



A series of research briefs designed to bring research findings to policy makers

## Alcohol management plans and related alcohol reforms

Brief 16, October 2013

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### Introduction

Alcohol Management Plans (AMPs) are a relatively new instrument joining the extensive range of regulations relating to alcohol supply and consumption. AMPs vary in design and implementation across Australia, and include strategies designed to reduce harms resulting from alcohol misuse. The majority of AMPs are based on the principle of harm minimisation and include supply, demand and harm reduction measures. Many include provisions that ban or restrict the supply, possession and/or consumption of alcohol in relevant areas and some have also been used to place restrictions on local liquor outlets. In addition, AMPs can include other measures, such as women's shelters, support groups and sobering up shelters, community patrols, education and awareness campaigns, sport and other youth diversion activities.

AMPs have primarily been adopted as a strategy or tool where Indigenous drinking is defined as a major issue in the range of drinking problems in the community. In Western Australia, the term 'alcohol management plan' is used in a more general sense to refer to community planning and periodic revision of plans concerning alcohol issues in the community (WA Drug & Alcohol Office, 2007). Liquor accords are another related strategy employed to manage alcohol-related problems at a local level. However, liquor accords generally centre on

relationships between alcohol sellers and the police, with varying degrees of input from other local stakeholders, focusing on controlling individual problematic drinkers and situations rather than on broader controls on alcohol sales.

The first AMP was designed and implemented in late 2002 by the Aurukun community in Queensland, and AMPs were subsequently adopted by governments and communities across Australia. AMPs have been adopted in regional towns, such as Alice Springs and Port Augusta, as well as remote Indigenous communities in the Northern Territory, Western Australia and northern Queensland. Although limited, the literature available shows that the most effective AMPs are those negotiated at a local community level. This includes involving community members and other stakeholders to identify the measures best suited to reducing alcohol-related harms to individuals, families and the community. In these cases, AMPs are designed to facilitate the empowerment of local communities to develop solutions appropriate to local conditions. They can also act as a device to mobilise support and negotiations with external agencies, such as police and health (d'Abbs et al. 2010).

AMPs have become contentious political policy instruments, initiating debates involving, among others, the Northern Territory and Queensland governments and the Australian Government. Debates have mainly

focused on the effectiveness of broad based supply restrictions compared to more individualised approaches that target problem drinkers, and issues relating to Indigenous civil rights (Aikman 2012; Northern Territory Country Liberal Party 2012; Queensland Department of the Premier and Cabinet 2012; Walker & Karvelas 2012).

This paper addresses and reviews the evidence on:

- similar reforms in international jurisdictions;
- background to the emergence of AMPs;
- the development of AMPs in Australia;
- different components and approaches of AMPs;
- evidence of the effectiveness of AMPs;
- community support and the process of design and implementation of AMPs; and
- current issues and challenges for AMPs.

Measures such as taxation, minimum pricing, residential treatment and clinical interventions involving pharmacotherapies will not be discussed in this paper. In addition, the paper will not address local alcohol management solutions used more widely in Australia involving supply controls that target nightclub precincts, many of which are known as 'Liquor Accords'.



## Similar reforms in international jurisdictions

Despite the wide range of social, cultural and economic diversity between nations, most developed nations have adopted some form of regulatory and legislative control over alcohol supply and consumption. Comparisons have been drawn between the alcohol-related harms experienced in Indigenous populations in developed nations such as the United States, Canada, New Zealand and Australia (Brady 2000). Indigenous communities in the United States and Canada have adopted a range of dry area alcohol restrictions, similar to those found in Australia, as a means to decrease consumption (Berman 2002; Berman et al. 2000a; Berman et al. 2000b; Campbell 2008; Chiu et al. 1997; Davison et al. 2011; Kovas et al. 2008).

In a recent study of 78 First Nations, Métis and Inuit communities in Canada, Davison et al. (2011) found that over 50 percent of studied communities had developed and implemented their own alcohol control measures. In Canada's northern territories (Northwest Territories, Yukon and Nunavut), local option provisions in the Liquor Control Acts have allowed for community-led alcohol regulation since the early 1970s. Local regulations can be established if more than 35 percent of the community are in favour of the proposed measures. The local option provisions give community members the opportunity to vote on the level of restrictions introduced. There are four levels of restrictions available to communities:

- limiting the places where alcohol can be sold (e.g., only in specific bars or liquor retailers);
- prohibiting the sale of alcohol;
- prohibiting the importation and sale of alcohol; and
- prohibiting the importation, sale and possession of alcohol (Davison et al. 2011).

There has been a steady increase in the number of communities adopting one of these forms of restrictions in Canada's northern territories (Campbell 2008).

In the United States, legislation prohibiting the sale of alcohol to Native Americans was only revoked in 1953. From this time, tribes were given the

option of abolishing prohibition and controlling the flow of liquor into their individual communities. By 1975, approximately 70 percent of the tribes upheld prohibition through their own governance; however, this had dropped to 36.2 percent by 2006. The majority of communities have adopted liquor control ordinances that sanction the sale and use of alcohol to varying degrees (Kovas et al. 2008: 186).

In the state of Alaska, legislation was introduced in 1981 that gave residents extensive regulatory control over the access to alcohol in individual communities, through local option provisions. Between 1981 and 1993, 99 communities exercised local options to hold 144 elections (Berman et al. 2000b: 312). As a result, 125 communities introduced alcohol restrictions and 19 had them removed. Berman et al. (2001) examined injuries resulting in deaths in these communities between 1980 and 1993, to compare injury rates in communities with different availability regimes, and in the same community under different regimes. They found that injury death rates were generally lower when restrictions were in place. It was estimated that the communities that imposed restrictions had prevented approximately one fifth of all injury deaths that would have occurred in the absence of controls. A control group of 61 small communities that did not change alcohol control status showed no significant changes over time in accident or homicide death rates. No evidence was found of injury deaths or problem drinkers being displaced when communities became dry (Berman et al. 2000a).

Several other studies have also shown positive correlations between area-based restrictions and the reduction of deaths from alcohol injury and alcohol-related outpatient admissions (Chiu et al. 1997; Landen et al. 1997). These studies conclude that banning the importation and use of alcohol was an effective public health intervention, particularly in remote communities. The communities examined in the Alaskan studies were all located in remote areas, and most of them had small populations of less than 1,000 people. These factors – remoteness and small populations – are both seen as relevant to the success of area-based restrictions.

Another issue frequently raised in

discussions of alcohol restrictions in Native American and Alaskan Native communities is the importance of adequate enforcement by police. One study that demonstrates this systematically is Wood & Gruenewald's (2006) examination of injury rates in isolated Alaskan Native villages, with and without local prohibition, and with and without local police. The authors examined injuries in 132 villages between 1991 and 2000. They found that controlling for effects of isolation, access to alcohol markets, local demographic characteristics and local prohibition was associated with lower rates of injury from assaults and 'other causes'. The researchers contend that the presence of police strengthened the beneficial effects of local prohibition. Wood & Gruenewald (2006) conclude that local restrictions are effective in isolated communities with no direct road access to legal purchases of alcohol.

This literature from North America provides strong evidence that area-based restrictions on alcohol availability have beneficial results in small, isolated Indigenous communities, but not in less isolated settings. However, this finding is difficult to substantiate in an Australian context due to a lack of research focusing on this issue.

## Background to the emergence of AMPs in Australia

Various initiatives preceded the introduction of AMPs, including 'restricted areas' or 'dry areas' established by legislation in the Northern Territory (d'Abbs 1990). These initiatives included permit systems to allow individuals to take alcohol into 'dry areas' and restrictions and penalties applied by 'wet canteens'. In 1995, the Queensland Government introduced the *Local Government (Aboriginal Lands) Amendment Act* that applied specifically to the Cape York community of Aurukun. The legislation allowed individuals to apply for bans or restrictions of alcohol in their homes or public areas. The decisions were made by the Aurukun Alcohol Law Council, which was made up of elders and other community members of Aurukun (Martin 1998). In the Northern Territory, the *Liquor Act 1979* (NT) contained a provision enabling communities to apply to the Liquor

Commission to become a 'restricted area'. For a community to become a 'restricted area', an application had to be submitted to the Chairman of the Liquor Commission, who then made a decision based on the application and the level of community support, which included consultation with police and other government agencies (d'Abbs 1990).

Another program that acted as an antecedent to AMPs was the banning of takeaway alcohol sales in major liquor outlets in Tennant Creek on Thursdays between 1995 and 2006, an initiative which became known as 'Thirsty Thursday'. These restrictions were put in place by the Northern Territory Liquor Commission in response to leadership from local Aboriginal organisations and Aboriginal elders requesting one day free from alcohol per week (d'Abbs et al. 2010b). The restrictions included banning takeaway sales in a number of regional towns in northern Australia, and banning the sale of glass bottles in Alice Springs (d'Abbs et al. 1998; d'Abbs et al. 1996; d'Abbs et al. 2000; Douglas 1995; Gray et al. 1998; Gray et al. 2000). Restrictions on the sale and supply of alcohol have been a major focus in the Australian literature concerning efforts to reduce the harms associated with alcohol misuse in Aboriginal communities (National Drug Research Institute 2007).

The National Drug Research Institute (2007) conducted a comprehensive, critical review of all restrictions in Aboriginal communities in Australia and found that there is no single mix of restrictions that would work for all communities. This review concluded that the effectiveness of restrictions were dependent on a number of factors in specific situations or circumstances (NDRI 2007). In some cases, a single targeted intervention, such as an alcohol free day, could be more effective than a suite of restrictions that are poorly implemented. Those interventions with the highest levels of efficacy were reported and included changes in: price/taxation; trading hours; minimum drinking/purchase age. Reducing access to high-risk beverages, reducing outlet density and dry community declarations all demonstrated effective outcomes for reducing consumption and alcohol related problems. There are also distinct challenges in remote Aboriginal communities where specific

restrictions require a certain level of enforcement that might be difficult for areas lacking in resources, such as numbers of police officers (NDRI 2007: 220).

## AMPs in Australia

The first AMPs to be introduced in Australia were adopted under a new Queensland Government policy formulated in response to the Cape York Justice Study, which found that alcohol abuse and violence had become normalised in Cape York communities (Fitzgerald & Queensland Department of the Premier and Cabinet 2001; Queensland Government 2002). The policy entitled, 'Meeting Challenges, Making Choices' provided a set of measures for reducing alcohol-related violence and other harms in Indigenous communities in Cape York and elsewhere in Queensland (Queensland Government 2002).

This policy included a provision for individual communities to develop their own AMPs through Community Justice Groups (CJGs) that were granted statutory powers through the *Community Services Legislation Amendment Act 2002* (Qld). While CJGs have been established in several Australian jurisdictions, only in Queensland do CJGs have a statutory role with respect to developing and overseeing AMPs. As noted above, in late 2002, Australia's first AMP was established in Aurukun, Cape York. This was followed by the implementation of AMPs in 18 remote communities in Cape York (Hudson 2011).

In July 2005, an AMP that was heavily based on a permit system for takeaway alcohol was launched in Groote Eylandt and Bickerton Island. Early anecdotal successes of the Groote Eylandt AMP endorsed the 'AMP' as a popular 'policy instrument' and subsequently AMPs were introduced in Alice Springs (2006), Katherine (2008), Tennant Creek (2008) and other communities (Katherine Region Harmony Group 2012; Northern Territory Department of Justice 2008; Northern Territory Government Department of Justice 2006; Senior et al. 2009). As at May 2013 there were 24 AMPs being either managed or developed in both regional and remote locations across the Northern Territory (NT Government 2013).

The Australian Government's

*Stronger Futures in the Northern Territory Act 2012* (Cth) establishes for the first time a role for the Australian Minister of Indigenous Affairs in approving or rejecting AMPs in the Northern Territory. This Act ascribes a central place to AMPs in reducing alcohol-related harms in Indigenous communities in the Northern Territory. The AMP framework has been designed as a means for Government to work with communities and address community safety with a particular focus on providing more support for women and children and people with alcohol problems. To facilitate the development and implementation of AMPs, the (then) Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) established five minimum standards to assist communities and local governments (FaHCSIA 2013b). This development followed the *Northern Territory Emergency Response Act 2007* (Cth), which imposed a ban on possession or consumption of alcohol on all Aboriginal land in the Northern Territory, including remote communities (with some exemptions, such as licensed clubs).

The 'Minimum Standards' provide guidelines for key processes and content of AMPs, which must identify community-based solutions to reduce harm to individuals, families and communities resulting from alcohol abuse (FaHCSIA 2013a). For example 'Standard 3' suggests strategies for supply, demand and harm reduction while the other standards focus on consultation and engagement, management/governance structures, monitoring, reporting, evaluation and geographical boundaries (FaHCSIA 2013b).

## Different Components and Approaches

AMPs significantly differ from earlier interventions in the processes used in their design and implementation, particularly in some jurisdictions with regard to the level of community engagement. They also vary in scope, statutory (or non-statutory) elements and relationship to supply, harm or demand reduction. The *Northern Territory Alcohol Framework Report* discussed the optional strategies that AMPs might include, such as:

- consultation processes;

- identification of required services and priorities including priorities for funding;
- local social control strategies;
- local community education strategies;
- undertakings by agencies and organisations to undertake specific tasks;
- ways in which policing will be carried out;
- plans of how information will be circulated;
- interaction between police and local community leaders and organisations; and
- undertakings by licensees about responsible service or other supply issues (Renouf et al. 2004).

Although AMPs are based on the principle of harm minimisation, in most communities several alcohol control measures, such as restrictions and permit systems, had been adopted prior to the introduction of AMPs. This may indicate that in these communities, by adding AMPs to their existing approaches, the residents developed and adopted a suite of strategies to suit their circumstances. If so, such a diversity of instruments to reduce alcohol-related harm brings these communities more into line with the legal and policy complexity of large urban settings where a combination of regulation, licencing conditions, inspections, penalties, controlled areas and police enforcement is the norm.

In the Aboriginal communities that adopted AMPs, work was undertaken by governments to re-engage with communities and develop local demand and harm reduction measures. Queensland, Northern Territory and the Australian governments emphasise that alcohol restrictions are only one aspect of a complete AMP, which should include other elements such as harm and demand reduction strategies (FaHCSIA 2013a; NT Government Department of Business 2012; Qld Department of Justice and Attorney-General 2012). However, current evaluations of AMPs have demonstrated that while supply measures have been implemented or associated with specific AMPs, little progress has been made in the areas of harm and demand reduction. d'Abbs (2011) contends that although governments are prepared to support changes associated with regulating the sale of alcohol, demand reduction strategies such as

treatment and rehabilitation garner less support. He further argues this is due to the comparatively low costs associated with amending regulations comparatively to higher cost of many demand reduction options. In the following sections, key examples of supply, demand and harm reduction initiatives associated with AMPs are briefly described.

### Supply

Supply reduction measures have often been the central part of AMPs in Australia. Supply reduction measures control the availability of alcohol through:

- banning or restricting the supply, possession and consumption of alcohol in certain places; or
- placing local restrictions on liquor outlets as part of a broader strategy for reducing local alcohol-related harm.

In all communities, supply measures that existed before the formal introduction of an AMP have been maintained. Any additional supply measures considered for the AMP often focus on tailoring aspects of existing supply restrictions. Some examples include: developing liquor accords; improving night patrols; flexible supply strategies around key community events; and streamlining the process of complaints against licensed premises (Conigrave et al. 2007; d'Abbs et al. 2010). This occurred in Tennant Creek where the AMP brought in a range of measures to implement and monitor more stringent supply plan provisions. This included a focus on: low priced, high level alcohol products; the support of increased enforcement to detect and prosecute illegal sales; compliance with licensing conditions; the establishment of alcohol free areas at community and sporting events; and developing liquor accords with businesses (NT Government Department of Justice 2008).

In some regions, the supply of alcohol is controlled through permit systems. On Groote Eylandt, individuals are unable to purchase takeaway alcohol unless they are permit holders. Requirements for permit holders are clearly specified, along with consequences for failure to comply. There is a provision in the NT *Liquor Act* that allows for the NT Licensing Commission to suspend takeaway liquor sales during times of community tension. This can also be applied in areas that do not have a permit system (NT Government

Department of Justice 2006).

### Demand

Demand reduction strategies have varied in communities across different AMPs. However, improved service delivery in addition to education and health promotion programs in schools and communities are a common approach. For example, the AMP in Katherine proposed demand reduction measures that included the development of better pathways between early intervention and withdrawal, rehabilitation and post-discharge programs in addition to responsible drinking education campaigns (d'Abbs et al. 2010a). In Tennant Creek, demand reduction measures included health promotion and education campaigns in schools and communities, development of community standard protocols on responsible drinking practices, implementation of best practice rehabilitation services among others (d'Abbs et al. 2010b). In Alice Springs, the AMP set out demand reduction measures, such as providing training for health professionals to better target and intervene with risky drinkers, local grants for community groups to address demand reduction strategies, school-based education programs and development of responsible drinking practices with licensed clubs and sporting venues (Senior et al. 2009). In Port Augusta, the AMP demand reduction strategies included appropriate integrated and enhanced service delivery, early intervention programs and community prevention programs (Port Augusta City Council 2010).

Although a range of demand reduction measures have been proposed under the majority of AMPs, a number of evaluations have highlighted that many of these measures have not been implemented (d'Abbs et al. 2010a; d'Abbs et al. 2010b; Senior et al. 2009). In the Katherine AMP evaluation, d'Abbs et al. (2010a) contended that the difficulties experienced in implementing harm reduction strategies were likely due to the higher levels of financial, capital and personnel resources required for their implementation.

### Harm Reduction

When applying harm reduction strategies to alcohol misuse the focus is on reducing those harms that directly impact upon the individual

drinker in a way that is detrimental to his or her health or wellbeing, as well as those that impact upon people around the drinker, whether members of the drinker's family or of the wider community. Although implemented in different ways, the most predominant harm reduction measures implemented in communities with AMPs have been night patrols and sobering-up shelters.

Harm reduction measures in Tennant Creek included: increased access to services, such as rehabilitation and withdrawal; identification of service gaps and better collaboration between services, such as police and night patrols. In the Alice Springs AMP, harm reduction measures focused on increasing the effectiveness of current services, such as the community night patrol, expanding sobering-up services and strengthening options available to support families (Senior et al. 2009). In Katherine, the emphasis was also on improving current services, including the provision of increased accommodation facilities for short-term visitors, targeted case management for at-risk drinkers and increased use of court-mandated treatment for alcohol-related offenders (d'Abbs et al. 2010a).

## Evidence of the effectiveness of AMPs

A number of AMPs across Australia have been evaluated (Conigrave et al. 2007; d'Abbs et al. 2011; d'Abbs et al. 2010b; Senior et al. 2009). These evaluations include qualitative accounts of the implementation process and the extent of community support for AMPs, as well as quantitative analyses of outcomes. Quantitative outcomes include key measures, such as:

- trends in alcohol sales;
  - hospital Emergency Department (ED) presentations for alcohol-related disorders;
  - hospital separations for injuries and alcohol-related mental and behavioural disorders;
  - trends in incidents of alcohol-related assaults;
  - trends in incidents of disturbances and anti-social behaviour; and
  - public drunkenness apprehensions.
- Additional quantitative measures have been used to evaluate AMPs, depending upon the restrictions or in

contexts where AMPs incorporate the requirement for permits to purchase take-away alcohol.

### Evaluations of AMPs

Evaluations of the impact of specific AMPs on a range of key indicators associated with alcohol-related harm have found variable results. General conclusions about the effectiveness of AMPs must be made with caution due to the limited number of evaluation reports and studies available to the public. An important further consideration is that in many cases, evaluations of AMPs have found that the full complement of demand, harm and supply reduction measures are rarely implemented.

While the Queensland Government commissioned a number of evaluative studies of AMPs in Queensland, some of which were made available to the public at the time, these studies are no longer in the public domain. However, two studies have been conducted examining data from the Royal Flying Doctor Service (RFDS) (Margolis et al. 2008 & 2011). Margolis et al. (2008) analysed the trauma retrieval rates from the RFDS from 1995 to 2005 in four Cape York communities where AMPs were in place. The authors found a statistically significant decline in injury retrieval rates following commencement of AMPs. When compared with rates for the two years immediately preceding AMPs, rates for the two years post-AMPs fell by 52 percent. Margolis et al. (2008) concluded that the AMPs had been effective in reducing serious injury in these communities. The subsequent study (Margolis et al. 2011: 503) continued this analysis, finding that serious injury rates fell from 30 per 1000 people in 2008, to 14 per 1000 people in 2010.

However, Gray and Wilkes (2011) questioned the use of RFDS retrieval rates for all serious injuries as a reliable indicator for alcohol-related harm. They suggested that aetiological fractions for ED presentations would have allowed for the presentation of more accurate data of the impact of AMPs.

Another location where positive outcomes have been recorded following the introduction of an AMP was for Groote Eylandt and Bickerton Island in the Northern Territory (Conigrave et al. 2007). Evidence from qualitative interviews conducted with residents and key stakeholders

in the region found that as a result of the AMP, community functioning had markedly improved, violence had decreased and engagement in the workforce had improved. As one informant put it:

*Before there was violence. Women scared, children scared. Children growing up seeing violence. Since the alcohol has stopped, the men who used to be drinkers and used to be violent are going hunting. Taking their children hunting. Getting good food. (Conigrave et al. 2007: 4)*

The researchers also analysed police law enforcement data in the region, and found there had been a reduction in incidence of aggravated assaults (-67%), house break-ins (-86%) and admissions to correctional centres (-23%) in the years following the introduction of the AMP (Conigrave et al. 2007). A key finding of the study was that the success of the AMP could be attributed to ownership and support of the system by the Aboriginal communities and by key local service providers, employers and by the licensed premises (Conigrave et al. 2007). Others, such as Gray and Wilkes (2011), have supported this idea and argued that in towns such as Hall Creek and Fitzroy Crossing, where Aboriginal and non-Aboriginal people worked together, alcohol restriction measures were more effective.

Evaluations of individual AMPs in other Northern Territory towns have shown variable outcomes, such as those conducted in Katherine, Alice Springs and Tennant Creek (d'Abbs et al. 2010b; d'Abbs et al. 2010a; Senior et al. 2009). The Katherine AMP commenced in January 2008, and in the six-month period following its introduction there was a significant decrease in the number of people presenting in the ED for 'mental and behavioural disorders due to the use of alcohol' (d'Abbs et al. 2010a: 4). However, the initial decline soon reversed. By the end of 2008, the total number of presentations was 7.8 percent higher than the preceding 12-month period prior to the introduction of the AMP (d'Abbs et al. 2010a: 4). A similar trend occurred with alcohol-related assaults, where the recorded level of assaults in the first six months of 2009 was 32 percent higher than the equivalent period, prior to the commencement of the AMP (d'Abbs et al. 2010a: 4).

Tennant Creek has an extensive history of measures to address alcohol-related harms and other social problems. An AMP took effect in the town in August 2008. This was preceded by the takeaway alcohol restriction, mentioned above, known as 'Thirsty Thursday'. An evaluation of these measures found that the only indicator that showed a substantial positive change as a result of the AMP compared to the rates achieved during the 'Thirsty Thursday' restrictions was in the reduction of public order incidents (d'Abbs et al. 2010b). In the year following the revocation of 'Thirsty Thursday' (2006-07), these incidents increased by 6.5 percent. However, after the introduction of the AMP (2008-09) they dropped to 27.1 percent lower than that of the preceding year (2007-08). Significantly, the post-AMP rates were also 25 percent lower than the year prior to the revocation of 'Thirsty Thursday' (d'Abbs et al. 2010b: 56-7). Although the number of assaults and apprehensions declined following the introduction of the AMP, they still remained higher than they had been prior to the 2005-06 period. The number of Indigenous people presenting at the Tennant Creek ED for alcohol-related disorders rose by 56 percent in 2005-06 and by a further 61 percent in 2007-08. This upward trend was reversed following the introduction of the AMP, but was still 61 percent higher than in 2005-06, prior to the 'Thirsty Thursday' restrictions being lifted (d'Abbs et al. 2010b: 8).

The Alice Springs AMP was implemented in 2006 and an evaluation found that for the period from 2006-08 that there was an 18 percent decrease in total alcohol consumption (Senior et al. 2009: 161). During the same period the absolute number of assaults rose marginally, however, the number of serious assaults recorded declined (Senior et al. 2009: 97-8). This finding was consistent with the qualitative data collected from interviews with police and staff from the Alice Springs Hospital. Admissions to the sobering-up shelter also increased from 2006-08, although the evaluators attributed this to more proactive policing during this time (d'Abbs et al. 2010). Lastly, there was an increase in the number of break-ins to commercial properties in 2007-08, particularly licensed premises (Senior et al. 2009: 100).

It is important to note that the

Katherine, Tennant Creek and Alice Springs AMP evaluations cite the difficulties in attributing the increases or decreases of indicators solely to the introduction of AMPs. This could be due to the introduction of many other government policies during the 2006 to 2012 period, such as the quarantining of income by the Australian Government as part of the *Northern Territory Emergency Response Act 2007* (Cth). Other factors that may impact on a range of indicators include changes to government operations, such as police reporting procedures and community events that occur during the development and ongoing management of AMPs.

### **Community support and the process of design and implementation**

The processes of the design and implementation of an AMP will vary depending on the way it is introduced to a community, town or region. In Australia, there have been three distinct pathways:

- strong community involvement in defining the AMP agenda (e.g. Groote Eylandt);
- government managed community participation (e.g. Tennant Creek, Katherine); or
- initiation of the process by government-appointed consultants (e.g. Yarrabah)

(Conigrave et al. 2007; d'Abbs et al. 2010b; d'Abbs et al. 2010a; Queensland Government Department of Aboriginal and Torres Strait Islander Policy 2006).

The limited evidence available on their design and implementation indicates that AMPs that are created through a relatively high level of community involvement, such as on Groote Eylandt, demonstrate stronger and more sustainable outcomes than those developed and managed through a more 'top down' approach. An AMP, regardless of its formulation, is an attempt to bring about individual and community change. At the level of the community they are designed to enhance local capacity to prevent, manage and treat alcohol misuse. It is expected that changes made at the community level will instigate behavioural changes at the individual level (Glanz et al. 2008). Successful community-level interventions to combat alcohol misuse, such as the

AMP in Groote Eylandt, have been preceded by a considerable amount of community activity and achievement (Conigrave et al. 2007).

At Groote Eylandt, the permit-based takeaway alcohol system introduced in July 2005 was preceded by sustained community engagement from local police. A series of meetings were held with the Anindilyakwa Land Council and other community members to ensure that issues were heard and reflected in the final plan submitted to the Northern Territory Licensing Commission. Other service providers, such as the health clinic and the mining company GEMCO, also played a key role in engaging with community members. (Conigrave et al. 2007)

Although both AMPs were initially community driven in Katherine and Tennant Creek, evaluations found that both AMPs were transformed into a government driven process (d'Abbs et al. 2010b; d'Abbs et al. 2010a). This was in regard to both the development and design of the AMP as well as the ongoing management. In the Katherine evaluation, a number of Indigenous organisations extensively involved in preventing, managing and treating alcohol-related problems reported that they were excluded from any meaningful discussions regarding alcohol issues and possible solutions (d'Abbs et al. 2010a). There was a similar finding in the Tennant Creek AMP evaluation, with some groups arguing that the agenda was controlled by the Northern Territory Government (d'Abbs et al. 2010b). Also, over half of the people surveyed in the Tennant Creek evaluation had no awareness of the existence of an AMP.

The Alice Springs AMP evaluation also reported that many community members believed the Northern Territory Government had introduced restrictions without adequate consultation. Many of those surveyed were not aware of the broader elements of the AMP, such as the demand and harm demand reduction strategies, and viewed the AMP as only containing alcohol restrictions (Senior et al. 2009).

### **Current issues and challenges for AMPs**

Although AMPs can be viewed as a viable way for all levels of government and local communities to

work together in addressing alcohol issues, there are many challenges facing AMPs in Australia. At a policy level, a key challenge remains in balancing the interests and principles of different actors and sectors within society. Policies and programs designed to reduce alcohol-related harms challenge the vested interest of those who gain from selling alcohol and also members of the community who strongly believe it is their right to purchase and drink alcohol when and where they choose (d'Abbs 2010b).

The evaluations carried out on AMPs currently in place have highlighted a number of weaknesses. For example, some of the AMPs adopted have initially been designed to incorporate measures addressing supply, harm and demand reduction, but when implemented, the agenda has often narrowed to primarily cover supply issues (d'Abbs et al. 2010b; Senior et al. 2009). Other criticisms challenge the lack of clarity in the roles and responsibilities of communities and governments, and lack of support in nurturing local community leadership committed to dealing effectively with alcohol related problems. It has been suggested that it is necessary for coalitions to be developed between those directly involved in an AMP and other invested individuals, institutions and organisations to support the goals of AMPs (d'Abbs 2011; d'Abbs et al. 2010a: 6-7; Senior et al. 2009a).

## Conclusion

A number of AMPs operate in Aboriginal communities in Australia with the aim of addressing local alcohol-related harms. AMPs are regarded as a vehicle for governments and communities to work together to combat a range of alcohol problems through the use of local community control over alcohol availability and the management of alcohol-related problems. Although evidence is limited, it has been found that where AMPs are locally driven and owned, there are stronger and more sustainable outcomes. Drawing on both international and Australian literature, there is a good evidence base for the individual components that make up an AMP. Success has been achieved through alcohol restrictions, and both harm and demand reduction strategies have an evidence base as targeted interventions. As more AMPs

are implemented across Australia, particularly in the northern jurisdictions, it is clear there is a greater need for further research to better understand the process of implementation of how communities can work together with governments to design, implement and evaluate AMPs.

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