions – prohibition orders banning individuals from purchasing alcohol.

Raising the price of alcoholic beverages has been found to be a very effective strategy to reduce consumption and this may particularly affect heavy drinkers and other at risk groups such as young people (Edwards et al. 1997: 119). Edwards reviews evidence which relates higher prices of alcohol to a reduction in alcohol related health problems, such as cirrhosis of the liver and such events as road fatalities. As such he concludes that “taxation is likely to be useful in support of and in alliance with, other

public health measures directed at curtailing the health and social burden resulting from drinking” (Edwards et al. 1997: 120). Since the High Court ruling on alcohol taxation in 1997, it is not possible for State and Territory Governments to raise license fees on alcohol (d’Abbs 2008: 64). So this is not a strategy which is available for the Alice Springs Alcohol Management Plan.

Restrictions on access to alcohol

Restrictions on access to alcohol are another possible universal approach and involve limiting the times that people can obtain alcohol as well as setting other restrictions such as those based on age that a person can purchase alcohol. Some possible approaches may include:

- Limiting hours and days of sale
- Limiting density of alcohol outlets
- Minimum drinking age
- Responsible beverage service.

Limiting the hours and days of sale has been found in Australian and international studies to decrease drinking and alcohol related problems. In the Northern Territory context, the most evaluated set of restrictions on access to alcohol are the Tennant Creek restrictions known as “Thirsty Thursday” (d’Abbs 2008: 67). These restrictions included a ban on takeaway sales of alcohol and front bar sales on Thursdays as well as restrictions on hours of sale, type and amount of beverages which could be sold (i.e. 2 litre wine casks) and banning third party purchase of alcohol (d’Abbs et al. 2008: 66)

These restrictions had a wide range of positive results including declines in alcohol sales, in alcohol related harm and in alcohol related offences (Gray, Saggars et al. 2000). The restrictions also appeared to have a high level of community support. It is interesting, however, that further evaluations of the alcohol free day, found that it was not as effective as it had been at the initiation of the project (d’Abbs et al. 2008: 68). It may be important to recognize that the period after the initiation of an intervention is the time when effects are most acutely felt and to use this period to further develop sustainable and community supported interventions.

Providing Information about alcohol

The provision of education and information about alcohol is a popular approach (as can require minimal resources and is not likely to upset the population) but it is not considered to be effective as a stand alone strategy. For example, advertisements which inform people about the dangers of alcohol misuse must compete with the

powerful advertising campaigns promoting alcoholic beverages (Edwards et al. 1997). The provision of information remains an essential tool, however, as part of an alcohol strategy, and is especially important to change the community climate regarding alcohol misuse and to maintain community involvement and interest in issues surrounding an alcohol intervention. Some possible strategies include:

- Advertising
- Mass educational campaigns
- Community organisation
- Education
- Labels on beverage containers.

Strategies which have been proposed to change community attitudes towards drinking usually involve educational and social marketing campaigns through the mass media and community development approaches. Education and mass media campaigns have been shown to have little effect on individual behaviours regarding drinking (Giesbrecht, 2007: 1345; Casswell, 1993: 464). What they can do, however, is raise awareness of problematic drinking at both individual and a community level. Most importantly, in the Alice Springs context, mass media and education campaigns can significantly alter the social climate relating to the acceptability of strategies that attempt to address alcohol misuse at a population level (Edwards et al. 1997: 174):

Highly visible and symbolic [strategies] such as restrictions on alcohol advertising and mass-media educational programmes, may have their most significant impact on the social climate surrounding alcohol use, rather than a direct effect on the individual's behaviour. These purposive efforts, by inserting a health perspective into the public discourse on alcohol, signal societal concern about alcohol related problems. This is then part of the social and political context in which decisions are taken about the development and implementation of public policies, many of which have larger direct influences on drinking behaviour (Edwards et al. 1997: 180).

Individually directed interventions

Primary Care and Brief Interventions

In a review of the Cochrane Drug and Alcohol Group specialised register, Kaner et al. (2002) reviewed the evidence related to the effectiveness of brief alcohol interventions in primary care populations. Many trials reported that brief interventions are effective in reducing excessive drinking. However, some trials have been criticised for being clinically unrepresentative and unable to inform clinical practice. From a sample of 21 RCT involving 7286 participants in total, Kaner et al. (2007) found that brief interventions consistently produced reductions in alcohol consumption. When data were available by gender, the effect was clear in men at one

year of follow up, but unproven in women. Longer duration of counselling probably has little additional effect. The lack of differences in outcomes between efficacy and effectiveness trials suggests that the current literature had clear relevance to routine primary care. Future trials should focus on women and on delineating the most effective components of interventions.

Generally, the implementation and evaluation of secondary interventions in Indigenous primary and secondary healthcare have been inconclusive. Brady drew attention to the emphasis placed in responding to Indigenous substance misuse issues on primary prevention and tertiary treatment services, and the associated neglect of secondary interventions, in particular, brief interventions in primary health care settings (Brady, 1995; Sibthorpe et al. 2002). However, the implementation and evaluation of brief interventions as part of GP's routine practice in Indigenous primary and secondary healthcare has been problematic (Sibthorpe et al. 2002). However, recent RCT research by Nagel has demonstrated positive outcomes associated with brief interventions and "motivational care planning" in three remote communities (Nagel et al. 2009). Other evidence on the effectiveness of interventions in primary and secondary health care has been limited. Few health promotion programs have been evaluated and, of those that have, none stand out as offering a model of program effectiveness. A number of tools have been developed recently to aid in secondary interventions, including a set of alcohol treatment guidelines, and a 13-item screening instrument known as the Indigenous Risk Impact Screen (IRIS). While validated as a tool for screening for Indigenous alcohol, drug and mental health risk, they have yet to be evaluated according to their effectiveness as a brief intervention (Schelsinger et al. 2007).

Specialised treatment of alcohol dependence

Specialised treatment refers to interventions directed at the management of alcohol withdrawal, the prevention of relapse to alcohol dependence and the social and psychological rehabilitation of the problem drinker. Specialised treatment services consist of both programmatic or setting components (e.g. detoxification facilities, inpatient residential programs, outpatient clinics) and therapeutic approaches (e.g. the twelve steps of Alcoholics Anonymous, relapse prevention) (Room et al. 2005).

Withdrawal is an important initial intervention for people with alcohol dependence and can help relieve discomfort, prevent medical complication and prepare an individual for rehabilitation. Non-pharmacological and pharmacological detoxification is possible, although the former is recommended for individuals with mild-to-moderate withdrawal (Naranjo et al. 1983). Pharmacological detoxification occurs in an inpatient setting and is recommended for individuals with serious medical illness or for individuals with a past history of adverse reactions such as

delirium tremens. Benzodiazepines are generally used due to their favourable side-effect profile (Room et al. 2005).

Alcohol rehabilitation has typically been provided in a residential setting lasting for anywhere between one to two months and up to one year in length. Residential settings include hospital-based rehabilitation programs, freestanding units, and psychiatric units. Because of increasing cost concerns, outpatient management has recently become the dominant setting in many countries. Residential treatment may be indicated for patients who are highly resistant to treatment, have few financial resources, come from environments that present a high risk of relapse, and have more serious, coexisting medical or psychiatric conditions. Indigenous people with alcohol problems often prefer residential rehabilitation units and there are a number of “freestanding” units which are Indigenous non-government organisations who receive a combination of State/Territory and Commonwealth government funding. There is little evidence related to long term treatment outcomes associated with this form of treatment, however, there are a number of studies documenting treatment processes and client experiences (Chenhall, 2007) and elements of best practice approaches in the delivery of services (Brady 1995, 2002; Gray et al. 2000).

Therapeutic approaches most often employed in both residential and outpatient programmes include behaviour therapy, motivational enhancement, Twelve Step Facilitation, family therapy, and pharmacotherapy. Behavioural therapies (relapse prevention, cognitive-behavioural therapy) have been shown to be more effective than insight-oriented, confrontational and family therapies (Room et al. 2005). However, programs that incorporate Twelve Step approaches (which help to increase drinker’s motivation for abstinence) are as effective as behavioural interventions, however some clients with specific characteristics might respond marginally better to some therapies (*ibid*). The research findings do not suggest that matching to therapeutic modality substantially improves treatment outcomes beyond the effect of receiving any intervention.

Pharmacotherapies have had a long history in the treatment of alcohol misuse (and more recently become popular in the treatment of co-morbid psychiatric disorders in alcoholics), however, to date there have been few studies that have demonstrated positive outcomes. This has been mainly due to poor medical compliance, resulting in a range of studies examining how to improve patient compliance (Kranzler 2000). The effectiveness of different drugs such as disulfiram, naltrexone and acamprosate have been compared with variable results (Laaksonen et al. 2008). However, recent research suggests that supervised disulfiram has the best results, especially during a continuous medication period, when compared to naltrexone and acamprosate (Alho 2009).

Drink driver rehabilitation programs

A major policy concern regarding the sentencing of drunk drivers is whether rehabilitation or punishment should be the dominant strategy. Essentially, rehabilitation attempts to treat the underlying alcohol problem of drunk drivers and inhibit future drunk driving, while punishment utilises the threat of punitive legal sanctions and various types of punishments to deter drunk drivers (Taxman and Piquero 1998). Taxman and Piquero's study was over an eight year period and included 3711 drunk driving convictions from the Motor Vehicle Administration (MVA) records for the state of Maryland, U.S.A. They concluded that although the data suggest that some rehabilitation and reintegrative sanctions have the potential to reduce drunk driving recidivism, the data also suggest that the movement toward more punitive sanctions against drunk drivers is not advantageous. Their results support a continued role for the education and treatment of drunk drivers and not the punishment of such offenders.

In Australia, Mills et al. (2008), evaluated the effectiveness of the New South Wales Sober Driver Programme (SDP), which utilised a combination of approaches including education components and group cognitive behavioural therapy in relation to drink driving in conjunction with punitive sanctions. They found that SDP participants were 43% less likely to re-offend over 2 years compared with community controls who had received sanctions alone. Survey respondents demonstrated improved knowledge, attitudes and skills regarding drink driving. They argue that education combined with punitive sanctions is effective, demonstrating greater reductions in recidivism when compared with legal sanctions alone.

Summary

Population based approaches may be unpopular and may face strong opposition in the community, but they are the most effective way to deal with alcohol related harm in the community. At the same time, it is also important to provide services for heavy or at risk drinkers. The best strategies will therefore be a combination of population and individual based approaches (Skog 2006). Community acceptance of a particular intervention is essential to ensure sustainability and advertising, community development activities, education and provision of information are all important tools to develop and maintain community motivation for change.

5. Recommendations from previous evaluations of alcohol interventions in Alice Springs

Alice Springs Alcohol Studies

Alice Springs is unique because of the many reports, surveys and evaluations associated with alcohol and alcohol interventions since the 1970s. Growing from early concerns about the high level of alcohol misuse in Alice Springs (Wauchope 1975; Lyons 1990; Brady and Martin 1995) there has been a number of subsequent evaluations (and critiques of evaluations) to assess the impact of various supply restrictions and other initiatives. In this section we will briefly review the main findings of a sample of these studies, providing important context to the development of the current Alcohol Management Plan. It is also important to review past recommendations to assess the various changes in approaches to alcohol control and community perceptions around alcohol use and misuse.

40 Gallons a Head

The first reports concerning Alice Springs noted high levels of alcohol use, crime and adverse social behaviour. The 1973 Federal committee into NT liquor laws, reported the need for corrective action in Alice Springs citing scenes of drunkenness and degradation (Adams 1973). Dr Gerald Milner (1975: 5) was even more provocative, claiming that Alice Springs was “stew[ing] in its own juices (distilled from a high average intake of alcohol [and] ethnocentric conflicts ...”.

One of the first reports to discuss the impacts of alcohol on the Alice Springs community was prepared by Wauchope (1975) and was entitled *40 Gallons a Head*. Referring to the higher levels of beer consumption per person at 40.9 gallons (about twice as high as other States), this study engaged a number of methodological approaches including collection of statistics (sourced from the medical superintendent, Clerk of Courts and NT Police), observation of liquor outlets, overview of existing services, gathering of public suggestions and community awareness feedback sessions. While we have to be careful relying on the validity of Wauchope’s statistical information, this report does give a fairly clear picture of some of the early issues that have continued to this day.

In 1975 there were 51 licensed liquor outlets within Alice Springs, who sold 762000 gallons of beer, 72400 gallons of wine and 16800 gallons of spirits. Of these, 17 were stores, 16 were restaurants or private hotels, 7 were clubs, 8 were liquor merchants

and 3 were publicans. From mid-1973 to mid-1975, around 52% of alcohol related fatalities were caused by motor vehicle accidents, 21% by violence and 23% through disease. For non-fatal/outpatient alcohol related attendances around 53% of cases were traffic accident related and 50% resulted from violence.

At the time, Wauchope noted that patterns of arrest showed that (excluding drunk related charges), Indigenous offences were those against the person or against property, whereas most non-Indigenous cases fell into the category of motor vehicle offences. A questionnaire with 413 individuals, demonstrated that the Alice Springs community (although the representativeness of different sections of the Alice Springs community is not evident in this survey), saw the following factors as the undesirable results of alcohol usage: drunks on the street; family problems; increased crime and violence; increased harm for the drinkers themselves; waste of money; increased pressure to drink and unsafe to go out and drunk driving. Respondents indicated the following reasons to explain the high level of drinking in Alice Springs including: the social desirability of drinking to excess; little affordable entertainment where alcohol was not involved; unemployment and social service “handouts”; too many outlets and long trading hours; low levels of enforcement with regards to drunks on the street, underage drinking and licensee responsibility; personal problems and the hot dry climate. Reference was made to the lack of community feeling due to transience, personal loneliness, the cultural loss of Indigenous people, lack of education and the “dehumanization of both Europeans and Aboriginals due to racism” (Wauchope 1975: 11). Public suggestions for improving Alice Springs included increased education around harms associated with alcohol misuse, increased legislation and medical services, community groups, and alternative entertainment. Thirty Indigenous fringe camp dwellers were also interviewed and they discussed the social pressures to drink exerted by the group, as well as personal problems and bad living conditions. They argued that meaningful employment would lesson alcohol consumption with opportunities for rehabilitation, counselling, sobering-up and medical services as important requirements.

In this report, Wauchope concluded that “Although some people seem to have developed a protective attitude towards their alcohol, and are extremely sensitive in matters relating to their own consumption, it is obvious from the tremendous responses to this survey that there is a great deal of concern in Alice Springs about excessive drinking” (1975: 15).

Recommendations from “40 Gallons a Head”

- Undertake a total community programme aimed at general education of the Alice Springs community (taking into consideration that alcohol use is an integral part of Australian society).
- The programme becomes the responsibility of a steering committee composed of representatives of organisations.

- Employment of an Indigenous and non-Indigenous consultant to act as coordinators, resource personnel and development officers of this programme.
- The consultants will conduct ongoing research and evaluation and report to the steering committee and the general public.

What Everybody Knows About Alice. A Report on the Impact of Alcohol Abuse on the Town of Alice Springs

Fifteen years later in 1990, Pamela Lyons, the Menzies School of Health Research and Tangentyere Council (1990) reported similar results. In their report, *What Everybody Knows About Alice. A Report on the Impact of Alcohol Abuse on the Town of Alice Springs*, stated that “alcohol abuse is a serious problem in Alice Springs which has a profound impact on the life of the community and the services provided within it” (Lyons 1990: 159). Lyons found that community attitudes – Indigenous and non-Indigenous – had not been conducive to constructive solutions to the problem of alcohol abuse in Alice Springs and that community attitudes needed to change if any attempts at a solution were to succeed.

Responding to claims that alcohol in Alice Springs had been overstudied, Lyons counters these claims stating that very little hard data is available and existing statistics are not easily accessible to document the harms caused by alcohol misuse. In the report, Lyons addresses a number of issues related to alcohol misuse in Alice Springs, utilising both qualitative and quantitative data sources.

Impact of alcohol abuse

Lyons found that alcohol consumption in Alice Springs was at 27.1 litres of pure alcohol per person per year, with large increases in wine sales contributing most significantly to the higher level of consumption in Alice Springs since 1980-81. At the time the impact of alcohol included: double the overall NT rate of police apprehensions for protective custody resulting from public drunkenness; 54% higher than average NT averages for drink driving offences and 3.6 alcohol-related motor vehicle accidents per 100000 population (2.9 for NT).

Tangentyere Council/Menzies School of Health Survey

The component of the study conducted by Tangentyere Council and the Menzies School of Health Research involved a survey to see what proportion of the patients seeking primary medical care in Alice Springs and the clients of various welfare and social service organisation had alcohol related problems. Out of the 6905 completed

surveys, alcohol was a factor in 44.9% of contacts with respondents. Patients seeking medical care comprised half of all contacts, and the proportion that was suspected to be alcohol related were relatively low (13.1%). If responses from medical respondents were excluded, the proportion of alcohol-related contacts rose to 53.3%. This included contacts recorded from police, the criminal justice system, welfare organisations, and crises, dependency, mental health and youth services. Crises services (84.8%) recorded the highest proportion of alcohol-related contacts, followed by Department of Corrections, police, courts and welfare and medical services. 44.4% of all non-medical contacts with young people aged 15 and under were alcohol related. The proportion of Indigenous contacts that were alcohol related were higher than for non-Indigenous contacts, however there was little different between the two groups in the number of clients presenting for drinking-related difficulties. The survey also demonstrated that Indigenous people were reluctant to access community services, other than for food and shelter.

Alcohol services

At the time there were few alcohol services for both Indigenous and non-Indigenous people. This included a lack of professional counselling services or treatment facilities for Indigenous people, no formal drink-driver programs, no residential alcohol treatment facility and no counselling or self-help groups.

Availability

While a number of factors were identified as contributing to excessive alcohol consumption, ease of availability was most cited in this evaluation. At the time, Alice Springs had 70 liquor outlets, 19 of which were takeaway outlets.

Role of the Liquor Commission³

Lyons noted that the Liquor Commission perceived its role to be mainly a regulatory body; however, initially it also had a social policy role, with obligations to monitor community harm. Lyons noted that enforcement of liquor laws in the NT, particularly in relationship to sales of alcohol to intoxicated and under-aged persons had been a problem with no prosecution or complaints against licensees between 1984 and 1989. Lack of coordination between police and the Commission meant that it was difficult for the Commission to enforce the Act and private citizens had various difficulties making complaints against licensees conduct.

³ The Liquor Commission was in operation until 1999 when it became the Licensing Commission.

Recommendations from the “What everyone knows about Alice” report

The report emphasises that the best hope for change must come from the community and that before any action, there needed to be community wide acknowledgement of the widespread harms from alcohol misuse in Alice Springs. The report made a number of recommendations around controlling the supply of alcohol, education, facilities, and programs, support for families of problem drinkers and statistics collection. These included:

- Tightening the *Liquor Act* (NT) in relation to complaints and prosecutions for sales of alcohol to intoxicated and under aged persons and better enforcement through closer cooperation with police.
- New legislation to make licensees legally liable for the harm caused by their inebriated or underage customers.
- Strengthening the “public interest” aspects of the *Liquor Act* to allow complaints against licenses “in the public interest”; appointing regional Indigenous Advisory Committees to the Liquor Commission; and ensuring that one Commission members has experience in the field of alcohol abuse.
- Allocating a proportion of government revenue from alcohol licensing and sales to alcohol education and treatment.
- Education campaigns directed at the attitudes and myths that sustain excessive drinking in the Indigenous and non-Indigenous communities.
- An awareness course in early detection of alcohol problems for medical practitioners and other professionals and training for counter-staff on licensed premises.
- Establishing an early intervention system at Alice Springs Hospital and development of a range of treatment and rehabilitation programs to which to refer clients.
- Residential treatment facilities to provide an alternative to gaol for alcohol-affected offenders as well as therapy for voluntary admissions.
- Establish an Indigenous AI-Anon and/or specialised Co-Dependency Program to support and strengthen Indigenous families affected by alcohol abuse.
- Re-establishing an Ala-teen and self-help group for young people in alcohol-affected homes.
- A variety of initiatives for Indigenous people to consider, including dry town camps and making all Indigenous organisations “grog free”.
- Alcohol related statistics to be kept by police, hospitals, Indigenous health and crises services.
- More research into Indigenous attitudes towards alcohol and excessive drinking to assist policy-makers in the designating of effective strategies and programs.

- As a top priority Government should provide support for Indigenous initiatives, such as Indigenous Alcohol Anonymous meetings and the Indigenous working party.

Dealing with alcohol in Alice Springs: an assessment of policy options and recommendations for action

In 1999, Brady and Martin provided a broad overview of possible policy directions to address the particular alcohol problems in Alice Springs. At the outset they note:

Disagreements and controversies in Alice Springs over what needs to be done to address alcohol problems usually arise from quite different views on the underlying nature of the grog problem, and it is most unlikely that these deeply held opinions can be reconciled in any simple fashion (ibid: 1).

Brady and Martin argue that aggregate consumption figures for all people living in Alice Springs requires the implementation of a long-term and broadly based public health strategy to reduce alcohol consumption levels. However, Brady and Martin note that this conflicts with a more widely held set of views in Alice Springs that most of the alcohol-related problems are associated with a relatively small group of problem drinkers who habitually drink to excess and cause harm. In this view, interventions should be aimed at identifying the problem drinkers and not at the general community. This viewpoint is problematised by Brady and Martin who state that it can be used to create discriminatory and racist beliefs, actions and policies towards Indigenous people. It also alienates non-government organisations and creates opposition from Indigenous people, organisations and communities. In 1999, Brady and Martin argue that these two viewpoints (generalised or targeted) have divided the Alice Springs community, making it very difficult for any agreed actions by all stakeholders.

Impact of alcohol abuse

While Lyons found that alcohol consumption in 1987-89 was 27.1 litres of absolute alcohol per person aged 15 and over per year, Brady and Martin (1999: 4) found it to be 23.8 litres per person aged 15 years and over per year (using the same methodology as Gray et al. 1998: 7-8). While this was a reduction by 12.1% since 1989, it was still one and a half times the NT rate.

While Brady and Martin (1990) state that their report does not provide details of the social and economic costs of alcohol misuse in the Northern Territory, they do report on alcohol related homicides and vehicle accidents. Between 1992 and 1997, alcohol was involved in 82% of Indigenous road deaths in the Alice Springs rural area

compared with 35% of non-Indigenous deaths, and in the Alice Springs urban area, 92% of Indigenous road deaths during this period involved alcohol. Homicide rates show similar patterns, with around 80% of homicides (both offender and victim) involving Indigenous people and 17% of the 30 victims were non-Indigenous. Brady and Martin note that this evidence suggests that a disproportionate number of alcohol related mortality is amongst Indigenous people in the Alice Springs region.

Density of Alcohol outlets

Brady argues that the total number of outlets in Alice Springs is high compared to national standards, however, the relative number of outlets since 1990 has decreased. Brady and Martin argue that closing down one or two outlets would have little impact. Due to the opportunistic way problem drinkers will access alcohol, availability is related to the total number of outlets rather than outlets per head of population. Nevertheless, Brady and Martin point to the anecdotal evidence that three or four liquor outlets situated along the Todd River were contributing disproportionately to Indigenous drinking problems. While there is evidence to support targeting drinking environments and sales outlets associated with high-risk drinking, there was no evidence as to the potential impact of closing specific outlets. Brady and Martin, suggest that problematic licenses should be replaced with more responsible licenses which moves away from a focus on Indigenous takeaway trade to a more responsible one (such as cafes that sell food and beverage) that value-add to the local economy.

Types of alcohol and retail availability

Following strong evidence that the type of alcohol beverages, such as cask wine, lead to increased harms (assaults, acute hospital admissions), restrictions on the availability and types of alcohol on sale was implemented in specific licenses in Tennant Creek. Following positive results from these trials and increasing Alice Spring community concerns, licensees introduced a limited period (1996) of voluntary restrictions limiting the sale of cask wine to 4 litres or less per person per day as well as providing server training courses. During this time, there was a shift to the increased sale of port and sherry in bottles.

From 1995 to 1998, sales of light (9%) and full strength (5%) beer decreased and the sale of cask wine increased by 68%. Brady and Martin stated that research links cask wine consumption, in particular, to high-risk behaviours, the large increase in cask wine sales in the Alice Springs area between 1995 and 1998 requires urgent address at the policy level.

Hours and day of sale

Brady and Martin state that changing the hours and days of sale, focusing on off-premises availability, can have an effect on Indigenous drinking. Drawing on international research and the restriction trials in Tennant Creek and Derby, Brady and Martin argue that such an approach can have an effect on alcohol-related problems.

Using the price of liquor as a policy tool

Brady and Martin argue that international evidence suggests that alcohol taxation can be a useful policy tool as part of public health measures. However, they expressed some doubt whether raising the price of alcohol in general, or of specific types of alcohol, would have an impact on Indigenous heavy drinkers, where research by Martin (1998) has demonstrated that for such individuals demand for alcohol is independent of price.

Responsible serving of liquor and server liability

Brady and Martin cite international research which suggests that changes in server behaviour can produce differences in the blood alcohol content of patrons leaving licensed premises. While training in server responsibility was more common in Australia in the late 1990s, it appeared that licensees had less exposure in Alice Springs. In 1999, there was only one complaint against a licensee under review.

Between 1995 and 1998, the Drug and Alcohol Services Association (DASA) conducted an accredited training module (BFB9) in Responsible Service Practices to 239 staff across a range of liquor traders in Alice Springs. Between 1995 and 1997, the Northern Territory Branch of the Australian Hotels and Hospitality Association (NTHHA) ran an accredited four-hour Patron Care course, which included the requirements of the *Liquor Act*, to 372 people.

Responding to research that demonstrated less than positive outcomes related to responsible service training, Brady and Martin advise that training needs to be mandatory and sanctions placed against recalcitrant licensees. They also strongly suggest that licensees and permit holders, as well as servers, undertake training. Additionally, it is crucial that policy implementation links licensees and servers, police, and Liquor Commission inspectors (Brady and Martin 1999: 15).

Education as a strategy

Bray and Martin (1999) suggest that education policies about alcohol and drug use are unlikely on their own to change the ideas of committed drinkers, however they can be successful as part of a broad based public health approach. The NT Living with Alcohol Program implemented in 1992 (funded by a levy on liquor with an alcohol content greater than 3%) had a significant community education component and demonstrated significant reductions in per capita alcohol consumption. Subsequent studies (Chikritzhs et al. 1995) confirmed that the combined programs and service activities of the Living with Alcohol Program reduced the burden of alcohol-attributable injury in the NT in the short-term and may have contributed to a reduction in chronic illness in the long-term.

Individually directed interventions

Brady and Martin cite a number of programs that provide individually directed interventions, including:

- CAAPU (which had recently reopened with 10 funded beds).
- Central Australian Aboriginal Congress (which had adopted a policy to encourage medical practitioners and other primary care workers to conduct brief interventions with clients).
- Changes to the *Mental Health and Related Services Act* (NT) which allowed more scope for admissions to Ward 1 at Alice Springs Hospital for individuals suffering from alcohol-related mental symptoms.
- DASA's provision of a sobering-up shelter (1906 individuals in 1996) which demonstrated that:
 - A relatively small core of committed drinkers are disproportionately represented in the statistics;
 - Alice Springs Town Camp residents are not the major source of intoxicated individuals; and
 - The residents of specific communities, most prominently Hermannsburg and secondarily others such as Papunya and Yuendumu are disproportionately represented in the alcohol statistics.

Popular solutions

Brady and Martin address a number of commonly held viewpoints together with a statement about their feasibility:

- *Reintroduce criminalisation of drunkenness*
 - Possible deterrent effect but little evidence to confirm that it will reduce consumption of committed drinkers.
- *The issue of canteens/liquor outlets on bush communities*

- In 1999, Brady and Martin found that a large proportion of alcohol related harm was caused by people who lived outside of Alice Springs, with a large proportion from Hermannsburg. The establishment of liquor outlets in remote communities was put forward as one solution; however, Brady and Martin argue that the establishment of such liquor outlets does not decrease problems in nearby towns. Rather it “supports the development of a pervasive and heavy drinking culture there, with drinking practices which pose severe threats to individual health and community wellbeing” (Brady and Martin 1999: 21). Research also suggests that the increased social problems caused by liquor outlets in the remote communities could, in fact, lead to a growth in net Indigenous migration into urban centres and that number of committed drinkers would increase leading to more drinkers coming into Alice Springs (d’Abbs 1987; Taylor 1988). Liquor outlets in remote communities would also lead to increases in the number of homicides and the net effects on the community would be negative with a drain on the regional economy (Brady and Martin 1999: 22).
- *Pay Indigenous people in vouchers*
 - A voluntary food voucher system was already in operation in 1999 for those people who cashed their welfare cheques at Tangentyere Council. Brady and Martin demonstrate that compulsory voucher system would be discriminatory towards all Indigenous people and ineffective in deterring committed drinkers.
- *Send people back to their communities*
 - In response to this view Brady and Martin (1999: 23) state “It is arguably neither politically nor legally feasible, nor indeed ethical, to institute policies which restrict the rights of Aboriginal people to have access to the better resources and facilities available in towns. This is particularly the case given the relatively poor facilities on the Aboriginal communities in the region.” It is clear that Indigenous people do not visit Alice Springs just to drink, but to utilise a number of different services, resources, to engage in Alice Springs events as well as to socialise with family and friends.
- *Sobering-up shelters just support drinkers’ bad habits*
 - Brady and Martin argue that sobering up shelters are important because they allow for a safe, clean and caring place for sobering up. They may not prevent people from drinking too much, but they do allow for a variety of education and brief intervention opportunities as well as being cost-effective compared to emergency medical treatment and law enforcement.
- *Inconveniencing the majority to cope with minority “trouble-makers”*
 - Brady and Martin (1999: 24) state “Making alcohol less easily available can be inconvenient for some people, but there is good international and Australian evidence that controlling physical access

to alcohol does preferentially lower the consumption of heavy drinkers, and thus lead to fewer alcohol related problems”.

Recommendations of dealing with alcohol in Alice Springs

- Build on existing programs
- Continue to target high-risk consumption practices
- Target high-risk sales practices
- Liquor outlet density
- Hours and days of sale
- Server training/patron care
- Police training and coordination.

Dollars Made from Broken Spirits

Co-funded by the Northern Territory Government’s Living with Alcohol Program, Territory Health Services, Alice Springs Town Council and Tangentyere Council, Hauritz et al. (2000) undertook the study *Dollars Made from Broken Spirits Alice Springs: Determining its well-being and responsible alcohol management as part of everyday life, A whole of community deal* to provide information about the current availability of alcohol in Alice Springs and harm-related effects directly linked with alcohol. The specific objective of the study was to conduct research to establish the perceptions and opinions of a representative sample of Alice Springs residents, tourists and visitors and the commercial and business sectors on the use and availability of alcohol and how best to encourage the minimisation of the current excessive alcohol consumption.

The research methodology involved three stages. The planning and development stage involved meetings with various individuals and organisations in Alice Springs, development of a research tool and a literature review. The implementation phase included planning, and implementation of public education, open community meetings and focus groups and a householder community survey. The final stage involved the development of the report.

In 2000, Hauritz and colleagues argued that Alice Springs had a whole-of-community drinking problem, rather than one caused by tourists, people from outside communities or local Indigenous people. They also argued that that there was no effective demonstrable regulation of the *Liquor Act* (NT).

Hauritz et al. (2000) present a range of data indicating the high level of alcohol-related harm in Alice Springs. This includes:

Consumption data

Hauritz et al. (2000) utilised the Brady and Martin (1999) alcohol consumption figures, however, present most of their consumption figures in dollar values stating that in total \$24.032 million dollars of alcohol was sold in the year 1998-1999. Stores represented the greatest dollar value selling about three times the amount in litres compared to hotels. At this time, full strength beer and cask wine had the highest sales. Alice Springs has a high density of licensed outlets, approximately two and a half times greater than the national per capita average, and in the last 20 years the number has risen substantially (Hauritz et al. 2000). In June 2000, there were 85 licensed outlets, which was an increase from 80 in June 1997 and 70 in June 1998.

NT Police and Road Safety Council of Australia

For data collected from hospitalisation, road trauma, deaths and personal trauma for other including the victim as well as families, alcohol offences from July 1988 to June 1999 indicated that 2999 of the 5311 (56.47%) offences recorded were alcohol related. The highest offences were for alcohol related assaults (337 in total with 286 assaults involving Indigenous people and 51 involving non-Indigenous people) and alcohol related driving and traffic related offences (1844 in total with 1577 offences involved Indigenous people and 267 for non-Indigenous people). Hauritz et al. (2000: 79) note that the workload of the NT Police Services in Alice Springs in relation to alcohol-related incidents and offences is “shocking”. Between 1992 and 1998, 122 deaths were recorded by the Road Safety Council and out of these deaths; approximately 62% were alcohol related, with Indigenous people having a higher rate of deaths compared to non-Indigenous people.

Accident and Emergency

Accident and Emergency data from the Alice Springs Hospital data was also reported. Assault data indicated that between 1994 and 1999, Indigenous people were admitted at significantly higher levels than non-Indigenous people, although Hauritz et al. (2000) do not give the data for admissions from long-term effects of alcohol consumption, such as diabetes and liver damage. Between July 1998 and June 1999, there were 268 Indigenous female and 156 Indigenous male admissions and 2 non-Indigenous female and 15 non-Indigenous male admissions for alcohol related assaults. Major trends indicated that the highest number of admissions was between January and March, total bed days were 1941, and that 40 occurrences were for a second admission. For the period July 1998 to June 1999, total number of alcohol separations from general admission data was at 1341 admissions. The highest number of admissions was non-dependent use of alcohol (804 admissions), alcohol dependency syndrome (324 admissions) and alcoholic liver disease (116 admissions).

Service data

Hauritz et al. (2000) also provided a variety of data from alcohol service organisation in Alice Springs. These included: DASA; Holyoake Inc.; Central Australian Alcohol and other Drugs Service (C.A.A.O.D.S); Tangentyere Night Patrol; and Congress. The details of these findings will not be reported here however the following summary comments can be made. For 1998-99, 6918 clients were accepted into DASA's Sobering up shelter, representing 61.1% of total apprehensions without arrest in Alice Springs and 34 clients were accepted into Detox. The majority of clients were Indigenous, 31% of clients seeking services from DASA were female, age ranges were increasingly from younger people and less than one fifth of clients were from Alice Springs. Between 1998 and 1999, Holyoake Inc. admitted a greater proportion of non-Indigenous people (234) compared to Indigenous people (30) and average ages were between 31 and 40 years old. Admission data from C.A.A.O.D.S also showed that a number of non-Indigenous people were seeking help. In 1999, Tangentyere had 1956 callouts with 660 alcohol affected groups being provided with assistance. Hauritz et al. (2000: 91) note that for the level of service they provide, Tangentyere is extremely underfunded and staff receive very little training. In 1999, Congress provided a range of services for Indigenous people including 24000 clinic consultations, 15000 patients' visits by Indigenous Health Workers and a number of targeted health programs including a social and emotional health program for children, families and communities in dealing with the problems of substance misuse.

Education

Hauritz et al. (2000) document school attendance rates which showed that the average percentages of absences for Indigenous children were higher by a factor of two to three times than for non-Indigenous children. However, their sample did not include schools run by Indigenous organisations.

Community Survey and Focus Groups

Community Survey

The community survey was conducted amongst 406 individuals in Alice Springs and asked a range of questions concerning alcohol management and drinking in Alice Springs. There was a range of findings associated with this survey, however, the main findings indicated that the majority of respondents:

- Believed that alcohol was a problem in Alice Springs (96% of respondents)
- 88% of respondents regarded the alcohol problem as serious or very serious

- Supported a range of alcohol management strategies such as reducing trading hours and banning specific sizes and types of alcohol
- Were in support of a Thirsty Thursday
- No increase in liquor licensees and increased inspection
- Harsher penalties for licensees infringements and sly grog runners
- Major breweries should foster responsible alcohol management with communities
- Liquor legislation should incorporate the need to address public health as part of issuing a liquor license
- Believed that town camps, government offices, public spaces and workplaces should be alcohol free
- Licensees should provide training in responsible hospitality, provide health information about alcohol, low alcohol beer should be cheaper than full strength beer, free water should be made available, provide safe transport home, ensure no intoxicated person are sold alcohol, introduce a teen ID card system
- Government should be required to promote information about safe drinking across media and no alcohol media at sporting events
- Believed there should be restrictions on drinking in public and that low alcohol beers are only sold at public events consumed in an enclosed area
- Tangentyere Night Patrol and Return to Country program hours of operations should be increased
- Emergency Services provided by CAAPU should be increased
- Alternative Sobering up and Detox centres provided other than DASA.
- Provision of a safe house for men, women and children at risk of alcohol related violence
- The community should informally monitor alcohol management in Alice Springs
- Adoption of a code of practice by licensees.

The majority of respondents did not support:

- The ban of happy hours or special promotions
- Reduction of the current number of licensees.

Focus Groups

Focus groups and open community group meetings were held as part of this study. This included consultation with people from the town camps and the Todd River, Indigenous direct services, community groups, businesses, legislators, health groups and emergency services. Hauritz et al. (2000) confirm that the comments from these groups were consistent with the findings of the community survey. All agreed about the serious nature of the alcohol problem in Alice Springs and that the community

wanted action and change. The only disagreement came from licensees who did not want restrictions.

Tourist Survey

The tourist survey was conducted with 16 tourists in the Todd River Mall during daylight hours. Tourists were unable to identify whether there was an alcohol problem in Alice Springs, nor were they concerned about alcohol availability. They did not experience feelings of lack of safety and the majority indicated that they would not be affected by restrictions.

Recommendations from Dollars Made from Broken Spirits

This report had 78 recommendations presented in four areas. These included recommendations for:

Northern Territory Government

- Dedicated government resources for restoration of community wellbeing;
- Indigenous representatives on the Licensing Commission;
- Development of graduated sanctions for breaches of *Liquor Act* (NT).

Licensing Commission

- Introduction of alcohol management strategies around sale of alcohol (trading hours, quotas, reduction of licenses, alcohol free days, amendment of *Liquor Act* (NT) to incorporate public health policy related to alcohol);
- Continuation of alcohol management strategies until alcohol indices reduced to national standards;
- Appointment of a Deputy Director to regulate the *Liquor Act* (NT), with power to refer breaches of the *Liquor Act* (NT) to the criminal justice system through the Commission. This person also must publish quarterly public data on alcohol statistics to the broader public.

Alice Springs Community: Taking on Empowerment

- The formation of an Alice Springs community action task force with a primary goal of reducing high levels of alcohol consumption and prevention of alcohol related harm in Alice Springs. The Task Force should publish collated monthly trend data for alcohol consumption indices, indices of alcohol related harm and breaches under the *Liquor Act* (NT). This quarterly data is presented to the licensing commission and a regular six monthly review be conducted to establish, maintain and embed community action in relation to alcohol;
- Effective utilisation of media supported by effective public information campaigns;

- Formation of a Regulators Task Group (20 recommendations related to alcohol free areas and events, alcohol and taxis, formation of common databases on alcohol sales, night patrols, call lines related to reporting of sly grogging, protection of young people), a Licensees Task Group (16 recommendations related to development code of practice for licensees, training on responsible service, crowd control and safety, health information, price of alcohol, ID cards) and a Common Issues Task Group (18 recommendations related to reporting of binge and underage drinking to liquor licensing, alcohol free zones, Tangentyere night patrols capacity increased, sobering and detoxification centres for young people operated by DASA., emergency services provided by CAAPU, establishment of a safe house for men, women and children as well as half-way houses, banning of alcohol) in the Community Action Task Force.

Provision of Technical Assistance

- The formation of a technical and expert assistance team for action research to provide support and expert information to a comprehensive series of initiatives including: the provision of planning and implementation workshops for the Community Action Task Force groups; develops public data monitoring reports for the Task Force and groups; conduct six monthly action reviews to the Task Force groups and provide reports to the Task Force groups, the Licensing Commission and the public.

Comment on Dollars Made From Broken Spirits – Gray

Following various criticisms made in the NT Parliament and in various public forums concerning the findings of Haurtiz et al. (2000), Gray (2000) prepared a response with Congress and Tangentyere Council to the report.

Gray notes that these criticisms can be divided into general and methodological criticisms. The general criticism of the report was that it did not address the issues underlying excessive alcohol consumption in Alice Springs. As Gray notes, this was outside their terms of reference and that their concern was with issues related to the availability of alcohol. There was also criticism that the Tennant Creek restrictions had been a failure and these should not be applied to Alice Springs. Gray points to research which clearly shows that the Tennant Creek restrictions did work, resulting in reduction in alcohol consumption, alcohol-related hospital admissions and the proportion of offences committed on Thursdays. The majority of the community was also in favour of restrictions. A further criticism was that the alcohol problem in Alice Springs was caused by “itinerant” Indigenous people. Gray also counters this point by demonstrating that even when Indigenous drinking is factored out, per capita consumption by non-Indigenous people in Central Australia is still 52% higher than the national average. A further criticism was that the restrictions would interfere with

businesses' abilities to expand. Gray notes that alcohol is not just another product and that it is the community's responsibility and not market forces to make decisions about the level of availability given the harms associated with excessive consumption.

Gray (2000: 5) also discusses a range of more methodological issues related to the Hauritz et al. (2000) report. The first is about calculations of per capita alcohol consumption. Hauritz et al. (2000) used a method to calculate consumption (based on Brady and Martin 1999), which did not take into account the unknown volume of alcohol sold in Alice Springs for consumption elsewhere. Gray argues that the calculation of consumption should be made on a regional basis. With this calculation, the figure decreases from 23.8 to 16.44 litres. This level is still, however, 70% higher than the national average.

In responses to criticism concerning the number of respondents in Hauritz's et al. (2000) report, Gray demonstrates that the sample of 407 people is statistically valid and within the bounds of error gradually regarded as acceptable in population surveys. However, the sample of 16 tourists in the tourist survey is too small to be generalisable to the larger group of tourists. The focus groups cannot be used to represent the views of the Alice Springs community, however, they do indicate the range and strength of views on alcohol related issues. Gray also addresses a number of criticisms with the wording of various questions in the community survey, however, he states that these criticisms do not negate the value of other questions in the survey. Gray also presents a range of problems with inappropriate calculations, particularly associated with the scaling of responses, in the presentation of the community survey data. However, while the scaling procedures were problematic their practical effect is negligible to the findings of the overall report.

Gray notes that part of the controversy of the report is that Hauritz et al. (2000) went beyond their brief and usurped the role of the Alice Springs Representative Committee whose aim was to represent the broad range of community interests in matters relating to alcohol in Alice Springs. Hauritz et al. (2000) were tendered to report on the opinions of Alice Springs residents on the nature of the alcohol problem and the strategies to address it. Instead they provide a set of recommendations which they believe should be accepted as a whole. Gray notes that these recommendations are problematic because:

- They are based on unambiguous evidence from the survey of majority community support
- It is unclear whether the opinions documented in the focus groups and community meetings have wider community support
- The strategies are proposed by the consultants themselves
- A small number of recommendations should be regarded cautiously based on the statistical evidence.

Despite these problems, Gray confirms that the report indicates that the majority of people in Alice Springs believe that alcohol represents a significant problem in their town and that they support increased restrictions on the availability, controls on public consumption, and responsible service of alcohol.

Report to the Licensing Commission: Summary Evaluation of the Alice Springs Liquor Trial – Crundall and Moon (2003)

Trial restrictions were implemented in Alice Springs from April 2002 to March 2003 for 66 of the town's 91 licensed premises (see NDRI 2007). They involved the provision of takeaway sales only from 2pm to 9pm on weekdays, the banning of takeaway sales in containers greater than two litres and light beer to be sold on premises before 11.30am during weekdays. A number of other measures were introduced including extension of Tangentyere Council Patrol's activities; extension of hours of operation of the sobering-up shelter accompanied by targeted interventions for clients; a youth drop in centre and alcohol free entertainment; increased brief interventions by primary health care workers; and a community day patrol.

The evaluation was carried out by the Northern Territory Licensing Commission (Crundall and Moon 2003). The findings of this evaluation are documented in NDRI's report *Restrictions on the Sale and Supply of Alcohol: Evidence and Outcomes* (2007).

In this evaluation pre- and post-measures of the effects of the restrictions were compared, a community survey of 402. Alice Springs residents was conducted to assess the effect of the restrictions and their attitudes to the trial, stakeholder interviews were conducted with police, licensees and other groups and harm indicator, such as alcohol consumption, was reviewed.

In the trial period there was an increase in the overall volume of wholesale alcohol sales by 5.5%, although there were fluctuations in the quarterly trends for the previous two years. Crandall and Moon (2003) explain that this may have been the result of outlets letting stocks run low prior to the trial because they were unsure how they would be affected by the trial, and also the events of September 11 may have resulted in less tourists visiting Alice Springs. Wholesale purchases of cask wine decreased by 83% which was offset by a rise in the sale of fortified wine from 2.3% before the trial to 21.6% after the trial. Sales of mid strength beer, spirits RTDs and spirits all increased

Total number of arrests for all offences decreased by 32% during the trial period, however, the total number of selected incidences, such as criminal damage and disturbance, increased by 20%. Criminal damage increased by 213%. Breaches of the

two kilometre law were 11% lower and police confiscations of alcohol, protective custody orders and the number of people placed in police cells were all lower during the trial.

A range of alcohol harm data was also collected and this included:

- Ambulance call outs (25% reduction)
- Selected presentation to Congress Medical Service (23% reduction)
- Presentations for assault (9% reduction in injuries and 80% reduction of self harm injuries and mental health problems)
- Acute alcohol related hospital admissions (increased by 159%)
- Separations for selected alcohol related injuries (increased by 18%)
- Selected presentation to the emergency department (decreased by 19%)
- Admission to sobering-up shelter (decreased by 28%).

A range of community views were collected via a website, written submissions and telephone calls. While responses indicated that the community believed that the town was quieter during the day, they indicated the trial had had little effect on alcohol consumption. Furthermore, the later takeaway trading hours had shifted the problem to later at a night, a point also made about increased activity on Town Camps to later in the evening. Sly-grogging activity was reported, as was an increase in the level of broken glass. The community telephone survey revealed that the majority of the restrictions, such as the earlier sale of light beer, the ban on 4 and 5 litre cask wine had not affected them. There was a majority of support for the restrictions, with 24% wanting them to be retained and 30% wanting them strengthened.

Recommendations from Report to the Licensing Commission: Summary Evaluation of the Alice Springs Liquor Trial – Crundall and Moon (2003)

- All three restrictions be continued. A further restriction on two litre Port casks be trialled for three months in conjunction with a focused campaign designed to reduce further substitution. This extension should be reviewed in three months and if there is no clear gain then all container limits be removed
- The local Indigenous leadership devises strategies in conjunction with the Licensing Commission and Police Members of the local liquor industry. A partnership approach should underlie this recommendation
- Relevant agencies collaborate and devise demand reduction strategies that reinforce and extend supply measures. This may mean redirecting current resources so they are more closely aligned to the intentions of the restrictions
- With the exception of SUS and Central Australian Division of Primary Health Care initiatives, the complementary measures be assessed again in twelve months in terms of viability and utility. A decision on maintaining or redirecting those resources should then be made. This decision should be made by a responsible body of local interest

- The ERG should continue as a local body to monitor alcohol issues in Alice Springs, to make recommendation to appropriate bodies about strategies and influence agencies to act differently
- A database of harm indicators be maintained and readily interrogated and the Licensing Commission take responsibility for maintaining a liquor database and the production of regular reports like those in this evaluation that can be made readily available to Alice Springs
- SUS continues to remain open for its current hours on a Monday
- Operations of the Day Patrol should be continually reviewed so it attends the areas most likely to exhibit problems. This should be negotiated with Police
- Once the necessary legislation is amended for insurance purposes, twelve months should be allowed for establishment and then a review of the Youth-drop-in Centre's contribution should be undertaken and made public
- As good practice, DASA. should follow up clients to determine whether referrals are acted on so it is clear whether change in admission associated with brief interventions is benefiting people or placing them at risk by not having access to a safe place to sober up
- Before the end of 2003 the Central Australian Division of Primary Health Care should follow up its brief intervention training course to determine whether it has contributed to more interventions and improved healthy outcomes
- Any future measures to address alcohol-related harm should clearly state what they are meant to achieve so it is understood what priority is being addressed
- Services should review their protocols and communication channels to ensure that access to health and safety interventions by those not drinking in the CBD is not compromised.

Survey of the Attitudes of Indigenous Town Camp Residents to the Alice Springs Liquor Licensing Restrictions: A Submission to the Northern Territory Licensing Commission – Tangentyere Council, National Drug Research Institute, and Centre for Remote Health. (2003)

Tangentyere Council held concerns that the Crundall and Moon's (2003) phone survey would not reach the town camp residents who may not have had telephone land lines. In association with the National Drug Research Centre and the Centre for Remote Health they conducted a survey with 277 randomised town camp residents to identify their views on the restrictions and additional measures that were required to address alcohol-related harm in Alice Springs. From this survey it is possible to conclude that respondents had good knowledge of at least one of the restrictions or complementary measures. However, there was variable support for the different

restrictions and mixed views concerning the effectiveness of the restrictions. Nevertheless, support for the continuation of the restrictions was more positive.

Recommendations from Tangentyere Council

- The current restrictions should be strengthened
- No takeaway alcohol should be sold on Sunday
- That the Licensing Commission support any further applications by town camp Housing Associations to be declared as a restricted area under Section 74 of the *Liquor Act* (NT).
- Where possible, there should be a reduction in liquor outlets in Alice Springs. No new licenses should be granted unless it can be demonstrated to the Licensing Commission that such licensees are part of a strategy to reduce alcohol-related harm.
- Restrict the supply of fortified wine and spirits
- Strengthen laws and consequences for traders selling alcohol to intoxicated persons and minors
- In the case of future restrictions, provision should be made for an interim review to address measures that may adversely affect the outcome of the restriction and the community as a whole
- Decrease drinking in public spaces by increasing the range of safe and responsible drinking environments
- Maintain the Day Patrol and the extension to the hours of the DASA. Sobering-up Shelter
- Develop a comprehensive strategy to address the problems of visitors on town camps
- Increased advertising of Night Patrol, Day Patrol and Wardens Programs
- Increased advertising of DASA.’s Sobering-up Shelter and CAAPU.

Review of the summary evaluation of the Alice Springs Liquor Trial. A report to Tangentyere Council and Central Australian Indigenous Congress, Gray (2003)

In October 2003, Gray reviewed the Crundall and Moon (2003) report at the bequest of Central Australian Indigenous Congress and the Tangentyere Council. Gray was able to confirm the majority of the findings by Crundall and Moon (2003), although he notes that there were some serious errors within the evaluation. Of these, Gray noted errors in the statistical analysis, in particular that the numbers of alcohol-related offences before and after the restrictions were not significant. Gray also found that apparent increases in alcohol-related offences reported by Crundall and Moon (2003) were caused by random fluctuations. The diurnal distribution of assaults was also disputed, with Gray (2003) demonstrating that the increase in the proportion of night-

time assaults was due to a reduction of incidents during the afternoon and early evening, rather than an increase in numbers of assaults later in the day. Gray identified a number of positive outcomes not noted by Crundall and Moon (2003) associated with the restrictions on full-strength beverage sales in licensed premises and the later commencement of takeaway trading. Gray also critiqued the community survey on the basis that respondents were not representative of the town population as a whole. Gray also notes that the response of Crundall and Moon (2003) to the failure of the restrictions on the container ban was inadequate and their recommendation for a three month trial ban on two litre cask wine would be ineffective.

Following the Gray review, Crundall and Moon make final comments in a published dialogue in the Central Australian Rural Practitioners Association Newsletter (2003). This will not be reviewed here.

An assessment of the impact of alcohol restriction in Alice Springs, October to December 2006

An assessment of the impact of alcohol restriction in Alice Spring over a three month period in 2006, was undertaken by Moon and Dempsey (2006). This evaluation report explored the immediate effects of the restrictions associated with the Alcohol Management Plan (AMP) in September 2006 (see above). Events in Alice Springs leading up to the development of the AMP are documented in a NDRI (2007) review of the effectiveness and outcomes of alcohol restrictions. Conclusions from Moon and Dempsey (2006) stated that decline in alcohol and injury related presentations and separations started one month prior to the introduction of the restrictions associated with the AMP. The authors note this may have been due to the increased police presence associated with the Master's Games in September.

Moon and Dempsey (2006) also noted that their capacity to evaluate sales restrictions were limited due to very low sample sizes and the very small amount of time between the introduction of the restrictions and the available data. There were falls in mean count of alcohol and injury related hospital separations during the three month period, however, these were not statistically significant. At the time the report was being compiled there were notable increases in alcohol and injury related presentations and increases in Sobering-up Shelter admissions.

Alice Springs Hospital studies

Further to the various reports and evaluation studies of alcohol related harm and supply restriction evaluations, there have also been a number of studies concerning alcohol-related admissions to Alice Springs Hospital (ASH). Two are presented here.

Flanagan and Reece (1982) conducted a study of alcohol related problems amongst the Alice Springs Hospital (ASH) inpatients in the early 1980s. Two hundred and thirty-six non-obstetric public admission patients over the age of 12 who were admitted to the ASH from October to November 1982 were included in this study [Indigenous (n = 99), non-Indigenous (n = 137)]. Each patient was administered a questionnaire about their alcohol consumption and a clinical examination was performed to diagnose their alcohol related disability or alcohol dependence syndrome (using ICD 9), according to the WHO definitions at the time (Flanagan and Reece 1982: 10). The study found that the prevalence of alcohol related morbidity in the ASH (25.4%) was slightly higher than that found by researchers in comparable Australian hospitals. The prevalence of alcohol related morbidity amongst Indigenous patients was twice that of non-Indigenous patients. Both Indigenous and non-Indigenous patients showed statistically strong relationships between alcohol related morbidity and trauma, as well as between alcohol caused admission and trauma.

The high incidence of alcohol caused admission amongst Indigenous people was described by Flanagan and Fleece (1982) as related to higher levels alcohol related trauma due to a high prevalence of binge drinking amongst Indigenous people but was also due to the tendency of medical officer in casualty to admit Indigenous people more readily than non-Indigenous people if their home environment was not conducive for optimum healing. The report urges strongly for a primary prevention approach, reinforced by a well planned and coordinated community education program. However, they note that any re-education scheme in the current Alice Springs environment “which valued highly the abuse of alcohol” would not succeed. The authors argue that for such a program to be effective, the program would need to be aimed at changing individual behaviour, achieved through the introduction of various health promotion packages directed at the level of the family and supported by a revision of community social values.

Alcohol related trauma in the Alice Springs Hospital has continued to be reported, with more recent studies reporting high levels of injury and trauma (Jacob et al. 2007; Ollapallil et al. 2008). Between July 1998 and June 2005, Jacob et al. (2007), reported that 1550 patients were admitted to Alice Springs Hospital with stab injuries. While the introduction of alcohol restrictions in Alice Springs dramatically reduced the incidence of stab injuries from 2002 to 2003, the annual incidence of stab injuries has been steadily increasing. The average incidence is 390/100 000 population per year. The mean age of the victims was 31 years. Sixty-four per cent of the patients were younger than 35 years. Fifty-three per cent (820) of the victims were young women, unlike the many reported studies where the typical victim is a young man. The stab injuries were recorded as either domestic (111 men, 228 women), interpersonal (451 men, 538 women) or self-inflicted (166 men, 56 women). Three hundred and eleven (20%) patients were readmitted with repeat stab injuries. Alcohol is also implicated in a large proportion of the stab injuries. Thirty-eight per cent (481) of the victims who were admitted to hospital were under the influence of alcohol.

While the Jacobs et al. study, does not give figures on the Indigenous versus non-Indigenous presentations, the report focuses its discussion on a description of Indigenous issues in Alice Springs. There are three unique demographic features reported in this study. The first is the large percentage of women victims involved in stab injuries (in most other studies it is young men), the second is the anatomical site of injury with predominant number of stab injuries to the thigh and finally town camps and homes being the commonest location of stab injuries (pubs and streets being more common in other studies). In another paper on injury and trauma in Alice Springs, the same authors argue that Indigenous Central Australians bear a disproportionate risk of injury and illness compared to their non-Indigenous counterparts (Ollapallil et al. 2008). They argue that “Rampant alcoholism” and “social and family breakdown” are significant contributors to the high incidence of violence in Alice Springs. In reference to the alcohol restrictions in Alice Springs, they state that the “root cause of this rampant alcoholism must be sought as measures to restrict alcohol have not achieved desired results” (Ollapallil et al. 2008: 58). While Ollapallil (2008: 58) urge for greater understanding of the problem, they do not provide recommendations to alleviate the “large scale alcohol genocide”.

Conclusions and Summary

It is clear that the issue of alcohol is an emotive and complex issue in Alice Springs. There have been a large number of reports and evaluations written about the effects of alcohol on the community and more recently various attempts to understand and calculate the impact of alcohol restrictions in Alice Springs.

There are some clear similarities in some of the findings of the various studies. All of the previous studies and evaluations have shown that the majority of Alice Springs residents perceive alcohol to be a problem in their community. Previous evidence has demonstrated that Alice Springs residents have higher levels of alcohol consumption, and this, in part, is related to the higher density of alcohol outlets compared to national averages. Evidence has also suggested that alcohol related mortality disproportionately affects Indigenous people in the Alice Springs region. However, the higher levels of aggregate alcohol consumption figures means that alcohol use is a much wider issue including the whole Alice Springs community. This means that the high levels of alcohol related harm will not be addressed sufficiently by strategies that target the problem drinkers alone. As Brady and Martin (1999: 1) argued there is a requirement for the implementation of a long-term and broadly based public health strategy to reduce alcohol consumption levels. However, this requires the reconciliation of the disagreements and conflicts between different groups in Alice Springs about what needs to be done. To achieve this, reports dating back to 1975 have argued for a community development approach in addressing alcohol issues in Alice Springs.

More recently, the focus has relied on the implementation of an effective set of alcohol restrictions. Alcohol restrictions have demonstrated positive effect in decreasing alcohol related harm in previous research. However, in the recent evaluation literature of Alice Springs alcohol restrictions, the focus has been on developing appropriate methodologies for the collection and analysis of indicator data. While it is vital that these are scientifically valid giving the Alice Springs community an accurate representation of outcomes, further developments of the Alice Springs Alcohol Management Plan needs to address strategies to coordinate and manage demand reduction and harm minimisation strategies, as well as alcohol restrictions. In developing a public health approach around alcohol related harm, it is important that earlier evaluations which emphasised the need for a community development approach not be forgotten.

The evaluation and re-evaluation of interventions to address drinking problems in Alice Springs has become something of an industry. Our concern is that the constant debate about achieving methodological perfection appears to be obscuring the real problem; that is, implementing an effective intervention in Alice Springs.

We share previous evaluators concerns about the quality of the statistical data and the need to present these accurately. However, we consider that the methodological processes for evaluation need to be simplified, ideally through the provision of a minimum data set. Alcohol Management Plans are community focused initiatives and evaluation and its associate methodologies should be pragmatic and readily understood by lay people.

6. The implementation of the Alice Springs Alcohol Management Plan

The introduction of the Alcohol Management Plans is embedded within the Northern Territory Alcohol Framework, which was developed in 2004. The NT Alcohol Framework was developed to provide an overarching structure, within which “Governments, community interests, licensees, agencies and other stakeholders could work cooperatively towards reducing alcohol related harm” (Northern Territory Government 2004).

There are seven key elements of the alcohol framework:

- Coordinated whole of Government approach to alcohol
- Effective engagement with the community and business
- Support for local and regional action on alcohol
- Promotion of a culture of responsible alcohol use
- Enhanced access to treatment and other forms of intervention
- Effective system for the supply of alcohol
- Support for the liquor and hospitality industry to contribute to the aims of the framework (Northern Territory Government 2004: 32).

The Alcohol Framework proposes a distinction between Liquor Supply Plans and Alcohol Management Plans. The first refers to “legally enforceable measures that control the availability of alcohol in a region or locality” (Northern Territory Government 2004: 46). In contrast, Alcohol Management Plans and the content and implementation of these plans are located within the sphere of the local community:

Alcohol Management plans are usually a community driven initiative, they can also be initiated by Government agencies seeking to implement government decisions. Government can also instigate a Plan in communities that are unable to act without additional leadership or assistance (Northern Territory Government, 2008: 3).

Alcohol Management Plans should be negotiated between local communities, community organisations, local governments, government agencies, licenses and other key stakeholders. Rather than being a set of rules imposed upon a community, they should be tailored to be locally appropriate and consider the resources within the community that are available to deal with the problem. The local development of Alcohol Management Plans should include:

- Consultation processes and work protocols

- Identification of required services and priorities, including priorities for funding
- Local control strategies
- Local community education strategies
- Undertakings by agencies and organisations to do particular things
- Way in which policing will be undertaken
- Ways in which information will be circulated including information about breaches of the law
- Interactions between the police and local community leaders and organisations
- Undertakings by licensees about responsible service or other supply issues (Northern Territory Government, 2004: 53).

An essential component of the Alcohol Management Plans is the appointment of a local alcohol committee, this committee which has oversight from the Department of Justice and has membership which represents the interests of community and government:

At a minimum the membership will include the regional coordinator, the local government council or similar body, at least two community members and representatives from Police, the Department of Health and Community Services and the Department of Local Government, Housing and Sport. Depending on the issues to be addressed, membership might be extended to other Northern Territory of Australian government agencies, non-government organisations and commercial interests than can include licensees. (Northern Territory Government 2008)

This local Alcohol Management committee is responsible for “generating ideas for action, coordinating the activities of local agencies and negotiating the local rules relating to alcohol use”. They are also responsible for the “oversight a process for canvassing the local community about potential strategies or the implication of specific strategies”.

There have been examples of positive outcomes arising from the development of Alcohol Management Plans; one of these is the Alcohol Management System which was introduced in Groote Eylandt in 2005. The development of this system involved “intensive community activity involving the mining company, Indigenous community leaders, Anindilyakwa Land Council and government agencies (d’Abbs et al. 2008: 88). As a result of the permit system that was introduced, there was a significant decline in violence, and assaults fell by 67% (d’Abbs et al. 2008: 88).

As d'Abbs et al. (2008) point out the success of this system was due to the high level of engagement between the key stakeholders and the community and the efforts put into the effective coordination of a response:

The Groote Eylandt AMP appears to be effective and to have community support. The success appears to be due as much to the processes involved in developing and implementing the system, as to the system itself: it is a product of sustained engagement and collaboration on the part of GEMCO, both community councils and Anindilyakwa Land Council, and also of active involvement on the part of the NT Licensing Commission which, at the request of community leaders, conducted several hearings and meetings on the island prior to formalising the management system.

Table 6.1: Components of the Alcohol Management Plan

AMP Goal one: reducing supply

This goal related to restricting the availability and accessibility of alcohol:

Strategy	Implemented-yes/no
Undertake targeted enforcement activities that focus on alcohol trouble spots	Yes
Implement, monitor and review alcohol restrictions introduced by the Licensing Commission	Yes
Develop a code for the responsible promotion and advertising of alcohol in Alice Springs	No
Introduce tailored alcohol management strategies before and after special events in Alice Springs	Yes
Enable quicker activation of emergency alcohol restrictions during violent incidents or natural disasters	Yes
Introduce simpler processes for complaints against a licensed premise	Yes
Obtain community input into further control on promotion, sale, supply or consumption of alcohol	Yes
Explore the feasibility of a permit system for buying alcohol	Yes

AMP Goal two: reducing harm

This goal is related to influencing drinking choices and drinking environments and providing interventions that prevent further harm:

Encourage high risk premises, public areas or general areas to be declared restricted from alcohol	Yes
Increase the effectiveness of the community patrol	No
Expand sobering up services to include assisting people into rehabilitation	Yes
Ensure the availability of quality alcohol treatment and withdrawal services	Yes
Develop a local liquor accord	No
Work with licenses and local communities to reduce antisocial behaviour around licensed premises	Yes
Promote low alcohol products and alternatives to drinking	No
Strengthen options available to support families to protect their income from drinker's requests and demands	Yes
Work with key communities in the region to develop local alcohol management plans	No
Support community to build zero tolerance of local alcohol related violence	Yes
Build an effective range of options for rehabilitating people who commit alcohol related offences	Yes

AMP Goal 3: reducing demand

This goal relates to changing individual attitudes to drinking and challenging community tolerance of harmful drinking patterns:

Expand the training for health professionals to effectively challenge the behaviour of the risky drinker	No
Provide small grants for local actions that address the impact of alcohol misuse and abuse	Yes
Develop a support program for families that involves parent and school based education	No
Work with local sporting clubs and recreation clubs and other licensed premises to promote a responsible drinking culture	Yes

The main emphasis of the Plans to do date has been around the supply reduction goal. Indeed, the Alcohol Management Plan is conceptualised by many members of the community in Alice Springs as a set of alcohol restrictions. Supply reduction is an important first step in alcohol management strategies, as it can immediately reduce

the sense of a crisis in the community and allow time for the community to consider their long-term goals around alcohol management.

It is difficult to assess how extensive and sustainable the developments in the other areas have been. The Alcohol Courts (which would be incorporated in the category of building an effective range of options for rehabilitating people who commit alcohol offences) were recommended by the NT Alcohol Framework (2004) and implemented in 2005. They provide alternative sentencing for people who have committed an alcohol related crime and can sentence people to alcohol interventions and prohibition orders. There is comment throughout our material that the Alcohol Courts are under utilised and that the process needs to be simplified.

Some aspects such as strengthening people's ability to protect their income from drinker's demand have been achieved through other interventions, in this case the quarantining of income, which was a component of the Federal Government Emergency Intervention. Other aspects have been extremely variable throughout the life of the plan, for example, the day and night patrols have experienced a range of hurdles affecting their ability to operate on a daily basis. Furthermore, the existence of such services is no measure of their efficacy and ability to contribute to the goal of harm reduction.

Finally, as the Alcohol Management Plans emerge, it is clear that the strategies for each goal will have to be updated and perhaps more clearly specified. Unintended consequences need also to be acknowledged and strategies developed to deal with them. For example, as drinkers move further out of town, what harm reduction measures can be put in place to minimise the risk to them and their families?

Alcohol Reference Panel

The Alcohol Reference Panel (ARP) was formed following the announcement by the then Chief Minister, the Honourable Claire Martin, MLA in September 2006 of the Alice Springs Alcohol Management Plan (AMP). It is an advisory group constituted of "local community interests bearing directly on alcohol" (Department of Justice 2006). The ARP, it was announced, would be chaired by Racing, Gaming and Licensing and comprise a core membership that would be appointed by invitation from the Chair.

The Alice Springs Alcohol Reference Panel has representatives from a range of government agencies including, and includes representation from alcohol and other drug services, the tourism industry and licensees. At the last meeting held on 24 September 2008, there were 12 members present, another 2 via phone link, 3 guests, 3 observers and Minister Burns, the Attorney-General.

An analysis of the minutes of the Alcohol Reference group since 2006, reveal that this group is primarily an information sharing group, rather than a group that takes responsibility for decision making and coordination of services. A significant amount of time is given to the discussion of data relating to alcohol misuse and whether this can be interpreted as providing evidence of positive change. There was discussion in the group about the need to engage with the local community about various issues (including the implementation of an alcohol free day) but it always seemed that someone external to the group would be responsible for undertaking this work and reporting back.

Its role, according to the terms of reference, is to:

- Assist the monitoring and dissemination of information about the AMP, including conditions of the Liquor Supply Plan imposed by the NT Licensing Commission.
- Facilitate an exchange of information that will aid decisions about the effectiveness and development of strategies that make up the AMP.

The ARP was to meet monthly for the first quarter and then once a quarter for the next nine months whence it would be reviewed.⁴ Records of meetings were to be published and made publicly available. The ARG had its first meeting on 2 November 2006 and has since met on 11 separate occasions.

Several of the current, and long-term members of the ARP, were interviewed as part of the evaluation process. It should be noted that the Menzies evaluation team were very impressed with the expertise, professionalism and passion about the issue that these people have. Their general responses to our questions about their knowledge of the role of the Committee, its effectiveness and how it could operate more effectively are as follows:

- The AMP was tabled at the first meeting and members were not involved in its development. They feel that there could have been, and should be now, more involvement of the ARG in the “grass-roots” development of alcohol plans and strategies
- The AMP for Alice Springs needs to be revisited. It requires clear goals, objectives and actions. It should be endorsed by the stakeholders. There needs to be clear responsibilities for actions and the resources for such actions to be implemented

⁴ The performance and effectiveness of the ARP does not appear to have been reviewed until this current evaluation.

- The ARG members are often unclear of changing conditions in the community, and often have problems relating the consumption of alcohol to such conditions and outcomes. They might, they argue, be better informed if a range of up-to-date statistics were presented at each meeting (data including consumption of alcohol, crime, health and rehabilitation)
- The meetings are not focused enough “too wishy washy” (ARG member: 2009). They go for too long and are often just discussion sessions. The meetings need to follow a strict agenda and have designated outcomes. There also needs to be rules about observers and proxies and their ability to intervene and “hold the floor” during the meetings.

Another issue that arose was the ability of members to attend meetings. For instance those members from outside Alice Springs, that represent the private sector, often do not have the budgetary resources to attend each meeting. Consideration might be given to formal appointment of members with appropriate remuneration of costs for their attendance at meetings.

Police responses to Alcohol Management Plan

Alice Springs currently has 202 police officers, of these 120 are consigned to general duties, there are 15 auxiliary and 9 Indigenous Community Police Officers (ACPO’s). On an average day there are three vans on patrol with six constables. There has been an increase in police numbers in Alice Springs since 2007, with 20 extra police in the community.

The police have responded in a proactive way to the Alcohol Management Plan, some of the new interventions which they have implemented include:

- A social order task force, which patrols places like the Todd River and can tip out alcohol
- Patrols on the town camps – previously police did not enter town camps
- Mounted police patrols, again to police areas such as the riverbed
- Proactive policing for special events such as the football. It is possible, for example, for extra police to be brought in from surrounding communities to deal with special events
- Focus on domestic violence, and encouraging people to report domestic violence
- Representation on the Alcohol Reference Panel.

The police consider that the alcohol restrictions have been effective. They have noticed a reduction in major violent assaults since the restrictions were implemented.

They comment that there has not been a reduction in assaults in general due to the fact that there is now a “much greater emphasis on reporting community violence”.

They also commented that the restrictions on fortified and cask wine appear to have had the greatest effect: “people have switched to beer, but they are not as drunk as they used to be; beer just isn’t as bad a wine when it is drunk at the same rate”.

The need to be able to sentence people to rehabilitation was raised by the police. At the moment drinking in public can result in a \$100 fine, but this is not a serious deterrent for a person who has no money and no possessions. A person caught fighting can go to jail for six months, but police are reluctant to take this path, as it is contrary to deaths in custody legislation. “Courts need to sentence people to rehabilitation, we don’t want people in cells. At the moment the Alcohol Court is time consuming, it needs to be simplified to be able to be effective”.

Finally, the police comment that law enforcement is only part of the equation in solving the problem of alcohol misuse in Alice Springs. There must also be a focus on improving the social determinants of health in order to achieve long term change:

“We need new houses and education, that is the key to achieving change”.

It is of interest that the police we interviewed considered that the initiatives they had been involved with were “complementary to the alcohol restrictions”, rather than part of the Alcohol Management Plan. This perception is despite their involvement in the Alcohol Reference Panel.

Night Patrol/Day Patrol

The Community Patrol is a service provided through Tangentyere Council. Funding is sourced from the Commonwealth Attorney General Department and the NT Department of Health and Families. The services delivered include a night and a day patrol. The role of community patrols is not clearly defined, but its core functions include the provision of basic services including:

- Safe transportation
- Diversion from contact with the criminal justice system
- Interventions to prevent disorder in communities (Blagg and Valuri 2003).

The actual functions of the night patrol may be variable from community to community, but one unifying factor is that they “do not work in the place of police and do not have policing powers” (ADG, 2008). This aspect needs to be made clearer to the wider community.

Community patrols are generally considered by the police to be an important tool in addressing alcohol misuse and related social disorder. However, the research team did, during one interview with a local authority, have the following opinion expressed about the efficacy of the current night patrol in Alice Springs:

Night patrols are not that useful in stopping drinking; they bring bugger all people in. They have no accountability. The concept is good though, because alcohol is not a criminal problem.

The night patrol in Alice Springs, from observations and from discussions with various authorities, appeared to function at variable performance levels throughout the study period (from September 2008 to March 2009). Some authorities advised that on occasions, they were less than effective, but during the end of the period, in particular, it appeared as though they were very active.

The night patrollers who were interviewed as part of this evaluation explained a range of barriers that their service faces. These included limited funding; night patrol in Alice Springs is only funded for Thursday, Friday and Saturday Nights. The night patrollers also explained that there was a lack of understanding from the police and the general community about their role. They indicated that they would like to work and communicate more effectively with police, but that confusion about roles made this difficult. The coordinator of night patrol training for Charles Darwin University considered that this was a common problem in communities, and that training was necessary for night patrols to liaise effectively with other organisations.

During an interview with the Tangentyere night and day patrol workers, important insights were gained into aspects of the social fabric in Alice Springs. Whilst the powers of the patrols may be restricted, they are nevertheless having face to face contact with drinkers, youth that are on the streets and many other citizens. The matters that were discussed during this interview included:

- A general opinion from within the patrol service that “things are worse since the intervention”. They commented that drinking in Alice Springs is now conducted “under a veil of secrecy” and vigilance about getting caught for drinking in restricted areas
- Indigenous drinkers, for various reasons including the intervention, have turned further toward consuming more accessible types of alcohol including mentholated spirits, mouthwash, vanilla essence and the like
- Drinkers, in some cases, now conduct their activities further out of town, such as outlets at Aileron and Ti Tree
- Some drinkers, mainly of Arrente and Walpiri descent, have shifted toward Mt Isa to drink
- Concerns about drinkers having to wait until 6pm to purchase wine. It should be earlier in the day because of dangers associated with drunken behaviour at dusk

- The major role of the patrol service is the picking up of drunks. During the day they are taken to the dry-out shelter. At night, if the shelter is full, they are taken to the police watch-house. Occasionally, the drunks become aggressive
- Youth are often seen on the streets. The workers talk to them and counsel them if necessary or help them home. If the youth cannot go home because of violence or other reasons, they are taken to the Youth Centre where they are “given a feed and a bed”. Non-Indigenous youth are counselled as well. If they appear at risk, they are assisted. The patrols have also assisted youth of African descent
- Central Australian Aboriginal Congress operate a youth patrol as well. They have their own “drop-in” centre
- Tangentyere day and night patrols also link up with the Tangentyere after-school programs and the family support program
- The age-group of youth underage drinking varies from about 9 to 18 years. Sometimes the parents will be drunk at home so their children go out
- The patrol workers think that the identification system has been valuable and should be kept in place.

The patrol workers appear to be knowledgeable, keen and passionate about the service they provide. However, they are often criticised and receive little recognition for the service they provide. They are very keen to work in closer with the Northern Territory Police. Such liaison, according to the workers, has in recent times improved quite a bit. More linkages can possibly be made in this area, thus improving the services of both agencies.

The Alice Springs Hospital

The Emergency Department of the Alice Springs Hospital has a social work program attached to it to deal with victims of violent crime, assault and domestic violence. Under this system everyone who is admitted to hospital from assault is seen by a social worker. An alert sticker is placed on the individuals file, so that repeat cases of assault are easily recognised. The social work assessment includes ensuring that no children are at risk and safe discharge planning. The social worker also provides information on domestic violence and the importance of reporting domestic violence, including how to contact police and other emergency services when violence occurs.

The Social Work Department works closely with the police and the women’s shelter to ensure the safety of assault victims.

The coordinator of the Social Work Department considers that the efforts of the hospital, in combination with the police and the women’s shelter had been instrumental in reducing the number and severity of assaults in Alice Springs. Again,

like the police, this was considered to be an initiative that was extra to the alcohol restrictions and not conceptualised as part of a broader Alcohol Management Plan.

7. Alcohol services and their coordination in Alice Springs

Interviews and site visits were conducted with a range of alcohol service providers in Alice Springs. The evaluation team asked staff to comment on their current service delivery activities and on the impact that the Alcohol Management Plan has had on their organisation. They were also asked whether they had been involved in any of the AMP activities and about their observations on the impact of the AMP on the community. Figure 7.1 outlines the current service delivery activities in Alice Springs.

Figure 7.1: Current service delivery activities in Alice Springs

- Rehabilitation/treatment
- Sobering up shelter
- Women's shelter
- Non-medical detoxification and home detoxification
- Education and support
- Training services
- Alcoholics Anonymous, Al Anon
- Self- help tools
- Support groups
- Non-residential counselling (family and individual)
- Outreach case management to young people
- Accommodation support service
- Night and Day patrols
- Alcohol courts

Engagement with Alcohol Management Plan

The services appeared to have little engagement with the Alcohol Management Plans directly, other than their participation on the Alcohol Reference Panel, or in the monthly inter-agency meetings.

Some representatives had limited understanding of the full scope of the Alcohol Management Plans and considered them to be primarily a set of restrictions. This influenced their support of the current plans:

I don't believe in prohibition, we need to start with education. I don't agree with the restrictions. I don't think they have helped people, our numbers are still going up, although that may be to do with proactive policing. There is a feeling of oppression in this town. People will always find a way to get a drink, that's why resources should be put into rehabilitation and education.

Perceptions of impact of Alcohol Management Plan

As stated above, many representatives of the treatment services had a limited understanding of the full scope of the Alcohol Management Plan, and tended to focus on the effect of the restrictions. This was despite their involvement in the Alcohol Reference Group. Amongst this group, there was a varying level of support for restrictions; however there was general support for the ID cards. Some staff commented that there had been initial changes after the introduction of restrictions, but these had not been sustained:

At first the restrictions seemed to be working, but then the numbers started increasing again.

Some services commented on a range of emergent issues that they had noticed since the introduction of alcohol restrictions, for example they considered that the Dry Town legislation may simply be “shifting the problem” to other areas.

When the restrictions came in at the end of 2007, people were crazy – they asked how does the AMP address social issues – the AMP has just shifted the problem.

People also commented that a strong racist discourse had emerged, with the positioning of alcohol misuse as an Indigenous issue rather than a community problem.

Linkages between services

There are some very good linkages and referral patterns between some of the services, especially those who are involved in inter-agency meetings and the Alcohol Reference Panel. There are, however, some services that remain isolated due to a

range of issues including past conflict, organisational issues and geographical distance.

There are linkages which involve the flow of information and referrals, but there is not a central body monitoring individuals through the system and into aftercare. It was also observed that some services are possessive of clients and may not refer them to other services.

Perceptions of what is needed to achieve change

The staff provided a great deal of information about what they considered was necessary to achieve change in the community. Key among this information was the need for services to have flexibility and resources to deal with emergent issues, education for both problem drinkers and the community as a whole and the development of appropriate indicators to monitor and assess change. A common theme running through the responses was that the current interventions were too focused on supply and that there needed to be greater emphasis on understanding the underlying social determinants of health as well as addressing demand and harm reduction strategies.

The need for more effective case management was also a common concern. Staff commented that case management for non-Indigenous clients, which included follow-up and after-care, was usually carried out. There was a perception, however, that there was very little case management and follow-up care for Indigenous clients, across all of the services. There was also concern that there were a wide range of treatment styles being utilised with Indigenous people, without a great deal of knowledge about the evidence base for best practice with Indigenous clients.

Finally, all services considered that more resources were needed to address the problem. They talked about their perception that bed capacity had not risen to accommodate the increased demand which was the result of the restrictions. They also talked about long waiting lists for services. Many of the services talked about the need for community based education and the role they could play in this, but considered that they were still in the midst of a crisis and the immediate needs of their clients must come first. In terms of community wide changes, they considered that there needed to be more resources put into policing, that there were still too many licensed premises and that there was a need for more comprehensive training for licensees in the responsible service of alcohol.

Sobering up service

DASA provides the sobering up service in Alice Springs. The service provides an alternative to police custody for intoxicated people who are taken into custody. It provides overnight accommodation, a meal, shower and a referral service. During the five years from 2003 to 2008, 6160 incidents of care were recorded at the sobering up shelter. It is not possible from this data to determine how many individuals are represented, as one person may be admitted several times during a given month or year. The following tables provide an indication of the usual place of residence for sobering up shelter clients. The figures must be regarded with some caution, as often community names are misspelt or entered in several different ways (for example, someone from Alice Springs may be entered under the name “Alice Springs” or “Alice” or by suburb name). Furthermore, it is difficult to determine the number of people from the town camps, as they may also be entered under the category “Alice Springs”.

Table 7.1: Place of usual residence for sobering up shelter clients (NT only)

Town - distance from Alice Springs	2003	2004	2005	2006	2007	2008	Total
Alice Springs	788	570	434	480	797	1040	4019
Town Camps	15	19	25	63	57	70	249
NT <100	39	26	18	13	33	63	162
NT 100-200	41	38	32	55	45	79	290
NT 200-400	52	64	41	50	56	45	308
NT >400	66	30	168*	158*	33	177	632

This table excludes the small number of interstate clients, those clients whose usual place of residence was unknown (121) and those clients whose place of residence was so badly entered in the database that it was impossible to distinguish where they were from (130).

* The high number of admissions in the category >400 kilometres from Alice Springs in 2005 to 2006 can be largely attributed to a large number of people, for whom Darwin was their usual place of residence, being admitted to the shelter.

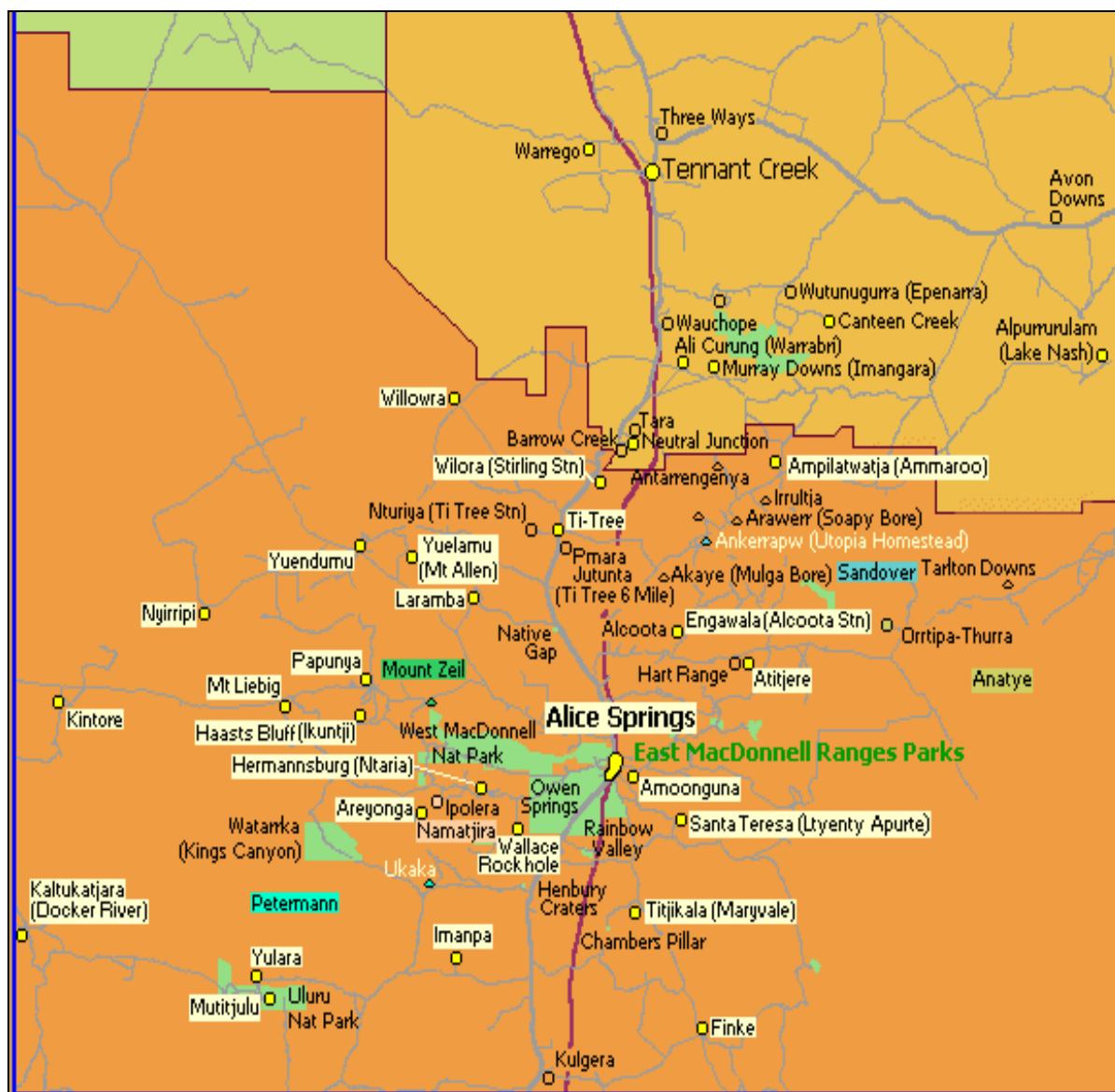


Figure 7.2: Central Australian communities

As can be seen from Table 7.1, Alice Springs residents make up the majority of the DASA client base, contributing to 66% of admissions over 5 years. Admissions have risen since 2007. In 1996 Brady and Martin found that only 16% of admissions were from Alice Springs, with a correspondingly low number of clients from the town camps (Brady and Martin 1999: 18). This is clearly not the case now. They saw that

30% of admissions were from communities within the 100-200 range from Alice Springs, with Hermannsburg contributing 17% of admissions. In the five years from 2003 to 2008, Hermannsburg residents only contributed to 1.5% of the total admissions. Papunya and Yuendumu were the other Indigenous communities who contributed most to the totals. Despite the popular argument that the problematic drinkers come from outside the Alice Springs community and that interventions should be focused on these communities, there is evidence to argue that the majority of drinkers who are so intoxicated that they are arrested for their own safety, are from within Alice Springs.

Table 7.2: NT communities outside of Alice Springs who contribute most to the sobering up totals by year

Town	2003	2004	2005	2006	2007	2008	Totals
Amooonguna	5	1	2	4	8	6	26
Santa Theresa	9	5	5	8	3	17	47
Hermannsburg	18	11	12	14	7	34	96
Papunya	18	5	19	15	11	21	89
Yuendumu	30	15	22	19	18	38	142
Mutitjulu	9	12	16	7	1	5	50
Ti-tree	4	3	9	11	13	9	49
Utopia	6	3	6	6	3	12	36
Kintore	18	8	10	8	10	5	59
Tennant Creek	13	14	18	12	30	29	116
Katherine	6	2	15	38	2	0	63
Darwin	13	13	73	115	8	51	273

Conclusion

All services in this evaluation study were in support of the Alcohol Management Plans, however, there were different opinions expressed about the current restrictions in Alice Springs. An organisations view(s) was often very much dependent on the type of service they provided and their philosophy of care. The majority of services who participated in this evaluation provided services mainly for Indigenous people. Much of this work involved a significant degree of “crises care” and many staff expressed frustration at being unable to treat the underlying social determinants of Indigenous health. While Alice Springs services can offer many of the therapeutic modalities designed for specialised alcohol interventions, Indigenous clients often receive various interventions after significant trauma and with little coordination of

care through a recovery process. Modalities such as self-help/mutual support groups are not offered to Indigenous people. While there is good coordination and various forums for agencies to share information, there is very little case management of individual Indigenous clients between services so that the best possible care is offered. There were exceptions of specific services that provided effective after-care programs, however, this was achieved through the efforts of a specific service rather than being an organisational wide strategic approach through which services could link and work more effectively together over the case management of individuals who require help.

8. Measuring the impact of the Alice Springs Alcohol Management Plan (AMP)

Consumption

The analyses presented in this section are based on wholesale alcohol sales data for each type of alcohol converted into litres of pure alcohol. These data do not take into account alcohol consumed by people in the Alice Springs region which was purchased elsewhere, so they will represent an underestimate of total alcohol consumption in the region.

There is a further limitation of the data which must be taken into consideration when interpreting these results. The conversion to litres of pure alcohol for wine sold in bottles is based on there being 10 bottles per crate. However, from 2002 the packaging was changed so that there are now 16 bottles of wine per crate. This means that total alcohol sales data represent an underestimate of the true volume of alcohol sold. However, the main focus of the analyses presented here is the impact of the introduction of the AMP on trends in sales of alcohol and the wine component of these trends is dominated by sales of wine in casks rather than in bottles. The total sales data can be adjusted to take account of the underestimate in wine sales by inflating the wine bottle sales by a factor of 16/10. However, as noted below, the analyses were done both with and without this adjustment with negligible effect on the results of the trend analyses. So the final trend results are only presented for the unadjusted data.

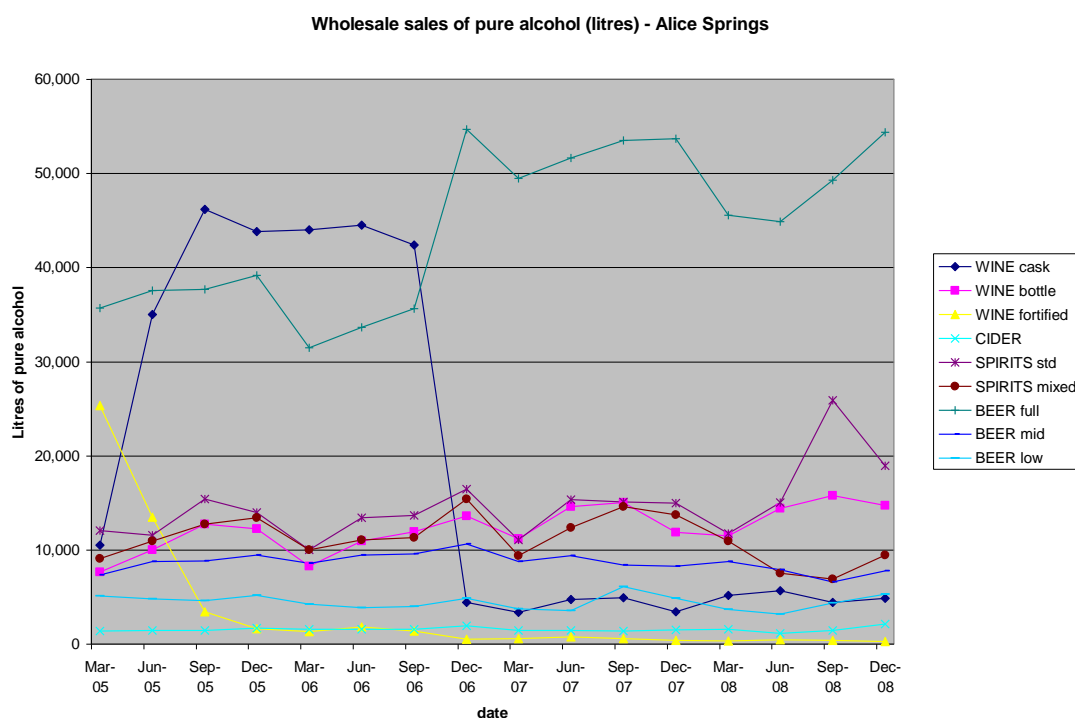


Figure 8.1: Wholesale sales of pure alcohol – Alice Springs

The figure presenting alcohol sales by type shows a drop in wine cask sales immediately following the AMP introduction. This is consistent with the restrictions on cask wine introduced in October 2007. The restrictions also applied to fortified wine, which also showed a dip in sales at this time. Sales of full strength beer increased at the same time, suggesting a shift in consumption between wine and beer. However, the data for overall alcohol sales shows a fall across the period 2006 to 2008, which suggests that although there was a shift from wine to beer following the AMP introduction, the overall total alcohol consumption decreased.

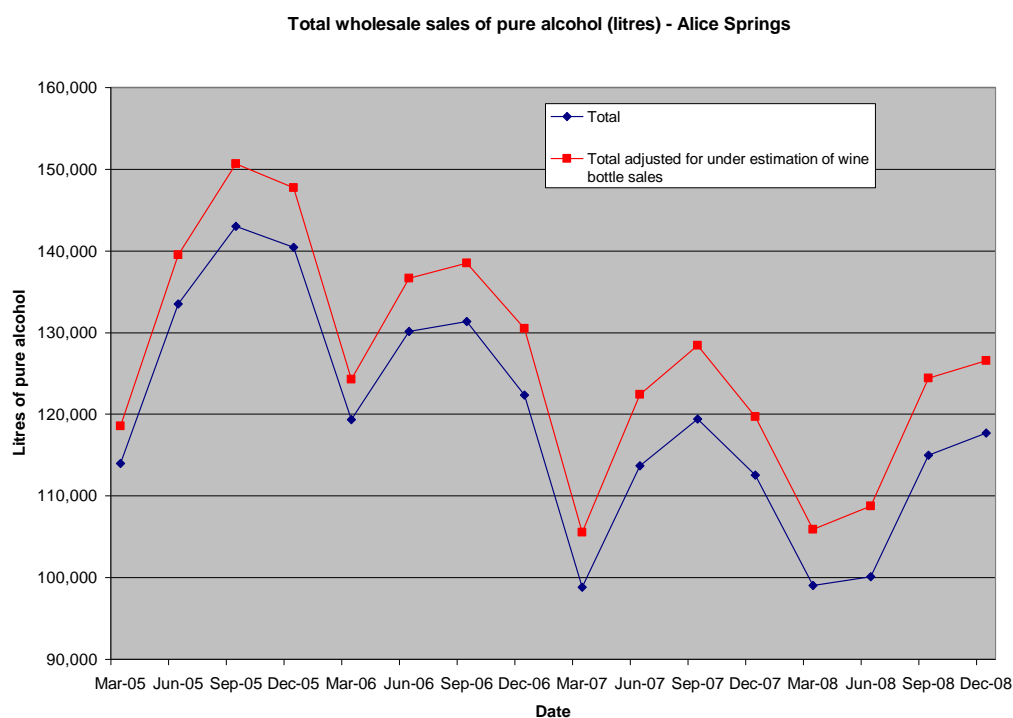


Figure 8.2: Total wholesale sales of pure alcohol- Alice Springs

The figure presenting total alcohol sales shows the total both adjusted for the underestimation of wine sold in bottles and unadjusted. There is little difference in trend between the two data series. The analyses presented here were done on both series with negligible difference in the results. So the results are only presented for the unadjusted data series.

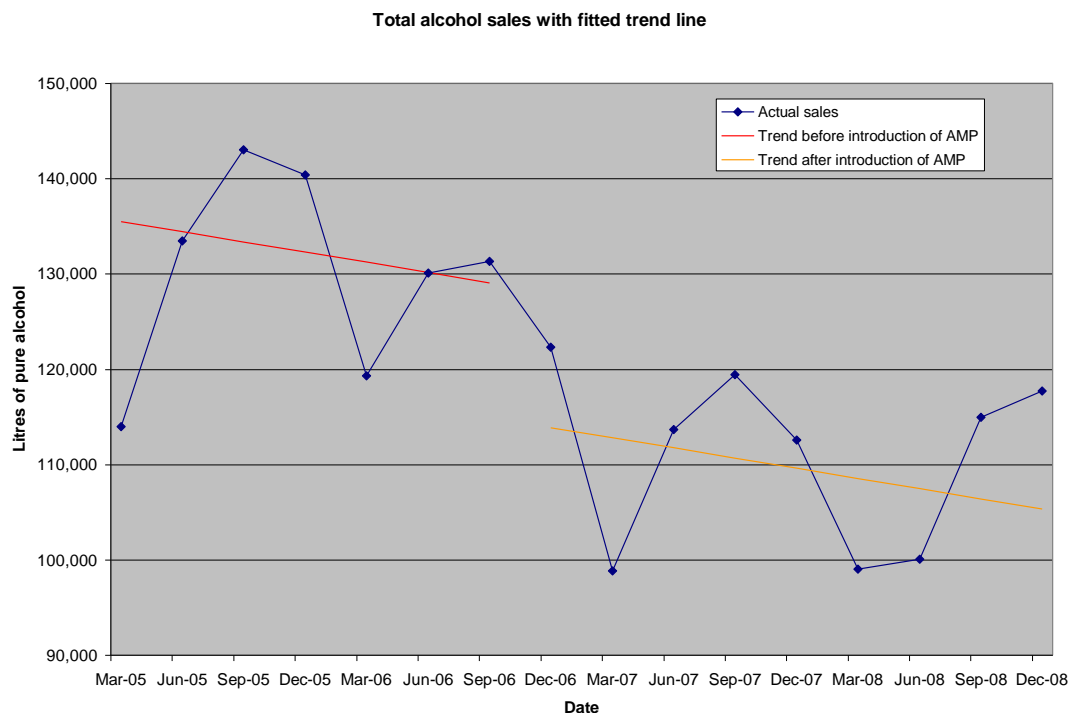


Figure 8.3: Total alcohol sales with fitted trend line

After adjusting for seasonal variability in the sales data, total alcohol sales show a significant downward trend across the whole period ($p < 0.001$). This raises the question of whether or not the AMP introduction had an impact on alcohol sales in addition to the downward trend already observed before 2007. However, further analysis shows that the downward trend on alcohol sales after September 2006 was significantly lower than the trend before September 2006 ($p < 0.001$), indicating that the AMP intervention had an effect on alcohol sales in addition to the existing downward trend.

Hospital separations

The data in Table 8.1 shows alcohol related hospital separations for Alice Springs hospital for the 12 months before and 24 months after the introduction of the AMP.

Table 8.1: Alcohol related hospital separations for Alice Springs Hospital, October 2005 to September 2008

	Oct 05 to Sept 06	Oct 06 to Sept 07	Oct 07 to Sept 08
All alcohol related separations	2494	2238	2521
- Indigenous	2268	2033	2304
- non-Indigenous	226	205	217
Total separations	15375	15885	17425
Alcohol related separations as a percentage of total separations	16.2%	14.1%	14.5%
Alcohol related separations per 100 adult population	12.3	10.6	12.0

The data in Table 8.1 show that alcohol related separations fell in the 12 months following the AMP introduction, in both absolute numbers and numbers per 100 population, but rose again in 2008 to their pre-intervention levels. However, the proportion of alcohol related separations as a percentage of total separations stayed low in 2008. Alcohol related separations as a proportion of total separations fell from 16.2% prior to the AMP introduction to 14.1% in the year following the introduction, which was a statistically significant fall ($p < 0.000$). The proportion remained at around this level (14.5%) in the following year.

Assaults

Assaults and homicides provide evidence of the acute effects of alcohol consumption and are one of the indicators which can provide evidence of change in the short-term and are therefore very important in assessing the effectiveness of the Alcohol Management Plan.

Our interviews with staff from the Alice Springs Hospital provided evidence that they considered that although the absolute number of assaults had not changed significantly, that the severity of assaults had decreased since the introduction of the Alcohol Management Plan. This perception is demonstrated in the data relating to severity of assault.

Table 8.2 presents the annual number of assaults and serious assaults (causing bodily, serious or grievous harm) for Alice Springs for each calendar year from 2005 to 2008

Table 8.2: The number of assaults and serious assaults for Alice Springs, 2005 to 2008

Year	Serious assaults	All assaults	Serious assaults as a proportion of total assaults
2003	85	4002	2.1%
2004	82	3639	2.3%
2005	111	4194	2.6%
2006	108	4495	2.4%
2007	91	5508	1.7%
2008	85	5285	1.6%

While the absolute number of assaults rose between 2003 and 2006, the proportion of assaults classified as serious assaults was relatively stable at around 2.4%. This proportion fell in 2007 after the AMP introduction to 1.7%—a statistically significant fall ($p = 0.004$)—and stayed at this lower level in 2008.

The impact of the AMP on assaults is also evident in the data for Alice Springs Hospital for assaults related hospital separations. Table 8.3 presents assault related hospital separations for Alice Springs Hospital for the 12 months before and 24 months after the introduction of the AMP.

Table 8.3: Assault related hospital separations for Alice Springs Hospital, October 2005 to September 2008

	Oct 05 to Sept 06	Oct 06 to Sept 07	Oct 07 to Sept 08
All assault related	1078	1009	996
- Males	366	329	348
- Females	702	667	648
Total separations	15375	15885	17425
Assault related separations as a percentage of total separations	7.0%	6.4%	5.7%
Assaults related separations per 100 adult population	5.3	4.8	4.7

There was a small decline in the total number of assault related separations after the AMP introduction, but there was a statistically significant reduction in the proportion

of total separations which were due to assault from 7.0% prior to the AMP introduction to 6.4% in the 12 months following the introduction ($p = 0.01$) and a further fall to 5.7% in the next 12 months ($p = 0.007$).

Table 8.4: Alcohol related assaults

	2006	2007	2008
Alcohol Involved	691 66.5%	848 71.7%	740 66.9%
No Alcohol Involved	76 7.3%	96 8.1%	115 10.4%
Not Known / NA / Missing	272 26.2%	238 20.1%	251 22.7%
Total	1039	1182	1106

Table 8.4 shows the number and proportion of assaults in the calendar years 2006, 2007 and 2008 where alcohol was involved. The proportion of total assaults where alcohol was known to be involved rose by 5 percentage points in 2007, but fell again by 5 percentage points in 2008. The proportion of assaults where no alcohol was involved rose by 1 percentage point in 2007 and a further 2 percentage points in 2008.

The 2007 rise in assaults where the involvement of alcohol was known was offset by a fall of 6 percentage points in the proportion of assaults where the involvement of alcohol was not known. This suggests better information on the involvement of alcohol in 2007, but no real change in the proportion of alcohol related assaults. However, the fall in the proportion of alcohol related assaults in 2008, along with the rise in the proportion of non-alcohol related assaults suggests a real fall in alcohol related assaults.

Table 8.5a: Offences recorded by police, December quarter 2005 to September quarter 2008

	Dec 05 to Sept 06	Dec 06 to Sept 07	Dec 07 to Sept 08
Offences against the person			
Homicide and Related Offences			
- Murder	5	6	1
- Attempted murder	0	3	0
- Manslaughter	2	1	1
Total homicide and related offences	7	10	2
Robbery	11	7	16
Assault	1084	1144	1073
Sexual assault	42	48	48
Other offences against the person	18	26	25
Total	1162	1235	1164
Property offences			
Break-ins			
House	261	233	256
Commercial or other premises	301	327	434
Motor vehicle theft and related offences	288	250	262
Other theft	1208	1232	1141
Property damage	1386	1669	1617
Other property offences	12	20	20
Total	3456	3731	3730

Table 8.5b: Offences by type as a proportion of the total offences

	Dec 05 to Sept 06	Dec 06 to Sept 07	Dec 07 to Sept 08
Offences against the person			
Homicide and Related Offences			
- Murder	0.4%	0.5%	0.1%
- Attempted murder	0.0%	0.2%	0.0%
- Manslaughter	0.2%	0.1%	0.1%
Total homicide and related offences	0.6%	0.8%	0.2%
Robbery	0.9%	0.6%	1.4%
Assault	93.3%	92.6%	92.2%
Sexual assault	3.6%	3.9%	4.1%
Other offences against the person	1.5%	2.1%	2.1%
Property offences			
Break-ins			
House	7.6%	6.2%	6.9%
Commercial or other premises	8.7%	8.8%	11.6%
Motor vehicle theft and related offences	8.3%	6.7%	7.0%
Other theft	35.0%	33.0%	30.6%
Property damage	40.1%	44.7%	43.4%
Other property offences	0.3%	0.5%	0.5%

Table 8.5 shows the number and proportion of offences recorded by police for the four quarters leading up to the AMP introduction and for the four quarters in each of the subsequent two years.

Total offences against the person rose slightly in 2007 and then fell to the 2005 level in 2008. The numbers of homicide and related offences are too small to draw reliable conclusions, though there is a suggestion of an increase in robberies ($p = 0.02$) and a suggestion of a fall in homicides ($p = 0.01$) in 2008 compared to 2007. There were no statistically significant changes across this period in the proportion of these offences due to assault, sexual assault or other offences against the person.

There was an important theme running through the interviews about the increase in break-ins to commercial properties, particularly licensed premises as a response to the alcohol restrictions. The crime related data does clearly show an increase in the number of break-ins during 2007 to 2008.

The causes for these increased break-ins, however, remain unclear — they could be a response to difficulties in purchasing alcohol due to the restrictions. They could also be a response to income quarantining imposed by the Commonwealth Government as part of the Emergency Intervention. Many of the break-ins appear to be conducted by youth, and from the licensee's perspective may involve as much criminal damage and vandalism as actual theft of alcohol. The rise in these sorts of crime may also be due to a rise in youth related crime and youth gangs in Alice Springs.

Total property offences rose significantly in each of 2007 and 2008 ($p < 0.0001$). There was a small but marginally significant fall in the proportion of house break-ins between 2006 and 2007 ($p = 0.01$). By contrast there was a significant rise in both the number and proportion of commercial break-ins between 2007 and 2008. Motor vehicle theft fell in 2007 ($p = 0.004$) and then rose slightly in 2008, but still to a level below that of 2006 ($p = 0.02$). Other theft fell in both 2007 and 2008 ($p = 0.01$). By contrast property damage rose across this period ($p = 0.002$).

It is difficult to interpret these statistics, as changes across the three years may be due to a change in the level of crime or they may be due to a change in the reporting of crime. If there are changes in levels of crime due to the AMP introduction, they appear to be seen in property offences rather than offences against the person — and particularly in rises in commercial break-ins and property damage but a fall in theft.

Table 8.6: Alcohol infringement notices, antisocial behaviour incidents, protective custody and sentencing occasions for driving under the influence, 2006, 2007 and 2008

	2006	2007	2008
Alcohol infringement notices	90	828	1308
Antisocial Behaviour Incidents	5243	10999	12834
Protective Custody	3508	3145	7012
Driving Under the Influence ^a			
- Indigenous	1392	1487	1849
- non-Indigenous	701	832	1030

This table includes those dealt with by Courts only.

Note (a) a large proportion of DUI are dealt with by way of infringement notices.

Table 8.6 presents numbers of alcohol infringement notices, antisocial behaviour incidents, protective custody and sentencing occasions for driving under the influence. All of these rose substantially between 2006 and 2008. Again the difficulty with the

interpretation of these statistics is knowing how much of the rise is due to an increase in the offences and how much is due to greater reporting of the offences.

Admissions to the sobering up shelter

Table 8.7 presents the number of admissions to sobering up shelters, the number of clients and the number readmissions during a calendar year for the years 2006, 2007 and 2008.

Table 8.7: Admissions and re-admissions to Alice Springs sobering up shelters, 2006, 2007 and 2008

	2006	2007	2008
Total admissions	3876	4661	6317
Client readmissions			
Number of clients admitted more than once in a year	775	628	728
Proportion of clients admitted more than once in a year	60%	43%	44%
Number of clients admitted more than 11 times in a year	63	83	108
Proportion of clients admitted more than 11 times in a year	5%	6%	7%
Total clients	1289	1466	1660

The total number of admissions and the total number of clients admitted both rose in each of the two years following the implementation of the AMP, suggesting that greater use was being made of the shelters in 2007 and 2008 compared with 2006. However, the proportion of clients who were admitted more than once in a year fell between 2006 and 2007 (a statistically significant fall— $p < 0.001$) and remained at this lower level in 2008. This suggests that the extra people using the shelters in 2007 and 2008 were at the less serious end of alcohol use. Both the number and proportion of people admitted to the shelters more than 11 times in a year rose by a small, but not statistically significant amount in each of 2007 and 2008 ($p > 0.1$).

Summary

The data presented in this section carry the caveat that while they show changes coinciding with the AMP introduction; some judgment should be exercised in concluding that they are caused by the AMP rather than any other influences which happened at the same time. However, given this caveat, the data do point to a positive effect of the AMP. There has been a clear decrease in the volume of alcohol

purchased in Alice Springs so, to the extent that this reflects actual consumption, there appears to have been a decrease on overall levels of consumption. There has been a decrease in alcohol related hospitalisations as a proportion of total hospitalisations. Given that most of the health effect of alcohol abuse reflects drinking over many years, this short-term effect on hospitalisations is likely to understate the true health effects of the AMP. Although the absolute number of assaults has risen over the evaluation period, the proportion of these which are serious assaults has fallen. Further, the proportion of assaults which are related to alcohol also appears to have fallen. Other justice data are more difficult to interpret, but the AMP may have contributed to rises in commercial break-ins and property damage, but a fall in theft.

9. Community perspectives of, and responses to, the Alcohol Management Plan

Introduction

Community perspectives of the Alcohol Management Plan are a key part of this evaluation; they provide us with information about how alcohol misuse is understood as a problem in Alice Springs, how the Alcohol Management Plans are understood, and provide an indication of community receptiveness to the range of initiatives included in the Plans. Through engaging with the community, we also were able to gauge the level and extent of concern about alcohol misuse in the community and the interest in acting as a community to address the problem.

We engaged with community perspectives in the following ways:

- In-depth qualitative interviews with key stakeholders and community members
- In-depth qualitative interviews with people living in the town camps
- A phone survey of 350 residents
- A call for public submissions through the local media.

Key stakeholder interviews

Eighty in-depth interviews were conducted with a range of key stakeholders in Alice Springs. The interviewer was guided by broad questions about the individuals' perceptions of the interventions and related strategies, and the interviewees were encouraged to talk at length about their particular concerns and interests. Each interview took between 1-2 hours and in some cases there were several subsequent interviews to follow-up material. A list of the individuals and organisations consulted is in Appendix 1, although there were some individuals and organisations who did not wish to be identified in this report.

Methods

In-depth Interviews

The evaluation team chose in-depth interviewing as a key methodology. In-depth interviews explore "the complexity and in process nature of interpretations" (Liamputtong and Ezzy, 2005: 56), from the individual's point of view and to capture their understanding of the issue in their own words. The sample size is necessarily lower than with other methods, such as surveys, or structured interviews, due to the

fact that the interviews themselves are lengthy and an individual may be interviewed on more than one occasion. We considered that the issues of alcohol and the Alcohol Management Plan were of such complexity in Alice Springs that it was necessary to tease these out during extended interviews.

The in-depth interviews were conducted by the three members of the interview team. Where possible at least two of the team were present at the interview and recorded notes. The notes were then transcribed by one member of the team and checked for accuracy by the other members who were present. The interviews were then thematically analysed and again the key themes were checked for accuracy by the other members of the team.

A purposive/snowball sampling method was used, whereby a range of key stakeholders were identified who then provided the evaluation team with contact details of further people who could provide important insights into the evaluation. Some contacts were re-interviewed on several occasions, when questions emerged from the analysis, or when clarification of a particular point was needed.

The phone survey

A phone survey was designed and implemented to obtain a broader community perspective about perceptions of the restrictions associated with the Alcohol Management Plan. In 2003, Crundall and Moon conducted a phone survey to gain an understanding of community attitudes to restrictions. This survey was heavily criticised by the Central Australian Aboriginal Congress as it “would not be representative of the town’s population as a whole because there are many Aboriginal and (some non-Aboriginal) families residing in the town who do not have telephones” (Gray, 2003: 23).

Any survey design will have a range of advantages and disadvantages from which the research must choose the most appropriate, efficient and cost effective method for a particular study (Neumann, 1997: 252). A household survey would have the advantage of reaching people without phones, but face to face interviewing also increases the risk of interviewer bias. Furthermore, a house to house survey would require a large team of people and maintaining consistency in the way questions are asked and probes delivered is extremely difficult to both manage and assess under these circumstances. Household surveys are inherently expensive, require the most amount of time of any survey technique, the most training for interviewers and also put interviewers in a high risk situation, which is not ethically desirable.

A phone survey conveys most of the advantages of a face-to-face household survey (for example, an interviewer is able to ask open-ended questions, and ask for clarification when required) without the disadvantages of high costs in terms of

resources and time. Phone surveys also allow respondents to discuss sensitive issues with a degree of anonymity, which may also be beneficial in this study and interviewer bias is significantly reduced. Furthermore, a phone survey allows the interviewer flexibility in the time of day they approach the population allowing, for example, respondents to be contacted in the early evening. It may not be safe for interviewers to conduct house-to-house surveys in the evening, and because of this, people who work during the day will be missed.

It is of utmost importance to recognise and respond to the potential sources of under-representation and bias in any survey. In this survey, we recognise that some Indigenous families may not have telephones. In order to counter this, one of the members of the evaluation team spent two weeks conducting in-depth interviews in the town camps, assisted by researchers from Tangentyere Council. In this way, the results of the community based interviews and the town camp interviews could be triangulated against those of the community phone survey. The results of the town camp interviews are discussed in the following section of the report.

The phone survey questionnaire was compiled on the basis of our analysis of 80 key stakeholder and community interviews. By this time, it was clear that only certain aspects of the Alcohol Management Plan were fully or even partially understood by the community. These were the aspects relating to supply reduction. We therefore asked a range of questions relating to the aspects of the Plan that people were most aware of, including the ID system and the changed times for purchasing cask and fortified wine. We attempted to gain an understanding of community wide effects by asking if the implementation of the Alcohol Management Plan had any good and bad effects on the community. We also asked the respondents what modifications they would like to see to the Alcohol Management Plan and if there were any other measures that could be taken, other than restrictions on the supply of alcohol that could be taken to reduce the alcohol problems in Alice Springs.

The phone survey was conducted from a random sample of telephone listings. Nine hundred and seventy-six phone calls were placed resulting in 350 completed surveys. Reasons for non-completion were listed and included non-answered calls, disconnected numbers, and refusal to participate. The total number of refusals was 127.

The survey was purposely conducted during different times of the day and week, with morning, afternoon, early evening and weekend shifts. Most surveys took 10-15 minutes to complete, usually because respondents provided a great deal of additional comments, which the interviewer recorded. The longest survey took 23 minutes to complete.

Results: In-depth interviews

All the people who were interviewed in Alice Springs considered that alcohol misuse was a serious issue in the town and that it had wide ranging affects including the disintegration of families, the rise in crime and negative effects on tourism. All respondents were in favour of some sort of intervention to address the problem. There were, however, a wide range of opinions on the current set of restrictions and their efficacy. A major theme of the interviews was “whose problem” drinking in Alice Springs was. Perceptions of who was responsible for the problems affected the types of interventions that were proposed and reception of the current range of restrictions.

Limited knowledge of the Alcohol Management Plan

The interviews revealed a high degree of confusion about the Alcohol Management Plans, most people were not conversant with the range of goals and strategies included in the Plans, and were instead aware of those aspects of the Plans which effected them directly; the restrictions on sales of alcohol. This perception was reinforced by the media coverage which focused on the effects of the restrictions. Often representatives of organisations such as the police, hospitals and the various alcohol services talked about activities that had been implemented which addressed either demand reduction or harm minimisation, but they usually described these as being an “extra” initiative or as being complementary to the alcohol restrictions, rather than as part of an Alcohol Management Plan. Interestingly many of the people espousing these views were also members of the Alcohol Reference Group.

A problem of the minority – recidivist drinkers

A recurring theme throughout the interviews was that alcohol misuse was a problem associated with a small sub-population of the community and as such, the town as a whole was being inconvenienced for the actions of a few.

I am disappointed that conditions are placed on the whole town, rather than just addressing the issue. We feel marginalised; there are different sets of rules throughout the Territory. As a community we feel: why do I have to keep paying for someone else’s mistakes?

There are 27000 people in town, why should 500 drinkers influence the drinking of others.

This sub-population was described as being Indigenous and the words that were used to describe this population included “recidivist”, “hard core” and “beyond help”.

The key to the problem is the recidivist hard core drinkers – they are beyond rehabilitation.

Furthermore, this population was considered to be self-perpetuating, respondents talked about a cycle of alcohol misuse, as children were exposed to the activities of their parents:

The kids turn out just as bad and the cycle continues.

Estimates of the size of this population ranged from 150 to 500 drinkers, however, several people commented that there were 150 people who had been put in protective custody more than 11 times in the past year.

Interventions that were suggested to deal with problematic drinking were therefore focused on individuals, rather than as a community as a whole and included monitoring the liquor purchasing activities of individuals as well as mandatory rehabilitation:

Third time offences should be sent to mandatory rehabilitation for three or four months. In this way the cycle can be broken.

Some people expressed the view that if these activities were carried out, that the current alcohol restrictions could then be lifted:

There needs to be a tracking device with the ID system, so that problem drinkers can only buy their quota, then you can open the hours back up.

Perceptions of the restrictions and their effect

Interviewees' perceptions of the restrictions must be considered in the context of the material presented previously. There was not a widespread view that this was a problem that the community as a whole should be mobilised to address. Key themes that arose centered on the lack of communication about the restrictions and subsequent confusion about their purpose, inconvenience to the local population of "moderate drinkers", the effect on tourism, difficulties with enforcing the restrictions, and changing patterns of drinking in the town as a result of the restrictions.

Communication and resultant knowledge of the restrictions

It was clear during our interviews that many people were confused about what the Alcohol Management Plan was and the range of restrictions. The Commonwealth

Government's Emergency Intervention made it difficult to understand which body was responsible for each of the restrictions that were in place:

The various initiatives, including the intervention, the dry town, prescribed areas and the restrictions have now become mixed together. Many people, Indigenous and Non-Indigenous are unclear about what the strategies are – communication is the key issue.

There was also the sense that Alice Springs had restrictions enforced upon them by the government, with very little public consultation. One interviewee described this process as having “layers of restrictions” imposed upon the town.

Inconvenience to moderate drinkers

The most frequently mentioned inconvenience to moderate drinkers were the restricted hours for the purchase of fortified and cask wines (which are only available in the last three hours of trading, i.e. from 6pm until 9pm). Interviewees often talked about the difficulties for elderly people “wanting to buy their sherry”:

Elderly people like to do their shopping early, but they can't buy their wine until 6pm, that means they have to go out two times in a day.

The elderly were not only considered to be inconvenienced by the necessity to go out after 6pm, they were also putting themselves at risk. The risk was associated with the large numbers of people at the bottle shop at 6pm, who may have been drinking beer until this time. This perception appeared to be heightened by media accounts of humbugging and violence in the town, but there is no evidence to suggest that elderly people were at increased risk during this time.

Effect on Tourism

Negative effects on tourism from the alcohol restrictions were a common theme. With respondents commenting that tourists were inconvenienced when they had to wait until after 6pm to buy wine for their travels. Also, overseas tourists may not understand the need to present their passport or other appropriate identification when buying alcohol:

The ID cards can be embarrassing for tourists and I feel embarrassed too, as a local person.

There was, however, little evidence for the restrictions having a major impact on tourists, or causing a reduction in tourist numbers. One long-term tourist operator

commented that most people respected that the restrictions were required to control alcohol in the town. The tourists we talked to not only respected the restrictions, but also talked about them being part of the “different experience” of travelling in the Northern Territory.

Interestingly, there was little comment on some of the potential positive influences on tourism, including the reduction of people who were obviously drunk in the town and the river and the reduction in the amount of alcohol-related litter.

Some respondents claimed that tourism numbers in Central Australia had actually declined as a result of the alcohol restrictions. When this was raised with a tourist operator, however, he said that there has been a decline in tourism nationally. On this point, Daley (Bloomberg Press 2009) notes that “tourism in Australia has stalled since 2005 after rising 250 percent in the previous 15 years”.

Perceptions of public safety

Media coverage of break-ins to licensed premises was frequent during the time of the evaluation as were accounts of increasing youth delinquency and violence:

We have a serious public safety issue; the clubs are literally under siege. The Memo club has been broken in to five times in the last five nights. These are clubs that contribute so much to this town.

Most prominently, an Alice Springs Aldermen was attacked in the Todd Street Mall, by an allegedly drunk Indigenous man, surrounded by a group of youths. This material often provided a basis for people’s comments that they were feeling unsafe in Alice Springs.

One member of the Alice Springs Town Council commented that he was concerned that individual homes would be the next target for people looking for alcohol:

There is another potential problem, now people are buying alcohol from wholesale wine sellers down south. Are we going to see a rise in home invasions too? We are all quite vulnerable.

Difficulties with enforcing the restrictions

The major liquor providers considered that the ID system only required an extra few seconds to implement in a routine transaction. Interviewees commented about the

inconvenience of having to produce a valid ID. More often, however, they pointed to observed inconsistencies with the use of ID cards:

There is no uniformity in how the ID cards are used. One day they ask you for your card and the next they won't. I have witnessed people getting alcohol without ID.

There was also a major theme — the lack of training and capacity of those people who were selling alcohol to successfully implement the ID system:

How come drunks are still being served alcohol? I've seen it, It happens at the largest bottle shops in town. The people serving alcohol think it's a dumb piece of legislation, so they don't abide with it.

Its not fair putting all this responsibility for people who are earning 15-18 dollars an hour, who are confronted by abuses day in, day out.

As a result of the restrictions, and the frustrations of purchasers, selling alcohol was considered to be a particularly unpleasant job. There was some comment that responsible service of alcohol training would have limited impact, due to the highly transient nature of the workforce:

There is a big staffing issue in Alice Springs, they are undertrained, only there for a couple of days. They have to make decisions about whether people are drunk or not.

Perceptions of the efficacy of services to deal with alcohol misuse

Rehabilitation, which was targeted to deal with the problematic “recidivist drinkers” was considered by all respondents to be one of the most effective ways of dealing with problematic drinking in Alice Springs. Often interviewees commented that there simply were not enough services to deal with the issue:

We had meetings with Mal Brough, and he offered a rehab centre. The Government is always making promises of rehabilitation and education, but there is nothing.

There was also a common theme that the existing services were not dealing with the problem effectively, although information about services was often based on hearsay, rather than any directly observed evidence.

Changing patterns of drinking in Alice Springs

A major concern was that the current restrictions were forcing drinkers to move out of town to drink, thus exposing themselves and their families to different sorts of risks:

I think we are exporting the problem to the edge of town. I worry about the welfare of drinkers in the hot sun, they have their kids tagging along. Maybe there need to be a place set aside as a drinkers" areas where families can check on each other. They can make sure that people are not dying of dehydration or choking on their own vomit.

Some Alice Springs Aldermen had been on a fact finding trip to Port Augusta after that town had been declared dry. They commented that by becoming dry Port Augusta "exported its problem" to surrounding areas such as Ceduna and Coober Pedy.

Suggested changes to the current restrictions

A wide range of changes to the current restrictions were suggested. The most controversial of these were the implementation of an alcohol free day aligned to Centrelink payments and further restriction of the hours of trading (for example, reducing the time takeaway alcohol was available to between 2pm and 7pm). These suggestions were by no means widely supported, but they did have strong advocates who drew on their knowledge of the restrictions that were implemented in Tennant Creek.

More popular responses focused on addressing the broader social determinants of alcohol misuse, including the need for education and addressing the housing shortage in the town. A common theme was that "Governments are not doing enough" to address these problems.

Call for public submissions

Four responses from individuals were received through the call for public submissions. As this group is self selected and were motivated enough to write a submission (often quite lengthy submissions) they can be considered to have particularly strong views on the subject.

Three out of four respondents were strongly in favour of the Alcohol Management Plan and advocated stronger restrictions, including alcohol free days, increased taxation of alcohol, banning of alcohol advertising and use of the ID system for increased surveillance of problematic drinkers. One respondent also commented on

the need for more services to deal with alcohol rehabilitation. The other respondent commented that “prohibition doesn’t work and that people will always find a way to obtain alcohol”. This individual advocated for the provision of clubs in communities to prevent people from “drifting into town”.

Community phone survey

Description of sample

Of the 350 people who responded to the survey, 276 were non-Indigenous and 65 were Indigenous. Nine people declined to respond to this question. One hundred and fifty-six people were male and 189 female, with this question remaining unanswered for 2 respondents. One hundred and eighty-six people were aged 45 and over and 162 people were under 45, 2 people declined to answer this question.

Results

Overall, 148 people described themselves as supporters of the Alcohol Management Plans, and 195 people were against the Alcohol Management Plans. Seven people said they were not sure, most of these people responded that it was still too early to determine if the Alcohol Management Plans had initiated positive change in the community.

Table 9.1: The characteristics of people who supported, or were against, the AMPs

	Support the AMP	Against the AMP	Unsure/did not answer	Total
Male	43 (28%)	110 (71%)	3 (2%)	156
Female	103 (54%)	83 (44%)	3 (2%)	189
Indigenous	17 (26%)	48 (74%)	0 (0%)	65
non-Indigenous	127 (46%)	142 (51%)	7 (3%)	276
Aged under 45 years	86 (53%)	73 (45%)	3 (2%)	162
Aged 45 years and over	61 (33%)	121 (65%)	4 (2%)	186
Lived in AS 10 years or less	69 (66%)	33 (31%)	3 (3%)	105
Lived in AS more than 10 years	78 (32%)	161 (66%)	4 (2%)	243

Table 9.2: Individual experiences of the Alcohol Management Plan

	Not personally affected	Personally affected	Total
Implementation of the ID system	193 (55%)	157 (45%)	350
Changes to takeaway times	212 (61%)	138 (39%)	350
Banning of drinking in public areas	304 (87%)	45 (13%)	349
Changes to the times cask and fortified wine can be purchased	261 (75%)	87 (25%)	348

Table 9.3: Objections to the ID system

Objection	Number of respondents
Inconvenience	50
Invasion of privacy	30
Annoying and pointless	26
Always forget license	21

Many of the objections to the ID system were quite mild — having to remember one’s ID and the problems that arose when a person forgot it. Thirty people voiced a stronger objection in terms of their anxiety at the level of surveillance they were being subjected to:

I always have to show it and it makes me feel like a criminal.

Shouldn’t have to prove who I am just to buy a drink.

Twenty-six people commented that they found the ID system annoying because they didn’t know what purpose it served.

One person described having to provide ID as a positive experience:

I have to show it, but I quite like it, it makes me feel young (elderly phone survey respondent).

Table 9.4: Objections to the change in takeaway times

Objection	Number of respondents
Forced to change shopping times	23
Annoying	18
Inconvenient	16
Invasion of rights	8
Difficult when you are planning a trip out of town	8
Shops busier after 2pm and intimidating	5

Being obliged to change shopping times was a common objection. Some people commented that they resented being forced to alter their usual patterns in order to deal with problems caused by a minority:

It never suits my day, I have had to change my plans just because of a few people.

A minority of people responded that they were personally affected by the restrictions on drinking in public areas. However, 63 people commented that this particular restriction was not working due to the fact that it was not being enforced properly by police.

I don't like them drinking behind my house, we call the police and they hardly ever come.

Eighty seven people said that they were affected by the changes to the times that cask and fortified wine could be purchased. The reasons that they provided are summarised in Table 9.5.

Table 9.5: Objections to the changed times for purchasing cask and fortified wine

Objection	Number of respondents
Difficult to purchase fortified wine for cooking	15
Have had to alter shopping times	13
Bottle shops intimidating and busy after 6pm	12
Difficult for elderly people, especially those who don't drive	11
Forced to order wine from wine clubs	9
Annoying, frustrating	6
Difficult for people who live out of town	4

I can only afford cask wine, but I hate going down so late, as there are always people there hanging around and wanting money (elderly respondent to phone survey).

Impact on the Alice Springs community as a whole

Table 9.6: Positive and negative effects on the Alice Springs community

	Yes	No	Unsure/ Not stated	Total
Positive effects on the Alice Springs community	102 (29%)	228 (65%)	20 (6%)	350
Negative effects on the Alice Springs community	186 (53%)	154 (44%)	10 (3%)	350

Note: Many respondents reported both positive and negative effects on the Alice Springs community.

Table 9.7: Positive effects of the Alcohol Management Plan

Perceived effect	Number of respondents
Town is cleaner	22
Less public drunkenness	19
Public places are alcohol free	9
Drinkers are not out so early	7
Town is quieter	7
Alcohol related crime has decreased	5

Table 9.8: Negative effects of the Alcohol Management Plan

Perceived effect	Number of respondents
Made community angry	38
Negative effects on tourism	20
Alcohol related crime and violence has increased	17
Increased break-ins to licensed premises	12
More rubbish and broken glass	12
Bottle shops crowded and intimidating	12
People drinking in residential areas	10
People coming into town to drink	10
Government imposed restrictions without adequate consultation and communication	8
Drinkers are now pushed into hiding	7
Made community more racist	5
More mouthwash bottles	5
Police treating Indigenous people unfairly	5
More drinking on town camps	3
More Indigenous people drinking than before	2

Modifications to the Alcohol Management Plan

Table 9.9: Changes to the Alcohol Management Plan

	Continued in present form	Continued with modifications	Abandoned	Not sure/ Not stated	Total
Supporters	71 (48%)	71 (48%)	4 (3%)	2 (1%)	148
Against	1 (1%)	68 (35%)	125 (64%)	0 (0%)	194

Table 9.10: Type of modifications suggested

Type of modification	Number of respondents
Focus restrictions on the minority of problematic drinkers	38
Tougher restrictions	10
Education	8
Exemptions for tourists and the elderly	8
Better enforcement	6
Fewer liquor outlets	6
Further consultation	4
Evaluate and then change if necessary	4
Pubs on communities	3
Further restrict sale times	3
Permits	2
Longer opening hours	2
Let people drink in town camps	1
Encourage community support	1
Further welfare quarantining	1

Table 9.11: Further things that could be done to address Alcohol issues in Alice Springs

Type of intervention	Number of responses
Education, especially for problem drinkers	62
Restrictions should only be targeted at problem drinkers	44
Tougher laws and more police	31
Alcohol should be available in communities and town camps	20
Reduce number of liquor outlets	13
Further and stronger restrictions	13
Remove all restrictions	11
Emphasis on consultation and communication with entire community	10
Provide opportunities for employment	8
Mandatory rehabilitation	6
More resources for rehabilitation	5
Permits to drink	5
Youth curfew	4
Ensure children go to school	4
Alcohol free day/days	3
Stop Indigenous people from drinking at all	3
More youth workers	3
New jail	2
Tourist exemptions	2
Housing	1
Increased taxes on Alcohol	1
Total prohibition	1

Discussion of results

There was, throughout the phone survey results, a high level of concern about alcohol misuse and its results; particularly violence and criminal activities. There was, however, a division in the community about the appropriateness of the current Alcohol Management Plan (which was usually conceptualised as a set of restrictions) and the efficacy of the current Alcohol Management Plan. More people described

themselves as being against the Alcohol Management Plans than supporters of the Plans. Of those who described themselves as being against the Plans, most considered that the current restrictions were unfairly placed on the entire community, when a more appropriate focus should be the problematic drinkers.

Most of the non-Indigenous respondents to the survey considered that alcohol misuse was an Indigenous problem and the solutions that they advocated reflected this viewpoint, for example, a frequently expressed idea was that communities should provide drinking facilities for their Indigenous residents, so they would no longer congregate in Alice Springs.

Negative sentiments towards the Alcohol Management Plan, or at least the restrictions associated with the Plan seemed to be strongly related with an individual's length of residence in Alice Springs. Sixty-six per cent of people who had lived in Alice Springs for 10 years or less described themselves as supporters of the Plan compared to 31% who were against the Plan. By contrast, only 32% of people who had lived in Alice Springs for more than 10 years supported the Plan, compared to 66% who were against it.

People who had lived in Alice Springs for longer than ten years were more likely to describe a high level of personal inconvenience as a result of the alcohol restrictions. They were also less likely to describe the Alcohol Management Plans as having any positive effect. It is difficult to ascertain whether this lack of a sense of improvement is due to their individual frustration as a result of the alcohol restrictions or because they have a longer time frame in which to assess and compare the current situation.

Some negative factors that people described included the increased number of break-ins, drinkers congregating in residential areas, increasing levels of violence in the town, different patterns of drunkenness, effects on tourism, feelings of intimidation at the bottle shop and a sense that the personal inconvenience of the restrictions has not been matched by any perceptible improvement in the community:

There is still a lot of violence and drinking in public places.

It's had a bad effect on tourism, the crime rate has risen and in some areas drinking still occurs.

People are drinking more in the evening, they are up all night. Before people used to drink in the morning and sleep all night.

Bottle shops are very busy and can be scary- especially for out of towners.

Those people, who had been resident in Alice Springs for less than ten years, were much more likely to report lack of inconvenience as a result of the alcohol restrictions and satisfaction with the changes in the town as a result of the Alcohol Management Plan.

Some positive changes that people described included less public drunkenness, less violence and less rubbish on the streets. Often people described these factors as having a positive impact on tourism:

The restrictions are great; the town is so much cleaner.

I don't see anyone in town drinking and there is less violence in the street and less rubbish.

I think the town is so much cleaner – it helps with tourism.

It has cleaned up the town dramatically.

Of the 13 people who advocated stronger restrictions, including less liquor outlets and alcohol free days, all had lived in Alice Springs for less than 5 years. The association between length of residence in Alice Springs and resistance to the changes associated with the Alcohol Management Plans indicates a sector of the community which has developed long standing and deeply entrenched attitudes towards alcohol and also to what they see as interference at the government level on their everyday lives. This division within the community is a significant barrier to the development of a sustainable Alcohol Management Plan.

Non-Indigenous perceptions on drinking

The discourse that emerged throughout many of the phone interviews leant strongly toward a belief that only one cultural section of the Alice Springs community has a drinking problem. The anonymity provided by the telephone interviews probably made respondents less guarded about their responses and the need to provide politically correct answers. Such discourse tending toward racism in the alcohol debate in Alice Springs is not a new phenomenon, for example, in 2003 Rosewarne and Boffa (2003) commented that:

This had led conservative voices in the alcohol debate to call for measures that focus on Aboriginal problem drinkers. This position ignores the reality that excessive consumption of alcohol is a problem which involves both Aboriginal and non-Aboriginal people. It is an attitude which stigmatizes Aboriginal people, and suggests that they are not part of the community.

Many of the non-Indigenous respondents in the survey wanted the focus of any restrictions to only be upon Indigenous people, with comments such as:

They need to say that Indigenous people cannot drink.

If you have restrictions they should only be on the Aboriginal people.

The whole town has to toe the line because of Aboriginal people.

Everything they are trying to do is affecting the white people and not helping the Aboriginals who are the problem.

There was also a strong theme of developing incentives to remove Indigenous people from Alice Springs. Often respondents commented that as a result of the restrictions, Indigenous drinking was beginning to impact on their own personal space and time as people started to move into residential areas to drink:

Now they drink behind my house.

Now they keep us awake all night behind our house, we ring up the police, but they hardly ever show up.

The way to remove Indigenous people from the town and at the same time remove the social impact of Indigenous drinking was to provide opportunities to drink in communities:

People should be taught in the settlements how to drink; liquor should be sold on the settlements.

Must have alcohol in their own communities – keep them out of town.

Focus on moving Aboriginal people back to their own communities.

Force communities to have pubs.

Respondents who espoused this view, provided little evidence of concern for what would happen when this return to community was achieved, as one respondent commented:

Let them all drink to oblivion.

Indigenous respondents to the phone survey expressed views of frustration at the restrictions and commented that they had nowhere to drink in the community:

Nowhere to drink, now, can't drink at home, in the street or in the car. It's made us hate the police and we have moved further away from the whites.

You can't drink anywhere – if you drink in the pubs then you have to drive home, there is 30 km between the town and the community.

Indigenous respondents commented on the stigma of being the target of the interventions and for also being blamed for the interventions:

There are many bad effects. Aboriginal people are being targeted but not all are drinkers, the town is more racist as people are annoyed at the restrictions.

Towards an understanding of “community” in Alice Springs in relation to alcohol issues

Alcohol Management Plans are interventions that have the community as their focus, rather than specific sub-sections of the community. Integral to the success of community based interventions is an understanding of what “the community” is, including conflicts of interest within the community (Fraser, 2005: 287). The results of the phone survey in Alice Springs have pointed to some important divisions in the Alice Springs community; these main divisions appear to be based on an individual's length of association with Alice Springs and Indigenous status. Those people who have a long association with Alice Springs tended to respond to the Alcohol Management Plans in a negative way, and this remained true even when they reported that they were not personally inconvenienced by the restrictions:

Even though I am not personally affected (I don't drink), I am still not happy that the town is being treated differently. Alcohol is a problem everywhere and Alice Springs should not be targeted so that the government looks like they are addressing the problem.

The responses (of which there are many) that the Alcohol Management Plan is making the town angry and is an embarrassment to local residents appear to be as much about people's sense of community and a shared desire to protect that community from government interventions than they are about alcohol. The responses are filled with statements about rights and freedom to make individual choices which appear to be strongly related to a sense of being disempowered by government actions:

Everyone is annoyed and hates being treated like second class citizens.

Government has no rights to restrict people in such a way.

Three respondents commented that they felt so affronted by the intervention that they were considering leaving Alice Springs. The strength of these responses must be considered within the context of the hard drinking pioneer culture which appears to underpin Alice Springs history (see Chapter 1). The government interventions were seen by this group of people to be attacking some of the very things which were considered to be the building blocks of the town.

Relative newcomers to town did not share the same discourse; they did not express their opposition to the Alcohol Management Plans in terms of an attack on community rights and values. Any opposition from this group (who were in fact largely positive) was voiced in terms of individual inconvenience.

The other major division was between Indigenous and Non-Indigenous residents. A commonly voiced sentiment was that if Indigenous people moved back to their own communities, the drinking problem would no longer occur. Throughout people's responses is a distancing of Indigenous people from the rest of the community (which is aided by the argument that the problem originates from outside of the town). As non-community members, Indigenous people, who are usually referred to as "they", do things to deliberately annoy and harass the non-Indigenous community, such as drinking in public residential areas, and humbugging people at the shops.

Indigenous respondents considered that they were the focus of most of the restrictions, and rather than being simply inconvenient, drinking had become almost impossible. Indigenous respondents also commented that they were being stigmatised by the non-Indigenous community as being the cause of the restrictions and that because of this the racial divide in the town was becoming more and more evident.

Interviews in the town camps

General

It is estimated that there are about 1115 Indigenous people living in town camps around Alice Springs. These people consist of local Arrernte people and others displaced from other language groups and areas in Central Australia. The displacement and movement of people into Alice Springs began to occur when colonisation of the area first commenced and has continued, often influenced by events such as the placement of Stolen Generation children into The Bungalow (and a desire by their relatives to be nearby), “equal wages” in 1965 and the laying-off of pastoral workers forcing many workers and their families into town. In more recent times it is suggested that the desire by Indigenous families to be closer to relatives in hospital and other reasons, continues to influence the short- or long-term residence of people in town camps.

Tangentyere Council was formed in 1974 to provide basic infrastructure and other services to the camps, and today there are 19 town camp leases or Indigenous housing associations serviced.

“Dry” town camps

The Commonwealth Government legislated on 15 September 2007 under the *Northern Territory National Emergency Response Act 2007* (Cth) to:

- Ban liquor in prescribed areas of the Northern Territory.
- Restrict the amount of liquor brought into communities through new requirements for take-away sales across the Territory.

Town camps were amongst the areas prescribed by the Minister for Families, Community Services and Indigenous Affairs under the *Northern Territory National Emergency Response Act 2007* (Cth). In October 2008, the government announced that the liquor bans (and other NTNER measures) would continue in their current form for at least another year.

The law states that if you live in or visit a prescribed area and:

- Consume, possess, supply or transport liquor in a prescribed area, you could face a fine of up to \$1100 for a first offence or up to \$2200 for a second or subsequent offence.
- Are found with 1350 mls or more of pure alcohol in a prescribed area, you could be charged with supplying liquor and may face a fine of up to \$74800 or up to 18 months imprisonment.

You could also be fined \$550 if you damage or remove a sign advising people they are entering a prescribed area.

Interviews

The Menzies research team was keen to include the “voice” of the town camps, and other Indigenous people, in the evaluation. Subsequently, the Tangentyere research hub was enlisted to assist with this process. It was decided that the most valuable input, given time constraints and other factors, was to conduct interviews with a representative sample from 8 of the camps. Thirty town camp residents in all were interviewed. Each interview took, on average, about 1-1½ hours. The length of time involved was due in part to a natural apprehension by people about intrusive-type surveys and also a need to explain reasons for the evaluation. However, the interviews, because of their qualitative nature, provided a wealth of opinion and input into the process.

The questionnaire form associated with the mainstream phone interviews was presented to the researchers as a model for the interviews. The Tangentyere team thought that some aspects of this questionnaire were problematic with room for possible misunderstandings. Hence it was revised and a copy is attached (see Appendix 6). This revised questionnaire was a catalyst for discussion rather than a rigid schedule.

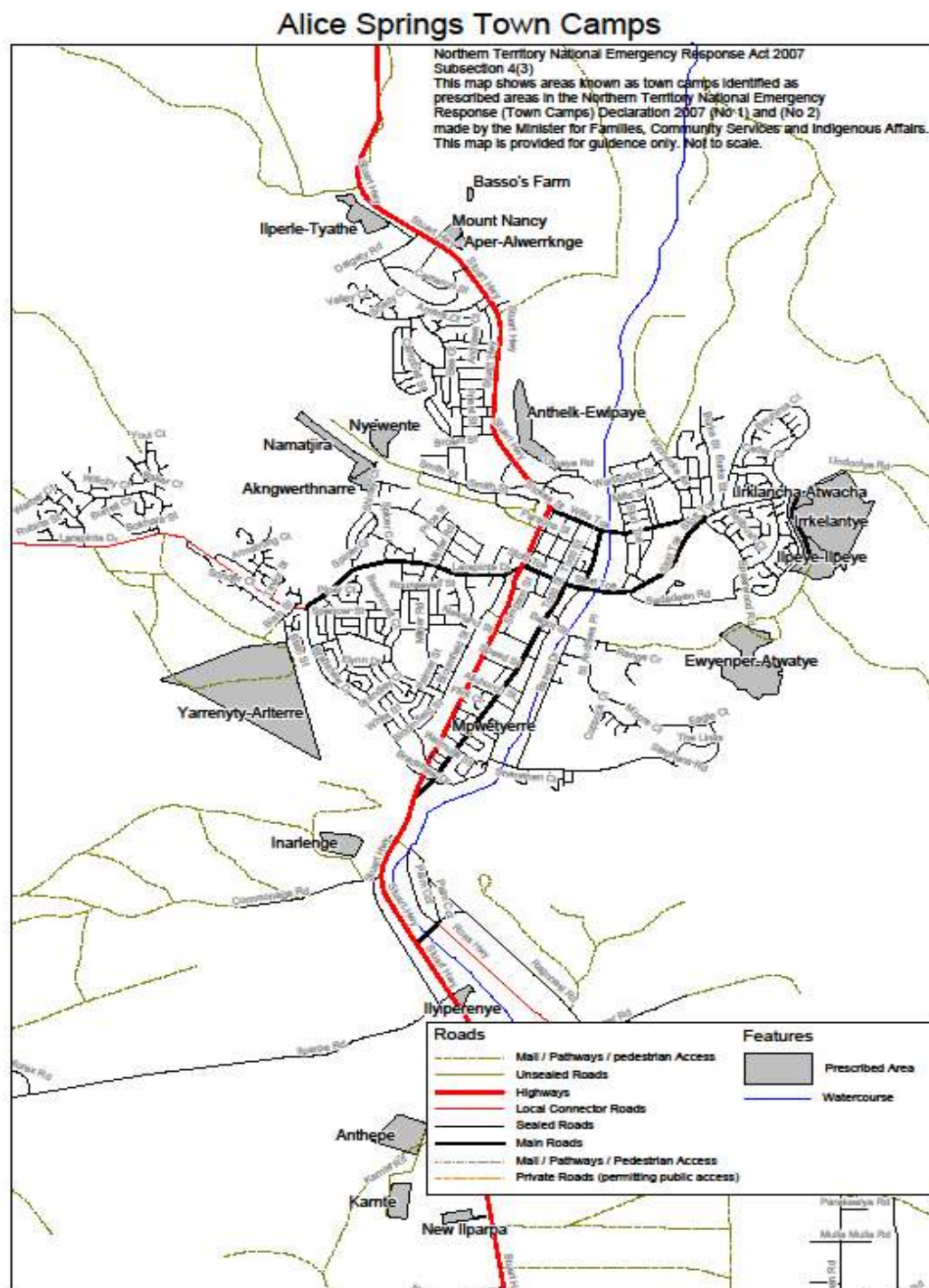


Figure 9.1: Alice Springs Town Camps

Town camp interview results

Most town camp people interviewed have the notion that they are “under siege” at the present time. Such siege mentality appears to be a result of a culmination of events and policies primarily related to the Federal intervention. The perceptions that people currently have of their situation impact substantially on their views about the success or otherwise of the NT Government’s Alcohol Management Plan.

Generally the outcomes of the interviews are as follows:

- There is substantial confusion about initiatives related to the Federal Government’s intervention policy and the NT Government’s Alcohol Management Plan (AMP) for Alice Springs
- Most people are only aware of certain elements of the AMP
- Most people know aspects of the AMP that relate to supply and, specifically, the hours that one can purchase alcohol and the need to have identification
- People are concerned about relations and “outsiders” coming into the town camps to drink. Such drinkers see the town camps as a sort of “refuge” for drinking even though, by law, the camps are “dry areas”
- Everyone said that it is common knowledge that people openly drink alcohol in all town camps in open flouting of the law. This was also observed by the researchers in every camp visited
- Many people we spoke with said that the ID system is satisfactory and that it assists community initiatives in restricting drinking particularly amongst those who are underage
- Most people appear to support the declaration of town camps as “wet” again; but with a proviso that individual house tenants can apply to the NT Licensing Commission for their house to be declared “dry” (a similar system was being implemented prior to the Federal intervention)
- Most people said that when there are initiatives such as the AMP, they need to be communicated properly to Alice Springs residents
- Most people said that there needs to be more individual and community alcohol education
- Most people support better alcohol detoxification and rehabilitation services in Alice Springs; “similar to CAAPU and DASA”
- Most people commented that whilst alcohol is an issue for all people in Alice Springs both Indigenous and non-Indigenous, an emerging concern for everyone is that of youth and the lack of appropriate initiatives and services for young people.

Key issues related to drinking in town camps

There are a number of key issues that emerged during our interviews with the town campers. These issues were raised on numerous occasions. They are:

- **Human rights and the “right” to drink** – several interviewees said that they drink in celebration of their rights (rights achieved in 1964 in the NT). One person at Mt Nancy said “it’s a basic human right to drink. If I can drink in my white friend’s house, then why can’t he drink in mine (on the town camp)?” People talk about having the “right to drink” as a right of citizenship. Brady (1991: 180; 1998: 10-11) argues that being able to drink alcohol has taken on a symbolic meaning for some Indigenous people. Such “celebration” is even more pertinent at a time when Indigenous people view their rights generally as being challenged.
- **Problem drinkers** – there was considerable discussion about who the “problem drinkers” in Alice Springs are. Town campers do not view themselves as being the major problem. The “problem”, as they define it, is the legislation, and the resulting effects of restrictions. Because people from communities out of town are constrained in their ability to drink in open areas around Alice Springs, they tend to come to the town camps with their alcohol. They can drink it here in a relatively “safe” environment. “Safe” in terms of being less visible to the Police and “safe” in that the camp provides an area that comes under the auspices of local leadership and family responsibilities. There is less chance drinking in such an environment that they can become the victims of violence by “outsiders”. However, for the permanent town campers, this phenomenon brings issues related to alcohol and additional responsibility in overseeing issues that may arise. One person said that “It’s a burden on me and my family ... like visitors; they come to the town camp to drink. Cops come round at night, with the spotlight, drinkers scatter like rabbits. Hide grog in washing machine. When the cops are gone, people go back to drinking”.
- **Youth** – Most people voiced their concerns about issues surrounding young people, both Indigenous and non-Indigenous. There is concern about their future and about their growing numbers. One person said “The kids that hang round the Mall at night. Urban Aboriginal kids, white kids, but most aren’t town camp kids. A lot of Indigenous kids from out bush walk the street. We call it the “moth syndrome” ... they come into the big city to see the lights. There’s not much for them in the communities”. One interviewee (Wailbri camp), referring to young people with families said, “It’s only the young people with the problems ... no jobs can’t support their family ... they feel shame ... turn to alcohol”. Another spoke about the emerging issues with

youth in suburban Alice Springs, “Look at Lyndavale (Drive) it’s turning into the Bronx ... all different tribes mixed up, creating problems”.

- **Treatment** – People in all of the camps visited are concerned about the lack of facilities for alcohol treatment and rehabilitation. One person said “Go hospital, doctors says don’t drink no more ... they go home (to their community)”. Another said “when it’s time to give up, it’s either cold turkey ... or Ward 1”. Many spoke about the need for better rehabilitation and treatment facilities for drinkers. Many were satisfied with the services provided through DASA and CAAPU, but said that the organisations were not big enough to meet the need. One person spoke about the need for “a half-way house, for Indigenous and non-Indigenous people. Somewhere that is like a retreat, where people can be repatriated, and where there is an awareness of culture”.
- **“Big” Issues** – There appears to be many people thinking beyond the immediate issue of alcohol. One person summed it up as “Aboriginal people have economic disability, powerlessness, and social segregation and don’t have moments to reflect. We need to look at the underlying issues in people’s lives”. Hence the reference to a “half-way house” arrangement where people are not just treated for alcohol dependency, but also are able to deal with any psychological issue that confronts them.

A culture of resistance?

The evaluation team’s interviews and observations allude to a “culture of resistance” that has emerged within the Indigenous quarter of the Alice Springs population; particularly amongst the young.⁵ In an effort to express anger and frustration at a perceived oppression by a dominant society, they break into premises, steal alcohol and vandalise property.

Whilst no doubt a key motivation is to acquire alcohol, money or other property, there also appears a strong indication that they also see their actions as statements against an unjust political and social situation. Resistance against lack of rights, jobs, opportunity coupled with low socio-economic status, and a perception that the majority of Alice Springs residents see them, and their case, as hopeless, further ingrains their frustration and predicament. Hence a resistance, demonstrated in various forms, continues and will probably further develop unless the situation is addressed.

⁵ Such drinking styles are not restricted to Indigenous youth. Non-Indigenous youth often drink in similar places, in drinking places on the outskirts of Alice Springs, as they all attempt to elude the law.

Such resistance is played out in various forms and is demonstrated not just in the stealing and destruction of property. At all of the town camps visited, young people in particular, openly drink alcohol and appear to deliberately flout the law. They hide it when the police arrive and as soon as they leave, the beer cans and other drinks reappear. Such open resistance may also have been for our benefit; in other words “take this message back to the government. We will drink regardless of what laws are imposed!”

We were told many stories about the “cat and mouse” activities of drinkers and the police. These included descriptions about how town campers have had their alcohol tipped out when leaving a bottle shop because on their identification card their address is a town camp. This occurs, they say, even when they do not intend to drink it in a town camp but in a relation’s residence in town. There were also stories of how groups leave the bottle shop and make haste to a refuge where the police cannot find them or the alcohol. Stories of how the police will “hide” down a lane waiting for people to make a purchase and then apprehend the person and confiscate the alcohol. Stories, from Alice Springs residents, about how they observe drinkers hide their cans in council rubbish bins, and retrieve them when the police move on. Stories of how people, including women, walk to rock shelters and hide so they can drink their cans without being disturbed.

All parties no doubt believe they are “in the right”. The drinkers, imbued with a need to resist the law and state their “right” to drink and the police who see it as their duty to enthusiastically enforce the law. Nevertheless it creates a situation of tenseness, for some a feeling of excitement, a “dangerous” drinking regime, and for others no doubt a sense of futility.

Community responses to the Alcohol Management Plan

A high level of resistance to alcohol restrictions which are imposed at the community level was a common theme throughout many of the key stakeholder interviews. Notable exceptions to this way of thinking were the police, who backed up their support of the restrictions with evidence of improvements in such areas as levels of assault. The Indigenous health organisations were also strongly in favour of the restrictions, again backing their arguments with statistical evidence demonstrating the improvements in areas such as assaults and homicides. This group advocated for stronger regulations, including the introduction of an alcohol free day, preferably aligned to pay days.

A pervasive theme, however, was that alcohol restrictions were inconveniencing the majority in order to deal with the problematic drinking of the minority. This minority group of drinkers was always described as being Indigenous. There was no mention of problematic drinking among the non-Indigenous population of Alice Springs. It is

important to recognise that many of the people who espoused these views were spokespeople for the community, including members of the Alice Springs Town Council and so could be expected to have an influence on the way that the broader population of Alice Springs considered the issue.

The health effects of problematic drinking were very rarely mentioned in interviews (with the exception of the Aboriginal Health Services and the Alice Springs Hospital). Instead the focus was the problems and threats caused by problem drinkers to the Alice Springs community, in terms of disorderly behaviour, threats to individuals and break-ins to commercial properties. High levels of interpersonal assaults within the drinking population were discussed as was the perception that children of drinkers were neglected and “left to roam the streets at night”. Limited interest in the health and wellbeing of the drinkers may relate to the perception that this group of people are beyond help and that strategies should be enforced primarily to prevent them causing damage in terms of persons and property to the larger community.

Solutions to the problem of this small group of problematic drinkers included strategies that focused on dealing with the individual, from education, through to mandatory rehabilitation and imprisonment. Another theme was the need for governments to address the underlying social determinants of alcohol abuse, including addressing low attendance at school (and improving access to school). Although it is salutary that people are thinking about alcohol abuse and its precedents in a broad sense, they are again advocating measures that take the onus of responsibility away from the community.

The key stakeholder group of interviews predominately espouse a perception of alcohol misuse that conforms to a disease concept of alcohol use and alcohol related problems. As Ashley and Rankin explain:

The Alcoholism Movement has promoted the concept that alcoholism is a disease, i.e. a biological condition, for which those who are afflicted are not responsible and that leads to an inability to control the use of alcohol. Corollaries of this view are that most problems of alcohol use are caused by those who suffer from alcoholism and that the vast majority of the community can drink with impunity (1988: 235).

The authors acknowledge that this view of alcohol use is widely accepted and “not surprisingly, it is also the concept of alcohol-related problems promoted by the alcohol beverage industry” (Ashley and Rankin, 1988: 236).

This viewpoint is in opposition to the underlying philosophy of Alcohol Management Plans, which are informed by a view that problematic alcohol use should be considered within the general overall consumptions in communities (Ashley and Rankin, 1988: 236).

Current public health strategies concerned with the prevention of alcohol related problems recognize that (a) alcohol is a risk factor in illness, (b) the magnitude of alcohol-related health problems in a populations has a direct relationship to per capita consumption, and (c) preventative strategies must include among their key objective a reduction in the per capita consumption of alcohol (Ashley and Rankin, 1988: 237).

In their review of strategies to reduce alcohol consumption described in the Kakadu/West Arnhem Alcohol Management Plan Project, report, d'Abbs et al. describe in detail the social conditions which are necessary for the implementation and subsequent sustainability of an Alcohol Management Plan. They argue that community engagement is the key to success:

An AMP, whatever its constituent elements, is an attempt to bring about change, both in the local environment, and in individuals" drinking practices. If the community members are not engaged in the development and implementation of the AMP, the plan is unlikely to bring about sustainable change (d'Abbs, Martin and Chenhall, 2008: 8).

It is clear from the majority of the key stakeholder interviews that interviewees are not engaged in consideration of community responses to the issue of problematic drinking, and nor do they see the wider community in having a role in reducing problematic drinking levels. The perception espoused by people in key positions that drinking is the problem of the minority, is a serious detriment to the long term success of any community focused interventions.

There was some discussion about lack of communication and the sense that the restrictions had been imposed on the community without extensive consultation. This perception was heightened by the Government Intervention (and the concerns about lack of consultation) being implemented in the same period. This perception is of concern, as d'Abbs et al. argue that success or failure of an AMP is related to the level of consultation that occurred:

The much less impressive outcomes of Alcohol Management plans in Cape York communities ... has been attributed in evaluations to a perception on the part of the residents in the community concerned that, notwithstanding the QLD Government's rhetoric about "community engagement" and "partnership", the original AMP-based restrictions on supply were imposed by the Government with little regard to community wishes or local conditions, and in isolation from complementary measures to reduce demand (2008: 121).

10. Community readiness for the Alcohol Management Plans in Alice Springs

The range of strategies that are available to deal with alcohol on a community basis have been discussed in Chapter 4. The strategies that have been adopted in Alice Springs, which focus on supply reduction and restrictions on public drinking have been shown to be effective (Edwards et al. 1997). It is clear, however, that lack of community support for such restrictions has the potential to undermine their efficacy as d'Abbs et al. point out:

Without sufficient popular support, enforcement of any restriction is handicapped, and means to circumvent the restrictions are likely to develop (Edwards et al. 1997: 145).

Current community attitudes

Community attitudes towards the measures that were implemented as part of the AMP can be assessed through a range of sources. The survey carried out by the Responsible Drinkers Lobby, revealed widespread opposition to the measures. This opposition was voiced in terms of the majority of “responsible, moderate drinkers, being inconvenienced by the minority of problematic drinkers”:

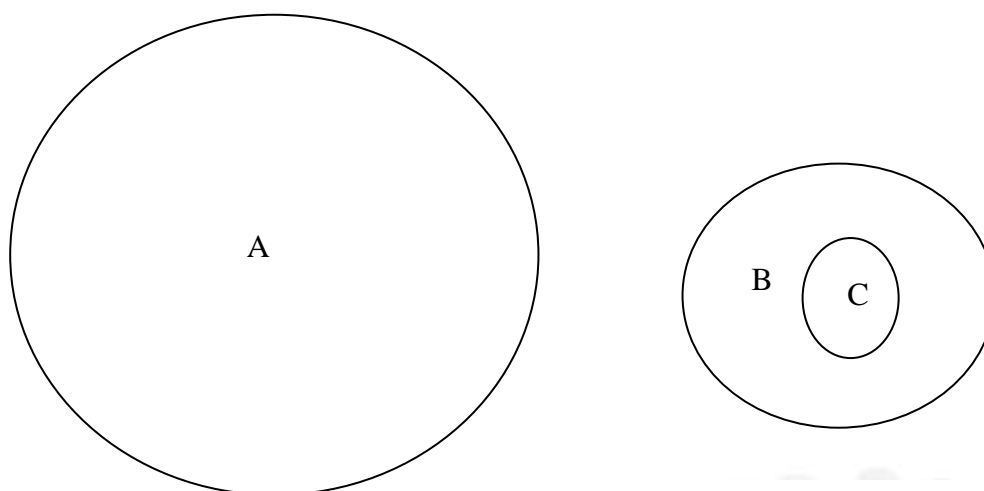
There are approximately to my knowledge, 200 problem drinkers in this town and roughly 27000 people who are inconvenienced by the failing restrictions (respondent to the Responsible Drinkers Lobby survey, 2008).

I am really sick of the majority being penalised for the minority. It is about time we stood up in front of all the discrimination calls and said enough is enough. How about reverse discrimination? Are we not being discriminated against? (respondent to the Responsible Drinkers Lobby survey, 2008)

The findings of this survey (which are discussed in a previous section) can be dismissed as the result of the way that the survey was conducted. It was not a random survey, instead interested people were asked to respond. It could therefore be assumed that the population of Alice Springs who were most opposed to the restrictions took the time to respond to the survey. Despite the limitations of the methodology, the survey reveals a group of vocal residents, who are actively engaged in denying community responsibility for alcohol problems in Alice Springs and who are strongly opposed to measures which focus on the community as a whole.

The phone survey conducted as part of this evaluation was entirely random, and purposely conducted at different times of the day and the week (including weekends) to ensure a wide distribution of respondents. This survey as, with the survey previously mentioned, revealed a high level of community concern about alcohol misuse and its results, particularly violence and criminal activities such as breaking into licensed premises. The survey, however, also revealed widespread opposition to the supply restrictions which are part of the Alcohol Management Plans, and again the sentiment that the majority of people were being impacted upon due to the actions of the minority of drinkers. The language used to describe this impact ranged from “inconvenience” to “gross infringement of human rights”.

In the typology of many of the non-Indigenous respondents in the survey there were three types of drinker in Alice Springs:



A: the majority of responsible drinkers

B: heavy drinkers

C: and within the category of heavy drinkers, a minority of “hard core” recidivist drinkers, who were largely responsible for the alcohol- related problems in the community

The defining characteristics of the groups are (as based on the comments of the respondents of the survey):

- A: Non-Indigenous, employed, housed, see their moderate drinking habits as a reward for their industry.
- B: Indigenous, unemployed, involved in a cycle of hopelessness. May be visiting Alice Springs from surrounding communities. Drinks in public. May be amenable to change through rehabilitation.
- C: Indigenous, unemployed, possibly homeless, hard core drinkers, with whom alcohol addiction is a disease. Possibly not amenable to rehabilitation, but should be subject to mandatory rehabilitation and treatment.

As a result of this classification, a strong view in the community is that Indigenous problem drinkers should be the target of interventions in the community, not the community as a whole.

In the phone survey conducted by the evaluation team, there were also a body of comments from Indigenous people, who also said they were against the restrictions, because they felt that increasingly they were being blamed both for the alcohol problems in the community and the implementation of the restrictions.

These results do not point to a community which is highly amenable to community based solutions to alcohol problems. Community insistence on interventions that target the minority of problem drinkers and leave the so called “moderate drinkers” alone, are in opposition to what is known about the creation of problem drinkers in a community. As Edwards points out, problematic drinking is strongly related to the culture of drinking in the entire community and that “heavy drinking is closely related to drinking in general” (Edwards et al. 1997: 92):

When considered as a whole, the data suggest that the drinkers’ risk of becoming a heavy drinker depends on the wetness of the culture to which the person belongs. Environmental factors thus play an important role in the production of drinking problems. It is simply not true that alcoholics are predetermined to heavy drinking more or less independently of their cultural environment (Edwards et al. 1997: 90-91).

As pointed out earlier, Alice Springs has a strong drinking culture, and Alice Springs residents consume alcohol at rates which are far higher than the Australian norms. The vehemence of many of the responses to the survey, and the suggestion which appeared many times that the restrictions were an infringement of human rights, point to a culture where alcohol plays an extremely important part for many of the respondents. It is, using Edwards’ et al. words “a wet culture” and as such interventions to address alcohol misuse must have the community as a whole as their focus.

Support for further restrictions including an alcohol free day

Thirteen respondents to the phone survey suggested further and stronger restrictions and only one person suggested an alcohol free day linked to Centrelink payment days. Overall there was very limited community or key stakeholder support for an alcohol free day. Notable exceptions to this were the views of Congress and a minority of staff working in some alcohol and drug organisations. Some potential difficulties were raised about the practicalities of linking alcohol free days to pension days due to the fact that Centrelink payments are no longer paid on a set day, but instead are paid on a day allocated by the individual.

A more serious barrier to the implementation of any further or stronger restrictions is the current community climate towards Alcohol Management Plans (or at least the restrictions associated with the plans) in Alice Springs. This climate which is characterised by a high level of community resistance and strong racial division will have to be addressed before any changes are made.

Engaging the community in processes of change

Successful and sustained implementation of an Alcohol Management Plan, therefore appears to require efforts to change the prevailing attitudes of the Alice Springs community, and reconsider the issue of problematic drinking as something which is caused and effects the community as a whole and cannot be isolated as a problem of the minority.

Education, media campaigns and other awareness raising efforts are often dismissed as not being effective strategies in controlling problematic alcohol use, as they have been found to have little impact on individual behaviours:

While provision of information and persuasion is perennially attractive as an intervention to reduce alcohol-related harm, particularly in relation to younger people, theory and evidence would suggest that this is unlikely to achieve sustained behavioural change, particularly in an environment in which many competing messages are received in the form of marketing material and social norms supporting drinking and in which alcohol is readily available (WHO 2007: 49).

Sustained behaviour change is, however, influenced by the prevailing community attitude towards alcohol, and the accepted social norms regarding alcohol which prevail. Education and media strategies have been found to be successful in altering the social environment. Edwards et al. argue that the highly visible and symbolic

strategies such as restrictions on alcohol advertising and mass media educational programs:

may have their most significant impact on the climate surrounding alcohol use rather than a discrete effect on the individual's behaviour. These purposive efforts, by inserting concerns about alcohol related problems into the public discourse on alcohol, signal societal concern about alcohol-related problems. This is then part of the social and political context in which decisions are taken about the development and implementations of public policies, many of which have larger direct influences on drinking behaviour (Edwards et al. 2007: 180).

11. Liquor industry responses to the Alcohol Management Plan

Five licensees were interviewed as a subsection of the key stakeholder interviews.⁶ These included the representatives from the major national retailers, the Australian Hoteliers Association and local licensees in Alice Springs. The responses from this group of people have been analysed separately as they can be assumed to have a strong interest in alcohol sales. Licensed premises, and particularly some of the licensed clubs in Alice Springs, have been positioned as “victims” of the alcohol restrictions (particularly by the local media), due to increasing levels of break-ins.

Consultation about the proposed changes with the licensees

A major concern of the licensees was their perception that there had not been adequate consultation about the restrictions that were put in place. They commented that they had not received feedback about what strategies were working, that the Alcohol Management Plan had not been clearly defined to them, and there was a lack of a cohesive plan that “was driven by the whole community”. Others commented that communication about the changes to the community and particularly visitors to Alice Springs, was not effective:

Communication is a big issue. The NT liquor restrictions were not communicated properly, particularly with tourists, tourists don't know what is going on.

ID system

The licensees did not voice strong opposition to the ID system, although most considered that there were still a range of issues that needed to be worked through.

The ID system needs to be upgraded; we have told the Licensing Commission but have had no response. There is the need to upgrade the system so that it reads the cards better. It sometimes struggles to come up with the proper address. (licensee Alice Springs).

⁶ As with the community interviews these interviews were in depth qualitative interviews, which aimed to gather rich contextual data exploring the issues and experiences of licensees. They were not intended to be a survey of licensees.

Although licensees commented that there were still people who had learnt how to “work the system” through swapping ID cards and buying alcohol for others, there had been some positive outcomes:

Keep the ID system, it is OK. It stops the under 18s from buying (licensee Alice Springs).

Licensees commented that the implementation of the ID system only required minimal staff training and that a high level of support was received from the Department of Justice.

Takeaway hours

Many of the licensees that we consulted desired a return to longer trading hours for takeaway alcohol to be sold. They presented their arguments in favour of longer trading times in terms of reducing binge drinking and spreading drinking across the day:

Takeaway should be 10am to 9pm. At the moment people binge drink from 2pm to 9pm. The hours on Saturdays are more realistic and give people more time to drink their grog. We have less problems on Saturdays.

Takeaway hours should be from 10am to 10pm. Why can't fortified wine be sold from one in the afternoon? It is only one bottle per person anyway.

Responsible serving of alcohol training

The national retailers commented that they had their own staff induction system which covered “ordering, operational issues and policy procedures”. The licensees discussed a range of issues confronting staff who were serving alcohol and the fact that the stresses associated with this type of work contributed to high staff turnover:

The challenge is community frustration. There are now more complaints about racism. This is taxing on workers.

Only one licensee commented that responsible serving of alcohol training courses may be available. This person commented that the available courses did not really address staff needs:

The training course run by CDU goes for about five hours. It's pretty boring. Some stuff, for example Government Regulations are not really relevant. It does tell you about your responsibilities.

Charles Darwin University do not currently run any Responsible Service of Alcohol Training. No mention was made about the responsible service of alcohol courses run by DASA. A member of the NT Licensing Commission recommended changes to the way that responsible service of alcohol courses are conducted. Focusing on the highly transient nature of this work force and the possibility that the individuals may be travellers who are new to the Northern Territory and possibly Australia, he suggested the incorporation of cultural awareness training in the Responsible Service of Alcohol Training Package. In this way, individuals may be better informed and equipped to deal with the issues surrounding service of alcohol to Indigenous people and obtain skills which may assist them as they look for similar work as they travel throughout the Northern Territory.

Variation in sales

Licensees described a number of factors which influenced the sale and consumption of alcohol in Alice Springs. Alcohol sales dropped in winter and rose in the summer months and during holidays and events. Interestingly, these events are those that have most relevance to the non-Indigenous population of Alice Springs, and contribute to the argument that excessive consumption of alcohol is as much a non-Indigenous problem in the town as it is an Indigenous problem:

When the winter cold weather comes in Alice, liquor sales drop off. Sales go up at Easter, Christmas, during the Finke Desert Race and Fathers Day. The Rudd bonuses made sales got through the roof.

However, other licensees commented that the Rudd bonuses had not impacted on consumption.

Thursday, Friday and Saturday were considered to be the busiest days of the week, requiring extra staff:

We need security at our takeaway outlets on Thursday, Friday and Saturday.

Break-ins

A licensee from one club which had experienced a high level of break-ins commented that it was difficult to link the rise in crime to the Alcohol Management Plans and that

other initiatives such as welfare quarantining may have had an effect. Nevertheless, the high levels of crime were a serious concern to the licensees:

The cleaners come in to the club at 4am, they fear for their lives in case they confront intruders.

There was a perception that a great deal of the crime was caused by children and youth, who were possibly being forced to break-in for their parents. There was also a perception that often the break-ins were as much about damage to property and vandalism as they were to the theft of alcohol.

Overall perceptions of the Alcohol Management Plans

The licensees, in general, were supportive of initiatives to curb alcohol misuse, including those initiatives which had the potential to impact upon their trade, such as the implementation of the ID system. Some people we interviewed represented the alcohol industry's concern on the Alcohol Reference Panel and so were involved in a continuing debate about the restrictions that had been implemented. Some licensees had suggestions about how to improve the AMP, which concerned clarity surrounding objectives and evidence of involvement in planning by all key stakeholders:

The AMP is too loose, it needs to have proper objectives.

We need a multi-faceted plan. The plan needs to be endorsed by the stakeholders, including the liquor industry and signed off by all the players.

Licensees attitudes toward AMP Initiatives

Licensees appeared keen to assist initiatives that might alleviate problem drinking in Alice Springs. They generally were open to government initiatives that will improve the overall situation. However, they are unanimous in their opinion that they need to be involved in any consultation process for the initiatives to be effective. The licensees are also very strong in their opinion that the liquor industry needs to be represented at the table on any advisory body that is established.

Other initiatives to curb alcohol misuse

Although the licensees were not opposed to the restrictions, they did comment that restrictions alone were not sufficient to deal with alcohol related problems in Alice Springs. They commented on the need for demand reduction strategies as well as examining and addressing the broad social determinants of alcohol misuse, including education and housing:

They are too focused on control. We have gone as far as we can. We need to look at reducing demand through education, intervention and rehabilitation. The industry wants to help, it is about sustainability.

Instead of looking at restrictions, governments would be better off looking at things like unemployment, education and housing.

12. Developing community involvement in the Alcohol Management Plan

The results of the community surveys, key stakeholder interviews and town camp interviews do not point to a community which is entirely amenable to community based solutions. Key among the results is a perception that what is needed are interventions which target the minority of problem drinkers and leave the so-called “moderate drinkers” alone. This perception is promulgated from the highest levels in the community; including the Town Council and from within the Responsible Drinkers Lobby and are perpetuated through the local and national media. Interventions which target high risk drinkers are important in any alcohol strategy, which ideally should include both structural and individual approaches (Staffrom et al. 2006: 814), but they are not the entirety of a strategy.

Another important finding from the community responses was a general lack of understanding about the breadth of the Alcohol Management Plan. Generally the Alcohol Management Plan was considered to be comprised of a set of restrictions limiting the purchase and drinking of alcohol. Wider understanding of the demand reduction and harm reduction components of the Plan may have influenced community acceptance, as people often advocated these kinds of measures in their responses. Furthermore, there is an obvious need for the community to provide input into these aspects of the Plan, to enhance their sense of ownership and to reinforce the message that Alcohol Management Plans are tailored to the needs of specific communities.

Under the current conditions, it is possible that existing interventions will be compromised and that people will develop ways of circumventing the restrictions (Edwards et al. 1997: 145). Furthermore, implementation of any further restrictions (such as an alcohol free day) will meet considerable resistance. Of even more concern is the deep racial division that the implementation of alcohol restrictions appears to have engendered. If these perceptions are not addressed and countered they may lead to even more entrenched racial divisions in the community.

One factor which could be utilised for positive change is the very deep sense of pride that many people have in Alice Springs which is coupled to a resistance to government intervention in their lives. If the Alcohol Management Plans can be re-framed to be community driven responses which are based on extensive consultation, then it is possible that the community might be prepared to own the Alcohol Management Plans, rather than resist them.

There is an obvious need to address the community climate regarding perceptions of problematic drinking and issues of responsibility and community readiness to change.

The re-focusing of community attitudes in Alice Springs needs to address the following issues supported by convincing evidence:

- Drinking in Alice Springs affects the health and wellbeing of the entire community, not just the minority
- Moderate drinkers and the culture of drinking within Alice Springs have a strong effect on drinking culture as a whole; and although Indigenous drinking and its effects is often highly visible, Indigenous people are not the only group drinking in a way that is dangerous to their health and to the wellbeing of their family and community
- Alcohol Management Plans have the community as their focus, and are more than a set of restrictions. Structures will be put in place whereby the community can be involved in the further evolution of the Alcohol Management Plans, and community discussion and input is strongly encouraged.

Strategies to change community attitudes

Efforts to change the prevailing social attitude towards alcohol and its use are not usually the focus of evaluations, which have focused on measurable impacts on communities and individuals, rather than changes in attitude. An exception is a project initiated in New Zealand by Casswell et al. (1989). This looked at evaluating the impact of a mass media campaign and various local community initiatives to raise awareness of alcohol problems in the community. The results from the qualitative interviews produced results that are important to consider in the context of the Alice Springs situation:

In the initial interviews, carried out 12 months after the start of the project, the predominant perception of alcohol-related problems was as a private individual concern, rather than a society or community concern. The emphasis was largely on the alcoholic and the effects of alcoholism on the family ... The drinking behaviour of adults (unlike that of young people) was seen as a matter of responsibility or failure and the reasons for excessive drinking proffered were usually concerned with personal traits or genetic predispositions. Controls on alcohol were rejected by those holding this viewpoint and this rejection was justified by an emphasis on freedom of choice and a belief that controls would not effect those who abuse alcohol (Casswell et al. 1989: 518).

When the interviews were revisited 18 months later, the researchers found an important change in the way that alcohol problems were discussed:

More respondents discussed alcohol abuse as a community problem, affecting the public purse, public health and community well-being rather than simply seeing it as a problem affecting the individual drinker and his or her family. (Casswell et al. 1989: 519)

A similar community action approach was utilised in Sweden from 1999 to 2003, to address harmful drinking behaviours among adolescents (Srafstrom, Otestergen, Larsson, Lingren and Lundburg, 2006). The local community was responsible for putting interventions into actions which addressed:

- Alcohol and drug preventions strategies among children and adolescents
- Decreasing heavy episodic drinking
- Delaying the onset age of alcohol consumption
- Achieving changes in attitude towards alcohol and drinking behaviour in the adult population. (Strafstrom et al. 2006: 814)

A coordinator and steering group played a key role in managing and coordinating the interventions. Five action groups were implemented consisting of key members of the community, and seven different intervention projects were implemented. These focused on developing an alcohol policy, a school policy towards alcohol, cross-sectorial initiatives between police and city administration, comprehensive curriculum for secondary students, educational resources for parents, and conducting a survey of adolescent alcohol and drug use in the community (Stafstrom et al. 2006: 815). Ongoing evaluation advice was provided by university staff.

The evaluation carried out three years later found that there had been a reduction in harmful patterns of drinking and that there was a much greater general awareness in both the adolescent and adult populations about the harmful effects of alcohol misuse.

Structures to facilitate community involvement in Alcohol Management Plans

Figure: 12.1 Essential elements of community driven initiatives

- The employment of a community facilitator to coordinate the project and interventions
- The establishment of a working party/parties composed of community members to develop and implement interventions
- The provision of sustainable government funding for a period of at least 5 years
- The provision of support and evaluation assistance from academics.

Both the studies described previously utilised a community development approach with a community development worker responsible for coordinating the approach, bringing community interest groups together and maintaining the impetus of the projects by facilitating community events and ensuring a regular supply of stories to the local media. In both studies, the community development worker was also supported by linkages with academic research, which assisted with providing the necessary information to demonstrate progress and change in community attitudes.

The authors comment that the employment of a single worker (in a city of 40000 people) was a cost effective and “feasible approach to primary prevention of alcohol problems” (Casswell et al. 1989: 519).

Alice Springs, as we have previously described, has a large group of organisations involved in alcohol and other drug services as well as those providing services to the Indigenous population. There are also some important and vocal community interest groups which have a range of different positions in the alcohol debate. There is an existing Alcohol Reference Group, whose members have shown a great level of dedication to addressing the problems associated with alcohol misuse in Alice Springs. Finally, although there is a level of resistance in the wider community to the alcohol restrictions, there is evidence that there is a high level of concern about alcohol problems and that a wide range of ideas have been suggested to address the problem.

A community development officer, or ideally an Indigenous and a non-Indigenous officer, would work towards providing linkages and communication between the different groups in Alice Springs and in collaboration engage with the wider community to communicate the aims of the Alcohol Management Plan and to encourage and support community initiatives into the Plans.

The results, from the range of methods used to engage with the community members as part of this evaluation, point to a community where there are serious divisions, both between old and new residents and between Indigenous and non-Indigenous residents. It is essential that any community development activity designed to build community participation from the ground up, is aware of these divisions and that participation of marginalised groups (particularly the Indigenous community) is not further compromised. The community development worker must have extensive knowledge of the dynamics of the community, including those people who are driving change, who are actively resisting change and those who are so marginalised that their opinion is not heard.

Furthermore developing social capital towards a shared idea of change (as challenging as this may be) is not sufficient for sustainable outcomes (Dale and Newson, 2008). Communities must not be expected to enact change in isolation from government

support. Initiatives which could be seen as having high internal or bonding social capital may still flounder due to lack of linking or bridging social capital (for an example, see Senior and Chenhall, 2006). Community based projects must have government support and as Mowbray (2005: 263) argues the type of support that is necessary might require a fundamental change in the way governments usually operate. Some of his advice to governments regarding support of community development projects which is pertinent for the implementation of the Alcohol Management Plans includes:

The need for governments to be prepared to adequately support community based projects so they can achieve long-term sustainability and “move beyond the dubious use of pilot, demonstration, or trial projects”. He also argues that governments must be prepared to “relinquish close control in favor of arm’s length mechanisms for ensuring that community programmes remain equitable and totally transparent”.

Demonstrating Change

A key feature of successful community focused interventions, such as the proposed changes to the Alcohol Management Plans in Alice Springs, is the means to effectively demonstrate and communicate evidence of change and improvement. Effective and ongoing evaluation of projects provides a range of positive outcomes. First, demonstrated success ensures that the community remains motivated and supportive of the initiative; second, funding bodies are reassured that their investment is causing positive change and; third, the outcomes provide incentives for other communities to become involved in such projects. Instead of being a cause for community embarrassment at being singled out (a response which was frequent in the phone survey) the Alcohol Management Plans become a source of community pride as a demonstration on how a community worked together to deal with a problem which is common both nationally and internationally.

To address this issue the evaluation team has worked to develop recommendations for a minimum data set and an evaluation framework, whereby the community development officer can monitor and assess the outcomes of their intervention. The evidence from the literature suggests that while self monitoring and evaluation are essential, communities will still require some outside support to maintain and conduct their evaluation activities (Casswell et al. 1989).

13. Developing evaluation framework and a minimum data set

We have argued in this evaluation report that we have been primarily confined to providing a process evaluation of the Alice Springs Alcohol Management Plan. This is because of the following reasons:

- The short time frame for implementation of various aspects of the plan (for example the ID system in place only since June 2008)
- The complexity of the evaluation environment, where the effects of a wide range of interventions (such as the Commonwealth intervention) have to be explored
- The lack of implementation of some aspects of the plan, including those addressing harm minimisation and demand reduction
- The complex community climate, where a high level of resistance to the introduction of the AMPs is evident
- The difficulties of accessing relevant data and lack of agreement about the quality and relevance of various data sets.

It is important however, that a framework is decided upon whereby a monitoring and outcomes evaluation of the Alice Springs Alcohol Management Plan can be established. Under the community development framework described in the previous section, it would be most appropriate if the Alcohol Management Plans could be evaluated from within the Alice Springs Community, by the proposed Alcohol Working Group. Under this model, Menzies School of Health Research could provide overarching advice to local evaluators. This type of model has been successfully used in other complex projects, including the evaluation of the National Palliative Care Trials which were conducted by the Centre for Health Service Development (University of Wollongong).

Under this model Eagar et al. (2004) provided local evaluators with an overview of evaluation methods, checklists to be used in assessing the evaluability of projects and to assist with developing a project plan and a comprehensive collection of possible tools to measure outcomes and impacts of the projects (Eagar et al. 2003). In this evaluation framework, the tools were divided into the categories of: 1. Impact and outcomes for the consumer; 2. Impact and outcomes for providers (professional and volunteers and; 3. Impacts on the system (structure and processes, networks and relationships) (Eagar et al. 2004: 17).

For the evaluation of the alcohol management plans, the possible levels to be addressed in the evaluation are:

1. Impacts on the individual. This would include the impact on individuals, overall perception of the Alcohol Management Plans, and perceptions of communication regarding the Alcohol Management Plans
2. Impacts and outcomes for the community. A key assessment at this level would be the measurement of community readiness for change. A range of such tools have been created and a tool kit is available through the Tri-ethnic Centre for prevention research at Colorado State University
3. Impacts on the system. This could include a self assessment conducted by various agencies involved in the roll out of the Alcohol Management Plans of their own sustainability, generalisability, capacity building and dissemination of results (see Appendix 3). These goals are often those that funding bodies want to see addressed in evaluation, but they also provide a means whereby projects can assess their own progress against various goals and revise their strategies accordingly. The extent of networking and coordination of services is also important to measure – an example of a tool to measure this is the System Level impacts and outcomes of project tool (see Appendix 4) developed by the Centre for Health Service Evaluation (2003).

Table 13.1: Possible tools which could be used to assess impacts and outcomes at each level

Level	Tools	Reference
Individuals	Community survey interview schedule (modified to focus on AMP, rather than restrictions)	Menzies School of Health Research
Community	Community Readiness assessment	Tri-ethnic center for prevention research Colorado state University www.triethniccenter.colostate.edu
System	System level impacts and outcomes of project Self assessment of sustainability, generalisability and Capacity building and dissemination activities.	Modified from CHSD (2003) Modified from Hawe et al. (2000).

Minimum data set for monitoring and assessing the impact of Alcohol Management Plans

It is essential that the Alcohol Working Group have access to timely and relevant data to monitor and assess the impact of the Alcohol Management Plans. The data must be presented in such a way that it is readily understood and easily communicated to a range of stakeholders including the media. Access to this data set will require the cooperation of a range of government agencies including Department of Justice, Police and Health. It is important that this data set is discussed and agreed upon by the key agencies. In this way, the current problem of the data itself being the focus of debate and contestation, rather than the story that the data is providing will be avoided. In their submission to this evaluation the People's Alcohol Action Coalition discussed the barriers that a community group had with obtaining relevant data to support their efforts, commenting that:

There is great difficulty in gathering timely, accurate and relevant and accessible data ... with no single point for accessing all of the relevant alcohol related statistics (PAAC written submission to Evaluation).

The data collected for monitoring and evaluation should in general be the minimum necessary to identify and estimate the size of the outcomes of an Alcohol Management Plan. This is because the collection and analysis of data carries a cost, both financial—in the direct costs of data collection and compilation—and in the person-time required for its collection, analysis and interpretation, and these costs represent resources which are not then available for wider use by the community. Hence monitoring data are referred to as a “minimum data set”.

The way to define a minimum data set is first to identify the specific goals of the AMP and then to identify the data necessary to quantify and evaluate the achievement of these goals. Data should then only be collected and analysed as part of the evaluation if it has a clear link to an identified AMP goal and outcome.

It is important that the monitoring and evaluation data be focused on the desired outcomes of the AMP and not the processes of implementing the AMP. For example, an AMP may involve changes to policing strategies in a community—such as the use of mounted police. Monitoring data which describe the numbers of such police and how they are deployed in the community may tell us how the AMP is being implemented, but they do not address the effectiveness of the AMP. Such data may be appropriate for managing the implementation of the AMP, but they are not appropriate for evaluating the outcomes of the AMP.

The details of the outcome goals are likely to be specific to a particular community, so we recommend that prior to an AMP implementation the key stakeholders go through a formal process of identifying key goals for, and outcomes expected from, the implementation of an AMP. Then, with assistance from Menzies School of Health Research, a minimum data set necessary for the evaluation of these specific goals can be identified and, where necessary, specific steps to collect such data (such as a community survey) can be initiated. Ideally such data collection should be initiated before the implementation of the AMP so that baseline data can be collected for comparison with post-implementation monitoring data.

The key stakeholders, with assistance from the Menzies School of Health Research, should also agree on a set of “indicators” linking the monitoring data to the desired outcomes and evaluation goals. An indicator is a specific analysis of the monitoring data which is designed to identify the achievement of an AMP goal. For example, one goal could be to achieve a reduction in alcohol related assaults within a community. One of the monitoring data sets could be the number and severity of assaults treated in the local hospital. In this case one indicator could be the total number of hospital admissions arising from assault in a calendar year and the proportion of total hospital admissions in that year which this number represents.

This example also highlights the importance of understanding the possible causes of changes in the indicator. For example, a rise in the total number of hospital admissions for assault following the implementation of an AMP could indicate either:

1. There were more assaults in the community (suggesting poor effectiveness of an AMP).
2. People in the community who were assaulted were more able to access hospital treatment (suggesting positive consequences of an AMP).

In developing the indicators it is important that stakeholders also discuss their interpretation.

The data collected for AMP monitoring and evaluation should cover a sufficient period before the AMP implementation to establish baseline values and pre-existing trends. They should also be collected for a sufficient period after the implementation to identify whether the immediate effects of the AMP persist beyond the immediate implementation period. The period recommended in this report is one year prior to the implementation and two years after the implementation. However, this period should be reviewed in the light of the specific details of a particular AMP implementation.

Where possible, monitoring data should be reported separately for Indigenous and non-Indigenous people. This is because patterns of alcohol consumption and abuse may vary between Indigenous and non-Indigenous communities, so an AMP is likely to have different effects in the different communities.

Although the detail of goals and objectives for an AMP will be specific to a particular community, there are some general recommendations we can make for monitoring data which will apply to most implementations of AMPs. These fall into three main areas: the total amount of alcohol consumed in a community, the impact of alcohol abuse on health and wellbeing in the community, and the impact of alcohol abuse on crime in a community.

Alcohol consumption

If an AMP is being effective then it should lead to a fall in the total consumption of alcohol. The obvious data for monitoring this goal is the total amount of alcohol purchased for consumption within a community. This can be collected as wholesale alcohol sales data for each type of alcohol converted into litres of pure alcohol. In this case the monitoring data (wholesale alcohol sales in a community) are a “proxy” for the actual data we would like to monitor (actual alcohol consumption). These data have the limitation that they may underestimate actual alcohol consumption within a specific community. For example, people may be purchasing alcohol outside the community and bringing it in to the community or they may be purchasing alcohol via such sources as mail-order.

The use of such proxy data requires consideration of how well the proxy tracks changes in the target data. We are interested in changes before and after the AMP implementation. If features of the AMP are likely to lead to people changing their alcohol purchasing from local shops to other sources then this proxy may over estimate the effect of the AMP.

These data should cover a sufficient time period to be able to allow for long-term trends which may not be related to the AMP. For example, the consumption trends presented in Chapter 7 of this report show a falling trend in total consumption prior to the AMP. However, analyses of these data also show a further fall in consumption associated with the AMP introduction.

These data should be reported by type of alcohol as well as for overall total consumption. This will allow the data to highlight any AMP impact on specific types of alcohol—as was done in Chapter 7.

The appropriate data table for collecting these alcohol sales data would be:

- **Pure alcohol wholesales in litres for each quarter for the year prior to the intervention implementation and for two years after the intervention classified by type of alcohol (wine cask, wine bottle etc.).**

Health and well-being

Alcohol abuse can have a major impact on the health and well-being of a community, so outcome goals and associated monitoring data and indicators should be identified for this area.

Deaths

One obvious indicator of the health impact of alcohol abuse is the number of deaths from causes related to alcohol. Ridolfo and Stevenson (2001) list the range of illness and injury, and causes of death, known to be related to alcohol. Some (such as, for example, alcoholic cardiomyopathy) are directly caused by alcohol abuse. Others (such as, for example, stroke or female breast cancer) have alcohol as a substantial risk factor, but are not directly caused by alcohol consumption.

Accurate deaths data are collected by the registrars of births, deaths and marriages in each State and Territory. These data can be obtained for specific communities from the Australian Institute of Health and Welfare. However, in reporting these deaths it is important to take account of the lag between alcohol consumption and death. For causes of death related to injury or poisoning an AMP may have an immediate effect which will show up in the data for the two years following implementation. However, for other causes such as alcoholic cardiomyopathy, the disease process takes many years and current deaths will reflect drinking patterns over many previous years. Hence, deaths from these causes may not show an AMP effect for several years after the implementation. Further, some causes for which alcohol is a risk factor (such as, for example, stroke) will also be influenced by other factors than alcohol. Hence, any trends in these deaths should be interpreted with caution.

The appropriate data table for collecting deaths data would be:

- **The number of deaths from alcohol related causes registered in each calendar year for the year prior to the intervention implementation and for two years after the intervention classified by age, sex and specific cause of death. The Northern Territory also has relatively complete identification of Indigenous people on its death register, so these data should also be further classified by Indigenous status.**

Morbidity data

Data on illness associated with alcohol is less readily available for a community than deaths data, but it is important to incorporate illness data in a monitoring data set. The most readily available source of illness data is a local hospital. These data should be collected for both emergency department visits and admitted hospital separations.

Ridolfo and Stevenson (2001) also provide a complete list of hospital diagnoses which are known to be related to alcohol. As with deaths data, these data should be interpreted with caution as there may be a lag between alcohol use and disease onset and there may be other causes influencing trends in some disease conditions. A further caveat on interpreting hospital data is that the number of hospital admissions is also influenced by how easy it is for community members to access a hospital and how willing they are to attend a hospital and both of these may be influenced by an AMP or by other factors.

The data for collection should be strictly defined by diagnosis rather than being left to the discretion of hospital staff as staff may be more vigilant in identifying alcohol related cases during the period of an alcohol management intervention—thus unintentionally biasing the data collection.

The appropriate data tables for collecting deaths data would be:

- **The number of emergency department visits and hospital separations with an alcohol related diagnosis and the total number of visits and separations in each month for the year prior to the intervention implementation and for two years after the intervention classified by age, sex, Indigenous status and specific diagnosis.**

Wellbeing data

There are a number of instruments which can be used to measure community levels of wellbeing independently of specific disease or injury conditions—such as, for example, the SF36 or its shorter version the SF12. These could be administered via community surveys before and after the intervention to gauge any effect on general community wellbeing. This would be most effective if combined with the collection of qualitative information which would allow a deeper assessment of any changes in levels of wellbeing.

Crime

A major source of the impact of alcohol abuse in a community is alcohol-related crime so outcome goals and associated monitoring data and indicators should be identified for this area. However, care should be taken in interpreting these data as changes in levels of reported crime may reflect an effect of an AMP in different ways. For example, an increase in reported assaults following the implementation of an AMP may reflect a real rise in assaults (suggesting poor effectiveness of the AMP) or it may reflect better policing strategies for identifying assaults or greater willingness in the community to report assaults (suggesting positive outcomes from the AMP).

This is an area where stakeholder involvement in developing monitoring data is particularly important. Specific communities are likely to have particular concerns relating to alcohol related crime which should be addressed in an evaluation. However, whatever the specific focus of stakeholder concern, data should generally be collected via the following table:

- **Number of criminal offences by type of offence (assault, break-in, ...) in each quarter for the year prior to the intervention implementation and for two years after the intervention classified where possible by the offender's age, sex, and Indigenous status.**

These data can also be supplemented for violent offences by data on emergency department visits and hospital separations due to such offences (for example, emergency department visits and hospital separations due to assaults, domestic violence, etc.).

Where possible these data should be classified by whether or not alcohol was a factor in the offence (such as, for example, alcohol related assault). However, care should be exercised in how such offences are identified. For example, if police or hospital staff use their discretion in recording whether or not an assault is alcohol related, then they may be more vigilant in identifying alcohol related cases during the period of an alcohol management intervention — thus unintentionally biasing the data collection.

Planning an evaluation

As previously noted, early involvement in planning an evaluation by the community and key stakeholders is important in achieving a complete evaluation of any policy intervention. We have described the key role of stakeholders in identifying goals and outcomes for evaluation and the associated data and indicators. In addition, the whole process of conducting an evaluation benefits enormously from close community and stakeholder involvement. However, without a clear understanding of the process of evaluation, community members and stakeholders may find such involvement difficult.

We recommend that the Menzies School of Health Research be commissioned to develop a handbook for the evaluation of Alcohol Management Plans. Such a handbook would describe, in language accessible to community members and stakeholders, the major steps in planning and carrying out an evaluation. It would cover the identification of the key evaluation questions relating to the AMP goals and outcomes and the development, collection, analysis and reporting of the minimum evaluation data set and associated indicators. It would also describe the role and importance of qualitative information in an evaluation and describe its collection,

analysis and reporting. Finally, the handbook would be designed to assist community members and stakeholders in accessing professional advice and support in those areas where it is appropriate. Such a handbook would be of major value in allowing communities to plan and implement AMP evaluations.

14. Findings and recommendations

The Alice Springs Alcohol Management Plan was launched within a milieu of other Northern Territory and Federal Government Restrictions in 2006. As such it is difficult to separate the effects of each initiative on the overall results and situation in Alice Springs. It is also difficult for Alice Springs residents to conceptualise the Alcohol Management Plan in isolation from these other elements. Perhaps as a result of this situation, Alice Springs residents (as demonstrated through the in-depth interviews and the survey) had limited understanding of the Alcohol Management Plan, which were generally thought of as being limited to a set of restrictions around the supply of alcohol in the town.

Most people consulted by the evaluation team did not have an understanding of the Alcohol Management Plan in its entirety. Neither were outsiders such as tourists provided with appropriate information on Alcohol Management measures. This sometimes caused confusion, frustration and anger.

Lack of communication at the community level around the implementation of the Alcohol Management Plans has led to a degree of hostility and opposition in the Alice Springs community. A commonly expressed viewpoint was that governments were imposing restrictions upon the Alice Springs community without addressing the needs or concerns of community members themselves. It appeared from the results of the survey that community members were as much resisting the imposition of Government as they were changes in the way they could purchase and consume alcohol.

Community members in Alice Springs, based on the results of the interviews and the phone survey were more likely to be against alcohol restrictions than in favour of them. Previous research (d'Abbs and Togni, 2000) found that alcohol restrictions are "likely to have strong community support, provided that other measures are also pursued". Community members often talked about the importance of other measures, such as education and the need for more rehabilitation services. The development of other complementary initiatives does not seem to have been adequately developed in the case of Alice Springs by the Northern Territory Government.

There is an influential body of people who have established themselves as being in opposition to the Alcohol Management Plans, on the basis that the AMP and associated alcohol restrictions in their efforts to address the problem of a minority of problematic drinkers, affect the entire town unfairly. This message is enforced by members of the Alice Springs Town Council and the Responsible Drinkers Lobby. It was also the opinion of the majority of the respondents to the phone survey. This perception is contrary to the evidence which demonstrates that alcohol misuse in

Alice Springs (and the Northern Territory as a whole) is a problem for the entire community. Indigenous drinkers are much more likely to be affected by the acute effects of alcohol, as is reflected in the number of assaults in the community, but non-Indigenous drinkers do suffer from the chronic long-term health effects caused by the over consumption of alcohol.

It is also of concern that the Alcohol Management Plans seem to have heightened racial tensions in the Alice Springs community. Respondents to the phone survey were largely of the opinion that problematic Indigenous drinkers were coming in to Alice Springs from outside communities and that a viable solution would be to provide canteens on communities to stop this from occurring. Analysis of the data from the sobering up shelter does not support this conclusion, with the majority of people coming from Alice Springs and a decline in people from the surrounding communities. Indigenous people considered that they were being stigmatised by the non-Indigenous community for both causing the drinking problem and being the cause of the ensuing alcohol restrictions.

Some indicators suggest that the Alcohol Management Plans are having a positive effect on the Alice Springs community. Current data indicates that there has been a decline in alcohol consumption, with overall consumption down by 18% since the introduction of the AMP (comparing the four quarters prior to the September 06 introduction with the four quarters from December 2007 to September 2008). The assault data does not demonstrate a downward trend, however there is evidence that the severity of assaults has declined since the introduction of the AMP. This result is consistent with evidence provided from the police and the emergency department of the Alice Springs Hospital, about educating victims of assault about the importance of reporting the event.

Admissions to the sobering up shelter have risen in 2008, however, this may be the result of proactive policing.

Despite the declaration of town camps as “dry areas”, residents still openly drink in the camps. Despite the view of the police that they now actively patrol the town camps, they do not appear to have the resources to enforce this rule. This also appeared to be the case with drinking in public places such as the Todd River. Many respondents to the telephone survey considered that this new restriction had considerable potential, but that it was not being adequately enforced by the police to have any effect.

There is a more general problem with both the accessibility and quality of the statistical data to report on the effects of an intervention such as the Alcohol Management Plan. The evaluation team found that the data was held by at least three different agencies, and that often there was limited agreement between these agencies about which data set was most appropriate. Obtaining access to the data was

extremely time consuming. Furthermore, the data itself and which data sets were most appropriate became the overwhelming focus of local alcohol interest groups, including the Alcohol Reference Panel, which tended to distract these groups from working towards strategies to address alcohol as a problem in the community.

The Alcohol Reference Group is an important part of the Alcohol Management Plan, composed of a range of influential and highly informed people in the alcohol debate, it has demonstrated a very high degree of passion for addressing the problem of alcohol in Alice Springs. The results of the interviews conducted by the evaluation team and an analysis of the minutes from the meeting, however suggest that this group is more a discussion group than a group that devises and enacts strategies to address the issue of alcohol in the community. Furthermore, the various interests in the alcohol debate are somewhat disconnected and there does not appear to be an overarching mechanism to provide linkages and connections between the groups.

Recommendations

At a superficial level it would appear that the alcohol restrictions in Alice Springs are unpopular and that further efforts in this direction are unlikely to be supported by the community. Further analysis however, reveals that although many people consider the current restrictions to be inconvenient, the underlying cause of their discontent is their perception that restrictions have been imposed upon them without adequate consultation.

Furthermore, there is a strong cultural resistance among the non-Indigenous population in Alice Springs to acknowledge that alcohol is a problem which affects both Indigenous and non-Indigenous people in the community. This perception adversely affects the non-Indigenous community's willingness to engage in strategies to address the problem of Alcohol in the community. On the basis of these findings, we recommend that the current alcohol restrictions be maintained in their current form and that extensive community consultation, education, social marketing be conducted before implementing any stronger measures. The current set of restrictions provide a good platform for the implementation of the broader range of measures associated with the Alcohol Management Plan, which must be done in wide consultation with the community.

Other specific initiatives which should be considered by the Northern Territory Government are listed below:

Implementing a community development model for reform

Strategies need to be implemented to engage the community in discussion about alcohol and the problems of alcohol misuse in the community. A community development model is needed to bring together and coordinate the various community interests in this issue. The NTG needs to consider the creation of community development positions, one Indigenous and one Non-Indigenous, whose responsibilities are to oversee the Alcohol Working Group, to coordinate community responses, to develop and maintain linkages between interest groups and alcohol services and to conduct the on-going evaluation of the Alcohol Management Plan. These people would also be responsible for developing relationships with the local media and ensuring the regular dissemination of information about the Alcohol Management Plan and associated activities to the media. This requires a long term commitment from Government for at least five years.

Ideally these positions should be jointly funded by the Department of Justice and The Department of Health, however the individuals involved must be primarily driven by the needs and agendas of the community, not the funding bodies.

The community development officers and the Alcohol working group will require access to specialist support, to assist with developing interventions and ensuring that these are established in a way that they can be monitored and evaluated. We recommend that the Menzies School of Health Research is retained to provide such on-going advice and assistance.

The evidence from the literature (see section 11) demonstrates that this is feasible and effective approach, and not only facilitates community involvement, but also produces measurable changes in alcohol risk behaviours.

Changing the social climate around alcohol issues in Alice Springs

There needs to be a social marketing campaign, which highlights that alcohol misuse is a problem of both the Indigenous and non-Indigenous communities in Alice Springs and which encourages the community to consider ways to deal with the problem. The NTG needs to investigate innovative social marketing campaigns, which are designed to capture the attention of a broad range of community members.

Education was a widely suggested solution to the alcohol problem, and there is a role for continuing public health education which can be aimed at a variety of levels, including school based education and the provision of information at public events. Again this has to be sustainable and must be implemented in combination with the mass social marketing campaign.

Training packages which combine community development, drug and alcohol issues and effective networking and communication between services should be made available to all members of the alcohol reference or working group. This training is currently available through the community services package, at certificate three and four levels offered by Charles Darwin University.

Ongoing communication about the Alcohol Management Plan and its components is essential to obtain public support. The NTG needs to develop and implement a more comprehensive public information and awareness process about the Alcohol Management Plan. This should be available through various medium to local residents in Alice Springs and also to visitors to the region. In addition, the Alcohol Management Plan and the relevant legislation should be adequately discussed with service providers, including police, night patrol, and the Liquor industry.

Establishment of a new Alice Springs Alcohol Working Group

The NT Government should consider the establishment of a new Alcohol Working Group. The current body (the Alcohol Reference Panel), whilst it has provided advice to Government since 2007, needs revisiting particularly in terms of community representation and how it operates. The Government may wish to consider a new membership, not precluding consideration of some current members, which better covers the scope of community interests.

Meetings need to be timely, structured and informed by data that is up-to-date and accurate. There needs to be a set agenda and actions flowing out of each meeting.

Suitable arrangements should be made, and funded by the government, in order that members can personally attend each meeting. Phone link-ups are not suitable and several current members said that they felt “left out” at current meetings by not being able to be present (sometimes because of budgetary issues).

The role of the Working Group needs to be clearly defined by the Minister. The current body appears to have “lost its way” to some degree and there has been an obscuration of what they originally were set out to do and achieve. Clear reporting mechanisms to the minister or appropriate body need to be clarified. The Alcohol Working Group needs to have a strategic plan with appropriate resources to achieve the agreed goals.

Importantly the wider community needs to be kept aware of the establishment of such a Working Group and its role.

Improving the resources and infrastructure to deal with the problems of alcohol misuse

The NTG needs to consider the wider implications and effects of alcohol misuse. Preventative type initiatives, such as education and support should be implemented, particularly for those at high risk, at an early age. In particular, existing institutions that can proficiently provide such programs, such as the Gap Youth Centre, Holyoake, CAAPU and DASA be sustained through adequate funding and other support.

Other programs, such as night and day patrols were mentioned by residents during the research as being very effective mechanisms when they operated properly. The NTG should consider reviewing the role and effectiveness of such services to ensure that they are sufficiently funded, adequately supported and proficiently operated. Again, the provision of certificate level training to night patrols covering the areas of alcohol and other drugs, and effective communication and networking with other agencies should be considered.

Developing an effective framework for on-going monitoring and evaluation

Monitoring and Evaluation of the Alcohol Management Plans should be conducted at the community level and be the responsibility of the community development officer and the alcohol working group. Resources must be available to support this process, including expert advice when needed.

The development of a pragmatic, reliable and agreed upon minimum data set to inform evaluation is essential. This will require the cooperation and input of a range of Government agencies. The provision of such information, will ensure that the Alcohol working group is able to demonstrate progress and that this progress will not be disputed on the basis of the reliability of the data. It will also ensure that data is available in a timely fashion and that the focus of future evaluations is not on how to obtain the data, but how to use it to demonstrate change.

The collection of statistical data to demonstrate progress is essential, but the on-going evaluation must also monitor the progress of the intervention in terms of the linkages, coordination of services, input from wide range of community organizations and the on-going communication and dissemination of results. It is recommended that the Alcohol Working Group examine and consider using the range of tools that are available for such monitoring (examples are provided in appendix 3-5).

Developing a “plain-language” handbook for the evaluation of alcohol management plans

A key resource to support the conduct of Monitoring and Evaluation of the Alcohol Management Plans at the community level would be a handbook for the evaluation of Alcohol Management Plans. Such a handbook should describe, in language accessible to community members and stakeholders, the major steps in planning and carrying out an evaluation. It should cover the identification of the key evaluation questions relating to the AMP goals and outcomes and the development, collection, analysis and reporting of the minimum evaluation dataset and associated indicators. It should also describe the role and importance of qualitative information in an evaluation and describe its collection, analysis and reporting. Finally the handbook should be designed to assist community members and stakeholders in accessing professional advice and support in those areas where it is appropriate. Such a handbook would be of major value in allowing communities to plan and implement AMP evaluations.

We recommend that the Menzies School of Health Research be commissioned to develop such a handbook.

Reassessing drinking in Indigenous communities

The inability to drink in public or in town camps has created a culture of resistance in Alice Springs among some Indigenous residents. This further serves to create a divide between Indigenous and Non-Indigenous residents of Alice Springs. The NTG need to engage in a more comprehensive negotiation process with town camp residents and organizations with regard to alcohol use on these leases and if necessary consider negotiating with the Federal Government to remove the “dry town camps law”. Consideration also needs to be given to a process whereby town camp residents can apply, through existing legislation, to have their premises declared “dry” if they so wish.

The NTG also needs to be aware and respond to the unintended consequences of the current restrictions, especially the needs of drinkers who move out of the town’s boundaries to drink. Consideration needs to be made of the harm reduction strategies that may be necessary to support this group of people and their families.

Numerous people interviewed, both Non-Indigenous and Indigenous, spoke about the possibility of establishing “wet canteens” or clubs in communities. Whilst such initiatives are essentially a business concern, the Government through its regional development arm may wish to consider how the most appropriate and responsible business climate can be established to possibly encourage such opportunities. This might possibly be initially instigated with an analysis of alternative community liquor alternatives. However it appears that the public perception that the problem drinkers are coming from outside the community may be overstated, with the sobering up data suggesting that there has been a decline in the contribution of communities outside of Alice Springs to the total numbers of people in sobering up shelters.

Licensed premises

The Alice Springs community has historically been serviced by an abundance of liquor outlets. A more rigorous and proactive program of “buy back” of licenses should be implemented by the NT Government.

The NTG commission a study which examines how a particular culture of drinking is perpetuated by the licensed premises that cater specifically for Indigenous people in Alice Springs. There are indications to suggest that practices such as book up for alcohol, which leave an individual indebted to a licensed premise are occurring, as well as variable pricing of some products. Whilst certain practices may currently be legal, there is still a responsibility for citizens to be fully aware of their rights.

Responsible service of alcohol training is considered to play an important role in reducing alcohol related harm, however with a highly transient workforce it is difficult to enforce such training in Alice Springs. Consideration should be made to the development of a training package which includes a cultural awareness component, which would assist the alcohol workforce as they moved through the Northern Territory.

Review of alcohol treatment services

Currently some of the services, especially those designed specifically for Indigenous people appear to be operating in isolation from each other. Services in Alice Springs must be encouraged to communicate with each other and consider collaborative approaches to issues such as referral, effective treatment and case management.

The NTG should consider implementing a round of competitive funding for existing services, which would encourage them to develop collaborative projects to address the needs of Indigenous clients and develop effective and sustainable networks between services.

The NTG needs to consider an audit and mapping of the services that are provided in Alice Springs, to determine the types of service that are being offered and to determine the linkages and potential for building further linkages between services.

There needs to be greater involvement of the services in a discussion about best practice when dealing with Indigenous clients and a consideration of the evidence base about effective and appropriate treatments.

Case management of Indigenous clients must be reviewed as a priority, with interagency discussion about how to best manage and refer clients through various services, including follow- up and after care.

Consider the needs of elderly people

The evaluation team heard the issues that some elderly people have in purchasing alcohol at a suitable time. However, it is inappropriate that any special dispensation be made for their concerns. It will open the situation and particularly for Indigenous elderly, the team believes, to exploitation by younger people and the negative outcomes outweigh the positives at this stage. Other mechanisms might be considered by the Alcohol Working Group, or other organizations in the future. At the present time, the elderly will have to bear the burden of alcohol responsibilities as will the wider community, in what is, essentially, a community problem.

An investment in community change

None of the strategies listed above are “quick fixes”. They require extensive inter-governmental cooperation and an investment of resources and time. This evaluation has demonstrated that Alcohol misuse in Alice Springs is a complex and enduring problem. We have reviewed evaluation reports and their recommendations for the last thirty years, which reiterate the same messages as this report. There needs to be a fundamentally different way to address alcohol issues in the community and this approach will require extensive community consultation and the embracing of a community development framework to enact change. There is a good evidence base that such interventions will be successful, both in terms of changing the community climate towards being more receptive and knowledgeable about the issues and in terms of demonstrating measurable change (see Section 11). If the Northern Territory Government is committed to developing a sustainable and community focused Alcohol Management Plan in Alice Springs (and elsewhere), these ground up interventions are necessary as the first step to move beyond the liquor restrictions.

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16. Appendices

Appendix 1: People and organisations consulted as part of this evaluation

Alcohol Reference Group
 Alice Springs Hospital
 Alice Springs Regional Development
 Alice Springs Town Council (alderman and officials)
 Amy Wilkinson, Australian Hotels Association
 Andrea Sullivan, Memorial Club
 Andrew Vodic, Team Leader, Community Services, Charles Darwin University.
 Anglicare
 Central Australian Indigenous Alcohol Programmes Unit (CAAPU)
 Central Australian Indigenous Congress (CAAC)
 Central Australian Indigenous Legal Aid
 Central Land Council
 Chamber of Commerce, Alice Springs
 Department of Justice
 Department of Families, Housing, Community Services and Indigenous Affairs
 Department of Health and Families
 Drug and Alcohol Services Association (DASA)
 Foodland Stores – Northside, Flynn Drive, East Side
 Gap Youth Centre
 Holyoake Inc (counselling and education service)
 Impartja
 Lhere Artepe Indigenous Corporation
 Licensing Commission
 Liz Martin and Kelvin Davis
 Northern Territory Council of Social Service (NTCOSS)
 Northern Territory Police
 Paul Fitzsimons, Charles Darwin University
 People’s Alcohol Action Coalition (PAAC)
 Public Submissions (10 received)
 Ray and Diane Loechel, Gapview Hotel
 Red Cross
 Responsible Drinkers Lobby
 Salvation Army
 Tangentyere Council
 Tony Bohning
 Town Camps (six visited)
 Yeperenye

Please note:

We apologise if any individual and organisation, that was consulted, has been inadvertently omitted from this list.

We attempted to consult with as many people as possible, however, due to various factors including their availability and our own time constraints, some individuals and organisations were not included.

Several organisations were contacted but for whatever reason did not wish to be involved.

Some of the individuals and organisations did not wish to be identified in this report.

Appendix 2: Community Telephone Survey

Alice Springs: Community survey interview schedule

Interviewer's Initials: _____ **Phone Number:** _____

Attempts: (No answer, completed, refused, disconnected, not eligible)

1: _____ 2: _____ 3: _____

*Hello, my name is [**first name**] and I'm conducting a survey on behalf of the Menzies School of Health Research in Darwin. The purpose of the survey is to obtain people's opinions of the current Alcohol Management Plan and associated liquor restrictions in Alice Springs, and it's part of an official evaluation commissioned by the Department of Justice and The Department of Health and Families. Would you be able to spare about 5 minutes to answer a few questions about your views of the restrictions? Neither your name, nor your phone number will be made available to anyone and all your comments are anonymous and confidential.*

YES (go to Q1.)

- (If in doubt) We can only survey people who are adults. Can I just confirm that you are 18 years or older? If YES (go to Q1.)

NO - Would anyone else in the household over the age of 18 like to participate?

- YES (go to Q1)
- NO (Ok, thank you for your time. Goodbye)

1. *Firstly, I am interested in whether the Alcohol Management Plan and associated restrictions have had any impact on you personally.*
(Note for interviewers: if the respondent starts talking about impact on the whole community, say something like "I'd like to ask your views on this in just a minute, but right now I'm interested in what effect – if any – the restrictions have had on you personally".)

- 1a. *Over the last 9 months has the Implementation of the ID system when purchasing alcohol affected you directly:*

- NO** (next question) **YES** (How has this affected you?)

1b. How about the changes to the times that takeaway alcohol is available for purchase (from 2pm-9pm). Has this affected you:

- NO (next question)** **YES (How has this affected you?)**

1c. What about the banning of drinking in public areas, such as parks, streets and the Todd River Bank. Has this affected you personally:

- NO (next question)** **YES (How has this affected you?)**

1d. What about the changes to the times when you can purchase fortified and cask wine (after 6pm). Has this affected you personally:

- NO (next question)** **YES (How has this affected you?)**

2. Now I'd like to ask about what you see as the impact on the Alice Springs community as a whole. I am interested in both the good and bad effects.

2a. Firstly, do you think the Alcohol Management Plan and associated restrictions has had any good effects on the local community?

- NO (next question) YES (Can you describe what these are?)
(Have you seen evidence of this yourself or is it hearsay?)

2b. Do you think the Alcohol Management Plan and associated restrictions has had any bad effects on the local community?

- NO (next question) YES (Can you describe what these are?)
(Have you seen evidence of this yourself or is it hearsay?)

3. Overall, would you describe yourself as a supporter of the Alcohol Management Plan and associated restrictions, or are you against them?

- Supporter Against

What are your main reasons for having this view?

4. *We are interested in whether you think the current Alcohol Management Plan and associated alcohol restrictions should be modified in any way. Do you think they should be:*

- continued in their present form (go to next Q)
 abandoned, OR (go to next Q)
 continued with modifications?

(If respondent calls for modifications :What modifications do you think should be made:

5. *Apart from restrictions on liquor supply, do you think that other things should be done to reduce alcohol problems in Alice Springs?*

- NO (next question)** **YES (What should happen?)**

Finally, just a few questions about you:

6. **How many years have you lived in Alice Springs**_____ years

7. **Are you of Indigenous or Torres Strait Islander origin?** YES
 NO

8. **Finally, do you mind telling me if your aged below 45 years, or 45 or older?**

? Below 45 ? 45 years or older

Note gender: Male Female

*Those are all of the questions I have.
 Thank you for your time. Have a good morning/day/ evening.*

Appendix 3: self monitoring tools for new projects

Sustainability Checklist

About the person competing this assessment

Project _____ Name _____

Date completed _____/_____/_____

What is your goal after project funding ends

- The project will be over and its impact will end soon after
- The project will be over but it will keep having an impact
- By the time funding ends, we will have found other ways to keep the project going

If your goal is for your project, or its effects to continue after funding ends, please circle the number that best describes your situation

The first set of items is about project design and implementation factors

1. People with a stake in the project- funders administrators, consumers/beneficiaries, other agencies- have been aware of the project and/or involved in its development	2	1	0	DK
2. The project has shown itself to be effective. Effects are visible and acknowledged	2	1	0	DK
3. The organization which you intend to host the project in the futures has been making some real or in kind support to the project in the past	2	1	0	DK
4. Prospects for the project to acquire or generate some additional funds or resources for the future are good	2	1	0	DK

The next set of items is about factors within the organizational setting which are known to relate to the survival of a project

5. The organization that you intend to host the project in future is mature (developed, stable, resourceful). It is likely to provide a strong organization base for the project.	2	1	0	DK
6. The mission of the project is compatible with the mission and activities of the intended host.	2	1	0	DK
7. Part of the projects essential "business" is integrated into	2	1	0	DK

other aspects of the host organization, e.g. in polices, practices, responsibilities etc. That is, the project does not exist as an entirely separate entity.				
8. The project is well supported in the organization. That is, it is not under threat and there are few rivals in the organization who could benefit from the closure of the project.	2	1	0	DK
9. The intended host organization has a history of innovation or developing new responses to situations in its environment	2	1	0	DK

The next set of items is about factors in the broader community environment which affect how long projects last

10. There is a favourable external environment for the project, that is, the values and missions fit well with community opinion and the policy environment	2	1	0	DK
11. People in the community, or other agencies and organizations, will advocate for and maintain a demand for the existence of the projects should it be threatened	2	1	0	DK

2= yes, fully
1= yes, in part

0=no
DK= don't know

Modified from Hawe, H, King, L, Noort, M, Jordens, C and Lloyd B, NSW Health Indicators to help with building capacity in health promotions (January 2000) NSW Department of Health.

Capacity building checklist

About the person competing this assessment

Project _____ Name _____

Date completed _____/_____/_____

The first set of items is about project design and implementation factors

1. People with a stake in the project- consumers/ beneficiaries, other agencies, health care providers- have been able to contribute to the development of the project.	2	1	0	DK
2. People involved in the project have been able to establish links with other organizations involved with addressing alcohol misuse in the community.	2	1	0	DK
3. People involved with the project have taken on leadership roles in the local community with regard to addressing alcohol misuse.	2	1	0	DK
4. People involved in the project have been able to resolves conflicting interests in the areas if alcohol misuse in the community.	2	1	0	DK
5. This project has been able to engage the local media in promoting issues relevant to addressing alcohol misuse in the community.	2	1	0	DK
6. This project has involved formal and/or informal training of people whose skills and interests are retained in the projects or its immediate environment.	2	1	0	DK

The next set of items is about factors within the organizations setting that relate to capacity building.

7. This organization has been able to establish agreed policies or memoranda of understanding with other organizations regarding the provision of alcohol treatment services in this community.	2	1	0	DK
8. This organization has generated and supported community skills to direct, provide, lead or otherwise contribute to the provision of services to address alcohol misuse in this community.	2	1	0	DK
9. More organizations resources have been directed to the area of alcohol misuse in this community.	2	1	0	DK

10. There is someone in authority or seniority, other than the director of the project itself, who is an advocate for the project at high levels in the organization.	2	1	0	DK
---	---	---	---	----

The next set of items is about factors in the broader community that affects the community's capacity to support the development of strategies and projects to address alcohol misuse

11. Community coalitions have formed to promote and advocate for projects to address alcohol misuse in this community.	2	1	0	DK
12. Community coalitions and organizations have a shared view of what comprises attempts to address alcohol misuse in this community.	2	1	0	DK
13. Key community leaders have engaged in critical appraisal of the need for projects to address alcohol misuse in this community.	2	1	0	DK
14. Community leaders have taken a leadership role to promote the importance of projects to address alcohol misuse in this community.	2	1	0	DK
15. Community events have occurred to acknowledge, promote or provide funds for projects to address alcohol misuse.	2	1	0	DK
16. Community members directly involved or affected by alcohol misuse are actively engaged in the oversight of the development, provision or management of projects to address alcohol misuse in this community.	2	1	0	DK
17. People in the community, or other agencies and organizations, will advocate for and maintain a demand for the existence of the project should it be threatened	2	1	0	DK
18. Community organizations that are similar to the intended host organization have taken the step of supporting projects somewhat like your project.	2	1	0	DK

2= yes, fully
1= yes, in part

0=no
DK= don't know

Modified from Hawe, H, King, L, Noort, M, Jordens, C and Lloyd B, NSW Health Indicators to help with building capacity in health promotions (January 2000) NSW Department of Health.

Generalisabilty checklist

About the person competing this assessment

Project _____ Name _____

Date completed _____ / _____ / _____

Please circle the number that best describes your situation

1. Our project is designed specifically to meet our own needs	2	1	0	DK
2. Other regions/services/organizations will learn useful lessons/information from our project.	2	1	0	DK
3. It is reasonable to expect that the outcomes of our project could be replicated elsewhere.	2	1	0	DK
4. Our project will depend on how sensitive and appropriate it is to our target organization.	2	1	0	DK
5. Our project is designed to develop capacity (skills or knowledge) in strategies to address alcohol misuse in our region.	2	1	0	DK
6. Our project is designed to enable people not directly involved in our project to develop capacity (skills and knowledge) in strategies to address alcohol misuse.	2	1	0	DK
7. We already have a strategy in place to ensure that our experience and findings are shared with other people.	2	1	0	DK
8. By the time the project ends, we will have a strategy in place to ensure that our experience and findings are shared with other people.	2	1	0	DK

2= yes, fully
1= yes, in part

0=no
DK= don't know

Modified from Hawe, H, King, L, Noort, M, Jordens, C and Lloyd B, NSW Health Indicators to help with building capacity in health promotions (January 2000) NSW Department of Health.

If you need more space, extend this table.

Modified from the Centre for Health Service Development, University of Wollongong (2003).

System level impacts, coordination and outcomes of the Alcohol Management Plan (modified from CHSD, 2003).

Agency name (optional)

Location (optional)

Date Completed

This survey was completed (tick one)

Through an agency/group meeting to consolidate one response

By an individual expressing their own views, and not necessarily those of the agency

Description of your agency service

Drug and alcohol service Police

Counselling

Youth service Corrections

Training organization

Indigenous health service Youth diversion

Other (please describe)

Hospital Night/day patrol

How did the Alcohol Management Plan go?

Did it change the way you deliver services?

Yes, positively Yes, negatively No change

Was the impact on the community acceptable?

yes No don't know

Agency, interagency and system effects of the project

Please tick the appropriate boxes. When a statement is irrelevant to your organization tick the box marked irrelevant

Impact statement	Agree	Unsure/don't know	disagree	Irrelevant	Comment
Different professionals and services now work better as a team to improve the services that people receive					
The AMP has improved the way that people involved in alcohol and its impacts communicate with each other					
The AMP provided a framework to improve information sharing between people involved in alcohol and its affects					
The AMP has resulted in our agency becoming more aware of the range of alcohol related services in the community					
The AMP has resulted in better treatment and support for clients/patients					
The AMP has raised community awareness of alcohol issues					
The AMP has increased the skills and knowledge of staff working in the alcohol areas					

We want the changes that the AMP has achieved to continue					
---	--	--	--	--	--

Add any further comments on consumer, agency or system level issues raised by any of the questions above, or on any other matters not covered in this feedback sheet

Appendix 5: Community Patrol training (community services package, Charles Darwin University)

COMMUNITY PATROL TRAINING PROGRAM

BC611

The following information is an outline of the Community Patrol Training that could be made available.

The Community Patrol training program has packaged together units from the Community Services Training Package so the students would receive a Statement of Attainment after successful completion of the units as selected by the community they serve.

Numeracy & literacy support units would also be made available and be incorporated into (or in conjunction with) the Community Services units.

The students would also have the option to complete additional units to receive a Certificate III in Community Services Work CHC30802.

Community Patrol Program: Available Units of Competency CHCA0D2C Orientation to the alcohol & other drugs sector. (50hrs)

This unit applies to all workers who may be working primarily with clients with AOD issues and provides a basic introduction to values, services and approaches applied to work in this sector

CHCA0D6C Work with clients who are intoxicated. (50hrs)

This unit relates to working with alcohol and/or other drug affected clients in a range of settings including night patrols, detoxification/withdrawal units and sobering up shelters.

CHCC0M2B Communicate appropriately with clients & colleagues. (20hrs)

This unit provides skills to exercise effective communication skills in the workplace.

CHCCS401A Facilitate cooperative behaviour (40hrs)

This unit concerned with the competencies required to respond to unacceptable behaviour and support responsibilities for behaviour management and change.

CHCOHS301A Participate in OH & S Procedures (30hrs)

On completion of this unit, the worker will be able to identify occupational health and safety hazards, and assess risks, as well as follow instructions and procedures in the

workplace with minimal supervision. The worker will also be capable of participating and contributing to health management issues.

HLTFA1A Apply basic first aid. (10hrs)

This unit deals with the provision of essential First Aid in recognising and responding to an emergency using basic life support measures, The First Aider is not expected to deal with complex casualties or incidents, but to provide an initial response where First Aid is required. In this unit it is assumed the First Aider is working under supervision and/or according to established workplace First Aid procedures and policies.

CHCCHILD1C Identify and respond to children & young people at risk of harm (50hrs)

This unit applies to all those workers (including the professions) involved in delivering services to children and young people including in community services, health, policing, juvenile justice, recreation, family services, education, alcohol and other drugs and mental health.

CHCDFV1B Recognise and respond to domestic and family violence (50hrs)

This unit is concerned with identifying and responding to domestic violence during professional contact with clients. It requires a knowledge and understanding of domestic and family violence and an awareness of its effects together with an ability to promote confidence whilst responding appropriately, including providing relevant timely information and referral.

CHCORG1B. (15 hrs)

Follow the organisation's policies, procedures and programs

CHCADMIN1B Undertake basic administration duties. (15hrs).

This unit relates to the range of basic administrative duties required in community services organisations.

APPENDIX 6: AMP Town Camps consent form and survey form

Tangentyere Council Evaluation of the Alice Springs Alcohol Management Plan.

Information Sheet

(To be read and/or handed to a potential participant)

My name is _____ and I am working for Tangentyere Research.

We are working with Menzies Health in preparing an evaluation report on the alcohol management plan in Alice Springs. We are seeking to speak to aboriginal people from the ages between 18 to 65 who are residents and visitors on town camp.

Information we collect will be used for input into an evaluation report that will be presented to the minister for Justice, N.T Government.

This interview won't take too long- not more than 10 minutes.

The Tangentyere Executive Committee and the Ethics Committee in Central Australia has approved this research.

This information from the survey will be PRIVATE (Confidential) and locked away.

Do you have any questions about what we are doing?

Do you have any worries about what we are doing?

It is your choice to be part of this research. You can stop taking part any time.

Can you help us by taking part in this survey?

Consent

[To be signed by the researcher on behalf of participant once consent is given]

Signature of consent _____ (researcher) Date: _____

If you have any problems please call Marg Reilly, Manager of Social Services at Tangentyere on 89514 241 regarding ethics approval or Jeremy Pyner Research Co-Ordinator on 89514 270.

Contact details Bill Ivory, Menzies School of Health Research.

Phone: 0403 546 494

E-Mail: William.ivory@Menzies.edu.au

Evaluation of the Alice Springs Alcohol Plan

Date: ___ / ___ / ___

CAMP NO: _____

AGE: _____

GENDER: Male Female

1. Do you know what the N.T. alcohol restrictions are?
2. What do you think about the alcohol laws?
3. How did you find out about the alcohol restrictions?
4. In what way have the N.T. Government Alcohol laws affected you?
5. *Have you noticed any positive (good) changes because of the alcohol laws?*
Have you noticed any negative (bad) changes because of the alcohol laws?
6. *What restrictions do people know about?*
7. What would you like to see happen with the alcohol laws here?
8. *What services, to help with alcohol problems, would you like see available in Alice Springs?*

Evaluation of the Alice Springs Alcohol Plan

1



discovery for a healthy tomorrow

PO Box 41096, CASUARINA NT 0811 | John Mathews Building (Building 58), Royal Darwin Hospital Campus, Rocklands Drive, CASUARINA NT 0810 Phone: 08 8922 8196 | Facsimile: 08 8927 5187 | Web: www.menzies.edu.au | Email: info@menzies.edu.au



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PO Box 41096, CASUARINA NT 0811 | John Mathews Building (Building 58), Royal Darwin Hospital Campus, Rocklands Drive, CASUARINA NT 0810 Phone: 08 8922 8196 | Facsimile: 08 8927 5187 | Web: www.menzies.edu.au | Email: info@menzies.edu.au