Evaluation of the Bourke Alcohol Action Plan: final report

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Abstract
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EVALUATION OF THE BOURKE ALCOHOL ACTION PLAN: FINAL REPORT

Prepared in collaboration with:
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June 2012
EVALUATION OF THE BOURKE ALCOHOL ACTION PLAN INTERIM REPORT

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June 2012
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- Bourke Aboriginal Community Justice Group.
- Bourke Indigenous Coordination Centre.
- Bourke Liquor Accord.
- Bourke Shire Council.
- Aboriginal Affairs, Human Services.
- Community Services, Human Services.
- Greater Western Area Health Service.
- Housing NSW, Human Services.
- Murdi Paaki Region Housing Corporation.
- NSW Police Force – Darling River LAC.
- NSW Office of Liquor Gaming & Racing.
- NSW Outback Division of General Practice.
- Juvenile Justice, Human Services.
- Murdi Paaki Drug & Alcohol Network.
- Centacare.

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Executive Summary

Background
In 2008, Bourke community members joined together to form the Bourke Alcohol Working Group (BAWG) due to increasing concerns regarding alcohol misuse in the community. Via community consultation, including distribution of a discussion paper and a holding a public forum, BAWG developed a five-year Bourke Alcohol Action Plan (the Plan).

The Plan comprises six priority areas:
1. Creating Positive Environments;
2. Education and Awareness;
3. Clinical and Support Services;
4. Partnerships;
5. Restrictions on Alcohol Sales; and

The George Institute for Global Health was approached by BAWG to evaluate the impacts of the Plan, with particular focus on the impacts of the alcohol sales restrictions. A team of collaborators was subsequently formed and funding secured from the Centre for Road Safety, Transport for NSW (formerly the Roads and Traffic Authority of NSW). Given the need for evidence-based policy to improve road safety among Aboriginal road users in NSW, the Centre for Road Safety had a particular interest in exploring the effects of the restrictions on road safety in the Bourke area.

Aims and objectives
The overall aim of the evaluation was to assess holistically the impact of the Bourke Alcohol Action Plan on community safety, health and wellbeing. More specific objectives included monitoring and reviewing the impact of the Plan’s initiative to restrict takeaway alcohol sales, and assessing the impact of the Plan on road safety. A secondary objective was to explore whether impacts had extended to Aboriginal residents as well as non-Aboriginal residents of Bourke.

Progress on the Bourke Alcohol Action Plan
Progress on the Plan was identified in all of the six priority areas. Positive environments had been created by the clearing of broken glass in the community and reduced public drunkenness and fighting in the streets was reported following the introduction of the takeaway alcohol restrictions. Many education and awareness initiatives, including public forums, information campaigns and a range of in-school activities, had been held and were ongoing. Increased clinical support via additional dedicated alcohol and drug personnel had been achieved and extensive partnerships established. A pivotal achievement was the introduction of alcohol sale restrictions, which were effected on February 16, 2009. These comprised:

- No fortified wine in containers greater than 750mL;
- No beer in 750mL glass bottles (longnecks);
- No wine in casks greater than two litres;
- Only drinks with an alcohol content of 3.5% or lower, packaged in non-glass containers, can be sold between 10am and 2pm. Residents living more than 50km from the licensed venue are exempt from this restriction;
The licensee must display and make information available for patrons. The information must be agreed to by the Darling River Local Area Commander (NSW Police) in consultation with the BAWG; and

A voluntary undertaking by the six licensees in Bourke at the time that all purchasers must place purchased alcohol into a motor vehicle (Liquor Accord).

The alcohol restrictions were a key focus on the review and explored in research literature on community alcohol management plans.

**Literature review**

This literature review focused on two main themes of this research: firstly, a review of previous evaluation research of alcohol management plans in other Australian communities; and secondly, a review of road safety research undertaken in Aboriginal and Torres Strait Islander and remote communities. This road safety literature is relevant for Bourke, a community situated in a very remote area of NSW and with a high Aboriginal population, including residents living considerable distances from the town centre.

**Alcohol management plans**

Several evaluations of alcohol management plans were identified, all implemented in remote or very remote communities across the country, spanning the Northern Territory, Queensland and Western Australia. All evaluations indicated injury reduction benefits, including among violence and road-related injuries. The types of restrictions on alcohol sales introduced within the plans varied widely, as did the methodological and statistical approaches used to determine potential decreases. Further, some were supported by wider community initiatives. Therefore it is not possible to state with any certainty whether one particular type of alcohol management plan or restriction on alcohol sales was more effective than others. However, the most common features were reductions in the alcohol strength of takeaway sales and reduced access hours in which to purchase takeaway alcohol from licensed premises. Beer and wine were most commonly targeted although specific restrictions for spirits were sometimes also included.

All studies highlighted the importance of community ownership and determination of alcohol management plans as a key contributing factor to the success and acceptance of the initiatives. Conversely, government imposed initiatives or perceptions that this was the case, rather than community initiation, was a key barrier to the community acceptance of the initiatives. Other features considered to contribute to the success of the alcohol restrictions included the harm reduction approach (rather than complete prohibition) and support of on-going educational information campaigns and alcohol treatment and rehabilitation services. Other challenges to the effectiveness and sustainability of the restrictions included under-resourcing, short timeframes to implement initiatives or incomplete implementation of initiatives, as well as short timeframes for evaluation or difficulties accessing quality, relevant data to provide evidence for increased support. These were important themes to attend to in the current evaluation.

**Alcohol and road safety**

Despite marked reductions in road traffic injuries and fatalities following changes to drink driving legislation and enforcement in Australia in the late 1970’s, alcohol continues to play a role in about 30% of all road-related deaths and 9% of crash injuries each year. This includes not only drivers or riders under the influence of alcohol, but also intoxicated pedestrians. While it is widely accepted that alcohol can impact on crash risk, the extent of that impact is not always well recognised. In fact, the 0.05% Blood Alcohol Concentration (BAC) set as a
limit for fully licensed drivers in Australia represents the threshold associated with double the risk of a crash when compared to zero BAC. This risk increases exponentially at higher BAC levels, such that for a BAC of 0.08 risk increases by seven times and for 0.15 the risk is 25 times.

While road crashes are typically less frequent in rural and remote areas when compared to urban settings, the crashes that do result are more likely to involve injuries, including fatalities. This is often attributed to higher speed zones and therefore higher travel speeds at the time of crash, but alcohol is also a contributor (as well as fatigue and road geometry, particularly curved road segments). With a lack of alternative public transport options in remote communities, driving under the influence of alcohol continues to be a major road safety issue. Further, in Australia, a high proportion of Aboriginal people live in rural and remote areas and Aboriginal people have a greater risk of a road injury or fatality than non-Aboriginal Australians. However, this higher road injury risk is also found for urban Aboriginal communities, so not all the difference can be explained by area of residence. On a population basis, Aboriginal Australians are two to three times as likely to have a transport-related fatal injury and 30% more like to have a transport-related serious injury requiring hospital treatment. Access to roadworthy vehicles and licensed drivers are factors that contribute to this increased risk, but overall, there is limited relevant information available in this field, which contributes to a lack of effective policies and programs to address the gap.

A particular concern regarding alcohol restrictions is that they might increase driving exposure, and therefore potentially drink driving exposure, due to increased distances travelled to neighbouring towns where restrictions do not apply. While there is some indication of this in previous research, overall road safety was found to improve nonetheless; however this remains a valid concern to explore for Bourke. Therefore, the current research included attention to potential impacts of the Bourke alcohol restrictions on road safety and any differences for Aboriginal and non-Aboriginal road users.

Methods
A mixed-methods approach was adopted utilising qualitative and quantitative approaches. Qualitative methods were used to explore community and stakeholder perspectives on alcohol in the community and the impact of the Plan and particularly the alcohol restrictions. Two waves of qualitative data were collected coinciding at approximately one year (April 2010) and two years (March 2011) post introduction of the alcohol restrictions. Wave one comprised a focus group with 12 participants and interviews with 17 participants, and the second a focus group with 13 participants and interviews with 6 participants (including several repeat participants from the first wave).

Quantitative methods were used to explore trends in alcohol-related injuries and offences before and after the restrictions were introduced, utilising a range of data sources, including: Emergency Department (ED) records from the Bourke Hospital; hospital admission data routinely collected by NSW Health; a police intelligence report provided by Bourke Police; and police-recorded road traffic offence and crash records routinely collected by Roads and Maritime Services (former RTA). Analyses focused on comparisons between the 12 months prior to and 12 months post introduction of the alcohol restrictions, although varied dependent on data availability.

BAWG formed the reference group for the research and ethical approvals were obtained from The University of Sydney Human Research Ethics Committee, the Aboriginal Health and Medical Research Council, and the Greater Western Area Health Service (analysis of Bourke Hospital emergency department data only).
Qualitative results

One-year follow up

All interviewees identified issues with alcohol misuse in Bourke and the majority reported visible improvements in the community since the forming of BAWG and the Bourke Alcohol Action Plan. This was appreciated and mostly considered valuable, both at the wider community level (less problems on the streets, potential increase in tourism) and individual level (perceived positive impact on problem drinkers and therefore their impact on others, including their families). Mixed opinions primarily arose in relation to the takeaway alcohol restrictions.

There was mixed understanding of the rationale behind the alcohol restrictions (“public health” versus “political”) and their community-led introduction, including perceptions of a lack of prior community consultation. This was despite advertised public forums. Education and promotion activities after the introduction were also perceived as limited. Concerns included lack of culturally specific education strategies for Aboriginal community members.

Some interviewees expressed a belief that the restrictions were the “best available” option, even those who perceived them as not necessary personally, but for the good of the community as a whole. Others however argued improved education and treatment programs would be more beneficial, viewing the restrictions as a “Band-Aid” solution only.

Several participants, while acknowledging concern about the restrictions from a “civil liberties” perspective, suggested they were “a small price to pay” given their perceived impact in reducing violence in the community. Some objected however to the majority being “punished” for the sake of a minority with alcohol misuse problems in the community, and expressed doubt that the restrictions could overcome these problems for this minority. Some acknowledged misperceptions of the alcohol issues being confined to Aboriginal residents, while others regarded heavy drinking as just part of the outback Australian culture, including ties to unemployment.

The most common perceived improvement since the introduction of the alcohol restrictions was reduced assaults, with others also reporting perceived improvements for children, including fewer injuries at house parties and more food for which funds might previously have been spent on alcohol, and noticeable reduction of broken glass and intoxicated persons in public areas. Several also reported improved tourism, also associated with improved “community pride”.

Perceptions of potential negative impacts included suggestions that restrictions on alcohol may have resulted in increased use of other drugs. It was also noted the restrictions pertained largely to the strength of alcohol and size of container but not the overall amount purchased and it was queried whether this was truly having an impact or whether total takeaway sales should also be capped. Manufacturers had adjusted the size of their containers and/or the strength of alcohol in popular beverages to be just below the threshold of the restrictions.

Two-year follow up

By the two-year mark, some issues touched on at one-year were more vocal and associated with a perceived backlash against the alcohol restrictions. This included concern regarding the 50km residency exemption and whether the restrictions should all be made voluntary.

The 50km residency exemption was viewed as simple to get around due to: ease in changing the residential address on a driver licence (although fraudulent changes were not believed to be a core problem); many locals also legitimately having residences in other towns; and asking those exempt to purchase for locals. From those working at the point of sale, the exemption...
was viewed as difficult to enforce if purchasers did not produce sufficient documentation or were known to be misrepresenting their address. They did not believe it was their role to call the police to address this and likewise the police did not see this as an acceptable or preferred option. Police expressed concerns that their crime figures appeared to be returning to increases and believed this particular “loophole” was the main contributor (albeit this could be a fluctuation only or a range of other factors could be contributing to any increase).

Some argued making the restrictions voluntary could be more empowering from a community perspective, although others reported this had been previously attempted in Bourke unsuccessfully. Examples were also reported of both successful and failed voluntary initiatives in neighbouring regional towns. In fact, Bourke was viewed as setting the example in the region and leading to these developments of community introduced alcohol management plans in other towns in the region. This has also resulted in a sense of pride in the community reported by several interviewees.

Also particularly evident at the two-year follow up was concern as to whether the alcohol issues, previously visible on the streets, had simply shifted into private homes. The Police reported that they had perceived some trend towards this prior to introduction of the restrictions. Mail order alcohol sales were also suspected to be increasing. A potential shift in increased consumption of spirits was also suspected but unconfirmed.

An obvious concern of the restrictions was a threat to businesses although there were mixed reports as to whether these had been realised. Sales had reportedly decreased on takeaway full strength alcohol but increased on low strength alcohol as well as increased in-premises sales of full strength alcohol, such that overall revenue remained relatively unchanged. Concern public hotel (“pub”) licences (to which the restrictions are attached) would be less value were in part supported by suggestions some establishments had closed; although it was suggested this had already been occurring due to the global financial downtown. Further, one establishment had recently sold for a large sum above others in the region. We were not able to verify these details from other sources and, despite attempts, were unable to access alcohol sales records for either retail or wholesale sales.

The potential increase in residents travelling to neighbouring towns to purchase alcohol without restrictions (known as the “rabbit run”), which could impact on both business and road safety was not evident. Nonetheless, given continued issues with a lack of taxis and other public transport, drink driving was still believed to be common at the one-year follow up but considered to have reduced overall by the two-year follow up. Concern was expressed however that a more recent occupational health and safety review had deemed only two locations in Bourke as safe for police to conduct random breath testing operations. Given these locations were known to residents and could be readily avoided, there was concern drink driving might subsequently increase.

Responses also indicated a sense that road safety was perceived as a secondary concern to violence. Despite reduced public drunkenness, it was unclear whether intoxicated walking had reduced at all following alcohol-involved events (such as parties and funerals). While child bicycle helmet use appeared on the increase and youth stealing cars on the decrease, there were concerns in relation to youth not gaining a driver licence and unlicensed driving generally and whether Roads and Maritime Services (former RTA) could assist with this.

By two years, the restrictions seemed to have been accepted overall among interviewees and rather than complete removal, changes were proposed instead: removing the 50km residency exemption; changing to voluntary restrictions; increasing and improving education (alcohol management, age and culturally appropriate resources, including addressing issues such as Foetal Alcohol Spectrum Disorder); and increasing treatment availability and diversionary
options for problem drinkers. Further in a sense of “moving on” from the focus on restrictions, a range of other positive activities for Bourke to explore were offered, such as recycling options and youth activities, particularly increased support for PCYC. Extension of the Plan to other drugs was also raised.

**Quantitative results**

**Emergency Department data, Bourke Hospital**

Analyses of the Bourke Hospital emergency department (ED) data first focused on the 12 months prior (February 2008 to January 2009) and 12 months following (February 2009 to January 2010) introduction of the alcohol restrictions in February 2009. There were too few cases to determine any changes in road-related injury presentations. Key findings included:

- There were 636 injury-related presentations, nearly 6% of all emergency related presentation to Bourke hospital during the study period (Feb 2008-Jan 2010).
- There was no overall change in the proportion of injury-related ED presentations.
- The proportion of alcohol-related injury presentations (of all injury presentations) showed a decline but this was not statistically significant at the 5% error level; however, approached significance at the 6% error level.
- There was a significant decline in the proportion of assault-related presentations.
- Across the study period, alcohol was involved in nearly 60% of all assault injuries (as opposed to 30% of all injury presentations).
- There was a significant decline in the proportion of injury presentations for Aboriginal residents.
- The proportion of alcohol-related injury presentations for Aboriginal residents showed a decline but was not statistically significant.
- The proportion of assault-related injury presentations for Aboriginal residents also showed a decline but was not statistically significant.

Given several positive trends were indicated but did not reach significance among the small number (statistically) of injury presentations available, and given the power of trend analysis is strengthened with additional data points, analyses were repeated with the full data set available from January 2008 to March 2010. For this larger dataset:

- There were 714 injury related presentations, also approximating 6% of all emergency related presentations.
- Similar to the smaller dataset, there was no overall change in the proportion of injury-related ED presentations.
- The previously indicated trend towards a decrease in the proportion of alcohol-related injury presentations reached significance.
- Similar to the smaller dataset, the proportion of assault-related injury presentations declined significantly.
- Also similarly, the proportion of injury presentations by Aboriginal residents declined significantly.
- The previously indicated trend towards a decrease in the proportion of alcohol-related injury presentations among Aboriginal residents did not reach significance at the 5% error level but approached significance at the 9% level.
- The previously indicated trend towards a decrease in the proportion of assault-related injury presentations among Aboriginal residents did not reach significance at the 5% error level but approached significance at the 8% level.
### Executive Summary

**Hospital Admissions Data, NSW Health**

Analyses compared findings for 12 months post restrictions (February 16, 2009 to February 15, 2010) to the 12 months prior (February 16, 2008 to February 15, 2009). There were too few cases to determine any changes in road-related hospital admissions. Key findings included:

- There were 229 injury-related hospital admissions of Bourke residents: 117 (51.1%) in the 12 months prior to the alcohol restrictions and 112 (48.9%) in the 12 months post their introduction.
- Males represented about half (50.4%) of all injury-related hospitalisations during the pre-period, rising to 61.6% during the post-period; however this difference was not statistically significant.
- The average age of those hospitalised was 31.3 (standard deviation 19.3) and 35.2 (standard deviation 21.6) during the pre- and post-periods, respectively. Almost one-quarter of the hospitalisations were of children and young people aged less than 15 years. Age differences were not statistically significant.
- 59% of admissions were reported to be of individuals who identified as Aboriginal (but not Torres Strait Islanders) during the pre-period, with this proportion decreasing to 48.2% during the post-period; however this was not statistically significant.
- Falls represented approximately one-quarter of all injury admissions during both the pre- and post-periods. Overall, there were no significant differences in the type of injury mechanism during the two time periods, however, the number of assault-related presentations reduced by one and a half times.
- The home was the most common location of the injurious incident during both the pre- and post-periods. There were no significant differences in the place of injury occurrence during the two time periods.
- There were no significant differences between the pre and post evaluation period for hospital admissions involving alcohol.
- Overall, there were no significant differences in the location of injury between the two time periods; however, the number of head injuries reduced by one and a half times.

**Police Intelligence Report, NSW Police**

The NSW Police Intelligence Report on crime statistics in Bourke comparing the 18 months pre and post the introduction of the alcohol restrictions reported the following:

- Bourke experienced a 32% drop in intoxicated persons; 22% drop in assaults; 25% drop in domestic-related assaults; 18% drop in sexual assaults; and 34% drop in malicious damage.
- Several of the reductions also showed time shifts that were over and above those that might be expected due to the 10am to 2pm restriction on takeaway alcohol sales.
- The use of glass as a weapon in offences did not however show any change during the evaluation period.
- Overall, 79 fewer people had been seriously affected by alcohol and there had been 86 fewer assaults overall.

**NSW Police recorded road traffic offences and crashes**

Police-recorded road traffic offences involving alcohol were found to vary considerably from month to month in Bourke. The number of offences appeared to reduce when the takeaway alcohol restrictions were first introduced and then increase to previous levels, although there was some indication of a decrease in the most recent months. Overall, 33 alcohol-related road traffic offences occurred prior to the restrictions and 41 following the restrictions, however,
the trend in offences did not vary to a statistically significant degree between the pre and post periods.

The number of alcohol-related crashes in Bourke was extremely low and therefore changes could not conclusively be attributed to the introduction of the Plan or the takeaway alcohol restrictions. Only two crashes involving alcohol were recorded in the 12 months prior to the restrictions and none in the 12 months following.

**Discussion, conclusions, recommendations**

There were several limitations to the evaluation that first need to be acknowledged:

- The qualitative data focused on community and stakeholder perceptions from a non-random sample at 1-2 years following the restrictions, and therefore was subject to recall and personal biases. Inclusions of a wide range of community residents, including patrons of licensed premises, licensees and alcohol and injury related service providers increased the likelihood that a full range of perspectives was addressed.
- For the analyses of data on ED presentations, it is important to note that alcohol involvement was unknown in over 40% of injury presentations.
- It is very likely that the identification of alcohol involvement in the occurrence of the injury-related hospital admissions was an under-enumeration due to multiple factors, including that the same data fields used to identify an injury-related admission or an external cause code were also used to identify possible alcohol involvement. Therefore the selection criteria for an injury event, may have excluded potential alcohol-related hospital admissions. Only the secondary and supplementary diagnosis and external cause codes were able to be used to identify a likely alcohol-related admission. In addition, blood alcohol levels may not have been assessed or alcohol involvement identified. It is possible that the identification of indigenous status may also be under-enumerated. In the past, it has been estimated that under reporting is by at least one-third due to a number of issues, including a lack of understanding as to why the information is collected, poor identification of indigenous status and inconsistent collection of data on indigenous status by hospital staff.
- No comparison community was able to be identified to act as a control. Therefore conclusive links between the introduction of the restrictions and identified improvements cannot be made, as other factors may have also contributed to the decline.

Notwithstanding these limitations, collectively the qualitative and quantitative results, and comparisons to previous evaluations identified in the literature, led to several conclusions and recommendations:

**Conclusion 1**: Overall the majority of impacts of the Bourke Alcohol Action Plan have been positive for the Bourke community, including in the streets and in the home.

**Conclusion 2**: Injuries, including those relating to alcohol, particularly severe (head) injuries and assaults, have shown substantial decreases since the alcohol restrictions were introduced.

**Conclusion 3**: Reductions in injury presentations to the Bourke hospital were evident for Aboriginal residents, including indications of reductions in alcohol-related injuries.

**Conclusion 4**: Police records indicate that time-based restrictions on alcohol sales have not simply shifted problems to later in the day/night, but have led to absolute reductions in assaults, including domestic violence-related assaults.
Conclusion 5: Police enforcement levels following the alcohol restrictions generally followed previous patterns and therefore could not be attributed as inflating the reductions in offences.

Conclusion 6: Current results were inconclusive in relation to potential impacts on road safety, primarily due to small numbers of police-recorded road traffic offences and crashes involving alcohol.

Recommendation 1: Reanalyse quantitative data at a three year follow up to strengthen the conclusiveness of the findings and identify potential demographic targets for future programs (currently limited by low statistical power).

Recommendation 2: Initial road safety developments should consider initiatives that would stimulate youth and others to gain or regain licensure, including liaison with Roads and Maritime Services (former RTA) regarding current services and information or other potential new initiatives.

Recommendation 3: Renewed attempts at a three-year follow up to review alcohol sales data and mail order sales data should also be reviewed.

Recommendation 4: Further investigation of glassing incidents is needed to determine sources of glass and incident locations to indicate whether restricting all alcohol sales to non-glass containers would lead to reductions.

Recommendation 5: Improved education and awareness initiatives are needed to increase community understanding of the alcohol restrictions as community-led and community owned, including age appropriate and culturally tailored initiatives, justifications for on-going and new initiatives, and expanded focus to alcohol management and treatments, including for alcohol-related health consequences (e.g., Foetal Alcohol Spectrum Disorder).

Recommendation 6: Extension of the Plan to address other drugs in addition to alcohol is important and should be assessed for impact and acceptability in future evaluations.

Recommendation 7: On-going monitoring and evaluation should include attention to any shift in misuse of alcohol and drugs from public places to the home.

Recommendation 8: The 50km residency exemption is not possible to enforce adequately, is problematic for licensees and Police alike, and therefore its removal from the restrictions should strongly be considered. This should be pursued with clear public debate, including Council. Initiatives to garner support of neighbouring communities should also be considered. No other changes to extend or alter the current restrictions are currently recommended.

Recommendation 9: Consider roles for BAWG in introducing suggested other activities in Bourke, including innovative initiatives that could also involve and support local businesses.
Chapter 1 Introduction

1.1 Background

The town of Bourke is located in the north-west of New South Wales (NSW), approximately 800 kilometres north-west of Sydney and 162 kilometres west of Brewarrina. It lies on the south bank of the Darling River, at the junction of three highways: the Kidman Way, Mitchell Highway and Kamilaroi Highway. The main industries in the area include sheep and cotton farming. Lying within the Murdi Paaki ATSIC region, Bourke has a population of approximately 2,145, of whom 815 or 33% identify as Aboriginal¹ (Australian Bureau of Statistics 2007).

In the late 1990s, a high rate of injury in the Bourke area was identified as a public health concern by the Far West Population Health Unit. The Bourke Injury Prevention Project was initiated advocating broad community consultation and development of an integrated community based program to reduce injury. In 2006-2008 a Commonwealth government funded workforce development and capacity building project, the Rural and Remote Aboriginal Safety Promotion Program, was implemented by the Bourke Aboriginal Health Service (BAHS) and The George Institute. This culminated in small safety promotion projects being conducted in the community and Aboriginal health and community workers developing skills in injury prevention and safety promotion.

Following these early initiatives, in 2008, several Bourke community organisations and representatives joined together to form the Bourke Alcohol Working Group (BAWG) due to increasing concerns regarding alcohol misuse in the community. At that time, Bourke was reported to have the highest rate of alcohol-attributed hospitalisations and assaults in NSW; an 85% increase in domestic violence offences and a 25% increase in malicious damage offences over the past decade (Office of Liquor 2009).

BAWG represents a partnership between the Bourke Community Drug Action Team, Bourke Police, Bourke Shire, Bourke Community Working Party, Greater Western Area Health Service, NSW Health, Bourke Aboriginal Medical Service, Bourke Liquor Accord and the NSW Office of Liquor, Gaming and Racing. The partnership aims to identify and address alcohol-related issues in Bourke, with members meeting and reporting on progress monthly.

One of the first actions by BAWG was to engage a consultant to investigate and produce a discussion paper that highlighted the areas of greatest concern with regard to alcohol use in Bourke. This paper became the basis of a two-day forum with guest speakers held in Bourke in mid-2008, aimed at identifying achievable strategies to reduce alcohol misuse and related incidents of violence, injury and disease. The forum was attended by approximately 80 people, including concerned community members and professionals from various agencies. Discussion was encouraged regarding the priority areas of Health, Education, Welfare, Housing and Environment, and Police and Justice.

Based on this process and outcomes of the discussion, BAWG developed a five-year Bourke Alcohol Action Plan (detailed in Chapter 2). One of the key strategies implemented, in negotiation with the NSW Office of Liquor, Gaming and Racing was the introduction of alcohol restrictions during February 2009. These primarily focused on takeaway alcohol sales,

¹ Indigenous residents of Bourke primarily identify as “Aboriginal” and this is their preferred description. The term “Aboriginal” is used interchangeably with “Aboriginal and Torres Strait Islander” and “indigenous” in this report. When referring more broadly than Australia, “Indigenous” is used.
including the maximum strength of alcoholic beverages, size of containers, type of container (non-glass) and need for purchasers to place takeaway alcohol into a motor vehicle.

Following the success with introducing the alcohol restrictions, BAWG invited The George Institute to evaluate potential impacts of the Plan, with particular focus on the alcohol restrictions. The George Institute subsequently formed a team of collaborators and secured funding for the evaluation from the Centre for Road Safety, Transport for NSW (formerly the Roads and Traffic Authority of NSW or RTA) in June 2009. Given the need for evidence-based policy to improve road safety among Aboriginal road users in NSW, the Centre for Road Safety had a particular interest in exploring the effects of the restrictions on road safety in the Bourke area.

1.2 Aims and objectives

The overall aim of the evaluation was to assess holistically the impact of the Bourke Alcohol Action Plan on community safety, health and wellbeing. More specific objectives included monitoring and reviewing the impact of the Plan’s initiative to restrict takeaway alcohol sales, and assessing the impact of the Plan on road safety. A secondary objective was to explore whether impacts had extended to Aboriginal residents as well as non-Aboriginal residents of Bourke.

1.3 Report structure

This report is divided into eight main sections. Following this introductory chapter, Chapter 2 provides a more detailed account of the Bourke Alcohol Action Plan and reports on progress to date. Given the key strategy of alcohol restrictions and focus on road safety, Chapter 3 provides an overview of evaluation research on alcohol management plans introduced in other Australian communities and a review of road safety research relating to alcohol use, and particularly road safety issues for Aboriginal and Torres Strait Islander and remote communities. This is followed by a Methods chapter (Chapter 4), which details the mixed-methods qualitative and quantitative approach undertaken to ascertain potential impacts of the Plan. Successive chapters report on the qualitative findings resulting from widespread stakeholder interviews (Chapter 5) and the quantitative findings based on statistical analysis of several available databases of alcohol-related injuries and offences (Chapter 6). Chapter 7 discusses the findings collectively in relation to the objectives and within the context of relevant published literature, with recommendations made for BAWG in relation to their ongoing efforts to progress the Plan. All references cited throughout the report are listed in a concluding References chapter (Chapter 8).
Chapter 2 Bourke Alcohol Action Plan

The Bourke Alcohol Action Plan (the Plan), developed by the Bourke Alcohol Working Group has the Mission Statement, “To strengthen community safety, health and wellbeing by preventing the uptake of harmful alcohol use and reducing alcohol-related harm in the Bourke community.” It comprises six priority areas:

1. Creating Positive Environments;
2. Education and Awareness;
3. Clinical and Support Services;
4. Partnerships;
5. Restrictions on Alcohol Sales; and

In each area, several initiatives and related actions were determined, and lead/shared agencies identified. Since first drafting the Plan in 2008, BAWG has actively worked to address their identified priority action areas and continues to update and refine the Plan. For example, more recently the Plan was extended from an alcohol only focus to also incorporate other drugs.

A summary of the Plan current at the time of evaluation, including initiatives, actions, lead person, partners and progress to date is presented in Table 1. The current evaluation therefore in represented by Priority Action Area 6, with a focus on Priority Action Area 5. Other efforts towards Priority Action Areas 1-4 are summarised here.

2.1 Activities and progress

2.1.1 Creating Positive Environments

One of the early projects towards the first Priority Area, Creating Positive Environments, and one contributing to the formation of BAWG, was an initiative within the aforementioned 2006-2008 Government-funded workforce development and capacity building project, the Rural and Remote Aboriginal Safety Promotion Program. The Safety in the Local Environment project highlighted the dangers of broken glass and used syringes in the environment and the need to develop strategies to address this. An audit and clean up of all parks and open spaces in Bourke was undertaken with the support of local council and proved a success.

Subsequently BAWG has been able to establish a waste management system to remove urban waste where these systems were no longer available to households affected by alcohol. Alcohol-free zones and events have also been achieved within the community.

2.1.2 Education and Awareness

Complementing the other priority areas for action was action around Education and Awareness. This has taken the form of a number of community and school activities conducted to increase awareness and understanding of the impact of alcohol on the community. The BAWG Project Officer, through the Outback Alcohol Project, had been instrumental in coordinating many alcohol education sessions with various community groups including interactive demonstrations and open discussion throughout 2009, 2010 and continuing in 2011.
### Table 1. Bourke Alcohol Action Plan priorities, identified activities and progress

<table>
<thead>
<tr>
<th>Priority Action Area</th>
<th>Initiative</th>
<th>Actions</th>
<th>Partners</th>
<th>Progress</th>
<th>Timeframe</th>
<th>Lead Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Creating Positive Environments</td>
<td>1.1 Creating safe and inviting home environments for families</td>
<td>Undertake a community improvement project to remove old buildings, cement slabs, rubbish and broken glass on vacant blocks and public areas to improve the amenity of the local area. Develop and cost project plan</td>
<td>Bourke Shire Council, Lands Council, Mardi Paaki Housing Dept, Housing, Community Working Party, GWABS, ODGP</td>
<td>June 2010</td>
<td>Shire</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Establish an effective waste management system to ensure the routine removal of urban waste where these systems are no longer available to households identified as being affected by alcohol.</td>
<td>Bourke Shire Council, Lands Council, Mardi Paaki Housing Dept, Housing, CWP</td>
<td>Ongoing</td>
<td>Shire</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community consultation around homes being designated as alcohol-free zones</td>
<td>Bourke Shire Council, Police, CWP, BAWG – media</td>
<td>Longer term</td>
<td>CWP</td>
<td></td>
</tr>
<tr>
<td>2. Creating safer drinking environments</td>
<td>Establish safe transport option from licensed venues</td>
<td></td>
<td></td>
<td>Ongoing</td>
<td>Li</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop a Men’s House for cooling off and sobering up</td>
<td>BAWG, DOCS, ICC, Premiers and Cabinet</td>
<td>June 2010</td>
<td>Premiers and Cabinet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 Creating a safer community through restricting the use of alcohol</td>
<td>Establish alcohol-free zones within the community</td>
<td>Bourke Shire Council, Police</td>
<td>Ongoing</td>
<td>Shire</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop alcohol-free community events</td>
<td>ODGP, CWP, Bourke Shire Council, Police</td>
<td>Ongoing</td>
<td>All</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Create community owned public spaces</td>
<td>Bourke Shire Council, CWP</td>
<td>Completed</td>
<td>Shire</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Implement evidence based alcohol and drug education programs targeting school aged children</td>
<td>ODGP, Dept Education, Police, BAHS, Centacare, PCYC</td>
<td>June 2010 Review (funding)</td>
<td>ODGP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Alcohol Education and Awareness</td>
<td>2.1 Enhanced and consistent school drug education</td>
<td>Re-establish youth interagency</td>
<td>BAWG Dept Education GWAHS ODGP PCYC / Police Bourke Shire Council DOCS Centacare ODGP</td>
<td>ongoing</td>
<td>PCYC</td>
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<tr>
<td>2.2 Young people engaged in the development of locally relevant activities and programs to promote school retention and community engagement.</td>
<td>Annual workshop with young people to direct BAWG programs and activities relevant to youth</td>
<td>BAWG Youth Interagency ODGP BAHIS</td>
<td>June 2010 Review (funding)</td>
<td>ODGP</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mentoring project for school students to increase school attendance and retention</td>
<td>Dept Education BAWG CWP Centacare Youth Interagency</td>
<td>June 2010 Review (funding)</td>
<td>ODGP</td>
<td></td>
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<tr>
<td></td>
<td>Good Sports Program</td>
<td>Central West Rugby BAWG Youth Interagency Dept Sport and REC Centacare</td>
<td>March 2010</td>
<td>Centacare</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Road safety licensing project, U-TURN</td>
<td>BAHIS The George Institute</td>
<td>Dec 2009</td>
<td>BAHIS</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.3 Strong young mums promote a healthy start to life</td>
<td>Ante natal and post-natal care linked with services and programs that engage young women and mothers</td>
<td>Centacare BAHIS ODGP GWAHS</td>
<td>Ongoing</td>
<td>Centacare</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.4 Sustained community awareness to change community attitudes and encourage a safe and sensible approach to alcohol use</td>
<td>Identify community attitudes to alcohol to inform the development and implementation of targeted community education programs and strategies using locally relevant resources.</td>
<td>BAWG ODGP The George Institute BAHIS</td>
<td>Dec 2010</td>
<td>Awaiting evaluation &amp; outcomes of forum</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Implement and evaluate locally relevant programs</td>
<td>BAWG GWAHS Mardi Paaki D&amp;A Network The George Institute ODGP CWP</td>
<td>Ongoing</td>
<td>ODGP</td>
<td></td>
</tr>
</tbody>
</table>
### 3: Clinical and Support Services

<table>
<thead>
<tr>
<th>3.1 To ensure the provision of quality advice and support for young people around alcohol (and other drugs).</th>
<th>Establish appropriate advice information resources.</th>
<th>Mardi Paaki D&amp;A Network ODGP BAHS GWAHS Lyndon Community Orana Haven DET</th>
<th>Ongoing</th>
<th>MPDAN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Establish service map for young people for people 25 and under.</td>
<td>Mardi Paaki D&amp;A Network ODGP BAHS GWAHS DET</td>
<td>September 2010</td>
<td>ODGP</td>
</tr>
<tr>
<td></td>
<td>Develop referral and care pathways in appropriate clinical services for young people</td>
<td>Mardi Paaki D&amp;A Network ODGP BAHS GWAHS</td>
<td>Ongoing</td>
<td>BAHS</td>
</tr>
<tr>
<td></td>
<td>Explore options for AA/Anon</td>
<td>Mardi Paaki D&amp;A Network ODGP BAHS GWAHS DOH</td>
<td>REVIEW THIS ACTION AS ATTEMPTS TO ESTABLISH AA HAS NOT BEEN SUCCESSFUL. REVIEW DATE 30 JUNE 2011.</td>
<td></td>
</tr>
<tr>
<td>3.2 Establish mechanisms for supporting those affected by own or others drinking.</td>
<td>Develop structured activities e.g. linked to Men’s Shed to provide diversion opportunities</td>
<td>ODGP BAHS GWAHS</td>
<td>REVIEW THIS ACTION AS ATTEMPTS TO ESTABLISH AA HAS NOT BEEN SUCCESSFUL. REVIEW DATE 30 JUNE 2011.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Establish links with HASI programmed</td>
<td>Richmond</td>
<td>Ongoing</td>
<td>Richmond</td>
</tr>
<tr>
<td></td>
<td>Continually scan the environment to identify strategies to maintain secretariat support to BAWG</td>
<td>Richmond</td>
<td>Ongoing</td>
<td>Richmond</td>
</tr>
<tr>
<td></td>
<td>Explore opportunities to deliver MERIT type court diversion programs</td>
<td>GWAHS</td>
<td>REVIEW THIS ACTION AS AWAITING EVALUATION OF MERIT PROGRAM. REVIEW DATE 30 JUNE 2011.</td>
<td></td>
</tr>
<tr>
<td>3.3 Ensure appropriate provision of programs to reduce alcohol related offending</td>
<td>Establish INFAD Groups for P&amp;P clients</td>
<td>Mardi Paaki D&amp;A Network ODGP BAHS GWAHS</td>
<td>RECOMMENDATION THAT THIS ACTION BE REMOVED FROM THE PLAN AS UNABLE TO BE IMPLEMENTED.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Establish protocols for effective management of high risk offenders in the community</td>
<td>Mardi Paaki D&amp;A Network ODGP BAHS GWAHS</td>
<td>REVIEW THIS ACTION AS AWAITING EVALUATION OF MERIT PROGRAM. REVIEW DATE 30 JUNE 2011.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop range of support options (including specialist treatment) and diversion activity to reduce recidivism among repeat offenders.</td>
<td>Mardi Paaki D&amp;A Network ODGP BAHS GWAHS</td>
<td>REVIEW THIS ACTION AS AWAITING EVALUATION OF MERIT PROGRAM. REVIEW DATE 30 JUNE 2011.</td>
<td></td>
</tr>
<tr>
<td>3.4 Establish Smart Recovery Groups</td>
<td>Replace current initiative with following: Providing a recovery type group for participants in Bourke</td>
<td>Develop a partnership for the sustainable delivery of Smart Recovery</td>
<td>Mardi Paaki D&amp;A Network ODGP BAHS GWAHS</td>
<td>RECOMMENDATION THAT THIS ACTION BE REMOVED FROM THE PLAN AS UNABLE TO BE IMPLEMENTED.</td>
</tr>
<tr>
<td>Establish cultural/literary appropriateness of Smart Recovery processes and resources</td>
<td>Mundi Paaki D&amp;A Network BAHS GWAHs</td>
<td>REPLACE ACTION WITH THE FOLLOWING: PROVIDE APPROPRIATE TRAINING/EDUCATION TO COMMUNITY ORGANISATIONS AS REQUIRED.</td>
<td></td>
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<tr>
<td>Implement a locally appropriate model</td>
<td>Mundi Paaki D&amp;A Network BAHS GWAHs</td>
<td>REPLACE ACTION WITH THE FOLLOWING: PROVIDE APPROPRIATE TRAINING/EDUCATION TO COMMUNITY ORGANISATIONS AS REQUIRED.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement the Nursing and Midwifery Guidelines on Assessment and Withdrawal Management</td>
<td>Mundi Paaki D&amp;A Network BAHS GWAHs</td>
<td>AWAITING IMPLEMENTATION OF RIVER TOWNS PROJECT.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5 Ensure that the health workforce is aware, trained and competent in the identification of interventions around alcohol and other drugs</td>
<td>Develop / co-ordinate education, training and awareness sessions through the Mundi Paaki Clinical Hub for front line health workers.</td>
<td>Mundi Paaki D&amp;A Network BAHS GWAHs</td>
<td>Ongoing</td>
<td>MPDAN</td>
</tr>
<tr>
<td></td>
<td>Develop local clinical protocols</td>
<td>Mundi Paaki D&amp;A Network BAHS GWAHs</td>
<td>Ongoing</td>
<td>MPDAN</td>
</tr>
<tr>
<td>3.6 Develop integrated and seamless care pathways for people with alcohol (and other drug) problems, including discharge planning.</td>
<td>Map local and out of area service provision.</td>
<td>DWHAP Mundi Paaki D&amp;A Network BAHS GWAHs</td>
<td>October 2010</td>
<td>ODGP</td>
</tr>
<tr>
<td></td>
<td>Establish referral sources and pathways.</td>
<td>Mundi Paaki D&amp;A Network BAHS GWAHs</td>
<td>October 2010</td>
<td>ODGP</td>
</tr>
<tr>
<td></td>
<td>Develop tools to support front line workers, communities and primary health care staff to facilitate appropriate referral to the most suitable service.</td>
<td>Mundi Paaki D&amp;A Network BAHS GWAHs</td>
<td>REVIEW THIS ACTION FOLLOWING THE IMPLEMENTATION OF THE RIVERS TOWN PROJECT.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Design and implement discharge planning tool?</td>
<td>Mundi Paaki D&amp;A Network BAHS GWAHs</td>
<td>REVIEW THIS ACTION FOLLOWING THE IMPLEMENTATION OF THE RIVERS TOWN PROJECT.</td>
<td></td>
</tr>
</tbody>
</table>
## Bourke Alcohol Action Plan

### 4: Partnerships

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
<th>Responsible Parties</th>
<th>Status</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Bourke Alcohol Working Group (BAWG) is recognized as the Alcohol and Drug Interagency to promote a collaborative and coordinated approach to the development and implementation of strategies to reduce the impact of alcohol in the Bourke community</td>
<td>ODGP Project Officer convenes the BAWG / Bourke AOD Intergancy</td>
<td>ODGP BAWG</td>
<td>Completed</td>
<td>June 2010</td>
</tr>
<tr>
<td></td>
<td>Mundi Paaki D&amp;A Network Bourke Co-Ord convenes health agency network as sub committee</td>
<td>Mundi Paaki D&amp;A Network</td>
<td>Incomplete</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continually scan the environment to identify strategies to maintain secretariat support to BAWG</td>
<td>BAWG</td>
<td>Incomplete</td>
<td></td>
</tr>
<tr>
<td>4.2 Bourke alcohol and related services work collaboratively to promote access to relevant services</td>
<td>Develop a Bourke Services guide</td>
<td>DWHAP Mundi Paaki D&amp;A Network</td>
<td>Going Ahead</td>
<td>June 2010</td>
</tr>
<tr>
<td></td>
<td>BAWG members channel funding notifications, grants, newsletters through ODGP PO to identify emergent opportunities for additional funding</td>
<td>BAWG Mundi Paaki D&amp;A Network Police</td>
<td>Going Ahead</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Link with relevant agencies, groups to develop write submissions eg Indigenous volunteers</td>
<td>BAWG</td>
<td>Going Ahead</td>
<td></td>
</tr>
<tr>
<td>4.4 BAWG members operate in spirit of partnership by providing an agreed view on public issues and documents</td>
<td>Peer review of drafts of public documents by BAWG members prior to release</td>
<td>BAWG</td>
<td>Going Ahead</td>
<td></td>
</tr>
</tbody>
</table>

### 5: Restrictions on the sale of alcohol

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
<th>Responsible Parties</th>
<th>Status</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Properly enforced controls on the sale of alcohol</td>
<td>Restrict the sale of bulk alcohol</td>
<td>OLGR Police</td>
<td>Completed</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Restrict the strength of alcohol sold</td>
<td>OLGR Police</td>
<td>Completed</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Restrict takeaway sales of alcohol</td>
<td>OLGR Police</td>
<td>Completed</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
<th>Responsible Parties</th>
<th>Status</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Formative and summative evaluation to inform the ongoing roll-out of strategies and assess impact of multi-pronged action plan</td>
<td>External evaluator engaged to develop evaluation framework, key performance measures, and mechanisms for relevant data capture</td>
<td>BAWG ODGP BAHS</td>
<td>Completed</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>The George Institute for Global Health will undertake the following: Monitoring of Data obtained from the following sources: - Police - Hospital ED and admissions - BOCSAR</td>
<td>The George Institute ODGP BAWG</td>
<td>Completed</td>
<td>March / April</td>
</tr>
<tr>
<td>6.2 Process and outcome evaluation</td>
<td>External evaluator engaged to develop evaluation framework, key performance measures, and mechanisms for relevant data capture</td>
<td>The George Institute ODGP BAWG</td>
<td>Completed</td>
<td>March / April</td>
</tr>
<tr>
<td></td>
<td>The George Institute for Global Health will undertake the following: Monitoring of Data obtained from the following sources: - Police - Hospital ED and admissions - BOCSAR</td>
<td>The George Institute ODGP BAWG</td>
<td>Completed</td>
<td>March / April</td>
</tr>
</tbody>
</table>

### Key:

- **Incomplete Action**
- **Going Ahead**
- **Action Underway**
- **Completed Action**

**Evaluation of the Bourke Alcohol Action Plan**
In the early months of BAWG, an alcohol free event was held with a live band *J C Epidemic* performing and promoting the message “You don’t have to drink to have a good time”. The community event was attended by over one thousand people, with good media coverage in the local newspaper, *The Western Herald*.

As a condition of the restrictions imposed by the NSW Office of Liquor, Gaming and Racing, the project supported local licensees with a variety of educational material to be displayed in their business. Educational material is regularly distributed to all licensees.

During October and November 2009, students from Bourke High School participated in workshops to develop, write and record radio advertisements around positive messages and a final radio commercial was produced. Plans are now to develop this into a television advertisement and to air on Imparja and National Indigenous Television. The songs can be found at: [http://www.ochrehealth.com.au/index.php?option=com_content&view=article&id=65&Itemid=67](http://www.ochrehealth.com.au/index.php?option=com_content&view=article&id=65&Itemid=67).

Other school based activities have since included a visit to the school by state rugby players promoting positive messages around not drinking or doing drugs, healthy eating and making good choices in life. The visit included St Ignatius School, Bourke Public School and the Bourke High School. Harm minimization radio advertisements were developed with students and subsequently played on two local radio stations. A media campaign was also developed to target youth and raise awareness of the risk of binge drinking. Furthermore photography workshops for students incorporated the topic of the impact of alcohol on family, friends and the community. The workshops produced a number of posters with key messages displayed around the community. Figure 1 displays several photos of the posters.

### 2011 Community Forums

More recently, BAWG together with the Bourke Aboriginal Health Service (BAHS) held a youth forum in May 2011. The objective of the forum was to jointly discuss drug and alcohol issues in Bourke, including with members of the Murdi Paaki Drug and Alcohol Network and the wider community, with the outcomes informing BAWG’s on-going planning. In total, nine focus groups with 64 young people were held in Bourke in schools, community organisations and youth groups during the week of May 16-20, 2010. Participants ranged in age from six to twenty-one years. Key themes and issues identified included:

- **Experiences of others’ substance use**: negative effects, including fights, threats, bullying, smashing street lights and racing and burning cars.
- **Reasons why people use**: perceived as positive affect outcomes, but also mental health conditions; however, most identified use as “learnt behaviour” particularly among families.
- **Impacts on young people**: these included, lack of food and clothes (when money spent on substances), domestic violence, other violence, concern for younger children and their safety and supervision when their parents were out or substance affected.
- **Impacts on health and wellbeing**: participants were well informed, including impact on liver, heart, teeth and lung cancer, particularly regarding tobacco; many identified tobacco as causing most health problems for adults and the most important to address.
- **Ways to address substance problems**: most suggested closing pubs; also, talking to young users; need for fast food outlets in Bourke and activities such as a skate park as distractions.
Figure 1. Photos of Bourke student posters and advertising
The youth forum was followed by a complementary public forum in Bourke regarding youth substance use on May 25, 2011, to engage agencies and the community and to identify whole-of-community practical strategies. Three information sessions were held with guest speakers from Western Local Health Network, Justice Health and Making Tracks (ADACSA). The forum was attended by 55 people from local community and various health and welfare organisations. Following information sessions, including feedback from the youth forum, approximately 30 people were divided into two focus groups. A summary report on the forums (Bourke Alcohol Working Group, 2011), reported on the following key findings:

- **Powerless/helpless and fear**: identified as differences between a community with rather than without alcohol and drugs.
- **Young people getting in trouble**: similar issues as raised by youth for those not using but negatively affected by others and health and other issues for youth; “escapism” also identified as a reason why use.
- **Parental lack of responsibility**: intergenerational problems within families were described, including unemployment, child abuse and substance use as long term issues affecting the way children are raised.
- **Ways to address substance problems**: a range of positive actions that could facilitate change in Bourke in the short term (18 months) and long term (5-8 years) were suggested, including improved coordination, communication and resources, identifying ways to work with families, alternative health approaches, engaging elders and local government, as well as local availability of more appropriate TAFE courses, activities such as skate parks, markets and cafes.

These findings together with the current Evaluation are being used to further update and refine the Bourke Alcohol Action Plan.

### 2.1.3 Clinical and Support Services, Partnerships

A key resource needed to ensure implementation and sustainability of the Plan, in particular achieving the priority area Clinical and Support Services, was dedicated staff primarily focused on addressing local alcohol issues. This was achieved through several avenues.

A BAWG Project Officer was established through the Outback Alcohol Project. Funding was also provided in early 2009 by the Office for Aboriginal and Torres Strait Islander Health in the Department of Health and Ageing for a Murdi Paaki Drug and Alcohol Network Coordinator. The Coordinator, employed with Bourke Aboriginal Health Service (BAHS), along with visiting Murdi Paaki Drug and Alcohol Network staff from the hub in Orange, assisted (and continues to assist) towards convening the health agency network as a subcommittee, to promote collaborative, coordinated, and evidence-based approaches to care and service development.

Further, since the beginning of 2011, Western NSW Local Health District (NSW Health) has also employed a Drug and Alcohol worker who provides a further resource within Community Health.

While BAWG itself represents extensive partnerships (as detailed in Section 1.1), these networks demonstrate other successful partnerships established by BAWG.
2.1.4 Restrictions on alcohol sales

Alcohol restrictions, while not the first listed priority or outcome achieved by BAWG, have possibly been the most high profile and the main activity for which improvements in Bourke are associated, despite being supported by a range of other activities.

The focus of the alcohol restrictions that were introduced, and currently remain in place, is on takeaway alcohol sales. Specifically, these comprise:

- No fortified wine in containers greater than 750mL;
- No beer in 750mL glass bottles (longnecks);
- No wine in casks greater than two litres;
- Only drinks with an alcohol content of 3.5% or lower, packaged in non-glass containers, can be sold between 10am and 2pm. Residents living more than 50km from the licensed venue are exempt from this restriction;
- The licensee must display and make information available for patrons. The information must be agreed to by the Darling River Local Area Commander (NSW Police) in consultation with the BAWG; and
- A voluntary undertaking by the six licensees in Bourke at the time that all purchasers must place purchased alcohol into a motor vehicle (Liquor Accord).

Through the efforts of BAWG and negotiation with the NSW Office of Liquor, Gaming and Racing, the restrictions were introduced on February 16, 2009.

2.2 Awards in recognition of BAWG’S achievements

Two prestigious national awards and a local award have been made to BAWG in 2011-2012 in recognition of their achievements through their implementation of the Bourke Alcohol Action Plan. These are important to acknowledge as part of the achievements and impact of the Plan.

2.2.1 National Drug and Alcohol Award

The National Drug and Alcohol Awards are a collaborative effort of the Ted Noffs Foundation (TNF), the Alcohol and other Drugs Council of Australia (ADCA), the Australian Drug Foundation (ADF) and the Australian National Council on Drugs (ANCD). They are held annually to encourage, recognise and celebrate achievements to prevent and reduce alcohol and other drug use and harm in Australia. The Awards are open to all people and organisations that work in alcohol, other drugs and related sectors (www.drugawards.org.au).

In 2011, the Awards recognised the enormous work and dedication of the Bourke Alcohol Working Group, honouring the Group with the Excellence in Law Enforcement at the Gala Awards ceremony held on June 24, 2011 in Sydney. Mr Alistair Ferguson, Chair, and other BAWG members present accepted the award on behalf of all members of BAWG. This award was important external recognition of BAWG and its partnerships working together to address the impact of the alcohol within the community. The official photo of BAWG accepting the award (Malcolm Lyons Photography, www.drugawards.org.au/2011-awards-photos-2.html) appears below in Figure 2.
2.2.2 Australian Crime and Violence Prevention Award

On November 25, 2011, BAWG was awarded a Certificate of Merit as part of the annual Australian Crime and Violence Prevention Awards. These Awards are sponsored by the heads of Australian governments and members of the Ministerial Council for Police and Emergency Management as a joint Australian Government, state and territory initiative.

The Australian Institute of Criminology describes the Awards as rewarding good practice in the prevention or reduction of violence and other types of crimes in Australia, to encourage public initiatives and to assist governments in identifying and developing practical projects that will reduce violence and other types of crime in the community. Projects may address specific groups such as rural and remote communities, women, children, youth or the family, or specific problems such as alcohol-related violence. An award may also be available for initiatives of great merit or for outstanding projects that have recently ceased operation. These awards are primarily designed to recognise community-led crime prevention activities. (See: http://www.aic.gov.au/crime_community/acvpa.aspx.)

2.2.3 Western NSW Local Health District Awards Expo 2012

Most recently, the Western Health District June 2012 newsletter announced the results of the Western NSW Local Health District Awards Expo, described as an event to showcase excellence in high quality health care and to formally recognise projects and initiatives that have brought about improvements to health outcomes and patient care.

Co-author, Sally Torr, Manager of the Bourke Health Service, was awarded the People’s Choice Award in recognition of her contributions to the development and implementation of the Bourke Alcohol Action Plan.
Chapter 3 Literature Review

This literature review focused on two main themes of this research: firstly, a review of previous evaluation research of alcohol management plans in other Australian communities; and secondly, a review of road safety research undertaken in Aboriginal and Torres Strait Islander and remote communities. This road safety literature is relevant for Bourke, which is classified as a “very remote” area of NSW (Australian Bureau of Statistics 2001), and with a high Aboriginal population, including residents living considerable distances from the town centre.

3.1 Evaluations of alcohol management plans

Evaluations were identified for alcohol management plans in the Northern Territory (NT), Queensland (QLD) and Western Australia (WA).

3.1.1 Living With Alcohol, NT

The Living With Alcohol program was introduced in the Northern Territory in 1992 as a “comprehensive public health strategy to reduce alcohol-related harm” [p.168] (Stockwell, Chikritzhs et al. 2001). The initiative included (Stockwell, Chikritzhs et al. 2001):

- Price increases on alcohol: a small levy (5 cents) was introduced on drinks with greater than 3% alcohol content, and later (1995) a specific levy on cask wine, primarily to fund the initiative;
- Additional funding for existing treatment, education and prevention programs;
- New mass media education programs on drink driving and responsible service of alcohol and increased enforcement in relation to these;
- Introduction of 0.05% BAC (1994); and
- Various local restrictions on hours of trading for licensed premises in communities such as Tennant Creek and Alice Springs.

This program has undergone the most rigorous statistical evaluations identified [multiple linear regression and auto-regressive integrated moving average (ARIMA) time-series analyses comparing trends in alcohol to non-alcohol related (control) harm indicators] (Stockwell, Chikritzhs et al. 2001; Chikritzhs, Stockwell et al. 2005). Stockwell et al (2001) reported on the first four years of the program and identified clear road safety benefits from the outset, sustained over the four years: 34.5% reduction in alcohol-related road deaths and 24.3% reduction in other alcohol-related deaths, as well as a 28.3% reduction in road crash injuries requiring hospital treatment. Later Chikritzhs et al (2005) applied similar analysis methods to evaluate pre and post changes in age standardised rates of acute and chronic alcohol-attributable deaths from 1985-2002. They reported significant declines in acute deaths to 1997 and a delayed decline in chronic deaths from 1998-2002 attributable to the combined levy and program initiatives.

The Tennant Creek and Alice Springs alcohol restrictions for licensed premises were also subsequently evaluated separately, with both evaluations finding overall reductions in alcohol-related injury hospital admissions/separations (Gray, Saggers et al. 2000; Senior, Chenhall et al. 2009). The restrictions varied with particular attention to Thursdays in Tennant Creek.
(‘Thirsty Thursdays’) as this was the day social security or Community Development Employment Program wages were paid (Gray, Saggers et al. 2000):

- Takeaway outlets from hotels and liquor stores closed on Thursdays;
- Sales of all wines in casks >2 litres volume prohibited;
- Sales of all wines in casks <2 litres restricted to one transaction per person per day;
- No wine to be sold in glass containers over one litre volume;
- No third party sales to taxi drivers;
- Hotel front bars to be closed on Thursdays;
- Lounge bars not to open before noon on Thursdays and Fridays;
- Lounge bars to make food available;
- On week days other than Thursdays, takeaway sales limited to between noon and 9 pm;
- In front bars, wine only to be sold with substantial meals;
- In front bars, light beer to be the only alcoholic beverage sold between 10am and noon; and
- Takeaway sales of fortified wines restricted to containers of <1125ml.

Alice Springs alcohol restrictions introduced in 2006 comprised the following (Senior, Chenhall et al. 2003):

- Takeaway alcohol available only 2.00pm-9.00pm Monday–Friday from, 10.00am-9.00pm Saturday and public holidays, and 12:00pm-9.00pm on Sundays.
- Alcohol with content over 3% must not be sold in pubs before 11.30am Monday-Friday.
- Takeaway sale of all wine products restricted to container size of no larger than one litre for fortified wine and no larger than two litres for other wine products.
- Sale of fortified wine and cask wine for consumption off premises restricted to one item of either product per person per day and sales only permitted during the last three scheduled trading hours of each day.

In addition, from 1 August 2007, public areas in Alice Springs became off-limits for drinking alcohol.

### 3.1.2 Community-owned Injury Control Strategies, Woorabinda, QLD

Alcohol management strategies featured among multiple initiatives introduced in the Queensland community of Woorabinda, an initiative undertaken by the community in conjunction with The University of Queensland and Queensland Health (Shannon, Canuto et al. 2001). The Community-owned Injury Control Strategies in Woorabinda project focused on empowering the local community to take control and improve the wellbeing of the community. Significant consultation with town residents was undertaken and multiple initiatives implemented. The initiatives were not fully detailed in the evaluation report, but were noted to include locally introduced alcohol management plans in the form of reduced public bar opening hours and reduced use of glass in public bars and other licensed premises. Other sources cite key objectives as addressing alcohol and violence, particularly including domestic violence, the safety of mothers and children, youth and the environment (Clapham, O’Dea et al. 2007) and identify the following initiatives (National Public Health Partnership 2004; Clapham, O’Dea et al. 2007):

- Rubber flooring in hotels to prevent head injuries from fights and falls.
- Improved policing at hotels and in domestic violence incidents.
• Establishment of a men’s group and counselling service.
• Structural solutions such as road speed humps.
• One local publican agreeing to provide alcohol in cans or plastic only.
• Funding of a local rugby league team, previously suspended due to violence on and off field, on their agreement to suspend any member reported for violence, alcohol or drug use and to undertake community activities (which included clean up of broken glass and help to install falls prevention surfacing in the children’s playground).

An evaluation at two years follow up found a decrease of approximately 30% in the number of injuries occurring per month in Woorabinda, with a 62% probability that this decreasing shift occurred immediately after the introduction of the program (Shannon, Canuto et al. 2001).

3.1.3 Meeting Challenges, Making Choices, Cape York, QLD
The Meeting Challenges, Making Choices Program was announced in 2002 by the Queensland Government focusing on alcohol supply restrictions and enforcement (Margolis, Ypinazar et al. 2008). Subsequently, elders in four Cape York communities, in partnership with government, formed Community Justice Groups to establish their management plans and the timing of its introduction. With slight variations resulting across the four communities, all focused on restricting takeaway sales of beer of >4% alcohol content and spirits >5.5% and were introduced between December 2002 and December 2003.

As all serious injuries in these communities require air ambulance services, Royal Flying Doctor Service retrieval records were analysed for these location from 1995-2005 (Margolis, Ypinazar et al. 2008). Statistical analysis pre and post the restrictions found that on average over the four communities there was a significant reduction of 51.9% in serious injury retrieval rates, although alcohol-related injury retrievals were not specifically analysed.

An additional update of this evaluation from the same research team was published in 2011 (Margolis, Ypinazar et al. 2011) following further introductions of alcohol management plans across all 19 discrete Aboriginal communities in QLD. These plans ranged from complete prohibition to limited access requirements. The authors did not specify changes within the four communities specifically, but repeated the evaluation for these four communities (only) with similar methods utilising 1996-2010 data. The results showed fluctuations from the initial decrease in 2002-2003 to an increase in the two years prior to the 2008 statewide initiatives, followed again by a decrease. Overall, a significant (p<0.001) decreasing trend was found reducing from an average 30 to 14 retrievals per 1,000 from 2008 to 2010, therefore a 53.3% decrease.

3.1.4 Alcohol Management Plan, Fitzroy Valley, WA
In October 2007, the town of Fitzroy Crossing in the Kimberley restricted the sale of packaged liquor exceeding 2.7% alcohol content at 20°C other than for lodgers within premises (Kinnane, Farringdon et al. 2009). Kinnane et al (2009) reported on health and social impacts 12 months pre and post the restrictions, primarily via interviews and qualitative methods.

Police reported that the ratio of random breath tests to drink driving charges had decreased from 6.1:1 to 20.5:1 and there had been a decrease in alcohol-related crashes. They also reported an increase in residents seeking to obtain a driver licence and settling overdue fines;
which included fines for offences unrelated to driving but attached to licensure in WA (e.g., littering or dog-off-leash infringements).

Of some concern was a 23% increase found in alcohol-related domestic violence. However, further investigation suggested this was due to an increase in reporting these incidences due to less intoxication. The local women's shelter reported a 25% decrease in attendance and fewer traumatic injuries. The researchers also noted that a concern that young people were driving to other nearby towns for alcohol was not supported by police data.

Staff at the Fitzroy Crossing Hospital reported a 36% reduction in the average number of alcohol-related emergency department presentations overall, with associated reductions in ambulance call-outs and after-hours presentations.

3.1.5 Summary and additional considerations

All evaluations of various alcohol management plans implemented in remote and very remote communities around the country indicated injury reduction benefits, including among violence and road-related injuries. The types of restrictions on alcohol sales introduced within the plans varied widely, as did the methodological and statistical approaches used to determine potential decreases. Further, some were supported by wider community initiatives. Therefore it is not possible to state with any certainty whether one particular type of alcohol management plan or restriction on alcohol sales was more effective than others. However, the most common features were reductions in the alcohol strength of takeaway sales and reduced access hours in which to purchase takeaway alcohol from licensed premises. Beer and wine were most commonly targeted although specific restrictions for spirits were sometimes also included.

All studies highlighted the importance of community ownership and determination of alcohol management plans as a key contributing factor to the success and acceptance of the initiatives (Shannon, Canuto et al. 2001; Kinnane, Farringdon et al. 2009; Gray and Wilkes 2011). Conversely, government imposed initiatives or perceptions that this was the case, rather than community initiation, was a key barrier to the community acceptance of the initiatives (Gray, Saggars et al. 2000; Kinnane, Farringdon et al. 2009; Senior, Chenhall et al. 2009; Gray and Wilkes 2011).

Other features considered to contribute to the success of the alcohol restrictions included the harm reduction approach (rather than complete prohibition) and support of on-going educational information campaigns and alcohol treatment and rehabilitation services (Chikritzhs, Stockwell et al. 2005; Clapham, O'Dea et al. 2007). Other challenges to the effectiveness and sustainability of the restrictions included under-resourcing, short timeframes to implement initiatives or incomplete implementation of initiatives, as well as short timeframes for evaluation or difficulties accessing quality, relevant data to provide evidence for increased support (Elek 2007; Senior, Chenhall et al. 2009). These were important themes to attend to for the current evaluation.

In terms of comparisons for Bourke, the measures introduced in Tennant Creek seem most aligned with those in Bourke, although with Tennant Creek including more stringent prohibitive restrictions on Thursdays (when social security payments or wages were typically received).
3.2 Road safety issues for Aboriginal and remote communities

Despite marked reductions in road traffic injuries and fatalities following changes to drink driving legislation and enforcement in Australia in the late 1970’s (Homel, Carseidline et al. 1988), alcohol continues to play a role in about 30% of all road-related deaths and 9% of crash injuries each year (Australian Transport Council 2011). This includes not only drivers or riders under the influence of alcohol, but also intoxicated pedestrians. While it is widely accepted that alcohol can impact on crash risk, the extent of that impact is not always well recognised. In fact, the 0.05% Blood Alcohol Concentration (BAC) set as a limit for fully licensed drivers in Australia represents the threshold associated with double the risk of a crash when compare to zero BAC (Roads and Traffic Authority of New South Wales 2011). This risk increases exponentially at higher BAC levels, such that for a BAC of 0.08 risk increases by seven times and for 0.15 the risk is 25 times (Roads and Traffic Authority of New South Wales 2011).

While road crashes are typically less frequent in rural and remote areas when compared to urban settings, the crashes that do result are more likely to involve injuries, including fatalities (Chen, Martiniuk et al. 2009). This is often attributed to higher speed zones and therefore higher travel speeds at the time of crash, but alcohol is also a contributor (as well as fatigue and road geometry, particularly curved road segments) (Chen, Martiniuk et al. 2009). With a lack of alternative public transport options in remote communities, driving under the influence of alcohol continues to be a major road safety issue.

Further, in Australia, a high proportion of Aboriginal people live in rural and remote areas (Australian Bureau of Statistics 2008) and Aboriginal people have a greater risk of a road injury or fatality than non-Aboriginal Australians (Styles and Edmonston 2006; Berry, Nearmy et al. 2007). However, a higher injury risk is also found for urban Aboriginal communities, so not all the difference can be explained by area of residence (Clapham, O'Dea et al. 2007). On a population basis, Aboriginal Australians are two to three times as likely to have a transport-related fatal injury and 30% more like to have a transport-related serious injury requiring hospital treatment (Styles and Edmonston 2006; Berry, Nearmy et al. 2007). Access to roadworthy vehicles and licensed drivers are factors that contribute to this increased risk, but overall, there is limited relevant information available in this field, which contributes to a lack of effective policies and programs to address the gap (Clapham, Senserrick et al. 2008).

A particular concern regarding alcohol restrictions is that they might increase driving exposure, and therefore potentially drink driving exposure, due to increased distances travelled to neighbouring towns where restrictions do not apply – known as “the rabbit run” (Kinnane, Farringdon et al. 2009). Further, this could particularly include increased drink driving exposure. There was some evidence of increases in the rabbit run in the Fitzroy Crossing evaluation to the distant neighbouring towns of Derby and Broome (Kinnane, Farringdon et al. 2009). The amount of alcohol brought into the community increased over the two years following the introduction of alcohol restrictions and there were noted crashes between the towns, but no details of crashes prior to the restrictions were provided to determine if this was an increase. Attributing potential increases to the restrictions alone was further complicated due to the local shopping centre being burnt down during the evaluation period, therefore requiring such travel for other needs.

Alternatively, the Police reported a high level of enforcement, including random breath testing, along these routes as well as in the Fitzroy Valley sustained over the two-year follow-up evaluation (Kinnane, Farringdon et al. 2009). While there was some potential increase in the alcohol infringements issued on these rabbit run routes, the Police reported the overall number of infringements issued in the region was far fewer than prior to the restrictions. The
evaluation findings also associated this increased Police activity with: better education of drivers as to their responsibilities on the road; more people wearing their seatbelts; and more people gaining a licence and licensing their vehicles. Overall, the authors concluded that by the end of the two year follow-up the rabbit run issue had appeared to have reached equilibrium due to the limited availability of vehicles in the community. While the overall impact of alcohol restrictions on road safety therefore was positive on balance, it remains a valid concern to explore the potential rabbit run issue for Bourke, particularly if Police are not heavily engaged in enforcement on such routes. The current research included attention to this issue among other potential impacts of the Bourke alcohol restrictions on road safety, including any differences for Aboriginal and non-Aboriginal road users.
Chapter 4 Methods

The evaluation was undertaken using a mixed-methods approach. Qualitative methods were used to explore Bourke community and stakeholder perspectives on alcohol in the community and the impact of the alcohol restrictions, including on road safety and among Aboriginal residents. As the project was commissioned after the restrictions were introduced, these were based on perceptions post the restrictions only (no baseline attitudes towards alcohol in the community were able to be explored). Quantitative methods were used to explore trends in alcohol-related injuries and offences before and after the restrictions were introduced, utilising a range of injury and offence data sources.

The Bourke Alcohol Working Group formed the reference group for this research, with progress reports provided for the Group’s monthly meetings. Ethical clearance for the evaluation was obtained from The University of Sydney Human Research Ethics Committee (all components), the Aboriginal Health and Medical Research Council (all components), and the Greater Western Area Health Service (analysis of Bourke Hospital emergency department data only). The approved research protocol included assurances of participant confidentiality and written consent.

4.1 Qualitative methods

4.1.1 Participants and procedures

Two waves of qualitative data were collected to gauge community and stakeholder perspectives, coinciding at approximately one year and two years post introduction of the alcohol restrictions (February 2009).

In the first wave during April 2010, approximately one year post restrictions, a focus group with 12 participants and interviews with 17 participants were held with representatives from core government and other service providers, local businesses representatives and other members of the Bourke community.

In the second wave during March 2011, approximately two years post restrictions, a focus group with 13 participants and interviews with 6 participants were held, including several repeat participants from the first wave.

Potential participants were identified through discussions with BAWG, and then invited by phone to participate in the study or in person during research visits to Bourke. BAWG also posted notices of the focus group dates and times. In accordance with ethics protocols, no individuals under 18 years of age participated in the study. In the majority of cases it was possible to conduct face-to-face interviews with respondents, typically at their place of work or at a local cafe. However, telephone interviews were required in some cases.

Focus group participants and interviewees were provided with an information sheet to retain (provided in Appendix A) and a consent form to sign and return to signify their agreement to participate in the study (Appendix B).

Focus groups were of approximately one hour duration and interviews typically approximately thirty minutes. With the consent of participants, the majority were digitally recorded to accurately capture the information provided, with recordings transcribed by a professional.
transcription agency. Participants were de-identified by removing any statements identifying an interviewee.

4.1.2 Focus group and interview schedules
A general schedule was used to guide each focus group and interview (Appendix C) in order to ensure the discussion of each critical issue. However, effort was also made to provide participants with the opportunity to raise additional issues. The main aim was to elicit community perceptions surrounding: the overall impact of the Bourke Alcohol Action Plan, more specifically the alcohol restrictions, and including business impacts; attitudes to alcohol misuse and road safety; and perceptions of changes needed or additional next steps. If not raised generally, prompts were included to explore road safety issues, including for Aboriginal residents and those living away from the main town area.

While participants were asked to respond from their perspectives as service providers, business owners or community members, the resulting interview data was not able to be reported precisely stratified by stakeholder group due to both the frequently overlapping nature of these roles within Bourke society, and to protect individuals’ identities.

4.1.3 Analysis
The processes used to facilitate the analysis of qualitative data initially involved producing one-page summaries of each transcript, with particular emphasis on the key issues raised. This provided a general source of information through which quick interview comparisons could be made.

Further thematic analyses of the interviews were then undertaken using the textual grouping software, NVivo8 at the one-year follow up. While a range of other functions exist within NVivo7 (e.g., data integration and theory testing), it was primarily used in this study to code and classify interview text into thematic categories that could then be easily cross-referenced with other interviews and categories. Key quotes were then used to exemplify emergent study themes. When combined with the acquired quantitative data, these results were used to outline the key issues surrounding the effects of the Bourke Alcohol Action Plan, including takeaway alcohol restrictions. These themes were revisited at the two-year follow up and others added where the original themes seemed insufficient.

4.2 Quantitative methods
Several data sources were explored to explore potential changes in alcohol-related injuries and offences, including Emergency Department (ED) records from the Bourke Hospital, hospital admission data routinely collected by NSW Health, a police intelligence report provided by Bourke Police, as well as police recorded road traffic offence and crash records routinely collected by Roads and Maritime Services (form RTA).

It is noteworthy here also that records of alcohol sales to determine potential business impacts including shifts in purchases by product types (e.g., beer/wine/spirits, light/mid/full strength), container sizes or amounts and impact to “bottom line” were sought, if only in summary form by percentage changes (rather than dollar amounts), both at a wholesaler and retailer level but none were provided. This was despite support from the Office of Liquor and Gaming (OLGR), as it was not compulsory that licensees report sales data to OLGR.
Analyses focused on comparisons between the 12 months (February 2008 to January 2009) prior to the introduction of the alcohol restrictions (February 16, 2009) and the 12 months post the restrictions (February 2009 to January 2010), although this varied dependent on data availability.

The significance level for all analyses was set at $\alpha=0.05$, therefore, all $p$ values below 0.05 were deemed statistically significant. Given the small numbers involved in the analyses, results at the less conservative $\alpha=0.10$ level are also highlighted as approaching significance.

### 4.2.1 Bourke Hospital Emergency Department presentations

Details of ED presentations to the Bourke Hospital were extracted manually from written records available for the period of January 2008 to March 2010. The dataset included information regarding age, gender, Aboriginal status, date of ED presentation, mechanism and type of injury, as well as alcohol involvement.

Negative binomial regression was used to examine the impact of alcohol restrictions, introduced in February 2009, on injury presentations by various characteristics, including Aboriginal status, alcohol and mechanism of injury. The negative binomial model included the month of the injury presentation, entered as a continuous variable representing the underlying trend during the study period, the intervention variable (1= Feb 2008 to Jan 2009 and 2= Feb 2009 to Jan 2010) and seasonality (with season as 1 = January, . . ., 6 = June, 6 = July, . . ., 1 = December). Given data was available for additional months, which strengthens the power of the analysis to detect significant differences in trends over time, analyses were also repeated with the full data set pre and post restrictions (1= January 2008 to January 2009 and 2= February 2009 to March 2010).

### 4.2.2 NSW Health hospital admissions data

The NSW Admitted Patient Data Collection (APDC) includes information on inpatient separations from NSW public and private hospitals, private day procedures, and public psychiatric hospitals. Included are data on episodes of care in hospital, which end with the discharge, transfer, or death of the patient, or when the service category for the admitted patient changes. Information collected includes patient demographics, circumstances of the incident, diagnoses, and clinical procedures. The hospitalisation data were coded using the International Classification of Disease, 10th Revision, Australian Modified (ICD-10-AM) (National Centre for Classification in Health 2004).

Injury-related hospitalisations for this evaluation were identified using the following criteria:

i. the hospitalisation occurred during 16 February 2008 to 15 February 2010;

ii. the principal diagnosis was coded as ‘injury, poisoning and certain other consequences of external causes’ (i.e. ICD-10-AM: range S00-T98);

iii. an external cause code was present (i.e. ICD-10-AM: range V01-Y98); and

iv. the hospitalisation was for a patient whose usual place of residence was Bourke.

Two potential comparison populations for the Bourke population were identified in Condobolin and Coonamble, identified by postcodes 2877 and 2829 respectively, and using the criteria (i) to (iii) above. However, the basic demographics of the injury-related presentations of these two communities to Bourke were significantly different (i.e. Condobolin - age (t (538)=-4.14; p<0.0001) and indigenous status - $\chi^2=57.0$, df=4, $p<0.0001$ and Coonamble - age (t (421)=3.43; $p=0.0029$) and indigenous status - $\chi^2=22.4$, df=3, $p<0.0001$) and the planned comparison were subsequently dropped due to the likelihood of...
other potential factors affecting injury admissions, other than alcohol restrictions. Seven other postcodes were also considered for possible comparisons (i.e. 2820, 2357, 2821, 2827, 2831, 2836, and 2878), however, again the demographic profiles differed significantly or the number of hospital presentations was too low to allow for planned statistical analyses.

Possible alcohol-related hospitalisations were identified using the secondary to the seventh diagnosis codes (i.e. F10 – mental and behavioural disorders due to alcohol or T51 – toxic effect of alcohol) or the secondary to fifth external cause codes (i.e. X45 – accidental poisoning by and exposure to alcohol, X65 – intentional self-poisoning by and exposure to alcohol, Y90 – evidence of alcohol involvement determined by blood alcohol level, or Y91 – evidence of alcohol involvement determined by level of intoxication).

Injury-related hospital admissions that occurred one year prior to the alcohol restrictions being introduced (i.e. during 16 February 2008 to 15 February 2009) were identified as the ‘pre’ period and admissions that occurred one year after the alcohol restrictions were introduced (i.e. during 16 February 2009 to 15 February 2010) were identified as the ‘post’ period.

Hospitalisations from the NSW APDC relating to transfers or statistical discharges were excluded in order to attempt to partly eliminate ‘multiple counts’. Due to the relatively small number of hospitalisations for each location and the undertaking to not disclose cell sizes less than five, limited analysis of the data was performed. To examine the association between the pre and post period and possible alcohol involvement, a chi-square test of independence was used. For the chi-square analysis, place of incident was grouped into ‘home’, ‘school’, ‘street/highway’ and ‘other’ and injury mechanism was grouped into ‘road traffic-related’ and ‘falls’, ‘assault’ and ‘other’. Ethics approval was provided by the University of Sydney HREC (ref: 03-2010/12640) and by the Aboriginal Health and Medical Research Council (ref: 720/10).

4.2.3 NSW Police Force Intelligence Report

During the course of the evaluation, NSW Police conducted their own quantitative analysis of local data to determine whether the alcohol restrictions had impacted on crime: Bourke, 18 Month Review of Section 54 Conditions, NSW Police Force Intelligence Report, September 2010. Data from 01 August 2007 to 31 August 2010 were analysed to approximate 18 months pre and post introduction of the restrictions. Data for assaults, sexual assaults, intoxicated persons and malicious damage were specifically examined. The data was charted on a month by month basis as well as occurrence time. Permission was granted to access and report on the findings included in the Intelligence Report for the purposes of our evaluation.

4.2.4 NSW Police reported road traffic offences

Trend analysis for the 12 months pre and post the introduction of the alcohol restrictions was conducted using negative binomial regression (as per the hospital ED data) based on number of police-recorded road traffic offences involving an illegal Blood Alcohol Concentration.

4.2.5 NSW Police reported road traffic crashes

The number of police-recorded road traffic crashes involving illegal Blood Alcohol Concentrations was too low to apply statistical analysis; therefore numbers were compared for the 12 months pre and post the introduction of the restrictions on alcohol sales.
Chapter 5 Qualitative Results

5.1 One-year follow up

Seven main themes emerged from the focus group and interviews held a year following the introduction of the takeaway alcohol restrictions. These related to overall impressions and rationale behind the restrictions, perceptions of the restrictions as a “best available” option or “a small price to pay”, views on the impact and practicality and on the implementation of the restrictions, as well as views of Bourke as setting an example for other communities.

5.1.1 Overall impressions of alcohol restrictions

All interviewees identified excessive alcohol consumption and alcohol-related violence as a major problem in Bourke requiring community action. The majority expressed support for the alcohol restrictions and the broader Bourke Alcohol Action Plan, however, several contentious issues were nonetheless identified.

Contrasting arguments are summarised in the following two quotes:

The Bourke community experiences a range of considerable health, social and economic impacts produced by excessive consumption of alcohol, and while alcohol restrictions are incapable of addressing the underlying socio-economic issues creating these problems, they represent the best available strategy to produce the immediate positive impacts required by the town. (Unidentified participant)

While only a limited number of individuals are responsible for the negative effects of alcohol misuse in the Bourke community, the entire community is being punished by these onerous restrictions that deny individual civil liberties and threaten the commercial viability of local businesses. Instead, high risk individuals and community groups should be targeted with effective educational interventions. (Unidentified participant)

An early work on social science and public policy described politics as being largely about the contest between multiple definitions of the same events (Rein 1976). Of the main themes and issues emerging from the interviews, several represented contesting interpretations of the same issues. These included the degree to which individual rights should be sacrificed for community benefits, the health and economic impacts of the alcohol restrictions, and implementation issues such as the adequacy of employed community consultation strategies. The varying rhetorical power of these claims constituted the public discourse to which the Bourke community was exposed over the course of the implementation of the Bourke Alcohol Action Plan.

5.1.2 The rationale for the restrictions

Interviewees generally agreed that the introduction of alcohol restrictions in Bourke was due to a combination of research evidence concerning the extent of alcohol-related health issues in the community, and the potential positive effects of alcohol and licensing restrictions. Reductions in public intoxication and violence, as well as the use of large glass beer bottles as projectiles, were commonly identified as more specific rationale. As an interviewee noted:
The international evidence was that changing people’s access to alcohol and licence conditions could have a profound impact… the clincher was the evidence that we were the worst in NSW… something had to be done… So we extended the period between when you wake up with a bad hangover and when you pat the head of the dog that bit you. (Service provider)

Despite the broad agreement among interviewees of the role of such rationale in driving efforts to introduce the restrictions, several interviewees nonetheless claimed that additional factors were inappropriately used by some stakeholders to justify the restrictions following their introduction. In particular, potential visible changes to the town impacts were noted, with an interviewee suggesting:

The argument that led to the restrictions being introduced was the police arguments… [But] if they are the reason, that’s what the restrictions should be measured against, and from the day the rules were introduced, those reasons have been totally forgotten. The issue that everything had been measured against is how the town is looking… If there was some other justification, it should have been placed on the table at the beginning. And whatever those things were, that’s where the benchmark data should have started. (Service provider)

5.1.3 Restrictions the “best available” option

Interviewees generally argued that excessive alcohol consumption in Bourke was primarily a cultural issue, with long-term educational strategies representing the best method of creating a “final solution” to the problem. However, due to its severity and the requirement for more immediate action, the majority of interviewees argued that alcohol restrictions represented an effective and necessary public health strategy. As a BAWG member noted:

Those adaptive challenges of changing people’s attitudes and values, that’s not going to happen overnight, but by the simple stroke of a pen you can cause some radical change and we could do that quickly and knew it would have an impact and hopefully a flow on effect from there. (BAWG member)

Indeed, several interviewees argued that while seemingly logical, educational strategies have previously produced minimal positive impacts in Bourke and were unlikely to in the future, for example:

The education side of it is one of the main factors, but a lot of the problem drinkers tend to ignore any type of education because they think they know all about it and they don’t really care. (Business owner)

Interviewees arguing this position commonly proposed that the main reason for the previous failings of education strategies had been the inability of service providers to render educational materials meaningful for relevant audiences within the Bourke community. The need for alcohol reduction education strategies to be culturally specific and interesting for Aboriginal communities was particularly emphasised.

While the majority of interviewees identified these failings of educations strategies as an important justification for the continued implementation of alcohol restrictions, several nonetheless described the restrictions as a “Band-Aid, short-term solution” incapable of resolving the complex and multifaceted problems associated with excessive alcohol consumption in Bourke. As a business owner argued:
At the end of the day when you have a community such as Bourke, and especially in our indigenous part of our community, where granddad has been on the dole so dad is on the dole so kids are on the dole, it’s not going to change by bringing in Band-Aid restrictions. It’s in no way changing how they drink or act in any serious way and the hardest part is working out how to then break that generational cycle of alcoholism… If you can’t educate people well, you’re never going to break this cycle. (Business owner)

A further contentious issue emerging from the interviews concerned whether the encouragement of Bourke licensees to voluntarily enforce alcohol restrictions represented a better alternative to the legislatively-enforced restrictions that were ultimately implemented. As an interviewee suggested,

They were brought in using legal powers because one of the six licensees convinced the other five not to go along with it… he convinced them to hunt as a pack, and not give in to the offer of doing it voluntarily… [Nonetheless] the eventual strong-hand tactics [by government] were not conducive to empowering the community to move forward. (Service provider)

A business representative similarly argued:

I’m a strong believer in community empowerment and it’s for that reason I argue very strongly that if the licensees were given an opportunity to voluntarily convert to the same conditions… It would have been done in a more genuine way. (Business owner)

However, the majority of interviewees claimed that the voluntary licensing restrictions that were initially introduced in Bourke were not sufficiently abided to by licensees, with this necessitating the introduction of the stronger legislative approaches. As a service provider argued:

You can’t put Ned Kelly in charge of the Victorian Bank and think that you are going to get a good return on your investment, so we couldn’t just rely on licensees to go along with it. We had to pull a big lever. (Service provider)

5.1.4 Restrictions “a small price to pay”

Several participants argued that while they may partially oppose the restrictions due to their perceived infringement upon civil liberties, the extent of alcohol-related violence in Bourke necessitated drastic actions. As such, interviewees arguing this position described the individual constraints imposed by the alcohol restrictions as “a small price to pay” (multiple participants) for the good of the community. Examples include:

Responsible service and drinking of alcohol should be up to the person and I don’t think someone should be crucified because of someone else’s problems, but you’ve got to draw a line in the sand somewhere and you can’t have the best of the both worlds. I personally don’t like it, but I think it is beneficial for the town. (Business owner)

While I personally have some issues with them, I don’t believe we could go back, as it couldn’t get any worse to what it was before they came in… I don’t like change, but I just took the attitude that I’m obliged to the town… and if I can see that things can be improved, I am prepared to change my position. (Service provider)
While the above arguments represented the majority opinion among interviewees, the main point of resistance to the restrictions by others was the view that they unnecessarily affect the entire community, despite alcohol-related problems being confined to a minority of the population. As such, the alcohol restrictions were commonly described as “punishing all for the sins of the few” (multiple participants), with an interviewee arguing:

The minority will choose to ignore it and it’s the minority that are the ones that cause the problems... I honestly don’t think someone should be crucified because of someone else’s problems. (Business owner)

We can put all the laws in place, but they can be broken as well. It’s got to come back to the individuals themselves, if they want to change. (Community member)

In summing up this general position, a service provider noted:

Half of the community and some of the councillors said, ‘why do we have to have new rules that impact on 95% of people’s rights because of what 5% of people are doing?... why do I have to change my right if I’m not doing anything antisocial, just for the sake of that small minority of people who are doing the wrong thing?’ (Service provider)

In response to this suggestion, several proponents of the restrictions claimed that such views were implicitly framed upon an incorrect, yet widely held belief among some sections of the community that the restrictions were solely introduced in response to the excessive alcohol-related health issues experienced by the Aboriginal population of the community. As an interviewee noted:

There was a perception when the interventions came in that it was only a couple of black fellas in town that were drinking and they were ruining it for the whole town and now we have got to have these new laws hanging over us. There was a lack of recognition in the wider community that we’re drinking to levels which are beyond or above what nationally we would consider to be nationally healthy levels. There’s a myth that we’re alright mate, it’s the blackfellas who’ve got the drinking problem. (Service provider)

Another suggested:

There is still wide community resistance and those reasons come from many different sources, but I think there’s still that element of racism… [But] Bourke as a town has always had an incredibly strong culture of excessive drinking. (Service provider)

Interviewees arguing this position generally claimed that remoteness, education and employment status were more accurate indicators of unsafe drinking behaviours. This issue was exemplified by the following anecdote provided by an interviewee:

He was Aboriginal but I didn’t know it, but he told me he was and he was a shearer and he was quite proud of it and he said I’m going to get drunk now he said because that’s what shearers do. (Unidentified participant)

5.1.5 Impact and practicality

A range of views regarding the impacts of the alcohol restrictions in Bourke emerged from the interviews. The majority of interviewees claimed that there had been a significant reduction in the severity of assaults, with this issue representing the most important outcome of the
restrictions. Further, it was suggested that problem-drinkers are now directing a greater proportion of their weekly income towards the provision of food for their children. The reduction of other neglectful behaviours, such as injuries to children suffered at house parties, were also identified, for example:

Previously, before the restrictions, there were a lot of children’s injuries from neglect. (Service provider)

In addition, the majority of interviewees argued that alcohol restrictions had produced significant improvement in the aesthetics of Bourke by reducing the presence of broken glass and intoxicated individuals in public areas. As an interviewee noted:

My perception as a member of this community who has lunch down the street or who goes out shopping or who’s out with small children, is that you don’t see as many people who are quite clearly intoxicated on the streets during daylight hours. (Community member)

An individual example was also reported:

There’s one fellow who was an alcoholic at about age fourteen and since the alcohol restrictions came in I’ve seen him walking around the town reasonably sober. I think he was a bit of the litmus test of how it was operating. (Community member)

This sense of improvement was described by one interviewee as:

The vibe of the place, and I can’t describe it any better than that, is better as a community member. The feel of the place is better. There’s a generally better feel. (Community member)

It was widely suggested that this change in town image has had a positive effect on tourism, for example:

It didn’t help with travellers coming into town seeing this sort of stuff. They got a bad vibe from it… [So] I think it’s great for the town. You've got people coming through town not seeing people intoxicated people walking round with beer and smashed glass everywhere. (Business owner)

This change was further suggested to have increased ‘community pride’ among the Bourke population:

It’s had a positive impact for the town because I think a majority of the town are very proud of their ownership of it and the fact that hey we have got a problem and we have done something about it. (Service provider)

Conversely, opponents of the restrictions described their introduction as having minimal impact on alcohol consumption or alcohol-related violence. As a business owner proposed:

I can’t see anything positive…we still have the same amount of people turn up at seven o’clock in the morning well and truly under the weather… Parties are still around town and people are drinking 24/7… nothing has changed… it just seems to be seven parties a week and they just change houses on different nights. (Business owner)

Furthermore, interviewees claimed that the alcohol restrictions have had minimal road safety impacts in Bourke. Indeed, while identifying drink-driving as a common behaviour due to the existing high rate of alcohol consumption and the lack of public transport and taxis,
interviewees suggested that road trauma represents a lesser problem than other alcohol-related injury mechanisms in Bourke, including interpersonal and domestic violence.

One of the main contentious points that emerged from the interviews concerned the impacts of the restrictions on local businesses, with several interviewees claiming that the financial viability of their businesses had been threatened. As a business owner explained:

> Wine dropped and that money didn’t go back into beer or spirits. That market was gone…we’re down that far with sales and we’re not allowed to sell long necks, we’re not allowed to sell flagons, we’re not allowed to sell casks, we’re not allowed to sell cocktails, what else is there? (Business owner)

Several interviewees from other stakeholder groups also identified business impacts as a major issue resulting from alcohol restrictions, for example:

> Our shire had been the fastest shrinking shire in Australia, year on year for the past five years… And so there are implications for consumption and viability for businesses… there was a lot of resistance at that time and they thought that they had had their throats cut. (Service provider)

Nonetheless, the majority of interviewees claimed that the restrictions had caused minimal impact on the profits of local businesses, including alcohol licenses. As a business owner discussed:

> It may have gone down a fraction, but overall, sales are probably close to what they used to be… instead of buying a pallet of big bottles, I will buy a pallet of stubbies or a pallet of twist tops, so really your margin or your profit is still set out on those commodities. (Business owner)

It was further noted that while restrictions on the sale of takeaway alcohol have resulted in reduced profitability, such losses have been partially offset by increased profits derived from the greater presence of patrons drinking at bars.

As well as highlighting the negative economic consequences of the restrictions, opponents also critiqued specific aspects of the implemented model, suggesting that amendments are required to ensure its future effectiveness. As a business owner proposed:

> I strongly believe that there needs to be some restrictions put in place but I do not believe the restrictions that have been put in place in Bourke are the right restrictions and they certainly need to be reviewed and some better restrictions created that actually work. (Business owner)

A commonly raised issue concerned the frequency with which community members use false licenses to overcome the exemption for those residing more than 50km away. As a service provider discussed:

> A lot of, particularly Aboriginal people, come from Dubbo and have Dubbo licences…they live, somewhat nomadic and will show their Dubbo licence and they are getting around the laws and there is intelligence to suggest that that is occurring. (Service provider)

A further issue identified by opponents concerned the prohibition of 750mL glass bottles (longnecks). One suggested:

> A soft drink weighs more than a beer bottle does, so that will be more of a weapon than a beer bottle, but they aren’t barred, so where do you draw the line? (Business owner)
It was frequently claimed that this component of the restrictions was primarily introduced for political purposes, with visual news media portrayals of Bourke proposed to have been influential, for example:

> They punched it into the Sydney papers a couple of weeks before they did anything in our communities… they took a photo and put it in the paper, it was one yard in the whole of Bourke and they portrayed that photo to be a norm in Bourke, which was disgusting on behalf of Bourke public… I think that was the first one when the Police were trying to push it through and they were using every little bit of evidence they can to push the restrictions through and that was on the sale of big bottles. (Business owner)

More broadly, some opponents of the restrictions argued that while alcohol-related problems targeted by the restrictions, including interpersonal violence and public intoxication, are highly visible manifestations of alcohol misuse, other less visible problems have not been adequately addressed by existing policies. Indeed, a small number of interviewees argued that reductions in alcohol consumption among problem-drinkers due to the restrictions may have resulted in their substitution of alcohol with other drugs:

> My concern is about the invisible impacts of the restrictions because problems with alcohol are very visible to the whole community in terms of the street violence, the violent statistics, the domestic violence cases… the harm’s very visible. It’s there for a community to see, and it’s great that that’s reduced as a result of these alcohol restrictions, but… we don’t know whether those people have just reduced their drinking or whether they have reduced their drinking and then swapped that for some other substance… people who are intoxicated with cannabis and opiates and whatever don’t go fight in the street and they’re not necessarily present at A and B all the time in an intoxicated state, but there’s still a level of harm there that is now hidden and we don’t actually know what it is. (Service provider)

When asked to reflect upon the reasons for the existing disagreement as to the impacts of the restrictions, several interviewees suggested that there was insufficient collection of baseline information and promotion of the core rationale for the restrictions. These two factors were seen as having largely impeded the development of a rational debate concerning the restrictions, with both sides generally focused on different issues. As a service provider argued,

> We should have really done that baseline work correctly… because the opponents in the community are left out there wondering if we really needed to do this or not… We needed something that said, listen guys, this is why we did it. (Service provider)

Finally, while the majority of interviewees supported the restrictions, it was nonetheless suggested that initial successes have subsequently plateaued:

> In terms of crime, there was a significant sudden impact as soon as the conditions came in. They have definitely petered out now. I’ve always said it’s not the silver bullet and it still isn’t. (Police representative)

As such, there was general agreement that while the restrictions have been moderately effective, further long-term interventions were required to continue to reduce the various social problems associated with excessive alcohol consumption. One interviewee noted:

> Someone once said, “it takes 100 days to walk into the bush, it takes 100 days to walk out”. We have still got a long way to walk and catch up on and it’s a
big battle, but saying that, the good thing about Bourke is that…it’s a strong, fantastic community… whatever comes out if it because it’s on the table and we are moving forward. (Service provider)

5.1.6 Implementation of the restrictions

The implementation of the restrictions emerged as a particularly contentious issue, with opponents voicing their criticism of the perceived inadequate degree of legitimate community consultation prior to the introduction of the restrictions. For example:

All key groups need to be involved, not just certain groups… We put a lot of suggestions forward and they [government]… didn’t want to know about it because this [alcohol restrictions] was on their mind already. (Business owner)

There was a strong push from certain members on the working group to get something done, perhaps at the expense of being impatient with process and consultation. (BAWG member)

This perceived lack of community consultation was proposed to have been partially responsible for the initial resentment towards the restrictions by particular segments of the Bourke community.

A small number of interviewees further claimed that BAWG failed to accurately reflect the position of the majority of the Bourke community:

The people that were on there from Bourke weren’t actually the people who mix with people in public who would actually go to pubs or clubs and who are in positions of trying to restrict people from drinking, so I feel that the range on that committee didn’t really suit everyone from the community. (Business owner)

It was further suggested that, due to the opposition to the restrictions from some sections of the community, some BAWG members ceased attending regular meetings to avoid being viewed as personally responsible for their introduction:

Quite frankly, the numbers on the Working Group dropped off, people for various reasons stopped participating. It was probably due to the restrictions… they didn’t want to be identified with any ongoing controversy. (Service provider)

Yet while these and other similar issues were raised by some interviewees, the majority forcefully argued that there was sufficient community consultation prior to the introduction of the restrictions, including an advertised public forum, and that BAWG is a legitimate and effective community representative body. Indeed, it was widely argued that the consultation process elicited a considerable community demand for immediate action to reduce alcohol-related violence through any available means, including alcohol restrictions, and that this was a critical influence on the eventual decision to implement the restrictions. As a BAWG member stated:

There was a real sense that something needing to happen… it was a call to arms in a sense, where a bunch of people stood up and said “we need to do something and we need to do something now”. (BAWG member)

It was further noted that immediate action was required to reduce the health issues associated with excessive alcohol consumption, with this preventing the undertaking of more extensive consultation, for example:
It’s a case of putting the cart before the horse… we put the cart here and the horse is slowly catching up…I don’t think we could have done it any other way in such a town like this, by doing all the consultation who ha, because we would still be sitting here talking about it. (Service provider)

However, even among those interviewees arguing that there was sufficient community consultation prior to the introduction of the restrictions, it was broadly noted that there has been insufficient health education and promotion activities following their implementation, with this identified as a potential area for improvement.

### 5.1.7 Example for other communities

Interviewees that were supportive of the restrictions argued that their successful implementation has provided a template that other towns may use to implement similarly effective alcohol management strategies:

> The lessons learned from this are going to help other communities who want to address alcohol issues, so well done Bourke for having a go, and hopefully from the evaluation, there will be a template that can then help other communities down the track… you’ve got to start somewhere and Bourke has done that. (Community member)

Nonetheless, several interviewees voiced concern that while providing a positive case study in this instance, they did not want Bourke to be used by government as a “guinea pig” to test the effectiveness of other potentially controversial and risky health interventions in the future:

> I don’t want Bourke to become this social studies group, which is really how we are at the moment. Every time they bring in a new law then we have people such as yourselves coming and doing and they’re social assessments… and then we’re the ones that are left with it again when they leave. (Business owner)

### 5.2 Two-year follow up

At the two-year mark, responses seemed to have moved on from judging whether the restrictions should have been introduced (“the rational for the restrictions”, were “the best available option” or “a small price to pay”), how they were introduced (“implementation of the restrictions”) or whether they had been successful at all – with this a given by this time. Rather there seemed to have been a shift to reviewing the positives, including continued comments on Bourke as an “example for other communities”, as well as the negatives, particularly a “backlash”, akin to sub-themes of the one-year theme “overall impressions of alcohol restrictions”. Following this there was also a concentration of suggestions on “potential changes or extensions to the restrictions or Plan” as a prominent sub-theme to the one-year theme of “impact and practicality” and more outstanding as a new theme by this time were a variety of suggestions on “other things to do”.

### 5.2.1 Continued example to other communities

Several other remote towns were reported to have introduced voluntary alcohol restrictions following the success in Bourke. As they were voluntary, no details were included in OLGA records in able to confirm these and how they compared to those in Bourke. Various towns were mentioned, but it was not clear what their restrictions involved, including: Walgett,
Collarenebri, Coonamble, Wilcannia and Lightning Ridge. An interviewee relayed the continued sense of pride:

[A] person can take the attitude that Bourke is a pretty special community and it’s got a lot of things going for it and one of the things we have got going for it is its relative geographic isolation and the other one is its incredibly high reputation for [tourism]… putting all that together, I think we are a pretty unique community where we [are] community driven. (Service provider)

5.2.2 Updated overall impressions

While the comments were somewhat framed around the alcohol restrictions as the timeframe under consideration, comments clearly reflected other themes in the priorities set in the Bourke Alcohol Action Plan.

Positive and sustained

All respondents reported on positive overall outcomes of the Plan and restrictions, irrespective of whether there were any components they thought could change. This included comments regarding the general town environment and people, including flow on affect to families. For example:

I go around the streets fairly early in the mornings fairly regularly and I can’t help but notice there is invariably more [water and] cordial bottles in the street than there are [alcohol brand] there is not very much, there is little in the street that is directly alcohol related. (Service provider)

One of the big components that come out of the alcohol initiatives, one of the initiatives that started in Bourke, was the recycling program with Kerang, it could be used a lot more commercially where [service provided] to different residences in town who chose to recycle their bottles and plastic and cardboard and have them collected from the house once a week and take them away for recycling… it has an impact on the amount of litter and the amount of waste that goes to the tip. (Police representative)

There is a reduced amount of people visibly around town drinking during the day… The antisocial behaviour that was so evident and visible during the day has definitely reduced. (Service provider)

Kids seem to be behaving more like kids [for example] laughing. It is sad to have to take notice of this. (Service provider)

This was in keeping with achievements of the first priority area of the Plan. Achievements were also noted in relation to clinical support and partnerships, despite the recent loss of a valued worker:

And so it does take time and its very resource specific… where we had none in town [alcohol and drug personnel], now there is two and a youth worker trying to do things and so again, I think it’s a time thing. It would be great if we had 40 of us, that would be great, but that’s not going to happen. (Service provider)

I think one of the good things that has come up, that has come, I guess it not necessarily the restrictions, but one of the things that will aid or be part of the restrictions or aid the restrictions is the other stuff that is happening. We’re all involved with it… so there is that development of partnerships, that
development of you know [name of service], which is opening very soon, and some people in this room are on the Board and some are on the Advisory… so this [is] starting to develop where we can actually do some sustainable things and some realistic things. (Service provider)

It was also recognised by others that these were considerable achievements:

So it has started to happen but it’s just been really slow and it’s been hard really. (Service provider)

Further, others offered that testament to the general acceptance and overall positive nature of the restrictions for the community was that it was not used as a platform for election of a local candidate in the recent state election: “changes needed continue not due to politics but due to Community”. This was despite the subsequently elected Premier having talked in the campaign of conducting local country surveys, possibly a referendum, and introducing more sober up shelters.

There was a noticeable lack of comments compared to the first follow up of any particular bias or focus on Aboriginal residents in Bourke as problem drinkers, rather than a community wide issue involving a range of individual problem drinkers:

Alcohol is such a part of life here! (Stakeholder)

The real problem (of alcohol) is an Australian problem. (Service provider)

A service provider reported based on statistics, “Most of drink driving is from the White community”. One interviewee wanted to comment personally, pointing to the issue of individual empowerment, irrespective of culture or background:

Now all the people that we see out in the country, Aboriginal people, well I [am] one… I know what the Aboriginal people go through, but it’s their problem themselves, no one will put a gun to their head and said, “You must drink this alcohol, you must take this needle.” …If I can go and do things and get to where I have with four years of education, I am certain a lot more people can do it… we put our hand up and said, “We don’t want to bludge off the government. The government doesn’t owe us anything, we can look after ourselves.” And that’s what the rest of the population has got to do. (Community member)

Most importantly to the issues of the effectiveness of the restrictions, there was a strong sense that achievements had been sustained over time:

I think sometimes you see shifts when you bring in a new program that the biggest effect you get [is] when it’s first bought in and then it dwindles… Like health programs and other programs and so I guess it’s just to, it seems generally we haven’t heard that necessarily… it’s been that people are on board with the restrictions still and they are operating to some sense, they have continued in the way that they were still showing 12 months ago. (BAWG member)

Also importantly, Police confirmed that, while there was a high level of policing in Bourke, the highest in NSW, there had been no absolute increase or decrease in the level of police or enforcement programs over the follow-up periods that could be influencing when offences were increasing or decreasing. The three-year terms had continued and another reported positive was that previously Bourke had been viewed as a “tough gig”
“Backlash”

In conjunction with these overall positive views however, were notable examples of what were viewed as a “backlash” against the restrictions, that people had “felt them out” since the one-year follow up and were working ways around them. The majority of comments in this respect related to the 50km residency exemption, far stronger than speculation at the first year follow up. The exemption was viewed as probably being included originally to allow for tourists and contractors who visit Bourke but now being extended to locals. There was concern that, as long as a change of address was within NSW (not interstate), Roads and Maritime Services (former RTA) would administratively change the address on a driver licence without requiring any proof of residency. This could also readily be done on the internet without any in person requirement. On balance, particularly through exchanges in the focus group and discussions with police representatives, it appeared this was not so much problem drinkers living locally (only) changing their address, but rather those who had multiple residences or friend and others passing through the town buying for locals:

There are a lot of restrictions that applies to half the people in town, because someone has always got a friend who has come from Bathurst or Dubbo to go and down and buy cartoons of coke and grog, so it’s self defeating. (Service provider)

…so you are meant to change your licence to you most recent address. A family will live in or a person will live in Dubbo and they live in Bourke also, they are backwards and forwards. (Stakeholder)

One business owner suggested there weren’t any major problems with the exemption:

I really don’t think it’s a big issue. The squeaky wheel gets the most oil and the more people who squeak about it, which it just seems to be the same people all of the time, then that’s when it is a problem. That’s when it is perceived as a problem. Myself and [indistinct] are quite happy with the way it is at moment. (Business owner)

However, many others, including another business owner, expressed difficulty enforcing this exemption. Even if they knew someone with a valid out-of-town ID was (also) a local, there was little they could do:

I think it’s a greater problem for the licensees than it is for the police, because the onus has really been dumped on the licensees to make the decision... and they shouldn’t have to... certainly they have got no ability to say, “No, that’s not your address”. No, they just have to follow the rules. (Business owner)

…not practical to think a licensee would have to call in the police if they think a licence address is incorrect. (Police representative)

People think a change in the law will have a magical effect… Hard cases make bad laws. (Service provider)

Police further suggested it was likely addresses were mostly legitimate as many community members had seasonal or shifting work in other towns and spend enough time in those towns to be viewed as a resident. Of concern, however, they also suggested [anecdotally] that they were perceiving a turnaround in assaults, such that they may now be on the increase again, and firmly believed this was due to the 50km residency exemption in particular. One service provider suggested however, that Council was unlikely to support BAWG if wanting to remove the exemption.
Others argued that without a cap on the total amount of alcohol that could be purchased, bulk sales might be reducing the impact of the restrictions:

The problem is the amount that they can purchase and how it can in some ways, ease the amount or even identify how much is being purchased in large amounts. (Service provider)

An incident was related of a group of members coming together to collectively purchase large amounts of (light strength) takeaways to take home for a binge session. Service providers however suggested that the shift to more lower strength alcohol over time rather than a binge on full strength alcohol was likely an improvement:

From a health perspective it may be better but, and again I don’t have any of the data, but I am just sort of wondering if I am drinking light at all day and then at two o’clock I start drinking the heavy, I have still been drinking all day. (Service provider)

From a win, win position I would rather people drinking light all day. (Service provider)

Another issue speculated as a way that some might get around the restrictions was via postal deliveries:

…if you had half a chance, I think it would be worthwhile talking to the people at the post office. Sort of establish whether they have observed any difference in pattern of parcels coming in, alcoholic sort of parcels coming in.

It was in particular reported that a certain company that had advance payment plans for Christmas hampers were allowing these to include bulk alcohol hampers at full strength and without any accompanying food. They had been requested to include mid-strength alcohol only although the outcome of this was unclear and requested for review. This seemed valid, although it was not clear whether this was being undertaken by problem drinkers per se and was considered beyond the scope of the current evaluation but worthy of tracking in future.

Certainly several queried whether the evaluation would determine whether there had been a shift to more drinking in the home, with this a noticeable concern:

…it’s probably… that it’s going underground, but that is the perception that we get, that there is a lot more drinking at home now and there’s a lot more. So whatever is causing it, we are just saying, so the effect that we are seeing, the fact the we are seeing is probably a higher percentage of our client group is actually you know, coming after they have been involved in domestics and involved in assaults at home and not necessarily in the street for example, so that’s definitely it. (Service provider)

So to me that drinking at home happened before the restrictions, which is a problem because the police have got no control over that whatsoever. That’s a problem, but then having that you can only get full strength in the pub, up till two o’clock is a way of encouraging people to actually be a bit more social when it’s under control. (Police representative)

One interviewee suggested the restrictions had resulted in a reduced focus on other pressing issues in Bourke:

Because of all the toeing and froing and the history around the restrictions, the focus has gone off on health, on housing… and it takes a huge amount of work… to move it forward. If we don’t do that, then you might as well pull up
sticks and go back to the old ways… move onto other stuff and get the council in place by whatever means and what needs to be done with the right lobbying, it has to be done. Because of the bloody alcohol restrictions, there is no movement. (Business owner)

Another summed up perspectives on the backlash, irrespective if responsible drinkers were negatively affected:

I mean the reality is, these are put in place because we are dealing with a substance that’s deadly. And so whether people can’t buy when they want to buy or someone’s feelings are hurt, I really don’t care. We have to deal with this issue which is alcoholism, which is alcohol abuse, which is families being destroyed and I guess for me personally there shouldn’t be a limit how far you can live out of town where you can buy this stuff… the reality is, if I can only drink light beer, then I will drink light beer until two o’clock when I can buy the heavy stuff, so it’s not really stopping me from drinking. If I am going to go out fishing, then I buy it the night before. It’s not a no brainer. I mean we are not talking about, oh well we have to make sure it’s accessible to those who don’t have a problem and not accessible to those who do have a problem, because as a matter of fact, a lot of the people that I deal with, they didn’t have a problem when they began with it. They became problematic drinkers because they could drink it. So I think we are just forgetting that these are restrictions, because there is a problem. Just like we don’t sell firearms because I mean if I had a gun I wouldn’t shoot anybody, but you wouldn’t sell it to anyone without certain restrictions, right? I mean, we have got to start thinking a little bit bigger here than the squabbles we have about whether we can have it now or later or whatever it is. (Service provider)

5.2.3 On-going impact and practicality

Business impact

In terms of income for licensee businesses, it seemed there had been little impact, rather a shift in spending, purportedly reflecting experiences of all licensees in Bourke as discussed at recent liquor accord meeting:

And in respect of take away bottle sales, there has probably been about a 4% difference [decrease] in the sale of takeaways since the restrictions, which represents, it meaningless on the bottom line from that point of view. (Business owner)

…and fact it’s probably been a positive thing to the extent that our on-venue sales have increased, because people are waiting until that time to have a beer. (Business owner)

I mean generally from an alcohol dependency point of view, if you can’t get the heavy, you drink the middle, if you can’t get the middle you drink the light. If you can’t drink light you drink the wine. (Community member)

Companies had changed the size of the alcohol containers or the alcohol strength of their products to fall under the thresholds within the restrictions. This included changing wine bottles from 750ml to 700ml and some spirit based mixed drinks (e.g., a popular brand of bourbon and cola) to fall to the 3.5% alcohol level. This was particularly commented on in
related to the popular events such as race meets where suppliers had changed alcohol products to mid-strength.

Historically drink driving was common on race days [where would] drink all day...increase of crime also on race days... The liquor industry has modified their ‘mixer drinks’ to make them lower alcohol and therefore showing that the liquor industry can respond to change. (Stakeholder)

Nonetheless, one interviewee expressed concern as to whether there had been a shift to consuming more spirits and whether this could be negatively impacting on health.

When the potential “rabbit run” issue was queried (not raised by interviewees), both business owners and police representatives did not regard this to have been a particular problem for Bourke:

I mean, I’m going to Dubbo to do my shopping, as people do in Bourke, you often run into 10 or 20 people down there. Of course you can get it in Bourke, you might sneak into the bottle’o and get a couple of cartons because it’s $6 bucks cheaper and that’s human nature, you just do that. You are not specifically going to Dubbo to buy a truck load of grog and coming back with it... it’s been negligible to us. (Business owner)

While income may not have been negatively affected, there were other business concerns for licensed venues:

...whilst the economics might not be real evidence of the impact on people’s sales, there is a belief that there has been a negative impact on the value of [their asset] and their view is that there is a pub for sale in Bourke and there is a pub for sale in [another town in the region] that doesn’t have a condition on the licence. (Community member)

One community member also proposed that there had a big decrease in the number of licensed venues in town compared to when younger, but others suggested this more due to the global financial climate over several years rather than the restrictions. One countered that a pub in Bourke had been recently sold at an amount much higher than in other towns. Others corroborated this report. It was also reported that while sale prices had reduced (by about one-third) in other towns, Bourke’s had increased. However, another suggested that the restrictions might still be impacting on the viability of multiple venues.

The other potential impact on business of the restrictions was the voluntary condition to ensure takeaway purchases were placed into a vehicle. Two interviewees expressed concerns:

...it would appear that [this condition that] unless it’s in the car and that’s a voluntary. And that appears to be policed by the licensees (Community member)

A bit of discrimination for those that use a push bike. (Community member)

However, police perceived this condition was working well and was mostly in place for drive-thru outlets and supermarkets or where licensees knew their clients. In fact this voluntary condition overall was viewed as being as successful as the mandatory components of the restrictions.

In other business respects, tourism was reported to have increased and being a real win for local businesses. In fact, a Tourism Master Class was being held in Bourke later in week the data was collected. Albeit there had generally seemed to be a boost in tourism in rural towns in recent times, Bourke seemed particularly popular, with high occupancy rates or public
accommodation (evidenced also by the researchers when planning travel). More than one person commented:

We need another hotel in Bourke! (Service providers)

One potential negative impact that a focus group member requested to be mentioned in our evaluation was a report that had been published on Bourke about two years prior that had misrepresented BOCSAR data. While BOCSAR had agreed to the misrepresentation, this was “still on the record” and “not publically declared”. All present at the focus group confirmed this misrepresentation.

**Road safety impacts**

In relation to road safety, there was a sense of improvement over time, but with mixed views as to whether this was necessarily specific to the timing of the alcohol restrictions:

People are educated now – you don’t see people drunk driving [much]. (Police representative)

I wouldn’t say it’s because of the restrictions. No, but it’s still an indicator of whether this is changing. But when I was younger, you would drive along and you would see people weaving all over the roads… you don’t see that these days. (Community member)

While there appeared to be some consensus that drink driving was not a major issue in Bourke, concern was nonetheless expressed that a more recent occupational health and safety review had deemed only two locations in Bourke as safe for police to conduct random breath testing operations. Given these locations were known to residents and could be readily avoided, there was concern drink driving might subsequently increase.

Despite overall perceptions of reduced drunkenness in the streets, perceptions of drink walking were viewed as “depending on what’s happening in the community” [such as funerals, weddings, parties] (focus group agreement) and some were uncertain if there has been a shift to later at night that they wouldn’t have observed, but did not believe had occurred.

One interviewee was however convinced there had been a visible improvement in road safety regarding youth wearing bicycle helmets in recent times, potentially indicating improved family dynamics, however the true impetus is unknown:

…observed increase in remarkable difference in children around the age of 7 to 10 years, including groups of boys, wearing bicycle helmets. (Service provider)

Several interviewees expressed concern as to whether the Plan was really reaching young people in the community (notably, these comments were made leading up to the youth forums detailed in section 2.1.2). Some, including police, perceived one of the biggest issues for youth is that they were not “turning up to get a [driver] licence” (Community members):

Main problem out here is that most young people don’t get their licence (Police representative)

Need to have driving instructors officially in schools and make sure kids have a licence by the time they leave. (Service provider)

This was viewed as important not only for road safety but for “building capacity” including access to employment given the remoteness of Bourke:
People affected have many more problems – incarceration, health. Governments haven’t worked together – too interested in ticking boxes – all little kingdoms. (Police representative)

However, this issue was not limited to young people only:

Unlicensed driving is generally a problem in the country… Driver never licensed is not an uncommon offence in Bourke. (Service provider)

Further it was reported that Legal Aid does not provide defence for traffic offences (or AVOs) compounding the impact of licensing (as well as other issues) for the community.

It was suggested that Roads and Maritime Services (former RTA) could consider initiatives that would stimulate more action in this respect in the community. In general however, police representatives reported improvements among youth, a “definite” reduction in “drunkenness and aggression” in the streets, plus other impacts:

Hardly any breaking into cars now that was very high in tourist spots such as in North Bourke… and mostly by youth (Police representative)

Potential changes or extensions to the restrictions or Plan

Given the general sense of acceptance of having alcohol restrictions as positive, more discussion on the restrictions focused on not removing them, but what could or should be changed or future directions. This focused on whether the 50km residency exemption should be removed (given the findings reported above).

Another explored issue was whether the restrictions should all be made voluntary, with many interviewees referring to other towns as having introduced voluntary only restrictions. This was despite claims in the one-year follow up of a previous failure to introduce voluntary restrictions in Bourke. Views on this were very mixed:

Many others towns however have been introducing voluntarily and having good results. Wilcannia has had 80% drop in assaults. (Police representative)

…empowering for the community. (Business owner)

Voluntary conditions are a total waste of time. (Stakeholder)

Strong belief it won’t work. Walgett tried and collapsed. Still big problem there. (Police representative)

There were also mixed views as to whether BAWG should be expanding to other drugs. Some were concerned there might be a shift in problem alcohol users turning to other drugs and therefore this move by BAWG was very valid and important, but most agreed it was not really clear if there had been any actual shifts:

Most clients that I see will use alcohol, you know, gunga, and something else... So I am assuming from a dependence point of view, if they can’t get one, they go to the other one, you know. (Service provider)

…there are a lot more poly drug users nowadays. So there are a lot of people that do cannabis, alcohol and something else, rather than just pure alcohol. So that’s a really hard one to sort of gauge as well. (Service providers)

They [BAWG] should stick to the same name and what they are good at. (Service provider)
…and when the offenders went to court for domestic violence, they had to go and have an interview. And he said that every one of them [was] alcohol related and everyone had a severe underlying drug problem. So the grog is getting blamed for a lot of the domestic violence and things like that. (Service provider)

We really haven’t seen drugs yet here. We have just seen the edge, the touch. You know, once you have had your…. Then people are going to go whoa. And then they are going to say we have got a problem, because they will see their kids up in the hospital… these are their kids…. It won’t only be Aboriginal kids, it will be White kids. (Service provider)

There was to some extent still a call for better education to complement the restrictions, not just the details of what was restricted by the “why and how”:

Not much going on in community education since [named person] left… Public education hasn’t been done well enough… You need to tell a story; that part of community education hasn’t been done… Ordinary people still see the restrictions as imposed and as taking away their rights. (Service provider)

Better tailored education was wanted, including age appropriate, culturally appropriate, and on how to manage alcohol, not just restrictions, as well as better treatment options for problem drinkers:

Not enough education around alcohol and also gambling. (Police representative)

So you know, we still do get people approaching us to say and say you know, is there an AA meeting? There is not. So very basic, very basic things. I am not saying you know, bring on AA or anything like that but... any counselling done that’s alcohol related or drug related is a one to one, it’s not group sessions at all and so we haven’t even had any discussion about what the situation is in this community. Is it better to have one to one or is it better to do group sessions or what sort of sessions? So there’s no support for those people who want to be helped. (Service provider)

Need for education – schools have resources but the teaching is unsuitable for the children that are there. (Service providers)

Several called for diversionary programs for offenders, able to be allocated by magistrates and done so in other towns, however Bourke had no such programs available:

Need for education – schools have resources but the teaching is unsuitable for the children that are there. (Service providers)

Magistrates because I know they see it…. That is another part of it. They are saying, “Go do this, go do this, go do this,” under orders, but there is none of that in town. (Service provider)

[There is] little available for juvenile justice diversionary programs but good programs being developed in Brewarrina with the Brahminy Group following from NT plans… [could do with such a] farm type program in Bourke. (Police representative)

Comments from some interviewees suggested there was increasing awareness of Foetal Alcohol Spectrum Disorder among service providers and that this could be included in plans
for “mums and bubs” programs by BAWG addressing alcohol use when pregnant and issues for babies and children with Foetal Alcohol Spectrum Disorder.

5.2.4 “Other things to do”

There seemed to be a sense of “time to move on” from just focusing on restrictions and thinking more about what else could be done in Bourke to make improvements for the town. These were many and various and while some might seemingly be beyond the scope of the evaluation, provide important informant for BAWG (and other community stakeholders) as to other potential revisions and activities to consider in relation to the evolution of the Plan. Generally, some comments suggested a need to go back to the Bourke Alcohol Action Plan and extend focus to the many other aspects in there besides restrictions.

Further encouragement of recycling and removing glass and rubbish in the streets was suggested:

I remember when I was a young boy and I used to collect bottles and take them to the shop and we had a [name of drink] bottle that would be worth five cents or whatever it was. If you took four or five bottles to the shop, you would have money to buy something else, but it doesn’t happen anymore. You know, that’s something for the whole community. (Community member)

Several suggestions focused on youth. The local radio station had opportunities and there was discussion of it becoming a cultural centre. Some argued the swimming pool should be open for at least five months and others argued all year. Revival of earlier interest in a U-Turn (driver training) program or skate/bike park project were repeatedly mentioned. Increased support for the PCYC in expanding activities for youth was commonly included:

The PCYC closes down for 2 weeks during the holidays… The PCYC performs an important role. School holidays are a big problem. The Christmas period used to be a period of high car theft. (Service provider)

There is a lack of diversion for young people…. There should be more [money spent] on PCYC. (Service provider)

[We] need to give kids hope. Review their strengths and interest in [things like] sport, intellectual and artistic [endeavours]. (Service provider)

The breaking of the drought was associated with improved opportunities:

The kids’ attitudes are better. With water in the river kids are busy swimming and fishing… also economic benefits as they can sell the fish. (Service provider)

It is noteworthy that suggested activities were echoed from several raised by youth themselves as well as youth services stakeholders in the May 2011 youth forums (section 2.1.2).

5.3 Limitations

While qualitative research can provide greater breadth and depth of information on an issue than pre-determined questions in quantitative survey, it can be limited by reaching only a small number of participants, who may not necessarily reflect the majority view of the community. This cannot be discounted in the present research, although efforts were made to reach a broad cross section of representatives from various services and businesses in the community, as well as other community members where possible. Including patrons of licensed premises,
licensees, and alcohol and injury related service providers as interviewees increased the
likelihood that a range of perspectives was encountered. The sample did not however include
political leaders or their advisors, so the results may not accurately reflect political rationale,
policy decisions and processes under study.

We also asked people to compare circumstances at the time of interview/focus group and
compare to a time one or two years previously, which was therefore subject to recall bias as
well as any personal biases. For some individuals, representing an organisation or business
might also present conflicts between their opinions as an individual community resident
compared to perspectives in their work role, although care was taken to document such dual
perspectives when noted by interviewees. The combined influence of interviewers with
independent roles relative to the restrictions, the rapport build via one-on-one interviews and
the confidentiality assurances given to participants aimed to minimise any potential for
misrepresentation of their perceptions.

5.4 Summary

All interviewees identified issues with alcohol misuse in Bourke and the majority reported
visible improvements in the community since the forming of BAWG and the Bourke Alcohol
Action Plan. This was appreciated and mostly considered valuable, both at the wider
community level (less problems on the streets, potential increase in tourism) and individual
level (perceived positive impact on problem drinkers and therefore their impact on others,
including their families). Mixed opinions primarily arose in relation to the takeaway alcohol
restrictions.

There was mixed understanding of the rationale behind the alcohol restrictions (“public
health” versus “political”) and their community-led introduction, including perceptions of a
lack of prior community consultation. This was despite advertised public forums. Education
and promotion activities after the introduction were also perceived as limits. Concerns
included lack of culturally specific education strategies for Aboriginal community members.

Some interviewees expressed a belief that the restrictions were the “best available” option,
even those who perceived them as not necessary personally, but for the good of the
community as a whole. Others however argued improved education and treatment programs
would be more beneficial, viewing the restrictions as a “Band-Aid” solution only.

Several participants, while acknowledging concern about the restrictions from a “civil
liberties” perspective, suggested they were “a small price to pay” given their perceived impact
in reducing violence in the community. Some objected however to the majority being
“punished” for the sake of a minority with alcohol misuse problems in the community, and
expressed doubt that the restrictions could overcome these problems for this minority. Some
acknowledged misperceptions of the alcohol issues being confined to Aboriginal residents,
while others regarded heavy drinking as just part of the outback Australian culture, including
ties to unemployment.

The most common perceived improvement since the introduction of the alcohol restrictions
was reduced assaults, with others also reporting perceived improvements for children,
including fewer injuries at house parties and more food for which funds might previously have
been spent on alcohol, and noticeable reduction of broken glass and intoxicated persons in
public areas. Several also reported improved tourism, also associated with improved
“community pride”.
Perceptions of potential negative impacts included suggestions that restrictions on alcohol may have resulted in increased use of other drugs. It was also noted the restrictions pertained largely to the strength of alcohol and size of container but not the overall amount purchased and it was queried whether this was truly having an impact or whether total takeaway sales should also be capped. Manufacturers had adjusted the size of their containers and/or the strength of alcohol in popular beverages to be just below the threshold of the restrictions.

By the two-year mark, some issues touched on at one-year were more vocal and associated with a perceived backlash against the alcohol restrictions. This included concern regarding the 50km residency exemption and whether the restrictions should all be made voluntary.

The 50km residency exemption was viewed as simple to get around due to: ease in changing the residential address on a driver licence (although fraudulent changes were not believed to be a core problem); many locals also legitimately having residences in other towns; and asking those exempt to purchase for locals. From those working at the point of sale, the exemption was viewed as difficult to enforce if purchasers did not produce sufficient documentation or were known to be misrepresenting their address. They did not believe it was their role to call the police to address this and likewise the police did not see this as an acceptable or preferred option. Police expressed concerns that their crime figures appeared to be returning to increases and believed this particular “loophole” was the main contributor (albeit this could be a fluctuation only or a range of other factors could be contributing to any increase).

Some argued making the restrictions voluntary could be more empowering from a community perspective, although others reported this had been previously attempted in Bourke unsuccessfully. Examples were also reported of both successful and failed voluntary initiatives in neighbouring regional towns. In fact, Bourke was viewed as setting the example in the region and leading to these developments of community introduced alcohol management plans in other towns in the region; resulting in a sense of pride in the community by several interviewees.

Also particularly evident at the two-year follow up was concern as to whether the alcohol issues, previously visible on the streets, had simply shifted into private homes. The Police also reported that they had perceived some trend towards this prior to introduction of the restrictions. Mail order alcohol sales were also suspected to be increasing. A potential shift in increased consumption of spirits was also suspected but unconfirmed.

An obvious concern of the restrictions was a threat to businesses although there were mixed reports as to whether these had been realised. Sales had reportedly decreased on takeaway full strength alcohol but increased on low strength alcohol as well as increased in premises sales of full strength alcohol, such that overall revenue remained relatively unchanged. Concern pub licences (to which the restrictions are attached) would be less value were in part support by suggestions some establishments had closed, although it was suggested this had already been occurring due to the global financial downtown. Further, one establishment had recently sold for a large sum above others in the region. We were not able to verify these details from other sources and, despite attempts, were unable to access alcohol sales records for either retail or wholesale sales.

The potential rabbit run, which could impact on both business and road safety was not evident, although requires confirmation via analysis of police crash and offence record. Further from a road safety perspective, given continued issues with a lack of taxis and other public transport, drink driving was still believed to be common at the one-year follow up but considered to have reduced overall by the two-year follow up, although there were concerns that changed operating conditions might reverse this trend. Responses indicated a sense that road safety was perceived as a secondary concern to violence. Despite reduced public
drunkenness, it was unclear whether intoxicated walking had reduced at all following alcohol-involved events (such as parties and funerals). While child bicycle helmet use appeared on the increase and youth stealing cars on the decrease, there were concerns in relation to youth not gaining a driver licence and unlicensed driving generally and whether Roads and Maritime Services (former RTA) could assist with this.

By two years, the restrictions seemed to have been accepted overall among the participants interviewed and rather than complete removal, changes were proposed instead: removing the 50km exemption; changing to voluntary restrictions; increasing and improving education (alcohol management, age and culturally appropriate resources, including issues such as Foetal Alcohol Spectrum Disorder); and increasing treatment availability and diversionary options for problem drinkers. Further in a sense of “moving on” from the focus on retractions, a range of other positive activities for Bourke to explore were offered, such as recycling options and youth activities, particularly increased support for PCYC.
Chapter 6 Quantitative Results

6.1 Bourke Hospital ED presentations

6.1.1 Pre-post comparison February 2008 to January 2010

The first set of analyses focused on trend analysis of Bourke Hospital emergency presentation data for the 12 months prior (February 2008 to January 2009) and 12 months following (February 2009 to January 2010) introduction of the alcohol restrictions in February 2009.

There were 636 injury related presentations, nearly 6% of all emergency related presentation to Bourke hospital during the study period (Feb 2008-Jan 2010).

Figure 3 depicts the percentage of monthly presentations to the Bourke ED that were injury related, with a dashed line indicating the month the alcohol restrictions were introduced. The proportion of injury presentations (denominator all ED presentations) did not vary significantly during the 12 months after alcohol restrictions were introduced compared to the 12 months prior (p=0.41).

![Figure 3. Trends in the proportion of injury presentations to Bourke ED: Feb 2008-Jan 2010](image)

Proportions of alcohol-related injury presentations are similarly depicted in Figure 4. There appeared to be a decline in the proportion of presentations for alcohol related injury (denominator all injury presentations) during the 12 months after alcohol restrictions were introduced compared to the 12 months prior. This decline was not however statistically significant (p=0.59) at the typical 5% error level (p<0.05), although approached significance at the 6% error level (p<0.10).
Figure 4. Trends in the proportion of alcohol-related injury presentations to Bourke ED: Feb 2008-Jan 2010

Proportions of presentations for assault-related injuries are shown in Figure 5. There was a significant decline in the proportion of presentations for assault related injury (denominator all injury presentations) during the 12 months after alcohol restrictions were introduced compared to the 12 months prior (p=<.001). It is important to note that the similarities between the alcohol and assaults trends are related to the fact that alcohol was involved in nearly 60% of all assault injuries as opposed to 30% for all injury presentations over the study period.

Figure 5. Trends in the proportion of assault-related injury presentations to Bourke ED: Feb 2008-Jan 2010

Figure 6 summarises the trends in injury presentations for Aboriginal residents in Bourke. There was a significant decline in the proportion of presentations for injury in Aboriginal people (denominator all injury presentations) during the 12 months after alcohol restrictions were introduced compared to the 12 months prior (p=.001).
Proportions of alcohol-related injury presentations for Aboriginal residents in Bourke are summarised in Figure 7. While there appeared to be a decline in the proportion of alcohol-related injury presentations among Aboriginal people (denominator all Aboriginal injury presentations) during the 12 months after alcohol restrictions were introduced compared to the 12 months prior, the decline was not significant (p=0.019).

Proportions of assault-related injury presentations for Aboriginal residents in Bourke are summarised in Figure 8. While there appeared to be a decline in the proportion of assault-related injury presentations among Aboriginal people (denominator all Aboriginal injury presentations) during the 12 months after alcohol restrictions were introduced compared to the 12 months prior, the decline was not significant (p=0.40).
6.1.2 Pre-post comparison January 2008 to March 2010

It was noticeable that several of the above analyses indicated positive trends in the figures but did not reach significance. Given the small numbers involved (statistically), it was not possible to conclude whether this was due to low power of the statistical analysis to detect differences or a true null finding. Given the power of trend analysis to detect differences is strengthened with additional data points, we therefore repeated the analyses using all months of data available that were coded for the study from ED records, namely for January 2008 to March 2010.

For this larger dataset, there were 714 injury related presentations, nearly 6% of all emergency related presentations to the Bourke hospital. Figure 9 presents the total participant data. Similar to the previous analyses, the proportion of injury presentations (denominator all ED presentations) did not vary significantly during the period after February 2009 compared to the period prior to that date (p=0.64).

Figure 10 shows the results of the repeat analyses for all alcohol-related injury presentations. In contrast to the previous analyses, this trend was now found to be significant. There was a significant decline in the proportion of presentations for alcohol-related injury (denominator
all injury presentations) during the period after February 2009 compared to the period prior to that date (p=0.016).

Figure 10. Trends in the proportion of alcohol-related injury presentations to Bourke ED: Jan 2008-March 2010

Figure 11 presents the results of the repeat analyses for all assault-related injuries. As previously, a significant trend was found. There was a significant decline in the proportion of presentations for assault-related injury (denominator all injury presentations) during the period after February 2009 compared to the period prior to that date (p=<.001). It is important to note again that the similarities between the alcohol and assaults trends are related to the fact that alcohol was involved in nearly 60% of all assault injuries as opposed to 30% for all injury presentations across the study period.

Figure 11. Trends in the proportion of assault-related injury presentations to Bourke ED: Jan 2008-March 201

The repeat analyses for injury presentations by Aboriginal residents are shown in Figure 12. There was similarly a significant decline in the proportion of presentations for injury in Aboriginal people (denominator all injury presentations) during the period after February 2009 compared to the period prior to that date (p=.001).
Proportions of alcohol-related injury presentations for Aboriginal residents in Bourke with the extended dataset are summarised in Figure 13. While there similarly appeared to be a decline in the proportion of alcohol-related injury presentations among Aboriginal people (denominator all Aboriginal injury presentations) during the 12 months after alcohol restrictions were introduced compared to the 12 months prior, the decline remained not significant ($p=.019$) at the typical 5% error level but now approached significance at 9% error ($p=.09$).

Figure 14 presents the repeat analyses for assault-related injuries among Aboriginal residents only. Similar to the earlier dataset, while there was an apparent decline in the proportion of assault related injury among Aboriginal people who presented to ED with an injury (denominator all Aboriginal injury presentations), the decline was still not significant during the period after February 2009 compared to the period prior to that date at the 5% error level but approached significance at 8% error ($p=.08$).
6.1.3 Limitations

As noted as part of the results, the more time points available, the stronger the power of the trend analysis methods to detect significant difference over time. Statistically speaking, the numbers of presentations to the Bourke Hospital emergency department were inevitably small both before and after the introduction of the restrictions. In addition, alcohol involvement was unknown in over 40% of injury presentations, therefore further reducing the number of cases available for analysis. This resulted in uncertainty as to whether decreasing proportions were truly non-significant for certain comparisons. With more data points, more significant findings emerged strengthening conclusions regarding the overall trends. Additional data points, when available, would be able to determine whether any comparisons approaching significance are found to be truly significant and whether any significant reductions currently detected continue to be maintained over time.

6.1.4 Summary

Overall, the emergency department data provided positive indicators that alcohol-related injuries requiring hospital attention have decreased in Bourke since the introduction of the restrictions on alcohol sales. While the overall proportion of injury-related presentations to the ED relative to all presentations did not change (averaging 6%), the proportion of alcohol-related injury presentations was shown to have declined significantly following the alcohol restrictions. The proportion of assault-related injury presentations was also shown to have declined significantly, with alcohol a factor in about 60% of these assaults.

Importantly, these positive declines were also reaching Aboriginal residents in Bourke. In fact, the proportion of (all) injury presentations by Aboriginal patients declined significantly following the restrictions. Of these, the proportion that were alcohol-related and those that were assault-related injuries also showed trends in downward declines, not quite reaching conservative estimates of significant difference (<5% error) but at the less stringent <10% level. Given the very small numbers involved (statistically), the pattern of findings suggests that additional months of data might prove to result in overall significant trends at the <5% level in the future.
6.2 NSW Health hospital admissions data

During the evaluation period, there were 229 injury-related hospital admissions of residents whose usual postcode of residence was Bourke. Of these, 117 (51.1%) admissions occurred prior to the alcohol restrictions being introduced and 112 (48.9%) admissions occurred post the introduction of the alcohol restrictions.

6.2.1 Gender, age and indigenous status

Around half the injury-related hospitalisations were of males (50.4%) during the pre-period, rising to 61.6% during the post-period (Table 2). However, there were no significant differences for gender during the pre- and post-periods ($\chi^2=2.9$, df=1, p=0.09). The average age of those hospitalised was 31.3 (standard deviation 19.3) and 35.2 (standard deviation 21.6) during the pre- and post-periods, respectively. Almost one-quarter of the hospitalisations were of children and young people aged less than 15 years. Fifty-nine percent of admissions were reported to be of individuals who identified as Aboriginal but not Torres Strait Islanders during the pre-period, with this proportion decreasing to 48.2% during the post-period. There were no significant differences by age or indigenous status for the pre- and post-periods ($t_{227}=-1.41$; p=0.16 and $\chi^2=3.9$, df=3, p=0.28, respectively).

Table 2. Demographics of individuals whose usual postcode of residence was Bourke and who were hospitalised for an injury-related admission one year pre and one year post the introduction of alcohol restrictions in Bourke in February 2009

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Postcode of usual residence</th>
<th>Test statistic, p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bourke Pre</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>59</td>
<td>50.4</td>
</tr>
<tr>
<td>Female</td>
<td>58</td>
<td>49.6</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>31.3</td>
<td></td>
</tr>
<tr>
<td>(Standard Deviation)</td>
<td>(19.3)</td>
<td></td>
</tr>
<tr>
<td>Age group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;15</td>
<td>27</td>
<td>23.1</td>
</tr>
<tr>
<td>15-19</td>
<td>7</td>
<td>6.0</td>
</tr>
<tr>
<td>20-24</td>
<td>13</td>
<td>11.1</td>
</tr>
<tr>
<td>25-34</td>
<td>20</td>
<td>17.1</td>
</tr>
<tr>
<td>35-44</td>
<td>27</td>
<td>23.1</td>
</tr>
<tr>
<td>45-54</td>
<td>12</td>
<td>10.3</td>
</tr>
<tr>
<td>55+</td>
<td>11</td>
<td>9.4</td>
</tr>
<tr>
<td>Indigenous status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal, but not Torres</td>
<td>69</td>
<td>59.0</td>
</tr>
<tr>
<td>Strait Islander</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both Aboriginal and Torres</td>
<td>#</td>
<td></td>
</tr>
<tr>
<td>Strait Islander</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neither Aboriginal or Torres</td>
<td>45</td>
<td>38.5</td>
</tr>
<tr>
<td>Strait Islander</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not known</td>
<td>#</td>
<td></td>
</tr>
<tr>
<td># Cell size less than five hospitalisations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6.2.2 Injury mechanism

Falls represented approximately one-quarter of all injury admissions during both the pre- and post-periods. Overall, there were no significant differences in the type of injury mechanism during the two time periods ($\chi^2=2.3$, df=3, $p=0.51$). However, the number of assault-related presentations did reduce by one and a half times between the pre- and post-periods (Table 3).

Table 3. Characteristics of injury-related admissions of individuals whose usual postcode of residence was Bourke and who were hospitalised one year pre and one year post the introduction of alcohol restrictions in Bourke in February 2009

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Postcode of usual residence</th>
<th>Pre</th>
<th>%</th>
<th>Post</th>
<th>%</th>
<th>Test statistic, p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bourke</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Injury mechanism</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Road trauma</td>
<td></td>
<td>13</td>
<td>11.1</td>
<td>16</td>
<td>14.3</td>
<td>$\chi^2=2.3$, df=3, $p=0.51$</td>
</tr>
<tr>
<td>Falls</td>
<td></td>
<td>30</td>
<td>25.6</td>
<td>27</td>
<td>24.1</td>
<td></td>
</tr>
<tr>
<td>Assault</td>
<td></td>
<td>27</td>
<td>23.1</td>
<td>18</td>
<td>16.1</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>47</td>
<td>40.2</td>
<td>51</td>
<td>45.5</td>
<td></td>
</tr>
<tr>
<td>Place of occurrence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td></td>
<td>33</td>
<td>28.2</td>
<td>27</td>
<td>24.1</td>
<td>$\chi^2=1.8$, df=3, $p=0.61$</td>
</tr>
<tr>
<td>School, other institution and public administrative area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street or highway</td>
<td></td>
<td>8</td>
<td>6.8</td>
<td>13</td>
<td>11.6</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>60</td>
<td>51.3</td>
<td>56</td>
<td>50.0</td>
<td></td>
</tr>
<tr>
<td>Identified alcohol involvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td>8</td>
<td>6.8</td>
<td>7</td>
<td>6.3</td>
<td>$\chi^2=0.03$, df=1, $p=0.86$</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>109</td>
<td>93.2</td>
<td>105</td>
<td>93.8</td>
<td></td>
</tr>
</tbody>
</table>

6.2.3 Place of occurrence

The home was the most common location of the injurious incident during both the pre- and post-periods (Table 3). There were no significant differences in the place of occurrence of the injurious incident during the two time periods ($\chi^2=1.8$, df=3, $p=0.61$).

6.2.4 Identified alcohol involvement

There were no significant differences between the pre and post evaluation period for hospital admissions involving alcohol ($\chi^2=0.03$, df=1, $p=0.9$) (Table 3).

6.2.5 Location of injury

Overall, there were no significant differences in the location of injury between the two time periods ($\chi^2=6.7$, df=4, $p=0.16$). However, the number of head injuries did reduce by one and a half times (Table 4).
Table 4. Injury-related admissions of individuals whose usual postcode of residence was Bourke and who were hospitalised one year pre and one year post the introduction of alcohol restrictions in Bourke in February 2009

<table>
<thead>
<tr>
<th>Location of injury</th>
<th>Postcode of usual residence Bourke Pre</th>
<th>Postcode of usual residence Bourke Post</th>
<th>Test statistic, p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head injury</td>
<td>35</td>
<td>22</td>
<td>$\chi^2=6.7$, df=4, p=0.16</td>
</tr>
<tr>
<td>Elbow and forearm injuries</td>
<td>22</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Wrist and hand injuries</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Knee and lower leg injuries</td>
<td>7</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>44</td>
<td>56</td>
<td></td>
</tr>
</tbody>
</table>

6.2.6 Limitations

It is very likely that the identification of alcohol involvement in the occurrence of the injury-related hospital admissions is an under-enumeration of alcohol-related injury admissions. This is because of multiple factors, including that the same data fields used to identify an injury-related admission or an external cause code were also used to identify possible alcohol involvement. Therefore the selection criteria for an injury event, may have excluded potential alcohol-related hospital admissions. Only the secondary and supplementary diagnosis and external cause codes were able to be used to identify a likely alcohol-related admission. In addition, blood alcohol levels may not have been assessed or alcohol involvement identified.

It is possible that the identification of Aboriginal and Torres Strait Islander status may be under-enumerated in the hospitalisation data. In the past, has been estimated that indigenous status is under reported in the NSW APDC by at least one-third due to a number of issues, including a lack of understanding as to why the information is collected, poor identification of indigenous status, and inconsistent collection of data on indigenous status by hospital staff (NSW Health Department 1999).

Similarly to the ED findings, the numbers involved in the analyses were statistically very small and therefore additional years of data are required to determine whether the lack of statistically significant findings are true no differences or simply were underpowered to be able to detect.

6.2.7 Summary

The overall number of Bourke residents being admitted to hospital for an injury was somewhat similar in the year prior to the introduction of the alcohol restrictions (n=117) as to the year following (n=112). Although some of the demographics showed potential changes, none reached statistical significance. For example, the proportion of presentations that were male increased from about half to over 60%; the average age increased from 31 years to 35 years, although almost one-quarter of presentations were among those aged under 15 years across both time periods; and the proportion identifying as Aboriginal decreased from around 60% to less than half.

While falls represented approximately one-quarter of all injury admissions at both time points, the number of assault-related presentations reduced by one and a half times. The home was the most common location of the injurious incident during both the pre- and post-periods. While there were no overall significant changes in the location of injury on the body, the number of head injuries reduced by one and a half times.
6.3 NSW Police Force Intelligence Report

The Intelligence Report supplied by Bourke Police reported several improvements in local crime statistics comparing the 18 months post since the introduction of the alcohol restrictions. It was found that in the 18 months since the alcohol restrictions were introduced, compared to the same time period prior to the restrictions, Bourke had experienced a:

- 32% drop in intoxicated persons.
- 22% drop in assaults.
- 25% drop in domestic-related assaults.
- 18% drop in sexual assaults.
- 34% drop in malicious damage.

It was concluded that 79 fewer people had been seriously affected by alcohol and there had been 86 fewer assaults overall.

Examining the time periods when intoxicated persons were detected, prior to the restrictions, these began to increase from 10am and peak at 3pm, followed by a decline and then increase in late night hours. Since the restrictions, the increase does not commence until 4pm and has a weaker decline to the evening hours compared to pre-restriction incidents. Comparisons for the 7-hour period of 3pm to 10pm, show a reduction in intoxicated persons by 39%, from 122 to 74.

There has also been a reduction in assaults in previous peak time periods. The 6pm to 10pm peak has experienced a 41% decrease in total assaults from 120 to 70. For the less marked second peak during 1pm to 4pm there has been a 46% decrease in total assaults from 61 to 33. For sexual assaults the largest peak was midnight and a lesser peak between 6am to 10am. The late night peak has not seen a significant reduction although there has been a shift to only peaking at 2am. The morning peak has however almost been eliminated. For domestic violence assaults there has also been a time shift. Previously these assaults would begin to increase from 10am reaching an initial peak at 2pm then decrease, with another peak at 9pm followed by a decrease that then again increased after 6am. Following the restrictions, there was a much lower number of assaults throughout the day, with increases only commencing from 5pm. There was a 34% reduction (from 70 to 44) during the 6pm peak and 47% reduction (30 to 16) for the 6am peak.

The peak time for malicious damage did not change from 6pm to midnight, but the number of cases reduced.

The number of incidents where glass was used as a weapon in a police recorded incident remained steady over the three years.

6.3.1 Limitations

We note here that that the report did not include statistical significance testing and we did not have access to individual data in order to perform such tests. Therefore we cannot be certain that the results are significant, although the changes reported were large and the findings are supported by other evaluations identified in the literature and a 2009 Bureau of Crime Statistics and Research (BOCSAR) report citing a significant 9.6% decrease in non-domestic alcohol-related assaults in Bourke in 2009 compared to previous years (figures provided by NSW Health).
6.3.2 Summary
Overall, these findings indicate considerable benefits to the Bourke community since the introduction of alcohol restrictions. According to Police statistics, there have been considerable reductions in the number of people affected by alcohol-related harm, including fewer intoxicated persons in public places, fewer assaults, including domestic and sexual assaults, and reductions in malicious damage offences. While the Bourke Alcohol Action Plan also included reductions of glass in the community, and there were several reports of less broken glass in public areas, the use of glass as a weapon in offences did not show any change during the evaluation period. Several of the reductions also showed time shifts that were over and above those that might be expected due to the 10am to 2pm restriction on takeaway alcohol sales.

6.4 NSW Police recorded road traffic offences
There were 74 road traffic offences in the town of Bourke that involved alcohol between 16 February 2008 and 15 February 2010; 33 occurred in the 12 months prior to 16 February 2009 when the takeaway alcohol restrictions were introduced and 41 occurred during the period following the restrictions.

Figure 15 shows there is considerable fluctuation in such offences on a month by month basis. There appeared to be an upward trend in offences prior to the introduction of the restrictions. This was followed by a sharp drop immediately following the restrictions but then returning to the higher level prior to the restrictions; although the last few months appeared to show a decreasing trend.

Overall, the number of alcohol-related traffic offences in Bourke did not vary to a statistically significantly degree between the period prior to February 2009 and the period following (p=0.62).

Figure 15. Trends in the number of alcohol-related road traffic offences in Bourke: 16 February 2008-15 February 2010
6.5 NSW Police recorded road traffic crashes

The number of alcohol-related crashes in Bourke was extremely low and therefore changes could not conclusively be attributed to the introduction of the Plan or the takeaway alcohol restrictions.

During the one year prior to the restrictions, there were 14 crashes in Bourke, of which two involved a driver with an illegal Blood Alcohol Concentration.

During the one year following the restrictions, there were 15 crashes in Bourke, of which none involved a driver with an illegal Blood Alcohol Concentration.

No crash (pre or post) involved an intoxicated pedestrian or other road user affected by alcohol.
Chapter 7 Conclusions and Recommendations

The formation of the Bourke Alcohol Working Group and their development and implementation of the Bourke Alcohol Action Plan has clearly been a major undertaking for the community. Significant progress has been made on the Plan in all six identified priority action areas, including: measures towards ensuring clean and safe public spaces in Bourke; a range of education and awareness activities throughout the community, including several youth-focused initiatives; securing dedicated alcohol and drug personnel; establishing a wide network of partnerships, both within BAWG and with BAWG as a member of other networks; the major achievement of restrictions on takeaway alcohol sales; and this current evaluation. Recognition of these efforts has also been recognised with two national awards, the National Drug and Alcohol Award and the Australian Crime and Violence Prevention Award, a Local Health District Award.

While all components of the Plan collectively contribute to addressing the negative impacts of the misuse of alcohol and other drugs, the main time point to focus data analysis comparisons was the introduction of the restrictions on alcohol, which commenced in February 2009. The mixed methods qualitative and quantitative approach to the evaluation indicated mostly positive impacts of the Plan overall, although not without some negative outcomes, for which several recommendations can be offered, particularly based on “lessons learned” from previous evaluations of alcohol management plans implemented in other very remote areas of Australia.

Notwithstanding methodological limitations, primarily restricted sample sizes and therefore lack of representative nature of the qualitative responses, as well as lack of power to identify significant differences in the quantitative results and no suitable control community able to be identified, several conclusions and recommendations can be drawn, albeit with caution and requirements for on-going review.

Overall, the evaluation highlights considerable benefits to the Bourke community since the introduction of the alcohol restrictions. Safety in the streets had increased, with noticeable improvements in visible signs of alcohol impacts such as fewer intoxicated persons, less public violence and less broken glass in public areas, confirmed by reduced crime and assault statistics. Increased safety in the home was also reported, including care of children and reduced domestic violence assaults in police records, despite concerns problem drinking may have shifted from public areas to the home.

By two years, interviewee responses indicated the community seemed to have “moved on” from viewing the alcohol restrictions as “the best available option” or “a small price to pay” to a general acceptance, moving more towards potential adjustments to the restrictions and a focus on other activities and initiatives for Bourke more generally. Increased tourism and the adoption of alcohol restrictions by other towns in the region were also evident of positive outcomes.

Conclusion 1: Overall the majority of impacts of the Bourke Alcohol Action Plan have been positive for the Bourke community, including in the streets and in the home.

Hospital emergency department data and Police offence data in particular indicate considerable declines in injuries and offences, including those primarily related to harmful
alcohol use. Alcohol-related injury presentations to the Bourke Hospital ED declined significantly as well as assault-related injuries. This included declines in injury presentations by Aboriginal residents, including positive indications that alcohol-related injury presentations were reducing. Overall, hospital admission data on injury, including alcohol related injury, did not show statistically significant declines, however, assault-related admissions and injuries to the head – those that could be considered to be among the most severe injuries – reduced by one and a half times. There were reductions in police offence records of intoxicated persons, assaults, including domestic and sexual assaults, and malicious damage. These were substantiated by similar reports of reductions in non-domestic alcohol-related assaults by BOCSAR data and are in support of previous findings for other remote and very remote communities in Australia following the introduction of local alcohol management plans (Margolis, Ypinazar et al. 2008; Kinnane, Farringdon et al. 2009; Margolis, Ypinazar et al. 2011). It should be acknowledged nonetheless that conclusive links between the introduction of the restrictions and these decreases cannot be made, as other factors may have also contributed to the decline. We were unable to find a suitable comparison community to act as a control to account for this potential.

**Conclusion 2**: Injuries, including those relating to alcohol, particularly severe (head) injuries and assaults, have shown substantial decreases since the alcohol restrictions were introduced

**Conclusion 3**: Reductions in injury presentations to the Bourke hospital were evident for Aboriginal residents, including indications of reductions in alcohol-related injuries

Importantly, several of the reductions in police offences also showed time shifts that were over and above those that might be expected due to the 10am to 2 pm restrictions, indicating that the time components of the alcohol restrictions did not just move the problem to later in the day but that absolute reductions had been achieved. This is particularly important to relay to the community, given a lack of certainty on whether the problem was moving into late night hours (and therefore potentially more disruptive) was raised as an issue in interviews. Police also confirmed there had been no specific increases to the (already high) levels of enforcement during the follow up that could be independently influencing the findings.

**Conclusion 4**: Police records indicate that time-based restrictions on alcohol sales have not simply shifted problems to later in the day/night, but have led to absolute reductions in assaults, including domestic violence-related assaults

**Conclusion 5**: Police enforcement levels following the alcohol restrictions generally followed previous patterns and therefore could not be attributed as inflating the reductions in offences

The small numbers (statistically) of data entries available in the analyses of hospital datasets and police road traffic records limit confidence in whether differences detected were truly not statistically significant or whether there was insufficient power to detect significant differences. This was particularly indicated in the hospital ED analyses, in which just three months of additional data showed shifts from non-significant to significant or near significant findings. A re-review of the analyses at a three-year follow-up would strengthen conclusions in this regard. It is also possible that the numbers pertaining to road-related injuries in both hospital datasets could increase to sufficient levels to allow statistical comparisons. This is also important due
to local Police concerns that number may be starting to increase as a result of the “backlash” against the alcohol restrictions, reported by many interviewees.

From a qualitative perspective, however, road safety was typically viewed as a secondary concern to violence. The hospital admission data did lend some support to this perception. Nonetheless, there were observed improvements in the longer term (two-year follow up) in terms of reduced drink driving and likely reduced drunk walking given lower incidence of public drunkenness, although this was also dependent on the occurrence of alcohol-involved events (such as parties and funerals). Moreover, concerns were expressed that the new limit on random breath testing locations could increase drink driving. There was perhaps incidentally a perceived increase in children wearing bicycle helmets and also a reduction in youth stealing cars. There were notable comments however in relation to youth not gaining a driver licence and whether Roads and Maritime Services (former RTA) could assist with this, although unlicensed driving likely extended to disqualified drivers and older never licensed residents also. There was no suggestion of a potential negative impact to road safety due to rabbit runs to neighbouring towns, and there was no strong evidence of this in police road traffic records given alcohol-related offences, while increasing slightly in number, did not statistically significantly increase and no alcohol-related crash occurred following the restrictions.

There were several calls to review additional indicators of the impact of the restrictions, such as increased mail orders of alcohol and the need to examine alcohol sales records, although these were not possible within the current project.

**Conclusion 6:** Current results were somewhat inconclusive in relation to potential impacts on road safety, primarily due to small numbers of police-recorded road traffic offences and crashes involving alcohol

**Recommendation 1:** Reanalyse quantitative data at a three year follow up to strengthen the conclusiveness of the findings and identify potential demographic targets for future programs (currently limited by low statistical power)

**Recommendation 2:** Initial road safety developments should consider initiatives that would stimulate youth and others to gain or regain licensure, including liaison with Roads and Maritime Services (former RTA) regarding current services and information or other potential new initiatives

**Recommendation 3:** Renewed attempts at a three-year follow up to review alcohol sales data and mail order sales data should also be reviewed

A concerning findings was that the use of glass as a weapon in police offence records did not show any change in the 18 months following the restrictions when compared to the prior 18 months, despite perceptions of less broken glass in the community. Therefore more needs to be done to address this issue. It is not possible to determine whether the glassing incidents involved alcohol containers or other glass receptacles, nor what proportion occurred within or outside of licensed venues. Police may be able to track this when recording offences in order to determine whether all alcohol containers, both within and outside of licensed premises and irrespective of time of day, should be limited to non-glass containers.

**Recommendation 4:** Further investigation of glassing incidents is needed to determine sources of glass and incident locations to indicate whether restricting all alcohol sales to non-glass containers would lead to reductions
There were mixed views regarding the manner by which the restrictions were implemented and the degree of prior community consultation. Given that public forum and advertising had been conducted throughout Bourke leading up to the restrictions, this suggests this process did not reach all those concerned. There were some misperceptions that the restrictions had been imposed on Bourke by government rather than being initiated by the community. The previous literature identified this as an issue in other communities and one that impacted negatively on acceptability of alcohol restrictions (Gray, Saggars et al. 2000; Kinnane, Farringdon et al. 2009; Senior, Chenhall et al. 2009; Gray and Wilkes 2011). Therefore, more effort is needed by BAWG and others in the community to increase understanding of how the restrictions came to be introduced to support continued efforts, and especially when introducing new initiatives. In particular, there was also a call for more culturally specific information for Aboriginal residents, including educational materials and strategies.

By two years, these concerns regarding how the restrictions were reduced and implemented had subsided considerably, and rather than removal of the restrictions, adjustments were proposed, including: removing the 50km residency exemption; changing to voluntary restrictions; increasing and improving education (alcohol management, age and culturally appropriate, including issues such as Foetal Alcohol Spectrum Disorder); and increasing treatment availability and diversionary options for problem drinkers.

Further to education, while some participants (particularly during the one-year follow up) voiced strong concerns for all residents being subject to the alcohol restrictions despite a minority of problem alcohol users, public health research has identified what is known as the “prevention paradox” (Rose 1985). This identifies that more harm can be prevented through interventions focusing on the majority who are less seriously involved in harmful alcohol (drug) use than through interventions that more narrowly target the minority of high-risk users (Alcohol Working Group for the National Preventative Health Taskforce 2009). Increased understanding of this somewhat perplexing phenomenon might be a useful addition to education initiatives.

Recommendation 5: Improved education and awareness initiatives are needed to increase community understanding of the alcohol restrictions as community-led and community owned, including age appropriate and culturally tailored initiatives, justifications for on-going and new initiatives, and expanded focus to alcohol management and treatments, including for alcohol-related health consequences

Concerns for a potential shift to other drugs, such as cannabis and opiates, and the need for long-term education and treatment support strategies are important, and should not be overshadowed by a focus on alcohol restrictions only. Importantly, BAWG had already been addressing this issue by incorporating “other drugs” into more recent revisions of the Plan as well as grant seeking opportunities for additional funding in this field.

Recommendation 6: Extension of the Plan to address other drugs in addition to alcohol is important and should be assessed for impact and acceptability in future evaluations

Also important is any potential shift to increased use of alcohol and alcohol issues in the home rather than in public. While it is promising that the NSW Police Intelligence Report found a substantial decrease in domestic violence at 18 months following the restrictions, concerns of Bourke Police and others at 24 months suggest this needs to be monitored and attention
should be given to ensuring on-going efforts, including access to treatment for problem alcohol users, also reach these residents.

**Recommendation 7:** On-going monitoring and evaluation should include attention to any shift in misuse of alcohol and drugs from public places to the home.

The concerns raised regarding the 50km residence exemption are also important. This is difficult for licensees to enforce, or Police, including in cases where they know a person with out-of-town identification in fact resides in Bourke. It is particularly concerning that local police associate this to potential reverse trend to increases in assaults, with any changing trends in assaults possible to confirm with the recommended three-year follow up analysis. Nonetheless, the difficulty of enforcing this exemption makes it a stressor despite being to some extent redundant and the perceived impact in terms of a “backlash” suggests the community should strongly consider removing this exemption.

Based on the positive findings and comparisons to previous literature, the evaluation suggests that level of restrictions currently in place is working well overall and is generally acceptable in Bourke. There was insufficient support for making the restrictions more stringent (such as a cap on total takeaway alcohol sales as suggested by participants, or prohibition on “pay day” as identified in the literature) (Gray, Saggers et al. 2000). The current “harm minimisation” approach (Roche 1997) to manage alcohol consumption and focus on improved outcomes rather than full prohibition is therefore recommended to continue; also found preferable for previous communities in the research literature (Clapham, O'Dea et al. 2007).

Likewise, there was insufficient support to make the restrictions voluntary given the reported history of unsuccessful such initiatives in the past and reported current failure in another neighbouring community. This however needs to be monitored following the potential removal of the 50km residency exemption and re-review of data at a three-year follow-up to ensure sufficient power in statistical analyses to determine true differences or lack thereof in injury and offence datasets pre and post introduction of the alcohol restrictions. Access and analysis to alcohol sales records from retail and wholesale outlets, as available, would also further strengthen the findings and on-going monitoring would allow early identification of any shift in sales trends that could indicate emerging issues. Further success might also be achieved generally by initiatives to garner support from neighbouring communities, such as Brewarrina and Eugonia. Further, such initiatives could be extended to all communities in the 50km residency area, particularly should the residency exemption be removed.

**Recommendation 8:** The 50km residency exemption is not possible to enforce adequately, is problematic for licensees and Police alike, and therefore its removal from the restrictions should strongly be considered. This should be pursued with clear public debate, including Council. Initiatives to garner support of neighbouring communities should also be considered. No other changes to extend or alter the current restrictions are currently recommended.

The considerable concerns for businesses at the one-year follow-up had subsided by the two-year follow up, at least in relation to income, with any loss in full strength alcohol takeaway sales during restricted hours compensated by alternative takeaway sales and increases in on-premises sales. Any negative impact on the value of the licensed venue or the viability to have a high number of venues in town could not be conclusively confirmed, given overlapping timing with the global financial downtown. Nonetheless positive signs were evident including
high sales prices for licensed venues in Bourke relative to others in the region reported at the two-year follow up.

Also by two years, there was a sense of the community wanting to “move on” from the focus on restrictions, with a range of other positive activities for Bourke to explore offered, both in the interviews and arising from the youth forums held in March 2011. These included activities such as renewed cash for recyclables programs, weekend markets, establishing a cultural centre at the local radio station, extending swimming pool opening months, and generally including increased involvement of community elders. Youth activities were a particular focus, most noticeably increased support for the PCYC, but also expanding TAFE courses, and revival of earlier interest in a driver training program or skate/bike park project.

**Recommendation 9:** Consider roles for BAWG in introducing suggested other activities in Bourke, including innovative initiatives that could also involve and support local businesses.
References


Appendix A. Participant information sheet
BOURKE ALCOHOL MANAGEMENT PLAN EVALUATION
PARTICIPANT INFORMATION STATEMENT
(This Statement will be also be verbally explained by the researcher/research assistant to the participant)

The Bourke Alcohol Working Group is made up of a number of organisations in Bourke that are involved in trying to make a difference in raising awareness of alcohol problems in the town. To decide whether their activities are making a difference, a group of researchers from The George Institute, University of Sydney and the University of Wollongong are undertaking an evaluation on behalf of the Bourke Alcohol Working Group.

We are keen to talk to as many people as we can on their perceptions of any changes in relation to alcohol use and outcomes over the past year. This includes issues such as how people access and use alcohol and potential related outcomes, such as access to services, less rubbish or fewer accidents and injuries. The Bourke Alcohol Working Group wants to find out what is working and what is not working so they can do things better in the future.

We want to hear what you have to say. We hope that you would like to share your experience with us. If you agree, our researchers will make a tape recording of the discussions so we can write down the views of everyone. If you do not want to be taped, we will make notes and check with you when these notes have been written up so that you’re happy with what has been written down.

All aspects of this study, including your answers, will be completely confidential, except as required by law. Your name will not be kept together with the information you provide. Only authorised study researchers will have access to this information. A report of the study may be published, but individual names or answers will not be included; only group answers.

If you would like to know more at any stage, please feel free to contact either Teresa Senserrick or Marilyn Lyford whose contact details are below:

Dr Teresa Senserrick  
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Ms Marilyn Lyford  
Research Fellow  
The George Institute  
University of Sydney  
Tel: (02) 9657 0334  
Email: mlyford@george.org.au
The study is being conducted by Dr Teresa Senserrick (Deputy Director), Associate Professor Rebecca Ivers (Director), Dr Soufiane Boufous (Senior Research Fellow) and Marilyn Lyford (Research Fellow) from the Injury Division, The George Institute for International Health and Professor Kathleen Clapham, University of Wollongong.

This project has received clearance from the Human Research Ethics Committee at the University of Sydney and the Aboriginal Health and Medical Research Council.

Any person with concerns or complaints about the conduct of a research study can contact the Deputy Manager, Human Ethics Administration, University of Sydney on (02) 8627 8176 (Telephone); (02) 8627 8177 (Facsimile) or human.ethics@usyd.edu.au (Email) or The Chairperson, Aboriginal Health and Medical Research Council on (02) 9698 1099 (Telephone)

This information is for you to keep
Appendix B. Participant consent form
PARTICIPANT CONSENT FORM

(This Consent Form will be also be explained verbally to the Participant by the Researcher/Research Assistant)

I..................................................................................................................................................

(PRINT NAME), give consent to my participation in the research project

TITLE: BOURKE ALCOHOL MANAGEMENT PLAN EVALUATION

In giving my consent I acknowledge that:

1. The requirements for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.
2. I have read the Participant Information Statement and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s.
3. I understand that I can withdraw from the study at any time without affecting my relationship with the researcher(s) or the University of Sydney now or in the future.
4. I understand that my involvement is strictly confidential and no information about me will be used in any way that reveals my identity.
5. I understand that being in this study is completely voluntary – I am not under any obligation to consent.
6. I understand that the interview discussion may be audio taped and that I can deny my permission if I so choose.
7. I understand that the information I give will be only be used with everyone’s answers pooled together, not my individual answer.

Signed..............................................................................................................................................

Name:................................................................................................................................................

Date:..................................................................................................................................................
Appendix C. General interview schedule
Evaluation of the Bourke Alcohol Management Plan
Qualitative Questionnaire

Name…………………………………………………………………………………………

Organisation………………………………………………………………………………

Position in Organisation………………………… Female / Male

Age   18-24          25-44          45-64          65 years and over

I am Aboriginal and/or Torres Strait Islander    YES / NO

Date……………………………………………………………………

Name of interviewer……………………………………………………………………

1. How is your organisation involved in alcohol management
   ● What is your particular role in these activities?

2. What have been the main impacts of alcohol restrictions on the community/your
   organisation or business/ yourself? (depending on participant type)
   (See below for prompts)
   ● personal health
   ● life style
   ● recreation, and,
   ● access to services
   ● your business

3. Do you support the restrictions? Why?

4. What further actions should be taken to reduce the effects of alcohol on the
   community?