Peter d'Abbs
Nicole Hewlett

Learning from 50 Years of Aboriginal Alcohol Programs

Beating the Grog in Australia

Springer

Learning from 50 Years of Aboriginal Alcohol Programs

Peter d'Abbs · Nicole Hewlett

Learning from 50 Years of Aboriginal Alcohol Programs

Beating the Grog in Australia

phn NORTHERN TERRITORY
An Australian Government Initiative

RURAL Workforce AGENCY NT

Springer

Peter d'Abbs
Menzies School of Health Research,
Darwin, and School of Public Health
University of Queensland
Brisbane, QLD, Australia

Nicole Hewlett
School of Public Health
University of Queensland
Brisbane, QLD, Australia

Foreword

This is a book about hope, resilience and lessons for how to survive and thrive in a challenging world, which since colonisation has been deeply unjust and unkind to First Nations peoples. It seeks to set out the interventions and pathways forward for combatting and overcoming alcohol harms and transforming current realities.

This is no easy task. However, as this book demonstrates, through the determination and innovations of First Nations people and communities, it can be done. What we need is serious investment and belief in our people's self-determination, so our communities, on our own terms, can develop the approaches and models to heal and reconstruct healthy, safe and flourishing societies.

Alcohol has had a devastating impact on our people and societies. We know this. But very rarely is the context understood in which the harmful overuse of alcohol has taken hold. It was only 50 years ago, just a few years on either side of the 1967 referendum, that state and territory governments began to dismantle discriminatory legislation. A part of this wave of reform was allowing Indigenous people to purchase and drink alcohol, which prior to this period had been prohibited.

This happened in my lifetime, while other great changes were taking place. From the late 1960s, huge numbers of our people were removed from our station lives and jobs and into small settlements often with no housing or services. This was an unintended consequence of the introduction of equal wages—a vital reform that happened without a broader appreciation for the racially divided world we occupied.

In the Kimberley, in Western Australia, where I grew up, it was during the peak of the turmoil of population displacement that the Western Australian Government altered the Liquor Act to remove all restrictions on Kimberley Aboriginal people's access to alcohol. It was done in the name of reform and equality, but it happened without any engagement or planning with the people who would be affected most. There was absolutely no consideration of the fact that Indigenous people throughout Australia live with the inherited trauma from invasion, prolonged frontier conflict and a history of deeply discriminatory laws and policies.

Many of our communities were overtaken by alcohol, which coalesced with minimal investment in community infrastructure and services, compounding generations of trauma.

This book situates itself with this contextual backdrop and then it looks outwards at solutions, at lessons learnt and a pathway forward into a future with significantly reduced alcohol harms.

It is a book written about the trail blazed by the many Indigenous and non-Indigenous peoples and organisations who have worked together to prevent more alcohol-related damage from being inflicted on Indigenous people, and to heal the harms already done.

Over the decades, communities have fiercely confronted harm head-on and led the introduction of a raft of initiatives from alcohol restrictions to establishing women's shelters and centres, night patrols, sobering-up facilities, rehabilitation centres, and family and youth supports, developed research approaches to gather the evidence of alcohol harms such as Fetal Alcohol Spectrum Disorders (FASD) and have developed prevention and diagnostic approaches. The chapters of this book trace these activities and detail the many successful initiatives as well as outline the lessons when approaches haven't quite worked. It is a reflective, historically informed and contemporary analysis of addressing and ending the harms of alcohol.

I have first-hand experience in my hometown of Fitzroy Crossing of community uniting in solidarity and working together to limit the supply of alcohol so as to bring about a more positive future for ongoing generations. I also know the challenges of doing this work, the heartache and the fight to make change happen with minimal resources and support. What we wanted in Fitzroy Crossing was the breathing space, so we could assess the damage wrought by trauma, begin to respond to the harms, and develop the social and economic infrastructure that would enable our community to be healthier and engaged. This community-led approach to holistic development is not new. It is built on a history of remarkable Aboriginal and Torres Strait Islander leadership.

This book highlights these real stories, while providing the evidence that our people have never been bystanders; we are actively always doing what we can to care for and support our families and communities. There is no silver bullet that will drive change, but there are many examples of community-developed holistic models and approaches that when brought together and supported will absolutely drive real and sustained change.

By reading this book, I believe, many others will be able to learn more about both the achievements of those who have gone before, and the challenges faced along the way. I believe that this book engenders hope and empowers us to know that by

working together we can reduce alcohol harm and bring about safer and healthier societies.

<div align="right">

June Oscar AO
Aboriginal and Torres Strait Islander
Social Justice Commissioner
Sydney, Australia

</div>

Acknowledgements

Beating the Grog: An Explanatory Note

The connotations of 'grog' in Australian and New Zealand slang do not, so far as we know, extend beyond those shores. Collins English Dictionary distinguishes two usages:

Grog
in British English

NOUN

1. Diluted spirit, usually rum, as an alcoholic drink;
2. *Informal, mainly Australian and New Zealand:* alcoholic drink in general, esp spirits.

WORD ORIGIN
C18: from *Old Grog*, nickname of Edward Vernon (1684–1757), British admiral, who in 1740 issued naval rum diluted with water; his nickname arose from his grogram cloak.[1]

The phrase 'Beat the Grog' first gained attention following a meeting convened in July 1986 in the Northern Territory town of Tennant Creek. Aboriginal leaders in the small mining town (population around 3,500, of whom 60% were Aboriginal or Torres Strait Islander), dismayed by the continuing damage inflicted by alcohol misuse and the failure of local or higher authorities to develop an appropriate strategy for addressing it, resolved to create and implement their own, community-led strategy (Wright 2010). 'Beat the Grog' was the label given both to the meeting, and to a Working Party later formed to coordinate activities. Some of the initiatives pioneered by the Beat the Grog Working Party are described in the pages that follow.

---

[1] Collins English Dictionary www.collinsdictionary.com/dictionary/English/grog (retrieved 16 November 2022).

Contents

Authors and Artist

Peter d'Abbs is a sociologist with an extensive research background in alcohol and other drug policy issues and program evaluation. He holds Honorary positions with the Menzies School of Health Research, Darwin, and the School of Public Health, University of Queensland. From 2001 to 2010 he was a Director of the Alcohol Education & Rehabilitation Foundation (AERF—subsequently renamed Foundation for Alcohol Research and Education, or FARE), and in 2007 he was placed on the Honour Roll of the National Drug and Alcohol Awards for his research into substance misuse in remote and regional settings. Between 2016 and 2021 he was a committee member of the National Health and Medical Research Council (NHMRC) Alcohol Working Group appointed to update the NHMRC drinking guidelines.

Nicole Hewlett is a proud Palawa woman with demonstrated knowledge translation experience in a range of areas including palliative care, suicide prevention, Close the Gap policy, cancer prevention, diabetes management and maternal use of alcohol, tobacco and other substances. Nicole currently holds positions with Queensland University of Technology, University of Queensland, and is a board member and Treasurer of the National Organisation for Fetal Alcohol Spectrum Disorders (NOFASD). At University of Queensland, Nicole is part of the First Nations Wellbeing team as well as the collaboration to revise the FASD assessment and diagnostic guidelines. From 2016 to 2021, Nicole was a committee member of the NHMRC Alcohol

Working Group, appointed to update the NHMRC alcohol drinking guidelines.

Delvene Cockatoo-Collins is a First Nations Quandamooka artist and designer, who lives on Minjerribah (North Stradbroke Island) in Queensland, Australia. Her work embodies a deep connection to country, and shares in the stories, culture and techniques developed over thousands of years and passed down from generation to generation. Amongst her commissioned designs are the prizewinners' medals and commemorative medal for the 2018 Commonwealth Games held on the Gold Coast, Queensland.

Abbreviations

AA	Alcoholics Anonymous
AAFR	Alcohol Awareness and Family Recovery
ADRES	Alcohol and other Drug Resource Education Service
ADSCA	Alcohol and other Drug Services Central Australia
AEC	Alcohol Education Committee
AGD	Attorney-General's Department
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
ALRC	Australian Law Reform Commission
AMP	Alcohol Management Plan
AOD	Alcohol and other drugs
AOG	Assemblies of God
APSU	Australian Paediatric Surveillance Unit
CAAAPU	Central Australian Aboriginal Alcohol Program Unit
CAGE	Cut down, Annoyed, Guilty, Eye-opener (Alcohol dependence screening test)
CDEP	Community Development Employment Program
CSR	Curtin Springs Roadhouse
DAA	Department of Aboriginal Affairs
DALY	Disability Adjusted Life Years
DASA	Alice Springs Drug and Alcohol Services Association
DLL	Director of Liquor Licensing
EBM	Evidence-based medicine
EBP	Evidence-based policy
ED	Emergency Department
ELT	Early Life Trauma
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
FAS	Fetal Alcohol Syndrome
FASD	Fetal Alcohol Spectrum Disorders
FORWAARD	Foundation of Rehabilitation for Aborigines with Alcohol-Related Difficulties

GAP	Grog Action Plan
GEAMS	Groote Eylandt Alcohol Management System
GEMCO	Groote Eylandt Mining Co
GGT	Gamma-glutamyltransferase
HREOC	Human Rights and Equal Opportunity Commission
IRIS	Indigenous Risk Impact Screen
LNAC	Larrakia Nation Aboriginal Corporation
LWAP	Living With Alcohol Program
MASH	Moree Aboriginal Sobriety House
MAST	Michigan Alcohol Screening Test
MCDS	Ministerial Council on Drug Strategy
MCMC	Meeting Challenges Making Choices
MPSC	Murrinh Patha Social Club
MWRC	Marninwarntikura Women's Resource Centre
NAIDOC	National Aboriginal and Islanders Day Observance Committee
NDRI	National Drug Research Institute
NDSHS	National Drug Strategy Household Survey
NEACA	National Expert Advisory Committee on Alcohol
NHMRC	National Health and Medical Research Council
NPA	Northern Peninsula Area
NPS	Nyoongar Patrol Service
NPY	Ngaanyatjarra Pitjantjatjara Yankunytjatjara
NTER	Northern Territory National Emergency Response
NTLC	Northern Territory Liquor Commission (sometimes also known as Northern Territory Licensing Commission)
NTPHN	Northern Territory Primary Health Network
OATSIH	Office of Aboriginal and Torres Strait Islander Health
ORIC	Office of the Registrar of Indigenous Corporations
OVAHS	Ord Valley Aboriginal Health Service
PAC	Pure alcohol content
PUBSC	Pormpuraaw United Brothers Sports Club
RCADIC	Royal Commission into Aboriginal Deaths in Custody
RCT	Randomised Controlled Trial
RDA	Racial Discrimination Act
SMC	Special Measures Certificate
TAFE	Technical and Further Education
WHO	World Health Organisation

List of Figures

List of Tables

List of Boxes

Chapter 1
Introduction

Artwork by Delvene Cockatoo-Collins

Abstract This chapter outlines the objectives of the book that follows and contextualises it. The objectives are, firstly, to review actions and programs adopted by Aboriginal communities and organisations to reduce alcohol-related harms in the half-century that has passed since legal prohibition on Aboriginal drinking alcohol in Australia was rescinded. A second objective is to synthesise evidence from these actions and programs in order to improve the evidence-base available to current and future initiatives. The chapter concludes with an overview of topics explored in the following chapters.

1.1 Introduction

This book is about actions taken to prevent or reduce alcohol-related harm in Aboriginal communities in Australia, with an emphasis on actions by Aboriginal communities or organisations themselves, rather than measures imposed by governments (although the two, as we show at numerous points below, are inextricably intertwined). It is *not* about why some Aboriginal people drink or how much they drink, or the impacts of drinking on health and wellbeing. By way of background and context, we summarise some indicators of these aspects below. But the focus of this book is on solutions, not problems.

The book is made up of two components: our own original writing, and extracts from pre-existing documents. Our rationale for writing and compiling it has several strands. The first is that in the fifty years or thereabouts that have passed since Aboriginal Australians in state/territory jurisdictions were granted the legal right to drink alcohol, many programs and measures have been tried in efforts to prevent or treat the harms that alcohol can cause. Some of these—both among the successful and the not-so-successful interventions—hold lessons for people or groups pursuing similar goals today or in the future. But in order to learn those lessons we need to have access to the experiences of those who went before.

For many people today, such access is limited or non-existent. In 2003, the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2006* drew attention to the damaging effects of a lack of evidence about alcohol and other drug (AOD) prevention and treatment options:

> In many Aboriginal and Torres Strait Islander communities, programs to deal with use of alcohol, tobacco and other drugs have made little impact on their health and wellbeing, increasing feelings of hopelessness and despair' (Ministerial Council on Drug Strategy (MCDS) 2003: 3).

The Complementary Action Plan, which was subsequently extended through to 2009, identified the need for information about what works and does not work in approaches to dealing with alcohol, tobacco and other drugs as a 'key action area' (Ministerial Council on Drug Strategy 2006). Despite these recommendations, it appears that little progress has been made (Gray et al. 2010). The *National Aboriginal*

and Torres Strait Islander Peoples Drug Strategy 2014–2019, which superseded the earlier Plan in 2014, stated:

> Despite a broader acceptance that there are principles and approaches that are successful, the 'evidence base' for Aboriginal and Torres Strait Islander-specific interventions relating to harmful use of AOD is limited for a range of reasons. These include a low number of formal evaluations of interventions, as well the complexity related to the diverse number of potential settings and solutions that exist within Aboriginal and Torres Strait Islander communities. There is therefore a need to improve the data (and supporting systems) available to build the evidence base and support those interventions that do show promise or success (Intergovernmental Committee on Drugs (Australia) 2014: 33)

Both of the factors cited in the *2014–2019 Strategy*—the dearth of evaluations of interventions and the complexity of the relationships between 'potential settings and solutions'—continue to this day to impede the creation of a robust evidence-base for interventions.

This brings us to the second strand in our rationale for writing the book: it will, we hope, contribute to redressing this gap, in at least two ways: firstly, by retrieving accounts of interventions, many of which are in danger of slipping into pre-digital era obscurity. Secondly, we hope to show that the available evidence regarding interventions and outcomes—for all its shortcomings—can do more to enhance our understanding of both the challenges and potential benefits of alcohol interventions than has been recognised to date.

The potential loss of information that we endeavour to alleviate is a by-product of the increasingly digitised world in which we live, and the search strategies used for retrieving information in this world. Many of the documents in which accounts of earlier interventions are to be found either belong in so-called 'grey literature'—that is, documents that, while not confidential, were never published or formally placed in the public domain—or they take the form of reports that, while possibly made publicly available at one time, have long since become out of print, and are unlikely to come to light in online literature searches.

To assert, as we do by writing this book, that earlier accounts of interventions contain relevant and useful evidence for present and future interventions is by implication to raise the question of what we mean by 'evidence' and how we assess evidence. Many existing accounts of interventions are not, to use the terminology of the Drug Strategy referred to above, 'formal evaluations of interventions'. Most are descriptions of programs, contain little or no quantitative data or outcome data, and have few of the attributes of evaluative or other social science research. (In this, as Sanson-Fisher et al. (2006) demonstrate, they are typical of literature published on Aboriginal health not only in Australia, but also in the US, Canada and New Zealand over recent decades.) From the perspective of the hierarchies of evidence that underpin contemporary evidence-based medicine (EBM) and evidence-based policy (EBP)– they would be classified as evidence of the lowest order, or in some cases possibly excluded altogether (Head 2010; Parkhurst and Abeysinghe 2016; Rychetnik et al. 2002). Such works are also unlikely to survive the culling process adopted in systematic literature reviews, that routinely exclude studies that fail to satisfy methodological selection criteria based on hierarchies of evidence.

The concept of a hierarchy of evidence evolved in the late twentieth century in conjunction with the promotion of EBM—that is, clinical practice informed by the highest quality evidence of treatment effectiveness rather than by other criteria such as customary practice (Sackett et al. 1996). At the top of the hierarchy are research designs that demonstrate a causal connection between intervention and outcome, control for possible effects of confounding variables, have high validity (that is, measure what they claim to be measuring) and are less susceptible than other designs to observer bias. The designs that best satisfy these criteria are large sample randomised control trials (RCTs) with randomised intervention samples (who receive the intervention) and control samples (who do not, but who may receive a placebo). Other evaluation designs, such as observational studies (where participants are tracked over time, but not assigned to an intervention and control group), case studies, or collation of expert opinions, are considered to be less robust on one or more of these criteria and therefore occupy lower places on the hierarchy (Kemm 2006).

The thinking behind EBM has also been extended to public health interventions, where its applicability, however, has been questioned. Rychetnik et al (2002), while accepting many of the principles of EBM and the hierarchy of evidence that underpins it, argue that both are insufficient as a framework for assessing public health interventions, for several reasons. Firstly, they argue, in reviewing evidence, practitioners sometimes mistake the quality of an evaluation for the quality of the intervention being evaluated. The failure of an evaluation to demonstrate an outcome may be due to flaws in the evaluation rather than in the intervention, but if the evaluation is excluded from systemic reviews because of those flaws, we have no way of knowing if that is the case. Secondly, they argue that public health interventions are typically complex and dependent for implementation on contextual factors—attributes that RCTs are ill-equipped to address. Public health interventions, they suggest, should be assessed according to at least four additional criteria: (1) consideration of *whose* interests are served by intervention outcomes, in particular whether or not the interests of those most directly affected by the intervention are served; (2) the emergence of unintended as well as intended effects; (3) the economic efficiency of the intervention, and (4) its transferability to other settings (Rychetnik et al. 2002).

The need to attend to the perspectives of practitioners and lay participants alike becomes even more important—and takes on added dimensions—when we consider interventions in Aboriginal settings. Here, questions concerning the kind of knowledge that is being generated in evaluations and other research, and whose interests are served by this knowledge, are framed by a historical context in which these activities are widely viewed among Aboriginal people as instruments of colonisation. Research has tended to be conducted *on* Aboriginal people rather than *with* them and has typically addressed questions posed by non-Aboriginal people (Katz et al. 2016; Smith 2021). Today, efforts to reform evaluation and other research practices are directed at two inter-related issues: the kinds of data generated by research, and the role of communities and community agencies in designing research and utilising findings.

Several Aboriginal and other researchers have argued a need for explanatory models of sickness and health grounded in Aboriginal cultural perspectives rather than western biomedical models (Atkinson 2006; Blignault and Williams 2017; Gray and Sputore 1998; Katz et al. 2016; Phillips 2003). McKendrick et al. (2017), reviewing Aboriginal healing programs, note the presence of tensions between mainstream notions of treatment efficacy and a belief among Aboriginal service providers that RCTs and similar designs are not suited to documenting the gradual and complex processes entailed in Indigenous healing. Moreover, because these programs emphasise concepts such as spirituality, they are often regarded with scepticism by mainstream funding and other bodies. Several attempts have been made to develop evaluation designs more attuned to Aboriginal priorities (eg., Nichols 2010; Williams 2018). Katz et al (2016) conclude a review of approaches to evaluating programs in Aboriginal settings by summarising what they view as the features necessary for a successful evaluation:

> There is little direct evidence relating specifically to evaluation but there is now a large body of evidence that research with Aboriginal peoples (and other Indigenous nations) is only successful if it is conducted with the participation (and preferably the control) of Aboriginal communities. Successful research is characterised by 'de-colonising' approaches which do not privilege western methods, understandings or theories over those of Indigenous peoples. In particular, community members should not be seen as passive subjects and evaluators should not have the role of experts – rather the project needs to be co-produced. In addition, Aboriginal knowledge should not be exploited by the evaluator and should be seen as the property of the community. Overall, research and evaluation must be seen as part of the self-determination of Aboriginal communities and the methods and approaches must be congruent with this objective (Katz et al. 2016: 36).

In the chapters that follow, we show how these issues have emerged in specific contexts such as evaluating residential treatment programs or monitoring community patrols. For now, we do no more than flag our use in this book of a more inclusive and less hierarchical notion of what constitutes evidence than trends discussed above allow. We draw on descriptions and analyses that we believe have useful insights or information for contemporary efforts to reduce alcohol-related harms, regardless of their ranking on a methodological hierarchy.

A third reason for writing this book is because the topic matters. Alcohol misuse is deeply implicated in many of the challenges facing Aboriginal people in Australia today. The nature of the nexus between alcohol and disadvantage, and the different ways in which people have attempted to understand and explain it, are the subject of the next chapter. Here, we note three key features of Aboriginal alcohol use. The first is that Aboriginal people are more likely *not* to drink at all than non-Aboriginal Australians. The most recent evidence for this long-standing difference comes from the 2019 National Drug Strategy Household Survey (NDSHS), which reported that the age-standardised proportion of Aboriginal and/or Torres Strait Islander people who reported not having consumed alcohol in the previous twelve months was 27.9%, compared with 24.1% among non-Aboriginal people (Australian Institute of Health and Welfare 2020). The proportion of non-drinkers is even higher in remote Aboriginal communities. According to the 2018–2019 National Aboriginal and Torres Strait

Islander Health Survey, 37% of people living in remote Aboriginal communities had not consumed alcohol in the previous 12 months, compared with 23% of people in non-remote areas (Australian Bureau of Statistics 2019).

A second characteristic of Aboriginal alcohol use is that, among drinkers, the proportion consuming at high risk levels is higher than among non-Aboriginal drinkers. Again, this was demonstrated in the 2019 NDSHS. Amongst Aboriginal and Torres Strait Islander drinkers, the proportion whose consumption exceeded the current NHMRC Guidelines of no more than two Standard Drinks per day (National Health and Medical Research Council (NHMRC) 2020) was 27.3%, compared with 21.4% among non-Aboriginal drinkers.[1] The disparity was even more pronounced for single occasion heavy drinking—or binge drinking—with 47.9% of current Aboriginal and Torres Strait Islander drinkers consuming more than four Standard Drinks on one occasion at least monthly, compared with 34.3% of non-Aboriginal drinkers. Taken together, these patterns mean that, in comparison with non-Aboriginal populations, where most people consume alcohol at moderate levels, Aboriginal populations tend to be polarised between non-drinkers and heavy drinkers. Both of these characteristics have also been found among Native American populations (Cunningham et al. 2016).

(It should also be noted that the proportions of Aboriginal people drinking at risky levels are declining: the proportion recorded in the NDSHS as consuming on average more than two Standard Drinks per day declined from 40.7% in 2010 to 27.3% in 2019, while the proportion consuming more than four Standard Drinks on a single occasion at least monthly fell from 52.5% in 2010 to 47.9% in 2019 (Australian Institute of Health and Welfare 2020). A cautionary note should, however, be attached to national level estimates of Aboriginal drinking patterns such as these: a recent meta-analysis of 41 studies reporting estimates of drinking patterns among Aboriginal samples found evidence of high levels of variation both within Aboriginal communities and between communities, particularly with respect to gender, age and region (Conigrave et al. 2020)).

A third feature of alcohol use among Aboriginal people is the heavy burden it imposes on the health, safety and wellbeing, not only of drinkers, but also their families and communities. Calabria et al (2010) compared alcohol-related harms among Aboriginal and non-Aboriginal Australian populations using as their measure disability-adjusted life years (DALYs).[2] They found that rates of alcohol-related harm among Aboriginal males were three times the rate in the general Australian male population, while rates for Aboriginal females were seven times higher than in the general female population (Calabria et al. 2010). The conditions causing the most harm among both males and females were homicide and violence, suicide, alcohol

---

[1] A Standard Drink (in Australia) is an alcoholic drink containing 10 g of pure alcohol. A 375 ml can of full strength (4.8%) beer contains 1.4 Standard Drinks.

[2] Disability-adjusted life years (DALY) is a measure of healthy life lost through either premature death or living with disability as a result of illness or injury, and is a standard measure for quantifying the impact on a population of a given risk factor, in this case, alcohol consumption. Australian Institute of Health and Welfare 2019 Burden of disease Glossary (https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/burden-of-disease/glossary).

use disorders (including harmful use and dependence), and road traffic accidents (Calabria et al. 2010).

These epidemiological comparisons do not begin to evoke the many other dimensions and consequences of alcohol misuse, such as the corrosive effects on household and community safety, or the illusory release that drinking offers from pre-existing intergenerational trauma. But these, as we said at the outset, are not the focus of this book. (For more detailed accounts of harms associated with alcohol among Aboriginal Australians, see Gray et al. 2018 and the 2020 report of the Productivity Commission (Australian Government Productivity Commission 2020, Chap. 11)).

This is not the first attempt to synthesise literature on Aboriginal alcohol programs in Australia. In addition to numerous journal articles focusing on particular types of programs and referred to elsewhere in this book, several more comprehensive studies precede this one. Saggers and Gray, in a monograph published in 1998, described dimensions of alcohol-related harms among indigenous populations in New Zealand and Canada as well as Australia, and reviewed explanatory models and intervention approaches (Saggers and Gray 1998). They attributed what they viewed as limited impact of interventions to two key factors: inadequate resources and failure to address the social and economic determinants of disadvantage and the substance-misuse that accompanied it. In other subsequent articles, the authors have also drawn attention to the need for evaluation approaches that pay due attention to Aboriginal cultural perspectives and intervention priorities (Gray and Saggers 2005; Gray et al. 2010).

Brady's *The Grog Book*, originally published in 1998 and revised in 2005 and 2012, carries a subtitle 'strengthening indigenous community action on alcohol' (Brady 2012). It is a rich resource that provides a handbook of evidence-based ideas for community groups seeking to broaden their options for managing alcohol at a local level, mainly in the form of brief case studies.[3] While *The Grog Book* and this book are dedicated to the same purpose—conveyed in the subtitle of the former—ours adopts a more historical and analytical perspective in tracing the evolution of intervention approaches and identifying achievements and continuing challenges.

1.2 Overview of the Book

The remainder of this book comprises nine chapters, the first of which, entitled 'Explaining Aboriginal alcohol use: changing perspectives, hidden assumptions', outlines different ways in which alcohol use by Aboriginal people in Australia has been conceptualised or 'framed'. Our purpose here is not so much to critique these frames but to show how each has informed distinctive approaches to the prevention and/or treatment of alcohol-related harms—approaches that are described in later chapters. We begin with biological explanations that posited race-based differences in the effects of drinking alcohol. While no longer accepted or supported

---

[3] *The Grog Book* is available as a free download from The grog book – strengthening indigenous community action on alcohol | Australian Government Department of Health.

by evidence, these explanations served a historically important role in legitimising policies prohibiting possession or consumption of alcohol by Aboriginal people. Other explanations outlined in this chapter are: Aboriginal alcoholism as a disease; psychological explanations; alcohol viewed as a public health problem warranting restrictions on supply; sociological and anthropological explanations for Aboriginal alcohol use, and critiques of these explanations, and conceptualisation of alcohol misuse as a product of unresolved, intergenerational trauma precipitated in the first place by the violence and dispossession wrought by colonisation.

This is followed by the first of two chapters focusing on demand reduction. In 'Prevention and early intervention', we look at the evolution of programs in the categories of 'primary prevention'—that is, programs intended to prevent or delay uptake of harmful alcohol use—and 'secondary prevention'—programs designed to prevent the onset or continuation of harmful alcohol use among people considered to be already drinking or at risk of harmful use. We note, as others have before us, that while primary prevention programs—especially media campaigns and health promotion initiatives—have long enjoyed funding support—secondary prevention was for a long time neglected in favour of residential treatment programs—the subject of the next chapter. Primary prevention initiatives have generated little by way of an evidence-base, but it is possible to identify several factors that appear to be conducive to successful implementation, including community leadership, strategic partnerships with both internal and external agencies, clearly defined and widely supported objectives, and use of data to demonstrate progress. Efforts to embed secondary prevention—also known as early or brief intervention—in routine primary health care settings have faced significant barriers (which are not exclusive to Aboriginal health care settings) but, as we show, efforts to identify and overcome the barriers are continuing.

The following chapter, entitled 'Treatment and rehabilitation' addresses activities in the domain known as tertiary prevention: facilitating recovery from dependent or otherwise harmful alcohol use and preventing relapses. We trace the emergence and long-standing dominance of residential treatment that combines the Twelve Steps approach to overcoming alcohol dependence with the self-help and mutual aid principles of Alcoholics Anonymous (AA). We note that many Aboriginal service providers view alcohol dependence as a cultural and spiritual illness requiring spiritual healing, an approach also associated with treatment programs that view alcohol misuse, together with associated violence, sexual abuse and self-harm, as products of unresolved intergenerational trauma requiring healing and cultural reconnection. We also discuss efforts to identify and address administrative and therapeutic challenges associated with residential treatment programs, and ongoing attempts to develop evaluation approaches that meet the requirements of both Aboriginal service providers and funding bodies.

In Chap. 5 we turn to 'supply reduction' measures involving local restrictions on alcohol availability (over and above restrictions that form part of liquor licence conditions in all Australian jurisdictions). Community-based restrictions are grounded conceptually in a public health approach to reducing alcohol-related harms that originated with the World Health Organization in the 1970s and was taken up by several

Aboriginal organisations in the 1980s. It led to the introduction of restrictions on trading conditions and/or types of liquor that could be sold by outlets in several towns in northern Australia. Restrictions can take the form of voluntary agreements between outlets and community groups; they can be 'negotiated/mandated'—that is, negotiated by parties involved, then incorporated formally into the licence conditions of relevant outlets, or they can be unilaterally imposed by governments, as when the Northern Territory Government in 2010 imposed a Territory-wide ban on sales of wine casks containing 4 litres or more. Partly because they are inherently politically contentious, examples of local restrictions are usually evaluated. As a result, considerable evidence exists that restrictions—provided they incorporate a high level of community input—are effective in reducing alcohol-related harms. However, they also require complementary action to reduce demand, such as early intervention and treatment options, and their effectiveness can also fade over time and generate unintended consequences along the way. One notable example of local restrictions being used as a 'breathing space' for developing more comprehensive measures to address alcohol problems in the community was the introduction of restrictions on take-away sales in Fitzroy Crossing, in the Kimberley region of Western Australia, in 2007. Chapter 6 describes the processes involved in bringing in the restrictions as a case study in community consultation and mobilisation.

In Chap. 7 we focus on two specific approaches to managing alcohol availability in communities: community-owned liquor outlets and liquor permit systems that entitle approved individuals to import and consume liquor in communities where drinking is otherwise prohibited. Both are intended to foster a culture of moderation in place of unsupervised binge drinking, often in unsafe locations. Community-owned liquor outlets are also seen by proponents as a way of keeping the profits from alcohol sales in the community and as an antidote to 'grog running'—that is, the practice of purchasing liquor and selling it, often with an exorbitant mark-up, on the black market in 'dry' communities.

Community-owned liquor outlets usually take the form of licensed clubs, sometimes called canteens. Available evidence indicates that most fail to achieve their objectives. Some become centres of chronic heavy drinking; some collapse under the significant administrative burdens they entail; none have been shown to reduce grog-running. In a few instances, however, community-owned outlets have become venues promoting a moderate, sociable style of drinking. The key ingredients appear to be clear (and quite restrictive) trading conditions imposed *and enforced* by licensing authorities; a community body able and willing to operate a venue under these conditions; effective policing of grog-runners, and availability of administrative support for the local body managing the outlet.

The use of liquor permit systems as part of community liquor management strategies appears to be limited to some remote Aboriginal communities in the Northern Territory and the territory of Nunavut in northern Canada. Evidence of their impact is limited and inconclusive. However, they appear to facilitate a degree of community control over alcohol use provided three conditions are met: local bodies responsible for administering permit systems are adequately supported and resourced; effective

controls are in place to deal with grog-running, and the rules and procedures associated with the permit system are accepted by the community as reflecting community wishes.

In Chap. 8 we turn to an area where some Aboriginal communities and organisations have arguably led the way nationally in developing evidence-based solutions: the prevention and diagnosis of Fetal Alcohol Spectrum Disorders (FASD) and provision of support to individuals and families impacted by FASD. The term FASD refers to neurodevelopmental and physical impairments that can result from prenatal alcohol exposure. Its prevalence in Australia is unknown, as no national study has been undertaken to assess it, but its consequences can be seen not only in families directly affected, but also in health, education, child protection, youth and criminal justice systems. Over the last two decades, several Aboriginal organisations and communities have prioritised prevention and diagnosis of FASD, entering into partnerships with universities and other research bodies to document prevalence and develop programs to support impacted families. These initiatives are described, along with innovative programs to enhance the capacity of primary health care services to diagnose FASD and related disorders.

Chapter 9 focuses on community-based policing of alcohol-related matters, particularly community patrols (or night patrols or street patrols as they are sometimes called) and warden schemes. The first examples of these began in the 1970s as unfunded, undocumented initiatives by elders in remote communities and were designed to utilise Aboriginal cultural authority and culturally-based ways of resolving disputes, either in the absence of a mainstream policing presence, or as an alternative to what were viewed in communities as inappropriate mainstream policing practices. Community patrols gained added prominence following the Royal Commission into Aboriginal Deaths in Custody (RCADIC), which in its final report, tabled in 1991, recommended their adoption as instruments of community-based policing (Royal Commission into Aboriginal Deaths in Custody 1991). The number of community patrols subsequently grew rapidly in remote, regional and urban locations. Some became subject to conflicting expectations as non-Aboriginal agencies insisted that they should serve first and foremost as a transport service for drunks rather than as community-based means of preventing and resolving disputes.

The 2007 Intervention, formally known at the Northern Territory National Emergency Response (NTER), which imposed new policies and new controls over Aboriginal communities in the NT, led to further expansion in resourcing of community patrols in remote communities—particularly but not only in the NT. However, the extra resources came at a price, as the national government sought to align the role of patrols to its own policies for promoting community safety. Anecdotal reports suggest that, since that time, while many patrols have come to enjoy a more secure funding base than in the past, community involvement in running them has declined.

Chapter 10 summarises conclusions from the preceding sections of the book.

As the foregoing summary shows, we have not addressed interventions directed at other drugs besides alcohol. Alcohol, we know, is often a component of polydrug use among Aboriginal people; the use of cannabis, in particular, has become widespread in recent decades. Our objective, however, has been to draw lessons for today from

the experiences gained in preventing and managing alcohol-related harms over five decades. Many of these experiences, particularly in prevention, early intervention and treatment, are relevant to other drugs, but to address polydrug use, in our view, would have threatened to blur our focus on the distinctive history of dealing with alcohol.

1.3   A Note on Terminology

Throughout this book we use the term 'Aboriginal' to refer to Aboriginal peoples, communities and organisations unless it is clear from the context that Torres Strait Islanders are also covered by the meaning, in which case we use the term 'Aboriginal and Torres Strait Islander'. We do not generally use the term 'Indigenous' (although it is sometimes the term used in texts that we are citing, in which case we retain it). Where we are using the term in the generic sense to refer to, say, 'indigenous peoples of Australia, the US, New Zealand and Canada', then we retain it without capitalising it.

In saying this, we recognise that all of these terms have problematic connotations, since all of them originate in a discursive world dominated historically by non-Aboriginal people and agencies. We intend our usage of these terms throughout this book to convey respect.

We are also open to being taken to task for our uncritical use of the word 'community'. This is one of the more value-laden terms in the English language for describing places, implying as it does a shared sense of identity and belonging as well as mutual proximity. In the domain of Aboriginal policy, the use of 'community' is a product of the transition from assimilation to self-determination in the early 1970s (Smith 1989). Prior to that time, throughout the assimilation era, Aboriginal localities were officially referred to as 'settlements', 'missions' or 'pastoral properties'—terms that evoked more explicitly the administrative arrangements that defined them. From 1973, the Department of Aboriginal Affairs—the recently created government agency established to implement the new policy—began replacing all of these labels with 'community', which had a much less colonial ring to it (Smith 1989). Communities, in the policy rhetoric of the day, were now viewed as self-managing entities. As Smith points out, however, the shift to 'community' was not accompanied by genuine changes in decision-making processes (Smith 1989).

The concept of community in fact conflated two distinct social entities: the geographic community composed of people occupying a particular locality, and the cultural or symbolic community of people linked by kin relationships, ceremonial responsibilities and obligations regarding significant sites (Sutton 2001, 2009). The two entities, as Brady and others have pointed out, did not necessarily coincide; some 'communities' were made up of Aboriginal people from different clan and language groups, whose traditional rights and obligations linked them to localities outside the geographic boundaries of the community (Alexander 1990). Rowse (1992) argues that Aboriginal communities, far from being organic expressions of

self-determination, were rather a new iteration of settlement patterns imposed by governments. Peters-Little extends the critique, contending that the term 'community' was adopted without consultation with Aboriginal people, who as a result have had little opportunity since then to define the term in ways which might advance genuine self-determination. Indeed, she argues that the term has become increasingly problematic in a context of addressing issues such as native title, reconciliation and self-determination (Peters-Little 2000).

In short, the term 'community' carries political baggage beneath its endearing connotations. We retain it, partly because we are not aware of any satisfactory alternative, and partly because it has come to be universally used, particularly with reference to remote Aboriginal localities. It is, however, important not to lose sight of these aspects, particularly when considering issues such as community control, or community action with regard to alcohol use.

1.4   A Time of Transition?

This book, as the title implies, looks back and ahead: back over half a century of efforts to grapple with the many harms that alcohol misuse has brought, ahead to draw lessons from the experiences of those who have gone before. As readers will discover, many of the documents reviewed in these pages—though by no means all of them— are the voices of non-Aboriginal observers. This is not surprising. With some notable exceptions whose voices are also heard in these pages, Aboriginal people throughout much of this period did not enjoy the access to education that gave them influence in shaping policies and priorities. (This is despite the fact, as readers will also find, that many of the programs described in these pages were designed, established and run by Aboriginal people, with varying degrees of governmental support).

That is changing. Today, it is becoming less acceptable to publish academic and other writings about Aboriginal alcohol programs that do not give priority to Aboriginal writers and perspectives.

We see this book as something of a marker of this transition. One of us (Peter d'Abbs) is a non-Aboriginal researcher whose own family came to Australia in 1948, and who has conducted research on alcohol-related issues for much (though not all!) of the half-century under review. The other (Nicole Hewlett) is a proud Palawa woman whose experience in knowledge translation includes, among other fields, maternal use of alcohol, tobacco and other substances.

We hope that this book will help to retain what is valuable from an earlier era as a useful contribution going forward in a context where the search for strength-based solutions to alcohol-related challenges is led by Aboriginal communities and experts.

References

Alexander, K (ed.). 1990. *Aboriginal alcohol use and related problems: report and recommendations prepared by an expert working group for the royal commission into aboriginal deaths in custody.* Phillip, ACT: Alcohol and Drug Foundation.

Atkinson, Judy. 2006. *Trauma trails, recreating song lines: the transgenerational effects of trauma in indigenous Australia.* Spinifex Press: North Melbourne.

Australian Bureau of Statistics. 2019. *4715.0 national aboriginal and torres strait islander health survey, Australia, 2018–19.* Canberra: Australian Bureau of Statistics. https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/national-aboriginal-and-torres-strait-islander-health-survey/latest-release. Accessed 15 April 2022.

Australian Government Productivity Commission. 2020. *Overcoming indigenous disadvantage: key indicators 2020.* Canberra: Productivity Commission. https://www.pc.gov.au/research/ongoing/overcoming-indigenous-disadvantage/2020. Accessed 13 April 2022.

Australian Institute of Health and Welfare. 2020. *National drug strategy household survey 2019 priority population groups chapter supplementary data tables.* Canberra: Australian Institute of Health and Welfare. www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/data. Accessed 12 April 2021.

Blignault, I., and M. Williams. 2017. Challenges in evaluating aboriginal healing programs: definitions, diversity and data.*Evaluation Journal of Australasia* 17: 4–10.

Brady, Maggie. 2012. *The grog book*. Department of Health and Ageing: Canberra.

Calabria, Bianca, Christopher Doran, Theo Voss, Anthony Shakeshaft, and Wayne D. Hall. 2010. Epidemiology of alcohol-related burden of disease among Indigenous Australians. *Australian and New Zealand Journal of Public Health* 34: S47–S51.

Conigrave, James H., K.S. Kylie Lee, Catherine Zheng, Scott Wilson, Jimmy Perry, Tanya Chikritzhs, Tim Slade, Kirsten Morley, Robin Room, Sarah Callinan, Noel Hayman, and Katherine M. Conigrave. 2020. Drinking risk varies within and between Australian Aboriginal and Torres Strait Islander samples: a meta-analysis to identify sources of heterogeneity. *Addiction* 115: 1817–1830. https://doi.org/10.1111/add.15015.

Cunningham, J.K., T.A. Solomon, and M.L. Muramoto. 2016. Alcohol use among Native Americans compared to whites: Examining the veracity of the Native American elevated alcohol consumption belief. *Drug and Alcohol Dependence* 160: 65–75. https://doi.org/10.1016/j.drugalcdep.2015.12.015.

Gray, Dennis, Kimberly Cartwright, Anna Stearne, Sherry Saggers, Edward Wilkes, and Mandy Wilson. 2018. *Review of the harmful use of alcohol among Aboriginal and Torres Strait Islander people.* Australian Indigenous HealthInfoNet Perth: Perth.

Gray, Dennis, and Sherry Saggers. 2005. The evidence base for responding to substance use problems in Indigenous communities. In Stockwell, T.R., P. Gruenewald, J. Toumbourou and W. Loxley (eds.) *Preventing harmful substance use: the evidence base for policy and practice.* Wiley, Chichester UK, pp. 381–393. ISBN: 0–470–09227–0 [CH128].

Gray, Dennis, and Brooke Sputore. 1998. 'The effective and culturally appropriate evaluation of Aboriginal community alcohol intervention projects. In Tim Stockwell (ed.) *Drug trials and tribulations: lessons for Australian drug policy*. National Centre for Research into the Prevention of Drug Abuse; Curtin University of Technology.

Gray, Dennis, Sherry Saggers, Edward Wilkes, Steve Allsop, and Coralie Ober. 2010. Managing alcohol-related problems among Indigenous Australians: what the literature tells us. *Australian and New Zealand Journal of Public Health* 34: S34–S35. https://doi.org/10.1111/j.1753-6405.2010.00550.x.

Head, Brian W. 2010. Reconsidering evidence-based policy: key issues and challenges. *Policy and Society* 29: 77–94. https://doi.org/10.1016/j.polsoc.2010.03.001.

Intergovernmental Committee on Drugs (Australia). 2014. *National aboriginal and torres strait islander peoples' drug strategy 2014–2019.* Canberra: Intergovernmental Committee

on Drugs. www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/natsip ds2014-19d. Accessed 16 Aug 2018.

Katz, I., B. Newton, S. Bates, and M. Raven. 2016. *Evaluation theories and approaches: relevance for aboriginal contexts.* Sydney: Social Policy Research Centre, University of New South Wales.

Kemm, John. 2006. The limitations of evidence-based public health. *Journal of Evaluation in Clinical Practice* 12: 319–324.

McKendrick, J., R. Brooks, J. Hudson, M. Thorpe, and P. Bennett. 2017. *Aboriginal and torres strait islander healing programs: a literature review.* Barton, ACT: Healing Foundation. https://healingfoundation.org.au/app/uploads/2017/02/Aboriginal-and-Torres-Strait-Islander-Healing-Programs-A-Literature-Review.pdf. Accessed 24 Mar 2020.

Ministerial Council on Drug Strategy (MCDS). 2003. *National drug strategy aboriginal and torres strait islander peoples' complementary action plan 2003–2006.* Commonwealth of Australia: Canberra.

Ministerial Council on Drug Strategy. 2006. *National drug strategy aboriginal and torres strait islander peoples complementary action plan 2003–2009.* Canberra: Ministerial Council on Drug Strategy. http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/AGI28. Accessed 16 Aug 2018.

National Health and Medical Research Council (NHMRC). 2020. *Australian guidelines to reduce health risks from drinking alcohol.* Canberra: National Health and Medical Research Council. www.nhmrc.gov.au/about-us/publications/australian-guidelines-reduce-health-risks-drinking-alcohol#block-views-block-file-attachments-content-block-1. Accessed 1 Apr 2021.

Nichols, Fiona. 2010. Aboriginal recommendations for substance use program evaluation. *Aboriginal and Islander Health Worker Journal* 34: 17–19.

Parkhurst, Justin O., and Sudeepa Abeysinghe. 2016. What Constitutes "Good" Evidence for Public Health and Social Policy-making? From Hierarchies to Appropriateness. *Social Epistemology* 30: 665–679. https://doi.org/10.1080/02691728.2016.1172365.

Peters-Little, Frances. 2000. *The community game: aboriginal self definition at the local level.* Canberra: Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS).

Phillips, Gregory. 2003. *Addictions and healing in aboriginal country.* Aboriginal Studies Press: Canberra.

Rowse, T. 1992. *Remote possibilities: the aboriginal domain and the administrative imagination.* Darwin: North Australia Research Unit, Australian National University.

Royal Commission into Aboriginal Deaths in Custody. 1991. *National Report,* vol. 5. Canberra: Royal Commission into Aboriginal Deaths in Custody.

Rychetnik, L., M. Frommer, P. Hawe, and A. Shiell. 2002. Criteria for evaluating evidence on public health interventions. *Journal of Epidemiology and Community Health* 56: 119–127. https://doi.org/10.1136/jech.56.2.119.

Sackett, David L., William M C. Rosenberg, J.A. Muir Gray, R. Brian Haynes, W. Scott, and Richardson. 1996. Evidence based medicine: what it is and what it isn't. *British Medical Journal* 312: 71–72. https://doi.org/10.1136/bmj.312.7023.71.

Saggers, Sherry, and Dennis Gray. 1998. *Dealing with alcohol: indigenous usage in Australia, New Zealand and Canada.* Cambridge University Press: Cambridge, UK.

Sanson-Fisher, Robert W, Elizabeth M Campbell, Janice J Perkins, Steve V Blunden, and Bob B Davis. 2006. Indigenous health research: a critical review of outputs over time. *Medical Journal of Australia* 184: 502–505. https://doi.org/10.5694/j.1326-5377.2006.tb00343.x.

Smith, Barry. 1989. *The concept "Community" in aboriginal policy and service delivery. NADU Occasional Paper No. 1.* North Australia Development Unit, Department of Social Security: Darwin.

Smith, Linda Tuhiwai. 2021. *Decolonizing methodologies: research and indigenous peoples.* Bloomsbury: London.

Sutton, Peter. 2001. *Aboriginal Country Groups and the 'Community of Native Title Holders'.* National Native Title Tribunal: Perth.

Sutton, Peter. 2009. *The Politics of Suffering: Indigenous Australia and the end of the liberal consensus*. Melbourne University Press: Melbourne.

Williams, M. 2018. Ngaa-bi-nya Aboriginal and Torres Strait Islander program evaluation framework. *Evaluation Journal of Australasia* 18: 6–20.

Chapter 2
Explaining Aboriginal Alcohol Use: Changing Perspectives, Hidden Assumptions

Artwork by Delvene Cockatoo-Collins

Abstract In this chapter, we review explanatory frameworks that have been used since the arrival of European colonisers in Australia to interpret Aboriginal alcohol use and provide a foundation for policies and programs. Eight frameworks are discussed: (1) models positing biological differences between Aboriginal and non-Aboriginal people in the effects of alcohol; (2) models of Aboriginal alcoholism as a disease; (3) psychological explanations for drinking among Aboriginal people; (4) policy approaches based on viewing alcohol misuse as a public health problem; (5) sociological and anthropological explanations for alcohol use by Aboriginal people; (6) explanations grounded in critiques of sociological and anthropological explanations; (7) alcohol misuse interpreted as a product of the social determinants of health and (8) interpretation of alcohol misuse as a product of unresolved, intergenerational trauma. Each of these frameworks has implications for policies and programs which are explored in subsequent chapters.

2.1   Introduction

Over the half century that has passed since Aboriginal Australians first gained the legal right to drink alcohol, several approaches have been taken to defining, explaining and addressing alcohol use by Aboriginal people and its consequences. Some, but not all, have been put forward by non-Aboriginal people. We can think of these approaches as interpretive frameworks that incorporate certain beliefs, which in turn provide a foundation for preferred policies and programs aimed at reducing alcohol-related harms. Some of these frameworks have held sway at different times, and others have been advanced in competition with each other at the same time. Between them, they have shaped the interventions described in this book. We therefore begin this book by outlining eight interpretive frameworks that have influenced policies and programs. These are.

- Biological explanations that posit race-based differences in the effects of drinking alcohol;
- Aboriginal alcoholism as a disease;
- Psychological explanations for drinking among Aboriginal people;
- Alcohol misuse as a public health problem;
- Sociological and anthropological explanations for Aboriginal alcohol use;
- Explanations grounded in critiques of sociological and anthropological explanations;
- Alcohol misuse and the social determinants of health;
- Viewing alcohol misuse (and violence) as products of unresolved, intergenerational trauma.

2.2   The Legacy of a Century of Prohibition of Aboriginal Drinking

By the time Aboriginal people were granted legal access to alcohol, their experience of it had been indelibly influenced by several decades of prohibition imposed by colonial authorities. The anthropologist Jeremy Beckett, in an article published in 1964—a time when some Australian states and territories still prohibited alcohol consumption by Aboriginal people while others had begun to remove these restrictions—succinctly described the assumptions and fears that had shaped policies not only in Australia but wherever colonising British settlers had encountered indigenous populations:

> Notions that members of coloured races cannot 'hold' liquor, fears that they will be debauched and depraved by its use, that law and order will be overturned, and, in particular, that European life and property will be endangered—all these precipitate prohibitionist policies. Discriminatory prohibition has been general throughout Australia and those parts of the South Pacific administered by the Anglo-Christian countries (Beckett 1964: 32).

Beckett's description captures both the belief in the innate superiority of white Europeans over 'coloured races' and the anxieties associated with colonising a land occupied by non-European Indigenous people, located far from Europe in a region peopled by Asian, Polynesian, Melanesian and other non-white peoples. The *Immigration Restriction Act 1901*, better known as the White Australia policy and one of the first pieces of legislation passed by the new Commonwealth, was designed to take care of the external danger, while laws restricting possession, consumption and supply of liquor and other drugs were central to the control of 'coloured races' within. Australia's first forays into illicit drug policy, which resulted around the beginning of the twentieth century in a ban on the importation and consumption of opium, were motivated primarily not by evidence of the harms arising from its use but by hostility towards Chinese settlers, who were the main consumers (Manderson 1993). Their presence, as Manderson shows, was seen as a threat to social and racial boundaries and, through inter-racial relationships, to the racial purity of the colonisers (Manderson 1993, 1999). The Queensland *Sale and Use of Poisons Act 1891* expressly prohibited the supply of opium to Aboriginal people, as did the South Australian *Opium Act 1895* which, because SA at the time included the NT, applied also to people in the NT (Manderson 1993: 32).

Although the prohibition on possessing and consuming alcohol was only one of a wide range of restrictions imposed on Aboriginal people, it was one of the most intensely resented by those subjected to it. As Eggleston noted, Aboriginal people committed an offence merely by possessing liquor, whereas whites were guilty of no offence unless they were drunk in public (Eggleston 1974). Aboriginal drunkenness also became an expression of resistance. Rowley, writing in 1972, observed:

> Of all the restraints on personal habits, that which forbade consumption of alcohol was the oldest and the most universal. And as from the days of first contact alcohol offered the main chance of escape for frustrated members of a disorganised and repressed community,

this restriction was from the beginning commonly evaded, with open drunkenness the most common mark of defiance of the police and other authority (Rowley 1972: 52).

Prohibition fostered a style of rapid consumption of high alcohol content beverages to minimise the chances of apprehension, and a market for sellers of 'sly grog'. Bill Harney, a long-time observer of life in northern Australia in the early decades of the twentieth century, described one such supplier in Katherine, NT, in the 1940s: "Methylated spirits, or metho for short, was sold to natives here in large quantities by people who, like vultures ever waiting to pounce upon a weaker prey, sat back in pious dignity in their sheltered homes and sold it at a large profit" (Harney 1946: 251). If apprehended, Harney continued, they faced only a small fine that had no deterrent effect.

By the 1960s, prohibition of Aboriginal drinking had become politically awkward for governments in Australia, particularly for the national government. In addition to facing pressure from Aboriginal rights activists, both Aboriginal and non-Aboriginal, to end discrimination (Clark 2008), the national government had to contend with international criticisms, fuelled by the Cold War, of the conditions of Aboriginal Australians (Parliament of the Commonwealth of Australia 1963). Moreover, under the assimilation policy of the day, the national government was committed in principle to winding back discriminatory legislation wherever it considered it expedient to do so. The 1963 conference of Commonwealth and State Ministers on Aboriginal Welfare, held in Darwin during 11–12 July, affirmed a commitment to removing legislation affecting consumption of liquor by Aborigines (Parliament of the Commonwealth of Australia 1963). Jurisdictions that had not already done so removed the prohibition on Aboriginal drinking, beginning with the NT in 1964 and extending to the remainder of the country by 1971.

It was not long before alcohol was implicated in concerns raised over the poor state of Aboriginal health. A national seminar on improving Aboriginal health in 1972 heard three separate papers on Aboriginal drinking patterns and the challenges involved in controlling alcohol use (Albrecht 1974; Bain 1974; Eggleston 1974; Hetzel et al. 1974). A Commonwealth Government inquiry appointed in 1976 to examine alcohol problems among Aborigines presented a bleak picture of violence, social disintegration and alcohol-related health problems (Commonwealth of Australia House of Representatives Standing Committee on Aboriginal Affairs 1976, 1977). Concerns were also voiced by Aboriginal leaders. Charles Perkins, who had become a household name in the 1960s for his role in organising 'Freedom Rides' that exposed systemic racism in NSW country towns, and had since become an Assistant Secretary in the Commonwealth Department of Aboriginal Affairs, wrote in 1977 that alcohol was doing more harm in Aboriginal communities than anything else. He warned, however, against stereotyping all Aboriginal people as problem drinkers and also insisted that any solutions, to be effective, must be grounded in strong Aboriginal community support and address a broad range of issues (Perkins 1977). Here is an extract from Perkins' analysis.

Box 2.1 Aboriginal Problems and Suitable Solutions
From Charles Perkins (1977: 22–23)

There is no doubt that throughout Australia there is a heavy drinking problem among Aboriginals. But is it any worse than the drinking problem of white Australians? This is hard to determine, but what we do know is that Aboriginal drinking is much more *visible.* It is easier to see that an Aboriginal is drinking heavily, because he drinks in public places like hotels and parks, because he often drinks with a group of friends, and just because of the colour of his skin.

To help understand how Aboriginals start drinking heavily, let me describe the situation in one country town in Western Australia. In this town, Aboriginals make up 99% of court convictions for drunkenness and related offences, and liquor trouble starts with ten-year-olds. The history of these people shows how this came to happen. The district where they live was made up of cattle stations. Often, the people were born and spent all their lives on one of these stations. When award wages for Aboriginals were introduced, the number of jobs on stations fell and they began to move to the towns. Because they had grown up in a tribal and station life, they were not prepared for town life. They did not have the right kind of skills for jobs in the town and were not used to the kind of social life there. They were introduced to social security benefits, but did not often receive vocational training to help them find jobs. Soon they were dependent on government hand-outs. With nothing to do all day and some money in their pockets, they got into the habit of drinking.

I have talked about this town because it shows how excessive use of alcohol among Aboriginals is not an isolated problem. It is linked with lack of employment, housing, education, proper health facilities and recreational facilities.

…

Is banning alcohol a solution? It failed before. Is education the answer? Certainly too few people understand the effect alcohol can have on them. Will we find the solutions when the scars of social and economic injustices have faded? One would not expect that a once proud and self-sufficient race would let itself be destroyed by alcohol. Perhaps we will find the answer to this question when the current Aboriginal cultural revival has spread further.

2.3 Biomedical and Psychological Explanations for Aboriginal Alcohol Use

Prohibition of Aboriginal drinking, as Beckett implied in the quotation above, was based on a belief that Aboriginal people were incapable of managing alcohol in a manner acceptable to the white colonisers. This belief did not disappear when official policies changed. The notion that Aboriginal Australians are genetically more susceptible to the effects of alcohol than Caucasians has its counterpart in North America where, according to what has become known as the 'Firewater myth', American Indians and Native Alaskans are believed to have a similar predisposition (Heath 1983). In neither population are the beliefs supported by evidence. In North America, Heath reviewed studies that attempted to compare rates of metabolising alcohol among various ethnic and racial groups; results were inconclusive and in some cases contradictory (Heath 1983). More recent North American studies have produced similar findings (Cunningham et al. 2016). In Australia, the only documented attempt at a similar comparison is a study conducted in 1976 by Marinovich et al., who compared rates of alcohol metabolism between 16 Aboriginal adult males and 12 Caucasian adult males (Marinovich et al. 1976). Participants were given 1 ml of ethanol per kilogram of body weight mixed with either iced water or fruit juice, and their blood ethanol levels were monitored at regular intervals for up to six hours after ingestion. The study found wide variation in rates among individuals but no evidence of a 'race'-based difference. Neither Marinovich et al.'s study nor more recent North American studies demonstrate conclusively that genetic or other biological factors play no part in determining the effects of alcohol among particular ethnic or racial groups. However, recent research into the genetics of alcohol dependence suggests that genetic risk is a product of many genes, each having a small effect, and that some genetic risk factors only come into effect in a context of childhood trauma—in other words, in interaction with environmental factors (Enoch 2013).

2.3.1 Alcoholism as a Disease

The notion that biological factors help to explain harmful drinking patterns underpins the concept of alcoholism. One of the most enduring approaches to addressing alcohol misuse among Aboriginal Australians rests on defining it as the 'disease' of alcoholism, characterised by an inability to control one's drinking even in the face of manifestly harmful consequences. The idea that alcoholism should be thought of as a disease dates back for at least 200 years (Hore 1991), but in its modern form originated in the US in the mid-twentieth century, particularly in the writings of Jellinek (1991, 1960, Kelly 2019). Jellinek distinguished several sub-types of alcoholism, only two of which he considered to be a disease: the first comprising people who were unable to abstain from drinking even for short periods, the second consisting of

people who could abstain, but once they started drinking were unable to limit their intake.

Jellinek's attempt to delimit the application of the 'disease' concept was largely lost in the popular take-up of the concept in the US, especially by Alcoholics Anonymous (AA), a spiritually oriented self-help group that had been formed in Akron, Ohio, in 1935 (Travis 2009). Jellinek's disease concept gave AA a scientifically respectable explanation and basis for treating compulsive drinking; AA gave Jellinek's disease concept a rapidly growing popular platform (Roizen 2004).

Despite its popularity among AA and lay circles, the conceptualisation of alcoholism as a disease has had a checkered career as a diagnostic and clinical term, with one alcohol researcher dismissing it as 'a harmful myth' (Fingarette 1991: 417). Room (1998) notes that 'alcoholism' and 'addiction' were included in the WHO International Classification of Diseases (ICD-8) published in 1965, but removed from ICD-9 published in 1975. 'Addiction' was replaced by 'dependence' in ICD-9, but underwent further changes in ICD-10, published in 1992. Valverde argues that, while the disease concept helped to reframe excessive drinking and drunkenness as a medical condition rather than a moral failing, it has enjoyed less acceptance in mainstream medical practice (Valverde 1998). One outcome of this history is a continuing gulf between popular perceptions—where the disease concept of addiction and alcoholism thrives—and professional clinical approaches to problem drinking.

The current version of the International Classification of Disease—known as ICD-11—is the 2022 release of the 11th revision, originally adopted by the World Health Organization in 2019 (World Health Organization 2022). Under ICD-11, three different categories of alcohol use are recognised: hazardous, harmful and dependent. *Hazardous* alcohol use is a pattern of use that exposes the drinker and others to increased harm, without such harm having yet occurred. *Harmful* alcohol use refers to consumption that has resulted in harm to the drinker and/or other people, and can arise from a single episode of drinking, or from a pattern of drinking over time. Harmful use is distinguished from alcohol *dependence*, which is described as a 'disorder of regulation of alcohol use arising from repeated or continuous use', characterised by an impaired ability to control use, prioritisation of drinking over other activities and persistence of use despite the experience of adverse consequences. Alcohol dependence, in other words, covers similar mental and behavioural characteristics to those associated with chronic alcoholism, without incorporating any assumptions about underlying causal factors such as the presence of a disease. The full descriptions of each of these terms in ICD-11 are shown in Table 2.1 below.

Throughout this book, we use the term 'alcohol misuse' to refer to drinking patterns that are hazardous, harmful and/or associated with dependence as defined under ICD-11.

Despite the objections raised against the disease model of alcoholism, it has been embraced by many Australian Aboriginal treatment providers, who see it as lending itself more readily to Aboriginal cultural perspectives than other therapeutic approaches. In 1974, Val Bryant, an Aboriginal woman of Gumbaynggirr descent, founded the first Aboriginal rehabilitation facility in Australia, initially in Sydney and later in Kempsey, NSW (Chenhall 2007). She believed that alcoholism among

Table 2.1 Categories of alcohol use as defined by WHO in International Classification of Disease (ICD-11)

Term	ICD Code	Description
Hazardous alcohol use	QE10	A pattern of alcohol use that appreciably increases the risk of harmful physical or mental health consequences to the user or to others to an extent that warrants attention and advice from health professionals. The increased risk may be from the frequency of alcohol use, from the amount used on a given occasion, or from risky behaviours associated with alcohol use or the context of use, or from a combination of these. The risk may be related to the short-term effects of alcohol or to longer-term cumulative effects on physical or mental health or functioning. Hazardous alcohol use has not yet reached the level of having caused harm to physical or mental health of the user or others around the user. The pattern of alcohol use often persists in spite of awareness of increased risk of harm to the user or to others
Harmful use of alcohol (episode)	6C40.0	An episode of use of alcohol that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour due to alcohol intoxication on the part of the person to whom the diagnosis of single episode of harmful use applies. This diagnosis should not be made if the harm is attributed to a known pattern of alcohol use
Harmful use of alcohol (pattern)	6C40.1	A pattern of alcohol use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others. The pattern of alcohol use is evident over a period of at least 12 months if substance use is episodic or at least one month if use is continuous. Harm to health of the individual occurs due to one or more of the following: (1) behaviour related to intoxication; (2) direct or secondary toxic effects on body organs and systems; or (3) a harmful route of administration. Harm to health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to alcohol intoxication on the part of the person to whom the diagnosis of Harmful pattern of use of alcohol applies

Table 2.1 (continued)

Term	ICD Code	Description
Alcohol dependence	6C40.2	Alcohol dependence is a disorder of regulation of alcohol use arising from repeated or continuous use of alcohol. The characteristic feature is a strong internal drive to use alcohol, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use alcohol. Physiological features of dependence may also be present, including tolerance to the effects of alcohol, withdrawal symptoms following cessation or reduction in use of alcohol, or repeated use of alcohol or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if alcohol use is continuous (daily or almost daily) for at least 3 months

Source World Health Organization (2022)

Aboriginal people was a disease, but one that required a different response to alcoholism among non-Aboriginal people because of distinctive features of Aboriginal society. She set out her views in an article co-authored with her husband Jim Carroll in 1978 and published in the *Aboriginal and Islander Health Worker Journal* (Bryant and Carroll 1978), an excerpt from which is shown below.

Box 2.2 Aboriginal Alcoholism-Where Are We Going? White Man's Way or Black Man's Way?
From Bryant and Carroll (1978)

Many reasons are given as to why the Aboriginal people have suffered so much from the disease of alcoholism. I am convinced that most reasons given are wrong. However, there is no doubt that the strong sense of community and the spiritual closeness of our people helped alcoholism spread faster.

This is the point of this article. White people become alcoholics one by one so we have white communities with alcoholics who do not drink together, often try to avoid each other, and often do not even know one another. On the other hand, our people become alcoholics in groups. They drink together and so become a strong force in influencing younger people and others to drink.

....

So far so good—but the method of treatment is the white man's way. Whites become alcoholics one by one, and the rehabilitation is on the same lines—one by one. Unfortunately, while the white man becomes an alcoholic more slowly, the treatment is even slower. In fact, it is a losing battle. More people become alcoholics each day than recover. The white man has great problems with alcohol. It will get worse, and I personally see no way out for them under present Government treatment policies.

The Aboriginal can get out of his alcoholic problems, but he must realise that he cannot go into alcoholism the Aboriginal way (IN A GROUP) and out the white man's way (ONE BY ONE). That way, there are always more becoming alcoholics than are recovering.

....

If you want a spaceship to go to the moon, ask the white man to build one—he is the best at that. But don't ask him about spiritual things or how to get pride and dignity or self-respect.

Christ came to earth two thousand years ago to tell the white man not to store up the things of this world, that if he looked at the birds in the trees he would see them clothed 'in the finest raiment'. I find it hard to believe they have taken much notice. The interesting thing is that at the same time, the Aboriginals were already doing that, and had been for thousands of years before Christ came. Not only do whites regard us as being lazy and having no 'go' in us, but they also try to teach us spirituality, and bring the words of Christ to us. I hope Jesus Christ has a sense of humour.

The Aboriginal Way.

My point is that there are things that white man can't teach us. How to help our alcoholic brothers is one area where we do not need his advice.

....

LET US TREAT ABORIGINAL ALCOHOLICS THE ABORIGINAL WAY—IN GROUPS.

In 1981, Harold Hunt, an Aboriginal man who was then Coordinator of Alcohol Services in the Aboriginal Health Section of the Health Commission of NSW, and a former alcoholism counsellor, extended the notion of disease to include the whole family: "whole families are affected and, hence, whole families need treatment" (Hunt 1981: 3, see also Box 4.4 in Chap. 4 below).

One reason for the controversy that continues to surround the idea of alcoholism as a disease is a lack of clarity about just what is being implied by calling something a 'disease'. Is it a biomedical entity like, say, diabetes, or is 'disease' being used as a metaphor, as the notion of a 'family disease' would suggest? In Chap. 4 below, we discuss the evolution of treatment and rehabilitation programs for Aboriginal people using the disease concept of alcoholism.

2.3.2 Social-Psychological Explanations

Several observers have attempted to explain Aboriginal alcohol use as a social-psychological response to discrimination and marginalisation. Alcohol, from this perspective, is a form of learned behaviour rather than a symptom of a disease. Larsen, for example, in a study based on interviews with 72 Aboriginal and Torres Strait Islander 'alcohol abusers' in Townsville, Qld, concluded that 'Aboriginal group identification' correlated with heavy drinking (Larsen 1980). According to Larsen, however, such identification was not based on a sense of pride in being Aboriginal, but rather was a defensive response to rejection by the dominant white society. The underlying assumption appeared to be that, if the local white society was more accepting of Aboriginal and Torres Strait Islander residents, those residents would willingly forsake Aboriginal (or Torres Strait Islander) identification, drink less liquor and become 'assimilated'. Such an analysis probably tells us more about white beliefs than about Aboriginal drinking.

Max Kamien, a GP and research psychiatrist who worked for 3 years in the northwestern NSW town of Bourke in the early 1970s, also explained the heavy drinking that he documented, particularly by men, as well as high levels of analgesic use by women, as maladaptive responses to stresses resulting from white settlement and ensuing racism and marginalisation (Kamien 1975, 1978). Kamien, however, viewed the response as a social phenomenon rather than a product of an underlying psychiatric disorder. Drinking offered not only personal relief in the form of drunkenness but also membership in a group:

> The giving and receiving of alcohol symbolised mateship and a common purpose in life. To refuse to drink with one's mates was a breach of etiquette of the same order as refusing an invitation to eat with a Bedouin. Refusal was regarded as rejection and betrayal of the group who then stigmatised their former member and left him socially isolated. Since few Aborigines were likely to be accepted into any other group except certain branches of the church, they were loath to risk the wrath or ridicule of their peers. The fear of a prison sentence for breaking a bond to the white man's court hung lightly on them in comparison to the fear of rejection by their friends (Kamien 1978: 152).

Since drinking in Kamien's view was due more to group psychosocial pressures than to individual psychological needs, attempts to reduce alcohol problems should be directed at the community and peer group norms rather than at individuals. For these reasons, he dismissed AA and other individualistic approaches as unsuitable (Kamien 1978: 159–60; 1975).

2.4 Alcohol as a Public Health Problem

Despite its widespread adoption among AA groups and in popular culture, the disease model of alcoholism attracted increasing criticism among both alcohol researchers and policy-makers (Roizen 2004). On the research side, not all alcoholics were found to be incapable of drinking in moderation. From a policy perspective, the model

exhibited two key flaws. Firstly, a broad range of alcohol-related problems—such as alcohol-related road crashes and FASD—could not be attributed solely to dependent drinkers, but rather were associated with a variety of drinking patterns. Secondly, the disease model offered only one treatment goal: total abstinence. Yet the prevalence of many alcohol-related problems could be lowered if people drank less, rather than ceasing drinking altogether. What was needed, therefore, was a broader range of prevention and treatment goals than the disease model allowed.

In the 1970s, these critiques gave rise under the auspices of the World Health Organization (WHO) to a new public health approach to alcohol policy, described by one observer as reflecting a shift from a concern with managing the 'addict' or the 'inebriate' to a focus on population-oriented measures (Bunton 2001). Under the shift, the alcohol domain was divided into two sectors: a clinical domain focusing on a newly formulated 'alcohol dependence syndrome' (Edwards & Gross, 1976) and a population-level domain concerned with what were initially labelled 'alcohol-related disabilities', later rephrased as 'alcohol-related problems'. The alcohol dependence syndrome was intended as an alternative to the disease concept. Alcohol-related problems included any adverse health outcomes that could be shown to be associated with alcohol use, and therefore covered phenomena as diverse as cirrhosis of the liver, injuries inflicted in a drunken brawl, alcohol-related car crashes and alcohol-related absenteeism from the workplace (Edwards et al. 1997). Alcohol-related problems became the domain of a public health-based approach to reducing alcohol-related harms (Berridge 1993).

The foundations for the public health approach were set out in a WHO-commissioned monograph, in which the authors asserted that "changes in the overall consumption of alcoholic beverages have a bearing on the health of the people in any society. Alcohol control measures can be used to limit consumption: thus, control of alcohol availability becomes a public health issue" (Bruun et al. 1975: 12–13). In other words, the focus of intervention shifted from individual drinkers to *per capita* consumption by the population as a whole. While education about alcohol and treatment of people with drinking problems had important parts to play, according to this approach, effective *prevention* of alcohol problems required controls on the supply of, as well as demand for, alcohol, whether in the form of taxation measures, restrictions on outlet density or trading conditions, limits on alcohol content of beverages, minimum drinking ages and other control measures.

In the 1980s, the public health approach became influential among health professionals and others working with Aboriginal community-controlled health services and organisations, particularly in Central Australia. For example, in 1990 the Pitjantjatjara Council, representing Pitjantjatjara, Yankunytjatjara and Ngaanyatjarra people living in a wide area in Central Australia extending into NT, SA and WA, made a written submission to a parliamentary inquiry in the NT into alcohol-related problems (Pitjantjatjara Council Inc. 1990). At the time, the Pitjantjatjara Council and other Central Australian Aboriginal organisations were locked in a dispute with the NT Liquor Commission over a decision by the Commission to permit take-away sales of liquor to Aboriginal people by a roadhouse in Central Australia, against the expressed wishes of several surrounding communities.

The Council's submission detailed the efforts of communities to combat alcohol problems but argued that these efforts were undermined by the Liquor Commission's unwillingness to use its regulatory powers to curb the increasing availability of alcohol. Most of those Aboriginal people who drank alcohol at all were, the submission argued, 'opportunistic' drinkers—that is, they were not 'addicts' as portrayed by the disease model:

> While there are Aboriginal people who will drive hundreds of kilometres to obtain alcohol, they are in a very small minority. Most Aboriginal people who drink—and an N.T. Government survey has shown clearly that most do not consume alcohol at all[1]—usually do so when grog is readily or easily available (Pitjantjatjara Council Inc. 1990: 23).

The submission then set out the case for a public health approach.

Box 2.3 Availability, Consumption and the Public Health Approach
From Pitjantjatjara Council (1990: 25–27).

There is a considerable body of compelling scientific evidence that availability is a significant factor in alcohol consumption generally—not just in the Aboriginal community.

The so-called 'availability hypothesis' states what seems mere common sense: the more available alcohol is, the more people will drink and, consequently, the more alcohol-related problems they will have.

Significant factors that affect availability include the minimum drinking age, the days and hours during which alcohol may be sold and the number and type of liquor outlets (e.g. off premises and on premises). According to the availability hypothesis, changes in any of these variables should result in changes in alcohol consumption and related problems.

The availability theory has been gaining increasing currency among alcohol researchers and government regulators since the mid-1970s. While the debate continues on this issue, a number of studies in Australia and overseas have provided strong support.

Dr. Ian Smith, director of the Road Accident Prevention Research Unit at the University of Western Australia's Department of·Medicine, has produced study after study of changes in various availability factors, most of which have provided substantial support to the theory.[2]

---

[1] This is probably a reference to a survey conducted by the NT Drug and Alcohol Bureau of alcohol and other drug use in Aboriginal communities in the NT; see (Watson, Fleming, and Alexander 1988).

[2] Several of the studies referred to here were never publicly released; however, two studies that were published are (Smith 1983, 1988).

From these data, Smith has concluded that when laws actually restrict alcohol availability in an absolute way and are then liberalised, increased consumption and related problems will result. Similarly, when alcohol is already available and its availability is increased, consumption and problems frequently (but not always) increase.

In the case of Aboriginal communities, sociological and anthropological experience has shown that increased availability of take-away alcohol has disastrous effects on individual and community health and wellbeing. Government resistance to the scientific evidence in support of the availability theory, therefore, carries a high price to those least able to afford it.

More strict control over the supply of alcohol is a central element of the public health approach to the prevention of alcohol problems.

The result of 30 years of health research, the public health approach is based on the fact that alcohol is a significant risk factor in illness and injury, and the more an individual or a community drinks, the more alcohol-related problems they will have. Reducing overall alcohol consumption should therefore be a key element of any strategy to prevent alcohol problems.

Increasingly, alcohol researchers and policy-makers are concluding that, to be successful, any prevention strategy must concentrate on reducing the supply of alcohol as well as the demand for it. These reductions in supply are most effectively done through control measures that affect availability of or ease of access to alcohol. Such measures include.

- restrictions on liquor outlets;
- increasing taxes on alcohol (and prices overall);
- differential taxation according to alcohol content;
- health warning labels on alcoholic beverages;
- limiting sales to outlets that sell only alcohol;
- banning advertising of alcoholic beverages;
- 'dram shop liability laws' that make servers of alcohol potentially legally liable for alcohol-related damage and injury.

The public health approach, which has been successful in anti-smoking campaigns, is one which the government should seriously consider to combat alcohol problems Territory-wide, in the non-Aboriginal as well as Aboriginal communities.

Obviously, control measures alone are not enough. However, there are aspects of traditional Aboriginal culture which make it difficult for communities and individuals to effectively address alcohol problems, which should be taken into account when policy-makers plan strategies and programs or when community advisers give advice.

2.4.1 The Northern Territory 'Living with Alcohol Program'

The most comprehensive example to date of a public health-based alcohol policy in Australia was the 'Living With Alcohol Program' (LWAP) introduced by the NT Government as a ten-year program between 1992 and 2001. The primary objective of the LWAP was to reduce alcohol consumption and related harms in the NT to the national level (Northern Territory Government 1991). This was more ambitious than it might sound, given that estimated per capita consumption of alcohol in the NT had for several decades stood between 50% and 100% above the national average, while death rates attributable to hazardous or harmful drinking were three times those for the nation as a whole, and alcohol-related hospitalisation rates around 50% higher (Chikritzhs et al. 2003; Skov et al. 2010) (Fig. 2.1).

The LWAP was based on a three-pronged strategy involving education, increased controls on availability and expanded treatment and rehabilitation services. Underpinning the reforms was a new levy which added 5 cents per standard drink to the cost of full-strength alcoholic beverages, while licence fees on beverages containing not more than 3% alcohol were reduced to 4%. Proceeds from the levy were paid into a separate 'Living with Alcohol' Trust Account for purposes associated with the new policy (d'Abbs 2004b).
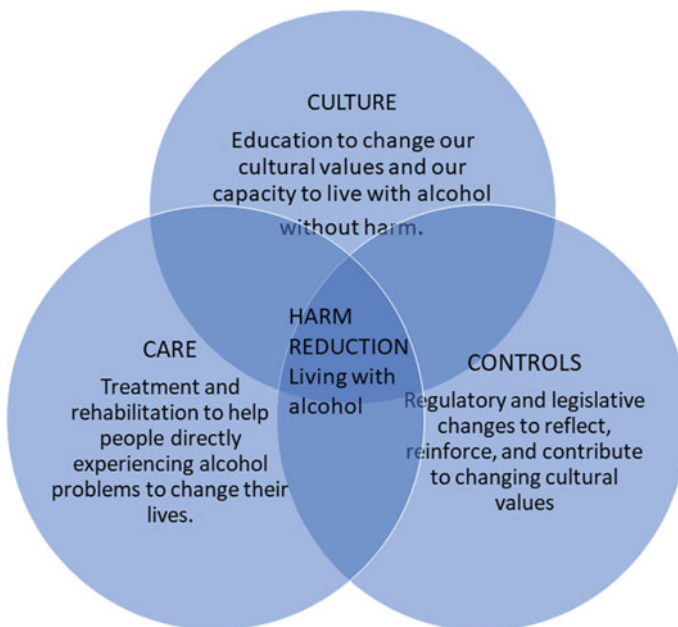
Fig. 2.1 The three core components of the NT Living With Alcohol Program, 1992–2001. *Source* Northern Territory Government (1991)

Unlike many alcohol policy initiatives in the NT both before and since, the LWAP did not specifically target drinking by Aboriginal people, but was rather based on the premise—supported by ample evidence—that excessive alcohol consumption was common among Aboriginal and non-Aboriginal drinkers alike, and that the proper goal of the policy was therefore to reduce overall alcohol consumption in the NT. This was probably both the strength and the Achilles heel of the LWAP: its strength, in that it provided a rationale for deploying evidence-based public health policy measures; it also, however, made the policy a target of vested interests who benefited commercially from the prevailing heavy drinking culture.

In 1997, following a High Court ruling that, under the Australian constitution, state and territory governments did not have the power to raise licence fees on alcoholic beverages, the Living With Alcohol Levy was discontinued. The national government subsequently stepped in and continued to raise an equivalent amount and return it to the NT Government, as a result of which the LWAP received ongoing funding; from this time onwards, however, the funds were no longer 'ring fenced' in a special account and became increasingly dissipated on projects outside the LWAP (d'Abbs 2004a).

Although the LWAP never achieved its initial goals, independent evaluations indicated that it brought about significant reductions in alcohol-related harms. An evaluation of the program in its first four years—1991–1992 to 1995–1996—by Stockwell et al. reported declines in estimated alcohol-caused deaths from acute conditions (road deaths 34.5%, other 23.4%) and in road crash injuries requiring hospital treatment (28.3%) (Stockwell et al. 2001). They also found that per capita alcohol consumption and self-reported hazardous and harmful consumption of alcohol declined. In a later study, Chikritzhs et al. examined the impact of the LWAP both up to and beyond the cessation of the levy in 1997, using comparable regions in WA and Queensland as controls, and distinguishing between acute and chronic alcohol-attributable deaths (Chikritzhs et al. 2005). They reported that acute alcohol-attributable deaths in the NT declined significantly between 1992 and 1997, although the effect was not sustained between 1998 and 2002. Chronic alcohol-attributable deaths in the NT, however, declined significantly in the post-levy period. These trends were observed among both Aboriginal and non-Aboriginal people. The authors concluded that the evaluation demonstrated that well-resourced programs and services, when combined with an increase in the real price of alcohol, were effective in reducing acute alcohol-related harms (Chikritzhs et al. 2005).

In 2001, the Country Liberal Party (CLP) Government that had presided over the LWAP was defeated at an election. The incoming Australian Labor Party (ALP) administration did not retain or renew the policy.

In Chap. 5 below, we explore several local interventions by Aboriginal communities and organisations that emerged in the 1980 and 1990s based on a public health approach to reducing alcohol-related harm.

2.5   Sociological and Anthropological Explanations for Aboriginal Drinking

While the public health approach focuses on the drinking of populations rather than individuals, and addresses enabling factors such as the availability of alcohol, it is not primarily concerned with the reasons underlying people's drinking. Another body of research, grounded in sociological and anthropological traditions, has sought to explain Aboriginal drinking patterns as an outcome of the historical, social, cultural and political contexts in which drinking occurs. These explanations differ from one another in the emphasis they place on micro-social forces, such as the internal dynamics of drinking groups, intermediate contexts such as inter-racial relations in regional towns and macro-social forces such as the legacy of colonisation and dispossession. All of them, however, conceptualise drinking behaviour not as individual pathology but as a collective response to circumstances over which Aboriginal people have little control. An implication of these studies—sometimes explicit, sometimes implicit—is that sustainable changes in drinking practices require changes in the social conditions that give rise to them.

In one of the earliest studies of this kind, anthropologist Jeremy Beckett described drinking by Aboriginal people in the towns of western NSW in the late 1950s—when Aborigines were still legally prohibited from drinking—in part as a consumption style picked up from the 'work and bust' drinking sprees of semi-nomadic, non-Aboriginal pastoral workers, and in part as an act of defiance in the face of social and spatial marginalisation on the edges of towns (Beckett 1964). The need to conceal liquor from the police and consume it as quickly as possible also placed a premium on the more potent beverages such as rum and fortified wine. Sackett, drawing on fieldwork conducted in the Western Australian Aboriginal community of Wiluna in the 1970s, explained the high levels of drinking that continued despite the efforts of governments and a mission to inculcate more sober habits as a 'drunken rejoinder'—a form of resistance to the policies and programs of the state that, regardless of the rhetorical connotations of 'self-determination' and 'empowerment', invariably left them in a dominated and dependent position (Sackett 1988). Similarly, Cowlishaw speaks of an 'oppositional culture' through which Aboriginal minorities in small Australian towns expressed their defiance of police surveillance and a justice system perceived as privileging the interests of the settlers over themselves (Cowlishaw 1994).

Aboriginal alcohol use, as portrayed in several studies, was both a product of and helped to reinforce race-based social inequalities. Healy et al., in a study conducted in Mt Isa, Queensland, in 1982, interpreted drinking by Aboriginal people as promoting group solidarity that helped to negate feelings of powerlessness and—especially when involving intoxication—express defiance towards the dominant society. The same dynamics had the further consequence of rendering Aboriginal drinking visible and subject to high levels of police surveillance, which in turn reinforced negative stereotypes held by non-Aboriginal residents (Healy et al. 1985). Through these processes, 'the alcohol problem' in Mt Isa was defined by non-Aborigines as an Aboriginal problem, thereby helping to divert attention from what the authors argued

were high levels of alcohol consumption among non-Aboriginal residents in the town (Healy et al. 1985).

Brady and Palmer, describing a remote South Australian community in the 1970s and early 1980s, also explained drinking—and, in particular, drinking with the express intention of becoming drunk—as a response to the powerlessness arising from being dependent upon the dominant society for meeting most of their needs, while having few resources with which to negotiate the terms of satisfying those needs. Unable to rectify these conditions, drinkers turned to the pursuit of drunkenness, which offered temporary transformation into a euphoric state of 'time out' in which they no longer felt powerless, and were not held accountable for their actions—at least by other community members (Brady and Palmer 1984).

Collmann (1979, 1988) conducted anthropological fieldwork in an Alice Springs fringe camp between 1974 and 1976—a time of major policy and administrative changes as assimilation gave way to 'self-determination'. He rejected the portrayal of fringe camps as marginal institutions peopled by 'detribalised' Aborigines, arguing that they were organised social entities in which the fundamental dynamic involved managing the incursions and demands of the welfare administration while securing needed resources. The procurement and sharing of liquor were central to this dynamic. Men converted income acquired through pastoral or unskilled urban work to liquor, which was in turn distributed as a primary way of managing relationships of credit and indebtedness, and also to gain access to the welfare-based income of which women were the most reliable recipients (Collmann 1988). In a similar vein, Sansom portrayed what he called a 'grogging community' in a Darwin fringe camp, arguing that the allocation of liquor and the management of drinking were core components of the local culture and social structure (Sansom 1980).

Ethnographic studies such as those by Collmann and Sansom sought to describe the meanings of actions and events from the perspective of those engaged in them—that is, to give, as much as possible, an insider's view—on the grounds that doing so was a precondition for understanding their actions. In doing so, they deliberately avoided defining alcohol use as a 'problem', preferring instead to understand how their research subjects thought and talked about alcohol.[3] This approach sparked a debate among anthropologists and alcohol researchers, with one eminent sociologist—Robin Room—arguing that some anthropologists were inadvertently 'deflating' the true seriousness of alcohol-related problems in their ethnographic studies (Room 1984). Without wishing to resurrect that debate, it is important to note that not all anthropologists have shied away from examining the harmful effects of excessive drinking in Aboriginal settings. McKnight's study of the introduction and impact of a licensed canteen on Mornington Island in the Gulf of Carpentaria, for example, is the story of an unfolding tragedy marked by escalating violence, suicides and deteriorating quality of life (McKnight 2002).

---

[3] In social science terminology, the two perspectives are referred to as *emic* (the insider's perspective) and *etic* (the more analytic perspective of outsiders such as researchers), and are the subject of a history of methodological debates about the proper role of each in sociological explanations.

The ethnographic focus on local-level social processes also attracted criticism from other social scientists who argued that, in order to understand drinking by Aboriginal people, it was necessary to broaden our focus to the wider networks of economic and political relationships that continued to shape the opportunities and constraints facing Aboriginal people (Saggers and Gray 1998). Saggers and Gray, in proposing what they labelled a 'political economy' approach to Aboriginal alcohol use, argued that these relationships were derived from experiences of colonisation shared by indigenous peoples in other societies settled by Europeans, notably Canada, the US and New Zealand, as well as more contemporary structural disadvantages such as high unemployment and inadequate housing. In all these societies, indigenous access to alcohol was prohibited, but alcohol was also used as an instrument of trade and sexual trafficking. The suppliers of alcohol, both illegal and legal, historical and modern, were therefore also important in explaining patterns of alcohol use (Saggers and Gray 1998).

2.5.1 Colonisation as a Structure

Common to all of these approaches is an implicit understanding of colonisation as a historical event belonging to a past that began with the European invasion of Australia and ended with the cessation of frontier violence. An alternative view of colonisation, as articulated for example by Patrick Wolfe, sees it as 'a structure rather than an event' (Wolfe 2006: 390). Settler colonialism, according to this perspective, is an enduring structure, the underlying logic of which is the settlers' appropriation of the land and the *elimination* of the native. For Wolfe, the ending of the physical liquidation of Aborigines in the frontier wars does not mark the ending of elimination, but rather its transformation into the more genteel processes of protection and assimilation. One implication of this perspective is that programs targeting Aboriginal health or wellbeing today—including programs to prevent or treat alcohol misuse—take place in a context defined by colonisation as an enduring structure. Another is that colonisation will cease only when and if Aboriginal sovereignty in Australia is recognised (Warrior and Kauanui 2018).

2.5.2 Structure and Practice

Several observers have attempted to integrate structural factors with social practices in developing explanatory models (Hunter 1993; Martin 1998). Martin, for example, in the extract below explores the relationship between commercial, political and regulatory factors on the one hand and, on the other, local values and practices.

Box 2.4 The Relationship Between Structural Factors, Cultural Values and Drinking Practices: An Explanatory Model
From Martin (1998: 12–13)

Thus, to give an instance, ready access to alcohol for fringe dwellers in towns like Alice Springs and Mt Isa is determined by a conjunction between the availability of cash through the welfare system, the commercial interests of breweries and opportunistic liquor outlets, and liquor licensing laws. At the same time, there are constraints placed on Aboriginal drinking behaviour by local by-laws, such as those relating to consumption in public places. The availability of alcohol, the commercial and political power of the liquor industry, and the nature of legislative controls on alcohol consumption both produce, and are the product of, the culture of alcohol in the dominant society.

Over time, a conjunction develops between these 'structural' features and others more related to the internal values and practices of Aboriginal groups. Heavy alcohol consumption and associated behaviours become normative for many in the fringe dwelling group, deeply embedded in the everyday life of the group, and reproduced through the generations (Martin 1993: 196–99). That is, the development of particular Aboriginal drinking practices and values is but one instance of the wider production and reproduction through time of contemporary Aboriginal societies, whereby the structures and forms of the wider system variously constrain, enable and are incorporated into Aboriginal people's own social and cultural forms.

To approach the development of particular Aboriginal drinking practices from this perspective then is to necessarily reject the view that Aboriginal people can only ever be seen as victims of history, passively accepting the dictates of the wider society, acted upon but never acting, empty cultural vessels into which the dominant culture and its alcohol is poured. The logical extension of such a position is that if people are essentially portrayed as victims, then responsibility for both causes and solutions lies solely within the dominant Australian society. Only if the mainstream institutions change, the argument runs, can Aboriginal drinking patterns change.

Rather, the recognition that the 'culture' of Aboriginal drinking has developed through the conjunction of both internal factors and wider structural ones suggests that actions at *both* levels are required—that of the institutions and structures of the wider society on the one hand, and that of the internal dynamics, values and practices of the particular Aboriginal group on the other.

This may seem to be a truism, but there are useful policy frameworks and directions that emerge from such an analysis.

The complete text of the paper from which this extract has been taken can be downloaded at Open Research: The supply of alcohol in remote Aboriginal communities: potential policy directions from Cape York (anu.edu.au).

Through the 1980 and 1990s, structural explanations were influential in the policy domain, giving rise to what Brady identified as a split in perspectives, in which non-Aboriginal problematic alcohol and other drug use were explained mainly in terms of factors such as low self-esteem or peer group pressure, while corresponding behaviour among Aboriginal people was attributed to historical and structural factors (Brady 1991). These informed, for example, the National Aboriginal Health Strategy published in 1989 (National Aboriginal Health Strategy Working Party 1989). While acknowledging that for many Aboriginal communities, alcohol was regarded as the most significant health and social issue confronting them, the authors of the Strategy stated:

> Non-Aboriginal Australia must recognise that alcoholism is an introduced illness caused primarily by political, social, economic and cultural deprivation imposed by non-Aboriginal society. Until such time that non-Aboriginal Australians as a whole accept this and acknowledge the need to redress this situation, there will be no lasting resolution of the alcohol abuse problem in the Aboriginal community (National Aboriginal Health Strategy Working Party 1989: 192).

Even as it was being published, however, the interpretation of Aboriginal alcohol problems as symptomatic of other underlying issues was coming under critical scrutiny by several Aboriginal thinkers.

2.6 Dissenting Voices

In 1987, Merv Gibson, an Aboriginal man from Hope Vale community on Cape York, Queensland, presented a paper at a conference convened in Townsville by the Australian and New Zealand Association for the Advancement of Science (ANZAAS). The paper was entitled 'Anthropology and Tradition: a Contemporary Aboriginal Viewpoint' (Gibson 1987). In it, Gibson developed two critiques. One was of contemporary life in his own community and, in particular, the place of alcohol in the community. The other was directed at the depiction of Aboriginal culture and tradition by anthropologists and other non-Aboriginal 'experts' on Aboriginal society.

Gibson argued that destructive alcohol use had become integrated into Aboriginal culture to such an extent that it functioned as an expression of identity: "For black people, to drink alcohol is to be an Aboriginal" (Gibson 1987: unpaginated). Social relationships and the sense of belonging to the community were maintained through, and subordinated to, the consumption of alcohol. But these meanings and practices, according to Gibson, represented a distortion and corruption of traditional culture. This in turn had come about, Gibson argued, because Aboriginal people had internalised the ethnographic portrayals of Aboriginal social life created by anthropologists. These portrayals, he argued, constituted a myth that now shackled Aboriginal society. The processes through which the use of alcohol insinuated itself into everyday life are summarised in the extract below.

Box 2.5 Anthropology and Tradition: A Contemporary Aboriginal Viewpoint
From Gibson (1987)

This paper argues that Aboriginal society is caught in the stranglehold of distorted and mythic traditions.

For example: Jack collects his pay cheque or social security cheque and spends most of it providing alcohol for himself and his cousins. His wife is unable to purchase enough food for their children until the next cheque, and therefore the children are hungry and his wife has to borrow food from a neighbour to feed them. Because Jack regularly appropriates the family income in this way, it is highly unlikely that his wife will ever repay what she was given. What was once a relationship of equal cadging between her family and the neighbours becomes unequal. What was once dependency by Jack's wife and children based on necessity becomes dependency by Jack based on social exploitation and parasitism.

Why is such exploitation and parasitism allowed to continue? It is allowed to continue because the myth has convinced the members of the society, that it is part and parcel of Aboriginal culture and tradition. Exploitation and social parasitism have been given such currency in Aboriginal society that the myth has to a large extent turned into reality. To return to our case example: Jack justifies his appropriation of the family income for the purposes of buying alcohol for his cousins, as a true expression of cultural identity and as a fulfilment of cultural and kinship obligations. Consuming alcohol for Jack in the way that he does is all about reinforcing kinship and cultural ties. During the course of consuming the alcohol, Jack can be heard explaining his kinship ties to his fellows. As any observer of Aboriginal alcohol consumption will testify, it is a ritual of reinforcing and observing so-called cultural ties and obligations. In fact it is a myth. It is a gross denial and distortion of true Aboriginal tradition.

Jack, either consciously or not so, thinks that he is being a true Aboriginal in sharing his cheque with his cousins who may have shared their cheque with him previously. He fails to realise that true Aboriginal tradition requires him to observe all his kinship obligations especially those towards his wife, children and parents, not just those involving alcohol. Jack has become a social parasite who uses Aboriginal tradition to justify what is in essence selfish exploitation based on an individual physical desire for alcohol. It will be evident that the kinship and cultural obligations which Jack is willing to acknowledge are those that can be centred around alcohol. He will be negligent in all of his other obligations. The myth that tradition is expressed during the consumption of alcohol by the group has gained tremendous currency in the Aboriginal community, and it has followed that any denial of the myth amounts to a denial of tradition.

The notion that Aboriginal alcohol problems were best understood as symptoms of two centuries of colonial domination and could not be addressed without first attending to the legacy of colonisation drew criticism from another Aboriginal thinker—Marcia Langton. In 1989, Langton was appointed to head an Aboriginal Issues Unit established under the Royal Commission into Aboriginal Deaths in Custody. The Unit was charged with preparing a report for the Commission "on the views of Aboriginal people in the Northern Territory on the underlying issues leading to the disproportionate rates in custody for Aboriginal people and sometimes deaths in custody" (Langton et al. 1991: 275).

Langton et al.'s report was published as an Appendix in Volume 5 of the final report of the Royal Commission into Aboriginal Deaths in Custody (Langton et al. 1991). In it, the authors stated:

> It may well be argued that substance abuse by itself is not a cause of Aboriginal people dying in custody, and that there are further underlying reasons or causes, for example, dispossession, poverty, lack of education, hostile police practices, and so on. Without doubt this is true in an absolute sense: we do not argue that substance abuse is a single cause. Clearly there is a complex of issues involved. Nevertheless, the Aboriginal Issues Unit has found that from **an Aboriginal perspective and from the Aboriginal experience** alcohol plays a primary role in both the reasons for detention, and for the subsequent chances of deaths occurring (emphasis in original) (Langton et al. 1991: 276).

Langton et al. identified four causal factors that, interacting with each other, gave rise to the problems experienced by Aboriginal people in association with alcohol: firstly, they insisted, alcohol was 'a powerful addictive chemical substance' (Langton 1992: 16); once in its grip, Aboriginal people found it difficult if not impossible to break free. Taking issue with the belief that excessive alcohol use was a symptom of dispossession and alienation, the report argued that "because alcohol is a powerful addictive chemical substance, it is more causal than symptomatic" (Langton 1992: 16; Langton et al. 1991: 288). Secondly, Aboriginal societies lacked the social rules and cultural controls needed to manage alcohol effectively at a community level: "Grog is a white poison and we have no rules to deal with it. Alcohol is but one aspect of the arrival of non-Aboriginal people, yet there is a clear perception among our people that its effects are the most devastating" (Langton 1992: 18; Langton et al. 1991: 292). Prior to colonisation, alcohol was not unknown in some Aboriginal societies; the Yolngu word for alcohol—*nganaji*, for example, is derived from a term used by Macassan trepang fishermen who for several centuries regularly visited the Arnhem Land coast, bringing their liquor with them. But nothing in traditional Aboriginal cultures prepared them for the amounts and pervasiveness of alcohol that accompanied European colonisation.

The third factor identified by Langton et al. was the ready availability of alcohol in the NT, which catered to a heavy drinking culture among non-Aboriginal as well as Aboriginal people, and which was supported by regulatory practices that prioritised the commercial interests of the liquor and hospitality industries over community well-being. The fourth factor was an absence of incentives or motivation to engage either in meaningful employment or in traditional or other activities. By an unfortunate coincidence, the arrival of Aboriginal drinking rights two decades previously had

happened around the same time as Aboriginal employment in the pastoral industry collapsed following the introduction of minimum wages for Aboriginal workers in the industry (Anthony 2007).

Policing practices, according to Langton et al.'s report, only made matters worse. With a few notable local exceptions—discussed in the report, and by us in Chap. 9 below—police showed neither understanding nor respect for Aboriginal ways of resolving conflicts or preventing violence, instead adopting heavy-handed, punitive measures that further disempowered communities. Atrocious housing and health conditions, and poor educational outcomes, were also both outcomes and drivers of excessive alcohol use (Langton 1992; Langton et al. 1991).

The foundation of Langton et al.'s critique—insistence that alcohol misuse was a primary problem rather than a symptom of other, underlying factors—was developed further by Noel Pearson. In a series of published and unpublished papers written at the beginning of the twenty-first century, Pearson attacked what he called 'the symptom theory of substance misuse' (Pearson 2000, 2001b, 2001a, 2002):

> Why are my people disintegrating, and why are we unable to do anything about it? I will go straight to the core of the matter and talk about addiction and substance abuse. Our worst mistake is that we have not understood the nature of substance abuse. I maintain a fundamental objection to the prevailing analysis of substance abuse among our people. The prevailing analysis is that substance abuse and addiction are a symptom of underlying social and personal problems. According to the symptom theory we must help people deal with the reasons that have seen them become addicted to various substances. According to this theory we must address the 'underlying issues' if we are to abolish substance abuse. The severe substance abuse in Aboriginal communities is said to have been caused by immense ingrained trauma, trans-generational grief, racism, dispossession, unemployment, poverty and so on.
>
> But the symptom theory of substance abuse is wrong. Addiction is a condition in its own right, not a symptom. Substance abuse is a psycho-socially contagious epidemic and not a simple indicator or function of the level of social and personal problems in a community (Pearson 2001a: 10).

Like Langton, Pearson acknowledged the legacy of colonisation and dispossession, identifying these processes as having created the conditions in which substance misuse first became prevalent among Aboriginal people. He argued, however, that once excessive alcohol and other drug use became widespread and culturally normalised in a community, it took on the characteristics of a psychosocial epidemic, and it was this epidemic that became the primary driver of ongoing substance misuse rather than the original causal events. In proposing what amounted to a distinctive theory of Aboriginal substance misuse, Pearson cited two key influences. The first was Mervyn Gibson's insight—referred to above—that alcohol abuse had insinuated itself into Aboriginal culture. The second was the concept of a 'psychosocial epidemic' that Pearson adopted from Nils Bejerot, a Swedish psychiatrist and criminologist renowned for advocating a zero-tolerance policy towards recreational drug use (Bejerot 1980, 1988). Bejerot distinguished between addiction to drugs arising from acts by individuals in a social context where the use of the drug in question was not a social norm and addictive behaviour in a context where such behaviour had itself become the social norm. Once the second type of drug use became established,

he argued, drug use was transformed from being a symptom of other causes to a causal phenomenon in its own right, one moreover that spread in the presence of just five enabling factors:

- availability of the substance;
- money to acquire the substance;
- time to use the substance;
- examples of use in the immediate environment;
- a permissive ideology in relation to using the substance.

In these circumstances, Bejerot argued, addressing substance misuse by treating individuals was ineffective; what was required was a policy of zero tolerance designed to remove the enabling conditions (Bejerot 1988).

Although Bejerot was influential in shaping Sweden's drug policies, his insistence that drug use be regarded as a criminal rather than health-related problem placed him at odds with the harm minimisation approaches to alcohol and other drug use adopted in many other countries, including Australia under the National Drug Strategy and its predecessors. (Commonwealth of Australia (Department of Health) 2017). For Pearson, however, Bejerot's explanations provided a key to understanding the nature of alcohol and other drug misuse in Aboriginal communities that other explanations, in his view, failed to do. He subsequently attempted to turn these insights into practical measures by proposing a substance misuse strategy for Cape York Aboriginal communities (Pearson 2001b, 2002). The strategy was both comprehensive and ambitious, and was made up of six components:

1. 'Rebuild[ing] a social, cultural, spiritual and therefore legal intolerance of abuse behaviour' by means including empowering Community Justice Groups and a regional Community Justice Board, entering into agreements with government agencies to cover policing, instituting zero tolerance of illicit drug use in the community;
2. Controlling availability and supply by banning take-away sales from canteens and banning the importation of alcohol into communities with canteens;
3. Managing money by, for example, implementing personal and family income management programs, providing counselling for gambling;
4. Managing time by, for example, running sport and recreation programs and staging events such as rodeos;
5. Expanding treatment and rehabilitation options including screening in primary health centres, AA-based counselling programs for addicts and 'codependants', medically supervised detox facilities in hospitals and enhanced treatment and rehabilitation facilities including provision for mandatory treatment;
6. Improving home and community environments by redefining local government responsibilities, developing local 'Pride of Place' strategies and working with government agencies to support families in communities aspiring to own their own homes (Pearson 2002).

Pearson's analysis of the nature and impact of substance misuse was linked to another phenomenon that, in his view, was corroding Aboriginal society—what he

called 'passive welfare', which he described as "unconditional cash pay-outs to needy citizens of whom nothing further will be required" (Pearson 2000: 137). Passive welfare according to Pearson traps recipients in an artificial economy unsupported by the responsibility and reciprocity of genuine economic activity; it becomes a method of governance, in which decisions are made on behalf of clients by bureaucrats, and a mentality, as a result of which recipients come to see themselves as victims, with rights to assistance without reciprocation (Pearson 2000). In a 2001 lecture ironically entitled 'On the human right to misery, mass incarceration and early death', Pearson argued that passive welfare, together with the epidemic of substance misuse, threatened the very survival of Aboriginal societies (Pearson 2001a).[4]

In the two decades that have elapsed since Pearson formulated his critique, some elements of his approach have been implemented. Restrictions on alcohol availability were introduced in 2002 by the Queensland Government in response to an inquiry into alcohol-related violence in Cape York Aboriginal communities (Queensland Government 2002). This response and the events leading up to it are discussed in Chap. 5 below. Other parts of the Cape York strategy, such as expanded treatment and rehabilitation options, were promised by the Queensland Government but never delivered. Family Income Management programs have also been set up in five Far North Queensland communities under the Cape York Income Management Program administered by the Family Responsibilities Commission, a statutory body composed of Elders from member communities.[5] There appears to be little appetite, however, either within Aboriginal communities or in the policy-making domain for the uncompromising zero-tolerance stance that Pearson advocated. Nonetheless, his conceptualisation of alcohol and other drug (AOD) misuse as a social epidemic, rather than a symptom of underlying causes, is valuable in pointing to the need for AOD intervention at a community as well as individual level.

2.7 Alcohol and the Social Determinants of Health

Another explanatory framework that draws both on the sociological perspectives outlined above and the discipline of social epidemiology is the 'social determinants of health' model of population health (Marmot and Wilkinson 2005b; Marmot et al. 1984; Marmot et al. 1991). From the perspective of this framework, the key drivers of health—and the factors that offer the most effective means of improving health—are to be found in the social environments into which people are born and grow up. The model rests on an observed phenomenon known as the 'social gradient in health': in any given population, the distribution of health status on almost all measured health conditions varies directly with socio-economic status. Those at the upper end of the scale are more likely to enjoy good health than those below them, all the way down

---

[4] The full text of Pearson's 2001 address can be downloaded from https://capeyorkpartnership.org.au/wp-content/uploads/2001/10/Dr-Charles-Perkins-Memorial-Oration.pdf.

[5] https://www.frcq.org.au/resources/income-management-models/ (retrieved 31 August 2021).

the socio-economic ladder (Marmot and Wilkinson 2005b). The social gradient is not simply a product of poverty. In the best known empirical demonstration of the social gradient, Marmot and his colleagues monitored the health of a sample of 17,530 British male civil servants over a ten-year period in what has become known as the Whitehall study (Marmot et al. 1984). All the civil servants enjoyed stable, sedentary jobs in the same environment—London—but their status (and incomes) ranged from senior administrative, down through professional, clerical and more lowly 'other' levels. The study found that men in the lowest grades had a mortality rate from coronary heart disease—and from all causes of death combined—three times higher than those in the highest administrative grades.

Australia exhibits its own social gradient in health, as Turrell and Mathers (2000) have shown. They found that, while health status across the whole population had improved over recent decades, socio-economic inequalities in mortality and many types of illness had not merely persisted but in some cases increased. The extent to which the health of Indigenous populations is shaped by a social gradient has not been well researched (Carson et al. 2007; Shepherd et al. 2011). Shepherd et al. reviewed existing studies of health among Aboriginal and Torres Strait Islander Australians and concluded that, in light of a dearth of studies and methodological problems among existing studies, it was not possible to describe the nature or strength of the relationship between health and socio-economic status, but that there was consistent evidence for a social gradient with respect to mortality, kidney disease, diabetes and smoking status (Shepherd et al. 2011).

While the causal pathways by which environmental factors shape health outcomes remain a matter of ongoing investigation (Krieger 2001; Saggers and Gray 2007), there is broad agreement on the factors themselves. A 2003 study commissioned by the WHO Regional Office for Europe identified ten key factors in creating the social gradient in health: stress, early childhood experiences, social exclusion, working conditions, unemployment, inadequate social support, addiction, food quality and transport policy. As Gray et al. observe, all these factors weigh disproportionately on Aboriginal Australians compared to most other Australians (Gray et al. 2018).

The social determinants perspective does not downplay the part played by behaviours such as alcohol misuse in contributing to poor health and wellbeing outcomes, or the need for programs aimed at changing these behaviours. It does, however, direct our attention to the social, economic and cultural processes that foster alcohol misuse in particular settings—to what Marmot and others have labelled 'the causes of the causes', such as availability, price, drinking cultures and the lack of alternative recreational or productive activities (Marmot and Wilkinson 2005a). It also follows from the social determinants perspective that we should not expect significant gains from, say, improved alcohol treatment services as long as major social determinants of poor health remain unaddressed.

2.8   Alcohol and Intergenerational Trauma

In the early 1990s, an alternative approach to understanding and intervening in Aboriginal alcohol problems began to gain influence in Australia, centred on the concept of unresolved intergenerational trauma. The approach originated in North America and was shaped by two inter-related beliefs. The first was that Western medical or psychological therapeutic approaches did not provide an adequate foundation for addressing the collective and personal trauma of colonisation and dispossession to which indigenous peoples in countries such as Canada, the United States, New Zealand and Australia had been subjected. The second belief was that indigenous cultures contained their own healing practices that were better suited to lead people on a 'healing journey' (Peeters et al. 2014).

Healing from this perspective is grounded in indigenous understandings of health and wellbeing rather than Western frameworks. Whereas the latter tend to locate problems and solutions alike in the individual substance user, wellbeing from an indigenous perspective is about relationships with family and community, with other natural elements of the surrounding environment, and with the ancestors. Healing is a process or journey designed to reconnect and restore the social, emotional and spiritual relationships that have been damaged through colonisation and its aftermath. An important source through which this approach became influential in Australia was the Nechi Institute and the associated Poundmakers Lodge in Edmonton, Alberta, Canada (Brady 1995). Established in 1974 by First Nations people, the Nechi Institute and Poundmakers Lodge offered residential treatment that combined an adaptation of the 12-step AA model of addiction with traditional First Nations healing practices such as medicine wheels and sweat lodges. Through the early 1990s, representatives of Nechi and Poundmakers visited Australia and gave public lectures, while at the same time numerous Aboriginal Australians visited the Canadian facilities.[6] One of these was Gregory Phillips, who later published a study of alcohol, marijuana use and gambling in a Cape York community in which he had grown up, to which he gave the fictitious name of 'Big River' (Phillips 2003). Phillips argued that understanding addictive behaviours among Aboriginal people required an appreciation of the presence of unresolved traumatic episodes, the impact of historical processes and the importance of culture and spirituality in the healing process. According to his analysis, displacement and settler violence were followed by strict mission control and surveillance into the 1970s. During this time, traditional, culturally valued ways of dealing with trauma, such as ceremonies and cultural and spiritual life, were suppressed, leaving alcohol, when it became available, as the most accessible if illusory way of dealing with unresolved trauma. This in turn led to more violence and trauma, and so the cycle continued: rage turned inwards, often directed to those closest (Phillips 2003).

---

[6] The first known visit by an Australian Aboriginal person to the Nechi Institute in fact occurred much earlier—in 1975—when Chicka Dixon, an influential activist, visited the Institute and was impressed by what he saw as a path that Australian Aborigines could emulate. Brady (1995)

According to Phillips, while some models of addiction, such as the disease model discussed above, recognise a spiritual dimension in addiction, biomedical models—along with harm reduction and public health approaches—do not. They are based on a mind–body model of humans that has no place for 'heart' or 'spirit'. In Chap. 4 (Sect. 4.5) below, we return to this critique of the biomedical model and caution against applying the label to all non-Aboriginal understandings of health, wellbeing and illness. Here, we focus on tracing the emergence of a new and distinctive model of healing.

In April 1993, Judy Atkinson, then an Aboriginal PhD student at the Queensland Institute of Technology (QUT), began helping a group of residents in the city of Rockhampton to address issues of Aboriginal family violence. The group met regularly over the next 12 months, during which participants developed a program of 'mutual support and self-supporting growth' that became, in time, We-Al Li—a Wappaburra (Keppel Islander) term meaning 'fire and water', connoting cleansing and regeneration (Atkinson 1994: 9). Workshops developed under the program sought to identify the layers of trauma and pain that extended in many cases over several generations, from beginnings in colonial violence and expropriation through the decades of institutional control, and to transform the pain into a source of strength (Atkinson 1994). Atkinson described the principles underpinning the first We-Al Li workshops in an article published in 1994.

Box 2.6 Layers of Pain
From Atkinson (1994: 10)

The common factor linking the individual and group experience was pain and the behaviours arising from unhealed pain: pain of violation and loss; pain in anger; pain in feeling helpless and powerless; pain of despair; and the fear of more pain (especially if the reality of the family situation was exposed). Such family and intra-community trauma has repercussions on the total wellbeing of Aboriginal families and communities across generations into the future.

To survive over the years, many Aboriginal people have had to suppress and/or deny their feelings of distress and despair. The pain becomes internalised within the family. For many, to focus on the abuse feels like betrayal. Denial requires the pain to be pushed down further. For such people, the only reality is the mantle and demeanour of pain. They neither see nor feel their own experiences as harmful or that they are hurting others through their own damaging behaviours. For the cycle to be broken, the WE-AL Li group saw the most essential need was to create safe places, healing circles or environments where people could start to break the denial, talk together and share stories.

To paraphrase the words of bell hooks,[7] we were inspired by the knowledge that we could take our pain, work with it, transform it and recycle it so it could become the source of our power. We understood the power of the ring, or circle place where all are equal within the circle, learners and teachers together.

WE-AL Li workshops do not tell people what violence is. Rather the group workshop process enables people to name and own abusive behaviours and attitudes from their own experiences and to see the connections between physical, mental, emotional and spiritual injuries across the generations and cultures. The emphasis is on personal and group responsibility through sharing and healing in holistic learning situations, as individuals within the group explore behaviours and define strategies for individual, family and community transformation.

The full text of the article from which the above extract is taken is available at https://search.informit.org/doi/10.3316/ielapa.282996974682707.

The We-Al Li workshops were based on another concept that expresses a profound and distinctively Aboriginal spiritual practice: *Dadirri*, meaning 'inner deep listening and quiet still awareness' (Bauman and Miriam-Rose 1988: 1). The term comes from the Ngan'gikurunggurr and Ngen'giwumirri languages of the Daly River region in the Northern Territory, and has been described most eloquently by the Aboriginal thinker, artist and teacher Miriam-Rose Ungunmerr Baumann (who in 2021 was named Senior Australian of the Year). An extract from her description is reproduced below.

Box 2.7 Dadirri: Inner Deep Listening and Quiet Still Awareness

A reflection by Miriam-Rose Ungunmerr (Bauman and Miriam-Rose 1988)

…

Many Australians understand that Aboriginal people have a special respect for Nature. The identity we have with the land is sacred and unique. Many people are beginning to understand this more. Also, there are many Australians who appreciate that Aboriginal people have a very strong sense of community. All persons matter. All of us belong. And there are many more Australians now, who understand that we are a people who celebrate together.

What I want to talk about is another special quality of my people. I believe it is most important. It is our most unique gift. It is perhaps the greatest gift

---

[7] The name bell hooks was the pen-name of Gloria Jean Watkins, a well-known American author, feminist and social activist who wrote extensively about relationships between race, gender and capitalism. She died in December 2021.

we can give to our fellow Australians. In our language, this quality is called *dadirri*. It is inner, deep listening and quiet, still awareness.

Dadirri recognises the deep spring that is inside us. We call on it and it calls to us. This is the gift that Australia is thirsting for. It is something like what you call 'contemplation'.

When I experience *dadirri*, I am made whole again. I can sit on the riverbank or walk through the trees; even if someone close to me has passed away, I can find my peace in this silent awareness. There is no need for words. A big part of *dadirri* is listening.

Through the years, we have listened to our stories. They are told and sung, over and over, as the seasons go by. Today we still gather around the campfires and together we hear the sacred stories.

As we grow older, we ourselves become the storytellers. We pass on to the young ones all they must know. The stories and songs sink quietly into our minds, and we hold them deep inside. In the ceremonies we celebrate the awareness of our lives as sacred.

The contemplative way of *dadirri* spreads over our whole life. It renews us and brings us peace. It makes us feel whole again.

In our Aboriginal way, we learnt to listen from our earliest days. We could not live good and useful lives unless we listened. This was the normal way for us to learn—not by asking questions. We learnt by watching and listening, waiting and then acting. Our people have passed on this way of listening for over 40,000 years.

There is no need to reflect too much and to do a lot of thinking. It is just being aware.

My people are not threatened by silence. They are completely at home in it. They have lived for thousands of years with Nature's quietness. My people, today, recognise and experience in this quietness, the great Life-Giving Spirit, the Father of us all. It is easy for me to experience God's presence. When I am out hunting, when I am in the bush, among the trees, on a hill or by a billabong, these are the times when I can simply be in God's presence. My people have been so aware of Nature. It is natural that we will feel close to the Creator.

The full text of Dr Ungunmerr Baumann's reflection is at https://www.miriam rosefoundation.org.au/dadirri/.

As the extract above shows, for Dr Ungunmerr Bauman, *dadirri* incorporates both Aboriginal and Christian spiritual streams, in part reflecting her own experience growing up in what for several years was a Catholic Mission, and in part, perhaps, the way in which spiritual experiences are both grounded in and transcend particular cultural and historical settings.

Since its beginnings in 1993, the We-Al Li program has continued to expand.[8] In 1997, the program was granted tertiary accreditation (Atkinson et al. 2014). In 2006, Atkinson published a more detailed, book-length account of the We-Al Li program (Atkinson 2006), and in 2014, together with several colleagues, she published an account in which the We-Al Li program is described as 'a trauma-specific blend of Aboriginal traditional healing activities and western therapeutic processes' (Atkinson et al. 2014: 298). The full text of the 2014 article is available for free download at https://www.telethonkids.org.au/globalassets/media/documents/aboriginal-health/working-together-second-edition/wt-part-4-chapt-17-final.pdf.

The establishment by the Commonwealth Government of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families in 1995, followed two years later by the tabling of the inquiry report *Bringing them Home*, led to Indigenous healing practices becoming more prominent at a policy level (National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families 1997). The report recommended that "all services and programs provided for survivors of forcible removal emphasise local Indigenous healing and well-being perspectives".[9] In 2009, a year after the Commonwealth Government issued a formal apology to those who became known as the Stolen Generations, the Government funded the establishment of an Aboriginal and Torres Strait Islander Healing Foundation (Caruana 2010).

In Chap. 4 below, we further explore the application of Aboriginal healing practices to treating alcohol and other drug problems, identifying associated issues and steps being taken to address them.

2.9 Conclusion

Each of the interpretive frameworks outlined above offers a distinctive approach to defining and explaining some types of drinking by some Aboriginal people as a problem requiring attention, and each leads to particular kinds of programs. The frameworks are not necessarily mutually exclusive; some descriptions and explanations combine more than one. The first approach considered above—based on the belief that Aboriginal people are biologically more susceptible than other 'races' to adverse effects of drinking and must therefore be prevented from accessing alcohol—is of historical relevance only as the justification for around a century of prohibition of Aboriginal drinking (although whether it has entirely disappeared from the stock of popular beliefs is far from certain). Each of the other approaches cited finds expression today in one or more kinds of intervention: the disease concept of alcoholism in both residential alcohol treatment programs and, often, in trauma-informed healing programs; psychological approaches in cognitive behavioural and other therapies; the

---

[8] See We Al-li—Culturally Informed Trauma Integrated Healing Training (wealli.com.au).

[9] Recommendation 33A at https://bth.humanrights.gov.au/the-report/report-recommendations (retrieved 31 March 2020).

public health approach in policies and strategies addressing availability and supply of alcohol. Sociological and anthropological approaches point to the importance of addressing underlying or structural issues such as employment and education—a stance that, as we have seen, has also generated criticism from those who insist on addressing alcohol misuse as a primary problem.

In the following chapters, we explore the application of the approaches identified above to programs addressing Aboriginal alcohol-related harms.

References

Albrecht, P.G.E. 1974. The social and psychological reasons for the alcohol problem among Aborigines. In *Better health for aborigines? report of a national seminar at Monash University*, eds. by Hetzel, B.S., M. Dobbin, L. Lippman and E. Eggleston. St Lucia, Qld: University of Queensland Press.

Anthony, Thalia. 2007. Reconciliation and conciliation: the irreconcilable dilemma of the 1965 'Equal' wage case for aboriginal station workers. *Labour History* 93: 15–34.

Atkinson, Judy. 2006. *Trauma trails, recreating song lines: the transgenerational effects of trauma in indigenous Australia.* Spinifex Press: North Melbourne.

Atkinson, J., J. Nelson, R. Brooks, C. Atkinson, and K. Ryan. 2014. Addressing individual and community transgenerational trauma. In *Working together: aboriginal and torres strait islander mental health and wellbeing principles and practice*, eds. by Dudgeon, P., H. Milroy and R. Walker. Canberra: Australian Government Department of the Prime Minister and Cabinet, Telethon Institute for Child Health Research/Kulunga Research Network and University of Western Australia.

Atkinson, J. 1994. Recreating the circle with We Al-Li: a program for healing, sharing and regeneration. *Aboriginal and Islander Health Worker Journal* 18: 8–13.

Bain, MS. 1974. Alcohol use and traditional social control in Aboriginal society. In *Better health for aborigines? report of a national seminar at Monash University,* eds. by Hetzel, B.S., M. Dobbin, L. Lippman and E. Eggleston. St Lucia: University of Queensland Press.

Beckett, J. 1964. Aborigines, alcohol and assimilation. In *Aborigines now: new perspectives in the study of aboriginal communities*, ed. by Reay, M. Sydney: Angus and Robertson.

Bejerot, Nils. 1980. Addiction to pleasure: a biological and social-psychological theory of addiction. *NIDA Research Monograph* 30: 246–255.

Bejerot, Nils. 1988. *The Swedish addiction epidemic in global perspective. Talk given to The Swedish Carnegie Institute, Stockholm.* Stockholm: The Swedish Carnegie Institute. http://www.rns.se/artiklar/pol/bej1eng.html.

Berridge, Virginia. 1993. The nature of the target disorder: an historical perspective. In *Drugs, Alcohol, and Tobacco: Making the Science and Policy Connections* eds. by Edwards, G., J. Strang and Jerome H. Jaffe (Oxford University Press: Oxford).

Brady, Maggie. 1995. Culture in treatment, culture as treatment: a critical appraisal of developments in addictions programs for indigenous North Americans and Australians. *Social Science and Medicine* 41: 1487–1498.

Brady, M, and K Palmer. 1984. *Alcohol in the outback*. Darwin: North Australia Research Unit, Australian National University.

Brady, Maggie. 1991. Drug and alcohol use among Aboriginal people. In *The health of aboriginal Australia*, eds. by Reid, J., and P Trompf. Sydney: Harcourt Brace Jovanovich.

Bruun, Kettil, Griffith Edwards, Martti Lumio, Klaus Mäkelä, Lynn Pan, Robert E Popham, Robin Room, Wolfgang Schmidt, Ole-Jørgen Skog, Pekka Sulkunen, and Esa Österberg. 1975. *Alcohol control policies in public health perspective.* Helsinki: Finnish Foundation for Alcohol Studies.

Bryant, Val, and Jim Carroll. 1978. Aboriginal alcoholism—where are we going?: white Man's Way or Black Man's Way? [online]. *Aboriginal and Islander Health Worker Journal* 2: 29–31.

Bunton, Robin. 2001. Knowledge, embodiment and neo-liberal drug policy, *Contemporary Drug Problems*, 28: 221–243.

Carson, Bronwyn, Terri Dunbar, R. Chenhall, and R.S. Bailie (eds.). 2007. *Social determinants of indigenous health.* Routledge: London and New York.

Caruana, C. 2010."Healing services for Indigenous people. In *Family relationships quarterly (The Newsletter of the Australian Family Relationships Clearinghouse)*, pp. 3–10. Melbourne: Australian Institute of Family Studies.

Chenhall, Richard D. 2007. *Benelong's haven: recovery from alcohol and drug use within an aboriginal Australian residential treatment centre.* Melbourne University Press: Carlton, Victoria.

Chikritzhs, Tanya, Tim Stockwell, and Richard Pascal. 2005. The impact of the Northern Territory's living with alcohol program 1992–2002: revisiting the evaluation. *Addiction* 100: 1625–1636.

Chikritzhs, Tanya, Paul Catalano, Tim Stockwell, Susan Donath, Hanh Ngo, Deidra Young, and Sharon Matthews. 2003. *Australian alcohol indicators: patterns of alcohol use and related harms for Australian States and Territories 1990–2001.* Perth: National Drug Research Institute, Curtin University of Technology.

Clark, Jennifer. 2008. *Aborigines and activism: race, aborigines and the coming of the sixties to Australia.* University of Western Australia Press: Crawley, WA.

Collmann, J. 1979. Social order and the exchange of liquor: a theory of drinking among Australian Aborigines. *Journal of Anthropological Research* 25: 208–224.

Collmann, J. 1988. *Fringe-dwellers and welfare: the Aboriginal response to bureaucracy.* University of Queensland Press: St Lucia.

Commonwealth of Australia (Department of Health). 2017. *National drug strategy 2017–2026.* Commonwealth of Australia (Department of Health): Canberra.

Commonwealth of Australia House of Representatives Standing Committee on Aboriginal Affairs. 1976. *Alcohol problems of aboriginals: interim report on Northern Territory Aspects. Parliamentary Paper No. 242/1976.* Commonwealth of Australia: Canberra.

Commonwealth of Australia House of Representatives Standing Committee on Aboriginal Affairs. 1977. *Alcohol problems of aboriginals: final report.* Canberra.

Cowlishaw, Gillian. 1994. Policing the races. *Social Analysis* 36: 71–92.

Cunningham, J.K., T.A. Solomon, and M.L. Muramoto. 2016. Alcohol use among Native Americans compared to whites: examining the veracity of the "Native American elevated alcohol consumption" belief. *Drug and Alcohol Dependence* 160: 65–75. https://doi.org/10.1016/j.drugalcdep.2015.12.015.

d'Abbs, P. 2004a. Alignment of the policy planets: behind the implementation of the Northern Territory (Australia) living with alcohol programme. *Drug and Alcohol Review* 23: 55–66. https://doi.org/10.1080/09595230410001645556.

d'Abbs, Peter. 2004b. Alignment of the policy planets: behind the implementation of the Northern Territory (Australia) living with alcohol program. *Drug and Alcohol Review* 23: 55–65.

Edwards, Griffith, and Milton M Gross. 1976. Alcohol dependence: provisional description of a clinical syndrome, *British Medical Journal* 1:1058–1061

Edwards, Griffith, Milton M Gross, M Keller, J Moser, and R Room 1977. *Alcohol-Related Disabilities* (World Health Organization: Geneva).

Eggleston, Elizabeth. 1974. Legal controls on alcohol. In *Better Health for aborigines? report of a national seminar at Monash University*, eds. by Hetzel, B.S., Malcolm Dobbin, Lorna Lippmann, and Elizabeth Eggleston. St Lucia: University of Queensland Press.

Enoch, Mary-Anne. 2013. Genetic influences on the development of alcoholism. *Current Psychiatry Reports* 15: 412. https://doi.org/10.1007/s11920-013-0412-1.

Fingarette, H. 1991. Alcoholism: the mythical disease. In *Society, culture, and drinking patterns re-examined*, eds. by J Pittman, David, and Helene Raskin White. New Brunswick: Rutgers Center of Alcohol Studies.

Gibson, Mervyn. 1987. *Anthropology and tradition: a contemporary Aboriginal viewpoint.* Townsville, Queensland: Paper presented to ANZAAS Conference 'Peoples of the North'.

Gray, Dennis, Kimberly Cartwright, Anna Stearne, Sherry Saggers, Edward Wilkes, and Mandy Wilson. 2018. *Review of the harmful use of alcohol among Aboriginal and Torres Strait Islander people.* Australian Indigenous HealthInfoNet Perth: Perth.

Harney, W.E. 1946. *North of 23°: Ramblings in Northern Australia.* Sydney: Australasian Publishing Co. Pty Ltd.

Healy, B., T. Turpin, and M. Hamilton. 1985. Aboriginal drinking: a case study in inequality and disadvantage. *Australian Journal of Social Issues* 20: 191–208.

Heath, Dwight B. 1983. Alcohol use among North American Indians: a cross-cultural survey of patterns and problems. In *Research advances in alcohol and drug problems*, eds. by Smart, R.G., F.B. Glasser, Y. Israel, H. Kalant, and Robert E Popham. Plenum, New York.

Hetzel, Basil S, Malcolm Dobbin, Lorna Lippmann, and Elizabeth Eggleston (eds.). 1974. *Better health for aborigines? report of a national seminar at Monash University.* St Lucia, Queensland: University of Queensland Press.

Hore, B.D. 1991. The disease concept of alcoholism. In *Society, culture and drinking patterns reexamined*, eds. by J Pittman, David, and Helene Raskin White. New Brunswick: Rutgers Center of Alcohol Studies.

Hunt, H. 1981. Alcoholism among Aboriginal people. *Medical Journal of Australia* 2: 1–3.

Hunter, Ernest. 1993. *Aboriginal health and history: power and prejudice in remote Australia.* Cambridge University Press: Cambridge, UK.

Inquiry, National, and into the Separation of Aboriginal and Torres Strait Islander Children from their Families. 1997. *Bringing them home: report of the national inquiry into the separation of aboriginal and torres strait islander children from their families.* Human Rights and Equal Opportunity Commission: Sydney.

Jellinek, E.M. 1960. *The disease concept of Alcoholism.* Hillhouse Press: New Haven.

Jellinek, E.M. 1991. Phases of alcohol addiction. In *Society, culture, and drinking patterns reexamined*, eds. by J Pittman, David, and Helene Raskin White. New Brunswick: Rutgers Center of Alcohol Studies.

Kamien, M. 1975. Aborigines and alcohol intake, effects and social implications in a rural community in western New South Wales. *Medical Journal of Australia* 1: 291–298.

Kamien, M. 1978. *The dark people of Bourke: a study of planned social change.* Australian Institute of Aboriginal Studies: Canberra.

Kelly, John F. 2019. E. M. Jellinek's Disease Concept of Alcoholism. *Addiction* 114: 555–59. https://doi.org/10.1111/add.14400.

Krieger, Nancy. 2001. Theories for social epidemiology in the 21st century: an ecosocial perspective. *International Journal of Epidemiology* 30: 668–677.

Langton, Marcia, Leslie Ah Matt, Bonita Moss, Evelyn Schaber, Chips Mackinolty, Merle Thomas, Edward Tilton, and Lloyd Spencer. 1991. Too Much Sorry Business: Report of the Aboriginal Issues Unit of the Northern Territory. In *National report of the royal commission into aboriginal deaths in custody*, ed. by Johnston, E. Canberra: Australian Government Publishing Service.

Langton, M. 1992. Too much sorry business. *Aboriginal and Islander Health Worker Journal* 10–23.

Larsen, K.S. 1980. Aboriginal group identification and problem drinking. *Australian Psychologist* 15: 385–392.

Manderson, Desmond. 1993. *From Mr Sin to Mr Big: a history of Australan drug laws.* Oxford University Press: South Melbourne.

Manderson, Desmond. 1999. Symbolism and racism in drug history and policy. *Drug and Alcohol Review* 18: 179–186.

Marinovich, N., O. Larsson, and K. Barber. 1976. Comparative metabolism rates of ethanol in adults of Aboriginal and European descent. *Medical Journal of Australia, Special Supplement* 1: 44–46.

Marmot, Michael, and Richard Wilkinson. 2005a. Introduction. In *Social determinants of health*, eds. by Marmot, Michael, and Richard Wilkinson. Oxford: Oxford University Press.

Marmot, M.G., M.J. Shipley, and Geoffrey Rose. 1984. Inequalities in death—specific explanations of a general pattern? *The Lancet* 323: 1003–1006. https://doi.org/10.1016/S0140-6736(84)923 37-7.

Marmot, M.G., S. Stansfeld, C. Patel, F. North, J. Head, I. White, E. Brunner, A. Feeney, M.G. Marmot, and G. Davey Smith. 1991. Health inequalities among British civil servants: the Whitehall II study. *The Lancet* 337: 1387–93. https://doi.org/10.1016/0140-6736(91)93068-K.

Marmot, Michael, and Richard Wilkinson. 2005b. *Social determinants of health.* Oxford: Oxford University Press.

Martin, D.F. 1993. Autonomy and Relatedness: an ethnography of Wik people of Aurukun, western Cape York peninsula, Ph.D. thesis, PhD, Australian National University.

Martin, David. 1998. *The supply of alcohol in remote Aboriginal communities: potential policy directions from Cape York. CAEPR Discussion Paper No. 248.* Canberra: Centre for Aboriginal Economic Policy Research, Australian National University.openresearch-repository.anu.edu.au/handle/1885/145592?mode=full. Accessed 3 June 2021.

McKnight, David. 2002. *From hunting to drinking: the devastating effects of alcohol on an australian aboriginal community.* Routledge: London.

National Aboriginal Health Strategy Working Party. 1989. *A national aboriginal health strategy.*Canberra: Department of Aboriginal Affairs.

Northern Territory Government. 1991. *Living with alcohol in the Northern Territory: a framework for action to reduce the costs of alcohol related harm to the Northern Territory 1991–2000 (unpublished).* Darwin: Northern Territory Government.

Parliament of the Commonwealth of Australia. 1963. *Aboriginal welfare: conference of commonwealth and state ministers, Darwin, July, 1963, Statement of Policy, Resolutions of Conference, Ministerial Statement. Papers presented to Parliament, 24th Parliament, 1st Session 1962–63,* vol. 3, pp.649–656. Canberra.

Pearson, Noel. 2000. Passive welfare and the destruction of indigenous society in Australia. In *Reforming the Australian Welfare State*, ed. by Saunders, P. Melbourne: Australian Institute of Family Studies.

Pearson, Noel. 2001a. On the human right to misery, mass incarceration and early death: the Charles Perkins Memorial Oration. *Quadrant*.

Pearson, Noel. 2001b. *Outline of a grog and drugs (and therefore violence) strategy.* Cairns: Unpublished Paper.

Pearson, Noel. 2002. *Cape York Peninsula substance misuse strategy.*Cairns: Alcohol and Drugs Working Group, Apunipima Cape York Health Council.

Peeters, L., S. Hamann, and K. Kelly. 2014. ʼthe marumali program: healing for stolen generations. In *Working together: aboriginal and torres strait islander mental health and wellbeing principles and practice,* 2nd edn eds. by Dudgeon, P., H. Milroy and R. Walker. Canberra: Telethon Institute for Child Health Research/Kulunga Research Network and University of Western Australia.

Perkins, Charles. 1977. Alcohol problems and suitable solutions. *Aboriginal and Islander Health Worker Journal* 1: 21–24.

Phillips, Gregory. 2003. *Addictions and healing in Aboriginal Country*. Aboriginal Studies Press: Canberra.

Pitjantjatjara Council Inc. 1990. *Submission to the sessional committee on the use and abuse of alcohol by the community, legislative assembly of the Northern Territory*. Alice Springs: Pitjantjatjara Council Inc.

Queensland Government. 2002. *Meeting challenges, making choices: the queensland government's response to the Cape York justice study.*Brisbane: Queensland Government.

Roizen, Ron. 2004. How does the nation's ʼalcohol problem' change from era to era? Stalking the social logic of problem-definition transformations since Repeal. In *Altering the American Consciousness: Essays on the History of alcohol and Drug Use in the United States, 1800–2000,* eds. by Tracy, S., and C. Acker. Amherst: University of Massachusetts Press.

Room, Robin. 1984. Alcohol and ethnography: a case of problem deflation? *Current Anthropology* 25: 169–191.

Room, Robin. 1998. Alcohol and drug disorders in the international classification of diseases: a shifting kaleidoscope. *Drug and Alcohol Review* 17: 305–317.

Rowley, C.D. 1972. *Outcasts in white Australia.* Penguin Books: Harmondsworth.

Sackett, L. 1988. Resisting arrests: Drinking, development and discipline in a desert context. *Social Analysis* 24: 66–77.

Saggers, S, and D Gray. 2007. Defining what we mean. In *Social Determinants of Indigenous Health*, eds. by Carson, Bronwyn, Terri Dunbar, R. Chenhall and R.S. Bailie. Routledge, London and New York.

Saggers, Sherry, and Dennis Gray. 1998. *Dealing with alcohol: indigenous usage in Australia, New Zealand and Canada.* Cambridge University Press: Cambridge, UK.

Sansom, Basil. 1980. *The camp at wallaby cross: aboriginal Fringe Dwellers in Darwin.* Australian Institute of Aboriginal Studies: Canberra.

Shepherd, Carrington C. J., Jianghong Li, and Stephen R. Zubrick. 2011. Social gradients in the health of indigenous Australians. *American Journal of Public Health* 102: 107–117. https://doi.org/10.2105/AJPH.2011.300354.

Skov, Steven, Tanya Chikritzhs, Shu Li, Sabine Pircher, and Steven Whetton. 2010. How much is too much? alcohol consumption and related harm in the Northern Territory. *Medical Journal of Australia* 193: 269–272.

Smith, D.I. 1983. Effectiveness of restrictions on availability as a means of reducing the use and abuse of alcohol. *Australian Alcohol and Drug Review* 2: 84–90.

Smith, D.I. 1988. Effectiveness of restrictions on availability as a means of preventing alcohol-related problems. *Contemporary Drug Problems* 15: 627–684.

Stockwell, Tim, Tanya Chikritzhs, Delia Hendrie, Richard Fordham, Faith Ying, Mike Phillips, Joanne Cronin, and Bridie O'Reilly. 2001. The public health and safety benefits of the Northern Territory's Living With Alcohol Programme. *Drug and Alcohol Review* 20: 167–180.

Travis, Trysh. 2009. *the language of the heart: a cultural history of the recovery movement from alcoholics anonymous to Oprah Winfrey.* University of North Carolina Press: Chapel Hill.

Turrell, Gavin, and Colin D Mathers. 2000. Socioeconomic status and health in Australia. *Medical Journal of Australia* 172: 434–38. https://doi.org/10.5694/j.1326-5377.2000.tb124041.x.

Ungunmerr Bauman, Miriam-Rose. (1988). *Dadirri: inner deep listening and quiet still awareness—a reflection by Miriam-Rose Ungunmerr.*Nauiyu (Daly River). NT: Miriam Rose Foundation. www.miriamrosefoundation.org.au/dadirri/. Accessed 31 May 2021.

Valverde, Mariana. 1998. *Diseases of the will: alcohol and the dilemmas of freedom.* Cambridge: Cambridge University Press.

Warrior, Robert, and J. Kehaulani Kauanui. 2018. Patrick Wolfe on settler colonialism. In *Speaking of indigenous politics: conversations with activists, scholars, and Tribal Leaders*, *Project MUSE. muse.jhu.edu/book/58884*, ed. by J. Kehaulani Kauanui. Minneapolis: University of Minnesota Press.

Watson, C., J. Fleming, and K. Alexander. 1988. *A survey of drug use patterns in Northern Territory aboriginal communities: 1986–1987* (Northern Territory Department of Health and Community Services, Drug and Alcohol Bureau: Darwin).

Wolfe, Patrick. 2006. Settler colonialism and the elimination of the native. *Journal of Genocide Research* 8: 387–409. https://doi.org/10.1080/14623520601056240.

World Health Organization. 2022. *ICD-11 International classification of diseases for mortality and morbidity statistics 11th revision, 2022 release.* World Health Organization: Geneva.

Chapter 3
Prevention and Early Intervention

Artwork by Delvene Cockatoo-Collins

55

Abstract This chapter focuses on primary prevention—programs designed to prevent or delay the commencement of harmful alcohol use—and secondary prevention, also called early intervention, namely programs targeting those who are already engaging in harmful alcohol use or considered at risk of doing so. Historically, programs addressing alcohol problems among Aboriginal people have emphasised primary prevention, especially through media campaigns and health promotion initiatives, and residential treatment, at the expense of early intervention. Primary prevention initiatives are reviewed. The evidence base for program effectiveness is sparse, although it is difficult to distinguish the effects of poor program quality from that of poor (or non-existent) evaluations. The limited evidence available suggests that a high level of community involvement, multi-component programs, promotion of cultural connectivity and skills development are all factors conducive to effective primary prevention. Initiatives in screening and early intervention are also reviewed. The chapter describes efforts to embed screening and early interventions in primary healthcare settings, and the barriers encountered in these efforts. The chapter also examines recent initiatives aimed at surmounting these barriers.

3.1   Introduction

Both the National Alcohol Strategy and the National Drug Strategy (NDS) in Australia are based on a policy of harm minimisation, as is the National Aboriginal and Torres Strait Islander Peoples Drug Strategy 2014–2019 (Intergovernmental Committee on Drugs (Australia) 2014). This policy in turn rests on three 'pillars': demand reduction, supply reduction and harm reduction (Commonwealth of Australia (Department of Health) 2017; Intergovernmental Committee on Drugs (Australia) 2014; Commonwealth of Australia 2019). Supply reduction measures are designed to reduce availability of alcohol and other drugs; harm reduction measures aim to reduce the harm caused by AOD use both on users themselves and on other people, for example by providing sobering-up shelters for persons intoxicated in public. In this and the following chapters, we focus on the remaining pillar–that is, measures aimed at reducing the demand for alcohol and other drugs.

Demand reduction measures are conventionally categorised according to a three-part prevention typology. In the case of alcohol, this comprises.

- Primary prevention: preventing or delaying uptake of harmful alcohol use among healthy individuals, for example through education and health promotion and provision of alternatives to alcohol and other drug use;

- Secondary prevention, also called early intervention: preventing the onset or continuation of harmful alcohol use among people who are already drinking or at risk of harmful use;
- Tertiary prevention, or treatment and rehabilitation: facilitating recovery from harmful use and/or alcohol dependence and preventing relapse to harmful drinking.[1]

This chapter addresses primary and secondary prevention, while the following chapter looks at tertiary prevention, or treatment and rehabilitation.

Ideally, as the National Aboriginal and Torres Strait Islander Peoples Drug Strategy 2014–2019 notes, a range of options will be available to cater to people with different needs and circumstances, including screening and brief interventions, withdrawal management, pharmacotherapies, counselling, social support and relapse prevention (Intergovernmental Committee on Drugs (Australia) 2014: 12). In reality, the options available to Aboriginal Australians have long been limited. A study published in 1998 confirmed what several critics had been arguing for well over a decade: firstly, that prevention programs for Aboriginal people with alcohol issues were concentrated in the first category—primary prevention—in the form of media campaigns and health promotion initiatives—and in the third category—in residential treatment programs for people who were in many cases in the late stages of drinking careers. Missing were early intervention programs targeting at-risk drinkers with evidence-based interventions designed to prevent them from adopting or continuing harmful drinking (Brady et al. 1998). The second finding was that clients of tertiary treatment services were in most instances offered only a very limited range of abstinence-oriented, disease-based treatment options of dubious effectiveness (Brady et al. 1998). In this chapter, we review developments that have occurred since that time in attempts to rectify these problems and gaps. We begin with primary prevention.

---

[1] Typologies of prevention sometimes specify two additional categories: primordial prevention and quaternary prevention. 'Primordial prevention' refers to measures that target underlying conditions that give rise to risk factors (Kisling and Das 2022). In the case of harmful Aboriginal alcohol use, these would include measures addressing inadequate housing, poor educational outcomes and high unemployment. The concept of quaternary prevention is associated with medical general practice, where it refers to actions taken 'to protect individuals (persons/patients) from medical interventions that are likely to cause more harm than good' (Martins et al. 2018). While adequately resourced primordial prevention measures are clearly required to improve the quality of Aboriginal life in many domains, including alcohol use, we do not use the term in this study as the policies and programs covered by it are beyond the scope of the study.

3.2 Primary Prevention

Primary prevention programs aim to educate people about the use and misuse of alcohol and other drugs, raise awareness, build resilience and/or enhance community capacity to prevent AOD problems. They are usually grounded in health promotion and/or community development principles. A study of alcohol and other drug intervention projects conducted by or for Aboriginal Australians and operating during 1999–2000 identified 277 projects, of which 57 (20.6%) were prevention projects offering one or more of health promotion, sporting, recreational or other alternatives or diversions from alcohol and other drug use, or community development (Gray et al. 2002). Although these projects accounted for one-fifth of all projects, they received only 10.5% of the total expenditure in that year of $35.4 million (Gray et al. 2002).

At present, the evidence base underpinning primary prevention initiatives in Aboriginal communities is sparse. Many primary prevention projects are not evaluated or, if they are, fail to demonstrate any changes in alcohol use or other behaviours. A study of evaluated interventions addressing Aboriginal alcohol use conducted in 2000 identified five health promotion projects, including a school-based education program implemented by the Queensland Department of Education and a Commonwealth-funded tour of NT Aboriginal communities by the band Yothu Yindi—together with a TV commercial (Gray et al. 2000). The study concluded that none of the evaluations demonstrated 'impressive' results, but added that these findings may have owed as much to inappropriate evaluation designs or other methodological flaws as to weaknesses in the programs themselves (Gray et al. 2000). Lee et al. (2013) conducted a systematic review of studies published in peer-reviewed journals between 1990 and 2011 that evaluated programs aimed at reducing substance misuse among young Aboriginal Australians (aged 8–25 years). Eight studies met their inclusion criteria, four of which reported reductions in substance misuse. In two of these, the focus of the interventions was petrol sniffing (Burns et al. 1995; Preuss and Brown 2006). The remaining two targeted alcohol and other drug use, one of them by means of a peer support and skills training program designed to raise self-esteem and reduce drug use (Gray et al. 1998), and the other through a community development-based program of training, recreational and cultural activities (Lee et al. 2008).

On the basis of their review, Lee and her colleagues identified several features common to all of the interventions that appeared to contribute to reductions in substance misuse. These are summarised in the extract in Box 3.1 below.

Box 3.1 Common Elements of Promising Interventions

Extract from Lee et al. (2013: 95)

The four programs that were associated with reductions in substance use shared several common elements: two incorporated cultural activities (Lee et al. 2008; Preuss and Brown 2006), all offered regular rather than one-off initiatives and all involved more than one component. Each was developed with communities to protect young people (and sometimes the whole community) against substance misuse. These broader elements were combined with other elements, such as education on the risks of substance use (Burns et al. 1995; Lee et al. 2008), recreational activities (Lee et al. 2008; Preuss and Brown 2006) or supply control (Burns et al. 1995; Preuss and Brown 2006). Two of these studies reported sustained benefits 20 months (Burns et al. 1995) and 12 years (Preuss and Brown 2006) after implementation, and each included elements of supply control.

School-based education, which is anecdotally a commonly implemented intervention, was not found to be effective in two studies (Gamarania et al. 1998; Sheehan et al. 1995). Although firm conclusions cannot be made based on these limited data, the findings are consistent with studies of general populations showing that school-based education focused on reducing the risks of substance misuse alone has variable effectiveness (Thomas and Perera 2006). Conversely, a small number of social learning-focused school-based prevention programs in general populations have been reported to be effective in reducing substance use (Teesson et al. 2012).

In the general population, although there is some evidence for the effectiveness of multi-component preventive interventions (Foxcroft and Tsertsvadze 2011), there is little evidence comparing these against single-component initiatives. In an Indigenous setting, a broad approach is compatible with the complexity of health and social issues affecting young people (Ministerial Council on Drug Strategy 2006).

The importance of interventions initiated and guided by the local Indigenous community is aligned with national (Ministerial Council on Drug Strategy 2006) and international (World Health Organization 1978) guidelines. This helps foster community acceptance and ownership of the intervention (Ministerial Council on Drug Strategy 2006). The importance of ongoing 'whole' community engagement in the design and delivery of the programs was also emphasised (Ministerial Council on Drug Strategy 2006).

The role of cultural (Ministerial Council on Drug Strategy 2006) and recreational (Cairnduff 2001) activities in reducing substance use is compatible with the current understanding of the risk factors for increased risk of substance use disorders among Indigenous people (Kirmayer et al. 2000). Cultural discontinuity is believed to be a risk factor for poor mental health, suicide, violence

and substance misuse (Kirmayer et al. 2000). Sometimes, whole communities (and young people in particular) may feel 'lost between two cultures' (Kirmayer et al. 2000). This, and social marginalisation, may contribute to a sense of lack of connectedness. Even in general populations, helping young people feel connected to family and school (Bond et al. 2007), or to community (Hawkins et al. 2009), helps protect them against substance misuse and mental health problems (Bond et al. 2007; Loxley et al. 2004). However, these approaches have not been systematically evaluated in an Indigenous context. Cultural or recreational programs are likely to support a sense of social and cultural connectedness and may also offer attractive alternatives (Ministerial Council on Drug Strategy 2006) to substance use.

More recently, Geia et al. (2018) also conducted a systematic review of studies in peer-reviewed journals of programs targeting substance misuse among Australian Indigenous youth. Only four studies met their inclusion criteria, three of which addressed petrol sniffing or other volatile substance misuse rather than alcohol. The sole study that focused on alcohol was an evaluation of a two-year community-wide intervention designed to reduce high-risk, binge drinking among young people in a far north Queensland Aboriginal community (Jainullabudeen et al. 2015). The program included social events, education, and youth-specific sporting and social activities designed to promote self-empowerment. A survey conducted at baseline and at the end of two years revealed a statistically significant reduction of 10% in the proportion of youths who reported having engaged in one or more episodes of short-term risky drinking, and in the frequency of short-term risky drinking for all beverages except wine. Mean expenditure on alcohol during drinking occasions marked by short-term risky drinking also declined, while participants' awareness of what constituted binge drinking and standard drinks rose (Jainullabudeen et al. 2015).

International studies corroborate the findings of the Australian studies referred to above. A review of programs aimed at preventing substance misuse among American Indian and Alaskan Native youths conducted in 2004 by Hawkins et al., while noting the paucity of methodologically sound evaluations, concluded that high levels of community involvement in developing and delivering programs, together with a skills development component, offered the most promising approach (Hawkins et al. 2004). More recently, Snijder et al. conducted a systematic review of evidence relating to substance use prevention programs among Indigenous adolescents in Canada, the US, Australia and New Zealand published between 1990 and 2017 (Snijder et al. 2020). Twenty-six papers which evaluated, between them, 27 prevention programs, met their selection criteria—18 conducted in the US, six in Australia and two in Canada. Fourteen programs were found to have had beneficial substance-related outcomes. Among these, the most common components were (1) a high level of community involvement in developing the program; (2) cultural knowledge enhancement through, for example, activities such as ceremonies and storytelling or learning about traditional practices; (3) skills development, for example, in problem solving,

resistance strategies and interpersonal skills; and (4) substance use education (Snijder et al. 2020). Snijder et al. also identified two domains in which further attention was warranted: family-based programs and the use of computers and online technology in delivering prevention programs to young people.

The principles underpinning good practice in community-based prevention programs are not new, even if they are not always followed. In 1992, the American sociologist Philip May outlined the need for a comprehensive, public health-based approach to preventing and reducing alcohol-related problems in American Indian communities. May cautioned against relying on single policy options or short-term measures, arguing for a range of measures to address both supply of and demand for alcohol. He also identified eight principles for community-based prevention, together with some 'don'ts'. These are reproduced below in Box 3.2 in the belief that they are no less applicable to Aboriginal Australian settings.

Box 3.2 Implementing Community-Based Prevention: Guiding Principles
Extract from May (1992: 47–48)

In terms of implementation, there are several suggestions that can be made.

1. Define where your community is regarding knowledge, attitudes and opinions on alcohol policy and its readiness to work for change and improvement A survey would be of tremendous value here.
2. Develop generalisations that are held by the majority and around which a consensus can be formed.
3. Based on the specific areas of consensus, select specific topics, policy options or techniques that can be pursued and accomplished through study, debate and work plans. For example, if fetal alcohol syndrome is an area of concern and consensus, begin with it. Or, if infant car seats are deemed important, do likewise.
4. Keep community-specific data and records on

   a. baseline indicators of mortality, morbidity (sickness and injury), public opinion and arrests related to alcohol;
   b. the process of intervention on problems; and
   c. the outcome (both intermediate and final) or outcomes of positive action taken.

5. Form explicit and positive ties between all constituencies in the community who play a role in the problem. Included should be the legal community, law enforcement, the media, business, government, schools, churches, service groups, families and others.
6. Emphasise positive programs in the media to keep the public informed and invested.

7. Fine-tune the programs and policies from time to time, for the effectiveness of events such as DUI crackdown recedes in the long run (12–18 months or longer) if the public perceives a reduction in enforcement effort, a reduced likelihood of being apprehended or less likelihood of being negatively affected by the problem.

8. Be creative. Public policy is not a science and cannot be completely fine-tuned so that it can be totally science directed. Seek new approaches that increase the *probability* of improvement; new, creative policies can be assessed retrospectively as to their effectiveness. Some detailed literature on local programs might be helpful.

There are some special issues or pitfalls in prevention that a community must avoid. These issues are very much at risk in western Indian, Native and bordertown communities. Specifically, a comprehensive program must avoid.

- Blaming any one type of individual or group, for alcohol abuse is everyone's problem.
- Championing one particular therapy, approach or ideology over other possible options, for many approaches must play a role.
- Looking for single case, 'magic bullet' approaches.
- Polar arguments such as us versus them; Indian versus non-Indian; or rural versus urban.
- Being coercive with large segments of the non-drinking or light-drinking population by enacting a policy that is radically different from the views of mainstream citizens.
- Focusing narrowly on the treatment, incarceration and processing of chronic alcoholics only.
- Expecting immediate success.
- Expecting 'someone else' (e.g. experts, or the federal or state government) to solve the problem for the community.

Instituting a comprehensive prevention/intervention alcohol policy in a community will take a great deal of detailed study, work and deliberation. It is a complex and complicated task and process. It is also a *contingent* process, that is, one decision will affect many others. Therefore, action in one part of a region will necessitate adjustment of policy in another part. A change in policy in one institution of the region (e.g. legislation) will necessitate an adjustment in other institutions (e.g. law enforcement, media and business).

The full text of the article from which the above extract is taken, together with commentaries on May's article by others, is available at https://coloradosph.cuanschutz.edu/research-and-practice/centers-programs/caianh/journal/past-volumes/volume4.

May's article, when originally published, generated several commentaries that can be read today at the URL above. Among these was a cautionary note about an issue likely to confront any group seeking to change drinking behaviour at a community level, not only in American Indian communities:

> A further important question needing to be answered is how do individuals or communities respond to policies that are at variance with their personal beliefs and values? Alternately, can policy change lead to changes in individual behaviour if there is no personal motivation to change? At a more philosophical level, how far can or should policy be pushed before there is a backlash based on infringement of individual rights? Underlying these and other similar questions is the search for barriers that prevent adherence to policy. On most reservations today there are very extensive policies regarding alcohol use, yet there is also a clear lack of compliance with these policies. We would do well to understand why past efforts to moderate drinking practices through policy means have been ineffective (Beauvais 1992: 77).

One community-led intervention that literally 'ticks all the boxes' in May's list of principles in Box 3.2 is the comprehensive set of alcohol control measures introduced into the Fitzroy Valley of the Kimberley region in north-western Australia from 2007. The origin and evolution of these measures were described in a report prepared in 2010 by the Aboriginal and Torres Strait Islander Social Justice Commissioner. An edited extract from the Commissioner's report is reproduced as a case study in Chap. 5 below. As the extract shows, what began as a 12-month trial of restrictions on take-away alcohol sales from a local outlet in response to a crisis of violence and self-harm evolved into an ongoing, comprehensive community program addressing, among other issues, the presence of Fetal Alcohol Spectrum Disorders (FASD) and Early Life Trauma (ELT) in the community.

Not all such preventive interventions, however, are destined to play out over such a long period and with such far-reaching consequences. The second example we have selected describes an initiative more limited in scope than the Fitzroy Valley example, but one that nonetheless displays the same principles of community leadership, strategic partnerships, clearly defined objectives and a pathway to achieving them. The initiative took place in the small town of Elliott, located 700 km north of Alice Springs in the Northern Territory, in 1991 (Walley and Trindall 1994). At the time, Gwen Walley and Darrin Trindall were Aboriginal Health Promotion Officers stationed in Alice Springs and Tennant Creek in the NT, respectively. They were already known in Elliott as a result of having taken part in several health promotion activities indirectly related to alcohol issues, including working with a women's centre, support for a recreation officer and health education in schools.

At the time of Walley and Trindall's intervention, Elliott had a population of around 400 Aboriginal and 100 non-Aboriginal people. Employment was provided mainly by pastoral properties and government agencies. Recreational facilities were limited, and many middle-aged and older people—both Aboriginal and non-Aboriginal—pursued a lifestyle that often involved heavy drinking (Walley and Trindall 1994). Many people in the community, including Health Centre staff, recognised alcohol misuse as a major problem, but lacked confidence in addressing it.

Aboriginal Health Workers at the Elliott Health Centre asked for help in developing their community development skills to work with the wider community. In collaboration with the local Gurungu Council, the two Aboriginal Health Promotion Officers encouraged community members to voice their concerns and consider possible solutions. The extract below, taken from a paper by Walley and Trindall, begins with the results of this process.

Box 3.3 Strengthening Community Action in the Northern Territory

Extract from Walley and Trindall (1994: 60–61)

Priority was given to short-term strategies that could be put in place almost immediately. These strategies were dependent on support from the Liquor Commission of the Northern Territory. Strategies included.

- limitations on 'take-aways'
- having only one liquor outlet
- a reduction in trading hours, e.g. no take-away on Sundays
- not allowing children in the public bar
- refusing to sell liquor to those considered intoxicated.

The Gurungu Council requested that the Liquor Commissioner ratify these areas of concern. The Commissioner responded by attending a community meeting to discuss these concerns and to explain the function of the Liquor Commission.

Although community members said they supported these strategies, they did not attend the meeting because of fear of possible repercussions. Therefore, ratification of these strategies did not occur.

As a result, Gurungu Council requested that the Health Promotion Team from Tennant Creek conduct a survey to determine community support of these strategies.

The purpose, process and methodology for the survey and how the results would be used were decided after a group discussion involving the Health Promotion Team and Gurungu Council representatives. Although the community identified five priority areas, it was decided that the survey should focus on three basic issues:

- the limits on take-away alcohol
- children being allowed in the public bar
- whether take-away on Sundays should cease.

As Elliot is only a small town, two members of the Health Promotion Team were able to conduct the survey. They walked around the community, explaining to people what the survey was about. A simple ballot-type paper was used and community members marked appropriate boxes. This was considered

to be the simplest method to collect the data. Analysis of the data was under-
taken by people elected by the community and included members from all
sections of the community.

Participation in the survey was by choice, but it did cover a very broad
section of the community and included known drinkers as well as non-
drinkers. According to the electoral roll, 188 out of a possible 287 adults (65%)
participated in the survey. The results are shown in Table 3.1.

Table 3.1 Responses to survey

Question	Answer	Number	(%)
Permissible take-away amount preferred	6 pack	91	49
	1 dozen	52	28
	No change	44	24
Kids in the bar	Yes	45	24
	No	143	76
Take-away sales on Sunday	Yes	56	30
	No	128	70

After the survey data was analysed, another meeting with the Liquor
Commissioner was arranged to report the results and discuss the appropriate
strategies. With community support, the three strategies were ratified and are
now formally in place and apply to all, including people passing through town.

Conclusion

The people of Elliott have set a precedent in the Northern Territory by imple-
menting these strategies, and they are proud of the way they confronted the
alcohol issue.

The community members pursued something they believed in and achieved
the outcome they desired. The confidence they have gained through this process
will place them in a strong position to further address alcohol and other drug
issues in the future.

Strengthening community action is dependent on community members
identifying the issues and implementing appropriate strategies to achieve their
desired outcomes.

In some instances, the community itself may not be the most appropriate level at
which to try to bring about change. Brady, in an article published in 1995, criticised
prevention programs based on health promotion and the public health model for
focusing on entire populations and paying insufficient attention to what she called
'the routines of everyday settings and activities' in communities (Brady 1995c).

These informal social contexts, she argued, influence behaviours no less than individuals' decision-making. While they may facilitate heavy drinking or other drug use, they also provide mechanisms for controlling alcohol and other drug use. Initiatives that enhance the capacity for informal social controls in everyday settings, she argued, were more likely to be effective than those focusing on individual drinkers or the community as a whole. While acknowledging that the normalisation of heavy drinking in some communities made it difficult to prevent young people from being drawn into the drinking culture, she argued that communities also harbour 'sources of resilience' (Brady 1995c: 19). In the extract below, she identifies some examples of local initiatives.

Box 3.4 The Importance of Informal Social Contexts Extract from Brady (1995c: 19–20)

Many of these [sources of resilience] are manifest in small grassroots projects, although some have governmental support (such as night patrols). We have to find ways in which governments can be encouraged to support non-government agencies and groups to address these problems; to improve the communication networks between the two; to provide better and faster sources of funding to those who can best use them; and, while encouraging monitoring, evaluation and competence, to give local organisations the freedom to act. Issues of sharing the best information available from a variety of sources, and giving the best possible advice, are significant. Research can have a role here, because actually involving people in research in their own communities acts to motivate people, as can the feedback of information. But research needs to be applied: 'no research without service' is a good motto.

Some of the best prevention initiatives in Australia for indigenous people include:

- The widescale use of indigenous media and other organisations for prevention messages aimed at young people: rock songs, rock concerts, alcohol-free discos, cartoons, radio and TV advertisements and 'soap operas'. These have more promise than handbooks and other written prevention material;
- Locally run drop-in centres which include access to counselling, birth control and health advice for teenagers;
- Community-based 'night patrols' working in close collaboration with police, as a means of defusing trouble and preventing alcohol importation;
- Community-wide lobbying and presentations to licensing authorities in order to limit supplies of alcohol;
- 'Mentor' programs for marginalised children such as 'Big Sister, Little Sister', where an older Aboriginal person makes a special friend of a young one to help them along;

- The use of wilderness and culture camps for young people as a means of strengthening the security of an identity as Aboriginal. Finding alternatives to substance abuse;
- Involving parents in all programs for young people so as not to further dispossess those adults of their roles;
- The development of counselling techniques such as 'narrative therapy' models which let Aboriginal people tell their own stories from the past, and help them to understand the nature of their negative stories of themselves and to re-work those accounts.

3.3   Secondary Prevention/Early Intervention

Early interventions, also called secondary prevention, focus on people who have begun to engage in harmful alcohol use or are considered at risk of doing so, but who have not reached a stage of requiring intensive treatment or rehabilitation. The settings best suited to early interventions are hospitals and—even more so—primary healthcare centres, where signs of harmful effects of drinking among patients are most likely to present healthcare providers with a 'teachable moment' (Anderson 1996). The potential value of early intervention was first highlighted by a WHO expert committee in the early 1980s (Saunders 1995). In Australia, the National Campaign Against Drug Abuse (NCADA), which commenced in 1985 and became the forerunner of the National Drug Strategy, included a commitment to developing early intervention programs as part of a range of evidence-based prevention and treatment strategies for licit and illicit drugs (Dillon 1995). However, as Brady observed in a paper published in 1995, emphasis on early intervention did not immediately find its way into Aboriginal primary healthcare settings, for several reasons including remoteness and the immediate demands generated by the presence of serious health problems in these settings (Brady 1995a).

Notwithstanding these barriers, the case for supporting alcohol interventions in Aboriginal primary healthcare settings remains compelling, in part because Aboriginal people with substance misuse problems are more likely to seek out treatment in these settings than to access specialist alcohol and other drug services (Gray et al. 2004; Loxley et al. 2004; Shakeshaft et al. 2010). For example, a supplementary survey conducted as part of the 1994 National Drug Strategy Household Survey found that, among urban Aboriginal and Torres Strait Islander people who reported seeking help in connection with their alcohol or other drug use, 67% had turned to a primary healthcare setting compared with 15% who used a rehabilitation centre (National Drug Strategy 1994). Medical practitioners can also influence

drinkers who subsequently stop drinking alcohol without the assistance of residential treatment, counselling or other programs. Brady (1993, 1995b) interviewed 37 people who had given up without formal intervention and been abstinent for at least 12 months. The most commonly advanced reasons for stopping drinking were a serious medical condition and/or a doctor's warning (17 cases), followed by family relationship reasons (9), accident trauma (4) and adoption of Christianity (3 cases).

A number of attempts and initiatives have been launched with a view to embedding screening and early intervention for problematic alcohol use into clinical practice in Aboriginal primary healthcare settings. In 1999, the Commonwealth Department of Health and Aged Care published *National Recommendations for the Clinical Management of Alcohol-Related Problems in Indigenous Primary Care Settings* (Hunter et al. 1999). The authors of the recommendations argued that the potential for health practitioners in primary healthcare settings to intervene opportunistically in alcohol and other drug problems being experienced by Aboriginal people was 'largely untapped' (Hunter et al. 1999: 8). They identified five major strengths that practitioners brought to such interventions. The first was that health practitioners, unlike many other people, were expected by Aboriginal patients to give advice about health matters. In a study based on interviews with Aboriginal people who had given up heavy drinking of their own accord, Brady (1993, 1995b) found that patients trusted doctors with whom they interacted, and believed that their doctors had acted appropriately in warning them about the dangers of continuing alcohol misuse. The second strength was that the advice offered by health practitioners was personalised rather than general. For Aboriginal and non-Aboriginal people alike, the authors argued, advice linked to a personal health problem had far more persuasive power than general information about the dangers posed by alcohol to the body. Further, as they noted: "Sensitively delivered personal information of this kind also helps to diminish the possibility that a patient will interpret well-meaning advice as personal criticism" (Hunter et al. 1999: 9).

The third strength was that health practitioners, more than others, were understood to have a detailed understanding of the internal organs of the body—an attribute that enhanced the credibility of their advice. The fourth strength was that medical advice to stop drinking could be and was used by some Aboriginal people as an excuse to legitimise their changed behaviour with respect to their kin and friends. As the authors noted, drinkers experienced strong social pressures to take part in collective drinking sessions, and attempts to extricate oneself from the drinking group threatened to jeapardise valued relationships. In these circumstances, citing medical advice—especially if backed up with 'proof' in the form of test results—provided an external legitimation for an otherwise difficult action.

Finally, the authors noted, consultations with health professionals were conducted in private. While some treatment programs utilised AA meetings and other forms of public disclosure, not everyone liked to air their alcohol-related problems in front of others (Hunter et al. 1999: 8–9).

3.3.1 Screening for Risky Alcohol Use

Early intervention typically involves two steps: screening for problematic alcohol use, and a brief interview with patients identified through screening as being at risk. Several validated questionnaire-type screening instruments exist; however, many of these, such as the Michigan Alcohol Screening Test (MAST) and the CAGE[2] questionnaire are designed to identify dependent drinkers rather than those at risk of harmful drinking, while others, such as the Indigenous Risk Impact Screen (IRIS), which was developed as a screening instrument for substance misuse and mental health problems among Indigenous Australians, are considered to be too long to embed in general clinical interviews or routine health checks (Islam et al. 2018).

The most widely used screening instruments are derived from the Alcohol Use Disorders Identification Test (AUDIT), a 10-item instrument developed through a six-country collaborative project in the early 1990s (Saunders et al. 1993). The questions in the original full AUDIT are set out below in Box 3.5.

Box 3.5 The Alcohol Use Disorders Identification Test: Self-report Version[3]
From Babor et al. (2001: 31)

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.

Place an X in one box that best describes your answer to each question.

---

[2] The label CAGE is derived from the themes of the four questions that constitute the instrument: Cut down, Annoyed, Guilty and Eye-opener (i.e. an alcoholic drink first thing in the morning) (Ewing 1984).

[3] Reproduced with permission from WHO Permissions Management, Geneva, World Health Organization (WHO) (2001), (https://apps.who.int/iris/handle/10665/67205, accessed (1 November 2021). WHO does not endorse any specific companies, products or services.

Questions	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2–4 times a month	2–3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

(continued)

(continued)

Questions	0	1	2	3	4
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor or other healthcare worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

The first three questions in AUDIT are designed to identify levels and patterns of consumption; Questions 4–6 focus on indicators of alcohol dependence, and Questions 7–10 address alcohol-related harms. In Australia, some versions of AUDIT replace 'drinks' in Questions 2 and/or 3 with 'standard drinks'—a modification that, as we show below, has posed difficulties for Aboriginal applications. Scores are aggregated. A score of less than 8 indicates low-risk drinking; a score of 8–15 indicates a medium level of alcohol problems, while a score of 16 and above points to a high level (Babor et al. 2001).

In June 2017, the Australian Government introduced a requirement that all Aboriginal Community Controlled Health Services (ACCHSs) in receipt of Australian Government funding must henceforth screen patients for alcohol use, using the first three questions in AUDIT. The shortened version, which focuses on alcohol consumption, is known as AUDIT-C (Islam et al. 2018). Around the same time, Islam et al. reviewed studies that reported on the validity, acceptability and feasibility of alcohol screening tools among Aboriginal Australians (Islam et al. 2018). They found that shortened forms of AUDIT—including AUDIT-C and also including a version consisting only of Question 3 (i.e. the one on binge drinking)—appeared to be suitable and valid for Aboriginal primary healthcare settings, provided that they were delivered in appropriate local languages (Islam et al. 2018). They noted, however, that training may be needed to encourage the implementation of screening. They also identified two continuing barriers to screening. The first was the episodic pattern of drinking by some Aboriginal people, particularly those living in remote

areas, which might consist of bouts of heavy drinking followed by long periods of abstinence. What was a 'typical' frequency of drinking under these conditions? Second, the need to convert amounts consumed—such as one individual's share of a cask of wine consumed by a group—to 'standard drinks' of alcohol sometimes presented difficulties.

3.3.2 Brief Interventions

Brief interventions typically include some or all of the following:

- Simple advice about drinking safely;
- More personalised advice based on a presenting problem or screening result;
- Referral to a specialist alcohol or other service;
- Initiating a brief motivational interview (described below); and/or
- Discussing relevant, practical ways to reduce or cease drinking alcohol (Hunter et al. 1999: 25).

The value of brief interventions to reduce harmful alcohol use derives from evidence that a discussion of as little as five minutes, delivered at an appropriate time in a primary healthcare setting by a health practitioner, can lead to reductions in the amount and frequency of drinking on the part of at-risk drinkers (Anderson et al. 2017). A systematic review of 69 controlled trials of brief interventions for alcohol use found that the amount of alcohol consumed each week one year after the intervention was reported in 34 trials, involving a combined total of 15,197 participants (Kaner et al. 2018). People who received the intervention drank less than the control group participants. Anderson et al. (2017) summarise the evidence in the extract in Box 3.6.

Box 3.6 Brief Advice in Primary Health Care
Extract from Anderson et al. (2017: 3)

Brief advice delivered in primary health care is commonly 5–10 min in duration and often based on the 'FRAMES principles' and the 'Five As' (Hester and Miller 1995). FRAMES is an acronym summarising the key components of brief advice: feedback (on the client's risk of having alcohol problems); responsibility (change is the client's responsibility); advice (provision of clear advice when requested); menu (what are the options for change?); empathy (an approach that is warm, reflective and understanding); and self-efficacy (optimism about the behaviour change). The five As are (1) assess alcohol consumption with a brief screening tool, followed by clinical assessment as needed; (2) advise patients to reduce alcohol consumption to lower levels;

(3) agree on individual goals for reducing alcohol use or abstinence (if indicated); (4) assist patients in acquiring the motivations, self-help skills or support needed for behaviour change; and, (5) arrange follow-up support and repeated counselling, including the referral of dependent drinkers to specialty treatment.

A series of systematic reviews over 15 years, covering a total of 56 unique primary healthcare-based randomised controlled trials, has consistently found that, up to 12-months follow-up, commonly the longest period studied, brief advice is effective in reducing heavy drinking, leading to lower average alcohol consumption, a reduction in alcohol-related problems, and reduced healthcare utilisation and mortality outcomes (O'Donnell et al. 2014).

Delivery by a range of practitioners has beneficial effects, and there is little evidence to suggest that any one profession of provider performs better or worse than another (Platt et al. 2016). Further, there is little evidence to suggest that the content of the advice is important for the outcome, or that longer or more sophisticated advice leads to better outcomes than shorter or less sophisticated advice (Platt et al. 2016). So, it seems that the length, complexity and sophistication of the advice are less important than the actual contact between provider and patient. Further, two systematic reviews that studied outcomes amongst control groups in studies of brief advice (Bernstein et al. 2010; McCambridge and Kypri 2011) found consistent evidence of reduced drinking. Thus, what is termed screening or assessment reactivity may be additional elements of the positive effects of brief advice.

Most of the evidence for brief advice has focused on adults aged between 18 and 65 years, rather than young or older people (O'Donnell et al. 2014). Thus, it is not possible to conclude that brief advice works just as well for the young and elderly as it does for adults.

Another approach widely used in early interventions for risky alcohol use is Motivational Interviewing (MI)—a form of counselling originally developed in the US by two clinical psychologists—William R Miller and Stephen Rollnick—as 'a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence' (Rollnick and Miller 1995: 326). 'Ambivalence' implies the client's awareness of both benefits and costs of persisting with, or changing, a particular behaviour such as heavy drinking. MI works by identifying and enhancing clients' own motivations to change their behaviour, rather than imparting information, advice or persuasion (Berman et al. 2020; Rollnick and Miller 1995). It proceeds through four steps: the first, termed *engagement*, involves building an open, trusting, client-practitioner relationship; the second, *focus*, involves identifying a specific behaviour as the target for the intervention; the third, called *evoking*, seeks to build the client's motivation to change her or his target behaviour in a healthier direction; and the fourth—*planning*—identifies the steps to be taken to bring about the change (Berman et al. 2020). From the outset, Miller and Rollnick have insisted that MI involves more than an intervention technique. What they call 'the *spirit* of

motivational interviewing', manifested in the relationship between the client and practitioner, is equally important (Rollnick and Miller 1995: 326). This should be one of partnership, rather than one of an expert and client.

Does this make MI particularly suitable for or adaptable to Aboriginal settings? Internationally, few attempts have been made to adapt MI to minority cultural contexts; however, Oh and Lee cite several studies that suggest MI might be both effective and acceptable among American Indian and Alaskan Native American populations (Oh and Lee 2016).

Strictly speaking, brief interventions based on advice-giving do not meet the criteria for MI as defined by its founders. However, the MI approach is often incorporated into brief interventions, as shown, for example, in the outline of a 'brief motivational interview' in the *National Recommendations for the Clinical Management of Alcohol-Related Problems in Indigenous Primary Care Settings* reproduced below in Box 3.7.

Box 3.7 The Steps in a Brief Motivational Interview Can Include the Following
Extract from Hunter et al. (1999: 82)

1. Take a drinking history and/or administer a screening test such as the AUDIT.
2. Discuss the pros and cons of the patient's drinking with him or her by asking, "What are the good things about drinking, the things you enjoy?" and provide prompts where necessary.
3. Discuss the 'not-so-good things about drinking' or ask, "What are your worries about drinking?"
4. Discuss any health problems the patient has which could be alcohol-related.
5. Make the link for the patient between these problems and their alcohol use. Discuss the general health effects of drinking too much. Discuss the problems associated with binge drinking (health/trauma, etc.).
6. Explain the standard drinks and the recommended levels for men and women.
7. If you have estimated the patient's consumption, show or explain how this fits in with levels in the overall population.
8. Ask the patient, "How do you feel about your drinking?" Based on the reply, you should assess whether the patient is ready, unsure or not ready to make a change.
9. If the patient is not ready, let him or her know that they can come back and talk any time.
10. If the patient is unsure, you could offer to talk again, offer a blood test or explore in more detail the good and not-so-good things about drinking.

---

11. If the patient is ready, you could offer some ideas on strategies for either cutting down or abstaining. Give out any pamphlet available (preferably those written for an Indigenous audience.) Offer to talk again.

One approach that follows MI in working with clients' own goals and priorities rather than externally imposed goals is Motivational Care Planning as described by Nagel and Thompson (2008). The approach is designed to identify and treat mental illness in Aboriginal communities by combining brief interventions, motivational interviewing, problem-solving therapy and a structured process of goal setting. A study conducted by the Australian Integrated Mental Health Initiative (AIMhi) in two remote Aboriginal communities in the Northern Territory recruited 49 patients with mental illness (most of whom were assessed as being psychologically dependent on alcohol and/or marijuana) and 37 carers. The study reported high levels of retention and goal achievement as assessed by both participants themselves and by clinicians (Nagel and Thompson 2008). Since then, the project and its findings have been used to develop a range of publicly available resources for both primary care and specialist health practitioners. These include a brief assessment form for alcohol and other drug interventions and the *AIMhi Stay Strong App*, which offers a structured wellbeing intervention for use by therapists in delivering an evidence-based, culturally appropriate intervention to Aboriginal clients. The assessment form is reproduced below in Boxes 3.8a, and 3.8b with permission from the Remote Alcohol and Other Drugs Workforce Program, NT Health, and the Stay Strong Mental Health and Wellbeing Project, Menzies School of Health Research. The resources are available from the Menzies School of Health Research website.[4]

---

[4] The assessment form is available from https://www.menzies.edu.au/page/Resources/?keywords=&research-area%5B%5D=Mental+Health+and+wellbeing. Information about accessing and using the AIMhi App is available at https://www.menzies.edu.au/page/Resources/?keywords=stay+strong+app&research-area%5B%5D=Mental+Health+and+wellbeing&resource-type%5B%5D=Apps. (Both links retrieved 6 January 2022).

Box 3.8a Alcohol and Other Drugs Brief Assessment Form, Page 1

Box 3.8b Alcohol and Other Drugs Brief Assessment Form, Page 2

Remote Alcohol & Other Drugs Workforce Program   Health Centre:
Client Number.................................

STEP 2 What keeps us strong?

PHYSICAL   FAMILY AND SOCIAL AND WORK

                MENTAL AND EMOTIONAL

SPIRITUAL AND CULTURAL

Art and Craft   Medication   Health Centre   Work   Keep About Sorry   Support

Dance   Good Tucker   Other   Teach Kids   Family   Think Positive

Exercise   GROW STRONG TREE   Hunting

RISK CHECK: Could I just check a few other things now?

Have you ever thought about hurting yourself or tried to hurt yourself in the past?	Y / N
Have you been thinking about or have you hurt yourself in the last few weeks?	Y / N***
Have you ever hurt another person in the past?	Y / N
Have you been thinking about hurting another person? Any particular person?	Y / N***
Are you feeling sick or have you stopped regular alcohol use suddenly?	Y / N***
For women: Is there a chance you are pregnant?	Y / N***

If YES take client to health centre immediately

Is it safe to go home today?   Y / N***
If NO talk to Manager right away

GOAL SETTING: What would you most like to change in your life right now?

With your alcohol or drug use, would you like to: ☐slow down ☐stop ☐not change ☐ think about changing

Or are you: ☐already slowing down and want more help   ☐already stopped and want more help

This is your goal for change: _____

How can I help? _____

What community activities could help? _____

What services could help? _____ I'll see you again on: _____

Outcomes:

☐ Enter into AOD Service → use Yarning tool for drug they want to change
☐ At risk → refer to Health Centre or Mental Health.
☐ Client not interested in AOD help → exit from service
☐ Client wants referral to another service: _____

Date: Worker's Name: Worker's Signature: Page 2 of 2

Source Menzies School of Health Research, Stay Strong Mental Health and Wellbeing Project.

Another research team composed largely of Aboriginal and Torres Strait Islander researchers has been engaged in developing and testing a tablet-based *Grog Survey App* for monitoring alcohol consumption and feeding results back, both to individual participants as part of a brief intervention, and to communities as part of community-level health promotion activities (Lee et al. 2018). The project has been funded by a 5-year Australian National Health and Medical Research Council (NHMRC) grant. Indigenous cultural experts and clinical experts worked together to produce an app that would incorporate a culturally appropriate questioning style, gender-specific voices and images, widely recognised events such as AFL/NRL grand finals to 'anchor' time points, and options for estimating consumption as an individual's share in a group drinking session rather than the individual's own consumption (Lee et al. 2019a, 2019b; Lee et al. 2018). For estimating consumption, participants are shown a range of types of alcohol and beverage containers, from which the app itself estimates Standard Drinks consumed.

In order to gauge the acceptability and feasibility of the app, a pilot version was administered in four communities in South Australia and Queensland between August 2016 and May 2017 (Lee et al. 2019c). Two of the communities were remote, one regional and one urban. A total of 246 people took part in the survey, recruited by five Indigenous field research assistants, whose experience and views on the survey were also collated and analysed. Most participants found the survey app easy to complete, in some cases reporting that completing the survey in itself promoted them to reflect on their own drinking.

3.3.3 Implementing Early Interventions in Aboriginal Settings: Barriers and Challenges

Despite the strong evidence that early interventions in primary healthcare settings are effective in reducing and preventing alcohol misuse, international studies show that implementation of early and brief interventions continues to be hampered by barriers (Anderson et al. 2017; Nilsen 2010; Roche and Freeman 2004). These include reluctance by health practitioners to offer brief interventions because they feel ill-equipped to do so or are sceptical about their value, and systemic factors such as competing demands on practitioners' time and lack of financial incentives to practice brief interventions. Roche and Freeman (2004) noted that many GPs were unwilling to offer brief interventions, preferring instead to refer patients to someone else (Roche and Freeman 2004). In light of GPs' reluctance, they suggested turning to practice nurses located in GP clinics, but more recent studies suggest that little progress has occurred along this path (Mitchell et al. 2018).

Aboriginal primary healthcare services in Australia have not been immune from these obstacles to the implementation and may face additional challenges. In 1997, a team of researchers collaborated with an urban Aboriginal Medical Service in Adelaide to conduct a randomised control trial (RCT) of a brief intervention for

hazardous alcohol use (Sibthorpe et al. 2002). Under the original project design, Aboriginal Health Workers were to screen patients using the 10-item AUDIT, then refer consenting patients classified as drinking at hazardous or harmful levels to GPs for a brief intervention or to a control group. Implementation proved difficult, in part because health workers found extended direct questioning of patients about alcohol use, as required by AUDIT, to be culturally inappropriate, and in part because of difficulties satisfying the methodological requirements of an RCT research project as well as an intervention (Brady et al. 2002; Sibthorpe et al. 2002). In response to these difficulties, the trial was abandoned and replaced by a 'demonstration project' designed to test the acceptability and cultural appropriateness of the intervention, and the impact of training on service providers' willingness and capacity to provide the interventions. The AUDIT screening was replaced by two questions, and over time, health workers became more comfortable in asking them. However, although the six GPs who took part in the demonstration project were supportive of brief intervention, the researchers concluded that time constraints and the severity and complexity of many patients' presenting problems continued to create challenges to routine interventions (Brady et al. 2002).

Since then, several attempts have been made to adapt both the content and delivery of screening to make it more congenial to Aboriginal primary healthcare settings. Conigrave et al. conducted a pilot study involving screening and early intervention with a series of eight groups of Aboriginal participants in south-west Sydney (Conigrave et al. 2012). They used the full 10-item AUDIT but modified the wording of some questions to make them easier to understand. For example, "have you had a feeling of guilt or remorse after drinking" (Question 7) became "have you felt bad about your drinking". They reported that participants were interested in their AUDIT scores, but none of the 58 participants in the study took up the opportunity offered for one-to-one counselling (Conigrave et al. 2012).

Clifford et al. have reported on a number of initiatives designed to increase the uptake of screening and brief interventions (SBIs) in Aboriginal Community Controlled Health Services (Clifford et al. 2011; Clifford and Shakeshaft 2011; Clifford et al. 2012, 2013). A study based on semi-structured group interviews with 37 staff members of five ACCHOs in New South Wales (65% of them Aboriginal) identified four factors that shaped their willingness or otherwise to practice SBIs. These are outlined in Box 3.9.

> **Box 3.9 Key Factors Influencing Alcohol Screening and Brief Interventions (SBI)**
> Extract from Clifford et al. (2012: 16–17).
>
> Four factors influencing healthcare practitioners' practices in alcohol SBI were prominent: outcome expectancy; role congruence; utilisation of clinical systems and processes; and perceptions of alcohol referral options.

Outcome expectancy. Healthcare practitioners generally had expectations that routine alcohol SBI would lead to a negative outcome for themselves or their patients.

First, routine alcohol screening could lead to more problems than it could solve. GPs in particular expressed concern that asking a patient about their alcohol use would identify multiple and complex problems they had neither the time nor expertise to treat.

> One of the reasons I don't really ask whether there is um, alcohol-related problems, like mental health problems and things, is so what . . . the patient's been drinking in a harmful way, so what? I mean, what can I do for him in my surgery? (GP rural ACCHS 2)

Second, nurses and AHWs expressed concerns that alcohol screening could offend patients and damage rapport.

> If someone comes in for a cough and we automatically start asking them about drugs and alcohol then they're going [to] turn around and go back out the door. You've sort of got to build up that rapport with them first before you know what you can and can't get out of them. (RN metro ACCHS)

...

Third, all types of healthcare practitioners expressed scepticism as to the effectiveness of alcohol BI: at-risk drinkers were described as attentive but non-responsive to advice to reduce alcohol consumption. General perceptions were that risky drinkers willing to change would change, while those resistant to change would not.

...

Role congruence. No healthcare practitioner rejected outright that they had a role in alcohol SBI. However, healthcare practitioners' perceptions of how well alcohol SBI fitted within their role appeared to influence their willingness to deliver it. For example, Indigenous healthcare practitioners with a defined role in drug and alcohol (D&A) prevention (e.g. AOD worker) or engaged in a structured process for its delivery (e.g. delivering health assessments) reported greater involvement in alcohol SBI than those with less defined and structured D&A roles.

...

General perceptions among RNs were that they had a key role in alcohol SBI as part of health assessment processes, but that it was the GP's role to deliver it opportunistically. GPs, however, said they were usually too busy treating the patient's presenting health condition to ask them about their drinking.

Utilisation of clinical systems and processes. Healthcare practitioners' utilisation of clinical systems and processes to deliver alcohol SBI appeared less than optimal.

...

Alcohol information in electronic and paper records was generally poorly linked and inconsistent, primarily because of different methods of recording by healthcare practitioners. Indigenous-specific alcohol SBI guidelines and resources, although available in all ACCHSs, were referred to infrequently.

Alcohol referral options. A lack of appropriate alcohol referral options was identified as a prominent barrier to alcohol SBI in all group interviews. Specifically, healthcare practitioners reported a lack of: adequate follow-up support for patients post-alcohol rehabilitation; appropriate alcohol detoxification services; AOD and counselling staff; and funding to transport patients to remote rehabilitation and detoxification units. Without accessible and appropriate alcohol detoxification and rehabilitation services for patient treatment and referral, healthcare practitioners perceived alcohol SBI to be of little benefit to their patients.

. . . it's wonderful to have all the latest and greatest resources, up to date information, but unless you have referral pathways that you can refer your patients onto, all the paperwork in the world's not going to do you any good. (RN rural ACCHS 2).

These obstacles are clearly formidable, though not—at least in principle—unsurmountable. In another paper, the same researchers reported on the results of an intervention designed to increase the use of screening and brief interventions in four NSW Aboriginal community-controlled health services by two supportive measures: (1) training, in the form of a three-hour workshop and (2) follow-up outreach support in the form of three to five one-day visits to the health centres by AOD clinicians and/or researchers (Clifford et al. 2013). Outcomes were assessed by analysing changes in the proportions of eligible clients who received alcohol screening and/or BI as recorded in the computer-based client record system used by the services. The results were mixed: all the ACCHSs recorded modest but statistically significant increases in proportions of eligible clients receiving alcohol screening (e.g. from 1.2% to 3.9% for receiving a complete alcohol screen). The proportion of at-risk clients receiving a BI also rose from 25.7% to 47.7%; however, this was almost entirely accounted for by an increase in one ACCHS; levels in two others actually dropped (Clifford et al. 2013).

More recently, Dzidowska et al. (2021) conducted a clustered, randomised trial involving 22 Aboriginal community-controlled health services across Australia, half of which were assigned a multi-faceted support program over two years, with the other half receiving the same support program after the two-year study period. The support program comprised eight components, including a two-day workshop in screening and BI, nomination of service champions, regular feedback of results, regular teleconferences with service champions, support in modifying practice software when needed and other resources. Outcome measures included the numbers of clients who received screening, BIs, or other treatment for unhealthy alcohol use, including counselling and provision of pharmacotherapies such as naltrexone or acamprosate (Dzidowska et al. 2021).The intervention resulted in a statistically

significant increase in clients receiving screening, but the results with respect to BIs and other treatment were inconclusive.

Despite these efforts, implementation of BIs in Aboriginal primary health settings continue to encounter challenges. In a recent systematic review of community-based alcohol and other drug programs for Aboriginal and Torres Strait Islander peoples, the authors concluded that "brief intervention for alcohol was generally not well received by clients and health workers"—largely for reasons canvassed above (Krakouer et al. 2022: 1424).

3.4   Conclusions

We began this chapter by noting a long-standing dearth of evidence-based secondary or early interventions targeting those who were at risk of harmful alcohol use or already engaging in the practice. We also noted that the evidence-base underpinning primary prevention programs—that is, programs designed to educate people about alcohol and other drug use, raise awareness of associated harms, build resilience and/or enhance the capacity of communities to prevent alcohol and other drug problems—was sparse. Historically, many such programs have been poorly evaluated or not evaluated at all. Many of those that have been evaluated have failed to demonstrate significant outcomes.

At the same time, examination of case studies of successful prevention programs points to a number of components that appear to be common to all of them. These include community leadership; strategic partnerships between community organisations and both internal and external agencies; limited, clearly defined and widely supported objectives; collation of data documenting both baseline and post-intervention indicators of the problem being addressed; and a pathway to achieving selected objectives. Accounts of two successful primary prevention initiatives are presented, one in the Fitzroy Valley region of WA, the other in the small town of Elliott in the Northern Territory. We also reproduce eight guiding principles for community-based prevention (Box 3.2) originally put forward for American Indian communities in the US, in the belief that these are no less relevant to Australian Indigenous communities.

We also cite Brady's observation that communities may not be the most appropriate level at which to initiate prevention programs. Communities are not always able or inclined to act collectively to address an issue as contentious as the prevention of alcohol-related harm. (Non-Aboriginal communities rarely do so.) Brady suggests that, rather than focusing on entire local populations, it may be more productive to concentrate on the informal social settings in which drinking takes place and through which controls over harmful drinking are most likely to be exercised effectively. Preventive interventions from this perspective would aim to strengthen the capacity for informal social controls to be exercised in everyday settings.

Secondary prevention or, as it is more widely known, early intervention aims to raise awareness and stimulate change among people who are at risk of harmful

alcohol use or have already begun harmful use without having reached a stage of requiring more intensive treatment. Early intervention typically involves opportunistic screening for risky drinking, usually conducted in hospital or primary healthcare settings, and one or more brief interventions conducted by a health practitioner. There is strong evidence that screening and brief interventions (SBI) delivered in primary healthcare settings are effective in helping to prevent alcohol-related harms. However, evidence also indicates that, in both Aboriginal and other settings, implementation of SBI faces several barriers, including competing demands on health practitioners' time, reluctance by health providers to question patients about their drinking, and a perceived lack of referral options for patients requiring follow-up treatment.

The most widely used screening instrument in Aboriginal primary healthcare settings is the 10-item Alcohol Use Disorders Identification Test (AUDIT), often in shortened versions with wording modified to make it more culturally appropriate. Since June 2017, the Commonwealth Government has required all Aboriginal Community-Controlled Health Services in receipt of government funding to screen patients using a three-question version of AUDIT known as AUDIT-C.

A number of research and other initiatives have explored options for increasing the uptake of SBI in Aboriginal settings. These include trialling support for Aboriginal primary healthcare practitioners in delivering SBIs; combining BIs with motivational interviews, problem solving and structured goal setting in a program known as Motivational Care Planning for mental health disorders, and developing a tablet-based app for monitoring alcohol consumption, identifying risky patterns and providing brief intervention.

References

Anderson, P. 1996. *Alcohol and primary health care*. World Health Organization Regional Office for Europe: Copenhagen.

Anderson, Peter, Amy O'Donnell, and Eileen Kaner. 2017. Managing alcohol use disorder in primary health care. *Current Psychiatry Reports* 19: 79. https://doi.org/10.1007/s11920-017-0837-z.

Babor, T.F., J.C. Higgins-Biddle, John B. Saunders, and Maristela Monteiro. 2001. *AUDIT: the alcohol use disorders identification test: guidelines for use in primary care. WHO/MSD/MSB/01.6a.* World Health Organization: Geneva.

Beauvais, F. 1992. The need for community consensus as a condition of policy implementation in the reduction of alcohol abuse on Indian reservations. *American Indian and Alaska Native Mental Health Research* 4: 77–81.

Berman, Anne H., Maria Beckman, and Helena Lindqvist. 2020. Motivational Interviewing Interventions. In *The Handbook of Behavior Change*, eds. by Hamilton, Kyra, Linda D. Cameron, Martin S. Hagger, Nelli Hankonen and Taru Lintunen. Cambridge: Cambridge University Press.

Bernstein, J.A., E. Bernstein, and T.C. Heeren. 2010. Mechanisms of change in control group drinking in clinical trials of brief alcohol intervention: implications for bias toward the null. *Drug and Alcohol Review* 29: 498–507. https://doi.org/10.1111/j.1465-3362.2010.00174.x.

Bond, Lyndal, Helen Butler, Lyndal Thomas, John Carlin, Sara Glover, Glenn Bowes, and George Patton. 2007. Social and school connectedness in early secondary school as predictors of late

teenage substance use, mental health, and academic outcomes. *Journal of Adolescent Health* 40: 357.e9–57.e18. https://doi.org/10.1016/j.jadohealth.2006.10.013.

Brady, M., B. Sibthorpe, R.S. Bailie, S. Ball, and P. Sumnerdodd. 2002. The feasibility and acceptability of introducing brief intervention for alcohol misuse in an urban Aboriginal medical service. *Drug and Alcohol Review* 21: 375–380.

Brady, Maggie. 1993. Giving away the grog: an ethnography of Aboriginal drinkers who quit without help. *Drug and Alcohol Review* 12: 401–411.

Brady, Maggie. 1995a. *Broadening the base of interventions for Aboriginal people with alcohol problems.* Sydney: National Drug and Alcohol Research Centre, University of New South Wales. https://ndarc.med.unsw.edu.au/resource/broadening-base-interventions-aboriginal-people-alcohol-problems. Accessed 18 Feb 2020.

Brady, Maggie. 1995b. *Giving away the grog: aboriginal accounts of drinking and not drinking.* Canberra: Commonwealth Department of Human Services and Health for the National Drug Strategy.

Brady, Maggie. 1995c. *The prevention of drug and alcohol abuse among aboriginal people: resilience and vulnerability.* Canberra: Australian Institute of Aboriginal and Torres Strait Islander Studies.

Brady, Maggie, Sharon Dawe, and Robyn L. Richmond. 1998. Expanding knowledge among Aboriginal service providers on treatment options for excessive alcohol use. *Drug and Alcohol Review* 17: 69–76.

Burns, C.B., B.J. Currie, A.B. Clough, and R. Wuridjal. 1995. Evaluation of strategies used by a remote Aboriginal community to eliminate petrol sniffing. *Medical Journal of Australia* 163: 82–86.

Cairnduff, S. 2001. *Sport and Recreation for Indigenous Youth in the Northern Territory: Scoping Research Priorities for Health and Social Outcomes, Report, viewed 04 January 2022,* https://www.nintione.com.au/?p=3048.Darwin: Cooperative Research Centre for Aboriginal and Tropical Health, and Australian Sports Commission. https://www.nintione.com.au/resources/rao/sport-and-recreation-for-indigenous-youth-in-the-northern-territory-scoping-research-priorities-for-health-and-social-outcomes/. Accessed 3 Jan 2022.

Clifford, A., L.J. Pulver, Robyn L. Richmond, A. Shakeshaft, and Rowena G. Ivers. 2011. Smoking, nutrition, alcohol and physical activity interventions targeting Indigenous Australians: rigorous evaluations and new directions needed. *Australian and New Zealand Journal of Public Health* 35: 38–46.

Clifford, Anton, and Anthony Shakeshaft. 2011. Evidence-based alcohol screening and brief intervention in Aboriginal community controlled health services: experiences of health-care providers. *Drug and Alcohol Review* 30: 55–62.

Clifford, Anton, Anthony Shakeshaft, and Catherine Deans. 2012. How and when health-care practitioners in Aboriginal community controlled health services deliver alcohol screening and brief intervention, and why they don't: a qualitative study. *Drug and Alcohol Review* 31: 13–19. https://doi.org/10.1111/j.1465-3362.2011.00305.x.

Clifford, Anton, Anthony Shakeshaft, and Catherine Deans. 2013. Training and tailored outreach support to improve alcohol screening and brief intervention in Aboriginal Community Controlled Health Services. *Drug and Alcohol Review* 32: 72–79. https://doi.org/10.1111/j.1465-3362.2012.00488.x.

Commonwealth of Australia. 2019. *National Alcohol Strategy 2019–2028.* Canberra: Department of Health.

Commonwealth of Australia (Department of Health). 2017. *National drug strategy 2017–2026.* Commonwealth of Australia (Department of Health): Canberra.

Conigrave, Katherine, Brian Freeman, Therese Caroll, Lynette Simpson, K.S. Kylie Lee, Vicki Wade, Keren Kiel, Steve Ella, Karen Becker, and Bradley Freeburn. 2012. The alcohol awareness project: community education and brief intervention in an urban Aboriginal setting. *Health Promotion Journal of Australia* 23: 219–25. https://doi.org/10.1071/HE12219.

Dillon, Paul (ed.). 1995. The national drug strategy: the first 10 years and beyond. In *Proceedings from the eighth national drug and alcohol research centre annual symposium. NDARC Monograph No. 27*. Sydney: National Drug and Alcohol Research Centre, University of New South Wales.

Dzidowska, Monika, K.S. Kylie Lee, James H. Conigrave, Timothy A. Dobbins, Beth Hummerston, Scott Wilson, Paul S. Haber, Dennis Gray, and Katherine M. Conigrave. 2021. Support for Aboriginal health services in reducing harms from alcohol: 2-year service provision outcomes in a cluster randomized trial. *Addiction* 1–8. https://doi.org/10.1111/add.15712.

Ewing, J.A. 1984. Detecting alcoholism: the CAGE questionnaire. *Journal of the American Medical Association* 252: 1905–1907.

Foxcroft, D.R., and A. Tsertsvadze. 2011. Universal multi-component prevention programs for alcohol misuse in young people. *Cochrane Database System Review* Cd009307. https://doi.org/10.1002/14651858.Cd009307.

Gamarania, G., T. Malpraburr, F. Johnston, R.K. Beecham, and P.G. Dalgleish. 1998. The Maningrida: "Be Smoke Free" project. *Health Promotion Journal of Australia* 8: 12.

Geia, Lynore, Kirstie Broadfield, Daniel Grainger, Andrew Day, and Felecia Watkin-Lui. 2018. Adolescent and young adult substance use in Australian Indigenous communities: a systematic review of demand control program outcomes. *Australian and New Zealand Journal of Public Health* 42: 254–61. https://doi.org/10.1111/1753-6405.12789.

Gray, D., B. Sputore, and Jill Walker. 1998. Evaluation of an Aboriginal health promotion program: a case study from Karalundi. *Health Promotion Journal of Australia* 8: 24–28.

Gray, D., S. Saggers, B. Sputore, and D. Bourbon. 2000. What works? a review of evaluated alcohol misuse interventions among Aboriginal Australians. *Addiction* 95: 11–22.

Gray, Dennis, Sherry Saggers, David Atkinson, and Phillipa Strempel. 2004. *Substance misuse and primary health care among indigenous Australians. Aboriginal and torres strait Islander primary health care review: consultant report No 7*. Australian Government Department of Health and Ageing: Canberra.

Gray, Dennis, Brooke Sputore, Anna Stearne, Deidre Bourbon, and Phillipa Strempel. 2002. *Indigenous drug and alcohol projects 1999–2000*. Australian National Council on Drugs: Canberra.

Hawkins, Elizabeth H., Lillian H. Cummins, and G. Alan Marlatt. 2004. Preventing substance abuse in American Indian and Alaska native youth: promising strategies for healthier communities. *Psychological Bulletin* 130: 304–323. https://doi.org/10.1037/0033-2909.130.2.304.

Hawkins, J.D., S. Oesterle, E.C. Brown, M.W. Arthur, R.D. Abbott, A.A. Fagan, and R.F. Catalano. 2009. Results of a type 2 translational research trial to prevent adolescent drug use and delinquency: a test of communities that care. *Archives of Pediatrics and Adolescent Medicine* 163: 789–798.

Hester, R.K., and W.R. Miller. 1995. *Handbook of alcoholism treatment approaches*. Boston: Allyn & Bacon.

Hunter, Ernest, Maggie Brady, and Wayne Hall (eds.). 1999. *National recommendations for the clinical management of alcohol-related problems in indigenous primary care settings*. Canberra: Commonwealth Department of Health and Aged Care.

Intergovernmental Committee on Drugs (Australia). 2014. *National aboriginal and torres strait Islander Peoples' Drug Strategy 2014–2019*. Canberra: Intergovernmental Committee on Drugs. www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/natsipds2014-19d. Accessed 16 Aug 2018.

Islam, M. Mofizul., Helen T. Oni, K.S. Kylie Lee, Noel Hayman, Scott Wilson, Kristie Harrison, Beth Hummerston, Rowena Ivers, and Katherine M. Conigrave. 2018. Standardised alcohol screening in primary health care services targeting aboriginal and torres strait Islander peoples in Australia. *Addiction Science Annd Clinical Practice* 13: 5. https://doi.org/10.1186/s13722-018-0108-2.

Jainullabudeen, Thameemul Ansari, Ailsa Lively, Michele Singleton, Anthony Shakeshaft, Komla Tsey, Janya McCalman, Christopher Doran, and Susan Jacups. 2015. The impact of a community-based risky drinking intervention (Beat da Binge) on Indigenous young people. *BMC Public Health* 15: 1319. https://doi.org/10.1186/s12889-015-2675-4.

Kaner, E.F.S., F.R. Beyer, C. Muirhead, F. Campbell, E.D. Pienaar, N. Bertholet, J.B. Daeppen, J.B. Saunders, and B. Burnand. 2018. Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database of Systematic Reviews*. https://doi.org/10.1002/14651858.CD004148.pub4.

Kirmayer, L.J., G.M. Brass, and C.L. Tait. 2000. The mental health of Aboriginal peoples: transformations of identity and community. *Canadian Journal of Psychiatry* 45: 607–616. https://doi.org/10.1177/070674370004500702.

Kisling, L.A., and J.M. Das. 2022. Prevention strategies [Updated 2022 May 8]. In *StatPearls [Internet]*. Treasure Island (FL): StatPearls Publishing.

Krakouer, Jacynta, Melissa Savaglio, Karinda Taylor, and Helen Skouteris. 2022. Community-based models of alcohol and other drug support for First Nations peoples in Australia: a systematic review. *Drug and Alcohol Review* 41: 1418–27. https://doi.org/10.1111/dar.13477.

Lee, K.S., James H. Kylie, Sarah Callinan Conigrave, Scott Wilson, Robin Room, Jimmy Perry, Tim Slade, Tanya N. Chikritzhs, Noel Hayman, Teagan Weatherall, Geoffrey Leggat, Dennis Gray, and Katherine M. Conigrave. 2019a. Asking about the last four drinking occasions on a tablet computer as a way to record alcohol consumption in aboriginal and torres strait Islander Australians: a validation. *Addiction Science and Clinical Practice* 14: 15. https://doi.org/10.1186/s13722-019-0148-2.

Lee, K.S., James H. Kylie, Scott Wilson Conigrave, Jimmy Perry, Sarah Callinan, Robin Room, Tanya N. Chikritzhs, Tim Slade, Noel Hayman, Geoffrey Leggat, and Katherine M. Conigrave. 2019b. Short screening tools for risky drinking in aboriginal and Torres strait Islander Australians: modified AUDIT-C and a new approach. *Addiction Science and Clinical Practice* 14: 22. https://doi.org/10.1186/s13722-019-0152-6.

Lee, K.S. Kylie, Monique Jagtenberg, Charles M. Ellis, and Katherine M. Conigrave. 2013. Pressing need for more evidence to guide efforts to address substance use among young indigenous Australians. *Health Promotion Journal of Australia* 24: 87–97. https://doi.org/10.1071/HE12923.

Lee, K.S. Kylie, K.M. Conigrave, Alan Clough, Cate Wallace, Edmund Silins, and Jackie Rawles. 2008. Evaluation of a community-driven preventive youth initiative in Arnhem Land, Northern Territory, Australia. *Drug and Alcohol Review* 27: 75–82.

Lee, K.S. Kylie, Scott Wilson, Jimmy Perry, Robin Room, Sarah Callinan, Robert Assan, Noel Hayman, T Chikritzhs, D Gray, E.T. Wilkes, and K.M. Conigrave. 2018. Developing a tablet computer-based application ('App') to measure self-reported alcohol consumption in Indigenous Australians. *BMC Medical Informatics and Decision Making* 18. https://doi.org/10.1186/s12911-018-0583-0.

Lee, Ks Kylie, James H. Conigrave, Mustafa Al Ansari, Scott Wilson, Jimmy Perry, Catherine Zheng, Bradley Freeburn, Robin Room, Sarah Callinan, Noel Hayman, Tanya Chikritzhs, Tim Slade, Dennis Gray, and Katherine M. Conigrave. 2019c. Acceptability and feasibility of a computer-based application to help Aboriginal and Torres Strait Islander Australians describe their alcohol consumption. *Journal of Ethnicity in Substance Abuse* 1–18. https://doi.org/10.1080/15332640.2019.1579144.

Loxley, Wendy, John W. Toumbourou, Tim Stockwell, Ben Haines, Katie Scott, Celia Godfrey, Elizabeth Waters, George Patton, Richard Fordham, Dennis Gray, Jann Marshall, David Ryder, Sherry Saggers, Lena Sanci, and Jo. Williams. 2004. *The Prevention of substance use, risk and harm in Australia: a review of the evidence*. National Drug Research Institute and the Centre for Adolescent Health: Canberra.

Martins, C., M. Godycki-Cwirko, B. Heleno, and J. Brodersen. 2018. Quaternary prevention: reviewing the concept. *European Journal of General Practice* 24: 106–11. https://doi.org/10.1080/13814788.2017.1422177.

May, P.A. 1992. Alcohol policy considerations for Indian reservations and bordertown communities. *American Indian and Alaska Native Mental Health Research* 4: 5–59.

McCambridge, J., and K. Kypri. 2011. Can simply answering research questions change behaviour? systematic review and meta analyses of brief alcohol intervention trials. *PLoS ONE* 6: e23748. https://doi.org/10.1371/journal.pone.0023748.

Ministerial Council on Drug Strategy. 2006. *National drug strategy: aboriginal and torres strait Islander peoples complementary action plan 2003–2009.* Background Paper) (Ministerial Council on Drug Strategy): Canberra.

Mitchell, A.M., D.S. Finnell, I. Kane, H. Halge, K. Puskar, and C.L. Savage. 2018. Time-conscious alcohol screening and brief intervention for students, nurses, and nurse leaders.*The Journal of Continuing Education in Nursing* 49: 467–73. https://doi.org/10.3928/00220124-20180918-07

Nagel, Tricia, and C. Thompson. 2008. Motivational care planning: self management in indigenous mental health. *Australian Family Physician* 37: 996–1001.

National Drug Strategy. 1994. *National drug strategy household survey: urban aboriginal and torres strait islander peoples supplement 1994.* Commonwealth Department of Health and Family Services: Canberra.

Nilsen, Per. 2010. Brief alcohol intervention—where to from here? Challenges remain for research and practice. *Addiction* 105: 954–59. https://doi.org/10.1111/j.1360-0443.2009.02779.x.

O'Donnell, Amy, Peter Anderson, Dorothy Newbury-Birch, Bernd Schulte, Christiane Schmidt, Jens Reimer, and Eileen Kaner. 2014. The impact of brief alcohol interventions in primary health-care: a systematic review of reviews. *Alcohol and Alcoholism (oxford, Oxfordshire)* 49: 66–78. https://doi.org/10.1093/alcalc/agt170.

Oh, Hans, and Christina Lee. 2016. Culture and motivational interviewing. *Patient Education and Counseling* 99: 1914–1919. https://doi.org/10.1016/j.pec.2016.06.010.

Platt, Lucy, G.J. Melendez-Torres, Amy O'Donnell, Jennifer Bradley, Dorothy Newbury-Birch, Eileen Kaner, and Charlotte Ashton. 2016. How effective are brief interventions in reducing alcohol consumption: do the setting, practitioner group and content matter? Findings from a systematic review and metaregression analysis. *British Medical Journal Open* 6: e011473. https://doi.org/10.1136/bmjopen-2016-011473.

Preuss, Karissa, and Jean Napanangka Brown. 2006. Stopping petrol sniffing in remote aboriginal Australia: key elements of the Mt Theo program. *Drug and Alcohol Review* 25: 189–193.

Roche, Ann M., and Toby Freeman. 2004. Brief interventions: good in theory but weak in practice. *Drug and Alcohol Review* 23: 11–18.

Rollnick, Stephen, and William R. Miller. 1995. What is motivational interviewing? *Behavioural and Cognitive Psychotherapy* 23: 325–334. https://doi.org/10.1017/S135246580001643X.

Saunders, John B. 1995. Early intervention for hazardous alcohol use: The first ten years and beyond. In *The national drug strategy: the first ten years and beyond. Proceedings from the eighth national drug and alcohol research centre annual symposium, potts point, november*, ed. by Dillon, P. Sydney: National Drug and Alcohol Research Centre, University of New South Wales.

Saunders, John B, Olaf G. Aasland, Thomas F. Babor, Juan R. De La Fuente, and Marcus Grant. 1993. Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol Consumption-II. *Addiction* 88: 791–804. https://doi.org/10.1111/j.1360-0443.1993.tb02093.x.

Shakeshaft, A., A. Clifford, and M. Shakeshaft. 2010. Reducing alcohol-related harm experienced by Indigenous Australians: identifying opportunities for Indigenous primary health care services. *Australian and New Zealand Journal of Public Health* 34: S41–S45.

Sheehan, Mary, Cynthia Schonfeld, Elizabeth Hindson, and Rod Ballard. 1995. Alcohol Education in an Indigenous Community School in Queensland, Australia.*Drugs: Education, Prevention and Policy* 2: 259-73. https://doi.org/10.3109/09687639509035749.

Sibthorpe, Beverly M., Ross S. Bailie, Maggie A. Brady, Sandra A. Ball, Polly Sumner-Dodd, and Wayne D. Hall. 2002. The demise of a planned randomised controlled trial in an urban Aboriginal medical service. *Medical Journal of Australia* 176: 273–276.

Snijder, Mieke, Lexine Stapinski, Briana Lees, James Ward, Patricia Conrod, Christopher Mushquash, Lorenda Belone, Katrina Champion, Cath Chapman, Maree Teesson, and Nicola Newton. 2020. Preventing Substance use among indigenous adolescents in the USA, Canada, Australia and New Zealand: a systematic review of the literature. *Prevention Science* 21: 65–85. https://doi.org/10.1007/s11121-019-01038-w.

Teesson, Maree, Nicola C. Newton, and Emma L. Barrett. 2012. Australian school-based prevention programs for alcohol and other drugs: a systematic review. *Drug and Alcohol Review* 31: 731–36. https://doi.org/10.1111/j.1465-3362.2012.00420.x.

Thomas, R., and R. Perera. 2006. School-based programmes for preventing smoking. *Cochrane Database System Review* Cd001293. https://doi.org/10.1002/14651858.CD001293.pub2.

Walley, G., and D. Trindall. 1994. Strengthening community action in the Northern Territory. *Health Promotion Journal of Australia* 4: 60–61.

World Health Organization. 1978. *Declaration of Alma-Ata international conference on primary health care, Alma-Ata, USSR*. Geneva: World Health Organization/www.who.int/publications/almaata_declaration_en.pdf. Accessed 21 Oct 2021.

Chapter 4
Treatment and Rehabilitation

Artwork by Delvene Cockatoo-Collins

P. d'Abbs and N. Hewlett, *Learning from 50 Years of Aboriginal Alcohol Programs*,

Abstract   This chapter focuses on treatment and rehabilitation programs for Aboriginal people—that is, programs and services designed to facilitate recovery from harmful alcohol use and/or dependence and to prevent relapse into harmful drinking. We trace the emergence from the 1970s of a distinctive approach based on residential treatment and combining a disease concept of alcoholism with the Twelve Steps pathway developed by Alcoholics Anonymous. This approach has remained widely used to the present day. We also discuss the growth of a variant of the disease model, in which alcohol misuse, together with associated harms such as violence, sexual abuse and self-harm, are viewed as products of unresolved intergenerational trauma associated with colonisation, requiring cultural reconnection and a healing process grounded in Indigenous rather than (or as well as) Western therapeutic approaches. The chapter also reviews initiatives in non-residential treatment, support for the Aboriginal alcohol and other drug workforce, and issues relating to the evaluation of treatment.

4.1   Introduction

This chapter focuses on tertiary prevention—that is, on programs designed to facilitate recovery from harmful use and/or alcohol dependence and prevent relapse to harmful drinking. As we noted in the preceding chapter, measures to prevent and treat harmful alcohol use among Aboriginal Australians have tended to take the form of primary prevention initiatives, such as education and media campaigns, or tertiary prevention, also known as treatment and rehabilitation programs (Brady et al. 1998: 47; Brady 1995a). In this chapter, we focus on treatment and rehabilitation. We begin by tracing the evolution of what has been, from the outset, the most widely favoured treatment approach among Aboriginal people: residential treatment using the Twelve Step treatment path to overcome alcoholism, combined with the mutual aid principles of Alcoholics Anonymous (AA), both of which are based on the concept of alcoholism as a disease. We then discuss a variant of the disease model, in which alcohol misuse is regarded as a 'family disease'. A third section examines a related but distinct treatment approach that views alcohol misuse, together with associated harms such as violence, sexual abuse and self-harm, as products of unresolved intergenerational trauma that in turn requires a process of healing and cultural reconnection. This is followed by sections dealing with non-residential treatment programs, support for the Aboriginal alcohol and other drug workforce and, finally, issues relating to evaluation and the demonstration of treatment effectiveness.

4.2   Twelve-Step-Based Residential Treatment

The first alcohol treatment program established for and by Aboriginal people in Australia, as mentioned above in Chap. 2, was Benelong's Haven, a residential facility set up in Sydney in 1974 by Val Bryant, an Aboriginal woman of Gumbaynggirr

descent. In 1976, with her husband Jim Carroll, Val moved the facility to the site of a former boys' home at Kinchela Creek, 35 kms from the town of Kempsey (Chenhall 2007).

Three inter-related components made up the approach to treatment at Benelong's Haven. The first, as mentioned earlier in Chap. 2 (Sect. 2.3.1) was the belief that alcoholism was a *disease*; the inability to cease or control one's drinking, according to this belief, resulted not from moral weakness (as earlier approaches to drunkenness in many societies assumed) but from the onset of a disease requiring treatment. The second component was the twelve-step pathway first enunciated by the founders of AA in the US in the 1930s and retained by AA in substantially the same form until the present day.[1] The third component was the principle of self-help through mutual support as developed by AA and practised in AA meetings.

All of these components have been subject to criticism, as we discuss below. But from the earliest days of Benelong's Haven, they have provided Aboriginal treatment services with an enduring rationale for program development.

As we noted earlier in Chap. 2 (see Box 2.2 above), Aboriginal alcoholism in the eyes of Val Bryant differed from its counterpart in non-Aboriginal society by virtue of two characteristics of Aboriginal society and culture: its group orientation (in contrast to non-Aboriginal individualism) and its spirituality. Both were central to the model of recovery, practised at Benelong's Haven, and both were facilitated by the AA approach, despite its non-Aboriginal origins.

The most detailed account of any Aboriginal residential treatment program in Australia is Richard Chenhall's ethnographic study of Benelong's Haven, based on fieldwork conducted over nearly two years in the late 1990s (Chenhall 2007). Chenhall noted that concepts such as 'disease' and 'treatment' took on distinctive meanings at Benelong's Haven:

> Although it does stress that alcoholism is a disease and not indicative of 'weak will', the AA program, set out in the Big Book, focuses on the subjective experience of the alcoholic rather than on any objective identification of alcoholism itself. Alcoholics are not 'treated' but 'work' a spiritual program, which is reinforced by the collectivity. Thus, AA is based on the idea that alcoholics can provide their own treatment. By regularly meeting together and engaging in the AA program, individuals become part of a group of like-minded people (Chenhall 2007: 142).

Culture, spirituality and political self-determination were all interwoven in the recovery program:

> For residents of Benelong's Haven, alcohol and drugs were viewed as having removed the Aboriginal spirit, leaving them a fractured and divisive people. With the forging of a shared identity through the formation of common goals and purpose, residents asserted that they were rediscovering their Aboriginal spirituality. AA teachings support a discourse where alcohol and drugs become a poison that render the user powerless and threatens loss of life or mind. Rather than engaging in the lies and excuses that are said to be the common practice

---

[1] The 12 steps, which can be read in full at aa.org.au/members/three-legacies/twelve-steps, include admitting that 'we were powerless over alcohol – that our lives had become unmanageable', deciding 'to turn our will and our lives over to the care of God *as we understood him*' (italics in original) and admitting 'to God, to ourselves, and to another human being the exact nature of our wrongs'.

of individuals who engage in substance misuse, relationships in Benelong's Haven are based on a concept of self-exposure and moral truth. The formation of group solidarity within the centre is seen as the main avenue through which residents can alter their relationship with the world. One resident expressed this when he stated: 'We gotta take the spirit out of the bottle and put it back between us'. Of course the readjustment of residents' relationship with the world is the aim of many other rehabilitation centres. However in Benelong's Haven this was politicised so that residents' efforts to regain what has been lost took on a historical perspective that was viewed as part of a larger Aboriginal movement of self-determination (Chenhall 2007: 225-26).

In the years that followed its establishment, Benelong's Haven became a model for other Aboriginal residential treatment programs, including Moree Aboriginal Sobriety House (MASH) in NSW, the Foundation of Rehabilitation for Aborigines with Alcohol-Related Difficulties (FORWAARD) in Darwin, Wandering in Western Australia, Namatjira Haven in Lismore, and a centre on Palm Island, Qld. (Brady 2002). Aboriginal Sobriety Groups, also based on AA, were also created in Adelaide (Sumner 1984) and Melbourne (Commonwealth of Australia House of Representatives Standing Committee on Aboriginal Affairs 1977).

One of the earliest residential treatment programs was established in Broome, in the Kimberley region of Western Australia, where a local group known as the Broome Aboriginal Alcohol Committee was formed in 1978 to generate community support and resources for an alcohol rehabilitation centre. The Committee's efforts are described in an account published in the *Aboriginal and Islander Health Worker Journal* in 1985:

> The Broome Aboriginal Alcohol Committee became known as Milliya Rumurra, meaning First Day, or Brand New Day, in July 1978, when their two alcohol counsellors returned from training in Perth. The committee was made up of a chairman and vice-chairman, a secretary/treasurer and six other members. The committee asked various members of the Broome community to give their services on an advisory committee. This meant that Milliya Rumurra had a lot of contacts and support with many different parts of the community. On the advisory committee were magistrates, the police superintendent, the assistant shire clerk, the prison superintendent, a shire councillor, a doctor from community health, a social worker, a local businessman, a teacher and an accountant. All kinds of expertise were available to Milliya Rumurra.

> The group sent information to the National Aboriginal Conference, who wrote to the Minister for Aboriginal Affairs in support of their work. The Broome Shire Council formally gave support to the group and offered them the use of the Civic Centre for educational films at only a small charge (Daniele 1985: 30).

The group was granted a site through the Aboriginal Lands Trust for a rehabilitation centre. Initially, counsellors worked without a regular income and used their own cars. Despite the extensive local support, it was not until January 1980 that Milliya Rumurra received ongoing government funding for its program (Daniele 1985).

By 1986, Milliya Rumurra had expanded both its funding base and range of activities. Clients attending the residential program stayed for a minimum of three months, sometimes alone, sometimes with their families (Read 1986). According to one staff member's account, clients on arrival were 'physically, mentally and spiritually sick', requiring one-to-one counselling to identify their challenges and

potential solutions (Read 1986: 38). The program had six main components, itemised in Box 4.1.

Box 4.1 Milliya Rumurra's Treatment Program in 1986
Extract from Read (1986: 39–40).

The permanent parts of the program are: (1) AA; (2) Medical talks; (3) Nutrition talks; (4) Financial budgeting; (5) Arts and crafts; (6) Women's programs.

1. AA
   We at Milliya Rumurra promote a total sobriety program. Clients meet twice a week for meetings to help them understand their ways when drinking and how to work for sobriety.
2. Medical talks
   Most of our clients are aged 30+ and have little understanding of how their bodies work and even less understanding of what alcohol and drugs do to their bodies. By the use of films, slides, charts and discussion, people gain knowledge of the effects of alcohol on the body. These talks extend into associated areas such as high blood pressure, diabetes, STD, and fetal alcohol syndrome.
3. Nutrition talks
   Alcohol dependents come into treatment poorly nourished, as all money goes for grog and very little for food. On discharge most clients will only be receiving unemployment benefits or pensions, so it is important to teach people how to purchase and prepare cheap nutritious food. Whilst at the centre we try and keep carbohydrates to the minimum, especially encouraging people to cut down on sugar intake. We encourage people by taking them bush or to the coast to use more traditional foods, bush tucker, fish, turtle.
4. Financial budgeting
   If previously all money has gone for grog, it is important to teach again how to budget money for rent, food, clothing and other things. All clients are encouraged to start up savings accounts and to save money from each cheque.
5. Arts and crafts
   Time passes for alcohol addicted people in buying alcohol, drinking it, or sleeping it off. When alcohol is no longer there they need activities to fill their time. We run many different courses but especially encourage the more traditional crafts such as carving.
6. Women's groups
   We believe that, although women could attend all other groups, there is a need for their own, away from the men. Again these groups are flexible, discussing issues such as parenting skills, child care, contraception, STD,

breast self-examination and women's health, assertion skills for women, and goal setting. Women also have an opportunity to discuss problems related to their drinking.

In order to assess the effectiveness of programs at the centre we rely mainly on verbal feedback and client assessment—if a client is showing overall improvement, that would indicate effectiveness of the program.

By the mid-1980s, Milliya Rumurra's staff had also become increasingly concerned with the need for prevention and education as well as treatment. In attempting to meet these needs, program staff discovered that most existing resources were designed for non-Aboriginal people with good literacy. So they set about developing their own resources. In collaboration with local schools, educational materials were incorporated into curricula for Years 9 and 10 at high schools and Year 6 at the primary school. Aboriginal student health workers also received training in physical and mental aspects of substance abuse and in prevention and counselling skills (Read 1986).

In later years, Milliya Rumurra underwent further changes. The most important of these was a shift away from relying on the disease concept of alcoholism to a harm-minimisation approach that incorporated controlled, moderate drinking as a treatment option alongside abstinence (Strempel et al. 2004: 44). Also, in 1998, Milliya Rumurra tendered successfully to manage a newly established sobering-up shelter in Broome (Strempel et al. 2004: 47). In 2004, the Milliya Rumurra Alcohol and Drug Rehabilitation Centre was selected by the National Drug Research Institute as an example of best practice in residential treatment that could be used as a model by other communities (Strempel et al. 2004). The Centre's program had four objectives:

- to promote safe drinking practices;
- to stop injuries and other harm caused by the misuse of alcohol;
- to strengthen family relationships and social environments; and
- to raise the health and quality of life of people who abuse alcohol and their families (Strempel et al. 2004: 44).

In order to be accepted for the residential program, clients had to have substance misuse as their primary presenting problem and to be willing to undergo detoxification at the local hospital if necessary. The program as it operated at the time is described in Box 4.2 below.

Box 4.2 Milliya Rumurra Rehabilitation Program in 2003[2]
From Strempel et al (2004: 44–46).

Program outline

To achieve program objectives, clients have to commit themselves to a structured three-month residential program. Clients and their immediate families can be accommodated at the centre, which has a capacity of 25 people. On arrival they are individually assessed by one of the three counsellors who works through their substance misuse histories with them, and how their issues will be addressed by the weekly program. On Mondays and Fridays clients voluntarily attend anger management sessions run by the Department of Justice. On Tuesdays and Thursdays clients participate in a health education program which outlines the health and social harms of alcohol and other substances, and a social learning program which encourages clients to address issues such as assertion. These are conducted in classroom-type situations and accompanied by videos, information sheets and teacher guides. Recreational activities are scheduled for Wednesdays, and the centre has a number of vehicles (buses and four wheel drives) for transporting people on hunting and bush outings, and a dinghy for fishing trips.

Childcare is available to parents attending education and counselling sessions. As well as these structured sessions, clients and their families have access to one-on-one counselling on request and other support to help them re-establish their lives outside the centre. Many people have chronic health problems associated with their drinking, and centre staff assist with the identification and treatment of medical, dental and mental health problems while clients remain at Milliya Rumurra.

Staffing

Seventeen permanent staff and other casual staff are employed to manage and run the rehabilitation program. These include the manager/coordinator, counsellors, other program staff, bookkeepers, receptionist, gardeners, cook, childcare workers and nightwatchman. Twelve of the 17 permanent staff members are Indigenous. Although the centre aims to employ as many Indigenous staff as it can, the demanding nature of the work and the remote location of Broome make it hard to attract and retain qualified people.

…

---

[2] The complete monograph from which this extract is taken can be downloaded from https://ndri.curtin.edu.au/research/project-detail/231.

Evaluation

Evaluation of the rehabilitation program's success is not easy. Currently the main measure the centre judges this on is the number of completions of the three-month program. As the coordinator says, completion for many clients is a considerable achievement:

> There's a misconception about rehabilitation — that clients walk in with a whole lot of problems and walk out with all the problems solved. We try to get people to accept that a lot of work needs to be done by them. Some people have been drinking 20 to 30 years; it's unrealistic to turn this around in three months. One client has been here seven times and is currently abstinent. Lots of clients say that there's so much content in the program, they don't get it the first time — especially those people with literacy and numeracy problems.

Of the 93 clients who commenced the three-month residential program in 2001–02, 25 (27%) completed 9–12 weeks, a further 17 (18%) completed 13–16 weeks, and three (3%) remained for 17–20 weeks. Before leaving Milliya Rumurra, all clients should have a Discharge Summary Plan, which outlines support for them in the community and any follow-up offered, or planned, between counsellors and clients.

At the time of the above report no resources were available for following up with clients to see whether or not they had ceased drinking and/or reduced levels of alcohol-related harm. However, an AA meeting was held on Tuesday mornings at Milliya Rumurra's sobering-up shelter, followed by a session of their Health Education Program. This enabled ex-clients and others to maintain links with Milliya Rumurra staff (Strempel et al. 2004: 46).

In 2014, the National Indigenous Drug and Alcohol Committee (NIDAC) singled out Milliya Rumurra as an example of an effective treatment program that combined evidence-based mainstream approaches to alcohol and other drug problems with culturally specific interventions (National Indigenous Drug and Alcohol Committee (NIDAC) 2014).

4.3   Alcoholism as a Family Disease

All of the residential treatment programs mentioned above, whatever the differences among them, shared a common focus on the individual drinker as the subject of treatment and rehabilitation. In the view of several people with 'front line' involvement in addressing Aboriginal alcohol issues, this was too narrow a scope. Harold Hunt, a one-time alcoholism counsellor with the Health Commission of NSW and Chairman of the National Aboriginal Campaign against Alcohol and Drug Abuse, argued that

alcoholism was a 'family disease' requiring interventions involving the whole family
(Hunt 1981: 3). He called for three levels of intervention, focusing on:

(a)   Alcoholism as it affects the individual alcoholic;
(b)   Alcoholism as it affects the alcoholic's family;
(c)   Alcohol abuse as it affects the community (Hunt 1977: 25).

In an article published in 1981 in the *Medical Journal of Australia*, Hunt argued
that interventions into alcoholism, which he described as a 'family disease', needed
to be embedded in a broader policy framework that addressed conditions giving rise
to alcohol misuse. An extract from the article is reproduced below.

Box 4.3 What Can Be Done?
Extract from Hunt (1981: 2–3).

Alcoholism in Aboriginal communities needs to be tackled on two fronts—one
front related to health programmes and the other to tackling the broader social
issues which confront Aborigines today. In the short term, we have to keep
Aborigines alive.

Health Programmes

AA, Al-Anon. AI-Ateen[3]

In treating alcoholism, we need to be aware of all the options available.
However, I believe that alcoholism is a family disease–whole families are
affected and, hence, whole families need treatment. There is a total treatment
available to the alcoholic and his or her family, and it has been around for a
long time. Possibly someone you know is a living proof of its effectiveness.
I refer, of course, to the treatment programmes which consist of Al-Ateen
for children, Al-Anon for spouses and close family members, and Alcoholics
Anonymous (AA) for the drinker. This family-treatment programme for alco-
holism has proved to be a most effective method, usually succeeding when all
other methods of treatment have been tried and found ineffective.
    …
    Treatment for alcoholism must be intensive in the early stages, and then
be continued on a regular basis. If a diabetic is taking insulin irregularly or
stops it altogether, he or she becomes sick—so, too, will those suffering from
alcoholism if their treatment is stopped or given only occasionally.
    …

---

[3] Al-Anon is a related program designed to support parents, spouses, siblings and other family
members of alcoholics, and Al-ateen has a similar role but with a focus on young family members.

I believe that AA, Al-Anon and AI-Ateen programmes are particularly relevant for Aboriginal people, as Aboriginal culture and lifestyle are identical to the AA philosophy. These programmes, like Aboriginal lifestyle, are based on communal spirituality.

Counsellors

Crucial to the success of the programme is the proper selection of alcoholism counsellors. Too often it has been assumed that it is most important to choose Aboriginal alcoholism counsellors for Aboriginal people. Yet, Aboriginal self-help organizations, such as the Aboriginal Medical and Legal Services, do not operate on this principle and recognize that skill is the crucial element in success; for example, they employ appropriately skilled people (doctors and lawyers) regardless of their race. The same applies to the various disciplines within the New South Wales Health Commission.

Until this rule is applied to counselling Aboriginal sufferers from alcoholism, success will be minimal. It follows that we should select staff with the most appropriate skills and provide them with an adequate training programme. Of course, we would prefer Aborigines with these skills, where possible.

Detoxification Units

There is a need for detoxification units to be established in many more hospitals throughout the State. Hospitals that need particularly urgent attention are those in Walgett, Bourke, Brewarrina, Wilcannia, Goodooga and Lake Cargellico, because of their large number of Aboriginal inpatients.

Health Education

Changing society's attitudes to drinking is a long-overdue health education activity.

Broader Issues Which Need Tackling

While the above strategies would deal with the health issues of alcoholism, there are a number of other issues which, strictly speaking, lie outside the health field, but which, nonetheless, have a significant effect on the prevalence of alcoholism amongst my people.

Unemployment

Aborigines have the highest level of unemployment of any group in our society today. It is normally easier to count the number who are employed rather than those who are unemployed. The provision of employment opportunities will significantly improve the well-being of my people.

The Welfare Society

Over the last 200 years, a welfare society has been created for Aboriginal people, which has destroyed incentive and created a state of apathy. This has been done by depriving our people of basic resources (such as hunting lands, our sources of traditional food and materials for shelter) and self-respect (by ignoring our religious beliefs, laws, languages and our views on possible ways of coexisting together). In their place, flour and blankets were handed out in the past, while today it is "cold cash" doled out by a host of competing and confusing welfare agencies, with no real dialogue taking place between the giver and the receiver. Further, in too many cases we are seen as a separate species, "the Aboriginals", rather than as Australian citizens of Aboriginal descent with the same rights and responsibilities as all other Australian citizens.

This situation can be corrected only by giving appropriate support (not necessarily financial) to people who are making personal efforts to improve their lot to their own satisfaction, rather than to the satisfaction of people unfamiliar with the realities of the situation.

Rights and Justice

The deprivation of hunting rights and of the rights to gather building materials (for example, timber, grass, brush), as a result of the takeover of our land without consultation with Aboriginal people, has been a denial of the people's rights and entitlement to justice.

This situation is not entirely reversible. However, the powers that be should at least consult with Aboriginal people and be guided by us in whatever action is necessary to deal with the present and to plan for the future. The past is where it belongs, so let us not be blinded by resentment and hence neglect to gain by the lessons learned from history.

In retrospect, Hunt's analysis is notable for several reasons. Firstly, like many Aboriginal people concerned with alcohol problems, he viewed the AA 'philosophy' as being congenial to Aboriginal culture, largely because of the emphasis both perspectives place on what Hunt called 'communal spirituality'. Secondly, he insisted that counsellors working in Aboriginal alcohol programs must be properly trained and skilled, and that level of skill was more important than being an Aboriginal recovering alcoholic. Thirdly, he argued that alcohol-focused interventions needed to be complemented by programs and policies that addressed contributing conditions such as high unemployment. Finally, he drew attention to the corrosive effects of the welfare system on Aboriginal society—an argument that Noel Pearson would later

develop in labelling what he called 'passive welfare' as a key factor in contributing to alcohol and other drug misuse.[4]

A shift in focus from individual drinkers to drinkers' families found practical expression in the 1980s in several programs in the Northern Territory. In 1985, Roger Sigston, an alcohol counsellor working in remote Aboriginal communities, published a paper in the *Aboriginal and Islander Health Worker Journal* in which he argued that the family—defined somewhat vaguely as 'close and/or important kin'—must be the focus of intervention for two reasons: firstly, in contrast to other social entities such as Aboriginal communities and community councils, families had the potential capacity to bring about change in the drinking behaviour of members (provided they were given appropriate support); secondly, families had also become unwitting facilitators of alcohol misuse as a result of drinkers appropriating resources intended for the wider kin network to fund their alcoholic lifestyles. Change in drinkers' behaviour would, therefore, require change at a family level (Sigston 1985).

At around the same time—between 1983 and 1985—the Darwin-based Catholic Missions established what was initially called the Alcohol Awareness Sobriety Centre, offering a treatment approach based on a 'family disease' model of chemical dependency (d'Abbs 1990: 21). The concept of chemical dependency originated in the US in the 1940s, where it became known informally as the Minnesota Model. The model retained the concept of alcoholism as a progressive disease that could be arrested but not cured, but broadened it to other addictive substances (Cook 1988). Like alcoholism, chemical dependency also had a spiritual dimension. The concept of chemical dependency as a family disease involved the recognition that dependency affected all members of the family as well as the drinker, exposing all of them to a risk of becoming emotionally, spiritually and physically sick (Cook 1988; d'Abbs 1990). In developing a residential treatment program for Aboriginal people in the NT, Catholic Missions also drew ideas from the Holyoake Institute, a Perth-based alcohol rehabilitation facility established in 1975, and Kakawis, a family residential alcohol treatment program in Vancouver, Canada.

In 1987, the Sobriety Centre—now renamed Alcohol Awareness and Family Recovery (AAFR)—opened a residential treatment program for families at Wulk Witby, 200 km southwest of Darwin and close to the Aboriginal community of Daly River (today known as Nauiyu). The program took the form of an intensive four-week course, with separate courses for drinkers—categorised as 'dependent'— and the spouses or partners of drinkers, who were categorised as 'codependents'. (A 'codependent' according to this perspective is someone—often a spouse of a dependent drinker—who is seen as meeting psychological needs of their own by facilitating the self-destructive behaviour of the dependent person, for example, by shielding them from the full consequences of their actions.) Sustainable change in the behaviour of the dependent, according to this model, also requires a change in that of associated codependents. (For accounts of the development and application

---

[4] Hunt's own remarkable life is told in his autobiography published in 2016 when he was 91 years old: (Hunt 2016) In 2014 he was awarded an Order of Australia Medal for services to the community.

of the concept of codependency, including critiques, see (Anderson 1994; Gordon and Barrett 1993; Haaken 1990; Gomberg 1989).

In an independent evaluation of the program conducted in 1990, the drinking status of 82 former clients of the Daly River Family Program was compared with that of a random sample of 79 residents of the same community who had not attended the program (d'Abbs 1990). Former clients were found to be more likely to be non-drinkers, and less likely to be heavy drinkers, than those who had not attended the program, although the differences were not statistically significant.

4.4   Criticisms of the Disease Concept and Twelve Step Programs

As we noted earlier in Chap. 2, the notion that habitual alcohol misuse is best conceptualised as the disease of 'alcoholism' has long been contentious. On the one hand, there is no doubt that some problem drinkers become physiologically dependent on alcohol to a degree that they are no longer capable of regulating their intake. Labelling this condition a disease, at the very least, indicates that the drinker's inability to regulate or stop drinking is not simply a product of moral weakness. On the other hand, not all those whose drinking harms themselves and/or others fall into this category. Many Aboriginal drinkers, for example, who engage in binge drinking when the circumstances allow, also demonstrate a capacity to cease drinking completely for long periods, often as a result of moving away from towns. Similarly, on occasions when the supply of alcohol to Aboriginal drinkers has been abruptly cut off, as has happened on occasions in some remote communities with local outlets, the streets and clinics have not been inundated with drinkers suffering from acute withdrawal symptoms, as the disease model sometimes leads people to expect.[5] Habitual drinkers may be very annoyed, but most do not lapse into delirium tremens or other symptoms of physiological distress. Finally, some Aboriginal people with long drinking careers stop consuming alcohol without going through any treatment program, as Brady has shown (Brady 1993, 1995c).

The disease concept of alcoholism and the associated Twelve Step programs have also been criticised for offering too few treatment options. Since alcoholism is a disease characterised by a lack of self-control over consumption, only one strategy is considered viable: abstinence. Critics argue that this is both impractical—insofar as for some drinkers at least the social and cultural settings make cessation almost unachievable—and unnecessary, in that some people who are currently drinking at harmful levels may, with appropriate guidance and support, be able to moderate

---

[5] To our knowledge, examples of such events have not been documented, probably because by their very nature they occur without warning. However, one example is furnished by the NT 'Intervention' in 2007, when the Commonwealth Government summarily prohibited drinking on almost all land in the NT designated as Aboriginal. At the time, the government, anticipating an upsurge in withdrawal symptoms, created new positions in NT hospitals to manage the expected demand—which in reality never materialised.

their intake without having to cease drinking altogether (Brady 1995a; Institute of Medicine 1990).

In part for these reasons, the enthusiasm of Aboriginal and other service providers for the disease model of addiction and Twelve Step programs has not been shared by the government agencies that normally fund them. As early as 1980, an internal Department of Aboriginal Affairs (DAA) review expressed scepticism about the effectiveness of programs being funded (Brady 2002). Another internal DAA review conducted in 1986 concluded that, in addition to weak evidence of treatment effectiveness, facilities were not provided with adequate support to fulfil whatever potential effectiveness they might have had, especially in regard to governance and staff training (Wilson 1986). The review called for a shift in policy away from residential rehabilitation towards prevention and community-based programs, including counselling, assessment and referral, as well as support for local AA groups. At the same time, recognising the continuing need for residential rehabilitation, the review recommended funding a smaller number of quality programs and supporting these with adequate staff training (Wilson 1986).

In 1995, responsibility for funding Aboriginal alcohol and other drug programs was transferred to the newly-formed Office of Aboriginal and Torres Strait Islander Health (OATSIH) in the Commonwealth Department of Health and Aged Care. In 2001, OATSIH commissioned Maggie Brady to review options for the improvement of residential treatment programs for Aboriginal people.

Brady noted that Aboriginal people with alcohol and other drug problems were more likely to seek residential treatment than non-Aboriginal people with similar problems, and that residential treatment facilities continued to absorb a large proportion of Commonwealth, State and Territory funds spent on Aboriginal and Torres Strait Islander alcohol and other drug services. She also identified several ongoing issues that compromised treatment outcomes. These included, firstly, continuing isolation from other services, a feature that Brady attributed to the fact that, when the first Aboriginal treatment programs were established in the 1970s, they had been able to secure their own funding stream through the Department of Aboriginal Affairs (DAA). As a result, they were independent of both Aboriginal community-controlled medical services that evolved around the same time, and from mainstream alcohol and other drug services. In general, according to Brady, once residential treatment programs had become established, they tended to receive ongoing funding, regardless of evidence of effectiveness, with a result that the structural isolation had endured (Brady 2002). One consequence was that people associated with Aboriginal treatment programs tended not to have networks linking them to a broader world of alcohol and other drug treatment. This contributed to a second issue identified by Brady: the narrow range of treatment options offered by most—though not all—residential programs. The majority were based on the Twelve Step disease model of treatment or the Minnesota Model, and promoted abstinence as the only viable treatment goal. The implied criticism, voiced by others besides Brady (e.g. (Alati 1996; Gray et al. 2000)) was directed not so much at Twelve Step programs themselves but at the absence of alternative treatment options for clients who might benefit from them.

A third issue identified by Brady was the generally low level of training in alcohol and other drug treatment among program staff, many of whose primary qualification was that they themselves were Aboriginal ex-drinkers. This was particularly problematic in light of a fourth issue identified by Brady: an increase in the numbers of people presenting for problems arising from drugs other than (or as well as) alcohol—especially opiates, amphetamines and cannabis—or polydrug use. Alcohol, though still the most common presenting drug issue, was declining in relative importance, but few treatment staff were equipped to address the emerging problems.

Finally, Brady drew attention to continuing problems with the governance of residential programs. Members of boards tended to have limited knowledge of alcohol and other drug treatment; some boards consisted entirely of members of one family group, and many board members had limited understanding of the functional differences between boards and managers (Brady 2002).

Brady recommended a number of measures to address these issues and contribute to more effective treatment programs. These are summarised in Box 4.4.

Box 4.4 Elements of a Successful Indigenous Residential Treatment Program
Extract from Brady (2002: 21–22).

So what are the essential elements of a successful Indigenous residential treatment program? Based on this research, and the advice of others (Ernst and Young Consulting Team 1996; Hunter et al. 1998; Sputore et al. 1998), the following is a guide.

Governance

- a good administrative and management base
- participation in regular quality improvement reviews by accredited reviewers
- a clear definition of the purpose of the program, either as a structured treatment program or a dry recuperative facility
- clear distinctions between the roles and responsibilities of boards and managers
- board members with knowledge and experience of mainstream residential programs
- participation by board members in training (both governance and AOD)
- rules to cover day release activities for clients, as well as rules of conduct within the program
- having the support of the local community or local population.

Training and networking

- counsellors who have training to increase their confidence and efficacy and to acquire new skills

- ongoing in-service training, staff exchanges and placements with larger organisations
- staff mentored by outside professionals
- close involvement with a local doctor to provide assessment before, during and after admission, supervision of detoxification, pharmacotherapy, assistance with care plans, advice to clients
- formal and informal partnerships with local public health professionals and State AOD services
- membership of, and participation in, relevant regional AOD NGO networks and TC associations.

Program content

- a safe drug/alcohol-free environment
- an environment that takes into account people's cultural, familial and social circumstances in an informed and respectful manner
- time and place for clients to withdraw from a high-risk lifestyle or situation
- peer support and encouragement to withdraw from use
- education regarding strategies for maintaining moderate drinking, or a lifestyle free of drugs and alcohol, to match client's needs
- encouragement of open reflection and discussion of personal issues related to use
- healthy lifestyle, structured activity, and balanced diet during residence
- assistance with a range of issues associated with community living and daily living skills
- providing vocational, recreational and 'cultural' activities
- providing practical skills through TAFE and other vocational training (literacy, carpentry, agriculture, permaculture, art production, etc.)
- planning for discharge, provision of after care and home visits after treatment, or referrals to achieve this.

4.5 Culture, Healing and Alcohol Misuse

Another approach to treating alcohol and other drug misuse among Aboriginal people focuses on the presence of unresolved, intergenerational trauma resulting from colonisation and dispossession, and the need for healing programs grounded in Aboriginal cultures. The origins of this approach were described in Chap. 2 (Sect. 1.7). As explained there, most programs based on this approach incorporate the AA-Twelve Steps treatment model but combine this with Aboriginal and other First Nations healing pathways. Many programs also incorporate one or more 'Western' therapies. The underlying rationale for this approach is (1) the belief that conventional Western therapies are not equipped (at least on their own) to address the traumas generated by

colonisation, and (2) a belief that Indigenous cultural traditions and identity *do* have healing powers and procedures that are better able to meet these needs.

One of the earliest instances in Australia of an alcohol treatment program based on overseas First Nations healing practices was a residential treatment facility established by the Central Australian Aboriginal Alcohol Program Unit (CAAAPU) in Alice Springs in 1992. The CAAAPU program evolved from extensive mobilisation and consultation in Central Australia, beginning in early 1989, when several Aboriginal people in Alice Springs set up a self-help group called 'Triple A'—or Aboriginal Alcoholics Anonymous—based on AA principles (Wynter 1991). Later in the same year, the Aboriginal Issues Unit of the Royal Commission into Aboriginal Deaths in Custody convened a 'grog forum' in Alice Springs, where Aboriginal participants called for a comprehensive alcohol strategy to cover the whole of the central Australian region (Lyon et al. 1992). This led to two more grog forums, at the second of which—a two-day meeting held in November 1990 and attended by more than 50 representatives of more than a dozen Aboriginal organisations—it was agreed to seek Commonwealth funding for a planning unit, which envisaged spending 12 months consulting with Aboriginal communities and organisations throughout the region and preparing a regional alcohol strategy (Lyon et al. 1992).

In the event, funding was provided for only six months, but consultation and preparation of a strategy went ahead. In its deliberations, the Central Australian Aboriginal Alcohol Planning Unit, as it was then called, drew on three main sources for ideas: a series of bush meetings held in remote Aboriginal communities; a commissioned review of alcohol interventions conducted by researcher/consultant Pamela Lyon,[6] and a team of Canadian Indian consultants from the Nechi Institute in Edmonton, Canada, and an associated treatment facility known as Poundmakers' Lodge (Miller and Rowse 1995). The resulting strategy was published in January 1992 as a three year, region-wide 'Grog Action Plan' (GAP) encompassing prevention, early intervention and treatment (Lyon et al. 1992). In anticipation of a change in role from planning to overall co-ordination of the GAP, CAAAPU itself changed its name from Central Australian Aboriginal Alcohol Planning Unit to Central Australian Aboriginal Alcohol *Programs* Unit (Miller and Rowse 1995). Central to the GAP was a residential treatment and training facility, to be tailored to the needs of local Aboriginal communities but "based on the model used at the Indian-run Poundmaker's Lodge in Alberta, Canada" (Lyon et al. 1992: 39).

The proposed treatment facility was just one of several program components that would be administered by CAAAPU. As it turned out, CAAAPU did not succeed in attracting the resources that such a broad role entailed and, through the three year period covered by the GAP, became increasingly focused on establishing and running the treatment centre. Under the GAP, a research team from the Menzies School of Health Research was invited to evaluate the implementation and outcomes of the treatment program (Miller and Rowse 1995: 1). In their evaluation, the researchers grappled with several issues that have relevance beyond the specific program under review. Two, in

---

[6] A summary of Lyon's review is reproduced as Appendix H in the Grog Action Plan (Lyon, Hill, and Wynter 1992)—unfortunately without the accompanying references.

particular, warrant consideration here. The first is: how does one adjudge success or failure in an Aboriginal residential treatment program such as CAAAPU? The second: what lessons should we take from what was, in effect, a treatment program created from three cultural components: Canadian Indian healing practices, Aboriginal cultural traditions and the principles and practices of Alcoholics Anonymous?

In evaluating treatment outcomes, the researchers—like most evaluators in comparable situations—had to make do with less than ideal, and less than complete, data. The principal data sources were records of 412 admissions from 1 October 1992 to 10 November 1994, and interviews with 97 program participants conducted between November 1993 and July 1994, including 25 who were ex-clients at the time of interview. Of the 25, only seven told the researchers they were sober, and one of these had been in jail ever since discharge.[7]

The evaluators' interpretation of these findings is summarised in the extract below.

Box 4.5 Interpreting Outcomes of Residential Treatment
Extract from Miller and Rowse (1995: 17–18).

It is debatable whether these figures attest to success or failure. Of one thing we are sure: to count sober people is too crude a measure of CAAAPU's success. We therefore offer three additional kinds of data to answer the question of 'effectiveness': (a) factors associated with length of stay; (b) ability to recall program content; and (c) orientation to aftercare.

Residential treatment is not something that Aboriginal people from central Australia take to easily. There has always been a high rate of drop-out from treatment, almost one half of all admissions staying less than two weeks. There is a slight but persistent association between dropping out early and being a person from Alice Springs, especially from a town camp or a creek-bed camp. There is a slight but persistent association between residing far (more than 150 kms) from Alice Springs and staying longer in the program. English as a first language is associated with a tendency to stay longer in the program. In short, if we take length of stay in the program as one measure of CAAAPU's success, then CAAAPU is working better for Aboriginal people who have more in common culturally with non-Aborigines: speaking English and living in a town house.

What orientation is being given to people by the program? CAAAPU's *Treatment Policies and Procedures Manual* states that 'the residential phase of the CAAAPU program is designed to provide only a foundation of knowledge, skills, and self-awareness on which the individual must build a lifelong program of continuing sobriety and recovery.' Our interviews with clients almost always impressed on us that clients were stimulated by the program. Their attention

---

[7] From the context, 'sober' here appears to mean having ceased drinking, rather than simply not being intoxicated at the time of interview, although this is not clear (Miller and Rowse 1995: 17).

was actively engaged with new and interesting information; they were not bored (though some would have liked better recreation facilities). In our follow-up interviews, we asked if people had understood the lectures. Over half (13 out of 25) admitted that they had had some difficulty, but 24 of them assured us that they had learned some important things. When we asked them to recall something which they had learned, four were unable to say anything. Only 12 could give us something specific: six mentioned the effects of alcohol on the body, four referred to CAAAPU's theories of illness/denial, and two referred to other matters.

The *Treatment Policies and Procedures Manual* also states CAAAPU's belief that 'the single most effective source of support for this ongoing process of self-help and recovery is the fellowship of Alcoholics Anonymous; thus, the AA philosophy and twelve steps of recovery are an integral part of the CAAAPU treatment program'. We are not sure whether clients are leaving the program with this orientation. Certainly, clients interviewed early in treatment or in the middle of their stay do not spontaneously voice an inclination to turn to AA after treatment. We asked them 'What is the hardest thing about giving up?' and 'What do you think it will be like when you get home?' These questions gave people an opportunity to mention any factors which they thought would affect their continuing recovery. Only one in ten (11%) mentioned 'aftercare' of any kind. More than three times that many mentioned 'moving' (to another city, to an outstation) as a promising possibility, and just under half spoke of the persistence of social pressures to drink. When we followed clients up, nine of the 22 interviewees who were not in gaol said that they had had no contact with aftercare agencies of any kind. Eleven mentioned having some contact with CAAAPU, but our definition of contact was loose enough to include occasional encounters in the street in which the merest pleasantries were exchanged. Among those eleven were two whose contact took the form of readmission to the residential treatment program and two who have been employed at CAAAPU since discharge. We have formed the impression that most of CAAAPU's clients do not leave the treatment program with a desire to establish themselves within an AA-style aftercare regime. They are more inclined to be considering factors such as where and with whom to live and whether they can get employment.

CAAAPU's treatment program drew on three sources: Australian Aboriginal cultural concepts and practices, Canadian Indian healing traditions as these had been adapted by the Nechi Institute and Poundmaker's Lodge, and Alcoholics Anonymous—a self-help movement that had been started by two non-Indigenous men in the US in the 1930s. The belief that these three strands would be mutually compatible and could be woven into an effective and acceptable treatment program rested on a number of premises: one was the shared history of colonisation, dispossession and cultural oppression common to Aboriginal Australians and Canadian Indians,

a history that had also resulted in parallels in the ways in which alcohol was used and alcohol-related difficulties experienced in both populations. Another was the Nechi Institute's apparent success in blending Indigenous healing practices with non-Indigenous therapeutic practices to create a treatment program that was culturally acceptable to Canadian Indians. A third was the already established acceptability of AA, the associated disease concept of alcoholism and the 12-step treatment pathway, among both Australian Aboriginal and Canadian Indian alcohol treatment agencies.

In practice, difficulties emerged, so much so that, in June 1994, CAAAPU terminated its relationship with Eric Shirt and Associates, the Canadian Indian consultants who had been engaged to help establish CAAAPU (Miller and Rowse 1995: 19). Miller and Rowse identified several sources of tension. One was the complex relationship between alcoholism and Aboriginal culture, as they note in the extract below.

Box 4.6 AA and Aboriginal Culture
Extract from Miller and Rowse (1995: 23–24).

CAAAPU's treatment philosophy, as we have pointed out, states that 'the AA philosophy and twelve steps of recovery are an integral part of the CAAAPU treatment program.' It has been essential to AA's work all over the world that clients learn to distance themselves from those aspects of their culture which have propped up their drinking. From the client's point of view, the AA group is a new (sub)culture which empowers the client to continue this critical review and, where necessary, repudiation of the culture which has supported his/her drinking. CAAAPU's commitment to AA is therefore crucial to its critical assessment of 'Aboriginal culture'.

…

By adopting the 'disease' notion and by fostering Alcoholics Anonymous as a form of aftercare, CAAAPU approaches Aboriginal traditions in ways both respectful and critically innovative. CAAAPU aims to confront the pathological while supporting the spiritually fortifying elements of Aboriginal culture.

It would be possible to argue that the 'disease' notion, the techniques of AA and the associated suspicion of the culture of the drinker as 'denial' are all North American impositions on local Aboriginal leaders. We do not share this view because we have witnessed the conviction with which the Aboriginal leadership of CAAAPU has tackled the task of sifting the good from the bad in 'Aboriginal culture'. This is a task they have performed in their own lives, struggling to be sober Aboriginal people in a cultural setting which has, in their view, long given too much ground to the culture of alcohol. There is an affinity between the North American view of what is required in the recovery from alcoholism and the challenges which have been faced by these sober Aboriginal people. This affinity was, for two and a half years, the basis of a

> powerful attraction between CAAAPU and Eric Shirt and Associates, giving rise to a mutually beneficial working relationship at CAAAPU.
>
> However, we have also noted that among Aboriginal people associated with CAAAPU there have been different views about what features of Aboriginal culture should be respected and sustained and what features should be confronted.

Miller and Rowse identify three issues around which controversies arose: one was the use of mixed gender group counselling sessions. In both AA tradition and that of the Canadian Indians as practised by Poundmakers' Lodge, men and women were expected to attend mixed counselling sessions, in part so that each could gain an understanding of the other's experience of harmful drinking. This did not accord, however, with local Aboriginal cultural practices and disturbed some participants. A second issue was the use of English for program purposes. For many participants, English was not their first language, and many reported difficulties in following lectures and counselling sessions, particularly given the use of technical terms such as 'dysfunctional families'. Thirdly, some participants in CAAAPU's training programs found the training styles of 'the Canadians' (which, as Miller and Rowse point out, included one Māori) to be too confrontational (Miller and Rowse 1995: 24–28). Today, CAAAPU continues to offer residential treatment, as well as outreach and daycare programs, on its five-hectare property on the outskirts of Alice Springs.[8]

Another attempt to integrate the treatment approach developed at the Nechi Institute with Australian Aboriginal cultural traditions, as well as AA principles, is Gregory Phillips' ethnographic study of alcohol, marijuana and gambling in a Cape York, Qld., Aboriginal community to which he gave the fictitious name of Big River (Phillips 2003). Phillips, an Aboriginal researcher, set out to understand the factors that shaped ongoing addictive behaviours in Big River, and why so many alcohol and other drug programs for Aboriginal and Torres Strait Islander people appeared to have little impact. He also expressed a wish to advance 'an Indigenous point of view' as an alternative to the analyses and explanations of non-Indigenous researchers (Phillips 2003: 2).

Phillips concluded that addictive behaviours and the violence and other harms associated with them were products of accumulated, unresolved trauma, the origins of which lay in the settler violence and displacement accompanying European colonisation, which was followed by several decades of strict missionary control, during which culturally valued ways of dealing with trauma, such as ceremonies, were suppressed. The introduction of 'drinking rights' in the 1960s created new, illusory opportunities for dealing with the unresolved trauma, as Bama (the name by which Aboriginal residents of the area refer to themselves) began directing their resentment and anger at each other.

'Western' models of sickness and health, Phillips argues, are incapable of addressing unresolved, intergenerational trauma of this kind (at least on their own)

---

[8] http://www.caaapu.org.au/caaapu-story/ (retrieved 9 December 2021).

because they are grounded in a mind-body dualism that does not recognise a spiritual domain. This domain, he argues, is central to understanding unresolved trauma. It was for this reason that Phillips turned to the treatment programs developed by the Nechi Institute.

In developing his thesis, Phillips explores the relationship between 'spirituality' and 'culture' and the part that both concepts might play in addressing addictions. The term 'spirituality' itself, he concluded, was problematic in that it tended to have two connotations in the community: for some, it evoked Christianity, which in itself had a complex cultural legacy, with some Bama believing that a Christian God could help them overcome addictions while others associated Christianity with the missionaries' suppression of their own culture. For others, 'spirituality' meant '*dhumboon*' or traditional sorcery, which also had its positive and negative aspects. Phillips concluded that notions of spirituality, healing and 'story places' were inter-connected, but most readily conceptualised as 'culture' rather than as spirituality. He also found that, while people's understandings of these phenomena were steeped in wisdom, many hesitated to invoke that wisdom, as if their confidence was still damaged by decades of mission-led denigration of traditional cultural practices and views—even though the era of mission control had long passed.

Like the founders of CAAAPU, Phillips believed that a program of healing based on re-invigorated Aboriginal healing practices, AA principles and the treatment program developed by the Nechi Institute in Canada offered an optimal founda-tion for overcoming alcohol and other drug dependence in a community. 'Culture and spirituality', he argued, should form 'the foundation, not totality, of health, addictions and well-being interventions' (Phillips 2003: 167), which would also include efforts to revive Indigenous healing practices and ceremonies; redefining community norms about acceptable and unacceptable behaviour; providing alcohol and other drug training to local people in local language; establishing a treatment centre/healing place, and educating non-Aboriginal health professionals about the nature of addictive behaviours in the community (Phillips 2003: 167–8).

Phillips' critique of 'Western models' of health and sickness raises two key questions that should be flagged, even though we cannot pretend to answer them adequately here. The first concerns the so-called 'biomedical model' that is said to pervade Western approaches to health and medicine. While it is true, as Phillips claims, that 'Western' clinical medicine has been built over several centuries on a philosophical foundation that portrays human beings in terms of a 'mind-body dualism', this model does not adequately represent contemporary 'Western' approaches to health and well-being. On the contrary, as long ago as 1947 the World Health Organization defined health as "a state of complete social, mental and physical well-being and not merely the absence of disease or infirmity".[9] The WHO definition also includes 'spirit' alongside 'body' and 'mind' in its conceptualisation of a human being (Mehta 2011). The 1947 definition was in turn incorporated into the Alma-Ata Declaration on Primary Health Care agreed to at an international conference held

---

[9] www.publichealth.com.ng/world-health-organizationwho-definition-of-health/   (retrieved   2 December 2021).

in 1978 (World Health Organization 1978). As Brady notes, the Alma-Ata Declaration and the approach to health underlying it were particularly influential among Australian health practitioners who, in the 1970s, established the first Aboriginal community controlled health services. They also underpinned the training of the first Aboriginal Health Workers (Brady 2004: 27–41).

Similarly, the 'biopsychosocial model' arose in the 1980s out of a critique of mind-body dualism, broadening the scope of medical and psychiatric intervention to include social, psychological and behavioural dimensions of illness and well-being (Ghaemi 2009; Engel 1978; Wade and Halligan 2017). To view Aboriginal healing practices as an alternative to Western biomedical medicine risks portraying a caricature rather than the reality of Western health care, one that may overlook potentially helpful 'Western' practices.

A second question concerns the healing capacities of traditional cultures. Brady, in an article published in 1995, sounded a note of caution, pointing out that in some parts of Australia, traditional healers had expressly indicated that their repertoires of healing practices did not equip them to address today's alcohol and other drug problems because such problems were unknown in traditional society (Brady 1995b).

More recently, Brady (pers comm.) has proposed distinguishing between two uses of 'culture' in relation to Aboriginal alcohol and other drug interventions in order to bring greater clarity to an inherently complex and imprecise concept. One—which she labels 'cultural affiliation or involvement'—refers to the role of cultural connectedness and cultural identity in strengthening people's capacity to deal with difficulties in daily life, including experiences of racism and use of alcohol and other drugs. 'Culture' in this sense can promote resilience, which in turn may reduce a propensity to resort to destructive forms of substance misuse. It is a basis for both primary and secondary prevention, rather than tertiary prevention or treatment. Brady also points out, however—as did the treatment providers at CAAAPU discussed above—that Aboriginal culture is not always antithetical to drinking; on the contrary, in some settings, Aboriginal culture had become, at least in part, a drinking culture.

The second use of 'culture' distinguished by Brady refers specifically to the use of healing practices grounded in Aboriginal cultural traditions to bring about recovery from damaging alcohol and/or other drug use and the many other problems that usually accompany entrenched substance misuse. She proposes the term 'cultural healing' for this usage which, unlike cultural affiliation of the first kind, constitutes a form of treatment or tertiary intervention.

One example of a 'cultural healing' program that has continued to evolve over the three decades since it commenced as a small self-help group is the We-Al Li healing program developed by Judy Atkinson and her colleagues in the Queensland city of Rockhampton in the early 1990s and briefly discussed earlier in Chap. 2 (Sect. 2.7). As we also indicated in Chap. 2, the We-Al Li program drew on another Aboriginal concept: *Dadirri* or 'inner deep listening and quite still awareness' (Ungunmerr Bauman 1988). In a description of the program published in 2014, Atkinson et al. explained that, like several other programs operating at the level of Aboriginal communities, and in light of the substantial resource requirements entailed in bringing about change at a community level, the We-Al Li program had moved to a 'train the trainer'

model which Atkinson et al. described as 'a whole of community model of education as healing' or 'educaring'. The model is described in the extract below.

Box 4.7 Education as Healing (The Educaring Model)

Extract from Atkinson et al. (2014: 298–99)

Educaring is a trauma-specific blend of Aboriginal traditional healing activities and western therapeutic processes. It uses experiential learning to enable participants to explore their understanding of the long-term consequences of trauma across generations and cultural tools for healing. It promotes and ensures relationships of mutual respect within the learning environment. Learning is through dialogue. Trauma-informed practice works to build cultural safety and spiritual integrity through individuals working together in the group. This requires the worker-educator to be culturally competent. It focuses on enhancing deep listening skills, self and other awareness, self and group reflective discussion and practice. Educaring is designed to heal the person while building on professional skills by focusing on transformational learning and social justice as fundamental to healing practice. It enhances levels of empowerment and self-confidence to support leadership potential (Atkinson 2006).

Educaring provides skills for working with individuals and groups using the healing power of story, cultural and personal narratives, emotional release and emotional regulation, in family history reconstruction, story maps, loss history graphs, trauma healing grams, using art, music, dance, theatre, in ceremonial processes, with children, young people, adults and Elders.

It is place-based. The stories of *place* can be both stories of trauma and stories of strength and resilience-healing. Place-based learning is community focused as it works to build sustainability while it skills local people to deliver local services. Aboriginal approaches to *education* place a strong emphasis on enhancing self and community learning. It is the *process* of becoming aware of self and others which underpins purposeful personal development and healing as a cornerstone to education, training and skill enhancement and professional practice.

The Educaring model, Atkinson et al. note, is designed both to heal personal trauma and to build a professional Aboriginal workforce skilled in addressing trauma-related issues in communities. The authors argue that addressing traumatic experiences as a therapeutic strategy is more likely to lead to sustainable change than therapeutic models that focus on psychosocial functioning or issues (Dudgeon et al. 2014: 299).

As mentioned earlier in Chap. 2, the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families—better known as the Stolen Generations Inquiry—led to increased Government support for healing programs. In 2009, a year after the Government issued a formal apology to the

Stolen Generations, the Government provided funding for the establishment of an Aboriginal and Torres Strait Islander Healing Foundation (Caruana 2010).

In 2017, the Healing Foundation published a review of Indigenous healing programs in Canada, the US, New Zealand and Australia (McKendrick et al. 2017). The reviewers noted that in all these countries, healing programs were intended to ameliorate a wide range of problems, including violence, poor self-esteem, suicide prevention, as well as substance misuse. While all the programs reviewed employed Indigenous healing practices, in some cases, these were combined with Western therapeutic interventions. Few programs had been formally evaluated, although the review found evidence that some of them had led to enhanced self-esteem, cultural connectedness and knowledge and skills.

4.6 Combining Healing and Therapeutic Interventions

One attempt to integrate 'cultural healing' with evidence-based therapeutic practices is the 'healing model of care' developed by the Aboriginal Drug and Alcohol Residential Rehabilitation Network (ADARRN), the peak body for Aboriginal residential rehabilitation facilities in NSW, in partnership with researchers at the National Drug and Alcohol Research Centre (NDARC), University of NSW (James et al. 2020). Staff and clients from six Aboriginal alcohol and other drug residential treatment centres worked with researchers, using a method known as Community-Based Participatory Research (CBPR, (Wallerstein and Duran 2006)) to define core treatment and organisational components in residential treatment services and in follow-up care, and to develop standardised assessment, data collection and evaluation models (Shakeshaft et al. 2018).

A key outcome of the project was a 'healing model of care' developed in the first instance at Orana Haven treatment centre and adopted by the other five centres. The model was made up of six treatment components and three organisational components. The central treatment component was 'healing through culture and country'. As shown in Fig. 4.1, this was linked to five other components: therapeutic activities, case management, life skills programs, time out from substances and aftercare support.

These components, as Fig. 4.1 shows, were supported by three organisational components covering governance, network linkages and staff skills. The steps involved in implementing, monitoring and assessing each of these treatment and organisational components were set out by Shakeshaft et al. in two program logic models developed in consultation with service providers and clients (Munro et al. 2017; Shakeshaft et al. 2018). One defined core treatment components, the other organisatonal level components. The first of these is reproduced in Table 4.1 on pages 118–119.

The report's authors argue that the program logic models have applicability beyond the six treatment facilities for which they were designed, not by prescribing a single treatment regime, but by providing a framework that identifies the necessary core

KEY:
• The **red** circle represents the overarching component to ensure client healing from substance misuse.
• The **yellow** circle represents the five most important program components of the Orana Haven program.
• The **black** circle represents 3 key organisational components to ensure that Orana Haven runs effectively.
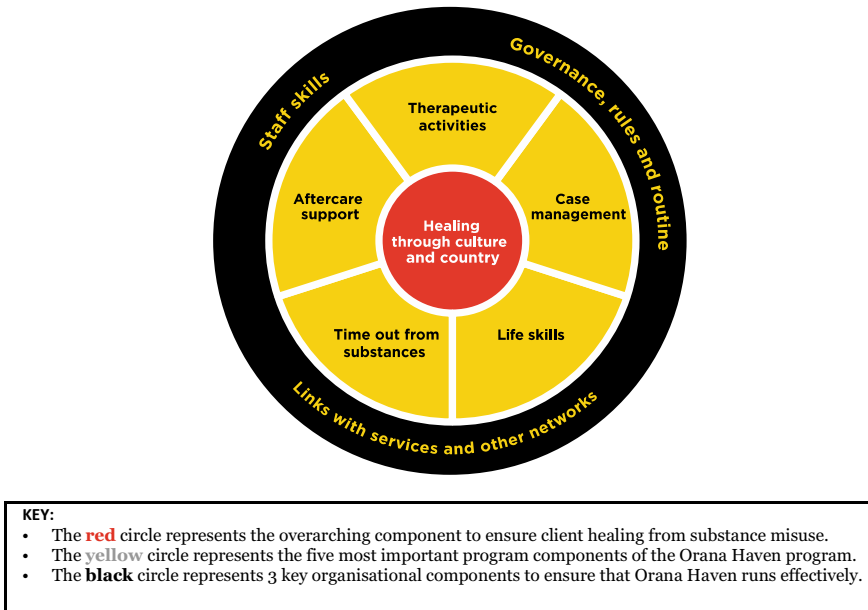
Fig. 4.1 Treatment and organisational components of a healing model of care. *Source* Shakeshaft et al. (2018: 82)

components of a successful program. How those components will be implemented, the report suggests, will vary according to local conditions and needs (Shakeshaft et al. 2018).

4.7   Non-residential Treatment

This chapter has shown that treatment options for Aboriginal people with alcohol and other drug problems have historically been dominated by residential treatment and rehabilitation programs. In recent years, however, increasing attention has been paid to developing non-residential treatment options. Gray et al. reviewed findings from five such projects, each of them set up and evaluated as a trial (Gray et al. 2014). Services delivered included screening and brief intervention, case management, pharmacotherapy and psychological and social support. While each of the programs encountered implementation barriers arising from tight time-frames and associated difficulties in recruiting and retaining staff, they also demonstrated that, with funding support, programs could be established to meet a genuine demand for treatment.

For example, one of the trial programs—known as The Grog Mob and administered by the Central Australian Aboriginal Congress in Alice Springs—offered

Table 4.1 Standardised program logic model of core treatment components and flexible program activities

a. Client areas of need	b. Treatment program		c. Mechanisms of change	d. Process measures	e. Outcomes
	Core treatment components	Program activities			
Primary client areas of need 1. Risky drug and alcohol use 2. Poor quality of life 3. Poor cultural connection ***Secondary client areas of need*** 4. Co-occurring mental illness 5. Criminal justice involvement 6. Chronic physical health needs 7. Tobacco use 8. Unemployed/limited education	Healing through culture and country	– Being on country/spirituality – Developing kinships – Making artefacts, fishing bush medicine	Reconnecting clients to culture and country via activities and strong relationships	No. of clients engaged in regular cultural activities	***Primary outcomes*** 1. Reduced substance misuse (AUDIT/DUDIT/IRIS & clean urines) 2. Improved quality of life (WHO-QoL) 3. Increased connection to culture (GEM) ***Secondary outcomes*** 4. Reduced psychological distress (K10) 5. Reduced risk of BBV (BBV-TRAQ—Needle syringe contamination) 6. Reduction in recidivism (Pre/post criminal justice data) 7. Improved physical health (Pre/post Indigenous health check outcomes) 8. Reduction in smoking (Fagerstrom) 9. Improvement in employment and education (three months follow-up data)
	Case management	– Referrals to local health services and visiting specialists – Regular client assessments – Case reviews	Clients engaged in the program via positive therapeutic alliance between staff and clients. Referrals to AMS to external health and social services. Client's social, psychological and physical needs managed concurrently.	No. of clients staying in the program for three or more months No. of Indigenous Health checks/other referrals No. of client's needs addressed	
	Therapeutic activities	– One-on-one counselling using evidence-based approach (e.g. motivational interviewing, community reinforcement approach, cognitive behavioural therapy) – Psychoeducational groups – Informal counselling (yarning)	Improving client quality of life. Increased understanding of substance misuse (e.g. triggers) and personal strategies (e.g. motivations, goals, timeout) for reducing it. Education and empowering clients to make positive changes in their life.	No. of clients engaged in support groups No. of external counselling sessions provided No. of clients implementing personalised strategies	

(continued)

Table 4.1 (continued)

a. Client areas of need	b. Treatment program		c. Mechanisms of change	d. Process measures	e. Outcomes
	Core treatment components	Program activities			
	Life skills	– Develop daily routine – Positive role modelling – Redevelop personal responsibility – Work readiness activities – Literacy/communication skills	Reconnecting clients to culture and country. Relearning daily routine and structure to maintain a healthy lifestyle after discharge. Learning and developing work ready and communication skills.	No. of work ready activities completed No. of vocational-related courses completed No. of clients achieving personalised life skills goals No. of clients following daily structure and routine	
	Time out from substances	– Improve physical well-being (e.g. sleep routine/nutrition) – Improve mental/spiritual well-being – Smoking cessation	Identify and engage in positive alternative activities to substance use to learn how to take time out from substances	No. of clients engaging in time out activities No. of clients quitting or reducing smoking	
	Follow-up support after discharge	– Referrals to services post discharge (e.g. ACCHOs) – Follow-up support – Follow-up assessment and brief counselling	Continue to access treatment and care required to maintain improved health and well-being post discharge. Ongoing tailored support for clients post discharge in the continuum of their treatment	No. of clients participating in follow-up care (e.g. phone calls, assessments, referrals) No. of clients maintaining contact with PHC services and other relevant services they were referred to upon discharge	

a. *Client areas of need*: the primary and secondary client needs that Aboriginal residential rehabilitation targets:

b. *Treatment program*: the five treatment components and flexible activities related to each

c. *Mechanisms of change*: key mechanisms of change to improve for clients

d. *Process measures*: key processes to measure or quantify client or change

e. *Outcomes*: key outcomes used to measure or quantify client change

Source Shakeshaft et al. (2018: 38)

three streams of care: pharmacotherapy, psychological counselling and social support (d'Abbs et al. 2013). A total of 129 clients were referred to the program during the evaluation period, 49 of whom consented to have their de-identified data used in the evaluation. Of these, 19 clients received one or more streams of care, while the remaining 30 had not participated in any of the three streams of care at the time of evaluation. Psychological counselling was the most frequently used stream, taken up by 16 clients; by contrast, only six clients received pharmacotherapy—a lower number than anticipated by the program's creators (d'Abbs et al. 2013). Of the 19 clients who had received one or more interventions, 15 (78.9%) reported that they had stopped or reduced their alcohol intake following participation in the program— but so too did 70% of those who did *not* receive any of the streams of care, leaving the evidence, hampered as it was by low numbers and a short time-frame, equivocal. This, and a need to understand an apparent reluctance among GPs to prescribe pharmacotherapies for Aboriginal clients, were two key findings from the study.

More generally, Gray et al. concluded from the five trials that, while they confirmed that there are no quick fixes for problematic alcohol use, beneficial programs can be established provided that they are controlled by Aboriginal people, culturally compatible, and resourced to a level sufficient to allow for recruitment and retention of staff (Gray et al. 2014).

In NSW, a group of researchers worked with a community-based alcohol and other drug treatment service in a rural town and an Aboriginal Community-Controlled Health Service towards developing and testing a treatment program that can be embedded into routine practice in a community-based treatment setting (Calabria et al. 2013, 2014, 2020).

The program is based on the Community Reinforcement Approach (CRA), adapted for use with Aboriginal clients following consultations with clients and service providers (Calabria et al. 2013, 2014). The original, US-based CRA is an evidence-based cognitive behavioural program for problem drinkers. Modifications requested by local Aboriginal people were for therapists to be local people, known and trusted by the community; for alcohol-related harms to be discussed sensitively; for detailed rather than brief interventions; for treatment sessions to talk about alcohol problems and the acquisition of skills to address these problems, and for follow-up support. Other modifications arising out of discussions with service providers included a reduction in technical language, an option for individual or group treatment sessions, and a reduction in the number of sessions (Calabria et al. 2014, 2020).

An evaluation conducted in 2013 involving 55 clients (24 of whom were Aboriginal), 58% of whom were followed up at 3 months, found that the program was considered acceptable and effective by clients, and associated with a statistically significant decline in self-reported alcohol and other drug use, a decline in psychological distress, and increased empowerment (Calabria et al. 2020). Although, as the authors acknowledge, the small sample in the study, its pre-test/post-test design and reliance on self-reported outcome measures all limit the weight that can be placed on the findings, the evaluation suggests that a suitably modified CRA-type program can feasibly be implemented in community-based alcohol and other drug treatment

settings, and that it can be both acceptable to clients and contribute to improved outcomes.

More recently, Krakouer et al. conducted a systematic review of community-based alcohol and other drug (AOD) programs for Aboriginal and Torres Strait Islander peoples (Krakouer et al. 2022). The review included outreach programs and programs based in community centres or community health centres (including brief interventions) but excluded residential rehabilitation services on the grounds that they were not community-based. Outcomes relevant to the review were the impact and acceptability of programs. Seventeen studies met the selection criteria. Among these, only three demonstrated a statistically significant reduction in substance use; two of these focused on smoking cessation, while the third was the Calabria et al. study described above (Calabria et al. 2020).

The review found that outreach programs for alcohol and other drugs were generally well supported, partly because they enhanced access to treatment and partly because they promoted connections with kin and community networks. By contrast—and as noted in the previous chapter—brief interventions were generally not well received (Krakouer et al. 2022). The review noted the poor quality of most evaluations and called for both more high-quality evaluations and programs based on a holistic, whole-of-community, approach that incorporated family, kin and other cultural connections and that was led by Aboriginal people.

Similar flaws bedevil evaluations internationally. Jiwa et al. reviewed articles relating to community-based alcohol and other drug programs in Indigenous communities in Canada, the US, Australia and New Zealand published between 1975 and 2007 (Jiwa et al. 2008). A total of 34 articles were selected, most of them according to the authors' opinion pieces and program descriptions (Jiwa et al. 2008: 1000). The authors argue that community-based prevention and treatment programs offer an alternative to residential treatment, which usually occurs away from clients' own communities. However, they do not present any outcome findings from the studies reviewed. The review also uses the term 'community-based' loosely. As Blagg (2006) has pointed out, 'community-based' and 'community-controlled' are not one and the same. The label 'community-based' indicates that the program in question is situated in a community, but tells us nothing about who controls it. In Australia, this distinction has assumed increasing importance in recent years, as Aboriginal Elders and other community leaders have insisted on greater community control over what is studied and how studies are conducted, and greater recognition of Aboriginal knowledge and cultural perspectives (Purcell-Khodr et al. 2020).

Purcell-Khodr et al. conducted a systematic review of peer-reviewed studies of alcohol treatments delivered in primary care and other non-residential settings to Indigenous clients in Australia, New Zealand, Canada and the US (Purcell-Khodr et al. 2020). They identified 28 studies—17 from Australia, seven from the US and two each from Canada and New Zealand. Two-thirds (18) of the studies focused on treatment accessibility and acceptability, and the remaining one third on treatment effectiveness and/or implementation. While most Australian studies focused on early and brief intervention for non-dependent drinkers; US studies reported on

interventions for alcohol-use disorders, including dependence. No studies, however, measured the effectiveness of brief interventions.

Two studies described home-based detoxification programs—an intervention which, in the view of the authors, showed promise. Three studies—all conducted in the US—reported on trials of relapse prevention medicines (disulfiram, naltrexone). The review noted that Aboriginal Australians are less likely to have access to pharmacotherapies than other Australians, and suggest that, on the basis of the evidence available, they may be a potentially effective and acceptable program if managed with a culturally-informed framework (Purcell-Khodr et al. 2020).

4.8 Supporting the Aboriginal Alcohol and Other Drug Workforce

Aboriginal alcohol and other drug (AOD) workers occupy roles that have been described as being 'often exhausting, poorly paid and under-recognised' (Roche et al. 2013). Roche et al. (2013) explored the workplace experiences of Aboriginal and Torres Strait Islander AOD workers in a study conducted in 2008 and 2009, involving 17 focus groups comprising a total of 121 participants (70 Indigenous, 20 non-Indigenous, 31 unspecified). Participants were drawn from most Australian jurisdictions, and included government and non-government services in rural, remote and urban settings.

Stressors identified in the study included the nature of drug and alcohol work; heavy workloads arising from juggling multiple roles and lack of role definition; 'dual accountability' to both their local community and employers; loss and grief in their own families' lives and poor remuneration and lack of job security. The study recommended several workforce development strategies, including clinical supervision and mentoring; more flexibility in allowing workers to choose how to engage with clients; improved remuneration and greater recognition of Indigenous ways of working (Roche et al. 2013).

Compared with the situation reported by Brady in 2002 and discussed above (see Sect. 4.4), the level of training among Aboriginal AOD workers appears to have risen in recent years. Ella et al. (2015) conducted a descriptive study of the Aboriginal AOD workforce in NSW, which found that 74.5% of the 51 participants already had certificates or university qualifications, and 35.3% were currently receiving AOD-specific training. Almost all participants felt that they had the necessary experience to deal with AOD issues, but more than half felt that too much was expected of them and almost one-in-three reported receiving no formal supervision (Ella et al. 2015). The study made several recommendations, including a need to address discrepancies in salary and award conditions, clarify position descriptions and improve access to supervision.

Since both of these studies were conducted, residential rehabilitation facilities have been subject to further cutbacks in government funding, resulting in forced

closures and adding to administrative difficulties. Most facilities are also forced to rely on short-term funding, which in turn necessitates 12-month contracts and associated problems in developing a stable, qualified workforce (Lee et al. 2017).

In NSW, support for the Aboriginal AOD workforce is provided by the Aboriginal Drug and Alcohol Network (ADAN), established in 2004 following a 'Talking about Grog' summit held in the previous year[10] (Lee et al. 2017). ADAN's objectives include supporting Aboriginal AOD workers across NSW; supporting Aboriginal individuals, families and communities in developing local strategies; enabling Aboriginal AOD workers to share information and resources and receive professional development and cultural support, and advising key stakeholders on policy development in the Aboriginal AOD sector.[11]

Another support network in the Aboriginal AOD treatment sector in NSW is the Aboriginal Drug and Alcohol Residential Rehabilitation Network (ADARRN), established in 2019 as a peak body for Aboriginal Community-Controlled residential rehabilitation services.[12]

4.9 Evaluating Treatment Programs—At Home and Abroad

Despite nearly half a century of programs aimed at helping Aboriginal people recover from alcohol and other drug misuse, the evidence base for assessing the effectiveness of interventions remains modest. A 2010 review of studies of Australian Aboriginal alcohol and other drug residential treatment programs found evidence of a narrow range of treatment options, continuing difficulties relating to staffing, management and record-keeping, and little evidence of program effectiveness (Taylor et al. 2010). The review also noted a lack of programs in urban settings and post-treatment relapse prevention programs. In 2018, James et al. published a systematic review of studies of Indigenous drug and alcohol residential rehabilitation services in Australia, US, Canada and New Zealand, published between 1 January 2000 and 28 March 2016 (James et al. 2018). Most of the 38 studies they located were of low methodological quality, and only one reported a treatment outcome evaluation. Most of the studies were program descriptions. Most services provided multiple components, including education, life skills, cultural education and support. The 12-step AA treatment model was the dominant therapeutic component (James et al. 2018). Both Taylor et al. and James et al. called for the development of a broader range of evidence-based, culturally appropriate treatment models (Taylor et al. 2010; James et al. 2018).

---

[10] See   https://www.ahmrc.org.au/programs/practice-support/workforce-strengthening/aod-net works/ (retrieved 28 October 2022).

[11] https://www.ahmrc.org.au/programs/practice-support/workforce-strengthening/aod-networks/ (retrieved 28 October 2022).

[12] https://www.ahmrc.org.au/programs/practice-support/workforce-strengthening/aod-networks/ (retrieved 28 October 2022).

Similarly, despite the long-standing and widespread use of mutual support groups—especially AA groups—in treatment programs for Aboriginal clients, there is little evidence of their effectiveness. Dale et al. conducted a systematic review of evidence from addiction recovery mutual support groups relating to Indigenous peoples in Australia, New Zealand, Canada, the US and Hawaii (Dale et al. 2019). They identified only four studies that met their selection criteria, all of them conducted between 2001 and 2006, and all conducted in the US with Native American Indian peoples and featuring AA. Although the four studies reported outcome variables such as the number of meetings attended, only one—an ethnographic study conducted in a single American Indian community—reported findings on the perceived usefulness and cultural suitability of AA—and these findings were mixed. Some participants felt that AA was congruent with their own cultural belief systems, while others considered its Christian underpinnings and use of concepts such as alcoholism made it more suited to western than Indigenous people (Dale et al. 2019).

Several systematic reviews have attempted—with limited success—to assess the impact of programs based on Indigenous cultures in international peer-reviewed literature. Rowan et al. (2014) conducted a scoping review of programs that used 'cultural interventions' to treat substance misuse among Indigenous populations. They defined cultural interventions as "Indigenous spiritual and healing practices or traditions introduced into residential or outpatient treatment centres to help achieve wellness following problematic substance use or addiction" (Rowan et al. 2014: 36). Wellness was conceptualised along four dimensions: spiritual, physical-behavioural, mental and social and emotional. The authors identified studies of nineteen programs, all of them based in Canada or the US—eleven residential, two that provided both residential and outpatient services, while the remaining six were either community-based or prison-based. All of the programs reviewed combined Western assessment, education, counselling and/or aftercare with cultural interventions. Among the latter, the most common were sweat lodges and ceremonial practices such as 'sage, cedar or sweet grass smudges' (Rowan et al. 2014: 37). All the programs were reported as leading to improvements in all dimensions of wellness, although the authors state that it is not possible from the studies to distinguish the impact of Western from cultural intervention components.

Leske et al. conducted a systematic review to assess the evidence base for culture-based interventions for Indigenous adults with mental and/or alcohol and other drug disorders in Australia, Canada, New Zealand and the US (Leske et al. 2016). The authors distinguished three types of interventions: (1) culturally unadapted—interventions that had not been modified for use with Indigenous populations; (2) culturally adapted—that is, programs adapted by, for example, administering in an Aboriginal language or using Aboriginal staff, or by involving the family in the treatment process and (3) culture-based—that is, based on cultural knowledge and traditional indigenous healing practices.

Sixteen studies met their selection criteria: seven in the US, four in Australia, four in New Zealand and one in Canada. Eight studies—including most of the US and Canadian studies—evaluated culturally unadapted programs. Seven studies evaluated culturally adapted programs, while the remaining study evaluated a culture-based

program in the US. All the studies reported improvements in at least one of the outcome measures used. However, the authors concluded that it was not possible to compare findings or programs for methodological reasons, in particular, poor study design, in some cases small, non-probabilistic samples, and diversity of both program components and outcome measures. They also concluded that it was not possible, on the basis of the selected studies, to assess the extent to which cultural adaptations improved program outcomes (Leske et al. 2016).

Another recently published study reviewed the limited literature on the lived experience of Aboriginal clients of AOD services in Australia (Heath et al. 2022). The review examined 27 studies, from which the authors drew three key themes. The first was the importance of cultural activities and cultural reconnection in programs; the second was the value of holistic and strengths-based approaches that enhanced confidence and a sense of pride among clients and provided them with opportunities for change, for example, through components of life skills. The third theme was the importance of organisational aspects of the program, such as having access to experienced Aboriginal staff who demonstrated empathy and the capacity to understand clients' needs (Heath et al. 2022).

Evaluations of Aboriginal treatment programs face a number of significant hurdles. Firstly, Aboriginal clients tend to bring a complex mix of needs and problems to treatment, as well as their alcohol or other drug use (Munro et al. 2017). A 2014 report by the National Indigenous Drug and Alcohol Committee (NIDAC) observed that these typically include physical health issues, mental health issues including grief and trauma, legal issues, cognitive impairment, family and other relationship issues, child protection issues, housing problems and unemployment (National Indigenous Drug and Alcohol Committee (NIDAC) 2014). Munro et al. (2017) examined admissions to a remote Indigenous rehabilitation facility in NSW and noted an increasing number and proportion of clients referred through the criminal justice system as well as high levels of multiple needs. Most clients were found to have at least two co-occurring risk factors, with 69% self-reporting polydrug use (mainly methamphetamines, alcohol and cannabis) and 51% reporting a current mental illness. Secondly, and in light of these needs, programs typically include multiple components, including counselling, life skills programs and case management. To link observed outcomes with specific program components under these conditions is methodologically difficult, if not impossible. The challenge is compounded by a third common feature: healing is by its very nature a protracted process rather than a one-off event, with multiple aspects occupying multiple domains, including social, emotional, cultural and spiritual dimensions (McKendrick et al. 2017). Fourthly, the accepted methodological tools for assessing treatment efficacy in mainstream research, such as randomised control trials and quantifiable biomedical indicators, are cultural products of the dominant society. In a context shaped by colonisation, contemporary power differentials, and differing cultural values, they can be resisted as being, at best, insensitive to Aboriginal cultural priorities and, at worst, instruments of continuing domination.

Chenhall (2008) argues that what constitutes 'treatment' in these settings is, in any case, not limited to the formal therapeutic components of the program. He notes

that Aboriginal residential treatment and rehabilitation programs can be viewed as modified therapeutic communities—that is, they combine a structured daily regimen, designed to encourage personal responsibility, self-help and the use of peers as role models, with group psychotherapy, case management and culturally appropriate treatments. In such a setting, Chenhall argues, 'treatment' is woven into the informal processes and structures of everyday life in the community, in particular, the processes through which privileges are bestowed and withdrawn in response to compliance with, or deviation from, the espoused values of the community. In Chenhall's view, evaluation designs that do not consider these aspects of treatment fail to describe what actually happens in the program (Chenhall 2008).

Chenhall and Senior (2013) attempted to build on these insights in a study based on ethnographic fieldwork and semi-structured interviews with staff and board members from three residential rehabilitation facilities located in the NT, northwest Australia and southeast Australia, respectively. The objective was to understand the key components of treatment as implemented in these facilities and barriers to effective outcomes. Two of the programs used an AA-based treatment approach, combined with other components such as education and life skills. Most treatments were group-based, with little one-on-one counselling. There was a broad agreement regarding the importance of Aboriginal culture, but differences in what this was taken to mean. In one case, because the program was run by Aboriginal people for Aboriginal people, it was considered by definition to be culturally appropriate, while staff from another organisation questioned the relevance of cultural 'appropriateness' on the grounds that, prior to European colonisation, Aboriginal cultures did not have to deal with severe substance misuse. At another facility, staff argued that cultural sensitivity, rather than appropriateness, was the quality required and that this involved interactions between staff and residents being conducted in a 'safe and understandable way' (Chenhall and Senior 2013: 89). Services were found to be well connected with other agencies, but there was little evidence of aftercare or follow-up, mainly because of resource limitations. The authors identified this as an important gap, and also stressed the need for strong and stable leadership. Finally, the physically constructed space of the facility was found to be important in influencing whether or not particular forms of treatment including counselling, could take place (Chenhall and Senior 2013).

One response to the challenges of evaluating Aboriginal healing programs is the Growth and Empowerment Measure (GEM), a measurement tool initially devised in conjunction with a program known as the Family Wellbeing Program (FWB) - (Hasswell et al. 2010). The FWB aims to enable participants to regain control over their everyday lives through physical, emotional, mental and spiritual transformations (Tsey et al. 2002, 2003, 2004, 2005). It has been implemented in several settings around Australia and has been evaluated in qualitative designs. The GEM is a quantitative measurement tool, incorporating dimensions of empowerment as defined by Aboriginal FWB participants. It consists of two scales. The first is a 14-item Emotional Empowerment Scale (EES14) designed to document the extent to which a person experiences well-being in various aspects of everyday life. The second comprises 12 'empowerment scenarios' (12S) designed to gauge the degree to which a participant has changed subjectively in relation to functional areas of

everyday life, as identified through prior qualitative research. Hasswell et al. (2010) conducted a psychometric validation of the GEM with a convenience sample of 184 Aboriginal and/or Torres Strait Islander people, drawn from urban, regional and remote communities in Queensland, the NT and NSW. The validation study also included a 6-item Kessler Distress Scale (K6) previously used in Indigenous well-being surveys and screening tools. Psychometric analyses corroborated the validity and reliability of both the EES and 12S scales and led researchers to distinguish four subscales: labelled self-capacity, inner peace, healing and enabling growth and connection and purpose, respectively.

Berry et al. (2012) used the GEM as one of three outcome measures—along with the Kessler 10 Psychological Distress Scale (K10) and a Drug Taking Refusal Self-Efficacy Scale (DTCQ-8)—in evaluating a 16-week residential AOD treatment program located on the south coast of NSW. The baseline study sample consisted of 57 Aboriginal and 46 non-Aboriginal male clients, although attrition saw this reduced to 34 participants at 16 weeks. Data was collected at three time points: baseline, 8 and 16 weeks. The study found statistically significant improvements on all measures between baseline and 8 weeks, and on most measures—including all four GEM subscales—between 8 and 16 weeks (Hasswell et al. 2010).

Blignault and Williams (2017) argue that program evaluations that are led by and responsive to Aboriginal and Torres Strait Islander communities need to be designed and implemented differently from mainstream evaluations:

> High quality evaluations will be rigorous and incorporate Indigenous perspectives and values. Timeframes, methods, relationships between evaluators and stakeholders, and the identification and measurement of outcomes all need to be context sensitive. Challenges include definitions of healing, diversity of landscapes and programs, and data collection. Qualitative open-inquiry models and data collection methods, which preference and support Indigenous worldviews and ways of creating and sharing knowledge, work well in this space. Working ethically and effectively in the Indigenous healing space means emphasising and enabling safety for participants, workers and organisations—adopting a trauma-informed approach as well as ensuring culturally sensitive methodologies and tools (Blignault and Williams 2017: 9).

One evaluation approach that seeks to meet these requirements is the *Ngaa-bi-ny*a framework proposed by Williams for evaluating Aboriginal and Torres Strait Islander health and social programs (Williams 2018). The term *Ngaa-bi-nya* means to examine, try and evaluate in the language of the Wiradjuri peoples of central NSW. The approach is said to be grounded in a holistic view of health and wellbeing and to privilege Aboriginal and Torres Strait Islander perspectives. It comprises four domains: landscape, resources, ways of working and learnings. The framework contains prompts within each domain, designed to elicit compliance with good practice. For example, the 'landscape' domain directs evaluators to gather data on the history of the local area and the program under review; the demographic and socio-economic environment, availability of services and programs, and the extent to which local Indigenous people have been involved in identifying local needs and priorities. Overall, the framework is intended to identify 'critical success factors' in programs targeting Aboriginal people (Williams 2018: 8).

Chenhall and Senior (2012) trialled the use of a Quality of Life measure to gauge treatment outcomes among 25 clients in an Indigenous residential treatment facility in the NT. Under the measure, known as SEIQoL-DW,[13] clients were asked to nominate five areas of their lives that they considered important and to rate their own functioning in each of these domains on a 10-point scale. Graphical techniques were then used to enable clients to weigh the relative importance of each domain. The results of these activities were then transformed into a score. In this study, frequently nominated domains included relationships with family, cultural activities, work opportunities, managing money, stopping drinking and specific issues such as regaining drivers' licences.

In principle, comparisons between clients' profiles before and after treatment enable changes to be measured, not against externally imposed treatment assessment criteria, but against clients' own values and concerns. In this instance, most of the 25 participating patients departed from the treatment program before the planned exit date, thereby making it impossible to assess change in all but a small number of cases (Chenhall and Senior 2012).

4.10 Summary and Conclusions

In this chapter, we have traced the emergence and evolution of several approaches to the treatment and rehabilitation of Aboriginal people with established patterns of alcohol misuse. All of these approaches labour under a considerable handicap, insofar as they do not and cannot address the conditions that give rise to alcohol and other drug misuse in the first place. At the same time, all of them attempt to support individuals and/or families in their efforts to regain control over their lives.

The dominant approach over most of the fifty years under review has been residential treatment based on the Twelve Steps and mutual support principles of Alcoholic Anonymous. In more recent years, treatment programs grounded in various forms of cultural healing have been introduced, designed to deal with the unresolved, intergenerational trauma that is widely seen as underlying alcohol and other drug misuse among Aboriginal people. In many instances, these programs combine Aboriginal and western therapeutic models.

Two other themes are woven into this account: one is the ongoing need for resourcing, training and supporting the Aboriginal alcohol and other drug treatment workforce. While the level of training among AOD workers appears to have risen in recent years, treatment facilities continue to struggle to provide adequate remuneration, working conditions and workplace support. A second theme is a continuing quest for ways of assessing treatment effectiveness in a manner that combines methodological rigour with cultural sensitivity.

---

[13] The acronym stands for 'Schedule for the Evaluation of Individual Quality of Life–Direct Weight'.

References

Alati, Rosa. 1996. *The role of alcohol and drug rehabilitation and treatment amongst aboriginal people: Report*. Commonwealth Department of Human Services and Health: Canberra.

Anderson, Sandra C. 1994. A critical analysis of the concept of codependency. *Social Work* 39: 677–685.

Atkinson, J., J. Nelson, R. Brooks, C. Atkinson, and K. Ryan. 2014. Addressing individual and community transgenerational trauma. In *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice*, eds. P. Dudgeon, H. Milroy and R. Walker. Canberra : Australian Government Department of the Prime Minister and Cabinet, Telethon Institute for Child Health Research/Kulunga Research Network and University of Western Australia.

Atkinson, Judy. 2006. *Trauma trails, recreating song lines: The transgenerational effects of trauma in indigenous Australia.* Spinifex Press: North Melbourne.

Berry, Stacey L., T.P. Crowe, F.P. Deane, M. Billingham, and Y. Bhagerutty. 2012. Growth and empowerment for indigenous australians in substance abuse treatment. *International Journal of Mental Health and Addiction* 10: 970–983. https://doi.org/10.1007/s11469-012-9393-2.

Blagg, Harry. 2006. *Models of best practice: Aboriginal community Patrols in Western Australia.* Nedlands: Crime Research Centre, University of Western Australia. http://www.crimeprevention.wa.gov.au/uploads/file/aboriginal_community_patrols_in_wa.pdf. Accessed 20 July 2010.

Blignault, I., and M. Williams. 2017. Challenges in evaluating aboriginal healing programs: Definitions diversity and data. *Evaluation Journal of Australasia* 17: 4–10.

Brady, Maggie. 1993. Giving away the grog: An ethnography of Aboriginal drinkers who quit without help. *Drug and Alcohol Review* 12: 401–411.

Brady, Maggie. (1995a). *Broadening the base of interventions for Aboriginal people with alcohol problems.* Sydney: National Drug and Alcohol Research Centre, University of New South Wales. https://ndarc.med.unsw.edu.au/resource/broadening-base-interventions-aboriginal-people-alcohol-problems. Accessed 18 Feb 2020.

Brady, Maggie. 1995b. Culture in treatment, culture as treatment: A critical appraisal of developments in addictions programs for indigenous North Americans and Australians. *Social Science and Medicine* 41: 1487–1498.

Brady, Maggie. 1995c. *Giving away the grog: Aboriginal accounts of drinking and not drinking.* Canberra: Commonwealth Department of Human Services and Health for the National Drug Strategy.

Brady, Maggie. 2002. *Indigenous residential treatment programs for drug and alcohol problems: Current status and options for improvement. Discussion paper No. 236*. Centre for Aboriginal Economic Policy Research, Australian National University: Canberra.

Brady, Maggie. 2004. *Indigenous australia and alcohol policy: Meeting difference with indifference.* University of New South Wales Press: Sydney.

Brady, Maggie, Sharon Dawe, and Robyn L. Richmond. 1998. Expanding knowledge among Aboriginal service providers on treatment options for excessive alcohol use. *Drug and Alcohol Review* 17: 69–76.

Calabria, Bianca, Anton Clifford, Miranda Rose, and Anthony P. Shakeshaft. 2014. Tailoring a family-based alcohol intervention for Aboriginal Australians, and the experiences and perceptions of health care providers trained in its delivery. *BMC Public Health* 14: 322. https://doi.org/10.1186/1471-2458-14-322.

Calabria, Bianca, Anton Clifford, Anthony Shakeshaft, Julaine Allan, Donna Bliss, and Christopher Doran. 2013. The acceptability to Aboriginal Australians of a family-based intervention to reduce alcohol-related harms. *Drug and Alcohol Review* 32: 328–32. https://doi.org/10.1111/j.1465-3362.2012.00525.x.

Calabria, Bianca, Anthony P. Shakeshaft, Anton Clifford, Chiara Stone, Philip J. Clare, Julaine Allan, and Donna Bliss. 2020. Reducing drug and alcohol use and improving well-being for

Indigenous and non-indigenous Australians using the community reinforcement approach: A feasibility and acceptability study. *International Journal of Psychology* 55: 88–95. https://doi.org/10.1002/ijop.12603.

Caruana, C. 2010. Healing services for Indigenous people. In *Family relationships quarterly (The Newsletter of the Australian Family Relationships Clearinghouse)*, 3–10. Melbourne: Australian Institute of Family Studies.

Chenhall, R. 2008. What's in a rehab? Ethnographic evaluation research in indigenous Australian residential alcohol and drug rehabilitation centres. *Anthropol Med* 15: 105–116. https://doi.org/10.1080/13648470802122024.

Chenhall, Richard D. 2007. *Benelong's Haven: Recovery from alcohol and drug use within an Aboriginal Australian residential treatment centre.* Melbourne University Press: Carlton, Victoria.

Chenhall, Richard, and Kate Senior. 2012. Treating indigenous australians with alcohol/drug problems: Assessing quality of life. *Alcoholism Treatment Quarterly* 30: 130–45. https://doi.org/10.1080/07347324.2012.663290.

Chenhall, Richard, and Kate Senior. 2013. "The concepts are universal, it is the picture you paint that is different": Key issues for Indigenous Australian alcohol and drug residential treatment centres. *Therapeutic Communities: The International Journal of Therapeutic Communities* 34: 83–95. https://doi.org/10.1108/TC-05-2013-0011.

Commonwealth of Australia House of Representatives Standing Committee on Aboriginal Affairs. 1977. *Alcohol Problems of Aboriginals: Final report.* Canberra.

Cook, Christopher C. 1988. The minnesota model in the management of drug and alcohol dependency: Miracle, method or myth? Part 1 the philosophy and the programme. *British Journal of Addiction* 83: 625–634.

d'Abbs, Peter. 1990. *Responding to Aboriginal substance misuse: A review of programs conducted by the council for Aboriginal alcohol program services (C.A.A.P.S.), Northern territory. A review conducted on behalf of the NT Drug and Alcohol Bureau, Department of Health and Community Services, and the Aboriginal and Torres Strait Islander Commission (ATSIC).* Darwin: NT Drug and Alcohol Bureau.

d'Abbs, Peter, Samantha Togni, Clive Rosewarne, and John Boffa. 2013. The grog mob: Lessons from an evaluation of a multi-disciplinary alcohol intervention for Aboriginal clients. *Australian and New Zealand Journal of Public Health* 37: 450–456.

Dale, Elizabeth, Peter J. Kelly, K. S. Kylie Lee, James H. Conigrave, Rowena Ivers, and Kathleen Clapham. 2019. Systematic review of addiction recovery mutual support groups and Indigenous people of Australia, New Zealand, Canada, the United States of America and Hawaii. *Addictive Behaviors* 98: 106038. https://doi.org/10.1016/j.addbeh.2019.106038.

Daniele, Evelyn. 1985. Milliya Rumurra—'The New Day' in Broome [online]. *Aboriginal and Islander Health Worker Journal* 9: 30–35.

Dudgeon, P., H. Milroy, and R. Walker (ed.). 2014. *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice.* Canberra: Telethon Institute for Child Health Research/Kulunga Research Network and University of Western Australia.

Ella, Steve, KS Kylie Lee, Steve Childs, and Katherine M. Conigrave. 2015. Who are the New South Wales Aboriginal drug and alcohol workforce? A first description, *Drug and Alcohol Review* 34: 312–22. https://doi.org/10.1111/dar.12199.

Engel, George L. 1978. The biopsychosocial model and the education of health professionals. *Annals of the New York Academy of Sciences* 310: 169–81. https://doi.org/10.1111/j.1749-6632.1978.tb22070.x.

Ernst and Young Consulting Team. 1996. *Review of long term residential treatment for people with alcohol and other drug use problems.* Canberra: Commonwealth Department of Human Services and Health.

Ghaemi, S. Nassir. 2009. The rise and fall of the biopsychosocial model. *British Journal of Psychiatry* 195: 3–4. https://doi.org/10.1192/bjp.bp.109.063859.

Gomberg, E.S.L. 1989. On terms used and abused: The concept of codependency. *Drugs & Society* 3: 113–132. https://doi.org/10.1300/J023v03n03_05.

Gordon, Judith R., and Kimberly Barrett. 1993. The codependency movement: Issues of context and differentiation. In *Addictive behaviors across the life span: Prevention, treatment, and policy issues*, eds. J. S. Baer, G. A. Marlatt, J. McMahon. Thousand Oaks, CA, US: Sage Publications, Inc.

Gray, D., S. Saggers, B. Sputore, and D. Bourbon. 2000. What works? A review of evaluated alcohol misuse interventions among Aboriginal Australians. *Addiction* 95: 11–22.

Gray, Dennis, Mandy Wilson, Steve Allsop, Sherry Saggers, Edward Wilkes, and Coralie Ober. 2014. Barriers and enablers to the provision of alcohol treatment among Aboriginal Australians: A thematic review of five research projects. *Drug and Alcohol Review* 33: 482–90. https://doi.org/10.1111/dar.12137.

Haaken, Janice. 1990. A critical analysis of the co-dependence construct. *Psychiatry* 53: 396–406.

Hasswell, M.R., David J. Kavanagh, Komla Tsey, Lyndon Reilly, Yvonne Cadet-James, Arlene Laliberte, Andrew Wilson, and Christopher Doran. 2010. Psychometric validation of the growth and empowerment measure (GEM) applied with Indigenous Australians. *Australian and New Zealand Journal of Psychiatry* 44: 791–799.

Heath, Airin, Mary Kristienne Martin, and Jacynta Krakouer. 2022. Exploring the lived experiences of Indigenous Australians within the context of alcohol and other drugs treatment services: A scoping review. *Drug and Alcohol Review*.

Hunt, H. 1977. The alcoholism counsellor among Aboriginal people. *Aboriginal and Islander Health Worker Journal* 1: 25–28.

Hunt, H. 1981. Alcoholism among Aboriginal people. *Medical Journal of Australia* 2: 1–3.

Hunt, Harold. 2016. *Along my way*. Glass House Books: Carindale, Qld.

Hunter, Ernest, Maggie Brady, and Wayne Hall. 1998. *Services relating to alcohol in Indigenous communities: A report for the Office of Aboriginal and Torres Strait Islander health services.* Brishane: University of Queensland; National Drug and Alcohol Research Centre; Australian Institute of Aboriginal and Torres Strait Islander Studies.

Institute of Medicine. 1990. *Broadening the Base of treatment for alcohol problems*. Washington, D.C.: National Academy of Sciences.

James, D., A. Shakeshaft, A. Munro, and R. Courtney. 2018. The need to move from describing to evaluating the effectiveness of Indigenous drug and alcohol residential rehabilitation services: A systematic review. *Current Drug Abuse Reviews* 11. https://doi.org/10.2174/1874473711666180404123904.

James, Douglas B., K.S. Kylie Lee, Tania Patrao, Ryan J. Courtney, Katherine M. Conigrave, and Anthony Shakeshaft. 2020. Understanding the client characteristics of Aboriginal residential alcohol and other drug rehabilitation services in New South Wales, Australia. *Addiction Science & Clinical Practice* 15: 27. https://doi.org/10.1186/s13722-020-00193-8.

Jiwa, Ashifa, Len Kelly, and Natalie Pierre-Hansen. 2008. Healing the community to heal the individual: Literature review of aboriginal community-based alcohol and substance abuse programs. *Canadian Family Physician* 54: 1000–00.e7.

Krakouer, Jacynta, Melissa Savaglio, Karinda Taylor, and Helen Skouteris. 2022. Community-based models of alcohol and other drug support for First Nations peoples in Australia: A systematic review. *Drug and Alcohol Review* 41: 1418–27. https://doi.org/10.1111/dar.13477.

Lee, K. S. Kylie, Bradley Freeburn, Steve Ella, Scott Wilson, Kristie Harrison, Monique McEwan, and Katherine M. Conigrave. 2017. Supporting the Aboriginal alcohol and other drug workforce in New South Wales, Australia. *Drug and Alcohol Review* 36: 523–26. https://doi.org/10.1111/dar.12465.

Leske, Stuart, Meredith G. Harris, Fiona J. Charlson, Alize J. Ferrari, Amanda J. Baxter, Jacquie M. Logan, Maree Toombs, and Harvey Whiteford. 2016. Systematic review of interventions for Indigenous adults with mental and substance use disorders in Australia Canada, New Zealand and the United States. *Australian & New Zealand Journal of Psychiatry* 50: 1040–1054. https://doi.org/10.1177/0004867416662150.

Lyon, P., J. Hill, and J. Wynter. 1992. *Final report and grog action plan.* Alice Springs NT: The Central Australian Aboriginal Alcohol Planning Unit.

McKendrick, J., R. Brooks, J. Hudson, M. Thorpe, and P. Bennett. 2017. *Aboriginal and Torres Strait Islander healing programs: A literature review.*Barton, ACT: Healing Foundation. https://healingfoundation.org.au/app/uploads/2017/02/Aboriginal-and-Torres-Strait-Islander-Healing-Programs-A-Literature-Review.pdf. Accessed 24 Mar 2020.

Mehta, Neeta. 2011. Mind-body Dualism: A critique from a health perspective. *Mens Sana Monographs* 9: 202–209. https://doi.org/10.4103/0973-1229.77436.

Miller, Kerrie, and Tim Rowse. 1995. *CAAAPU: An evaluation. Menzies occasional Papers No. 1/95.* Darwin: Menzies School of Health Research.

Munro, Alice, Anthony Shakeshaft, and Anton Clifford. 2017. The development of a healing model of care for an Indigenous drug and alcohol residential rehabilitation service: A community-based participatory research approach. *Health & Justice* 5: 12. https://doi.org/10.1186/s40352-017-0056-z.

National Indigenous Drug and Alcohol Committee (NIDAC). 2014. *Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples.* Canberra: Australian National Council on Drugs.

Phillips, Gregory. 2003. *Addictions and healing in Aboriginal country.* Aboriginal Studies Press: Canberra.

Purcell-Khodr, Gemma C., K.S. Kylie Lee, James H. Conigrave, Emma Webster, and Katherine M. Conigrave. 2020. What can primary care services do to help First Nations people with unhealthy alcohol use? A systematic review: Australia, New Zealand, USA and Canada. *Addiction Science & Clinical Practice* 15: 31. https://doi.org/10.1186/s13722-020-00204-8.

Read, Vanessa. 1986. Prevention through Health Education. *Aboriginal and Islander Health Worker Journal* 10(3): 38–43. ISSN: 1037-3403.

Roche, Ann M., Vinita Duraisingam, Allan Trifonoff, Samantha Battams, Toby Freeman, Amanda Tovell, Donna Weetra, and Nancy Bates. 2013. Sharing stories: Indigenous alcohol and other drug workers' well-being, stress and burnout. *Drug and Alcohol Review* 32: 527–35. https://doi.org/10.1111/dar.12053.

Rowan, Margo, Nancy Poole, Beverley Shea, Joseph P. Gone, David Mykota, Marwa Farag, Carol Hopkins, Laura Hall, Christopher Mushquash, and Colleen Dell. 2014. Cultural interventions to treat addictions in Indigenous populations: Findings from a scoping study. *Substance Abuse Treatment, Prevention, and Policy* 9: 34–60. https://doi.org/10.1186/1747-597X-9-34.

Shakeshaft, Anthony, A. Clifford, D. James, C.M. Doran, A. Munro, T. Patrao, A. Bennett, C. Binge, T. Bloxsome, J. Coyte, D. Edwards, N. Henderson, and D. Jeffries. 2018. *Understanding clients, treatment models and evaluation options for the NSW Aboriginal Residential healing drug and alcohol network (NARHDAN): A community based participatory research approach.* Sydney: Prepared by the National Drug and Alcohol Research Centre (UNSW Sydney) for the Department of the Prime Minister and Cabinet, Canberra ACT. https://pmc.gov.au/resource-centre/indigenous-affairs/understanding-clients-treatment-models-and-evaluation-options-narhdan. Accessed 17 Oct 2018.

Sigston, Roger. 1985. The family is the key in alcohol abuse. *Aboriginal and Islander Health Worker Journal.*

Sputore, Brooke, Dennis Gray, Deirdre Bourbon, and Kimberley Baird. 1998. *Evaluation of Kununurra-Waringarri Aboriginal Corporation and Ngnowar-Aerwah Aboriginal Corporation's Alcohol Projects.* Perth: National Centre for Research into The Prevention of Drug Abuse, Curtin University of Technology. https://ndri.curtin.edu.au/ndri/media/documents/publications/T77.pdf. Accessed 23 Nov 2021.

Strempel, Phillipa, Sherry Saggers, Dennis Gray, and Anna Stearne. 2004. *Indigenous drug and alcohol projects: Elements of best practice. ANCD Research Paper 8.* Australian National Council on Drugs: Canberra.

Sumner, Basil. 1984. The Aboriginal Sobriety Group of South Australia Inc. *Aboriginal and Islander Health Worker Journal* 8: 33–36.

Taylor, Kate, Sandra Thompson, and Robyn Davis. 2010. Delivering culturally appropriate residential rehabilitation for urban Indigenous Australians: A review of the challenges and opportunities. *Australian & New Zealand Journal of Public Health* 34: S36-40. https://doi.org/10.1111/j.1753-6405.2010.00551.x.

Tsey, Komla, David Patterson, Mary Whiteside, Leslie Baird, and Bradley Baird. 2002. Indigenous men taking their rightful place in society? *Australian Journal of Rural Health* 10: 278–284.

Tsey, Komla, David Patterson, Mary Whiteside, Leslie Baird, Bradley Baird, and Kwame Tsey. 2003. Indigenous men taking their rightful place in society? A follow up report. *Australian Journal of Rural Health* 11: 285–286.

Tsey, Komla, Mark Wenitong, Janya McCalman, Mary Whiteside, Leslie Baird, David Patterson, Bradley Baird, Ruth Fagan, Yvonne Cadet-James, and Andrew Wilson. 2004. A participatory action research process with a rural Indigenous men's group: Monitoring and reinforcing change. *Australian Journal of Primary Health* 10: 130–136.

Tsey, Komla, Mary Whiteside, Sathyabhama Daly, Audrey Deemal, Teresa Gibson, Yvonne Cadet-James, Andrew Wilson, Radhika Santhanam, and Melissa Haswell-Elkins. 2005. Adapting the 'family wellbeing' empowerment program to the needs of remote Indigenous school children. *Australian and New Zealand Journal of Public Health* 29: 112–116.

Ungunmerr Bauman, Miriam-Rose. 1988. *Dadirri: Inner deep listening and quiet still awareness—A reflection by Miriam-Rose Ungunmerr*. Nauiyu (Daly River), NT: Miriam Rose Foundation. www.miriamrosefoundation.org.au/dadirri/. Accessed 31 May 2021.

Wade, Derick T., and Peter W. Halligan. 2017. The biopsychosocial model of illness: A model whose time has come. *Clinical Rehabilitation* 31: 995–1004. https://doi.org/10.1177/0269215517709890.

Wallerstein, Nina B., and Bonnie Duran. 2006. Using community-based participatory research to address health disparities. *Health Promotion Practice* 7: 312–323. https://doi.org/10.1177/1524839906289376.

Williams, M. 2018. Ngaa-bi-nya Aboriginal and Torres Strait Islander program evaluation framework. *Evaluation Journal of Australasia* 18: 6–20.

Wilson, W.T. 1986. *An analysis of federal government action on the provision of effective preventive, treatment, and rehabilitative services for Aboriginal alcohol abusers.* Canberra, ACT: Unpublished.

World Health Organization. 1978. *Declaration of Alma-ata international conference on primary health care, Alma-Ata, USSR.* Geneva: World Health Organization. www.who.int/publications/almaata_declaration_en.pdf. Accessed 21 Oct 2021.

Wynter, Jo. 1991. Central Australian Aboriginal alcohol planning unit: A challenge for change. *Aboriginal Law Bulletin* 2: 7.

Chapter 5
Community-Based Restrictions on Alcohol Availability

Artwork by Delvene Cockatoo-Collins

Abstract   This chapter reviews the emergence from the 1980s of community-based initiatives aimed at reducing alcohol-related harm by curtailing the availability of alcohol. We distinguish three types of local restrictions on supply: voluntary agreements negotiated between liquor outlets and neighbouring communities; restrictions negotiated between outlets and communities and then incorporated into the licence conditions of the outlets concerned, and restrictions imposed by state/territory licensing authorities. Local restrictions on supply are usually based on a public health approach to alcohol problems which focuses on reducing alcohol-related harms at a local population level rather than focusing on individual drinkers. Historically, and particularly in central Australia, campaigns to impose restrictions were often led by women, who experienced at first hand the violence associated with excessive drinking. We discuss evidence from local restrictions in remote communities and regions, and in regional towns with large Aboriginal populations. Evidence suggests that, where restrictions are a product of genuine community input, they are effective in reducing alcohol-related harms and enjoy strong support. Where they are imposed with little regard to community input—as in the case of some Alcohol Management Plans introduced by the Queensland Government in the early 2000s—they are often perceived by those affected as discriminatory and disempowering. Community-based restrictions are also often politically contentious, largely as a result of opposition by the liquor and hospitality industries. The chapter also discusses the relationship between alcohol restrictions and anti-discrimination legislation and summarises factors associated with effective community-based restrictions on supply.

5.1   Introduction

In 1970, leaders of the Aboriginal community of Yirrkala in north-eastern Arnhem Land lodged the first of two objections with the Northern Territory Licensing Court to the granting of a licence for a new hotel on Aboriginal land (Parliament of the Commonwealth of Australia House of Representatives Standing Committee on Aboriginal Affairs 1975). Their action is the first known instance of Aboriginal people in Australia invoking licensing laws to control the accessibility of alcohol (Brady 2004; Reid 1983: 24–27). The action occurred seven years after the community's leaders had sent a bark petition to Canberra in an attempt to stop the federal government from excising a portion of their traditional land to make way for a new bauxite mine and township (Reid 1983). Neither the petition nor the licensing objections prevailed. The township of Nhulunbuy—20 km from Yirrkala—was built to service the mine, along with an alumina refinery and a new deep-water port.[1] Today, 50 years on, the refining of bauxite has ceased but the Walkabout Hotel still stands.

Since then, other Aboriginal communities and organisations have initiated local interventions aimed at preventing alcohol-related harms by curtailing access to

---

[1] http://ncl.net.au/welcome-to-nhulunbuy/local-history/ (retrieved 19 October 2020).

alcohol, often with more success than the leaders of Yirrkala had in the 1970s. Such interventions focus on the 'supply reduction' component of alcohol and other drug harm minimisation policies, as outlined at the beginning of Chap. 3. In this chapter, we review evidence from local 'supply reduction' interventions. As we show, the approach can take different forms, but common to all of those reviewed here is a focus not on individual drinkers but on local *populations*—in some cases, the local Aboriginal population, in others, the entire local population, Aboriginal and non-Aboriginal.

In some Aboriginal communities, access to alcohol is managed not by population-based measures such as those discussed below, but by community-controlled licensed clubs or other outlets and/or by liquor permit systems under which approved individuals are permitted to import and consume liquor. These measures are examined separately in Chap. 7.

5.2   Local Restrictions: A Framework

In examining supply-based measures, it is useful to distinguish two dimensions, both of which influence outcomes: the measures themselves, and the sources of authority on which they rest. The former typically take one or more of five forms:

- Price-based restrictions;
- Restrictions on outlet trading conditions (over and above those applying to all outlets under the relevant jurisdiction's licensing laws);
- Restrictions on sales of particular beverages, such as cask wines;
- Place-based restrictions;
- Restrictions on sales to particular categories of people (again, over and above those applying to all outlets under the relevant jurisdiction's licensing laws, such as minimum purchasing age).

The authority underpinning restrictions can take three forms:

- *voluntary*: informal arrangements made by outlets at a local level, usually in consultation with community organisations;
- *negotiated-mandated*: arrangements negotiated by stakeholders at a local level and given statutory recognition (e.g. as special conditions attached to a liquor outlet's licence);
- *imposed*: restrictions unilaterally imposed by governments or other higher-level authorities.

Combinations of these two dimensions are summarised in Table 5.1. In reality, these measures are rarely found in pure form on their own but are normally packaged with other supply reduction measures, and sometimes also with demand reduction measures such as education campaigns and/or harm reduction measures.

Table 5.1   Typology of restrictions on supply of alcohol, with examples

Type of restriction	Voluntary	Negotiated-mandated	Imposed
Price-based	Agreement by outlets not to discount certain beverage types		Taxes on alcohol (in Australia, can only be levied by Commonwealth); Minimum Unit Price for alcohol, introduced in Northern Territory in 2018 (Northern Territory Government 2021)
Outlet trading conditions	Agreements by outlets to limit sales at the request of local communityorganisation	Negotiated restrictions between outlets and local alcohol action groups on hours and/or days of sale	Trading conditions prescribed under relevant licensing laws
Restrictions on sales of high-risk beverages	Voluntary agreements by outlets to restrict sales of certain beverages, eg bottles of fortified wine	Negotiated, formalised arrangements under which outlets do not sell certain types of liquor	Imposed restrictions—e.g. NT-wide ban on sales of 4 L cask wines from 2010 (Northern Territory Licensing Commission 2010b)
Place-based	Locally generated bans on possession and consumption of alcohol in specified homes, town camps and/or communities	Dry area declarations under *Pitjantjatjara Land Rights Act* or *NT Liquor Act*	Imposed prohibitions on possession or consumption of liquor in designated public places—e.g. NT Two Kilometre Law
People-based	Bans by a local outlet on serving individuals at the request of local community organisation, police or health centre	Negotiated agreement not to serve residents of designated Aboriginal communities	Prohibition orders issued under state/territory laws

5.3   The Foundations of Restriction-Based Approaches

As explained earlier (see Sect. 2.4 in Chap. 2), the strategy of preventing and managing alcohol problems by restricting supply, as well as reducing demand through early intervention and treatment, is based on a public health approach to alcohol policy that emerged under the auspices of the World Health Organization in the 1970s. As we showed in Chap. 2, in the 1980s the approach found favour among health professionals and others involved in the initial establishment of Aboriginal community-controlled health services.

In some areas, notably in remote Aboriginal communities in central Australia, the need for effective restrictions on availability also became a rallying cry among Aboriginal people, especially but not exclusively women (Brady 2019). In April 1993, for example, an estimated 300 Aboriginal women from central Australian

communities converged on Alice Springs and marched to the office of the NT Licensing Commission to demand the revocation of licences of retailers believed to be selling alcohol to 'grog runners'. At the time, with more than 70 outlets in a town of 26,000 people, Alice Springs was said to have the highest per capita number of outlets of any town in Australia (Northern Territory News 1993).

The context in which these and similar initiatives arose was shaped by three powerful factors. The first was an awareness, shared by many Aboriginal community residents and non-Aboriginal health and other service providers, of the terrible damage being wrought by excessive alcohol use by some drinkers. The second was the significance that many Aboriginal people attached to the 'right to drink' as a symbol of social and political equality—a view in turn derived from the many decades through which the same entitlement was denied to Aboriginal people (Brady 2004). The third—which was not always easy to reconcile with the second factor—was a deeply held desire on the part of many Aboriginal people to keep alcohol out of their communities.

In the NT, the introduction of a new *Liquor Act* in 1979, following on from the granting of limited self-government to the NT in 1978 after more than a century of rule from Adelaide or Canberra, gave legislative expression to these sentiments. On the one hand, it defined an entitlement to purchase and consume alcohol free of any race-based discrimination. At the same time, through the so-called restricted area provisions of the Act, it enabled communities to define their own regimes of restrictions or outright bans on importing and consuming alcohol, and to have these restrictions given the weight of NT law (Northern Territory of Australia 1979).

Take-up of the restricted areas provisions was rapid. Within four years, 50 communities—including most major communities—had become restricted areas (Northern Territory Racing Gaming and Liquor Commission 1988). It continued to grow, reaching 112 in 2010 (Northern Territory Licensing Commission 2010a).[2]

While the restricted area provisions in the NT were the first and most widely used example in Australia, other jurisdictions also legislated to give Aboriginal communities control over alcohol. In Western Australia, the *Aboriginal Communities Act*, also

---

[2] By this time, the legislative authority underpinning restricted areas had been undermined by the Commonwealth Government, which in 2007 without prior notification introduced a Northern Territory National Emergency Response Act (NTER)—better known informally as 'the Intervention' (Australian Government 2007). The NTER was the Commonwealth's response to a report commissioned by the NT Government alleging widespread alcohol and other drug-fuelled child sexual abuse in Aboriginal communities in the NT (Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse 2007). Under the NTER, possession and consumption of alcohol was immediately banned not only in discrete Aboriginal communities or restricted areas, but on all land in the NT defined as Aboriginal land under the Aboriginal Land Rights (Northern Territory) Act 1976—that is, approximately 50% of NT land—unless specifically exempted. In 2012 the Commonwealth Government introduced new legislation under which effective control over liquor licensing matters was transferred back to the NT Liquor Commission, although not without residual Commonwealth powers to over-ride the NT (Australian Government 2012; Minister for Families Community Services and Indigenous Affairs 2013).

Since 2006, restricted areas of this type have formally been known as General Restricted Areas to distinguish them from restrictions imposed on public drinking in urban areas. The latter, which are based on little or no community input, are known as Public Restricted Areas.

introduced in 1979, enabled communities to create by-laws prohibiting or restricting alcohol and other substances (Western Australia 1979). Section 175 of the *WA Liquor Control Act 1988* also enables the Minister, in consultation with local communities, to declare an area a 'restricted area' in which possession of alcohol is prohibited—a power first used in 2008 at the request of two Aboriginal communities (Western Australia 2022; Calladine 2009). In South Australia, amendments to the *Anangu Pitjantjatjara Yankunytjatjara Land Rights Act 1981* introduced in 1987 empowered communities in the APY lands to restrict or prohibit alcohol (and other 'regulated substances') and gave police powers to enforce the provisions (South Australia 2017).[3]

In the NT, independent reviews of the restricted area provisions of the *Liquor Act* showed that the provisions were by no means free of administrative and operational challenges, but nonetheless were associated with reductions in alcohol-related harms in communities and enjoyed widespread community support (d'Abbs 1989, 1990a, b; Legislative Assembly of the Northern Territory 1993; Reilly 1982). The restricted area provisions did not, however, curtail the activities of alcohol retailers, who remained free to compete for, and in some cases probably depended on, Aboriginal customers.

This was the nub of the issue that advocates of supply restrictions were determined to address. Without restrictions on suppliers over and above those universally applicable under the trading conditions of the *Liquor Act*, they insisted, efforts to reduce the harms that flowed from excessive drinking were doomed to fail. From the outset, however, proponents of restrictions encountered resistance, most predictably from drinkers and those who catered to them, but also from regulatory authorities, which were often reluctant to use their legal powers to promote public health, and from politicians, who showed little appetite for being seen to interfere with constituents' 'rights' to drink or sell alcohol.

---

[3] These changes were not unique to Australia. The shift away from prohibiting Indigenous people from drinking, towards vesting powers over alcohol in local communities, echoed similar changes in the US, where Congress in 1953 transferred legislative control over alcohol to tribal communities (Kovas et al. 2008), and similar shifts elsewhere, reflecting in part the winds of decolonisation blowing through much of the world at the time. In 1981, the US State of Alaska legislated to give small communities the power to regulate alcohol through Local Option referenda, with available options including no restrictions, prohibition, or restricted sales through specified outlets (Berman et al. 2000; Berman and Hull 2001; Hladick and Eldemar 2017). In Canada where, as in Australia, control over liquor became a tool in the federal government's assimilation policy (Campbell 2008; Valverde 1998) the government in 1985 repealed the liquor section of the *Indian Act* and transferred powers over liquor to local community councils (Campbell 2008). In the remote territory of Nunavut in northwestern Canada, communities may choose by local plebiscite under the *Nunavut Liquor Act* to prohibit or restrict alcohol (Nunavut Liquor Commission 2018; d'Abbs and Crundall 2019).

5.4   Restricting Alcohol Availability in Yalata, S.A.

One of the earliest instances where these issues were contested was in Yalata, a small community located on the far west coast of South Australia, close to the Eyre Highway that traverses the Nullabor Plain (Brady et al. 2003). Yalata was founded in 1952 as a Lutheran mission to house people from the Anangu Pitjantjatjara lands who had been displaced to make way for a testing site for British nuclear weapons at Maralinga. Following the repeal of laws prohibiting drinking by Aboriginal people in SA in 1965, mission authorities at Yalata sponsored the establishment of a beer canteen designed to foster a culture of moderate drinking (Brady et al. 2003). The canteen, which operated between 1969 and 1982, is examined further in Chap. 7 below. In 1975, a roadhouse at Nundroo, 47 km away from Yalata, was granted a liquor licence and began selling two litre glass flagons of fortified wine to customers from Yalata. Over the following years, levels of alcohol-related violence in the community climbed; deaths outstripped births and 30% of all deaths were alcohol-related (Brady et al. 2003).

In 1984, the community gained freehold title to its land following the introduction of land rights in South Australia by the State Government. Six years later, the Yalata council applied successfully to have Yalata declared 'dry' under the *Aboriginal Lands Trust Act*. Concurrent attempts to negotiate voluntary agreements with the licensee at Nundroo, however, were not successful. It was in this context that the events described by Brady et al. (2003) in Box 5.1 unfolded.

Box 5.1 A Crisis Precipitates Action

Extract from Brady et al. (2003: 67–69).

There was a multiple-fatality car accident on Good Friday 1991 that finally precipitated decisive action. Five Yalata people were killed on the Eyre Highway when their car, driven by an intoxicated 22-year-old man, pulled out of the Yalata roadhouse into the path of a semi-trailer. The community was traumatised by the accident, which happened in full view of anyone in the vicinity of the roadhouse. Two weeks later the council wrote to the Licensing Commissioner, asking him to visit and discuss the uncontrolled access to alcohol. The commissioner wrote to all licensed roadhouses, alerting them that he was considering an application to the Licensing Court for restrictions on take-away sales. In July he visited the community. They were ready for him.

A report had been commissioned through the local Yalata Maralinga Health Service to brief the commissioner on the mortality and morbidity associated with alcohol use (Brady 1991). When he arrived on 10 July, he was taken first to the Women's Centre, where 20 women, all of the mature spokeswomen for the community and several who were council members, were gathered. They told him they were worried about their people, their children and their community. They told him that they had no old people left because of alcohol.

They stated unequivocally that they wanted a prohibition on take-away sales to Yalata people, and that they wanted a ban on drinking at the bar in Nundroo as well. This meeting was followed by an enlarged council meeting at which the women's suggestions were endorsed by the others present.

The meetings with the Liquor Commissioner marked the beginning of yet another round of complex interchanges and negotiations, which, it must be said, served to confuse and dismay community members. At the height of the negotiations about whether and how there were to be changed licence conditions, licensees began to circulate petitions objecting to these plans, inviting Yalata drinkers to sign up. In response to this, a Yalata woman dictated a letter that was circulated at the time, which read as follows:

> Will the government take notice of those people signing names? Or are they going to listen to the people who have been arguing for that strong law for a long long time? And the bloke who's sitting down with all the grogs [the licensee], he's only trying to get the people: 'you want to come and drink here, you sign your name here' and he'll argue for the people who sign it.
>
> It's for a lot of the kids, the tjitji tjuta. How many times you see tjitji [children] wandering around here, no mai [food], no camp, no tucker. In many areas peoples have strong laws. Why can't Yalata stand up with those strong laws? Which bloke would stand up for Yalata and say we need kapi wiya [no grog].

The hotels all announced that they would oppose the suggested conditions. One hotel hosted a meeting with the surrounding farmers that reinforced the mistaken view that the take-away restrictions were going to affect local people not associated with Yalata. It was hoped that Yalata would be able to present its position to the Judge of the Licensing Court, which was that no take-away sales at all be available to residents of or visitors to Yalata. Instead, initially the Liquor Commissioner sought to negotiate a 'compromise' agreement with the hotels that they would sell only low-alcohol beer as both on- and off-sales for Yalata customers. Questioned by a local Aboriginal and Torres Strait Islander Commission (ATSIC) officer, some Yalata residents apparently acquiesced to the low-alcohol beer idea; this kind of beer had never previously been discussed in the community. The women's group was unhappy with this proposed compromise. In the event, the proposal was declined by Judge Kelly of the Licensing Court on 13 September 1991, and the matter was further delayed.

Finally a hearing date was announced: 19 December 1991, eight months after the Easter deaths, and even then the matter was not simple. With the support of ATSIC, a large contingent of Yalata Council and community members drove the 1000 kms to Adelaide to attend and support their case at the court hearing. The licensees had hired lawyers to object to the proposed restrictions. Legal counsel for the community had been briefed to put the Yalata case, but South Australia is the only jurisdiction in Australia where parties do not have *locus standi* (the right of standing before the court); the community

was supposed to rely on the Liquor Licensing Commissioner to speak on its behalf (Bourbon et al. 1999: 29).

There was some discussion before the Judge agreed to inform himself of the issues by agreeing to hear from lawyers. The court did not take any verbal evidence from community members. Judge Kelly finally announced his decision that no full-strength alcohol was to be sold for off-premises consumption to residents of, or travellers to or from, Yalata community and the Maralinga Lands by the licensees of Nundroo, Nullarbor and Penong. Light beer was excepted from this ruling. Commenting on the continued availability of low-alcohol beer, a council member observed that because of this, the 'footsteps' would still lead to the roadhouse: 'Low alcohol beer is no good. It's still drink, and it's still Nundroo. They follow their step.'

Conclusion

The community had finally succeeded in imposing restrictions on the supply of alcohol in the region, after 16 years of struggle. Reflecting on the court hearing, Mabel Queama, a senior Oak Valley woman, observed in 2001:

> Yes, we have been there [to the court case] for the drinking. To stop the alcoholic, Nundroo, Penong, Nullarbor. Too much fighting, murders, too many men and women drinking. Kids left behind, spend all the money on drinking. That was a long time ago [i.e. in 1991]; we have been at Oak Valley for a long time.

These restrictions remain in place today. Has the struggle been worthwhile for the community? A recent ten year follow-up study supported by Yalata Council and Yalata Health Service[4] provides evidence of improvements in the quality of life for the residents of Yalata, and a statistically significant decline in deaths from all causes, particularly in the 15–29 year age group. This was mainly due to a dramatic decline in alcohol-related motor vehicle accident deaths (Byrne et al. 2001). There is also now good evidence from a number of evaluated trials elsewhere in the country of the benefits of restrictions (d'Abbs et al. 1996; d'Abbs and Togni 2000; Gray 2000; Gray et al. 2000). Many long-term health and social problems remain in the community. Yvonne Edwards, a senior Yalata woman and one of those who drove to the court hearing in Adelaide in December 1991, said ten years later that 'Everyone goes past Nundroo now, they go straight for Ceduna for the grog. Nullarbor, people don't go there, people go straight past Penong.' Colin Murka, a respected Yalata man and supporter of the restrictions, said in 2001 that 'the legislation helped half-half—better than before, other people still drinking in their homes'.

---

[4] Formerly known as the Yalata Maralinga Health Service.

Fig. 5.1 Aboriginal women rallying on the Lasseter Highway in central Australia in July 1989 to demand an end to take-away alcohol sales to Aboriginal people from Curtin Springs roadhouse. (Photograph courtesy of NPY Women's Council.)

5.5 The Struggle for Restrictions at Curtin Springs Roadhouse (CSR)[5]

Another protracted struggle to restrict sales from a liquor outlet—one that was to have consequences beyond the immediate contestants—focused on the Curtin Springs Roadhouse (CSR), located on the Lasseter Highway linking Alice Springs with Uluru (Ayers Rock). Although situated in one of the remotest parts of Australia, CSR was readily accessible by three Aboriginal communities: Mutitjulu (100 km away, near Uluru), Imanpa (105 km away) and Amata (150 km away). It was also connected by road with several more distant communities.

Traditionally, roadhouses in the NT have been subject to few restrictions on the hours during which they can serve fuel, liquor, food and other wares to the travelling public. In January 1988, the licensee of CSR reversed a long-standing policy under which he had voluntarily refrained from selling take-away liquor to Aboriginal people and began selling under what he described at the time as a 'limit' of no more than one carton of beer and one 4 L cask of wine per person per day (Kavanagh 1996). His reasons for doing so quickly became one of several matters of dispute. Pitjantjatjara Council, representing Aboriginal communities located in the Anangu Pitjantjatjara lands extending across parts of South Australia, Western Australia and the Northern Territory, claimed that CSR was bound by an informal agreement with

---

[5] The following section draws on three main reports: a written submission by Pitjantjatjara Council Inc to the Northern Territory Legislative Assembly Sessional Committee on Use and Abuse of Alcohol by the Community (Pitjantjatjara Council Inc. 1990); a submission by the Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council to the Race Discrimination Commissioner (Kavanagh 1996) and an evaluation of liquor restrictions at Curtin Springs roadhouse (d'Abbs et al. 1999).

local communities not to sell take-away alcohol to their residents (that is, a voluntary agreement in Table 5.1). Peter Severin, the licensee, denied the existence of any such agreement. Whatever the truth, the impact of the change was immediate and devastating, as Anangu from many communities converged on Curtin Springs to drink and take liquor back into their communities. Levels of alcohol-fuelled violence increased rapidly in communities that had previously opted to become 'dry' under the various state/territory-based laws referred to above.

In February 1988, the chairman of Amata community wrote to the CSR licensee asking him to reinstate restrictions on alcohol sales to Anangu, a request reiterated shortly afterwards by Pitjantjatjara Council. Both requests were declined. The licensee's refusal precipitated a struggle that spanned almost ten years of negotiation and disputation involving the licensee, Pitjantjatjara Council, Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council, the NT Liquor Commission, NT Supreme Court and the Commonwealth Human Rights and Equal Opportunity Commission (HREOC).

Following the licensee's refusal to reimpose restrictions, Pitjantjatjara Council and NPY Women's Council took their grievances to the NT Liquor Commission, requesting that, should the CSR licensee persist, his licence be suspended. The NTLC dismissed the complaints, accepting the licensee's assurance that no informal agreement existed and ruling that the complaints were, therefore, groundless. By this time, another roadhouse located on the Lasseter Highway—the Erldunda Roadhouse—had also applied to the NTLC for a take-away licence in the face of objections from Pitjantjatjara Council. The NTLC subsequently conducted hearings in relation to CSR and the Erldunda application, during which 23 witnesses testified about increases in injury, violence, intoxication and child neglect with take-away alcohol purchased from CSR In a decision announced in May 1989, the NTLC dismissed all objections, renewed CSR's licence with no restrictions and granted Erldunda an unrestricted licence.

The decision prompted an anguished response. In July 1989, over 300 women from all member communities of NPY marched down the Lasseter Highway to CSR (See Fig. 5.1) The NPY Chairwoman voiced their frustration:

> The roadhouses are just too close to our communities. Since the Northern Territory Liquor Commission has allowed unrestricted amounts of alcohol to be available we are having lots of problems on our communities. We have been talking to the Northern Territory Government for almost 2 years now about these problems. We went to the Liquor Commission and a lot of people from our communities spoke out strong about these roadhouses. Why didn't the Government listen to all of our stories? We have been saying the same story again and again but they still won't listen. Now we are trying to fight this battle in the Northern Territory Supreme Court.
>
> We are the women trying to be strong, trying to keep our families together, our communities together. But we can't be strong with all the grog coming in - it's just too much. We hear Mr Perron[6] talking about wanting to help Aboriginal women in Central Australia fight the grog problem. If he is really serious, why doesn't he do what we are asking him. STOP THE TAKE-AWAY LICENCES FROM CURTIN SPRINGS. How many more Aboriginal people have to die and get hurt before the Northern Territory Government will listen? (Kavanagh 1996: 3)

---

[6] Chief Minister of the Northern Territory Government at the time.

5.6   Alcohol Restrictions and Racial Discrimination

Around this time, the Council and NPY began to explore a different approach. One of the arguments used by licensees against restricting sales to Aboriginal people was that it would expose them to charges of racial discrimination. To test this assertion, in 1990, the Pitjantjatjara Council and NPY, together with several other Aboriginal organisations, asked the Commonwealth Human Rights and Equal Opportunity Commission (HREOC) to examine the effects of alcohol on Aboriginal communities in the NT. Five years were to pass before the Race Discrimination Commissioner released HREOC's report (Race Discrimination Commissioner 1995). In it, HREOC criticised the NT Government and NTLC in particular. For immediate practical purposes, however, the report's most important outcome was a qualified endorsement of a legislative measure known as a 'Special Measure' for dealing with specifically Aboriginal alcohol-related harms. These are defined in Section 8(1) of the *Racial Discrimination Act 1975* as follows:

> Special Measures taken for the sole purpose of securing adequate advancement of certain racial or ethnic groups or individuals requiring such protection as may be necessary in order to ensure such groups or individuals equal enjoyment or exercise of human rights and fundamental freedoms shall not be deemed racial discrimination, provided, however, that such measures do not, as a consequence, lead to the maintenance of separate rights for different racial groups and that they shall not be continued after the objectives for which they were taken have been achieved. (Cited in (Race Discrimination Commissioner 1995: 137)).

The Report stated that discriminatory restrictions requested by Aboriginal groups could qualify as 'Special Measures' under Section 8 (1) provided they satisfied three conditions:

1. they could be shown to lead to a reduction in alcohol-related harms in a community or communities, and to health, social and cultural benefits;
2. a community's own advancement was the sole motivation behind restrictions and
3. the alcohol-related problems were sufficiently serious (Race Discrimination Commissioner 1995: 137–49).

Where these conditions were satisfied, HREOC would be prepared to issue a Special Measures Certificate (SMC) formally endorsing the measures.

As we show below, the interpretation as to what does or does not qualify as a 'Special Measure' under the *Racial Discrimination Act* appears to have changed since HREOC issued its report. The immediate effect of the report, however, was an application by NPY Women's Council, lodged late in 1996, for a SMC under which CSR would not be permitted to sell any take-away alcohol to Anangu from member communities and only four cans of beer per person per day for drinking on the premises (Kavanagh 1996). At this point, CSR licensee Peter Severin ended his resistance. On 6 December 1996, he entered into an agreement with NPY to conduct two consecutive six-month trials of restrictions, commencing on 1 January 1997. Under the first set, no take-away sales were to be made to Anangu residents of 28 specified communities. Sales of liquor to Anangu for on-premises consumption were

limited to between 1 and 4 pm only. The second set of restrictions, to operate from 1 July–31 December 1997, effectively reversed the emphasis of the first set. There were to be no sales to Anangu for on-premises consumption, while take-away sales were limited to six 375 ml cans of beer per person per day.

The new conditions were formally incorporated as an amendment to CSR's liquor licence and endorsed in a SMC issued by the Commonwealth Race Discrimination Commissioner.[7] They were also the subject of an independent evaluation conducted by a team from the Menzies School of Health Research (d'Abbs et al. 1999). The evaluation found that sales of alcohol fell sharply (down by 79% on the previous year in the first six months, and by 59% during the second six months), with no evidence of a compensating increase in sales from the three other outlets in the region. Over the twelve month period, the value of meals sold by CSR *increased* by 25%. Alcohol-related contacts at Mutitjulu and Amata clinics fell by between 58 and 24% when compared with the preceding year. Examination of trends in selected offences (assaults, property damage, property theft, motor vehicle offences and unlawful entry of a building) recorded at Yulara and Kulgera police stations revealed similar declines compared with the preceding year. Over the same period, admissions to the Alice Springs sobering-up shelter from two communities affected by the restrictions at CSR increased, suggesting that some drinkers may have moved to Alice Springs following imposition of the trial restrictions (d'Abbs et al. 1999).

Qualitative data on people's experiences of the restrictions were gathered through field trips to four communities and conducting interviews with drinkers, non-drinkers and other stakeholders. The reported experiences and opinions of Anangu are summarised in Box 5.2.

Box 5.2 Evaluation of Restrictions on Sales of Alcohol from Curtin Springs Roadhouse, NT, Anangu Perspectives
Edited extract from d'Abbs et al. (1999: 8).

The experiences and views of Anangu regarding alcohol in general, and the restrictions at CSR in particular, are complex, diverse and, often, a source of contention within communities. The evaluators do not claim to be able to represent all of these complexities and differences in the time available to conduct this evaluation. However, a number of points were made by Anangu men and women of various ages in the course of consultations.

...

Many drinkers—most of whom were young men—opposed the restrictions at CSR, claiming that as a result they had no alternative but to go to Alice Springs to drink, which involved longer journeys, more expenditure (and therefore more reductions in money available to the rest of the family) and greater danger. Some drinkers also held the CSR licensee, Peter Severin, in high regard,

---

[7] The texts of both the amended licence and the Special Measures Certificate are reproduced as Appendix A and Appendix B of the Curtin Springs evaluation (d'Abbs et al. 1999).

although others pointed out that Anangu had in the past had to pay considerably more for a carton of beer than non-Indigenous customers, and some complained of poor treatment by staff at CSR. Opponents of the restrictions also objected to what they regarded as their discriminatory nature; in the words of one man, the restrictions took people "back to the days of no black drinking". It was also alleged that NPY, in negotiating the restrictions, had usurped more than its rightful powers, a reminder of the undertone of 'gender politics' that permeates much of the Indigenous discourse on controlling alcohol misuse.

Non-drinkers—who, in most Aboriginal communities constitute at least half of all adults—generally supported the restrictions. Communities were said to be more peaceful since the ban on serving Anangu at CSR, and women were not as scared because there was less violence. Some senior women spoke about the strain that they and others had experienced as a result of alcohol misuse, not only through physical harm but also because in many cases they had had the added responsibility of caring for their grandchildren. Since CSR stopped selling alcohol to Anangu, they added, these pressures had been reduced.

Senior men and women told of how, when alcohol had been available to Anangu at CSR, people from the community would drive there nearly every day and come back intoxicated and cause disruption in the community at night. Since the ban was introduced, they said that a few people were travelling into Alice Springs to buy alcohol, but this was not happening on a daily basis, and therefore the problems had lessened.

None of the supporters of the restrictions appeared to believe that the ban at CSR was, of itself, a total answer to the problems associated with alcohol misuse, particularly as CSR was not the only source of alcohol.

As the 12-month trial drew to a close, the licensee and NPY met again with a view to reaching an agreement for the longer term. On 2 December 1997, at a meeting at Ayers Rock Resort, Yulara, the parties agreed that henceforth *no* alcohol—either 'sit down' or take-away—would be sold to Anangu residents of communities covered by NPY Women's Council, or to persons travelling to or through these communities (d'Abbs et al. 1999). Anangu present at the meeting undertook to encourage other Anangu to patronise CSR for purchases of food, fuel and other items. At the request of the licensee, the new agreement was endorsed by a revised HREOC Special Measures Certificate. The new special condition attached to the licence had no time-limit attached to it; it read:

Box 5.3 Curtin Springs, NT, Liquor Licence, Special Condition

Extract from d'Abbs et al. (1999: 14).

It is a condition of the Liquor Licence of these premises that there be a prohibition on the sale of liquor to Aboriginal residents of certain Lands and specific communities. This prohibition has been imposed at the request of the residents of:

1. The Pitjantjatjara Lands in South Australia;
2. The Ngaanyatjarra Lands in Western Australia; and
3. The Northern Territory communities of:

    (a) Docker River
    (b) Mutitjulu
    (c) Imanpa
    (d) Finke.

The prohibition is to combat alcohol-related harm and damage to Aboriginal culture.

- Licensee—Curtin Springs Roadhouse
- Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council
- Pitjantjatjara Council Inc.
- Northern Territory Liquor Commission

Today, while some of the wording has changed, the same conditions form part of the CSR liquor licence (Northern Territory Government 2020). That the restrictions are seen as having continuing significance is shown by the NPY Women's Council's call in 2017 for similar restrictions to be imposed on other roadhouses in the area, especially at Kulgera (Zillman 2017). In January 2020, the NTLC imposed what it referred to as 'the Curtin Springs special condition' on Erldunda Desert Oaks Resort and the Kulgera Hotel (Northern Territory Liquor Commission 2019, 2020).

5.7 Restricting Alcohol Sales in Towns: 'Thirsty Thursday' in Tennant Creek

Both the CSR and Yalata campaigns were responses to problems faced by Aboriginal people living in remote communities. But much of the alcohol causing problems for Aboriginal people was consumed or at least purchased not in remote communities or nearby roadhouses but in towns, as participants in the April 1993 march by 300 Aboriginal women in Alice Springs, mentioned earlier (Sect. 5.5), were determined to point out. Over the years that followed, a number of measures aimed at reducing access to alcohol were trialled in Alice Springs and elsewhere (National

Drug Research Institute 2007: 125–31) but the most prominent initiative and one that became a model for other towns was the trial of restrictions dubbed 'thirsty Thursday' in Tennant Creek, a town with a population of around 3,000 located a little over 500 km north of Alice Springs. At the time, 37% of Tennant Creek's population were Aboriginal.[8]

Tennant Creek was established in 1935, according to one possibly apocryphal story where a beer truck broke down, following the discovery of gold in the area (Brady 1988; Wright 2010). It is located on Warumungu land, its Warumungu name being Jurnkurakurr. By the mid-1980s, the town had entered a population decline caused by the closure of several mines and a meatworks. This left some 14 liquor outlets—including eight that sold take-away liquor—competing for a shrinking customer base (Wright 2010). In response, members of two Aboriginal organisations in the town—Julalikari Council that operated housing, employment and other services and Anyinginyi Congress Aboriginal Corporation that provided primary health services—became increasingly concerned with the part played by alcohol misuse in the poverty, marginalisation, violence and poor health being experienced by many Aboriginal people in the town.[9] Alcohol was also deeply implicated in racial tensions in the town, as non-Aboriginal residents chose from a variety of venues that afforded privacy, while Aboriginal drinkers had access to only one bar and faced restrictions on where they could drink (Brady 1988).

One resulting initiative was the formation of a community night patrol in collaboration with local police—a program described in more detail in Chap. 9. Another was a successful campaign to stop hotels from holding striptease shows in public bars (Boffa et al. 1994). The two Aboriginal organisations also formed a Beat the Grog Working Party (the name of which helped to inspire the title for this book) which adopted a strategic approach to alcohol problems. This included lobbying for restrictions on take-away sales on Thursdays, the day that most welfare payments were received. All of these efforts are described in detail in Alexis Wright's book *Grog War: Shifting the Blame: One Town's Fight Against Alcohol* (Wright 2010).

Here, we focus on the restrictions themselves and their outcomes. On 12 July 1995, at the request of Julalikari Council, the NT Liquor Commission (NTLC) imposed restrictions on trading by selected liquor outlets in Tennant Creek, initially for a trial period of six months. Outlets affected were prohibited from selling either take-away liquor or liquor from 'front bars' on Thursdays.[10] On other days, take-away liquor sales were limited to between 12 noon and 9 pm; front bar sales could commence at 10 am, but only low alcohol 'light' beer could be sold before noon. Sales of wine were permitted only if accompanied by a substantial meal, and sales of 4 L casks of

---

[8] https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2001/quickstat/UCL 706800?opendocument (retrieved 6 October 2020).

[9] In 2003, the health service changed its name to Anyinginyi Health Aboriginal Corporation (www.anyinginyi.org.au/about-us (retrieved 29 September 2020)).

[10] In fact, the ban on all take-away sales on Thursday applied only for the first 13 weeks of the trial period, and was succeeded by a modified restriction that allowed take-away and front bar sales between 3 and 9 pm on Thursdays for the remaining 13 weeks. Following an evaluation of both sets of measures, the former set of conditions was retained.

wine were banned (Liquor Commission NT 1995). The restrictions were applied to the two public hotels in Tennant Creek and to an independent take-away liquor store. They did not apply to the two licensed restaurants in the town, or to three private hotels, or to the four licensed clubs. None of these outlets had licenses entitling them to sell liquor to the general public. The clubs also undertook not to accept new members during the trial period other than newly arrived residents of Tennant Creek (d'Abbs et al. 1996).

The NTLC's decision was highly controversial at the time, with hotels campaigning vociferously against them (Wright 2010). An independent evaluation conducted for the NTLC by a team from the Menzies School of Health Research (d'Abbs et al. 1996), however, found the restrictions to have been effective and to enjoy wide community support. The evaluation gathered quantitative data on health and welfare indicators, public order and liquor sales, and included a household face-to-face survey, using a probability sample from 273 households. These included both individual households and town camps. The survey was conducted towards the end of the six-month trial period (d'Abbs et al. 1996).

The effects were particularly striking during the first 13-week phase of stronger restrictions. For example, presentations at the Tennant Creek Hospital Emergency Department in which alcohol was coded as a feature fell by 34% compared with the same 13-week period in 1994, while presentations involving 'assault' fell by 21% (d'Abbs et al. 1996). Admissions to Tennant Creek Women's Refuge also declined by 46% during the first 13-week period compared with the same period in 1994. Reductions were also recorded in criminal damage, unlawful entry and stealing and interfering with a motor vehicle.

Apparent impact on alcohol consumption was assessed by using quarterly 'purchase into store' figures supplied by liquor outlets in and around Tennant Creek to the NTLC for October–December 1995, compared with the same quarter in the previous year. Although the total amount of alcoholic beverages purchased by outlets in the town fell by only 2.7%, the impact in terms of the amount of pure alcohol purchased declined by 10.0%, largely because of a decline of 54% in purchases of cask wine.[11] As Table 5.2 shows, this change was partially offset by an increase in purchases by roadhouses within a few hours' drive of Tennant Creek.[12] However, even with these included, the total amount of pure alcohol purchased fell by 7.6%.

The community survey found that 58% of those interviewed supported the trial measures, 21% opposed them and 16% supported some but not all of the measures. Asked what should be done in future to address alcohol problems in Tennant Creek, just over 50% favoured retaining or even strengthening the trial restrictions, compared

---

[11] The changes in amounts of pure alcohol purchased were not published in the original evaluation report (d'Abbs et al. 1996) and have been calculated by a secondary analysis using data collated for the evaluation. The amount is derived by applying alcohol content fractions to the amounts of various kinds of alcoholic beverages recorded, as follows: cask wine 0.10; bottled wine 0.125; fortified wine 0.18; cider 0.05; spirits 0.385; spirits, pre-mixed 0.05; beer full strength 0.05; beer light 0.03.

[12] Purchases were aggregated from seven roadhouses located between 25 km and 320 km of Tennant Creek.

Table 5.2 Changes in apparent consumption of pure alcohol, Tennant Creek, 1995

Outlets	Purchases into store 1/10–31/12 (litres of pure alcohol[a])			
	1994	1995	Change	% Change
Tennant Creek	17,846.8	16,070.3	−1776.5	−10.0
Roadhouses within 320 km of Tennant Creek	2461.4	2693.2	231.7	9.4
Total	20,308.2	18,763.5	−1544.8	−7.6

[a]Based on application of alcohol content fractions to alcoholic beverages purchased into store by liquor outlets and reported to NT Liquor Commission

with only 6% who advocated returning to pre-trial conditions (d'Abbs et al. 1996). Following the trial and another hearing, the NTLC announced that the restrictions imposed in the first 13-week trial period would be retained for the indefinite future.[13]

Over the next ten years, the Tennant Creek restrictions were evaluated on two further occasions. The first was in 1998, following a request by Tennant Creek Town Council for the restrictions to be reviewed in light of allegations that their initial beneficial effects had worn off (Northern Territory Liquor Commission 1999). Critics claimed that the restrictions were being circumvented, and that other unintended effects had emerged, including adverse impact on tourism and other commercial activity (Gray et al. 1998). The 1998 evaluation was undertaken by a team from the National Drug Research Institute (NDRI) at the Perth-based Curtin University of Technology (Gray et al. 1998).

The second evaluation was even more constrained by time limits than the first had been, with only nine weeks made available. Within this time-window, the evaluators conducted a qualitative analysis of more than 100 written submissions to the NTLC and interviewed 39 key stakeholders. They reported finding a wide range of opinions, with a majority in favour of the restrictions, cautioning, however, that the opinions may not have been representative of the whole community (Gray et al. 1998). They also interviewed managers of 12 neighbouring pastoral stations, a majority of whom were in favour of the restrictions.

The evaluation included a community survey, similar in design to the earlier survey, with a sample of 271 individuals. Finally, the evaluators analysed available data on alcohol sales, health and welfare and public order. Box 5.4 contains an extract from the NDRI evaluation in which the authors report findings from the community survey.

---

[13] The text of the NTLC decision is reproduced as Appendix 4 in d'Abbs et al. (1996).

Box 5.4 Community Opinions Regarding Alcohol Restrictions in Tennant Creek, NT

Edited extract from Gray et al ([1998]: 16–22).[14]

As previously indicated, we conducted a survey of a randomly selected sample of the Tennant Creek population aged 18 years and over which was stratified for Aboriginality (thus ensuring that both non-Aboriginal and Aboriginal people were represented in proportion to their numbers in the total population). In the first section of the interview schedule we asked questions aimed at identifying the effects of the current restrictions on respondents personally and their perceptions of the effects of the restrictions upon the community as a whole.

Personal effects of the restrictions

Between four and 24% of respondents reported that they had been negatively affected by at least one of the restrictions. The restrictions reported as having the greatest adverse effects were the closure of hotel front bars on Thursdays (17%), the ban on the sales of wine in casks of greater than two litres (18%), and the closure of take-away outlets at hotels and liquor stores on Thursdays (24%). In contrast, between four and 12% of respondents reported that the restrictions had positive effects on them personally.

However, the majority of respondents reported that the restrictions had not affected them personally. Even if the responses to questions about the personal effects are interpreted conservatively—that is, assuming the actual percentage in the community is at the upper end of the 95% confidence intervals—less than 30% of the population has been adversely affected by any one restriction.

....

Effects of the restrictions on the community

When asked about the effects of the restrictions on the community as a whole, responses were mixed. 31% reported the restrictions had only negative effects, 16% that they had only positive effects, and 33% that they had had both negative and positive effects (with many reporting more than one such effect).

....

In answer to the question 'Do you think the restrictions have had any bad effects on the community of Tennant Creek', the most common response was that people had found ways of getting around them (see Table 5.3). In essence, this is not a negative effect per se, but people clearly recognize the fact that this is a factor which has served to limit the effectiveness of the restrictions. The

---

[14] The complete evaluation report from which this extract is taken can be downloaded at https://ndri.curtin.edu.au/ndri/media/documents/publications/T79.pdf. A journal article based on the evaluation was published in the Australian and New Zealand Journal of Public Health (Gray et al. 2000).

second most widely cited negative effect of the restrictions was an unintended consequence of them. That is, the increase in broken glass in public places as a result of the ban on the sale of wine in casks of greater than two litres. Those who thought the restrictions had generally positive effects on the community sometimes cited these most common negative responses.

Table 5.3 Respondent perceptions of the negative effects of the restrictions on the community (n = 271)

Effect	% (95% CI)*
People have adjusted their drinking to circumvent the restrictions	28 (22.9–33.6)
Increase in broken glass on the streets	21 (16.5–26.2)
Increase in good order problems	14 (10.3–18.5)
Caused inconvenience	12 (8.7–16.5)
Infringed on the individual rights of the majority	12 (8.7–16.5)
Other negative effects	14 (10.3–18.5)
Decline in tourism and business activity	11 (7.7–15.2)
Increased tension between different segments of the community	10 (6.8–13.9)
Total negative effects	69 (63.3–74.3)
No negative effects	22 (17.5–27.4)
Don't know	9 (5.9–12.7)

*For those readers unfamiliar with statistical methods, the 95% confidence interval (CI) limits enable us to estimate—with 95% probability—the range of percentage values within which members of the wider population are likely to respond to a question in the same way as those in the sample. That is, they provide an estimate of the range of sampling error

...

53% of the respondents identified positive effects of the restrictions on the community as a whole (Table 5.4). Among these positive effects were improvements in personal welfare, less drinking and/or public drinking and consequent reductions in disruptive behaviour, and an improvement in the general ambience of the town.

Table 5.4 Respondent perceptions of the positive effects of the restrictions on the community (n = 271)

Effect	% (95% CI)
Improvements in personal welfare	29 (23.9–34.8)
Less drinking and/or less public drinking	22 (17.5–27.4)
Less disruptive behavior	19 (14.5–23.8)
Town is quieter and appearance and tone has improved	13 (9.3–17.3)
Police incidents reduced and/or people feel safe	6 (3.5–9.2)

(continued)

Table 5.4 (continued)

Effect	% (95% CI)
Other positive effects	7 (4.4–10.5)
Total positive effects	52 (46.1–57.9)
No positive effects	36 (30.6–42.0)
Don't know	12 (8.7–16.5)

Implementation of the restrictions

As with the introduction of the trial restrictions, a significant percentage of respondents (38%) thought there had been insufficient consultation with the community over the introduction of the restrictions. These people included those who were both for and against the restrictions.

...

Attitudes to the current restrictions

Despite the perceptions of negative consequences of the restrictions and the perception that both licensees and some drinkers are circumventing them to varying degrees, there was considerable support for the existing restrictions (Table 5.5). Support ranged from 55% of respondents who wished the restriction on front bar trading on Thursdays to either remain the same (46%) or be strengthened (9%) to 86% who believed that the requirement that lounge bars make food available remain the same (75%) or be strengthened (11%).

As we would expect, the restrictions that had the least support were those that are the most onerous; that is, the closure of take-away outlets at hotels and liquor stores on Thursdays, the ban on the sale of wine in casks of greater than two litres, and the closure of hotel front bars on Thursdays. Respectively, 30 and 7%, 28 and 9%, and 35 and 4% thought these should be dropped or eased. It should be noted, however, that a small number of the respondents who took this position did so because the restrictions were not working, rather than because they were opposed to them in principle. Thus, 18% of those who thought the ban on sale of wine in casks of more than two litres should be dropped or eased, stated that their decision was based on the increase in broken bottles consequent upon the ban rather than whether it was effective in reducing alcohol consumption. Nevertheless, even if we take the conservative position and assume that the percentage in the total population is at the upper end of the 95% confidence interval, those who believe that the restriction with the least support—the closure of hotel front bars on Thursdays—should be dropped (41%) or eased (7%) make up slightly less than half of the population (48%). Importantly, although a large proportion of respondents identified some negative effects of the restrictions, overall the majority of the population

(although in regard to some this might be small) is in favour of retaining or strengthening all the current restrictions.

Table 5.5 Respondent attitudes to the future of current restrictions (n = 271)

Restrictions	Attitude			
	Strengthen	Remain same	Ease	Drop
	% 95% CI	% 95% CI	% 95% CI	% 95% CI
Lounge bars to make food available	11 (7.7–15.2)	75 (69.5–79.8)	1 (0.3–2.9)	10 (6.8–13.9)
No third party sales to taxi drivers	26 (20.83–31.3)	51 (44.9–56.8)	2 (0.7–4.0)	17 (12.8–21.8)
No wine to be sold in glass containers over one litre volume	22 (17.5–23.4)	54 (47.9–59.8)	2 (0.7–4.0)	17 (12.8–21.8)
Sales of fortified wines restricted to containers of less than 1.25 L	24 (19.1–29.3)	51 (44.9–56.8)	2 (0.7–4.0)	15 (11.2–19.7)
Take-away sales limited to between 12:00 and 9:00 pm on week days	14 (10.3–18.5)	57 (50.9–62.6)	7 (4.4–10.5)	18 (13.8–23.0)
Lounge/back bars not to open before 12:00 pm on Thursdays and Fridays	11 (7.7–15.2)	59 (53.1–64.8)	3 (1.4–5.5)	23 (18.2–28.2)
Sales of all wines in casks of two litres or less restricted to one transaction per person per day	7 (4.4–10.5)	61 (54.9–66.6)	4 (2.2–6.9)	22 (17.5–23.4)
Wine only sold with meals in front bars	7 (4.4–10.5)	59 (53.1–64.8)	4 (2.2–6.9)	23 (18.2–28.2)
Between 10:00 am and 12:00 pm bar sales limited to only light beers	9 (5.9–12.7)	56 (50.1–61.9)	2 (0.7–4.0)	29 (23.9–34.8)
Take-away outlets from hotels and liquor stores to be closed on Thursdays	13 (9.3–17.3)	46 (40.2–52.1)	7 (4.4–10.5)	30 (24.7–35.5)
Sales of all wines in casks greater than 2 L volume prohibited	8 (5.3–11.8)	47 (40.9–52.8)	9 (5.9–12.7)	28 (22.9–33.6)
Hotel front bars to be closed on Thursdays	9 (5.9–12.7)	46 (40.9–52.8)	4 (2.2–6.9)	35 (29.5–40.9)

In effect, the community survey added weight to observations made by residents of Tennant Creek in written submissions or interviews: some drinkers and some

suppliers had found ways to circumvent the restrictions, and the restrictions them-selves also had unintended consequences, notably an upsurge in purchases of wine in glass containers following the ban on sales of large casks of wine and an atten-dant increase in discarded and often broken bottles around the town. Despite these shortcomings, the restrictions continued to enjoy widespread support as they were regarded—by many Aboriginal and non-Aboriginal residents alike—as yielding a net benefit to the community.

The evaluators analysed trends in liquor purchases by Tennant Creek outlets over nearly four years, from the third quarter of 1994—12 months prior to commence-ment of the trial—to the second quarter of 1998. They estimated that *per capita* consumption of pure alcohol by persons in Tennant Creek aged 15 years and over fell from 25 L in the year prior to restrictions to 22 L in the following year and, in the following year, to 20 L. The report also examined figures for the NT as a whole over the same period, and showed that the decline in purchases in Tennant Creek could not be attributed to a Territory-wide trend (Gray et al. 1998).

Examination of alcohol-related admissions to Tennant Creek Hospital also showed a downward trend following introduction of the restrictions (Gray et al. 1998: 28). The authors were not able to obtain data to assess any possible economic effects of the restrictions on commercial activity in the town.

The evaluators concluded their report by recommending that the restrictions in place be retained and complemented by additional measures, including extending restrictions to other outlets in and around Tennant Creek. In response, the NTLC retained the restrictions, but declined to extend their scope. It also committed the Commission to yet another review of the restrictions to be conducted in November 2000 (Northern Territory Liquor Commission 1999).

The subsequent review was conducted by a team from Menzies School of Health Research, using similar methods to the two earlier evaluations (d'Abbs et al. 2000). It found that the decline in apparent per capita consumption of alcohol had flat-tened out at a level well below pre-restriction levels and also below the NT-wide level of consumption at that time. It also found that the impact of Thursday-specific restrictions had weakened, partly because some drinkers and licensees had become more adept at exploiting loopholes in the restrictions, and partly because, as of July 1999, Centrelink had altered their payment systems to allow recipients to nominate any weekday of their choice for receiving payments (d'Abbs et al. 2000). Despite the apparent weakening impact of the restrictions, the evaluation found that the majority of Tennant Creek residents wished to retain them, with some modifica-tions, including the introduction of additional measures such as the stationing of a permanent licensing inspector in the town (rather than relying on local police with periodic visits from licensing inspectors), more alcohol education, stronger enforce-ment of laws, and greater attention to underage drinking and broken glass litter from discarded containers (d'Abbs et al. 2000). In response, the NTLC, after conducting another hearing and receiving further submissions, resolved to extend the ban on take-away sales on Thursday to all outlets in and close to Tennant Creek (Northern Territory Licensing Commission 2001).

The much-evaluated Tennant Creek restrictions remained in place for another five years. In October 2005, the NTLC undertook its own review and concluded that, while the restrictions continued to be associated with reduced levels of alcohol-related problems on Thursdays and Sundays, this was not true with respect to other days (Northern Territory Licensing Commission 2006). In the NTLC's view, the restrictions were no longer contributing to reducing alcohol-related harm, and no longer enjoyed community support (although no data was presented to support either conclusion). The restrictions on Thursday take-away and front bar sales were revoked (Northern Territory Licensing Commission 2006). In their place, the NTLC introduced what it referred to as a 'Liquor Supply Plan' that retained bans on sales of 4 L wine casks, limited purchases of 2 L casks and prohibited take-away sales before 12 noon (Northern Territory Licensing Commission 2006).

5.8   Other Communities, Other Restrictions

In part because of the repeated evaluations, the Tennant Creek restrictions became the best documented and probably best known measures of their kind in Australia. But they were by no means the only examples. Two similar interventions—the introduction of purchase limits in the town of Elliott, NT, and restrictions on take-away sales from outlets in Fitzroy Crossing, WA, in 2007—have already been mentioned (see Sect. 3.2 in Chap. 3). Outcomes of other instances in Western Australia, South Australia, the Northern Territory and Queensland are described in a comprehensive review of evidence relating to restrictions on sale and supply of alcohol published in 2007 by the National Drug Research Institute (NDRI) (National Drug Research Institute 2007). 'Restrictions' were defined in the review more broadly than our usage in this chapter, to include not only limitations on physical availability of alcohol, but also price-based measures such as taxation, and measures targeting service to drinkers, such as responsible server training and changes to minimum drinking ages. As the authors noted, most Aboriginal community-based initiatives designed to reduce availability among Aboriginal drinkers combined restrictions on trading conditions with restrictions on sales of 'high risk' beverages such as cask wines (National Drug Research Institute 2007).[15]

The NDRI review found that, in most cases, restrictions contributed to reductions in alcohol consumption, alcohol-related police incidents and alcohol-related presentations to health facilities. While displacement to other locations and/or other beverages often occurred, these effects only partially offset the reductions in consumption brought about the restrictions. The review, however, added two qualifying conclusions: firstly, restrictions on availability on their own could not overcome a community's alcohol problems but required complementary measures to reduce demand and address causal factors such as inadequate opportunities in employment, housing,

---

[15] The full text of the 2007 NDRI review can be downloaded from https://ndri.curtin.edu.au/ndri/media/documents/publications/R207.pdf.

education and recreation. Secondly, in at least some cases, evidence suggested that the effectiveness of restrictions eroded over time, as both drinkers and suppliers found ways of circumventing them. These changes, however, generally weakened rather than cancelled out the beneficial effects of restrictions on supply (National Drug Research Institute 2007). On the basis of these findings, the NDRI review identified five 'success factors' which, they argued, shaped the outcomes of restrictions. These were:

- The need for effective enforcement;
- Attention to beverage substitution and drinker displacement to other localities;
- Attention to the specific and changing needs of the target population;
- Community control, support for and awareness of restrictions;
- Evidence-based measures, situational suitability and evidence of outcomes (National Drug Research Institute 2007: 206–12).

We summarise their conclusions regarding each of these below.

Enforcement

Without adequate, sustained enforcement, the review argued, restrictions on availability of alcohol were unlikely to be effective. They noted that prime responsibility for enforcement on a day to day basis normally lay with police, with licensing inspectors sometimes also playing a role. They also noted that enforcement posed significant challenges in remote communities, where police resources were likely to be sparse or absent altogether. To be adequate, enforcement practices must create a genuine likelihood that breaches of restrictions would be detected and incur significant penalties (National Drug Research Institute 2007: 206–07).

Beverage substitution and displacement of drinkers

Substituting other alcoholic beverages (and/or other drugs) for restricted types of liquor, travelling to outlets outside restricted areas to purchase liquor, and 'grog running'—that is, smuggling liquor into restricted areas and selling it at inflated prices—were all, as the review noted, well attested ways by which determined drinkers circumvented restrictions. As the review also noted, it was not only drinkers who resorted to such means. Liquor suppliers on occasion exploited loopholes in restrictions in order to undermine them. For example, in the town of Newman, WA, alcohol outlets began selling port wine in 1.5 L plastic bottles labelled 'Ridgy Didge Wine' in response to a local ban on sales of two litre casks of fortified wine (National Drug Research Institute 2007: 207).

The review suggested that efforts to circumvent restrictions were an inevitable by-product of local supply reduction initiatives, and that those overseeing implementation of restrictions should anticipate them. They also recommended, wherever possible, monitoring sales and/or purchases of liquor not only within areas affected by restrictions, but also in the surrounding region to detect both beverage substitution and shifts in purchasing locations. Finally, and perhaps most importantly, the review pointed out that, in all of the cases where the impact of local restrictions had been examined in detail, circumventing of restrictions had the effect of offsetting *some*

but not all of the reductions in alcohol consumption ensuing from restrictions. These practices, therefore, may be grounds for modifying restrictions or enhancing enforcement, but they are usually not in themselves legitimate grounds for abandoning them (National Drug Research Institute 2007: 207–09).

Meeting specific and changing needs of target populations

Restrictions, the review concluded, need to be tailored in the first instance to the needs of local settings and responsive to changes in these needs. These in turn could result from implementation of the restrictions themselves or from external changes such as changes in the economic or commercial environment (National Drug Research Institute 2007: 209–10).

Community control, support and awareness

One of the most common criticisms made by people affected by local restrictions, according to the NDRI review, was a perceived lack of consultation, representation and involvement. Regardless of how warranted these criticisms may be in particular instances, the report argued, restrictions that are externally imposed tend to be less effective than those backed by a high level of community control and involvement. In this context, they singled out for criticism the processes through which 'alcohol management plans'—with in-built supply reductions—were imposed on Queensland Aboriginal communities from 2002 under the state government's 'Meeting Challenges, Making Choices' program (Queensland Government 2002). This initiative is discussed further below.

The review argued that, as well as a high level of local community control, successful supply reduction programs required active support from agencies such as police and other government agencies. In the absence of such support, community-based efforts would struggle to be effective. Finally, the review stressed the importance of keeping people affected by restrictions fully informed both before and during the implementation of restrictions (National Drug Research Institute 2007: 210–11).

Evidence-based measures, situational suitability and evidence of outcomes

Faced with pressure to act in response to alcohol-related problems, but unfamiliar with the range of intervention options available and supporting evidence, community groups may be urged to adopt measures such as education campaigns or voluntary agreements, which are uncontentious and relatively simple, but which, according to available evidence, are usually ineffectual in reducing harms. The review argued that community-based measures should be based on both empirical evidence of effectiveness and a coherent theoretical base. On these grounds, the review concluded, restrictions on hours of trading by licensed outlets were well supported by evidence.

Whatever measures were selected, however, also needed to be suited to local conditions. As the review noted, there was little point in banning alcohol in a community if there were no police on hand to enforce the decision. Interventions needed to be tailored to limitations imposed by local contexts, and/or resources needed to be provided to overcome those limitations. The review also noted the importance

of ongoing evaluations of interventions to provide feedback on whether or not they were having the desired effect (National Drug Research Institute 2007: 211–14). We return to this issue below.

5.9 More Recent Examples of Restrictions on Supply

5.9.1 Fitzroy Crossing and Halls Creek, WA

Since publication of the 2007 NDRI review, several other studies have examined the effects of restrictions on sales of high-risk alcoholic beverages in the Kimberley region of WA and elsewhere. One of these—the introduction of community-led restrictions on take-away sales from two liquor outlets in Fitzroy Crossing—is the subject of a separate case study in Chap. 6. In another, similar restrictions were introduced in 2009 by the WA Director of Liquor Licensing on sales from the hotel and liquor store at Halls Creek, also in the Kimberley. Both premises could sell only low strength beer (up to 2.7% alcohol) for take-away consumption, and the hotel could not sell liquor for on-premises consumption before 12 noon except to a lodger or in conjunction with a meal. An evaluation of the restrictions by University of Notre Dame examined indicators over three 12-month periods: pre-restrictions (June 2008–May 2009), the first 12 months following the restrictions and the second 12 months following restrictions (Western Australia Drug and Alcohol Office 2011). Among key findings were the following:

- Alcohol-related assault offences fell from 243 incidents in the pre-restriction period to 156 and 86 incidents in post-restriction periods 1 and 2 respectively; total assaults followed a similar trend;
- Police tasking in Halls Creek decreased from 2,058 tasks pre-restriction to 1,027 tasks in post-restriction period 2;
- Alcohol-related presentations to the Halls Creek ED fell by 34% in post-restriction period 1 and a further 45% in post-restriction period 2;
- In the first 12 months of the restrictions, admissions to the Halls Creek Sobering-up Centre decreased by 70%, from 1,084 pre-restrictions to 328; the decline continued in the second 12 month, although the data was incomplete.

5.9.2 Norseman, WA

In all of the examples discussed to this point, restrictions on supply have been imposed by state/territory licensing authorities at the request of Aboriginal community groups. In one other instance, restrictions came about through a voluntary agreement between a liquor outlet and Aboriginal residents of a small remote town and appear to have had sustained beneficial impact. The town of Norseman in WA, with a population of

a little over 1,000 of whom 10% are Aboriginal, is served by just one hotel which also holds the only licence in the town to sell take-away liquor to the general public. In 2008, at the request of Aboriginal members of the community, and with the support of the state alcohol and other drug authority and other agencies, the outlet agreed to place daily limits on take-away purchases of beverages known to be favoured by Aboriginal drinkers, including 5 L cask wines, and to limit take-away sales to between 12 noon and 6 pm (Midford et al. 2017; Schinenu et al. 2010). An independent evaluation reported that, in the 12 months following introduction of the agreement, per capita consumption of alcohol in the town declined by 9.8% with accompanying falls in assaults, public drunkenness and alcohol-related hospital admissions (Schinenu et al. 2010). Qualitative data also indicated that health seeking behaviour and family activities had also increased. The restrictions, with some modifications, were subsequently retained. A follow-up evaluation, conducted after the restrictions had been in place for seven years, found that, while the decline in apparent per capita alcohol consumption was not sustained, mainly as a result of a subsequent increase in sales of spirits, levels of assaults, burglary, domestic violence and public drunkenness all remained below pre-restriction levels (Midford et al. 2017). Qualitatively, the evaluators reported that Aboriginal drinkers were commencing consumption later than was normal prior to the restrictions, and more likely to drink at home than in public. The evaluation found that these changes had contributed to an improvement in community relations and enjoyed broad support, although they cautioned that the shift to domestic drinking may also have added to difficulties experienced by children in getting enough food and sleep to be able to function well at school (Midford et al. 2017).

5.10   Alcohol Management Plans in Queensland

All the local alcohol restrictions considered above were initiated by communities or Aboriginal organisations, and therefore, belong in the 'voluntary' or 'negotiated-mandated' columns of Table 5.1. These can be compared with restrictions in the form of Alcohol Management Plans (AMPs) introduced into Aboriginal communities in Queensland from 2002 under the Queensland Government's *Meeting Challenges Making Choices* (MCMC) policy (Queensland Government 2002). AMPs were the centrepiece of the government's response to the Cape York Justice Report, an investigation commissioned by the Queensland Government at the request of Cape York Partnerships and Apunipima Health Council (Queensland Department of the Premier and Cabinet 2001; Smith et al. 2019). The report corroborated evidence from earlier studies that had revealed high levels of alcohol-related violence and associated community dysfunction in many communities (Queensland Department of the Premier and Cabinet 2001; Gladman et al. 1997; Martin 1998). It recommended, among other changes, that community councils be divested of responsibility for running licensed canteens and that access to alcohol in communities be curtailed.

Under MCMC, AMPs were supposed to include three components: new restrictions on alcohol availability, which in practice took the forms of 'carriage limits' specifying how much and what kinds of liquor residents were permitted to bring into communities; measures to reduce demand for alcohol, including treatment and rehabilitation programs and, in communities where local councils had hitherto operated licensed canteens, new governance arrangements under which licences would be taken away from community councils and vested in separate Community Canteen Management Boards. By these means, it was hoped that the existing dependence of councils on alcohol-generated revenue would end (Queensland Government (Department of the Premier and Cabinet) 2005). On paper, AMPs were also portrayed as incorporating a high degree of local community control, to be exercised through Community Justice Groups, which in turn would be given enhanced powers and responsibilities by the government (Queensland Government 2002).

In practice, as Clough and Bird (2015) have shown, the reductions in access to alcohol entailed in AMPs were widely perceived to be externally-generated impositions rather than expressions of community wishes (much less, community control). Many councils, not surprisingly, strongly opposed them. Nonetheless, over the next 3 ½ years, AMPs were formalised and approved in 19 Aboriginal and Torres Strait Islander communities in Queensland. An internal evaluation conducted by the Queensland Government in 2005 concluded that AMPs had been only partially implemented, in that, while carriage limits had been introduced, proposed accompanying measures such as alternative management structures for canteens, and establishment of treatment and rehabilitation programs had not eventuated (Queensland Government (Department of the Premier and Cabinet) 2005). Even the restrictions on availability were said to have been implemented with such haste that there was little evidence of community ownership.

Nonetheless, the 2005 evaluation reported evidence of reduced assaults and more peaceful environments in several communities, although later government reports indicated that some of these benefits were short-lived (Queensland Government (Department of the Premier and Cabinet) 2005; Queensland Government 2008).

Clough and Bird (2015) have documented the evolution of AMPs in Queensland over the first 11 years, up to 2013. They depict a sequence of steadily expanding legislative restrictions, beginning with the carriage limits incorporated in the 19 community AMPs. Between 2005 and 2006, restrictions were extended to 148 liquor outlets located outside communities but within what were considered to be 'catchment areas' of communities, setting new conditions on selling liquor to residents of communities. Under a series of legislative amendments introduced from 2008, councils throughout Queensland were prohibited from holding a general liquor licence; it became an offence, punishable by substantial fines, to attempt to bring liquor into a restricted area; private residences became subject to carriage limits, and police became empowered to search without a warrant if they suspected a person was holding more than permitted amounts or types of liquor. By early 2009, canteen closures resulting from these legislative changes had made seven communities legally 'dry' (Clough and Bird 2015). Throughout this period, as Clough and Bird point out,

virtually nothing was done to expand demand reduction measures. In the community of Pormpuraaw, located on the western side of Cape York Peninsula, a Shared Responsibility Agreement signed in 2006 by community, commonwealth and state governments promised funding for an alcohol rehabilitation facility, and a building was subsequently established at a reported cost of $10 million. The facility opened in September 2009, offering a 15-week therapeutic rehabilitation program for 2 families at a time. Nine months later, after 4 families had completed the program, funding ceased and the facility closed (Smith et al. 2019).

The restrictions have almost certainly led to reductions in alcohol-related violence. Margolis et al. examined Royal Flying Doctor Service retrievals for serious injuries in four communities between 1996 and 2010 (Margolis et al. 2008; Margolis et al. 2011). They found that, following introduction of restrictions in 2002–03, injury retrievals declined for two years, but then started to increase. However, with the introduction of further restrictions in 2008, injury rates again declined from 30 per 1,000 in 2008 to 14 per 1,000 in 2010.

Clough et al. (2017) studied residents' perceptions and experiences relating to AMPs through a survey of 1,211 persons aged 18 years and over in ten remote Aboriginal and Torres Strait Islander communities. On the basis of previously conducted semi-structured interviews, the researchers had identified seven 'favourable' impacts of AMPs, and seven 'unfavourable' impacts. These were used to construct survey questions. Responses are summarised in the Table reproduced in Box 5.5. As the table shows, on the 'favourable' side, a majority of respondents—though by no means an overwhelming one—saw AMPs as enhancing community and child safety (although the proportion who believed AMPs had reduced violence against women fell just short of a majority). On the 'unfavourable' side, clear majorities criticised AMPs for having ensnared people in fines and criminal convictions and led to an increase in smoking cannabis (gunjah) and binge drinking. They were also perceived as discriminatory. Smaller majorities also considered that the AMP had not reduced access to alcohol in the community or helped people reduce their drinking.

Box 5.5 Residents' Perceptions and Experiences of Alcohol Management Plans in Queensland
From Clough et al. (2017)

Table 5.6 Proportions of participants agreeing with seven 'favourable' propositions and seven 'unfavourable' propositions about possible impacts of Alcohol Management Plans (AMPs) put to 1211 residents of 10 Aboriginal and Torres Strait Islander (Indigenous) communities in a survey conducted in Queensland (Australia) in 2014–15

Variable name	Propositions (to avoid conditioned responses propositions were arranged in the survey according to the order specified by the number enclosed in brackets)	Proportion of participants who 'agree' (n responding)	p*
'Favourable' impacts			
f1	The AMP has helped make children safer in this community (6)	56% (1007)	<0.001
f2	The AMP has made people more safe in this community (11)	53% (1019)	0.097
f3	The AMP has reduced violence against women in this community (4)	49% (1017)	0.363
f4	Since the AMP, violence has gone down in this community (5)	53% (1072)	0.024
f5	Since the AMP, school attendance has gone up in this community (7)	66% (899)	<0.001
f6	The AMP has been good for this community and made it a better place to live (1)	54% (1026)	0.012
f7	People are more aware of harmful effects of alcohol/drinking now (since the AMP) (2)	71% (1057)	<0.001
'Unfavourable' impacts			
u4	The AMP has caused more people to get fined, criminal records and convictions (3)	90% (1064)	<0.001
u1	There is more (not so much) gunjah being smoked in this community since the AMP (12) †	69% (944)	<0.001
u3	There is more "binge drinking" now than before the AMP (13)	73% (1006)	<0.001
u6	The AMP has discriminated against some people (14)	77% (1026)	<0.001
u5	Police can't (can) enforce the AMP effectively and stop the alcohol coming in (9) †	51% (1098)	0.365
u7	The AMP has not (has) reduced the alcohol people can get in this community (8) †	58% (1118)	<0.001

(continued)

	Table 5.6 (continued)		
u8	The AMP has not (has) helped people change their drinking and they are (not) drinking less (10) †	56% (1076)	<0.001

*One-sample test of proportions—stated proportion agreeing is different from a theoretical reference proportion of 50%, i.e. no majority agreeing/disagreeing
†These propositions were put to participants with reverse logic but then reverse coded for analysis to reduce possible bias where participants' views may have been led towards agreeing with some of the more critical and contentious unfavourable impacts

The authors noted that the perceptions of reduced violence and improved community safety were corroborated by objective data. They also suggested, however, that the perceived failure to reduce alcohol consumption or curb binge drinking, the criminalisation and experienced discrimination resulting from AMPs and the continuing failure to address demand reduction measures, were all grounds for concern. Citing publicly available Queensland Government data, they noted that, as of 30 June 2014, a total of 6,961 individuals had been convicted of 15,511 charges for breaching sections of the *Liquor Act* restricting importation and possession of liquor in AMP communities. Over 100 persons had been incarcerated. Almost all of those convicted were Indigenous residents of AMP communities, leading the authors to the astonishing observation that up to 70% of adults in these communities may have accrued at least one conviction (Clough et al. 2017).

In light of the reductions in violence and improvements in safety, the authors recommended against rolling back restrictions, but suggested that the limits of what could feasibly be achieved through supply reduction may have been reached. Smith et al., in their study of the AMP at Pormpuraaw, reached a less charitable conclusion, arguing that governments have represented AMPs as exercises in community empowerment but, by under-resourcing programs associated with those AMPs, have in fact undermined communities' capacity to deal with alcohol (Smith et al. 2019).

In recent years, alcohol management plans as instruments of alcohol policy have been deployed in two other contexts, both in the NT. The first consisted of several local initiatives in regional towns of the NT, where community groups developed local strategies to reduce alcohol-related problems under the auspices of the NT Department of Justice (Buckley et al. 2016; d'Abbs et al. 2010a, b; 2011; d'Abbs and Whitty 2016; Jilkminggan Community Aboriginal Corporation 2012; Katherine Region Action Group (KRAG) 2013; Success Works Pty Ltd nd; MacKeith et al. 2009; Northern Territory Department of Justice 2008; Senior et al. 2009). Although all of these plans contained some sort of restrictions on the supply of alcohol, such restrictions were not central to the plans, and in some cases pre-existed them. They are not, therefore, included in this chapter.

The second category of AMPs originated under legislation introduced by the Commonwealth Government in 2012 to supersede the 2007 NT Emergency Response ('the Intervention'). Called the *Stronger Futures in the Northern Territory Act*, the new law designated community AMPs as expressions of alcohol control policy in

Aboriginal communities (Australian Government 2012, 2013; Minister for Families Community Services and Indigenous Affairs 2013). These AMPs were intended to be tailored to the needs and wishes of individual communities, but in order to gain recognition required formal approval from the Commonwealth Minister for Aboriginal Affairs. For reasons that lie beyond this analysis, this proved to be a major stumbling block. A 2016 review by the Parliamentary Joint Committee on Human Rights concluded that the process of developing and approving AMPs was not functioning effectively (Parliamentary Joint Committee on Human Rights 2016, Para 3.53). It noted that, as of October 2015, only one AMP had received ministerial approval, while another seven, all approved by their communities, had been rejected by the Minister. Although not formally amended, the AMP policy has since been quietly abandoned and replaced by other measures. For a useful overview of AMPs as policy instruments, see Smith et al. (2013).

5.11 Special Measures Revisited

Ironically, one by-product of the controversy generated by the Queensland AMPs has been a re-interpretation of Special Measures under the *Racial Discrimination Act* (RDA) which, as we showed earlier (in Sect. 5.5) had been instrumental in enabling Aboriginal communities in Central Australia to negotiate restrictions with a roadhouse licensee.

On 31 May 2008, Joan Maloney, an Aboriginal resident of the Queensland community of Palm Island with no prior criminal record, was apprehended carrying one bottle of Bourbon and one bottle of rum in contravention of the Palm Island AMP, which permitted residents to possess only one carton of light or mid-strength beer. She was fined $150 and forfeited the liquor (High Court of Australia 2013). Subsequent appeals to the Queensland District Court and Supreme Court failed, but she was granted leave to appeal to the High Court of Australia.

Palm Island's AMP had been unilaterally imposed on the community by the Queensland Government in 2006, following the failure of groups in the community to agree on the kind of restrictions that should be imposed. In appealing against her conviction, the appellant argued that the AMP discriminated against community residents on the basis of their Aboriginality, since 97% of the population of the Island was Aboriginal, and since it deprived these people of entitlements available to other Australians. In dismissing her appeal, successive courts—including the High Court—conceded that the AMP measures were discriminatory but ruled that they did not contravene the *Race Discrimination Act* as they qualified as a Special Measure under Section 8 (1) of the Act. The counterargument—namely, that the AMP did not qualify as a Special Measure because it was not based on consultation with the parties affected and did not have their consent—was dismissed by the High Court on the ground that consultation was not a requirement of a Special Measure (High Court of Australia 2013).

This marks a significant shift from the position taken by the Race Discrimination Commissioner in her 1995 *Alcohol Report*. In addressing the question of whether and under what conditions alcohol restrictions qualified as a Special Measure, the Commissioner stated: 'The wishes of the community to whom the restriction applies, and that community's concept of their own advancement, is [sic] the motivating force behind the restrictions' (Race Discrimination Commissioner 1995: 146). Elsewhere the Commissioner stated 'Alcohol restrictions imposed upon Aboriginal groups as a result of government policies which are incompatible with the policy of the community will not be Special Measures' (Race Discrimination Commissioner 1995: 141).

At the time of Maloney's appeal, approximately 10% of Palm Island's population had been convicted under the same provisions as Maloney and were awaiting the outcome of her appeal. As Gear (2014–2015) pointed out, as a result of the High Court's decision, a substantial proportion of the island's Aboriginal population now had a criminal conviction for behaviour that would not be illegal in mainstream Australia. She argued that as a result of the Court's interpretation, the Special Measures provision of the RDA now had very different implications from those intended when the RDA was drawn up.

5.12   Evaluating Outcomes

One of the 'success factors' identified in the 2007 NDRI review of restrictions on supply, and listed above in Sect. 5.8, was the use of evaluation to demonstrate outcomes. In concluding this chapter, we reproduce in Box 5.6 an extract from the review offering some useful pointers for evaluating restrictions on supply.

Box 5.6 Evaluating Implementation and Outcomes of Restrictions
From National Drug Research Institute (2007: 220–22).

There are many ways to conduct an evaluation but foremost, the approach taken should be tailored to address the questions that have been posed (e.g. have the restrictions on trading hours reduced levels of alcohol consumption and harms among hotel patrons? has the increased police enforcement of minimum purchase age legislation reduced alcohol consumption and harms among young people?).

Well-designed evaluations typically include a core set of characteristics: a complementary collection of reliable, relevant and objective data to 'measure' outcomes (e.g. wholesale alcohol purchases, police reported assaults; local resident survey); a comparison of measures taken 'before' and 'after' the implementation of the intervention; inclusion of a 'control' town or area not subject to the intervention with which to compare to and help rule out alternative explanations; and the identification and consideration of other characteristics

or interventions which might also be responsible for apparent outcomes (e.g. economic recession, mining boom).

The application of objective and reliable evidence in an evaluation is crucial; undue reliance on personal opinion, conjecture and anecdote and other biased observations may create false impressions, ultimately leading to erroneous and at worst, harmful decision making. Table 5.7 provides details of measures or 'indicators' which have been used to objectively evaluate restrictions in the past. These indicators should be considered in the first instance but may be supported by additional measures sensitive to characteristics of the specific populations involved.

Table 5.7 Indicators of alcohol consumption and related harms for use in evaluation*

Measure	Comment	Data source
Volume of pure alcohol consumption by beverage type (may also be expressed as per capita consumption).	Estimates of pure alcohol consumed are superior to total volume. Estimated residential population (ERP) is needed to estimate per capita pure alcohol consumption.	Wholesale alcohol purchases—liquor licensing authorities. ERP—Australian Bureau of Statistics. Total volume to pure alcohol conversion factors see Catalano et al. (2001).
Numbers/rates of police reported offences; e.g. violent assault, disturbances, drunk and disorderly, drink-driving, road crashes, drink-driver road crashes.	May be affected by changes to policing and/or reporting practices over time. Use of subjective reports of alcohol-related offences should be treated with caution. Night-time rates (surrogate for alcohol-related offences) may be used where numbers permit.	Local policestation(s)/ state or territory Police central data collation.
Numbers/rates of alcohol-attributable deaths.	Based on alcohol ætiologic fraction method using systematically recorded ICD codes to identify alcohol-attributable conditions. May be divided into acute/chronic conditions for further information. One of the most objective measures of alcohol-related harms available. Small numbers of deaths in some regions may preclude use of death data (e.g. remote communities).	State/territory health departments, Australian Bureau of Statistics (collates records from all jurisdictions).

(continued)

Table 5.7 (continued)

Measure	Comment	Data source
Numbers/rates of alcohol-attributable hospital separations (hospitalisations).	Based on alcohol ætiologic fraction method using systematically recorded ICD codes to identify alcohol-attributable conditions. May be divided into acute/chronic conditions. Use of hospital admissions for comparative purposes (e.g. between jurisdictions) should be treated with caution as numbers may be affected by administrative procedures.	State/territory health departments, Australian Institute of Health and Welfare (collates records from all jurisdictions).
Numbers/rates of emergency department presentations.	Systematic reporting and ICD coding of emergency department presentations may not be in place in some areas precluding direct identification of alcohol-attributable conditions. May focus on injury-related presentations and information on diagnostically related groups where possible. May use surrogate measures were possible (e.g. night-time injuries). Use of subjective reports of alcohol-related admissions should be treated with caution.	Local emergency department(s) State/ territory health departments (where available).
Representative community survey(s)	Should be fully inclusive, canvassing views of all sub-populations (esp. Indigenous community members).	General population/ specific sub-populations.
Key stakeholder interviews	Should be fully inclusive, canvassing views of all representatives.	Stakeholder representatives.

*This is an edited version of Table 18 from p. 213 of NDRI (2007)

Logically, in order to mount a reliable evaluation based on reliable information, data collection procedures should be in place before the restrictions are implemented. When this is not the case, analysts are sometimes fortunate enough to have access to a collection of high-quality indicators that cover the population of interest. However, more often than not, evaluations must be designed to fit within data limitations. In many cases, the objective data necessary to answer the questions raised by stake holders, communities and policy makers about restrictions cannot be retrospectively collected. This results in considerable knowledge gaps and a tendency to fall-back on subjective information—thus highlighting one of the practical virtues of adopting a forward-looking pro-active policy approach rather than a reactive one.

Different indicators of alcohol-related harms will not necessarily respond to restrictions in a uniform manner. Hospital admissions provide a good example of this variability. Typically, alcohol-attributable hospital admissions

for injuries or 'acute conditions' are likely to respond more immediately to changes in the availability of alcohol within a population than are disease-based or 'chronic' alcohol-attributable conditions. This is because acute alcohol-attributable conditions such as violent assault injury, falls, road crash injury, tend to occur as a short-term outcome of episodic binge drinking or intoxication. By comparison, the progression of chronic disease (e.g. alcohol liver cirrhosis) is typically slower, often requiring the accumulation of many years of problem drinking to appear and a proportionate amount of time to positively respond to reduced consumption.

Outcomes from particular evaluations are rarely so marked and consistent that there remains no question as to cause and effect. Yet, a collection of reliable and valid indicators, expertly applied and interpreted, can considerably increase the degree of certainty about conclusions reached. The standard scientific approach to determining the efficacy of an intervention is to apply tests of statistical significance which estimate the likelihood that the findings are due to chance. Despite the reliance on objective mathematical parameters, there is always room for error. The possibility that a statistically significant finding is due to chance can be markedly reduced when the result is interpreted in concert with other indicators. However, the absence of statistically measurable change does not guarantee that change has not actually occurred. The inability to demonstrate an effect of a particular restriction may well be due to: lack of sensitivity of the measure employed; failure to include a valid measure of the behaviour of interest; too few observations; the presence of other factors which counter or confound the expected effect, and unaccounted for changes to standard reporting practices. Thus, in any determination provision should be made for the possibility that actual change may have been 'missed' by the evaluation. Perhaps more importantly however, is that in practice, it may be sufficient to demonstrate that restrictions have been effective at reducing consumption and or harms 'on the balance of probabilities'. What constitutes statistical 'significance' from a scientific perspective (e.g. 95% confidence) is far greater than that required to be demonstrated in a legal sense for instance, where a probability greater than 50% may be enough to merit attribution. The following are some key points for decision makers to keep in mind when gauging expectations:

- Even modest changes in measurable outcomes, can in reality, bring welcome relief to communities beset with the burden of alcohol-related problems;
- Evidence of short-term improvement may be preferable to no improvement at all;
- Evidence of short-term change is typically easier to show than long-term change;
- Evidence of ongoing change should be the ultimate goal;
- To produce evidence of ongoing change enduring but flexible evaluation strategies are necessary;

- Piece-meal changes may be easier to implement than comprehensive strategies but are less likely to result in optimal and ongoing change;
- Restrictions that are politically attractive, met with little resistance and relatively easy to implement are not necessarily effective;
- Restrictions may require multiple transformations and adjustments to reach their optimal potential and should be monitored over time;
- A goal should be to sustain the impact of restrictions; and,
- Wherever possible it is preferable to err on the side of minimising—not continuing—harm.

5.13 Conclusion

As numerous studies have shown, tailored restrictions on local alcohol availability can reduce consumption and associated alcohol-related harms (Gray and Wilkes 2011; Saggers and Gray 1998; Gray 2000; National Drug Research Institute 2007). Restrictions on hours and conditions of trade are particularly well supported by evidence of effectiveness. While restrictions will inevitably incur opposition, the evidence also suggests that, where there is a high degree of community involvement, they enjoy sustained community support. In themselves, however, restrictions do not constitute a solution to high levels of alcohol-related harm, but also require investment in measures to reduce demand, including early intervention, treatment and rehabilitation, as well as measures addressing the underlying drivers of alcohol misuse, such as lack of opportunities for a safe and productive life. A key word here is 'investment'; unlike regulatory changes, intervention and treatment programs cost money. A recurring theme in studies of local restrictions is the failure of authorities to provide resources for complementary demand-reduction measures (Hudson 2011).

The impact of restrictive measures is also liable to fade over time, making it necessary to monitor them and adapt them as necessary to changing circumstances. Local restrictions can also generate unintended and sometimes adverse consequences, including 'sly grogging' and displacement to other drinking venues and/or other substances, such as cannabis. As we have seen, while these responses offset the gains from restrictions, they rarely negate them.

Evidence suggests that—in the categories set out above in Table 5.1—'negotiated/mandated' restrictions are the most robust, combining as they do 'grass roots' engagement with the enforcement power of the state. Voluntary agreements can be unilaterally abandoned, as may have been the case in Curtin Springs, and imposed restrictions—as many Queensland AMPs appear to be—generate high levels of opposition. Negotiated/mandated restrictions, however, require a supportive licensing authority—which, as we have seen, is not always present.

Notwithstanding the evidence of effectiveness, local restrictions on access to alcohol also come with limitations. As Calladine (2009) notes, restrictions on access

to alcohol by Aboriginal people, or on Aboriginal lands, or even in places occupied largely by Aboriginal people, have three key features:

1. They are inherently discriminatory, in that the same restrictions do not normally apply to non-Aboriginal people;
2. They have historical antecedents in earlier policies that prohibited Aboriginal people from possessing or drinking alcohol and
3. They do not address the underlying reasons why Aboriginal people drink in the first place (Calladine 2009).

Restrictions can, however, provide a 'breathing space' that allows the community to attend to other issues, as the Fitzroy Crossing example discussed in the following chapter demonstrates.

Despite the evidence of effectiveness (or perhaps, so far as some liquor industry interests go, *because* of such evidence), local restrictions are usually controversial. Typically, opponents will complain that the 'rights' of the moderate majority are being curtailed because of a small minority of alcohol abusers, whose needs—the argument sometimes continues—could be better addressed through targeted restrictions and/or treatment. A related argument is that heavy or dependent drinkers will somehow get around the restrictions anyway, making the impositions on everyone else pointless. Again, the evidence suggests that while some drinkers will indeed do whatever it takes to keep drinking, at a community level tailored restrictions yield a net benefit.

References

Australian Government. 2007. *Northern territory national emergency response act 2007*. Canberra: Australian Government. http://www.comlaw.gov.au/ComLaw/Legislation/Act1.nsf/asmade/bynumber/60A86C8151980495CA25733E0016F8C0?OpenDocument. Accessed 9 April 2008.

Australian Government. 2012. *Stronger futures in the northern territory act 2012.* Canberra: Australian Government. http://www.comlaw.gov.au/Details/C2012A00100/Download. Accessed 6 Aug 2012.

Australian Government. 2013. *Stronger futures in the northern territory (Alcohol management plans) rule 2013.* Canberra: Australian Government.

Berman, Matthew, and Teresa Hull. 2001. Alcohol control by referendum in northern native communities: The Alaska local option law. *Arctic* 54: 77–83.

Berman, Matthew, Teresa Hull, and Philip May. 2000. Alcohol control and injury death in Alaska native communities: Wet, damp and dry under Alaska's local option law. *Journal of Studies on Alcohol* 61: 311–319.

Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse. 2007. *Ampe Akelyernemane Meke Mekarle—"Little Children are Sacred"*. Darwin:Northern Territory Government.

Boffa, John, Chris George, and Komla Tsey. 1994. Sex, alcohol and violence: A community collaborative action against striptease shows. *Australian Journal of Public Health* 18: 359–366.

Bourbon, Deirdre, Sherry Saggers, and Dennis Gray. 1999. *Indigenous Australians and Liquor LicensingLegislation.* Perth: National Centre for Research into the Prevention of Drug Abuse, Curtin University of Technology.

Brady, M. 1991. Morbidity and mortality associated with alcohol consumption at Yalata, South Australia, a briefing paper for SA Liquor Licensing Commissioner, unpublished report. Canberra: AIATSIS

Brady, M. 2019. Radical actions: Aboriginal and non-Aboriginal women's temperance activism in nineteenth- and twentieth-century Australia. In *The Social History of Alcohol and Drugs*, 286–309

Brady, Maggie. 1988. *Where the beer truck stopped: Drinking in a northern Australian town.* Australian National University North Australia Research Unit: Darwin.

Brady, Maggie. 2004. *Indigenous Australia and alcohol policy: Meeting difference with indifference.* University of New South Wales Press: Sydney.

Brady, Maggie, Joe Byrne, and Graham Henderson. 2003. Which bloke would stand up for Yalata? The struggle of an Aboriginal community to control the availability of alcohol. *Australian Aboriginal Studies* 2003: 62–71.

Buckley, Jennifer, Matthew Stevens, and R. Midford. 2016. *Developing a place-based alcohol indicators framework to monitor and evaluate alcohol management plans and other alcohol initiatives in the northern territory: final report*, Vol 1–3. Darwin: Menzies School of Health Research.

Byrne, J., M. Brady, and G. Henderson. 2001. *Monitoring the longterm social and environmental effects of changes in alcohol availability in an Aboriginal community: a ten-year follow up study, unpublished report*. Canberra: AIATSIS

Calladine, K. 2009. Liquor restrictions in Western Australia. *Indigenous Law Bulletin* 23: 7.

Campbell, Robert A. 2008. Making sober citizens: The legacy of indigenous alcohol regulation in Canada, 1777–1985. *Journal of Canadian Studies* 42: 105–126.

Catalano, Paul, Tanya Chikritzhs, Tim Stockwell, Matthew Webb, Carl-Johan Rohlin, and Paul Dietze. 2001. *Trends in per capita alcohol consumption in Australia, 1990/91–1998/99. National Alcohol Indicators Bulletin No.4.* Perth: National Drug Research Institute.

Clough, A.R., and Katrina Bird. 2015. The implementation and development of complex alcohol control policies in indigenous communities in Queensland (Australia). *International Journal of Drug Policy* 26: 345–351.

Clough, Alan, Stephen Margolis, Adrian Miller, Anthony Shakeshaft, Christopher Doran, Robyn McDermott, Rob Sanson-Fisher, Valmae Ypinazar, David Martin, Jan Robertson, Michelle Fitts, Katrina Bird, Bronwyn Honorato, Simon Towle, and Caryn West. 2017. Alcohol management plans in Aboriginal and Torres Strait Islander (Indigenous) Australian communities in Queensland: Community residents have experienced favourable impacts but also suffered unfavourable ones. *BMC Public Health*. https://doi.org/10.1186/s12889-016-3995-8.

d'Abbs, P. 1989. Alcohol controls and Aboriginal society: The effecths of the Northern territory restricted areas legislation. *Australian Drug and Alcohol Review* 8: 21–29.

d'Abbs, P. 1990a. *Dry areas, alcohol and Aboriginal communities: A review of the northern territory restricted areas legislation.* Darwin: Drug and Alcohol Bureau, Department of Health and Community Services and the Racing, Gaming and Liquor Commission.

d'Abbs, P. 1990b. Restricted areas and Aboriginal drinking. In *Alcohol and crime: Proceedings of a conference held 4–6 April 1989,* ed. J. Vernon. Canberra: Australian Institute of Criminology.

d'Abbs, P., and I. Crundall. 2019. Do individual liquor permit systems help Indigenous communities to manage alcohol? *Drug and Alcohol Review* 38: 766–773. https://doi.org/10.1111/dar.12994.

d'Abbs, P., S. Togni, and I. Crundall. 1996. *The tennant creek liquor licensing trial, August 1995—February 1996: An evaluation. menzies occasional papers No. 2/96.* Darwin: Menzies School of Health Research and NT Living With Alcohol Program.

d'Abbs, P., Bill Ivory, Kate Senior, Teresa Cunningham, and Joe Fitz. 2010a. *Managing alcohol in Tennant Creek, northern territory: an evaluation of the tennant creek alcohol management plan and related measures to reduce alcohol-related problems: A report prepared for the NT Department of Justice.* Darwin: Menzies School of Health Research.

d'Abbs, P., Rachael McMahon, Teresa Cunningham, and Joseph Fitz. 2010b. *An evaluation of the Katherine Alcohol Management Plan and Liquor Supply Plan: A report prepared for the Northern Territory Department of Justice.* Darwin: Menzies School of Health Research.

d'Abbs, P., S. Togni, N. Stacey, and J. Fitz. 2000. *Alcohol restrictions in tennant creek: A review prepared for the beat the grog committee, tennant creek, northern territory.* Darwin: Menzies School of Health Research.

d'Abbs, P., Samantha Togni, and Anthea Duquemin. 1999. *Evaluation of restrictions on the sale of alcohol from curtin springs roadside inn, northern territory: A report commissioned by the office for aboriginal and Torres Strait Islander health, commonwealth department of health and aged care.* Darwin: Menzies School of Health Research.

d'Abbs, P., and Megan Whitty. 2016. *Implementation and outcomes of the revised Katherine alcohol management plan: An evaluation.* Darwin: Menzies School of Health Research. http://katherine amp.com/news/62-kamp-2013-16-evaluation-report.

d'Abbs, Peter, Gillian Shaw, Hope Rigby, Teresa Cunningham, and Joe Fitz. 2011. *An evaluation of the Gove peninsula alcohol management system: A report prepared for the northern territory department of justice.* Darwin: Menzies School of Health Research.

Gear, R. 2014–2015. Alcohol restrictions and Indigenous Australians: the social and policy implications of Maloney v the queen. *James Cook University Law Review* 21: 41–68.

Gladman, Douglas J., Ernest M.M. Hunter, Robyn A. McDermott, Tony D. Merritt, and Fiona J. Tulip. 1997. *Study of injury in five cape york communities.* Australian Institute of Health and Welfare and Queensland Health.

Gray, D., S. Saggers, Atkinson, B. Sputore, and D. Bourbon. 1998. *Evaluation of the tennant creek liquor licensing restrictions: A report prepared for the tennant creek beat the grog sub-committee.* Perth: Curtin University of Technology, National Centre for Research into the Prevention of Drug Abuse.

Gray, D., and Edward Wilkes. 2011. Alcohol restrictions in Indigenous communities: An effective strategy if indigenous-led. *Medical Journal of Australia* 194: 508.

Gray, Dennis. 2000. Indigenous Australians and liquor licensing restrictions. *Addictions* 95: 1469–1472.

Gray, Dennis, Sherry Saggers, David Atkinson, Brooke Sputore, and Deirdre Bourbon. 2000. Beating the grog: An evaluation of the Tennant Creek liquor licensing restrictions. *Australian and New Zealand Journal of Public Health* 24: 39–44.

High Court of Australia. 2013. *Maloney v The Queen [2013] HCA 28 (19 June 2013).* Canberra: High Court of Australia. http://www.iilj.org/documents/MaloneyvtheQueen2013HCA28.pdf. Accessed 5 April 2015.

Hladick, Chris, and Katherine Eldemar. 2017. *Title 4 local option law: Controlling alcohol in Alaska's cities and villages.* State of Alaska, Department of Commerce, Community, and Economic Development. https://www.commerce.alaska.gov/web/Portals/4/pub/Title4Loc alOptionLaw.pdf. Accessed 17 July 2018.

Hudson, Sara. 2011. *Alcohol restrictions in indigenous communities and frontier towns.* Canberra: Centre for Independent Studies. https://www.cis.org.au/images/stories/policy-monographs/pm-116.pdf. Accessed 29 Aug 2014.

Jilkminggan Community Aboriginal Corporation. 2012. *Jilkminggan alcohol management plan 2012–2016.* Katherine: Jilkminggan Community Aboriginal Corporation.

Katherine Region Action Group (KRAG). 2013. *Katherine Alcohol Management Plan 2013–2016.* Katherine, Northern Territory: Katherine Region Action Group.

Kavanagh, Maggie. 1996. *Submission to the Race Discrimination Commissioner by the Ngaany-atjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council Aboriginal Corporation on behalf of Member Communities in South Australia, Western Australia and the Northern Territory Seeking a Special Measures Application under the Racial Discrimination Act 1975 (Cth) Section 8(1) Concerning the Operations of Curtin Springs Roadhouse (Unpublished).* NPY Women's Council.

Kovas, A.E., B. McFarland, Michael G. Landen, A. Lopez, and P.A. May. 2008. Survey of American Indian alcohol statutes, 1975–2006: Evolving needs and future opportunities for tribal health. *Journal of Studies on Alcohol and Drugs* 69: 183–191.

Legislative Assembly of the Northern Territory. 1993. *Inquiry into the operation and effect of part VIII 'Restricted Areas' of the liquor act. Report of the sessional committee on use and abuse of alcohol by the community report No.4.* Darwin: Legislative Assembly of the Northern Territory.

Liquor Commission NT. 1995. Decision Arising from a Hearing conducted in Tennant Creek During the Week Commencing 5 June 1995, 12 July 1995.

MacKeith, Suzanne, Dennis Gray, and T. Chikritzhs. 2009. *Review of 'Moving beyond the restrictions: The evaluation of the alice springs alcohol management plan': A report prepared for the Alice springs people's alcohol action coalition.* Perth: National Drug Research Institute, Curtin University of Technology.

Margolis, Stephen A., Valmae A. Ypinazar, and Reinhold Muller. 2008. The impact of supply reduction through alcohol management plans on serious injury in remote indigenous communities in remote Australia: A ten-year analysis using data from the royal flying doctor service. *Alcohol and Alcoholism*, 43: 104–110.

Margolis, Stephen A., Valmae A. Ypinazar, Reinhold Muller, and Alan Clough. 2011. Increasing alcohol restrictions and rates of serious injury in four remote Australian Indigenous communities. *Medical Journal of Australia* 194: 503–506.

Martin, David. 1998. *The supply of alcohol in remote Aboriginal communities: potential policy directions from Cape York. CAEPR Discussion Paper No. 248.*Canberra: Centre for Aboriginal Economic Policy Research, Australian National University. openresearch-repository.anu.edu.au/handle/1885/145592?mode=full. Accessed 3 June 2021.

Midford, Richard, John McKenzie, and Rachel Mayhead. 2017. 'Not your typical alcohol accord: The long-term impact of a voluntary liquor agreement in a small Australian town'. *Substance Use & Misuse* 52: 1546–1556. https://doi.org/10.1080/10826084.2017.1281312.

Minister for Families Community Services and Indigenous Affairs. 2013. *Explanatory Statement: Stronger Futures in the Northern Territory Act 2012, Stronger Futures in the Northern Territory (Alcohol Management Plans) Rule 2013.*Canberra: Department of Families, Community Services and Indigenous Affairs.

National Drug Research Institute. 2007. *Restrictions on the sale and supply of alcohol: Evidence and outcomes.* Perth: National Drug Research Institute, Curtin University of Technology.

Northern Territory Department of Justice. 2008. *Tennant creek alcohol management plan.* Darwin: NT Department of Justice.

Northern Territory Government. 2020. *Liquor licence (Liquor Act 2019, NT) 81202431: Curtin springs roadhouse.* Darwin: Northern Territory Government.

Northern Territory Government. 2021. *Alcohol minimum floor price.* Darwin: Department of Industry, Tourism and Trade, NT Government.

Northern Territory Licensing Commission. 2001. *Decision: (1) Wycliffe Well Store; (2) Wauchope Hotel; (3) Sporties Club Inc.; (4) Tennant Creek Memorial Club.* Darwin: Northern Territory Licensing Commission. https://justice.nt.gov.au/regulatory-services/licensing-decisions-publications-strategies/licensing-decisions/licensing-commission-decisions. Accessed 13 Oct 2020.

Northern Territory Licensing Commission. 2006. *Final liquor supply plan for tennant creek and threeways.* Darwin: Northern Territory Department of Justice. www.nt.gov.au/justice/commission/decisions/060531_Tennant_Creek_General_Decision.pdf.

Northern Territory Liquor Commission. 1999. *Review of "Tennant creek liquor restrictions": Reasons for decision, 15 January 1999.* Darwin: Northern Territory Liquor Commission.

Northern Territory Licensing Commission. 2010a. *2009–2010a annual report*. Darwin: Northern Territory Licensing Commission. https://www.nt.gov.au/__data/assets/pdf_file/0009/170856/nt-licensing-commissions-annual-report-2009-10.pdf. Accessed 14 July 2016.

Northern Territory Licensing Commission. 2010b. *Reasons for decision: Review of the restriction and/or removal of cheap and problem liquor products, particularly Four (4) and Five (5)*

litre wine casks including their hours of sale. Darwin: Northern Territory Licensing Commission. https://industry.nt.gov.au/__data/assets/pdf_file/0009/253269/100901_Four_and_Five_Litre_Wine_Cask_Review_Policy.pdf. Accessed 12 Jan 2022.

Northern Territory Liquor Commission. 2019. *Second proposed variation of the conditions of licences.* Darwin: Northern Territory Liquor Commission. https://justice.nt.gov.au/__data/assets/pdf_file/0010/762409/Alice-Springs-s33-proposed-variation-Nov-19.pdf. Accessed 19 Oct 2020.

Northern Territory Liquor Commission. 2020. *Decision Notice: Second variation of the conditions of licences*. Darwin: Northern Territory Liquor Commission. https://justice.nt.gov.au/__data/assets/pdf_file/0006/784086/Decision-Notice-Alice-Springs-s33-second-variation-130120.pdf. Accessed 19 Oct 2020.

Northern Territory News. 1993. '300 women in anti-grog rally', *Northern Territory News,* 24 April, pp. 6.

Northern Territory of Australia. 1979. *Liquor act 1979.* Darwin: Northern Territory Government.

Northern Territory Racing Gaming and Liquor Commission. 1988. *Annual report 1988*. Darwin: Northern Territory Racing, Gaming and Liquor Commission.

Nunavut Liquor Commission. 2018. 'Liquor enforcement and inspections: Enforcement and inspection activity report', Government of Nunavut. www.gov.nu.ca/finance/information/liquor-enforcement-and-inspections. Accessed 5 July 2018.

Parliament of the Commonwealth of Australia House of Representatives Standing Committee on Aboriginal Affairs. 1975. *Report on the living conditions of Yirrkala people 1974, Parliamentary Paper No. 227.* Canberra: Government Printer of Australia. https://nla.gov.au/nla.obj-1473867973/view?partId=nla.obj-1479370960#page/n0/mode/1up. Accessed 12 Aug 2020.

Parliamentary Joint Committee on Human Rights. 2016. *2016 review of stronger futures measures.* Canberra: Commonwealth of Australia. https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Human_Rights/Committee_Inquiries/strongerfutures2/Final_report. Accessed 19 Oct 2017.

Pitjantjatjara Council Inc. 1990. *Submission to the Sessional committee on the use and abuse of alcohol by the community, legislative assembly of the northern territory*. Alice Springs: Pitjantjatjara Council Inc.

Queensland Department of the Premier and Cabinet. 2001. *Cape york justice study report* (3 Vols.). Brisbane: Department of Premier and Cabinet, Queensland Government. http://www.communityservices.qld.gov.au/community/publications/capeyork.html. Accessed 25 Feb 2010.

Queensland Government. 2002. *Meeting challenges, making choices: The Queensland government's response to the Cape York justice study*. Brisbane: Queensland Government.

Queensland Government. 2008. *Quarterly report on key indicators in Queensland's discrete Indigenous communities: July – September 2008*. Brisbane: Office for Aboriginal and Torres Strait Islander Partnerships, Department of Communities and the Indigenous Government Coordination Office, Department of the Premier and Cabinet. http://www.datsima.qld.gov.au/resources/atsis/government/programs-initiatives/reports/quarterly-jul-sept-2008.pdf. Accessed 19 May 2014.

Queensland Government (Department of the Premier and Cabinet). 2005. *Meeting challenges, making choices evaluation report*. Queensland Government: Brisbane.

Race Discrimination Commissioner. 1995. *Alcohol report: Racial discrimination act 1975 race discrimination, human rights and the distribution of alcohol.* Canberra: Australian Government Publishing Service.

Reid, J. 1983. *Sorcerers and healing spirits: Continuity and change in an Aboriginal medical system.* Australian National University Press: Rushcutters Bay, NSW.

Reilly, Marion. 1982. *Report on restricted areas.* Darwin: Northern Territory Liquor Commission.

Saggers, Sherry, and Dennis Gray. 1998. *Dealing With alcohol: Indigenous usage in Australia, New Zealand and Canada.* Cambridge University Press: Cambridge, UK.

Schinenu, A., F. Velander, and S. Saggers. 2010. *"Don't wake up angry no more" The evaluation of the norseman voluntary liquor agreement*. Perth: National Drug Research Institute, Curtin University of Technology.

Senior, Kate, Richard D. Chenhall, Bill Ivory, and Chris Stevenson. 2009. *Moving beyond the restrictions: The evaluation of the alice springs alcohol management plan*. Darwin: Menzies School of Health Research.

Smith, Kristen, M. Langton, Richard Chenhall, Penelope Smith, and Shane Bawden. 2019. *The alcohol management plan at Pormpuraaw, Queensland, Australia: An ethnographic community-based study*. Melbourne: University of Melbourne and Foundation for Alcohol Research and Education.

Smith, Kristen, Marcia Langton, Peter d'Abbs, Robin Room, Richard D Chenhall, and Alyson Brown. (2013). *Alcohol management plans and related alcohol reforms. Indigenous justice clearinghouse brief 16*. Canberra: Australian Institute of Criminology.

South Australia. 2017. Anangu Pitjantjatjara Yankunytjatjara Land Rights Act 1981. Adelaide.

Success Works Pty Ltd. (nd). *Timber creek alcohol management plan 2007–2010*. Melbourne: Success Works Pty. Ltd.

Valverde, Mariana. 1998. *Diseases of the will: Alcohol and the dilemmas of freedom*. Cambridge University Press.

Western Australia. 1979. Aboriginal communities act, No. 8 of 1979.

Western Australia Drug and Alcohol Office. 2011. *The impact of liquor restrictions in halls creek: Quantitative data—24 months review*. Perth: Western Australian Drug and Alcohol Office.

Western Australia. 2022. Liquor control act 1988. Perth: Government of Western Australia.

Wright, Alexis. 2010. *Grog war: Shifting the blame: One town's fight against alcohol*. Magabala Books Aboriginal Corporation: Broome, Western Australia.

Zillman, Stephanie. 2017. Calls to extend alcohol sale ban to Aboriginal people at remote roadhouses in central Australia. *ABC News,* 26 May.

Chapter 6
Case Study of Community-Led Alcohol Restrictions: The Fitzroy Valley

By Aboriginal and Torres Strait Islander Social Justice Commissioner 2010 (Mick Gooda)

Artwork by Delvene Cockatoo-Collins

P. d'Abbs and N. Hewlett, *Learning from 50 Years of Aboriginal Alcohol Programs*,
https://doi.org/10.1007/978-981-99-0401-3_6

Abstract In his 2010 Social Justice Report, the then Aboriginal and Torres Strait Islander Social Justice Commissioner, Mick Gooda, described the events behind what he called a transformation from 'community crisis to community control' in the Fitzroy Valley in the Kimberley, WA. Here, we reproduce the Commissioner's account of the first of two key components of this transformation: the introduction in 2007 of community-led restrictions on sales of take-away alcohol. The second component—the creation of a community-led strategy to reduce high levels of Fetal Alcohol Spectrum Disorders (FASD) in the community—is described below in Chap. 8. Both of these initiatives remain in place at the time of preparing this book in 2023.

In 2007, a number of Fitzroy Valley community leaders decided it was time to address increasing violence and dysfunction in their communities. Alcohol abuse was rife across the Valley—and rather than healing the pain of colonisation and disempowerment, it was causing violence, depression and anguish amongst residents. By 2007, there had been 13 suicides in the Valley over a 12-month period.

The actions of these leaders were careful and modest, aimed at bringing the Fitzroy Valley residents with them on a journey to understand two things, that the alcohol situation was dire, and that the problems of the Valley could be reversed.

The recent history of the Fitzroy Valley reads as a 'how-to manual' for the development and implementation of a bottom-up project for social change. It is the story of a movement that engages with, rather than further marginalises, the local communities. These events demonstrate approaches to community crisis that encourage and build the positive, willing participation of the affected people.

The principles emerging from the Fitzroy experience can inform the development and delivery of government services across the diversity of Aboriginal and Torres Strait Islander communities throughout Australia. If governments apply these principles, they can shift from a service delivery paradigm to become enablers and facilitators of community-based agents of change.

6.1 The Fitzroy Valley

For thousands of years there were many different language groups living on this land and we are still here today. The Bunuba and Gooniyandi people are the people of the rivers and the ranges. The Walmajarri and the Wangkatjungka people are the people of the great desert. Today these different language groups all live together in harmony in the Fitzroy Valley. That's what makes this place so special. We have strong culture here and we welcome you to our place and our dreams.[1]

---

[1] J Oscar, community member and CEO of Marninwarntikura, in *Yajilarra* (Hogan 2009, 00:30).

The Fitzroy Valley is in the Kimberley region of Western Australia. The town of Fitzroy Crossing is situated near the centre of the Fitzroy Valley. It is the regional hub of the Valley. Fitzroy Crossing is on the traditional lands of the Bunuba people. There are 44 smaller communities spread around the Valley in a diameter of approximately 200 kms. Of these smaller communities, a number are sub-regional hub communities, while others are smaller satellite communities or outstations.

The area is extremely remote. The nearest major centres are Derby(258 km), Halls Creek (263 km) and Broome (480 km). Of the approximately 4000 people who live in Fitzroy Valley, 1600 live in Fitzroy Crossing. The majority of the population across the Valley is Aboriginal (Latimer et al. 2010).

The Fitzroy Valley is serviced by a range of different providers, government departments and agencies, as well as non-governmental organisations. Government services include education, police, health and child protection. Local non-governmental organisations provide a range of cultural and social welfare services. For example, the Marninwarntikura Women's Resource Centre (MWRC) provides domestic violence services, and the Kimberley Aboriginal Law and Culture Centre (KALACC) is the peak body for developing, promoting and maintaining law and culture across the Valley.

6.2   Community Crisis

> We worry all the time for this land and our people. Especially when we see and live in the shadows of the painful effects of dispossession, oppression, racism and neglect. And when we see how alcohol is being used to mask this pain in our community and how it creates more pain.[2]

In 2007, the communities of the Fitzroy Valley were in crisis. The Fitzroy Crossing Hospital staff described the abuse of alcohol in the communities as 'chronic, chaotic and violent'—it was common for them to treat between 30 and 40 people a night for alcohol-related injuries (Kinnane et al. 2010: 24).

Too many people were dying. Community member, Joe Ross, suggested that "the community had become immune to attending funerals".[3] The Fitzroy Valley had 55 funerals in one year, of which 13 were suicides. If this rate of suicide was applied to a population the size of Perth, it would equate to 500 suicides per month (White 2009: 12). These astounding figures prompted local community leaders to call for an inquest by the State Coroner of Western Australia, Alistair Hope. In 2008, the Coroner handed down his findings on 22 self-harm deaths in the Kimberley region. A 'striking feature' of the Coroner's findings was the 'very high correlation between death by self-harm and alcohol and cannabis use' (Hope 2008: 5).

---

[2] J Oscar, in *Yajilarra* (Hogan 2009, 02:18).

[3] J Ross, community member, meeting with the Aboriginal and Torres Strait Islander Social Justice Commissioner, Fitzroy Crossing, 31 July 2010.

> We had a community that was just being decimated by alcohol abuse. Children weren't feeling safe about going home. Old people running to a safe place. Old people crying, wanting to move out of their homes because, you know, they were just being harassed by family members who was coming home drunk (Hogan 2009, 02:53).

The Coronial Inquest into 22 deaths in the Kimberley also found that the Aboriginal people in the Kimberley region had a real desire for change and that they wanted to play an active role in designing and developing programs to improve their living conditions (Hope 2008: 57).

The abuse of alcohol in the Valley has historical roots that can be linked to the processes of colonisation and the accompanying social policies that alienated and marginalised the Aboriginal people of the region.

Box 6.1 History, Trauma and Alcohol Abuse (Oscar 2010: 7)

After the period of frontier violence in the late nineteenth and early twentieth century, Aboriginal people worked on stations for little or no wages. For decades, Aboriginal people were the backbone of the industry. Without the Aboriginal women and men who sheared the sheep, mustered the cattle, built the fences and windmills and cooked the food, the pastoral industry would not have been able to operate.

Then in the late 1960s and early 1970s when the equal wage decision for Aboriginal stock workers was implemented in the Kimberley, our people were discarded. We were treated with contempt and expelled on mass from the stations.

Aboriginal people throughout the valley resettled in congested, squalid conditions. In the early 1970s, the population of Fitzroy Crossing rose from 100 to over 2000 people within two years. It became a tent-camp of refugees fleeing a humanitarian disaster.

Like many such people alienated from their lands, alcohol abuse started and it got worse and worse over the years. At first, only the older men and middle-aged men drank, then some of the young men and then more and more women and then teenagers, some of them quite young.

The grog has affected every single person in the valley at one level or another. Aboriginal people in the valley have identified grog as the most important health priority that must be confronted.

Fitzroy Valley residents had been cognisant of the damage that alcohol was causing for some time, and they had taken steps to address the problem. For example, in 2004, 300 residents from the Valley met to discuss the issues of alcohol and drug abuse. The attendees of the meeting agreed that there was a need to focus on counselling

and treatment.[4] However, very few resources were available, and little was done to address what was an overwhelming problem.

In 2007, in the face of this ongoing and escalating crisis, the senior women in the Fitzroy Valley decided to discuss the alcohol issue and look for solutions at their Annual Women's Bush Meeting. The Women's Bush Meeting is auspiced by Marninwarntikura; it is a forum for the women from the four language groups across the Valley. At the 2007 Bush Meeting, discussions about alcohol were led by June Oscar and Emily Carter from Marninwarntikura. The women in attendance agreed it was time to make a stand and take steps to tackle the problem of alcohol in the Fitzroy Valley (Latimer et al. 2010: 4). While the women did not represent the whole of the Valley, there was a significant section of the community in attendance. Their agreement to take action on alcohol was a starting point, and it gave Marninwarntikura a mandate to launch a campaign to restrict the sale of alcohol from the take-away outlet in the Fitzroy Valley. The community-generated nature of this campaign has been fundamental to its ongoing success. The communities themselves were ready for change.

Following this bush camp, on 19 July 2007, Marninwarntikura wrote to the Director of Liquor Licensing (Western Australia) seeking an initial 12-month moratorium on the sale of take-away liquor across the Fitzroy Valley (Director of Liquor Licensing Western Australia 2007). The only take-away outlet in the Valley is located in Fitzroy Crossing. As a consequence, much of the focus of the campaign for alcohol restrictions was on Fitzroy Crossing, although its effects would apply across the Valley region.

Marninwarntikura argued that alcohol restrictions were necessary for the following reasons:

- the high number of alcohol and drug-related suicides in the Fitzroy Valley;
- the communities were in a constant state of despair and grief;
- there was extensive family violence and the women's refuge was unable to cope with the demand from women seeking refuge from violence at home;
- childhood drinking was becoming normalised behaviour;
- local outpatient presentations from alcohol abuse were unacceptably high;
- local hospital statistics suggested 85% of trauma patients were alcohol affected and 56% of all patients admitted were under the influence of alcohol;
- criminal justice statistics showed a disproportionally high number of alcohol-related incidents;
- local employers were finding it difficult to retain staff as a result of alcohol consumption;
- a reduction in school attendance;
- child protection issues including a significant number of children under the age of five exhibiting symptoms associated with Fetal Alcohol Syndrome (Director of Liquor Licensing Western Australia 2007: 3).

---

[4] E Carter, community member and Chair of Marninwarntikura, meeting with the Aboriginal and Torres Strait Islander Social Justice Commissioner, Fitzroy Crossing, 2 August 2010.

Marninwarntikura called on the Director of Liquor Licensing to restrict access to take-away alcohol purchased in Fitzroy Crossing in order to provide some respite for the communities and to allow time to address the 'deplorable social situation' in the Fitzroy Valley (Director of Liquor Licensing Western Australia 2007: 3).

During this process, Marninwarntikura liaised with the cultural leadership of the communities through KALACC, one of the three Kimberley-wide Aboriginal organisations which promotes law and culture for the different language groups in the region. KALACC gave its support to the restrictions campaign. The CEO of Marninwarntikura noted the importance of this support from the cultural leadership:

> It was really important to let elders know what was happening. We liaised with cultural leaders and elders through KALACC. KALACC helped facilitate approval from elders for the alcohol restrictions.[5]

The support of the elders and cultural leadership cannot be underestimated. It was a factor that influenced the discretion of the Director of Liquor Licensing to issue the alcohol restrictions (Director of Liquor Licensing Western Australia 2007). The support from elders gave the campaign the necessary legitimacy to withstand some strongly held views by sectors of the communities which were against the restrictions.

Support for the restrictions was not isolated to the women and the cultural leadership of the Valley. Many of the men from the Valley were strong advocates for the restrictions campaign. The women indicated that "we couldn't have done it without the men".[6] However, this campaign was not about gender difference, it was about these communities striving for a better future.

> … and this must be understood—what we have achieved so far [in the Fitzroy Valley] could never have been done by government acting alone. The leadership had to come from the community. We had to OWN our problems and create pathways for recovery (Oscar 2009b: 4).

A strategic partnership was formed with the Western Australian Police, who also supported the campaign. This strategic alliance bolstered the campaign but did not detract from its community-controlled nature.

Despite obtaining significant community-level support for the campaign, there remained strong voices in the communities who opposed the proposed restrictions. However, those supporting the restrictions stood firm knowing that they would buy the Valley some necessary respite from the trauma and chaos of excessive alcohol misuse. The strength of these leaders was decisive, and the campaign came at a significant personal cost for some key leaders.

---

[5] J Oscar, interview with the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, 24 May 2010.

[6] J Oscar, meeting with the Aboriginal and Torres Strait Islander Social Justice Commissioner, Broome, 3 August 2010.

6.3   Alcohol Restrictions in the Valley

It was September 2007 when the Western Australia Director of Liquor Licensing decided that the sale of take-away liquor was a major contributor to high levels of alcohol-related harm at Fitzroy Crossing. The Director deemed the harm sufficient to justify the imposition of a six-month trial during which the sale of take-away liquor from the outlet in Fitzroy Crossing would be restricted. The trial commenced on 2 October 2007.

> The sale of packaged liquor, exceeding a concentration of ethanol in liquor of 2.7 per cent at 20 °C, is prohibited to any person, other than a lodger (as defined in Section 3 of the Act) (Director of Liquor Licensing Western Australia 2007: 9).

The trial conditions stipulated that only low-strength beer could be purchased from the take-away outlet in Fitzroy Crossing. Full-strength beer, wine and spirits could not be purchased for take-away. These heavier drinks could still be purchased from the two licensed premises in the Valley (both located in Fitzroy Crossing) but they could only be consumed on the premises during opening hours.

Approximately eight months after the restrictions came into force, a review was conducted to assess their impact and to determine their future. The review meeting included the Director of Liquor Licensing and was attended by various members of the Aboriginal communities in the Valley. June Oscar, the CEO of Marninwarn-tikura, stated that the meeting was the 'most important 30 min of our lives'.[7] It gave community members the opportunity to present their cases to the Director of Liquor Licensing. Their views were summarised as follows:

- the women were more empowered, confident and able to speak up and be involved in community-level discussions;
- sly grogging was a real problem;
- Fitzroy Valley was much quieter and safer;
- other Aboriginal communities were looking to the positive example in the Fitzroy Valley;
- the restrictions have seen government agencies and non-government organisations become more involved in the communities;
- there was a strong desire not to return to the pre-restriction chaos;
- substantial and lasting change is needed;
- children need to be the priority and the next generation of children need to grow up without the problems of alcohol;
- families are stronger and sober, old people are being cared for, young people are thinking about owning homes and children are learning skills;
- communities with people affected by FASD need assistance;
- "if we return to the past, all hope will be stripped away" (Director of Liquor Licensing Western Australia 2007: 15).

---

[7] Quoted in Director of Liquor Licensing Western Australia (2007: 14).

After the review meeting in May 2008, the Director of Liquor Licensing extended the restrictions on take-away alcohol indefinitely (Director of Liquor Licensing Western Australia 2007). Following the implementation of the restrictions, four of the communities in the Fitzroy Valley—Wangkatjungka, Noonkanbah, Yakanarra and Bayulu—also adopted alcohol restrictions that prevented the possession and consumption of alcohol in these communities.

6.4 Issues of Consent

> We dealt with dissenting voices by trying to keep all people in the Valley informed. We used media to help keep people informed and to combat misinformation. I agreed to attend all meetings with dissenting voices in the community but only if the meetings were respectful and outcomes could be generated from meetings.[8]

Issues of consent in the Fitzroy Valley were resolved over time. It was a process rather than a single transactional event. The Fitzroy women wanted to create a 'space for reflection' amongst their community members. They knew that excessive alcohol needed to be taken out of the picture in order for reflection to occur. This would give people the time and opportunity to think about the crisis that had befallen the Valley. It was not possible for the residents to make informed decisions while they were in crisis.

> Alcohol restrictions are just a small toe hold into the enormous challenges we face. It is not the answer to our problems. It was never intended to be. Its purpose was always to give us breathing space from the trauma and chaos of death, violence and fear; breathing space to think and plan strategically (Oscar 2009a).

Rather than focusing on obtaining majority support for the restrictions in the first instance, the women acted upon the mandate given to them at the Bush Meeting. Following this, the women consulted with KALACC elders, health providers and community leaders and others to obtain support from a significant portion of the residents of the Valley.

Twelve months after the alcohol restrictions commenced, an independent review showed increased community-level support for the restrictions (Kinnane et al. 2010). The increased support shows that a 'space for reflection' and a different lived experience can change community attitudes. This could be described as building community capacity.

The process for implementing alcohol restrictions in the Fitzroy Valley demonstrates some stark contrasts to the implementation of alcohol restrictions and other measures under the Northern Territory Emergency Response (NTER) (Aboriginal and Torres Strait Islander Social Justice Commissioner 2008, Chapter 3). In many ways, the intended outcomes were to be the same—a reduction in social problems

---

[8] J Oscar, interview with the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, 24 May 2010.

as a result of a reduction in access to alcohol. What is strikingly different between the two approaches is the paths that were taken to achieve the same ends. In the Fitzroy Valley, the decisions were made by the communities at a time chosen by the community leaders.

In the Northern Territory, a policy developed in Canberra was imposed by the Australian Government. The most stridently voiced criticisms of the NTER were about the lack of opportunity for the affected people to participate in any decision-making about the policies affecting them:

> The single most valuable resource that the NTER has lacked from its inception is the positive, willing participation of the people it was intended to help. The most essential element in moving forward is for government to re-engage with the Aboriginal people of the Northern Territory (Northern Territory Emergency Response Review Board 2008: 10-11).

6.5 Restrictions Evaluated

The Drug and Alcohol Office of Western Australia commissioned the University of Notre Dame to independently evaluate the impacts of the alcohol restrictions. This review of the impact of the first 12 months of the restrictions was publicly released in July 2009.

The report, *Fitzroy Valley Alcohol Restriction Report: An evaluation of the effects of a restriction on take-away alcohol relating to measurable health and social outcomes, community perceptions and behaviours after a 12 month period,* provided evidence that the alcohol restrictions were a circuit breaker and had given the residents of the Fitzroy Valley breathing space. It identified an increase in support for the alcohol restrictions from the Fitzroy Valley residents. The report indicated that almost all survey respondents accepted the need for some type of alcohol restrictions and that no one wanted a return to the social conditions prior to their introduction (Kinnane et al. 2010).

The University of Notre Dame evaluation found that the alcohol restrictions were having health and social benefits including.

- reduced severity of domestic violence;
- a 23% increase in reporting domestic violence and a 20% increase in reporting alcohol-related domestic violence (police and other service providers attributed this to a range of factors including lower tolerance of domestic violence and increased sobriety);
- reduced severity of wounding from general public violence;
- a 36% reduction in alcohol-related emergency department presentations; during the busiest period (October–March) this increased to a 42% reduction;
- reduced street drinking;
- a quieter and cleaner town;
- families were more aware of their health and were being proactive in regard to their children's health;

- reduced humbug—that is, harassing another individual for money, cigarettes, etc.—and anti-social behaviour;
- reduced stress for service providers leading to increased effectiveness of these services;
- generally better care of children and increased recreational activities;
- a 91% reduction in the amount of pure alcohol purchased through the take-away outlet;
- a reduction in the amount of alcohol being consumed by Fitzroy Valley residents (Kinnane et al. 2010).

The evaluation also indicated that domestic violence and other anti-social behaviour had not been totally eradicated. However, since the restrictions had come into force, there was a lower tolerance for domestic violence.

A number of negative impacts have resulted from the restrictions including.

- increased travel to Derby and Broome to obtain alcohol;
- increased prevalence of people leaving children in the care of grandparents to drink at the licensed premises in Fitzroy Crossing and to travel to other towns to obtain alcohol;
- increased pressure on heavily dependent drinkers and their families who are paying substantially more for alcohol;
- reducing but still ongoing divisions within the town about the restrictions;
- a general sense that there has not been the expected follow through of targeted government services to deal with the problems of alcohol dependence;
- an impact on some local businesses who have seen a downturn in business based on people choosing to shop in other towns (partly) related to obtaining full-strength alcohol (Kinnane et al. 2010).

Overall, the Notre Dame study concluded that the benefits generated by the alcohol restrictions outweighed the detriments. It reported that the communities are beginning to stabilise from their chaotic pre-restriction state. This perception has contributed to the increasing support for the restrictions from Fitzroy Valley residents.

However, the alcohol restrictions are not a silver bullet for addressing the social crises in the Fitzroy Valley. Despite the significant reduction in alcohol consumption and alcohol-related violence, the Fitzroy Valley faces an immense task to rebuild the social fabric of the communities.

> The grog restrictions were never intended to be a panacea for the enormous social disadvantages we face. What we have to imagine is a long term and permanent healing of the gaping wounds that arise from alcohol abuse and violence. This will require collaboration and cooperation (Oscar 2010: 8).

The restrictions in the Fitzroy Valley are a circuit breaker; they have provided the communities with the necessary reprieve from the pre-restriction chaos to allow time to consider their futures. The Notre Dame Study noted that the gains from the restrictions alone would not be sufficient for the communities to address the ingrained issues associated with alcohol abuse, and ongoing support must build upon these gains:

Significant gaps in support services that are needed to enable the social reconstruction of the Fitzroy Valley continue to hinder the community. There continues to be a state of under-investment in the people of the Fitzroy Valley. This gap requires the resourcing of community based organisations operating at the coal face of community development, cultural health, mental health (counselling), education, community safety (policing) and training, to build on the window of opportunity that the restriction has created (Kinnane et al. 2010: 10).

References

Aboriginal and Torres Strait Islander Social Justice Commissioner. 2008. *Social Justice Report 2007*. Sydney: Australian Human Rights Commission.

Aboriginal and Torres Strait Islander Social Justice Commissioner. 2011. *2010 Social Justice Report*. Australian Human Rights Commission: Sydney.

Director of Liquor Licensing Western Australia. (2007). *Decision of Director of Liquor Licensing, decision number: A 185682 (2007), p 1. At.*Perth: Department of Local Government, Sport and Cultural Industries.http://www.rgl.wa.gov.au/ResourceFiles/Decisions/CrossingInnSection 64InquiryDecision.pdf. Accessed 25 Aug 2010

Hogan, M. 2009. "Yajilarra (Film)." In. Australia.

Hope, A. 2008. *Coronial inquest into 22 deaths in the Kimberley, Ref No: 37/07, Coroner's Court of Western Australia.* Perth: Coroner's Court of Western Australia.

Kinnane, S., F. Farringdon, L. Henderson-Yates, and H. Parker. 2010. *Fitzroy Valley Alcohol Restriction Report: An evaluation of the effects of a restriction on take-away alcohol relating to measurable health and social outcomes, community perceptions and behaviours after a two year period*. Perth: Western Australian Drug and Alcohol Office.

Latimer, Jane, Elizabeth Elliott, James P. Fitzpatrick, Manuela Ferreira, Maureen Carter, June Oscar, and M Kefford (ed.) 2010. *Marulu: The Lililwan Project Fetal Alcohol Spectrum Disorders (FASD) Prevalence Study in the Fitzroy Valley: A Community Consultation* (The George Institute for Global Health: Sydney).

Morphy, F. 2010. *Population, People and Place: The Fitzroy Valley Population Project, CAEPR Working Paper No 70/2010*. Canberra: Australian National University, Centre for Aboriginal Economic Policy Research. http://caepr.anu.edu.au/system/files/Publications/WP/CAEPRWP70. pdf. Accessed 12 July 2010.

Northern Territory Emergency Response Review Board. 2008. *Northern Territory Emergency Response: Report of the NTER Review Board*. Canberra: Attorney-General's Department, Australian Government.

Oscar, June. 2009a. *Speech to the Western Australian Equal Opportunity Commission Forum, Perth, 10 August 2009).*

Oscar, June. 2009b. *To Dream the Gift of a Better Life (Speech delivered at Parliament House, Canberra, 18 August 2009..*

Oscar, June. 2010. *Through women's hearts – indigenous people, history, environment and an inclusive future. Speech delivered at WA Women's Advisory Council Conference, Perth, 14 June 2010).*

White, M. 2009. *Community-Owned Approaches to Social Recovery – Overcoming Despair in the Fitzroy Valley: Service Analysis of the determinants necessary for a good life well lived. Submission to Senate Standing Committees on Community Affairs, Inquiry into Suicide in Australia.* Fitzroy Crossing: Marninwarntikura Fitzroy Women's Resource & Legal Centre, Marra Warra Warra Aboriginal Corporation, Nindilingarri Cultural Health, Kimberley Aboriginal Law and Cultural Centre. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2008-10/suicide/index. Accessed 29 Jan 2020.

Chapter 7
Community-Controlled Liquor Outlets and Permit Systems
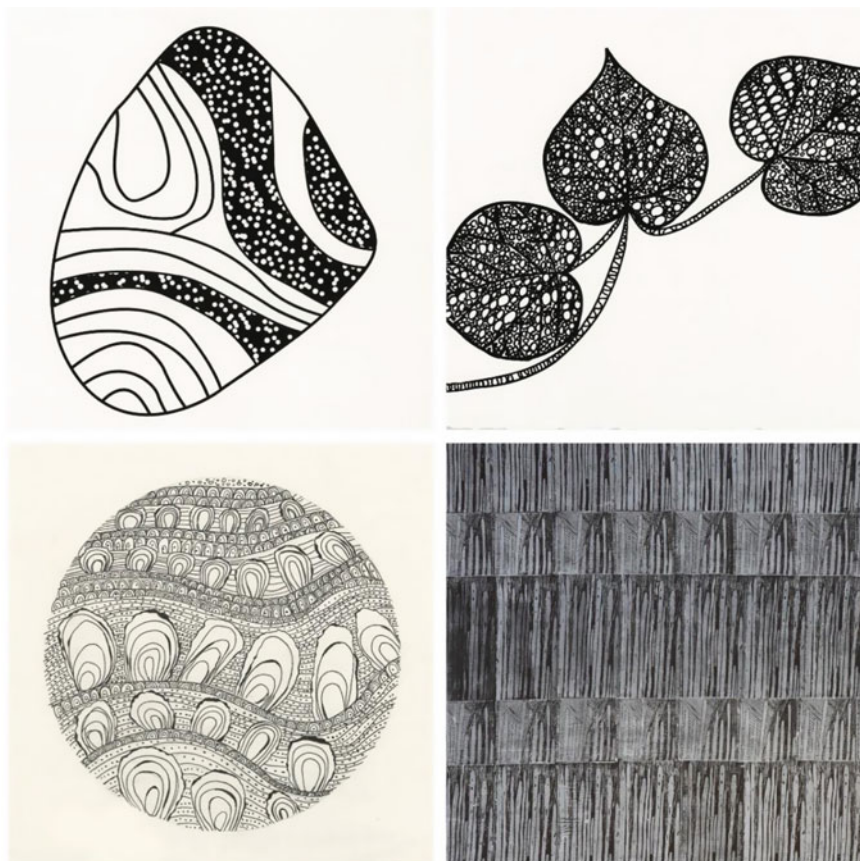
Artwork by Delvene Cockatoo-Collins

Abstract This chapter reviews two strategies for managing alcohol deployed in some Aboriginal communities: community-owned liquor outlets, usually in the form of licensed clubs, and liquor permit systems that authorise approved individuals to import and consume liquor in communities where doing either is otherwise not allowed under local restrictions.

   The rationale underlying community-owned outlets is that they retain the revenue derived from drinking by community members in the community, foster a culture of moderation and deter illicit importation of liquor (i.e. 'grog running'). Historically, most community-owned outlets have failed to achieve either the second or third of these objectives, but rather have become centres for heavy drinking and associated harms. Some community-owned outlets, however, have succeeded in fostering moderate drinking, and the chapter outlines factors conducive to their doing so.

   The use of individual liquor permit systems today is confined to some remote communities in the Northern Territory, Australia, and some Inuit communities in Nunavut, Canada. Evidence of their impact is sparse but suggests that liquor permit systems can enhance community management of alcohol provided three conditions are met: permit committees and others responsible for administering permit systems are adequately supported and resourced; effective controls are in place to deal with illegal supply of alcohol, and the rules and procedures that constitute the permit system enjoy legitimacy in the eyes of the community.

7.1   Introduction

In Chap. 5, we examined attempts to reduce alcohol-related harms by restricting the conditions under which alcohol was sold to residents of specified communities. These restrictions usually limit the days and hours of sale and/or the kinds and amounts of liquor that may be sold. Such measures target *populations* rather than individuals. Two other strategies used by some Aboriginal communities to manage access to alcohol are (1) operation of community-owned liquor outlets, usually in the form of licensed clubs and (2) liquor permit systems that authorise approved individuals to import and consume liquor in communities where doing either is otherwise prohibited. In this chapter, we explore both options, beginning with evidence relating to community-controlled outlets.

7.2 **Community-Controlled Liquor Outlets: The Rationale**

The idea behind establishing licensed outlets under community control in Aboriginal communities has wide appeal: it offers an alternative to a *status quo* in which drinkers in many communities must choose between purchasing liquor at inflated prices from unscrupulous 'grog runners'—that is, individuals buying and selling liquor on the black market—or heading into towns where alcohol is legally available, but where drinkers are often forced by laws and policing practices to consume in unregulated, sometimes dangerous settings. In contrast, a community-controlled liquor outlet promises to enable drinkers to remain in their community, close to families and to drink with their friends in a relaxed setting that encourages moderation while at the same time keeping profits in the community.

The idea is not a new one. Brady (2017) describes its origins in the Swedish city of Gothenburg in the late nineteenth century, where it attracted international interest, including in Australia. Today, the Renmark Hotel in South Australia, founded in 1897, claims to be the first community-owned hotel established in the British Empire and remains to this day in community ownership.[1] According to Brady, however, community hotels have generally struggled to meet what she calls the 'inherently paradoxical goals and principles' of remaining economically viable without contributing to the harms created by alcohol misuse (Brady 2017: 55).

The ending of legal prohibition of Aboriginal drinking in Australian states and territories through the 1960s and 1970s led some Aboriginal and non-Aboriginal groups to promote community-owned liquor outlets or, in a few cases, purchase of existing liquor outlets by Aboriginal bodies. In the 1980s, the Aboriginal Development Corporation, a statutory authority established by the Commonwealth Government to foster Aboriginal enterprises, facilitated the purchase by Aboriginal organisations of hotels in Walgett, NSW; Oodnadatta, SA; Woden, ACT and Fitzroy Crossing, WA (Brady 2017: 58–59). The strategy is a distinctively Australian one. In other countries with indigenous populations, such as Canada and New Zealand, short-term licences are more likely to be sought for special events in specified facilities, rather than long-term licences for permanent facilities (Shaw et al. 2015: 34–40).

In the decades that have passed since, community-owned liquor outlets have been established in a small number of Aboriginal communities in South Australia, Queensland and the Northern Territory. Some have endured, others have closed—either at the behest of the communities themselves or as a result of changes in government policy. Several examples have been studied.

---

[1] About Us —Renmark Hotel (retrieved 7 June 2021).

7.3   Beer Canteen in Yalata, South Australia, 1969–1982

As mentioned in Chap. 5, one of the first documented examples of a licensed outlet in a community was a beer canteen that operated in Yalata, on the west coast of South Australia, between 1969 and 1982 (Brady et al. 2003; Brady and Palmer 1984). The impetus for the canteen came not from Aboriginal residents of the community, but from the Lutheran mission that administered Yalata over two decades between 1954 and 1974. The mission authorities hoped that by setting up an outlet selling controlled quantities of beer in the community they would put an end to the importation of port wine, at the time being purchased in the township of Ceduna, 200 km away, and subsequently from a roadhouse established 47 km from Yalata. They also hoped to foster a more moderate style of drinking than the unsupervised bingeing typically associated with the externally obtained port (Brady and Palmer 1984).

Neither of these hopes was realised. As Brady and Palmer (1984) observed, the cans of beer carefully rationed by the canteen to individuals became currency in games of 'two up', through which Aboriginal drinkers were able to impose their own systems of accumulation and distribution. The beer was consumed in small drinking groups away from the settlement—the same groups that drank the more intoxicating port wine, the importation of which continued unabated. Brady and Palmer analysed clinic data on alcohol-related injuries, illnesses and deaths. They found that alcohol-related deaths accounted for 30% of all deaths occurring in the community between 1972 and 1982. In the six-month period that they examined in greater depth, two-thirds of a drinking population of around 100 people were found to have sought medical attention at least once because of their drinking (Brady and Palmer 1984).

In 1982, the canteen closed in response to the wishes of the community, in part as a result of the growth of evangelical Christianity in the community. In an extract from their analysis that is reproduced in Box 7.1, Brady and Palmer argue that in introducing the beer canteen, the mission authorities made four assumptions, all of which turned out to be wrong. Although written more than 30 years ago, their analysis, we suggest, has continuing relevance for contemporary discussions about licensed outlets in Aboriginal communities.

Box 7.1 Lessons from a Beer Canteen
From Brady and Palmer (1984: 75–76).[2]

In their attempts to direct and curb Aboriginal drinking acts, Europeans associated with this community have consistently misunderstood and misread the actions performed by Diamond Well[3] Aborigines. There have been four major assumptions made about the drinking at Diamond Well:

(a)   The first was that the ready availability of beer at the Canteen would lessen the demand for fortified wine (port) and therefore bring the carting of wine to an end.

(b)   The second was that the reallocation of beer cans by gambling (Two-up) indicated that the supply of beer was 'inadequate', and that gambling was in any case a problematic exercise which encouraged ill-feeling.

(c)   The third was that structured educational programmes would be able to instruct Aborigines how to drink 'properly', and alert them to the deleterious effects of excessive drinking.

(d)   The fourth was that the Aboriginal community and its Council had both the desire and the power to intervene in or prevent uncontrolled drinking.

All four assumptions were incorrect, and yet they have guided missionaries, government officials and even funding allocations to the community. The assumptions continue to be important and remain central to the development of community policies regarding drinking.

The instigation of the Canteen was, as we have shown, not a purely altruistic innovation on the part of the Lutheran Church. Its inception made no impact whatsoever upon the business of running port from outside sources through the use of taxis and later Aboriginal-owned vehicles. The Canteen may have had some beneficial impact in the sense that it provided an overt statement for the Aboriginal people of their right to purchase alcohol on their own premises. The Two-up game was a means by which the Aborigines undermined the White-imposed regime of the Canteen and transformed it into a wholly Aboriginal exploit. It did not evolve necessarily because the ration was inadequate but because the game injected a social and interactional component into an otherwise bland interchange. We found no evidence to support the assumption that the gambling itself aroused ill-feeling or hostility among participants.

---

[2] The complete text of the monograph from which this extract is taken can be downloaded from Open Research: Alcohol in the Outback: Two studies of drinking (anu.edu.au).

[3] 'Diamond Well' was the fictitious name given to the community at the time of publication.

Aborigines at Diamond Well have evolved a style of drinking which acts to fulfil certain requirements. They drank large amounts of port, irrespective of the availability of beer, though consumption was related to availability of cash and vehicles. They drank in their camps rather than in the settlement, with their own choices of drinking partners and on their own terms. It was generally accepted that drinking was synonymous with getting drunk—this was in fact the desired state. When the state of drunkenness was achieved, then other business could be accomplished—assignations fulfilled, arguments fought through, Europeans accosted—all encompassed and protected by the state of desocialisation which drunkenness wrought. Attempts to trammel and contain these established and deliberate patterns of consumption through instruction on the dangers of intoxication, or even undisguised efforts to make Aborigines drink in the Western 'sociable' sense have, in the past, failed and will probably continue to fail.

The fourth assumption is less easy to criticise. It has to do with matters of jurisdiction and of responsibility and is veiled with the jargon of self-determination and decision-making. Affairs on Aboriginal settlements, as we have stated, are ostensibly under the control of their Aboriginal Councils but are, in effect, strongly influenced by immediate and more distant advisors and government policy. Suggestions that 'something' must be done about drinking arose largely from concerned Europeans and occasionally from abstainers or ex-alcoholics among the Aboriginal population. These suggestions, accompanied by examples of disruptive behaviour, have been endlessly mooted at Council meetings over at least a decade. Councillors (some of whom were drinkers themselves) were expected to consider a variety of means by which their own drinking behaviour was to be contained. Moreover, men and women whose area of jurisdiction and influence over others was contained within certain structural boundaries were supposed to pass judgement, in effect, on others and interfere in the drinking business of social groups over which they had no right or powers of jurisdiction. Despite a public display of concern over the issue of drinking, evidenced by the minutes of Council meetings, the members of the community subscribed to the view that drinking was a universal right. As a result of this belief they avoided committing themselves to long term or authoritarian intervention strategies on the one hand, while simultaneously instituting minor 'rules' of comportment to keep the Europeans happy, on the other.

The missionaries, Brady and Palmer concluded, misunderstood not only the nature of drinking in Aboriginal communities, but also the ways in which social control was exercised. Drinking, they argued, took place in a context of structural powerlessness—that is, a setting in which Aboriginal people were dependent on non-Aboriginal authorities for meeting almost all of their daily needs—such as income, housing and material goods—while having few resources of their own for use as negotiating

levers. Faced with this unsatisfactory situation, Aboriginal drinkers could escape temporarily into a transformed state of intoxication in which they experienced a feeling of power and control, however fleetingly, and with whatever adverse subsequent consequences. This was why the purpose of drinking was to get drunk. Many community councillors shared this predilection for drinking, but even if they did not, the authority to interfere in the behaviour of others, in this as in other Aboriginal communities, was constrained by strong traditional norms of personal autonomy. Similar ill-founded assumptions, Brady and Palmer argue, have continued to inform policy making by non-Aboriginal authorities—a point further developed in Brady's more recent discussion paper on beer canteens and licensed clubs in Aboriginal communities (Brady 2014).

7.4   Liquor Outlets in Queensland Communities

In 1984, after one hundred years during which Aboriginal access to alcohol in Queensland was heavily restricted, Aboriginal councils on former reserves were granted qualified local government powers which included the authority to operate licensed canteens under the *Community Services (Aborigines) Act* (Martin 1998). The Queensland Government subsequently promoted community canteens as a source of local revenue, to the point where several Cape York communities became dependent on revenue from alcohol sales to fund local services (Smith et al. 2019). In some instances, beer canteens appear to have been introduced *against* the wishes of a majority of community members. In the north Queensland community of Palm Island, a public meeting was held following the passing of the 1971 *Aborigines Act*—which allowed beer to be sold on reserves with the approval and under the control of the Director of Aboriginal and Island Affairs (McCorquodale 1987; Barber et al. 1986). Those present were told that the state government had decided to establish a beer canteen on the island, despite indications that a majority of those present opposed the idea (Barber et al. 1986). A beer canteen was initially set up in the town hall, and in 1976 a purpose-built canteen opened on Palm Island. Five years later Willie Thaiday, a Torres Strait Islander who spent part of his adult life on Palm Island, claimed that police on the island were doing nothing to stem a tide of 'broken chins, split heads, gunshot and knife wounds' fuelled by alcohol (Thaiday 1981: 47).

In the Cape York community of Aurukun following the 1984 Act, drinkers called for a beer canteen, but according to Martin (1998), they were repeatedly outvoted by women, non-drinking men and others at public meetings. In November 1985, however, the shire clerk convened a committee meeting of the council, open only to councillors, a majority of whom were male drinkers. The committee voted to establish a beer canteen (Martin 1993: 185–86). Martin describes what followed:

> Initially, the canteen was opened only three nights a week, from 5pm to 7pm, and each drinker was limited to two 'jugs' of beer, each of 1.14 litres and selling at $6 per jug. The Council established rules whereby non-drinkers were not allowed to purchase beer on behalf of their drinking relations or partners, and a check list was kept at each session to monitor

and police the amount bought by each person. Gradually however, under pressure from male kin on Councillors and as the result of the incentive to maximize Council profits, these rules were relaxed and amended.[4] The 'two jug limit' was no longer enforced, and the number of trading days was increased in mid June 1986 from three to four per week. The canteen as a result showed a steady increase in takings . . .. With the nominal two-jugs per drinker limit, a price of $6 per jug and just over 250 people who were known drinkers, there should have been a maximum taken in any one week of some $9000. By the end of the sample period however, weekly takings were on occasion reaching over $15,000. (Martin 1993: 186).

In another paper—an extract from which has been reproduced below in Box 7.2— Martin describes the impact of these changes at the community level in the months following the opening of the canteen. Martin collated income and expenditure data over 52 weeks between September 1985 and August 1986.

Box 7.2 The Impact of Establishing a Beer Canteen in a Cape York Community

Extract from Martin (1998: 14–18).[5]

Because of the relatively closed nature of the cash economy of this township, with few sources of income outside of CDEP and welfare payments, and a limited number of locations in which money could be spent, it was possible to accurately quantify virtually all expenditures on a weekly aggregated basis. Some 13 weeks into the survey period the Council opened a canteen, which allowed a comparison to be made of expenditure patterns prior to and subsequent to its establishment. Data were detailed enough that the expenditure on illicit alcohol could also be quite accurately estimated each week both before and after the opening of the canteen.

In comparison with those in the broader Australian community with a similar *per capita* income and dependent on welfare incomes, Aboriginal people in this township spent on average twice as much *per capita* on food over the total survey period. This was a reflection of the extremely high price of basic commodities in this remote location. However, up to nine times as much of their income, -23% -was used in the purchase of alcohol (Martin 1993: 110). The establishment of the canteen was clearly implicated in a major shift in expenditure patterns. There was, for instance, a significant reduction in expenditure on basic foodstuffs and other items from the store, as can be seen from

---

[4] Profits from the canteen, although under the *Local Government (Aboriginal Lands) Amendment. Act 1978* required to be used for the "welfare of residents of the Shire", were the largest source of untied moneys which the Council received.

[5] The Discussion Paper from which this extract it taken can be downloaded in full at openre-search-repository.anu.edu.au/handle/1885/145592?mode = full.

Fig. 7.1. This shift in expenditure away from basic sustenance to alcohol for this community has been mirrored elsewhere in Cape York, when canteens moved from restricted hours to 10 am to 10 pm trading.
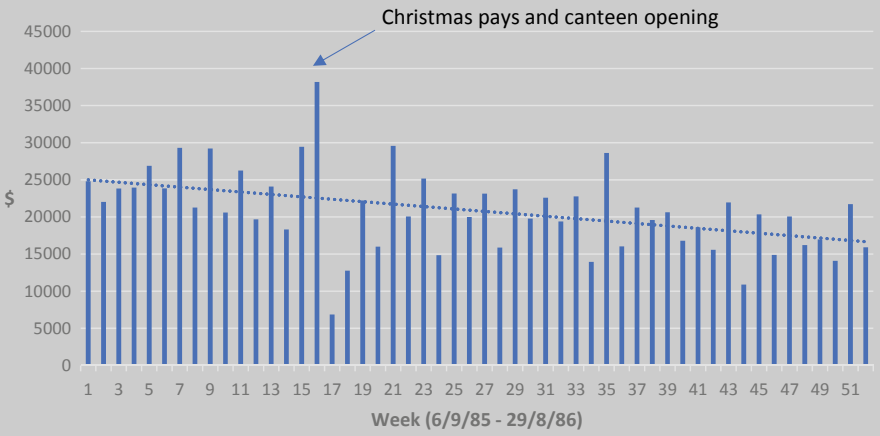
Fig. 7.1 Sales of food and basic goods, September 1985-August 1986

At the same time. as demonstrated in Fig. 7.2, relatively more was spent on convenience foods and other items from take-away outlets than had previously been the case; that is, fewer foods requiring preparation were being purchased. Children, in particular, were increasingly given cash to buy take-away foods. rather than having food prepared for them. Sales of alcohol from the canteen continued to trend upwards (Fig. 7.3). in part because of removal of the initial limits to the quantity of alcohol that individuals could purchase, and also because of price increases set by the Council.
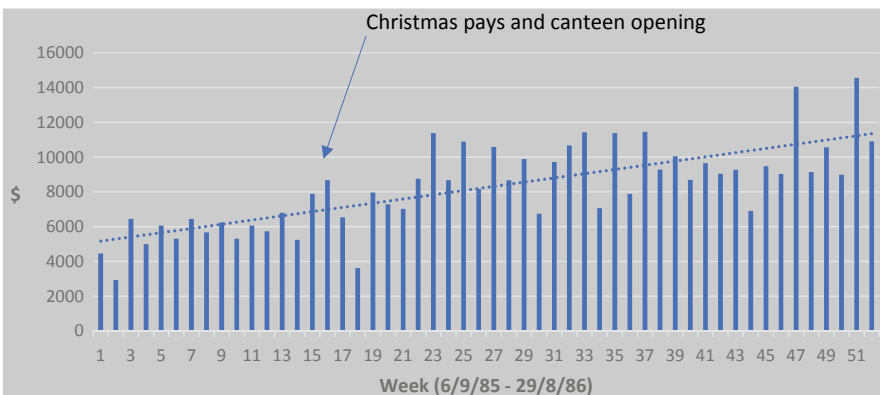
Fig. 7.2 Take-away food sales, September 1985-August 1986
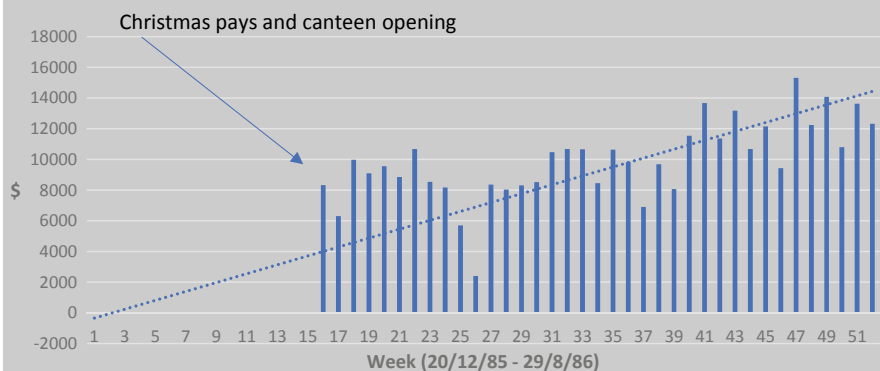
Fig. 7.3 Canteen alcohol sales, September 1985-August 1986

One of the main reasons advanced by those supporting the establishment of a canteen in this township was that it would reduce the expenditure on illicit alcohol, as well as encourage more responsible drinking patterns. There is no evidence to support either of these contentions. Large quantities of illicit alcohol continued to flow into the township. Expenditure on illicit alcohol—on average between $7,000 and $10,000 per week—was only marginally affected by the availability of alcohol in the canteen.

Neither did drinking become more 'responsible'. Arrest rates and criminal offences escalated dramatically from the time the canteen was established, even though there had been a significant amount of alcohol, both licit and illicit, available prior to this (Martin 1993: 175). The above data underscore a distinctive feature of drinking amongst the Aboriginal people of this township; most who were not abstainers, particularly men, drank to the limit of available alcohol. Within the canteen, this meant that those who had the cash purchased

the two or three of the litre jugs that had been decreed the limit while this was still enforced, or organised for non-drinking partners or relations to purchase extra beer on their behalf to circumvent the limit. This was not, however, sufficient for many committed drinkers; men in particular stated that they 'drank for satisfy', that is until they were completely inebriated. Drinkers would often get 'charged up' before the canteen opened, and after closing time, would seek out the illicit alcohol sellers or 'sly groggers· to purchase beer, cask wine or spirits at hugely inflated prices (Martin 1993: 190–1).

During this time, very large profits were made by those illicitly reselling alcohol ('sly groggers'). Cartons of beer, comprising two dozen 375 ml cans, which sold in the regional town for around $25 at this time, had a standard price of $240 on the illicit market. Poor quality cask wine sold for between $100 and $150, and spirits fetched $150 per bottle. These prices were relatively fixed and did not, in fact, reduce for some years. While the extent of the illicit alcohol trade was accentuated in this township by particular historical, geographical and social factors, it is a significant feature of most Cape York Aboriginal communities. lt exists because there is a demand for alcohol that is essentially not price-related, and because there are individuals who are prepared to make the large profits despite the (fairly minimal) risks of prosecution and the major social dislocation which results from their trade.

One conclusion which can be reached is that just as the locus of Aboriginal drinking practices lies in the particular group, and not solely in the individual (Martin 1993: 198), so too in the policy context the locus of demand must be seen to lie within the group, rather than just in the aberrant individual. A further implication of these data is that if the present extremely high levels of alcohol consumption are to be lowered, the supply of alcohol has to be controlled in some way.

In his paper, as well as documenting some of the adverse effects of the canteen on community life, Martin describes an interesting community-based initiative designed to control the importation and use of alcohol and reduce associated harms. Called the Aurukun Alcohol Law Council, its founding principles are set out in Box 7.3.

Box 7.3 The Aurukun Alcohol Law Council
Extract from Martin (1998: 23–25).

Amendments enacted in 1995 to the *Local Government (Aboriginal Lands) Act 1978*, by which Aurukun was established as a local government shire, provide an interesting example of legislation that seeks to operate at both structural and internal levels.[6] Crucially, these amendments were initiated through an extended process of community consultations and negotiations which themselves formed a part of a wider community development exercise that had raised alcohol as an issue of fundamental concern to Aurukun people. A broad consensus was developed amongst both drinkers and non-drinkers as to the principles by which alcohol supply and consumption should be regulated in Aurukun (Adams, Castelain, and Martin 1994). The details of the amending legislation were then negotiated with relevant State officers. This process ensured the broad support for the measures which is essential to their successful implementation. Moreover, the process by which this legislation was developed itself provides one instance of how the wider structural dimensions and those lying within the Aboriginal domain can be linked.

The stated objects of the new Part 6 of the Act include providing mechanisms to control alcohol being brought into the Shire, deterring the illegal sale of alcohol, and minimising alcohol related disturbances. This Part of the Act attempts to link the operations of Aboriginal custom and tradition together with those of the mainstream legal system through a number of specific mechanisms.

Part 6 of the Act establishes an 'Aurukun Alcohol Law Council' as an advisory and decision-making body recognised under Aboriginal tradition and, as far as appropriate, operating in accordance with it. Mechanisms are provided for the Law Council to declare both 'public places' and 'private places' either 'controlled' or 'dry'. Alcohol cannot be consumed or brought into dry places at all, while there can be limitations declared by the Law Council for a controlled place on the type or quantity of alcohol consumed, possessed, or carried in a vehicle, aircraft or boat. Public places are defined as roads, places occupied or under the control of the Shire Council or of the State, such as the barge landing, the airport, and the school. Private places are those occupied by individuals, groups, or entities other than the State or Shire Council, or places over which a person or group have the authority to control access under Aboriginal tradition. Private places then would include individual dwellings, or outstation areas.

---

[6] By 'structural', Martin refers to agencies and processes external to the community that nonetheless impact on the community, such as government departments, laws, and economic factors; 'internal' refers to the intra-community domain.

The Law Council can declare public places to be dry or controlled on its own initiative, or on written application from the Shire Council or a State agency. However, declarations over private places can only be made by the Law Council following written or personal application from the occupier (as in a dwelling) or from those with authority under Aboriginal tradition (as for an outstation or traditional land area within the Shire). The Law Council can, however, be proactive over a particular private place by inviting the relevant people to make an application to have it declared dry or controlled. It must provide assistance to those who may wish to make a written application.

Before the Law Council can decide whether a place should be dry or controlled however, whether it is private or public, it has to display written notices with information on the proposal inviting both written objections and supporting submissions. As well as issuing written notices, the Law Council can consult with the Aurukun community in any way it considers appropriate, for example through public meetings or discussions with relevant individuals. Any person who considers their interests are affected by a proposed declaration over a public area can make objections or supporting submissions. However, declarations over private places can only be objected to or supported by those who occupy or use it or neighbouring areas, or by those who have the right under Aboriginal tradition to control access over it or neighbouring places. The operations of this Part of the Act are shown schematically in Fig. 7.4.

	Dry places	Controlled places	Declarations by Law Council	Support and objections
Public places			Law Council agencies, or Shire Council initiate declarations	From those whose interests are affected
Private places			Occupiers or those with traditional authority initiate declarations	From occupiers of, or those with traditional authority for, these or adjacent places
	No alcohol	Restrictions on type, quantity etc.		

Fig. 7.4 'Dry' and 'controlled' places, Aurukun legislation

...

Crucial principles in Aboriginal traditions of this region are recognised in the way in which 'private places' are defined, and in the mechanisms by which the Law Council can make declarations over them.

Firstly, the definition of private place encompasses both the situation within the township itself, in which indigenous mechanisms for controlling access to places are severely compromised, and the lands around it within the shire, where there is a vibrant indigenous system relating groups to defined sites and areas and broadly establishing those with the authority to control access to these places. Secondly, the requirement for declarations over both categories of private place to be formally initiated by occupiers or those with traditional authority as the case may be, incorporates fundamental Aboriginal principles relating to personal autonomy and the right to speak for traditional lands.

Once the due processes have been undertaken, declarations of places as dry or controlled have the force of law. Infringements can be investigated by the State police or Aboriginal police officers, and penalties for possessing or consuming alcohol in contravention of a declaration are set out in the Act and can be instituted by the courts. This means that the Law Council, importantly, is removed from dealing with particular instances of infringement, which can place individual members in situations of conflict with kin. However, early experience with the operations of the Alcohol Law Council demonstrates that without effective support mechanisms including proactive and committed staff working with the body, the potential of such a legislative scheme will not be realised.

Part 6 of the amended *Local Government (Aboriginal Lands) Act 1978* thus provides a more sophisticated set of mechanisms for controlling the consumption of alcohol than are provided for in most other legislative schemes.

The Law Council as described by Martin was an attempt to bring Aboriginal processes and perspectives and those of the state into an integrated framework and to enhance control over alcohol at both community and household levels, while at the same time recognising the rights of drinkers. Whether or not it represented a viable strategy we cannot know, as its implementation was effectively forestalled by the decision of the Queensland Government to commission a review of alcohol-related violence in Cape York communities and, in 2002, to introduce new restrictions on alcohol availability. These events are described below.

The most detailed account of the impact of a licensed canteen in a Queensland community is McKnight's monograph on Mornington Island in the Gulf of Carpentaria (McKnight 2002). McKnight was an anthropologist who first visited the settlement in 1966 when it operated as a Presbyterian mission. Over the ensuing decades, he spent a total of six years in the community before writing his account, bluntly

entitled *From Hunting to Drinking: the Devastating Effects of Alcohol in an Aboriginal Community*. McKnight does not downplay the traumatising effects of the violent history of dispossession with which the various tribes that today occupy Mornington Island or the adjoining mainland had to contend, or the disruptive impact of changes in the 1960s, such as the collapse of Aboriginal employment in the pastoral industry. But in explaining the transition from a peaceful settlement to one where, by 1997, a person was 25 times more likely to be killed on Mornington Island or the nearby community of Doomadgee than anywhere else in Queensland, he points to two events: the establishment of a canteen in 1976, and the creation of a shire council in 1978 that assumed control of the canteen. By the 1990s, the canteen had become the social, economic and cultural centre of the community and the source of a rising tide of violence, including suicides. McKnight estimates the suicide rate among Mornington Island residents between 1996 and 1998 as 34 times the Queensland rate (McKnight 2002).

The canteen was closed in 2009 after the Queensland Government introduced legislation prohibiting local councils from holding liquor licences and since then Mornington Island has been legally 'dry'. Today, the prevalence of home brewing on the island has prompted renewed calls for the canteen to be re-opened (Butterworth 2021; Mellor 2021).

As we reported earlier (see Sect. 5.10), by the 1990s, the mounting evidence of high levels of injury and violence associated with alcohol in some Cape York communities was attracting increasing concern. A study of injuries in five Cape York communities conducted in 1995 and 1996 compared clinic register data over the six months January–June 1996 between a community with a beer canteen and another, less remote Cape York community that did not have a canteen. It showed the injury rate in the former to be approximately double that in the community without a canteen. The study also included a clinical file audit of all clinic presentations over a 12-month period in the community with a beer canteen (Gladman et al. 1997). A total of 24% of all new presentations, and 34% of presentations resulting in medical evacuations, were for injuries, 51% of which were associated with alcohol.

In July 2001, in response to calls from Apunipima Cape York Health Council and other organisations, the Queensland Government appointed Justice Tony Fitzgerald to examine the extent and causes of violence, injury, ill-health and crime in north Queensland communities and recommend steps to address them. Fitzgerald's report, as mentioned in Chap. 5, depicted alcohol misuse as a cause of high levels of injury, mortality and other problems, including fetal alcohol problems, abuse and neglect of children and untreated mental health problems. Central to the problem of alcohol abuse, according to the report, was the combination of illegal and legal sources of alcohol supply: the former through 'grog running', the latter through the dependence of community councils on profits derived from canteen sales, while the same councils were responsible for the wellbeing of the community (Fitzgerald 2001; Queensland Department of the Premier and Cabinet 2001). Fitzgerald's criticisms were not directed at community-based licensed liquor outlets per se, but at the structural arrangements that encouraged high levels of sales. Accordingly, the report did

not call for canteens to be closed, but for councils' financial dependence on them to be terminated.

As we saw in Chap. 5, the Queensland Government's response—as set out initially in its 2002 policy labelled *Meeting Challenges, Making Choices* and subsequently amended on several occasions—ultimately prohibited local councils throughout Queensland from holding liquor licences (Clough and Bird 2015; Queensland Government 2002, 2008). In most Aboriginal communities where councils had previously operated canteens, attempts to foster alternative administrative arrangements came to nothing, resulting in most of the canteens closing and the communities becoming legally 'dry'.

These policy shifts, however, did not spell the end of licensed liquor outlets in Queensland Aboriginal and Torres Strait Islander communities. As of June 2021, outlets continued to operate in Pormpuraaw on western Cape York and on Palm Island, while several premises in the Northern Peninsula Area (NPA) on Cape York were licensed to sell alcohol to residents and guests only.[7] In addition, the Kowanyama Sports and Recreation Association Club in Kowanyama had a temporary licence to sell take-away light or mid-strength beer.[8] In an interesting case study that probably has echoes in other communities in the region, Moran traces the history of attempts by groups in the Kowanyama community to manage the availability of alcohol in the face of equally persistent efforts by government bodies to promote their own desired outcomes (Moran 2016: 15–28).

One community where a locally-owned outlet appears to have contributed to managing alcohol effectively is Pormpuraaw. Following the Queensland Government's introduction of legislation prohibiting councils from operating liquor outlets in 2008, the Pormpuraaw United Brothers Sports Club (PUBSC), a local community club, applied for a restricted club licence to replace the licence previously operated by the Pormpuraaw Aboriginal Shire Council (Smith et al. 2019). The application was granted, initially with a provision for take-away purchases of up to six cans of mid-strength beer per person per day (Smith et al. 2019). Following an alcohol-related tragedy in the community, the licence was amended in 2009 to allow on-premises sales only. According to a 2019 study of Pormpuraaw's Alcohol Management Plan, the club, 'supported by government licensing restrictions, is one example of a dynamic, community-driven alcohol management measure reducing alcohol-related harm and contributing to community development across multiple measures' (Smith et al. 2019: 32). The club is permitted to trade up to 25 h per week, with sales restricted to six 375 ml cans of mid-strength beer or unlimited amounts of low alcohol beer per person per day. Meals are provided, and the club also hosts special events such as fishing contests and televised sporting events. Patrons require a club licence that is scanned on entry and must return a zero breathalyser reading in order to enter. The PUBSC Board periodically bans individuals from attending the club for

---

[7] Alcohol restrictions in Queensland communities Community | Aboriginal and Torres Strait Islander peoples | Queensland Government (www.qld.gov.au) (retrieved 15 June 2021).

[8] Alcohol restrictions in Queensland communities | Aboriginal and Torres Strait Islander peoples | Queensland Government (www.qld.gov.au) (retrieved 15 June 2021).

specified periods at the request of family members, the Community Justice Group or other groups (Smith et al. 2019).

The study found that rates of two indicators of alcohol-related harm—hospital admissions for assault and recorded offences against the person—both of which had already declined following the introduction of restrictions in 2003, dropped further following the establishment of the PUBSC-run club. However, the study also identified several areas of concern. In particular, the club was not an antidote to illegal 'sly grogging', which continued unabated, leading the researchers to call for a regional approach to addressing alcohol supply chains. Governments had also failed to honour commitments to provide funding and other resources for measures to reduce demand for alcohol, in particular for an alcohol rehabilitation facility.

7.5 Liquor Outlets in Northern Territory Communities

Under the 1979 *NT Liquor Act* introduced shortly after the NT was granted self-government by the Commonwealth, Aboriginal communities gained the power to impose their own conditions on access to alcohol. As explained in a previous chapter (see Sect. 5.3), most communities used this provision to ban alcohol altogether. A small number, however, established licensed clubs. Some of these—such as Ngukurr in the Top End and Santa Teresa in central Australia—abandoned their attempts because of the difficulties entailed in managing the clubs. Others persisted; by June 1995, eight communities in the NT had licensed clubs, although one of these did not trade in that year. All of them were located at the Top End of the NT (d'Abbs 1998).

Clubs sometimes attract controversy. The most extreme example is probably the Murrinh Patha Social Club (MPSC), which commenced trading in 1979 in the Top End community of Wadeye (formerly known as Port Keats). Port Keats had been established in 1935 as a Catholic mission that brought together several disparate tribal groups (Moore 1994). The MPSC was established in response to concerns about residents travelling to nearby towns and drinking heavily, placing financial and other strains on their families back in the community. It was promoted by its advocates as a way of fostering a culture of drinking in moderation (Brady 2017).

Brady (2017) traces the rise and demise of the MPSC in her monograph on Aboriginal-owned liquor outlets. Initially, it operated as intended, trading for two hours each weekday evening and 2 1/2 hours on Saturday, selling strictly limited quantities of beer. But before long, it became a centre for heavy drinking which in turn led to violence, especially against women and children, and damage to property. By 1988, health clinic staff were at desperation point in the face of alcohol-related child malnutrition, domestic violence and petrol sniffing by young people. The club manager on several occasions requested help from the NT Liquor Commission, which reportedly did not respond (Moore 1994). Finally, in the same year, a group of non-drinkers, some of them affiliated with an Alcoholics Anonymous

(AA) group in the community, and led by Freddie Cumaiyi, an ex-drinker and Elder, smashed their way into the club, seized and poured out the beer and demolished fittings (Brady 2017: 118–22). Predictably, news media reported the event as a riot. Brady, however, later interviewed several participants and onlookers, all of whom described the event as a carefully premeditated and planned intervention, orchestrated by Cumaiyi. Onlookers applauded, no one was injured and the police had been notified beforehand (Brady 2017).

The outcome, perhaps inevitably, was a mixed blessing. While levels of harm declined and indicators of children's health and wellbeing improved following the club's closure, the amount of alcohol being purchased outside the community also increased, with associated increases in vehicle crashes and fatalities. A debate about whether or not to re-open the club ensued. In 1992, it recommenced trading as the Kardu Numida Social Club under the control of the local council, which put in place an ambitious program designed to foster moderation. These efforts, however, also failed to achieve their aims, and shortly afterwards, the council itself collapsed. Today, the club remains closed (Brady 2017).

Most Aboriginal-operated liquor outlets are located in remote settings, but in another of her case studies, Brady recounts the creation and eventual demise of an outlet in Alice Springs. In 1993, the Twereretye Club was granted a licence to sell beer for on-premises consumption (Brady 2017: 139–73). Brady describes the difficult political environment that the club's founders had to navigate from the outset, with support from both Aboriginal and non-Aboriginal bodies but also opposition—both from Aboriginal bodies who saw it as only adding to the damage caused by alcohol and, particularly in the early years, from the NT Liquor Commission, which twice refused it a licence, the second time being overruled by the NT Supreme Court.

The club never achieved either the economic viability envisaged or the anticipated level of patronage from Aboriginal drinkers. Brady offers a number of explanations: opposition by Aboriginal groups who believed that abstinence was the only strategy for dealing with alcohol misuse; under-estimation of the social significance of established patterns of drinking take-away liquor by Aboriginal drinkers, and competition from commercial outlets which, unlike Twereretye, were licensed to sell cheap take-away liquor. In 2005, the club closed its doors. Brady suggests that, had the distinction between economic and social objectives been better understood, and the importance of the latter more appreciated, the club might have received the support it needed to survive (Brady 2017).

7.5.1   Community Clubs and Urban Drunkenness

One of the most persistent arguments advanced in favour of licensed clubs in communities in the NT—mainly by non-Aboriginal people who do not live in them—is that they will reduce the number of Aboriginal people coming to town and drinking. For

example, in November 1995, after police in Alice Springs had taken more than 400 Aboriginal drinkers into 'protective custody' for public drunkenness over a three-day period, Alice Springs mayor and former Assistant Police Commissioner, Andy McNeill, called publicly for the establishment of licensed clubs in bush communities (Hartshorn 1995). Two years later, the then NT Chief Minister Shane Stone was quoted as calling for bush communities to be 'forced to accept wet canteens to prevent problem drinkers from heading to town to get grog' (Northern Territory News 1997). Similar pronouncements continue to be made today. In August 2020, the NT Police Commissioner called for what he described as a ban on alcohol in Aboriginal communities to be lifted, a stance supported by NT Chief Minister Michael Gunner who, after drawing attention to the availability of alcohol in Darwin, asked rhetorically 'Why can't Aboriginal people make that same choice on their country about whether they have or haven't got community clubs?' (Abram and Brash 2020). It is difficult to believe that such politically prominent individuals are genuinely unaware that the choice is already available, and that the reason only a handful of communities in the NT have licensed clubs is that other communities do not want them. Moreover, the then Federal Minister for Indigenous Australians Ken Wyatt in 2019 indicated that the national government would not stand in the way of communities establishing licensed clubs should community members wish to do so (Smail and Jeffery 2019).

Quite apart from the ethical implications of putting pressure on communities to facilitate the sale of a substance that has inflicted such devastating damage on Aboriginal people, the limited evidence available suggests that, contrary to the assumption underlying these calls, community clubs do not deter people from drinking in towns. In 1982, the NT Liquor Commission reviewed the operations of the Restricted Area provisions (Reilly 1982). At the time, eight communities operated wet canteens or social clubs. The report found that licensed outlets made little difference to the number of drinkers visiting towns (Reilly 1982). In 1987, d'Abbs was commissioned by the NT Government to review the effects of the Restricted Area provisions of the *NT Liquor Act* (d'Abbs 1990). One of the terms of reference was to investigate whether restriction or prohibition of alcohol in communities led to increases in apprehensions for public drunkenness in towns. d'Abbs compared the number of apprehensions per 100 adult population originating from communities with and without licensed clubs over three months between April and June 1986. In Darwin, three out of the four communities with the highest rates of apprehensions had licensed clubs (1990).

7.5.2   Licensed Clubs and Drinking Patterns

Historically, licensed clubs in NT Aboriginal communities have been associated with widespread, regular, frequent drinking—a very different pattern from the intermittent binge drinking associated with extended visits to towns by residents of remote communities. In 1988, Watson, Fleming and Alexander published the findings of what remains the most detailed study of alcohol and other drug use by Aboriginal

people in the NT conducted to date (Watson et al. 1988). The study was based on a sample of 1,764 individuals from 55 Aboriginal communities, which in turn were stratified by region, community type (major community, town camp, cattle station, outstation) and liquor status (no restrictions, permit systems, licensed clubs, or 'dry'). Data was collected through both questionnaires and group discussions.

Around two-thirds of males (64.7%) and one-fifth of females (20.1%) reported currently consuming alcohol. In communities with clubs, the proportion of males currently drinking—83.6%—was higher than in other communities, while the proportion of females was similar to the overall level (18.5%) (Watson et al 1988: 10–13). Drinkers in communities with clubs reported a much higher frequency of drinking than those in other settings. As the extract in Box 7.4 shows, the proportion of drinkers consuming alcohol 4–7 days per week was more than double the comparable figure in completely unrestricted communities, and far higher than the proportion in dry communities or communities with liquor permit systems. Conversely, as Box 7.4 also shows, drinkers in dry communities or communities where drinking was regulated by permit systems were more likely to consume their liquor in less frequent drinking 'sessions'. The contrast is depicted graphically in Box 7.4.[9]

Box 7.4 Drinking Patterns by Liquor Status of Communities

Edited extract from Watson et al (1988: 16)

Table 7.1 Frequency of drinking by liquor status of community (% drinkers, N = 727)

Frequency of drinking	Open	Club	Permit	Restricted[a]
4–7 days per week	30.9	63.6	1.7	4.8
1–3 days per week	12.4	19.3	19.3	7.3
4–7 days per fortnight	19.1	7.9	5	13.9
2–4 days per month	17.1	2.1	34.5	22.4
5–12 sessions per year[b]	13.4	2.9	28.6	32.1
Up to 4 sessions per year[c]	5.7	4.3	6.7	16.4
Other	1.4	0	4.2	3
Total	100	100.1	100	99.9

[a] i.e 'dry' under the NT Liquor Act.
[b] Drinking sessions may last up to 7 days at a time
[c] Drinking sessions may last up to 4 weeks at a time

[9] The graph shown in Box 7.4 is derived from the data reported in the table reproduced from Watson, Fleming and Alexander; it is not in the monograph itself.
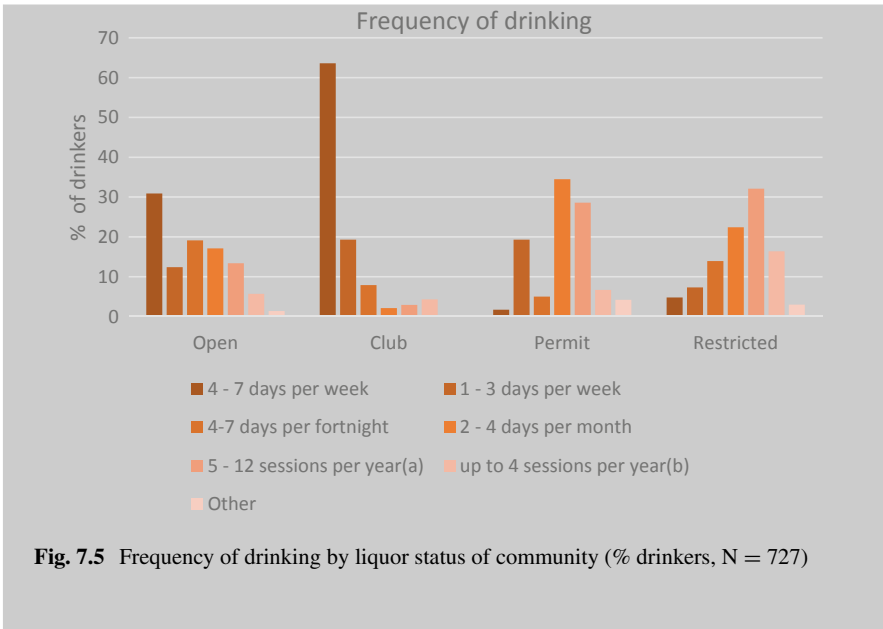
Fig. 7.5 Frequency of drinking by liquor status of community (% drinkers, N = 727)

d'Abbs ([1998](#)) examined apparent alcohol consumption in the seven licensed clubs operating in NT Aboriginal communities in 1994–95, using alcohol purchases reported to the NT Liquor Commission. Apparent per capita consumption by male and female drinkers in each of the clubs was estimated by adjusting for non-drinkers and non-Aboriginal residents. Overall per capita consumption of pure alcohol over the year by male drinkers was estimated at 42.5 L—76% higher than the figure for the NT as a whole. This in turn was 42% above the national level. Similar elevated levels were found among female drinkers, as Fig. [7.6](#) shows.

These estimated mean consumption levels are equivalent to 9.3 standard drinks per day for male drinkers and 5.8 for female drinkers (d'Abbs [1998](#)). The evidence associating clubs in communities with a pattern of high, frequent consumption of alcohol had a number of implications which were summarised by d'Abbs in Box [7.5](#).
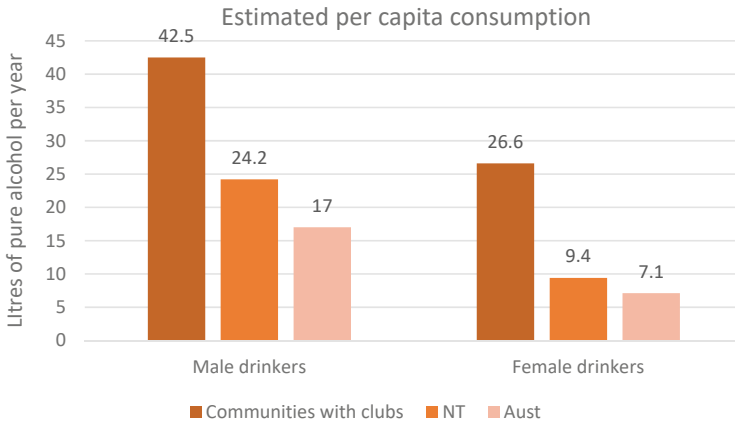
Fig. 7.6 Estimated per capita consumption of alcohol by drinkers aged 18+, 1994–95, Australia, NT and in Aboriginal communities with licensed clubs. *Source* d'Abbs (1998: 682)[10]

Box 7.5 Licensed Clubs, Frequent Consumption and Health
Extract from d'Abbs (1998: 683).

The above analysis suggests that clubs carry serious risks as well as potential benefits to the communities that introduce them. First, they are conducive to very high levels of alcohol consumption, much of it in the form of frequent, regular consumption rather than binge drinking. Second, the more successfully they are managed, the more they are likely to become powerful economic and political institutions in their respective communities. Because Aboriginal communities also tend to be polarised into two distinct groups of drinkers and non-drinkers, and because clubs, as institutions, represent (and are sustained by) drinkers, this creates a context in which the interests of drinkers may attain priority over those of non-drinkers.

The prevalence of high levels of chronic consumption carries implications for those working in the health area, since the health-related consequences of these patterns may be less visible—to drinkers themselves, among others—than the consequences of binge drinking.

To date, almost all the public concern expressed about Aboriginal alcohol misuse has focused on problems associated with *intoxication*. Police, politicians, civic authorities and others with a particular interest in public order are all too ready to maintain Aboriginal drunkenness on the 'social problems'

---

[10] The main sources of data used in creating the chart were the *Apparent Consumption of Selected Foodstuffs Australia 1995–96*, published by the Australian Bureau of Statistics (1997) and alcohol purchase into store data collected by the NT Liquor Commission. The procedures used to derive the per capita estimates are described in d'Abbs (1998: 682).

agenda, while Aboriginal organisations, as pointed out earlier, are particularly concerned with the violence, social and cultural disruption attendant upon intoxication. The longer-term consequences of chronic consumption, however, have received much less attention, probably because they are not experienced as an immediate problem by articulate, powerful groups.

Yet chronic consumption at the levels depicted earlier almost certainly *does* have potentially serious consequences. A study conducted in one community with a licensed club found drinking to be associated with a 2.8-fold increase in rates of elevated GGT[11] (and, at the same time, lower HDL-cholesterol levels). Drinkers with elevated GGTs were also at higher risk of insulin resistance, hyperlipidemia, impaired glucose tolerance and diabetes, and albuminaria. These differences, moreover, were partly independent of body weight (Hoy et al. 1997).

Such consequences are not as obviously associated with drinking as are the injuries, fatalities and property damage attendant on intoxication. Nonetheless, an awareness of them is a pre-condition for making an informed judgment about whether or not to establish or maintain a licensed club, and how best to do so.

7.5.3   Licensed Clubs and the 2007 Intervention

The 2007 Intervention (or, to give it its formal title, the NT National Emergency Response (NTER)) by the Howard national government drastically altered the conditions under which licensed clubs in NT Aboriginal communities operated. Under the NTER, possession and consumption of liquor were prohibited on all land designated as Aboriginal land unless specifically exempted by the government. Licensed clubs were exempted, provided they adhered to a new and more restrictive set of trading conditions drawn up and imposed by the national government. Clubs were permitted to trade for no more than 12 hours per week, spread over four days and could sell light or mid-strength beer only, for on-premises consumption only (Shaw et al. 2015: 64).

In 2012, the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and the NT Department of Justice commissioned a study to examine the operations and impact of licensed clubs in Aboriginal communities in the NT under the new conditions. The study was also intended to identify elements of best practices that might be used as guidelines for other communities wishing to establish community-owned liquor outlets in future (Shaw et al. 2015). Researchers conducted fieldwork in 2013 in the eight communities with licensed liquor outlets in the NT—all of which were located in the Top

---

[11] GGT stands for gamma-glutamyltransferase. An elevated GGT score is indicative of liver disease and alcoholic cirrhosis.

End of the NT. Qualitative data were gathered through observations, interviews with club management and staff and with community members and service providers, as well as through a survey of 362 community residents. Quantitative data was analysed covering liquor sales, assaults, alcohol-related hospital separations and admissions to sobering-up shelters in seven communities[12] (Shaw et al. 2015: 16–22).

The study found that the trading restrictions imposed under NTER in 2007 had brought about a significant reduction in sales. In 2008, the wholesale supply of alcohol to clubs in the six communities for which data was available, measured in terms of pure alcohol content (PAC), fell by 36.2% compared with the previous year. It remained at this level throughout the period covered by the study—i.e. up to and including 2012.[13]

Alcohol-related harms in communities with clubs also declined following the introduction of restrictions in 2007. For example, in 2006–07, the rate of alcohol-related assaults in communities with clubs was 231.6 per 10,000 population—75% above the NT-wide level of 134.9 per 10,000 population. By 2011–12, the level in communities with clubs had fallen by 25% to 174.4 per 10,000 population, slightly below the concurrent NT-wide level of 175.3 assaults per 10,000 population (Shaw et al. 2015: 82–84).

As the study points out, the drop in the amount of liquor turned over by clubs should not be interpreted as indicative of a corresponding decline in consumption by drinkers in the communities concerned. Although clubs were the sole legal liquor outlets in communities, they were not necessarily the only sources of alcohol consumed by community members. Indeed, when asked 'if you have drinkers in your family, where do they buy most of their grog?', fewer than half of those interviewed (41.5%) nominated their local club. A higher proportion (44.8%) nominated other outlets, such as nearby roadhouses or towns[14] (Shaw et al. 2015: 71–72).

The study found that a slim majority of a sample of residents interviewed (51.7%) were happy with the current trading hours of their clubs, compared with 43.1% who would have preferred longer opening hours (Shaw et al. 2015: 75). On the basis of these findings, the report recommended that the restrictive trading conditions introduced under the NTER be retained and also applied to any new licensed outlets that might be established in communities.

7.5.4 How Clubs Operate

Despite the concerns sometimes raised about the impact of clubs in communities, little is known about how clubs actually operate. Shaw et al. (2015) reported on the experiences and views of managers, staff, patrons and other community members,

---

[12] One of the eight venues in the study did not trade during the period under review.

[13] Analysis of these trends is based on data made available by the NT Liquor Commission for the 2012 licensed clubs study (Shaw et al. 2015).

[14] These figures are derived from further analysis of data presented in the report.

and also drew on researchers' observations in communities. The study identified five elements that shaped the impact of clubs in communities, namely:

- Governance;
- Physical amenities;
- Practices around how alcohol is served;
- Club rules;
- The role of the club in the community.

Here we summarise some of the study's key findings in each of these areas.

Governance

The governance of licensed clubs in Aboriginal communities entails formidable challenges, and in the past several communities have shut down their clubs rather than keep struggling to meet them. The report identifies several key aspects of governance, namely:

- The legislation under which clubs are incorporated;
- The kinds of liquor licence under which clubs trade;
- The quality and role of club committees and their relationship with club managers;
- The quality and role of club managers.

In all these domains, the study found anomalies, some of which have since been addressed. At the time of the study, some clubs were incorporated under the NT *Associations Act*, and some under the Commonwealth *Corporations Act* (which allows profits to be distributed to directors and shareholders but does not require organisations to operate for the benefit of the community). Two clubs were incorporated under the Commonwealth *Corporations (Aboriginal and Torres Strait Islander) Act*, administered by the Office of the Registrar of Indigenous Corporations (ORIC). Of the administrative bodies responsible for overseeing these Acts, only ORIC supported organisations with governance training and guidance—something that the report argued was much needed. Under a revised *NT Liquor Act* introduced in 2019, all licensed clubs in the NT are required to be incorporated under the *NT Associations Act 2003* (Northern Territory of Australia 2020).

Similarly, while most outlets operated under club licences, in which the outlet was expected to operate in the interests of its members, two did so under tavern licences similar to those governing public hotels (Northern Territory of Australia 2020). Since then, under the 2019 revisions to the *NT Liquor Act*, licence categories in the NT have been collapsed into a single licence, to which can be attached one or more 'authorities'. The two authorities relevant to licensed clubs in communities are a 'club authority' and a 'community club authority'. Both allow a licensee to sell liquor to club members, guests and visitors for on-premises consumption. The latter also allows the NT Liquor Commission to stipulate a maximum volume of alcohol that may be sold annually (Northern Territory of Australia 2020).

The study also found evidence of variation in the effectiveness of club committees, with one meeting rarely and only when the manager chose to convene a meeting. Three communities revealed evidence of tensions between committees and managers,

with committee members claiming that their managers did not keep them informed or implement their decisions (Shaw et al. 2015).

Physical amenities and serving practices

Most of the clubs operated in pleasant physical settings conducive to relaxed socialising and all offered some form of entertainment, such as live or piped music and pool tables. All of them used measures to discourage intoxication, over and above the restriction of selling light or mid-strength beer only imposed by the Commonwealth government under the NTER. These included breathalysing people on entry and limiting the amount that could be purchased on any one day.

Club rules

All of the clubs in the study had formulated rules of conduct to govern members' behaviour—both inside and, in some cases, outside the club. Box 7.6 is an edited extract from the 2015 report, describing the rules in place in clubs.

Box 7.6 Rules Governing Club Members' Behaviour
Edited extract from Shaw et al. (2015: 110–13).

Rules related to patron behaviour whilst in the club, the health and safety of patrons, and behaviour in the wider community.

Rules about behaviour in the club.

No humbug

All clubs had rules which prohibited patrons from 'humbugging'—that is, asking others for money or to buy them drinks. This aimed to prevent tensions arising over the sharing of money, and to ensure that patrons who did have money could enjoy the club in peace. One club had an associated rule that all patrons had to show that they had $20 before they entered the club.

Our researchers found that many people approved of this rule, as this woman commented: *'Previously there was bad humbug, no humbug a rule now and it is way better'*. However, there was also feedback that this rule was offensive because it denied their culture. These people felt that it was part of their culture to share, and there were people in the club whom they could legitimately (in cultural terms) ask for money. They felt that the club had no right to outlaw the practice.

No arguing/fighting/violence

All clubs had rules outlawing any kind of arguing or physical violence. No patrons could threaten staff—either verbally or physically. In addition, no patron could become violent either in or immediately outside the club. Three clubs also forbade people from making too much noise, particularly while

barracking for their football teams when matches were broadcast on TV. This rule was recent and was not well received by many patrons who were surveyed, as this comment indicates:

> *No barracking for your team, you can't scream. A strict manager—even a pub in Darwin you can sing out for your club. People get pissed in one place then go to another place no worries. Here got to be quiet like a mouse.*

No spitting, rubbish in bins, butts in ashtrays

All the clubs had rules about patrons behaving in a way that kept the club clean and tidy. These rules were about spitting, and where to put rubbish. These rules were some of the most frequently cited by survey respondents, which suggested that people were aware of them, and took them seriously.

Dress regulations

Most clubs had dress regulations which stipulated that patrons must have some sort of footwear and that their clothes should not be in bad disrepair. One club also forbade steel cap boots and studded belts, both of which were said to have been used as weapons in the past.

No drugs

Two clubs had rules stipulating that no drugs were to be brought or sold on the club premises.

Rules for the health and safety of patrons

Health rules

Several clubs had rules against serving people with health conditions that made drinking inappropriate. Two clubs had rules that pregnant women were not to be served, and in one, these extended to not serving either parent for the first six months of a child's life. These arrangements were usually made through the community health clinic. However, one nurse said that she did not participate directly in any process of arranging for an individual not to be served at the club, because she didn't want to jeopardise her relationship with clients. Instead she approached family members and explained that a particular person should not be drinking and left it to their discretion to approach the club.

Sober Bob

One club which had many patrons from neighbouring communities had a 'sober Bob' rule, which required people from other communities to come with a driver who had a valid driver's license, stayed away from the club for the evening and consumed no alcohol. A security staff member at this club described the arrangement:

> *We have a nominated driver system for people who have driven from other communities to come to the pub. We take down the car rego, a description of the car and the driver's name, the nominated driver has to stay outside. If the driver ends up getting drunk, I take the keys. People have to camp with family for the night and I look after the car. They can get the car back and head home in the morning. Last time this happened was 2 years ago. If I see people trying to come to the club already drunk I check the driver, because they must have been drinking elsewhere.*

The club management took this policy seriously. One person was banned after returning to their home community without a 'sober Bob'. As one respondent explained: *'People there worked it out and rang the club to let them know'.*

Rules responding to behaviour in the wider community

All clubs also had rules relating to patrons' behaviour in the broader community. For example, one young man was banned for being drunk and breaking a bus window. He had been banned until he pays to have the window repaired.

<u>No work, no club</u>

One club has a 'No work, no club' rule. If people in this community did not turn up for work, they were kept out of the club for that evening, as this patron described:

> *I didn't know. A couple of days after I arrived [several months previously from another community] the security asked me if I was working and when I said no she told me to go home. Then I started working [laughs].*

Another community used to have the same rule, however it had fallen out of use because of the decline in employment in the community.

<u>No domestic violence</u>

Several clubs also had rules that banned any individual with a charge for domestic violence. It was unclear whether this rule related to all domestic violence, or only to instances that were alcohol related, and the alcohol concerned was drunk at the club. Different clubs had slightly different versions of this rule.

The main mechanisms used to enforce rules were security staff, gates and fences, security cameras, and bans.

All but the smallest club had security guards. In one club, the licence conditions required that some of the security staff had to be non-local, a condition that, according to a police officer interviewed, made them more effective. Several club managers reported difficulties in employing and retaining trained and certified security staff. The study identified six main roles of security guards:

- be present at the gate to make sure no banned people came in;
- assess patrons' intoxication on arrival at the club—either by breathalysers, or judgement;

- assess patrons' intoxication as the night goes on;
- ask people who've had too much to drink to ease up or go home;
- break up any loud arguments or fights; and
- police the 'no humbug' rule (Shaw et al. 2015: 116).

The design of fences and gates was seen as an important factor in enforcing rules—especially those forbidding taking liquor out of the club or arriving intoxicated. Two clubs had security cameras, which also helped to prevent the removal of liquor.

The most important control mechanism used by clubs was banning patrons—described in more detail in Box 7.7.

Box 7.7 Banning Patrons from Licensed Clubs as a Form of Control

Edited extract from Shaw et al. (2015: 118–25).

Banning people is the most powerful sanction available to the club and it makes people take the rules seriously. Probably because of this, it is a contentious issue. The longest banned list had 113 people, and the shortest had three. Most of the communities had around 50 people on their lists.

Survey respondents were asked whether they thought that what people had been banned for was fair. Almost two thirds (64.9%) thought that the ban was fair, with the following comment being typical: *'I did run amok so I should be banned. I've settled down now'*. On the other hand, a significant number reported that banning was not fair because the law was there for punishing bad behaviour, and the club shouldn't be able to do it as well: *'Not fair for us, we go to court get punishment and get banned as well'*.

Who decides on bans?

It was difficult to identify the mechanisms through which people were banned, and the typical length of bans, as feedback on this issue was very diverse. Most clubs reported more than one banning mechanism, and survey respondents identified several pathways to being banned, including bans issued by the club management, club committees, and police. Some survey respondents reported that traditional owners and heads of family groups could also ban people, however this was not corroborated by the police, club managers or members of club committees.

Bans by the club

Club managers and club committees tended to ban people for behaviour that occurred inside the club and violated club rules—such as spitting, humbug or arguing. Offenders tended to get banned for relatively short periods, and the ban was given out the same day. Survey respondents recalled some instances of this sort of banning that certainly did not relate to any broader laws being breached: *'My brother was banned for screaming for his team, Hawthorn and*

Sydney game, last month, screamed, talked back then was asked to leave'. On other occasions the ban was not for a set period, but until the offender had made recompense: *'My cousin smashed the TV at the club. Got banned till he paid it off'*.

The manager and committee were sometimes approached by community members who wanted an individual banned. These requests were considered at the monthly club committee meetings. Several committee members from each community were interviewed about this: most commented that it was quite difficult to decide on the length of the ban, but community members generally supported their decisions.

Sometimes the requests for bans come from family *'If my son run amok I go and see the manager and ask him to ban him'* and *'I was banned for one month—arguing with my sister about a tape, at home, and my sister rang the club and reported me'*. On other occasions other community members requested the ban. Sometimes the motivation may be purely personal: *'I had a fight after I had been drinking at the club. The person I fought with reported me to the club to get me'*. Some can be open to a lack of balance. One police officer corroborated the lack of balance, saying: *'Bans can be used for family politics—for example if someone didn't share something they try to get them banned'*. There was also feedback that the banning process was open to manipulation, and could be influenced by your place in the community: *'It depends on who you know, your relations, rules vary for committee members as they have a big say about who gets banned and whether someone gets let back in'*.

Bans by police

The police also issued bans without referring to the club. It seemed to be general practice that if police were called to an incident that involved people who had been drinking at the club, those involved were banned.

What behaviour can lead to a ban?

In addition to bans being issued for violating club rules, they are also sometimes imposed for acts not directly related to the club. Club management can be approached by agencies in the community to request that an individual be banned.

...

Several club managers found the banning systems frustrating. They reported that being banned from the club had become the de facto social control system for the whole community—and made their businesses much less profitable. Some survey respondents agreed: *'It's too cheeky to do that. Not fair. What has it got to do with the club. Club should only be involved if it's grog'*. Other stakeholders, however, including both service providers and community members, reported that banning was one of the few effective forms of social control, and was a good option to have available. This person summarised this

point of view well: *'Kids stealing out of houses—parents get banned, that's good, no-one steals.'* Another survey respondent characterised it as 'instant justice'. The banning happened quickly and was an effective punishment. In their opinion this was better than the justice provided by the police because 'you don't have to wait'.

Bans were also imposed in some communities for other reasons, including misbehaviour by children, parental neglect of children, domestic violence, and other domestic issues.

How long are people banned for?

Bans varied in length. Most bans appeared to be for less than six months; some were for a matter of days.

All communities had some people who were banned for life. This was generally for repeated and serious offences. In one quite small community there were 43 people on the banned list, and 28 of these (65%) were life bans. Another community had a banned list of 113 people, 19 (17%) of whom were banned for life.

There was some debate about whether life bans were a constructive strategy. Several survey respondents felt that a really long ban simply sent people away from the community to drink elsewhere. As one survey respondent who has been banned for life declared *'This community is trying to kill me. They want me to drink somewhere else and get myself killed!'*.

Does banning improve behaviour?

Most survey respondents felt that banning was a constructive strategy, as long as the ban was not for too long. They felt that being banned teaches people a lesson in respect, and how to drink in moderation: *'They have to take punishment. Banning teaches them a lesson—teaches them not to run amok, that they should drink like normal people, be sensible and drink in moderation. Some people drink too much'*.

It was not only people who observed the impact of banning on other people that were positive about it. Several people also spoke positively about the fact that the threat of being banned kept their own behaviour in check: *'I don't get banned because I love my beer'*. One person also referred to banning as the tool to achieve the original idea behind the clubs—to teach people moderate drinking: *'The club is made for people to socialise in. It shouldn't be really intoxicated. It's like a learning thing, that's why it was opened in the first place.'*

...

Does banning result in people leaving their community to drink in more risky environments elsewhere?

A dilemma regarding the impact of banning people is the extent to which banned drinkers then leave the community to drink in other places. One person summarised the issue well: *'People get banned for life and then go to Darwin to drink. Get in trouble and accident, and coffin coming back'*. There was consistent feedback that some people who are banned do go to other places to drink. In one community the son of a local research assistant was banned while the research team was in the community. The mother was very worried and went to the club and police to ask that he not be banned. Meanwhile the son vowed to go to the nearest town to drink and started to walk along the road out of town. The whole family was genuinely concerned that the young man would come to harm.

Further investigation of the impact of being banned was done by accessing the list of people who had been banned in one community. Researchers sat down with local research assistants to ask who had left the community and who had stayed. Of 30 people on the list, 20 (66.7%) were said to have subsequently left the community, although some people who had left were also said to have returned. Young people were particularly likely to have left the community, with 13 of the 20 who had left being aged less than 30 years.

Key points—banning

- *Banning can become a system of social control for the whole community, and in particular a community-controlled response to bad behaviour.*
- *Most people think the bans are fair.*
- *Banning systems sometimes get used for more petty family politics.*
- *An issue arises concerning the extent to which it is reasonable to use access to the club as a major carrot for a whole range of behaviour.*
- *Banning is seen as a tool to teach more moderate drinking.*
- *Many (particularly the young) that are banned leave the community to drink in other places.*

Role of clubs in the community

The final element listed above as key to shaping the impact of licensed clubs in communities was the role of clubs in the wider community. Almost two-thirds of survey respondents (59.9%) reported that their clubs conducted community events, including occasions such as Christmas Day, New Year's Day, International Women's Day and NAIDOC. These events appeared to be popular, although communities were divided on whether or not children should be included in community functions, with some believing that their inclusion signalled that the club connoted more than drinking, while others believed that their presence served as an endorsement of

alcohol in the community. Club facilities were also sometimes hired out to other community organisations.

Several clubs had contributed financially to their communities by sponsorships— such as a football team—or purchases, with two clubs buying buses for community use. At least two clubs had also used revenue generated from the clubs to build commercial accommodation facilities which they ran as small motels. However, the study also found evidence of a lack of transparency in club operations. Levels of knowledge about such matters as club profitability, what happened to profits, and salaries paid to staff were low, and in some communities the subject of disquiet and suspicion.

On the basis of its findings, the study prepared a checklist for consideration by new licensed club ventures. This is reproduced in Box 7.8.

Box 7.8 A Checklist for New Licensed Clubs in Communities
Extract from Shaw et al. (2015: 7–8).

If a decision to establish a club is made the following checklist should be followed in creating standards for the design, construction and management of it:

1. Plans for such a licensed facility should include a range of hot meals as well as entertainment and activity—not just the consumption of alcohol.
2. The design of such a facility should demonstrate it will have a kitchen and dining area, as well as a bar area, and should be spacious and able to accommodate small groups of people who may wish to drink separately.
3. The design also needs to demonstrate that alcohol will be stored in a highly secure manner that mitigates the risk of being stolen.
4. The club should be incorporated through a legal vehicle which sets a high standard of governance.
5. The club committee should have access to professional advice over the recruitment and supervision of a manager and be fully aware of its responsibilities.
6. Governance training should be provided to club committee members and regularly updated. Training on committee requirements under the NT Liquor Act needs to be included in this training.
7. As part of capacity building of the club committee, members should learn more about alcohol related matters affecting their community. This could include arranging for the local health service to provide quarterly reports on the level of alcohol related presentations in their community.
8. The club management should commit to a transparent process for the return and use of profit to their community, with procedures established for the fair and equitable distribution of benefits to appropriate groups in the community.

9. The club committee should agree that the club venture be evaluated after the first two years and commit funds to undertake the evaluation.

7.6 Liquor Permit Systems

The second strategy for managing alcohol use at a community level under review in this chapter is the use of liquor permits, issued to approved individuals to allow them to purchase, import and/or consume alcohol subject to conditions attached to the permit. Throughout the first half of the twentieth century, liquor permit systems formed a central part of alcohol control policies in Canada, some US states and much of Scandinavia (Genosko and Thompson 2009; Room 2012). From the 1950s, these systems were progressively dismantled in most places, having come to be regarded as intrusive, discriminatory and ineffectual (d'Abbs and Crundall 2019), although they survive in some states of India (Varma 1984). Today, they are no longer considered as a serious policy option in most settings—with two exceptions, namely some remote Inuit communities in the territory of Nunavut in northern Canada, and some Australian Aboriginal communities in the Northern Territory (d'Abbs and Crundall 2019).

7.6.1 Nunavut, Canada

In both regions, liquor permits were introduced in the latter half of the twentieth century as an option for community-based control of alcohol following the dismantling of laws prohibiting First Nations peoples from possessing or consuming alcohol. In Nunavut, a remote, sparsely populated area that makes up one-fifth of Canada's landmass, most of the population are Inuit, living in 25 communities which, for much of the year, are accessible only by air (Nunavut Bureau of Statistics 2018). Under the Nunavut *Liquor Act*, these communities may select one of four systems for controlling alcohol:

a. *Open:* the community is subject only to the general liquor laws of Nunavut;
b. *Restricted quantities*: the quantity of liquor that a person may purchase is limited;
c. *Permits:* a locally elected Alcohol Education Committee (AEC) issues permits stipulating who may import, possess, consume and/or purchase liquor in the community, and the conditions under which they may do so. The AEC is also expected to provide education and counselling services;
d. *Prohibition:* no alcohol is permitted (Nunavut Liquor Licensing Board 2018).

As of July 2018, 13 communities had permit systems, six had prohibition and the remaining six were unrestricted (Nunavut Liquor Commission 2018).

Most of the limited evidence available about the impact of AEC-based permit systems is anecdotal and inconclusive (d'Abbs and Crundall 2019). Wood examined rates of homicide, serious assaults and sexual assaults in 23 Nunavut communities between 1986 and 2006 (Wood 2011). He categorised communities as 'dry' (type 'd' in the list above) or 'wet', in which he included open and restricted (permit-based) communities. Rates of all the offences under review were significantly lower in dry communities than in wet communities, although even in the former they were above comparable national rates. He also found little difference between permit-based restricted communities and those with no restrictions, with the former recording 64 violent crimes per 1,000 persons, compared with 67 violent crimes per 1,000 persons in open communities.

A task force appointed in 2010 to review the *Nunavut Liquor Act* was repeatedly told in consultations that current control systems were not working and that AEC members lacked the resources to perform either an educational or control function (Nunavut Liquor Act Review Task Force 2012). One AEC member told the task force: 'No one has provided us with the proper education on alcohol so how can we make good decisions and be expected to educate others?' (Nunavut Liquor Act Review Task Force 2012: 28). The permit system was also widely reported as being exploited or circumvented by 'bootleggers'—the local term for people illegally importing and selling liquor. Despite these criticisms, the task force also found high levels of support in communities for AECs, suggesting that most people wanted an effective, community-based system for managing alcohol. In response to the Task Force's report, the Nunavut government, in 2016 introduced an action plan in which it promised, among other changes, to improve permit systems and increase resources for AECs (Government of Nunavut 2016).

7.6.2 *Northern Territory, Australia*

In the Northern Territory, provisions for issuing permits to approved individuals to import and consume liquor were incorporated into the Restricted Area section of the *NT Liquor Act* in 1979, when communities first gained the authority to determine their own arrangements regarding the availability of alcohol in communities. Although the *Liquor Act* has undergone major revisions since that time, the liquor permit provisions have been retained with little alteration. (In the *NT Liquor Act 2019* they occupy Part 8, Division 6 (Northern Territory of Australia 2020)). Permits are formally issued by the Director of Liquor Licensing, who must consult with community members, police and, if there is one, a local permit committee before reaching a decision.

As indicated earlier (see Chap. 5, Sect. 5.3), most Aboriginal communities in the NT have elected to ban alcohol, and most have chosen *not* to make provision for liquor permits. In 22 communities, however, permit systems are in place (d'Abbs and Crundall 2019). A review commissioned by the NT Government in 2015 found that two types of liquor permit systems had evolved. In the first, which the reviewers labelled *exemption* schemes, liquor permits in practice served as a means of allowing

employees in communities—most of whom were non-Aboriginal—to import and consume liquor in their own homes in what for everyone else was a dry or heavily restricted community (d'Abbs and Crundall 2016, 2019). In principle, any adult resident of these communities was entitled to apply for a permit. In practice, while non-Aboriginal residents were routinely granted permits, Aboriginal applicants could count on little support, either from their own communities or the administrative authorities. Twelve of the 22 communities with liquor permit schemes fell into this category. In these communities, liquor permits were a peripheral rather than a core part of the local provisions for managing alcohol. The review found that community input into making recommendations had declined over time. None of these communities had a functioning permit committee, with a result that effective power to recommend in favour of or against issuing permits had fallen by default to local police, who acted without administrative support or operational guidelines. Both in the past and at the time of the review, permit systems of this kind had generated resentment in some communities over what were perceived to be race-based double standards (d'Abbs and Crundall 2016). At least one community had abolished its liquor permit system for these reasons (ABC News 2005).

The second type of liquor permit system identified in the review, although based on the same enabling legislation as the first, played a very different role in the community. Liquor permits, far from being a peripheral mechanism, served as the main means of managing local alcohol use in what the reviewers labelled *permit-based alcohol management systems* (d'Abbs and Crundall 2016, 2019). Permit systems of this type emerged initially in the 1980s in the Arnhem Land community of Maningrida and in communities located in the Tiwi Islands, off Darwin. More recently, they have been introduced in the East Arnhem regions of Groote Eylandt and the Gove Peninsula. In the Tiwi Island communities, permits co-exist with licensed clubs and allow holders to import limited amounts of liquor and consume it privately. In Maningrida, the system allows approved persons to import limited amounts of liquor via a barge that visits the community every fortnight from Darwin. All other ways of importing liquor into the community are illegal. The permit system has been modified several times since being introduced in 1983. Today, applicants may select one of three permits, with a fourth category reserved for people who are reapplying for a permit after they have had one revoked, as set out in Table 7.2.

At the time of the 2015 review, applications under the Maningrida liquor permit system were submitted through the Maningrida Progress Association, a community organisation responsible for a range of local government and other functions, and vetted by police and the community night patrol before being forwarded, with recommendations, to the Director of Licensing. The application form also set out a number of grounds on which liquor permits could be refused or revoked, including assaults, alcohol-related family violence, supplying drugs, littering or causing substantial annoyance in the community (Northern Territory Government Department of Industry Tourism and Trade 2021).

The review found that the Maningrida permit system was working well, an outcome attributed to a high level of community input and consistent application of rules that were widely understood in the community. It also noted, however, that

Table 7.2 Liquor permit categories, Maningrida, Northern Territory

Permit category	Entitlement
Class A	• One carton of heavy beer; OR • 20 cans of heavy cider and one carton of light or mid-strength beer per fortnight
Class B	• One carton of light or mid-strength beer and six bottles of wine; OR • One carton of heavy beer; OR • 20 cans of heavy cider and one carton of light or mid-strength beer per fortnight
Class C	• Two cartons of light or mid-strength beer per fortnight
Class D	• One carton of mid-strength beer; OR • Two cartons of light beer per fortnight

Note If you have had a liquor permit revoked and are reapplying for a new permit—you can only be granted a Class D permit.
Source Application form for a liquor permit for Maningrida (https://nt.gov.au/__data/assets/word_doc/0004/174622/application-for-a-liquor-permit-Maningrida-general-restricted-area.docx.).

grog-running continued to occur, especially during the dry season when roads were usable, as did the practice of permit holders supplying liquor to non-permit holders in contravention of their permit conditions (d'Abbs and Crundall 2016).

The liquor permit systems in Groote Eylandt and Gove Peninsula were both established more recently—the latter being modelled in part on the former—and incorporated several innovations, as set out in Box 7.9.

Box 7.9 Origins of the Groote Eylandt Alcohol Management System
Extract from d'Abbs and Crundall (2016: 78–82).

In July 2005, a permit-based strategy for managing alcohol use, known officially as the Groote Eylandt Alcohol Management System (GEAMS), commenced operation. Groote Eylandt (Dutch for 'big island') lies in the Gulf of Carpentaria, approximately 600 km east of Darwin. It contains three major settlements—the Aboriginal communities of Angurugu and Umbakumba—and the mining town of Alyangula, as well as a number of smaller settlements, including nearby Milyakburra (Bickerton Island). The Estimated Resident Population of the Anindilyakwa Statistical Area—comprising Groote Eylandt and Bickerton Island—in 2011 was 2,571 persons, of whom 1,559 (60.6%) were Indigenous (Australian Bureau of Statistics 2012).

The GEAMS incorporated two important innovations: firstly, liquor permits were used to regulate *purchases* of take-away liquor, rather than possession, consumption or importation of liquor; secondly, permits were activated electronically. Groote Eylandt is home to just two take-away liquor outlets: Alyangula Golf Club and Alyangula Recreation Club.[15] Under the GEAMS,

each take-away outlet has a computer node linked to a central server in Darwin, where all permit information is stored. Under the system, it became illegal to buy or sell take-away liquor without a permit. On-premises sales were not contingent on having a permit.

Prior to commencement of the GEAMS, Groote Eylandt had a history of alcohol-related problems dating back to the commencement of manganese mining on the island by Groote Eylandt Mining Co (GEMCO) in the 1960s (Conigrave et al. 2007). Over the years a number of measures had been implemented, including GRA declarations under the *NT Liquor Act* and, in the case of Umbakumba on the north coast of the island, establishment of a licensed club allowing limited purchases of beer to residents of the community. Despite some of these initiatives bringing apparent benefits, the situation by the early twenty-first century was continuing to cause alarm, especially among Aboriginal communities.

In July 2005, following extensive engagement and consultation involving the Anindilyakwa Land Council, GEMCO, Angurugu Community Council, local NT Police officers and the NT Licensing Commission, as well as a series of community meetings, the GEAMS came into effect. Under it, any person—Aboriginal or non-Aboriginal—wishing to purchase take-away alcohol required a permit, which also stipulated where the alcohol could be consumed, and the amounts and types of liquor that could be purchased. Applications for a permit are considered by a local Permit Committee, which makes recommendations to the Director of Liquor Licencing (DLL), who in turn is required to take account of the Committee's recommendation before deciding on whether or not to issue a permit. The Permit Committee was initially composed of representatives of:

- Police;
- Anindilyakwa Land Council;
- GEMCO;
- each of the three Community Councils;
- each of the two licensed clubs in Alyangula;
- health services, and
- a community or consumer representative (2007).

Under the GEAMS, the DLL can also suspend all permits for 24 hours on recommendation of the Permit Committee or Police for reasons of community safety or events of cultural significance. Permits can also be revoked for breaches of permit conditions.

An independent evaluation of the GEAMS, conducted in 2007, described the origins and implementation of the system, and its impact over the first

---

[15] The Alyangula Recreation Club, now known as The ARC Alyangula, no longer has a licence to sell take-away liquor.

12 months of operation (Conigrave et al. 2007). It reported that, at the time of commencement in July 2005, a total of 1,020 annual permits were issued. Over the following year, permits continued to be issued at an average of 46 permits per month. The steps involved in applying for a permit, as the system had evolved at the time of the evaluation, were as follows:

1. The applicant would collect an application form from Alyangula Police, fill it in, and submit it to the Permit Committee;
2. If the applicant was resident in one of the Aboriginal communities, a letter from the Community Council was required to support the application.
3. Police would perform a criminal record check on all new permit applicants.
4. Any applicants with a criminal record or police record of concern (particularly if it involved alcohol-related offences, or violence) would be discussed at the Permit Committee meeting with a view to determining the applicant's suitability.
5. Other applications were checked by at least two Committee members for any concerns; if there were concerns the application would be referred to the Permit Committee.
6. A recommendation would be sent by the Permit Committee to the Licensing Commission in Darwin, recommending granting or refusal of permits
7. The Licensing Commission generally agreed with the Permit Committee's recommendation and sent back to the Police a letter granting or refusing the permit. As of 2007, there had been no cases where the Commission failed to endorse the Committee's recommendation on individuals, but one case where it had overruled a Permit Committee decision to license an outdoor event (Conigrave et al. 2007).

The evaluation found strong evidence of beneficial outcomes. For example, all of the women interviewed at Angurugu community indicated that their community was now safer for women and children, while some drew attention to the positive impact on role models for children:

Before, there was violence. Women scared, children scared. Children growing up seeing violence. Then when they grow up, they think 'If it is alright for my father, why shouldn't I do that? [ID 37, Indigenous woman, Angurugu]

Before kids suffering, teenagers suffering, wives suffering, partners suffering... teaching younger men into alcohol. [ID 45, Indigenous woman, Angurugu] (Conigrave et al. 2007, p. 31)

In 2005–06, the year following introduction of the system, recorded assaults and aggravated assaults fell by 73% and 67% respectively in comparison with the preceding year, and the number of persons placed in 'protective custody' for being publicly intoxicated fell from 90 to 11 over the same period. The number of reported domestic disturbances did not decline over the same period, in fact increased by 17% over 2004–05, to a point still below the level of 2003–04.

Police suggested that these figures may have been due to the introduction of a more pro-active policing role with respect to domestic violence, together with greater willingness of people to report incidents, rather than an increase in the number of incidents themselves. The evaluators also found that the permit system was widely supported among Aboriginal and non-Aboriginal residents alike. However, they also found evidence of problems. The most prominent was the considerable administrative burden that the permit system generated for the Permit Committee, and the inadequacy of financial or administrative support provided by the Licensing Commission or other NT Government agencies. As a result, much of the work involved in setting up the Permit Committee, developing operating procedures, creating signage and educating the community about the system had been performed by local police. According to some of those interviewed for the evaluation, this had in turn contributed to a perception that the permit system was a police rather than a community initiative.

An associated complaint aired by some interviewees was the need for the Permit Committee to develop clear operating guidelines to assist it in making consistent and defensible decisions, and to ensure that community members were aware of these guidelines. The evaluators also heard reports of high and increasing levels of cannabis use, which sometimes generated violence, especially when individuals ran out of supplies.

Do liquor permit systems in Aboriginal communities work? If we put aside what d'Abbs and Crundall categorised as 'exemption' permit systems—which arguably are community-based in name only—and focus on permit-based alcohol management systems as described above, it is apparent that they have three main objectives:

1. To enhance community management of alcohol use in the community;
2. To discourage harmful drinking patterns by community members and thereby
3. To reduce alcohol-related harm in the community.

As the above discussion makes clear, there is very little evidence available from either Nunavut or the Northern Territory to assess the extent to which permit systems achieve any of these objectives. The most that can probably be said from existing evidence is that liquor permit systems can contribute to these objectives under three conditions:

1. Provision of adequate administrative support: liquor permit systems generate heavy administrative demands both in communities and government agencies, and these need to be recognised by all parties and adequately resourced. To date, this appears not to have happened in either Nunavut or the Northern Territory.
2. Effective controls over illegal purchasing and supplying of liquor (including 'grog-running'). Realistically, in remote communities in sparsely populated regions, illegal supply of liquor will probably never be eliminated while demand exists, but in the absence of some sort of effective policing, regulation of access via permits becomes meaningless.

3. Legitimacy in the eyes of the community: community support for a permit system, and willingness to abide by it, depend on the system being seen as embodying the wishes of the community, and as being administered transparently and equitably.

7.7 Conclusions

In this chapter, we have examined evidence relating to two strategies for managing alcohol at a community level: controlled liquor outlets and liquor permit systems that allow approved individuals to import and consume liquor in a community subject to conditions.

Licensed clubs in Aboriginal communities, as the evidence presented above attests, have generally—although not universally—failed to achieve the three primary objectives for which they are usually intended: to foster a culture of moderate drinking in communities, to reduce the unregulated importation of liquor into communities ('sly grogging') and to reduce the exodus of would-be drinkers from communities to towns (Brady 2014, 2017). Some have had almost the opposite outcomes, becoming sites for heavy, chronic drinking and all the harmful consequences that flow from it, while having little impact on either illicit grog-running or periodical movement of drinkers away from the community.

Why is this so? In each community, drinking patterns and their consequences are shaped by distinctive combinations of causal factors, but four factors appear to be especially salient. The first is a naïve belief held by some, particularly non-Aboriginal promoters of licensed outlets in communities, that by creating the right setting you can bring about a cultural shift from binge drinking to moderation. As Brady observes, the reality is usually the other way around: drinkers adapt the setting to their preferred drinking culture (Brady 2017: 92). The second factor consists of unrealistic expectations placed on the capacity—and often, willingness—of Aboriginal authority figures—whether councillors or traditional Elders—to control the behaviour of drinkers. This does not mean that respected Aboriginal leaders cannot prevent and resolve conflicts arising from excessive drinking; as we show in Chap. 9 on community patrols, they can and do. But at a community level, and in a context where licensed clubs generate their own economic interests, the exercise of effective social controls on harmful drinking is often compromised. Thirdly, governance of licensed outlets in Aboriginal communities presents formidable challenges, and those who undertake it require both external administrative support and monitoring to assist them in meeting these challenges. To date, this support has been conspicuously absent. Finally, the goals of pursuing economic viability while avoiding social, health-related and other harms from alcohol misuse are often inherently contradictory.

However, as the above analysis also suggests, licensed outlets in communities need not fail or have harmful outcomes. In recent years in both Queensland and the NT, the imposition of restrictions on trading conditions by governments, combined with the presence in communities of people and organisations willing and able to

operate within those restrictions, have led to instances of community-owned outlets operating venues for sociable drinking without exacting unacceptable harms and costs.

Liquor permit systems authorising approved individuals to consume liquor in otherwise restricted communities are not widely used today in either Aboriginal or non-Aboriginal settings. However, in some communities in the NT in Australia, and in the territory of Nunavut in northern Canada, they continue to form an important part of community liquor management strategies. Evidence about the impact of permit systems is sparse and inconclusive. It does appear, however, that permit systems can enhance community control over alcohol use, and thereby possibly reduce levels of harmful consumption, if three conditions are met: permit committees and others responsible for administering permit systems are adequately supported and resourced; effective controls are in place to deal with illegal supply of alcohol and the rules and procedures that constitute the permit system enjoy legitimacy in the eyes of the community.

References

ABC News. 2005. Alcohol permit system abolished in remote community. *Australian Broadcasting Commission,* 12 August.

Abram, Mitchell, and Stewart Brash. 2020. Police Commissioner says NT needs to rethink Indigenous communities alcohol ban. *ABC News,* 17 August.

Adams, J., J. Castelain, and D.F. Martin. 1994. *Aurukun Community Plan: Report 2. Dealing with Grog.* Cairns, Qld.: Yalga-binbi Institute for Community Development.

Australian Bureau of Statistics. 1997. *Apparent consumption of selected foodstuffs, Australia. 1995–96, preliminary. Cat. 43 15.0.* Canberra: Australian Bureau of Statistics.

Australian Bureau of Statistics. 2012. *2011 Census of Population and Housing, Basic Community Profile (Catalogue number 2001.0), Anindilyakwa (702041062).* Canberra: Australian Bureau of Statistics.

Barber, James G., Jeanine Punt, and Jules Albers. 1986. Alcohol and power on Palm Island. *Australian Journal of Social Issues* 23: 87–101.

Brady, M. 2017. *Teaching Proper Drinking? Clubs and Pubs in Indigenous Australia.* ANU Press: Canberra.

Brady, M, and K Palmer. 1984. *Alcohol in the Outback* (North Australia Research Unit, Australian National University: Darwin).

Brady, M. 2014. *Lessons from a history of beer canteens and licensed clubs in Indigenous Australian communities. Discussion Paper 290/2014.* Canberra: Centre for Aboriginal Economic Policy Research, Australian National University. http://caepr.anu.edu.au/sites/default/files/Publications/DP/DP290_Brady_alcohol_management.pdf. Accessed 22 June 2015.

Brady, Maggie, Joe Byrne, and Graham Henderson. 2003. Which bloke would stand up for Yalata? The struggle of an Aboriginal community to control the availability of alcohol. *Australian Aboriginal Studies* 2003: 62–71.

Butterworth, Kelly. 2021. Dry Indigenous community 'months' from opening tavern to combat home-brew. *ABC News,* 23 April.

Clough, A.R., and Katrina Bird. 2015. The implementation and development of complex alcohol control policies in indigenous communities in Queensland (Australia). *International Journal of Drug Policy* 26: 345–351.

Conigrave, K. M., Elizabeth Proude, and Peter d'Abbs. 2007. *Evaluation of the Groote Eylandt and Bickerton Island Alcohol Management System. A report produced for the Department of Justice, Northern Territory Government*. Sydney: Royal Prince Alfred Hospital.

d'Abbs, P. 1990. *Dry Areas, Alcohol and Aboriginal Communities: A Review of the Northern Territory Restricted Areas Legislation*. Darwin: Drug and Alcohol Bureau, Department of Health and Community Services and the Racing, Gaming and Liquor Commission.

d'Abbs, P. 1998. Out of sight, out of mind? Licensed clubs in remote Aboriginal communities. *Australian and New Zealand Journal of Public Health*, 22: 679–84.

d'Abbs, P, and I Crundall. 2016. *Review of Liquor Permit schemes under the NT Liquor Act: Final Report. A report prepared for the NT Department of Health.* Darwin: Menzies School of Health Research. https://www.menzies.edu.au/icms_docs/272714_Review_of_Liquor_Permit_schemes_under_the_NT_Liquor_Act_Final_Report.pdf. Accessed 15 May 2019.

d'Abbs, P., and I. Crundall. 2019. Do individual liquor permit systems help Indigenous communities to manage alcohol? *Drug and Alcohol Review* 38: 766–773. https://doi.org/10.1111/dar.12994.

Fitzgerald, Tony. 2001. Cape York Justice Study – Digest. *Australian Indigenous Law Reporter 104*, 6: unpaginated.

Genosko, Gary, and Scott Thompson. 2009. *Punched Drunk: Alcohol, Surveillance and the LCBO 1927–1975* (Fernwood Publishing).

Gladman, Douglas J, Ernest M.M. Hunter, Robyn A McDermott, Tony D Merritt, and Fiona J Tulip. 1997. *Study of Injury in Five Cape York Communities* (Australian Institute of Health and Welfare and Queensland Health).

Government of Nunavut. 2016. *Taking Steps to Reduce Alcohol-Related Harm in Nunavut*. Government of Nunavut: Iqaluit, Nunavut.

Hartshorn, Michael. 1995. Urgent action over town drunks. *Centralian Advocate,* 25 November, pp. 1.

Hoy, Wendy E., Robert J. Norman, Beverly G. Hayhurst, and David J. Pugsley. 1997. A health profile of adults in a Northern Territory Aboriginal community, with an emphasis on preventable morbidities. *Australian and New Zealand Journal of Public Health* 21: 121–126.

Martin, D.F. 1993. Autonomy and Relatedness: an ethnography of Wik people of Aurukun, western Cape York peninsula, PhD thesis. Ph.D., Australian National University.

Martin, David. 1998. *The supply of alcohol in remote Aboriginal communities: potential policy directions from Cape York. CAEPR Discussion Paper No. 248.* Canberra: Centre for Aboriginal Economic Policy Research, Australian National University.openresearch-repository.anu.edu.au/handle/1885/145592?mode=full. Accessed 3 June 2021.

McCorquodale, John. 1987. *Aborigines and the Law: A Digest*. Aboriginal Studies Press: Canberra.

McKnight, David. 2002. *From Hunting to Drinking: The devastating effects of alcohol on an Australian Aboriginal community*. Routledge: London.

Mellor, Leonie. 2021. Mornington Island's push to lift alcohol ban to reduce reliance on deadly home brew. *ABC News,* 7 July.

Moore, Elizabeth A. 1994. *Trial Of An Early Detection Instrument for Hazardous Alcohol Consumption in a Rural Aboriginal Community of the Northern Territory*. University of Sydney: Master of Public Health.

Moran, Mark. 2016. *Serious Whitefella Stuff: When Solutions Became the Problem in Indigenous Affairs*. Melbourne University Press: Carlton, Victoria.

Northern Territory Government (Department of Industry Tourism and Trade). 2021. Application for a Liquor Permit in Maningrida. Darwin: Department of Industry, Tourism and Trade, NT Government.

Northern Territory News. 1997. Race row: Stone blasts Aborigines. *Northern Territory News,* 12 April 1997, pp. 1.

Northern Territory of Australia. 2020. *Liquor Act 2019 as in force at 20 November 2020.* Darwin: Northern Territory Government.legislation.nt.gov.au/Legislation/LIQUOR-ACT-2019. Accessed 22 March 2021.

Nunavut Bureau of Statistics. 2018. *Nunavut Quick Facts.* Iqaluit, Nunavut: Government of Nunavut.

Nunavut Liquor Act Review Task Force. 2012. *What We Heard: A Public Consultation Report.*Iqaluit, Nunavut: North Sky Consulting Group Ltd.

Nunavut Liquor Commission. 2018. Liquor enforcement and inspections: Enforcement and Inspection Activity Report. Government of Nunavut. www.gov.nu.ca/finance/information/liquor-enforcement-and-inspections. Accessed 5 July 2018.

Nunavut Liquor Licensing Board. 2018. *Consolidated Liquor Act.*Iqaluit, Nunavut: Government of Nunavut.nllb.ca/governing-documents/liquor-act. Accessed 10 July 2018.

Queensland Department of the Premier and Cabinet. 2001. *Cape York Justice Study Report (3 Vols.).*Brisbane: Department of Premier and Cabinet, Queensland Government. http://www.communityservices.qld.gov.au/community/publications/capeyork.html. Accessed 25 Feb 2010.

Queensland Government. 2002. *Meeting Challenges, Making Choices: The Queensland Government's Response to the Cape York Justice Study* . Brisbane: Queensland Government.

Queensland Government. 2008. *Media release: tougher alcohol restrictions and more help: The way forward for Queensland's Indigenous communities* . Brisbane.

Reilly, Marion. 1982. *Report on Restricted Areas.* Darwin: Northern Territory Liquor Commission.

Room, R. 2012. Individualised control of drinkers: Back to the future? *Contemporary Drug Problems* 39: 311–343.

Shaw, G., M. Brady, and P. d'Abbs. 2015. *Managing Alcohol Consumption: a Review of Licensed Clubs in Remote Communities in the Northern Territory. A Report for the NT Department of Business.* Canberra: Bowchung Pty Ltd. https://justice.nt.gov.au/attorney-general-and-justice/law/managing-alcohol-consumption. Accessed 20 July 2017.

Smail, Stephanie, and Yasmin Jeffery. 2019. NT given federal support for social clubs in Indigenous communities, as Michael Gunner calls for equality. *ABC News,* 29 August.

Smith, Kristen, M. Langton, Richard Chenhall, Penelope Smith, and Shane Bawden. 2019. *The Alcohol Management Plan at Pormpuraaw, Queensland, Australia: an ethnographic community-based study.*Melbourne: University of Melbourne and Foundation for Alcohol Research and Education.

Thaiday, Willie. 1981. *Under The Act* (N.Q. Black Publishing Co. Ltd.: Townsville, Qld.).

Varma, Vijoy K. 1984. Alcohol Control Policy in India. In *Prevention of Alcohol Abuse,* ed. by Peter M. Miller and Ted D. Nirenberg (Plenum Press: New York).

Watson, C., J. Fleming, and K. Alexander. 1988. *A Survey of Drug Use Patterns in Northern Territory Aboriginal Communities: 1986–1987* (Northern Territory Department of Health and Community Services, Drug and Alcohol Bureau: Darwin).

Wood, Darryl S. 2011. Alcohol controls and violence in Nunavut: A comparison of wet and dry communities. *International Journal of Circumpolar Health* 70: 19–28. https://doi.org/10.3402/ijch.v70i1.17801.

Chapter 8
Meeting the Challenge of Fetal Alcohol Spectrum Disorders (FASD)

Artwork by Delvene Cockatoo-Collins

Abstract Fetal Alcohol Spectrum Disorders (FASD) is a major source of neurodevelopmental impairment among both Aboriginal and non-Aboriginal Australians. Its effects are experienced not only by families directly affected, but also in health, education, child protection, youth and criminal justice systems. Nationally, the prevalence of FASD is poorly documented and services for prevention, diagnosis and treatment are inadequately resourced. In the case of remote Aboriginal communities, the challenges inherent in diagnosing FASD are compounded by the costs of delivering specialist services to remote settings. In recent decades, several Aboriginal communities have taken the initiative and developed community-led programs for assessing the prevalence of FASD, creating culturally appropriate education and support services, and developing capacity to diagnose FASD in primary health care settings. This chapter describes these initiatives and considers the implications for other communities and policy-makers.

8.1 Introduction

One of the most significant developments in the first decades of the twenty-first century in Aboriginal alcohol interventions is the concerted attempt mounted in several communities to prevent and diagnose Fetal Alcohol Spectrum Disorders (FASD) and to support impacted individuals and families. In taking a lead in responding to FASD, these communities have arguably moved ahead of much of the mainstream Australian health sector, where FASD remains poorly understood and inadequately treated (The Senate Community Affairs References Committee 2021). In this chapter, we describe recent Aboriginal initiatives and the concerns and aspirations that lie behind them. We begin with some context-setting by summarising recent developments in the clinical criteria and terminology used to define FASD and reviewing what little is known about its prevalence in Australia. We then describe recent initiatives by Aboriginal communities and organisations in documenting, preventing, diagnosing and supporting people affected by FASD.

8.2 What is FASD?

The term *Fetal Alcohol Spectrum Disorders* (FASD) refers to neurodevelopmental and physical impairments that can result from prenatal alcohol exposure (Bower and Elliott 2020: 115–130). Alcohol crosses the placenta and is teratogenic—that is, it can cause malformations in the developing embryo or fetus. As Rendall-Mkosi et al. put it

> Alcohol consumed by the mother at any stage in pregnancy may affect the fetus and result in permanent impairments of growth and brain development problems. The more the mother drinks, the worse the effect is likely to be (Rendall-Mkosi et al. 2008: 5).

No level of alcohol consumption has been shown to be safe during pregnancy, and the current NHMRC alcohol guidelines state that pregnant and breastfeeding women should not consume alcohol (National Health and Medical Research Council

(NHMRC) 2020). FASD can be considered as a 'whole body' condition. The most widely known features are brain-based, affecting areas such as brain structure, cognition, language, memory and impulse control. A small proportion of children also have characteristic facial features: a smooth philtrum—that is, absence of a ridge between the base of the nose and the upper lip; a thin upper lip and small palpebral fissures[1] (Bower and Elliott 2020). Prenatal alcohol exposure can also impact all the developing organs and systems of the body. Research is demonstrating a wide range of physical health problems for children, young people and adults with FASD (Reid et al. 2021). The effects of FASD are irreversible and, in some cases, generate a need for lifelong support. While Australia still lacks reliable data on prevalence, FASD is considered to be the leading cause of preventable birth defects and intellectual disability in Australia (The Senate Community Affairs References Committee 2021, para 1.7). However, as we explore further below, prevention is not simply a matter of persuading individual pregnant women to stop drinking. Efforts to prevent FASD are unlikely to be effective unless the structurally generated inequities that give rise to high levels of FASD in particular settings are addressed (Lyall et al. 2021; May and Gossage 2011; Gonzales et al. 2021).

Australia exhibits high rates of prenatal alcohol exposure compared with other countries. According to data collected through triennial National Drug Strategy Household Surveys, the proportion of women aged 14–49 who abstained from alcohol while pregnant rose from 39.7% in 2007 to 64.6% in 2019. Over the same period, the proportion abstaining while breastfeeding rose from 24.5% in 2007 to 49.2% in 2019 (Australian Institute of Health and Welfare 2020a, c Table 8.14). While these trends are encouraging, they also indicate that around one-third of pregnant women and one-half of breastfeeding women continue to drink alcohol—much higher than Popova et al.'s estimate of the global prevalence of alcohol use during pregnancy of 9.8% (Popova et al. 2017). A review of Australian studies of women's alcohol use during pregnancy conducted by the National Drug Research Institute reported that, contrary to what stigmatising stereotypes might lead one to expect, Australian women who continued to drink while pregnant tended to be older, to have higher incomes, education and socio-economic status, and to live in rural and remote regions (McBride and Ward 2019).

Although alcohol has long been known to have harmful effects on human embryos, the contemporary concept of a syndrome is of more recent origin. (The term 'syndrome', for non-clinical readers, refers to a group of indicators and/or symptoms that occur together, and in doing so, are used to define a medical condition.) The term 'Fetal Alcohol Syndrome (FAS)' was first used in 1973 (Calhoun and Warren 2007; Jones et al. 1973, 1974; Jones and Smith 1973; Lemoine et al. 1968). Since then, the terminology and associated diagnostic criteria have undergone several changes. The *Australian Guide to the diagnosis of FASD*, published in 2016, proposed adoption of FASD as a diagnostic term, with two sub-categories: (1) FASD with three sentinel facial features and (2) FASD with fewer than three sentinel facial features (Bower and Elliott 2020; Bower et al. 2017). The 2016 Guide was updated in February 2020 (Bower and Elliott 2020) and is currently undergoing a more comprehensive review

---

[1] That is, the area between the open eyelids.

by a team from the University of Queensland in collaboration with a wide range of key stakeholders around Australia, due for completion in 2023 (The Senate Community Affairs References Committee 2021, para 4.79). The diagnostic criteria as set out in the updated *Guide* are shown in Box 8.1.[2]

Box 8.1 Diagnostic Criteria for Fetal Alcohol Spectrum Disorders (FASD)
From Bower and Elliott (2020: 5)

FETAL ALCOHOL SPECTRUM DISORDER		
Diagnostic criteria	**Diagnostic categories**	
	FASD with 3 Sentinel Facial Features	FASD with < 3 Sentinel Facial Features
Prenatal alcohol exposure	Confirmed or unknown	Confirmed
Neurodevelopmental domains - Brain structure/Neurology - Motor skills - Cognition - Language - Academic achievement - Memory - Attention - Executive function, including impulse control and hyperactivity - Affect regulation - Adaptive behaviour, - Social skills or social communication	Severe impairment in at least 3 neurodevelopmental domains	Severe impairment in at least 3 neurodevelopmental domains
Sentinel facial features - Short palpebral fissure - Smooth philtrum - Thin upper lip	Presence of 3 sentinel facial features	Presence of 0, 1 or 2 sentinel facial features

Key components of the FASD diagnostic assessment include documentation of:

- History – presenting concerns, obstetric, developmental, medical, mental health, behavioural, social;
- Birth defects – dysmorphic facial features, other major and minor birth defects;
- Adverse prenatal and postnatal exposures, including alcohol;
- Known medical conditions – including genetic syndromes and other disorders;
- Growth

In Table 8.1, the left-hand column lists the three types of diagnostic criteria: prenatal alcohol exposure (confirmed or unknown); neurodevelopmental domains

---

[2] The updated *Australian guide to the diagnosis of FASD* can be downloaded as a single document or in sections from FASD Diagnosis: Australian Guide to the diagnosis of FASD | FASD Hub (retrieved 11 March 2021).

(10 domains listed) and the three sentinel facial features mentioned above. Diagnosis of one or other of the sub-types of FASD hinges on the presence or absence of these criteria. For example, a person exhibiting three sentinel facial features plus severe impairment in at least three neurodevelopmental domains would be diagnosed as 'FASD with three sentinel facial features' even if the mother's alcohol consumption during pregnancy (i.e. prenatal alcohol exposure) was unknown, but if fewer than three sentinel facial features were present, the person would only be categorised as having FASD if the mother was known to have consumed alcohol while pregnant.

8.3 How Big a Problem is FASD in Australia?

Nobody knows how widespread FASD is in the Australian community. This is partly because determining the prevalence of FASD is difficult, for reasons discussed below, and partly because no one to date has made a methodologically robust attempt to estimate its prevalence in the general population (Reid 2018). Indeed, prior to the beginning of the twenty-first century, FASD received little attention in Australia, either among health service providers or policy-makers. This was in contrast to countries such as Canada, the US and South Africa, where the burdens imposed by FASD on individuals, families and sectors such as the education system had begun to be recognised. In 2002, partly in response to concerns expressed by some Aboriginal people about levels of FASD in their own communities, the National Expert Advisory Committee on Alcohol (NEACA) commissioned a literature review and convened a National Fetal Alcohol Syndrome Workshop in Adelaide (O'Leary 2002). Since then, several parliamentary inquiries have taken place, FASD Action Plans have been formulated, funding for diagnostic and support services has increased, and in 2020 Commonwealth, State and Territory governments agreed to make pregnancy warning labels mandatory on alcoholic beverages from 2023.[3] Despite these welcome changes, a House of Representatives Standing Committee inquiry in March 2021 concluded that awareness of FASD was still limited both among health professionals and in the wider community and that existing diagnostic and support services continued to struggle to meet demand (The Senate Community Affairs References Committee 2021).

International research suggests that the prevalence of FASD is higher than previously thought. May et al., drawing on studies conducted in South Africa, Italy and the US, concluded that FASD affected 2%–5% of young school-age children in the US and other Western European countries, with higher rates among disadvantaged populations (May et al. 2009). Lange et al. (2017) conducted a systematic review and meta-analysis of studies that estimated prevalence of FASD among children and youth in general populations, on the basis of which they estimated global prevalence at 7.7 cases per 1,000 population (95% CI 4.9–11.7 per 1,000 population).

---

[3] For a summary of these inquiries and policies, see the report of the Senate Community Affairs References Committee (2021: 1–12).

Three main methods have been used to estimate prevalence of FASD: clinic-based studies, usually conducted in hospital prenatal clinics; passive surveillance studies using administrative datasets such as birth defect registers and perinatal data collection systems, and active case ascertainment methods that involve identifying children with FASD in a given population (Burns et al. 2013). Clinic-based methods allow maternal alcohol consumption to be recorded, something usually not available to passive surveillance studies. However, because FASD is often not diagnosed until several years after a child is born, the method is likely to miss cases. No recent clinic-based studies of FASD have been reported in Australia (Burns et al. 2013). Most Australian studies have been based on passive surveillance. Bower et al. examined cases of birth defects among children born in Western Australia between 1980 and 1997 and recorded in either the WA Birth Defects Registry or the Rural Paediatric Service database (Bower et al. 2000). From these records, they estimated prevalence of FAS as 0.02 per 1,000 live births among non-Aboriginal children and 2.76 per 1,000 live births among Aboriginal children—more than 100 times higher than the non-Aboriginal rate (Bower et al. 2000).

Harris and Bucens (2003) conducted a retrospective review of medical records of children—both Aboriginal and non-Aboriginal—born in the Top End of the Northern Territory between 1990 and 2000. They estimated the prevalence of FASD in the Aboriginal population at 4.7 per 1,000 live births.[4] One surprising finding of the study, given the well-documented high levels of alcohol consumption by non-Aboriginal residents of the NT, was that *no* cases of FASD were identified among non-Aboriginal births (Harris and Bucens 2003).[5] The authors acknowledge that the finding is difficult to explain, but suggest that it may point to what they call 'ascertainment bias'—that is, reluctance on the part of paediatricians to ask non-Aboriginal mothers about their alcohol consumption during pregnancy, and/or to attribute observed signs to mothers' drinking (Harris and Bucens 2003: 531).

Both the WA and the NT studies are thought by the researchers who conducted them to have under-estimated true prevalence of FASD, for reasons discussed below. So too, in all likelihood, did a more recent national study, in which researchers analysed cases of FAS diagnosed by paediatricians and reported to the Australian Paediatric Surveillance Unit (APSU) between January 2001 and December 2004

---

[4] The terms used at the time of Harris and Bucens' study to diagnose and describe FASD differed from those in use today and set out in Box 8.1. Harris and Bucens distinguished 'Full Fetal Alcohol Syndrome (FAS)' which corresponds with 'FASD with 3 sentinel features' in Box 8.1. They also used three other terms to cover diagnoses that today would be incorporated under the umbrella term FASD. These were 'partial FAS', Alcohol Related Neurodevelopmental Disorders' (ARND) and 'Alcohol Related Birth Defects' (ARBD). Harris and Bucens estimated the prevalence of FAS among Aboriginal children in their study at 1.87 per 1,000 live births. The higher estimate of 4.7 per 1,000 live births is based on prevalence of FAS plus the three additional conditions.

[5] In 2007, according to the National Drug Strategy Household Survey, the proportion of females aged 14 and over drinking at 'risky' lifetime risk status in the NT was 17.4% compared with a national figure of 12.1%. A similar disparity prevailed in 2019, with the NT figure at 15.1% compared with a national level of 9.5%. Similar disparities were found for single occasion risk levels (Australian Institute of Health and Welfare 2020b).

inclusive (Elliott et al. 2008). Of 169 cases notified by paediatricians, 92 were classified by the researchers as FAS, partial FAS or suspected FAS.[6] In 60 of these cases (65.2%), the mothers were of Aboriginal and/or Torres Strait Islander descent. Of the 92 cases, only six had been diagnosed at birth. The median age at which children had been diagnosed was 3.26 years, with some diagnoses taking place as late as 12 years of age (Elliott et al. 2008).

Surveillance studies such as these present several problems when estimating prevalence of FASD. Firstly, residents of remote, rural or low socio-economic status communities often have poor access to specialised paediatric and obstetric services. Secondly, diagnosing FASD is a complex task, and the necessary data is often poorly recorded in medical notes (Elliott and Bower 2004). Many of the cases identified by Harris and Bucens in their study, for example, had not previously been diagnosed in the children's medical records (Harris and Bucens 2003). Thirdly, recording of maternal alcohol consumption—a necessary component in diagnosing FASD—is often incomplete or missing altogether in medical records (Burns et al. 2013). A study of paediatricians in Western Australia found that only 23% routinely asked patients about their alcohol use when taking a pregnancy history, and fewer than 5% routinely provided patients with information about the effects of drinking alcohol (Elliott et al. 2006). Fourthly, making a diagnosis in the absence of the facial abnormalities associated with FASD is particularly difficult, as indicators such as growth retardation and central nervous system dysfunction can have other causes besides alcohol exposure (Burns et al. 2013). Finally, clinicians may be poorly informed about FASD and/or unwilling to make a diagnosis for fear of stigmatising mothers and their children. Elliott et al.'s survey of paediatricians in WA (2006) found that only 4.5% considered themselves very prepared for dealing with a patient with FAS. Fewer than one-in-five (18.9%) correctly identified all four essential diagnostic features for FAS. Three-quarters (76.5%) had suspected but not diagnosed FAS, while 12.1% had been convinced of, but not recorded, a diagnosis of FAS. More than two-thirds of paediatricians (69.6%) considered such a diagnosis might be stigmatising. Finally, and perhaps most alarmingly, fewer than half (43.9%) believed that women should abstain from alcohol while pregnant (Elliott et al. 2006).

To date, no national studies have been conducted in Australia using the third and most accurate method—active case ascertainment—to estimate the prevalence of FASD (Reid 2018). The only case ascertainment study conducted to date was initiated in 2009 by two Aboriginal organisations—Marninwarntikura Women's Resource Centre and Nindilingarri Cultural Health Services—in the Fitzroy Valley region of the western Kimberley in WA. As the Australian Medical Association (AMA) noted in a submission to the recent Senate inquiry into FASD, the absence of population-level data on prevalence of FASD has at least two unfortunate consequences. Firstly, it makes it difficult to identify funding needs or priorities or to measure progress in reducing harms generated by FASD. Secondly, because much of the research on FASD that has been done focuses on Aboriginal communities, it fosters a mistaken

---

[6] See footnote 2 above for the meaning of these terms. In this study, cases of ARND and ARBD were excluded (Elliott et al. 2008).

notion that FASD is solely an Aboriginal problem (Australian Medical Association 2019).

8.4   Conducting a Community Prevalence Study

The 2009 decision by Aboriginal organisations in Fitzroy Valley to conduct a case ascertainment-based FASD prevalence study arose in the context of the 'breathing space' that had been created by the introduction of restrictions on local sales of take-away alcohol in 2007, described in the case study reproduced above as Chap. 6. Box 8.2 contains another extract from the same report, recounting the steps taken in developing a community-based FASD strategy, and the central place of the prevalence study in the strategy.

> **Box 8.2 Designing a Community-Based Fetal Alcohol Spectrum Disorders (FASD) Strategy**
>
> Edited extract from Aboriginal and Torres Strait Islander Social Justice Commissioner 2010 Social Justice Report (2011: 93–105).
>
> FASD has been an issue of concern for Fitzroy Valley residents for some time. It was discussed at a community meeting on alcohol and other drugs in 2004.[7] However, it took the advent of the alcohol restrictions to unite the communities into taking action.
>
> In October 2008, just over a year after the alcohol restrictions were brought into the Fitzroy Valley, members of the communities gathered to discuss FASD and other alcohol-related problems. The meeting was led by Aboriginal organisations Marninwarntikura and Nindilingarri Cultural Health Services. Community members voiced their concerns that many children and families were suffering from the effects of FASD and Early Life Trauma (ELT). ELT is a term used to describe the environmental factors that can negatively impact on a child's development. Poor nutrition, neglect, and exposure to violence and stress can all lead to ELT. Meeting participants agreed to a multi-pronged strategy of action to address these challenging issues (Latimer et al. 2010).

---

[7] E Carter, meeting with the Aboriginal and Torres Strait Islander Social Justice Commissioner, Fitzroy Crossing, 2 August 2010.

In November 2008, a coalition of government agencies, business and community organisations formed a 'Circle of Friends'. All parties pledged in-principle support to a FASD/ELT strategy and action plan. Below is a diagrammatical representation of the 'Circle of Friends' (Fig. 8.1).
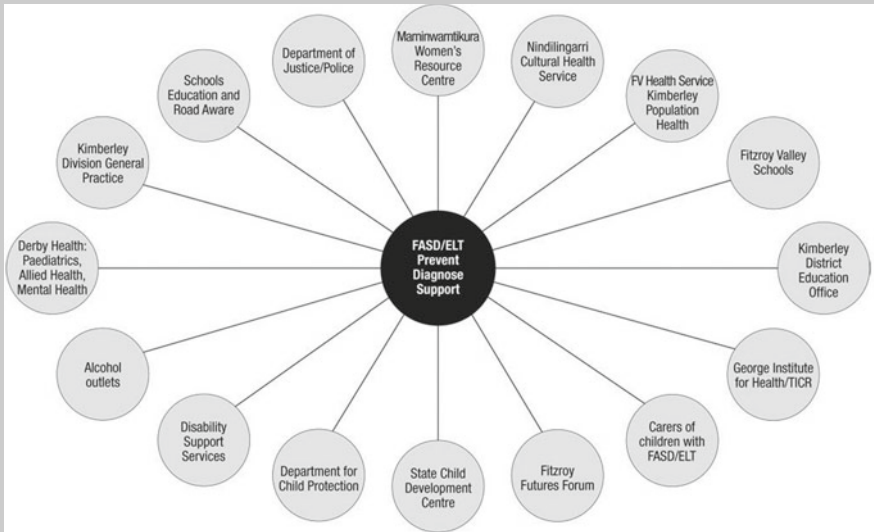
Fig. 8.1 A Circle of Friends

All participants in the Circle of Friends are actively involved in the development and implementation of the FASD/ELT Strategy that was endorsed by the FASD leadership team.

The Marulu Project

In November 2008, a draft strategy was developed by the CEO of Marninwarntikura, June Oscar, and Dr James Fitzpatrick, a paediatric trainee serving the communities. The strategy was called *Overcoming Fetal Alcohol Spectrum Disorders (FASD) and Early Life Trauma (ELT) in the Fitzroy Valley*: *a community initiative*. This strategy is now described locally as the *Marulu Project*. Marulu is a Bunuba word meaning 'precious, worth nurturing' (Latimer et al. 2010: vi).

Nindilingarri is the head of a leadership team guiding the project. The *Marulu Project* has a number of areas of focus:

- Prevention—including consulting with the communities to raise awareness of the *Marulu Project*, education across the communities and working with women who are pregnant to prevent alcohol use.

- Diagnosis—including the development of screening and diagnostic processes.
- Support—including mapping the support services in the Valley and developing a network of carers.
- High level dialogue—including strategic use of media, contributing to scientific discussions on FASD, and raising the profile of FASD through strategic partnerships.
- Build local capacity—including participation in relevant workshops and conferences and capturing the process of the project.
- Focus resources—identify and leverage existing resources, approach government and other funders to secure targeted funding for the strategy, and engage local community resources in FASD prevention, support and diagnosis (Latimer et al. 2010).

Below is a schematic overview outlining the journey in developing the *Marulu Project* (Fig. 8.2).

Fig. 8.2 Schematic of the *Marulu Project*[8]

---

[8] The Marulu project team: M Carter, J Oscar, E Elliott, J Latimer, J Fitzpatrick, M Ferreira, M Kefford.

Nindilingarri uses the Fitzroy Futures Forum meetings to report to the communities, government and businesses on the progress of the *Marulu* Project (Latimer et al. 2010).

Working with trusted partners

> In Fitzroy we bring people in when we identify a problem and a need, rather than people coming in and telling us our problems and our needs. It is about forming strategic partnerships with government and the corporate sector. It is about asking for help but that is strategic and targeted help.[9]

In 2009, the *Marulu Project* leadership group began discussions with researchers from the George Institute for Global Health (The George Institute) about the possibility of conducting a prevalence study of FASD in the Fitzroy Valley. The rationale for conducting a prevalence study was to understand how many children were affected by FASD and to attract funding and resources to manage these children, and prevent FASD. Funding would only be forthcoming once there was a strong evidence base.[10]

The *Marulu Project* leadership team identified The George Institute as the most appropriate organisation to provide technical and other expertise to the project. The George Institute had previously developed relationships with the communities in producing a documentary, *Yajilarra*. The documentary told the story of alcohol restrictions in Fitzroy Valley. *Yajilarra* was a solid foundation for further partnership with The George Institute:

> Because of the relationship The George knew about the people they were working with. That is the big difference, it is always the academics that had seen a problem and tell the people 'we are doing it my way'. This is totally different, here the Aboriginal people said FASD was a problem and we worked with The George Institute on the project.[11]

The George Institute engaged an expert paediatrician, Professor Elizabeth Elliott from The University of Sydney, to provide clinical expertise on FASD and sought approval from the leadership team for her involvement in the project.[12] The current research team includes Nindilingarri, The George Institute, and the Sydney University Medical School at The University of Sydney. Maureen Carter (community member and CEO of Nindilingarri) leads the team that includes June Oscar (community member and CEO of Marninwarntikura), Professors Jane Latimer (The George Institute) and Elizabeth Elliott (Sydney Medical School, The University of Sydney), Dr Manuela Ferreira (Faculty of Health Sciences, The University of Sydney) and paediatric senior registrar Dr James Fitzpatrick.

Community consent

The prevalence study is known as the *Lililwan Project*. Lililwan is a Kriol word meaning 'all the little ones' (Latimer et al. 2010: vi). The prevalence

study focuses on children in the Valley aged seven and eight years. The entire study, from the decision to proceed with it through to actual participation, employs an informed consent process.

The research team was invited to consult with the communities and service providers in the Fitzroy Valley between 19 and 23 October 2009. Members of the consultation team who were not from the Valley undertook cultural awareness training. The consultations were conducted in a range of formats including community forums, planned meetings with key stakeholders and informal meetings. All relevant information about the prevalence study, its aims, methods and possible outcomes was transmitted to the communities. Importantly, a full explanation of the possible risks associated with undertaking this research project was clearly explained. Follow-up consultations were had with the Fitzroy Futures Forum and regional government agencies. This consultation process has been documented in *Marulu: The Lililwan Project Fetal Alcohol Spectrum Disorders (FASD) Prevalence Study in the Fitzroy Valley: A Community Consultation*, which includes summaries and recommendations from each of the consultation sessions (Latimer et al. 2010).

The consultations showed overwhelming support to proceed with a prevalence study from all stakeholders, including the Aboriginal communities and service providers. The widespread feeling was that this study would be an integral component to addressing FASD in the Valley. The community-led nature of this project and the continuing engagement through public forums like the Fitzroy Futures Forum ensured that the residents were kept up to date and were fully informed about the proposed prevalence study. This was fundamental to obtaining consent to proceed with the FASD prevalence study.[13]

This research project is setting an example to the rest of Australia of how best to approach Indigenous affairs. A process guided by a relationship underpinned by meaningful, respectful engagement and collaboration will always be more effective and successful than one that is not. Harnessing this way of thinking and operating opens a myriad of opportunities to address difficult and sensitive issues in Aboriginal and Torres Strait Islander communities.

Having received informed consent to proceed with the project, the research team set out designing the study. Associate Professor Jane Latimer of The George Institute, described this process:

> So then we started to design the study with the community. We would teleconference each week and we would design it a bit more. From our end we had ethics committees to go through.[14]

Maureen Carter, CEO of Nindilingarri and community member, outlined her perspective of the project's development:

> We would look at information given to us by The George Institute but we could sit with them to change the words to make it culturally appropriate. We put the research into our context but it still had to fit within the ethical guidelines of The George.[15]

The project is designed to incorporate necessary elements of Indigenous culture and knowledge as well as meeting the requirements of Western research ethics standards. For example, the parent/carer questionnaire developed by Professor Elliott and Dr Fitzpatrick was modified extensively following consultations with Fitzroy Valley residents and the Kimberley Interpreting Service to ensure its content and language were culturally appropriate.[16]

The *Lililwan Project* is guided by a set of principles and preconditions that are relevant to each phase of the project. These are:

Principles

1. First, do no harm.
2. Commit to a process of two-way learning.
3. All activity must deliver short and longer term benefits for the communities.
4. Informed participation and consent must be ensured through the sharing of information and knowledge.
5. All activities must preserve the dignity of participating individuals and communities.

Preconditions

1. Clear and broad informed consent from

   a. the communities broadly
   b. local service providers.

2. Local Control—The Project Leadership Team must be, and perceived to be by the communities as being, in control of the study.
3. An appropriate and adequate workforce (Latimer et al. 2010: 17–18).

The project was divided into two discrete stages to ensure that the communities are comfortable with the sensitive process:

[9] J Oscar, meeting with the Aboriginal and Torres Strait Islander Social Justice Commissioner, Broome, 3 August 2010.

[10] J Latimer, The George Institute, meeting with the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, Sydney, 22 July 2010.

[11] M Carter, meeting with the Aboriginal and Torres Strait Islander Social Justice Commissioner, Fitzroy Crossing, 2 August 2010.

[12] J Latimer, meeting with the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, Sydney, 22 July 2010.

[13] J Latimer, meeting with the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, Sydney, 22 July 2010.

[14] J Latimer, meeting with the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, Sydney, 22 July 2010.

[15] M Carter, meeting with the Aboriginal and Torres Strait Islander Social Justice Commissioner, Fitzroy Crossing, 2 August 2010.

Stage 1. Collection of demographic, prenatal and early childhood data from parents/carers using a diagnostic checklist and review of medical records. This involves interviews with parents/carers including questions on the drinking patterns of mothers during pregnancy and the development patterns of children.

Stage 2. Health and developmental screening, opportunistic treatment and referral. This includes medical and allied health examinations of all children born in 2002 and 2003 to estimate the prevalence of FASD.

This study will provide an individual assessment of children and estimate the prevalence of FASD in the Valley. The data from the project will stay with the Kimberley Population Health Unit. The study was designed so that it did not simply diagnose children and leave them in limbo. A care plan will be developed for every child with identifiable problems and ensure they are referred for appropriate and ongoing care. The study will also use the principal findings to advocate for better health and education services. The evidence-base generated can be used by governments to develop a targeted service response to FASD in the Fitzroy Valley.[17]

Continuing consent in action

Ongoing consent is a precondition of the *Lililwan Project*. Therefore, all participants in the study are to give their informed consent throughout the life of the project and before any new developments are undertaken.

In April 2010, the research team began Stage 1 of the *Lililwan Project*. This involved interviews with mothers and carers of seven and eight-year-old children in the Valley. The research team was led by two 'community navigators':

> We had Aboriginal navigators to help locate the people. These navigators were chosen because of their standing in the community. We had a male and a female navigator, so it was culturally appropriate. Going in with people who know the community meant we gave the researchers information about the families that might be relevant. You know if there had been a loss. The project was done at the pace of the community and that is key. We met with the right significant people in each community first. The researchers were led by the community navigators.[18]

The use of the navigators was an essential component of the continuing consent process. Most of the interviews were conducted by the navigators in conjunction with Dr James Fitzpatrick and Ms Meredith Kefford, a volunteer with Indigenous Community Volunteers, who were both well known in the Fitzroy Valley.

Even though Nindilingarri had been given a strong mandate to proceed with the *Lililwan Project* from the community consultations, obtaining the informed consent from individual families was a fundamental component of Stage 1.

> Women are giving you the most sensitive data in the information they provide as part of this research. This information is so incredibly sensitive in relation to terminations

of pregnancies, in relation to drug and alcohol use. It is the most sensitive data in their lives. We wanted to make sure no one was coerced in any way.[19]

The consent processes were embedded into the fabric of the project. Consent was sought at every step of the project to ensure participants were not being coerced or did not understand what their involvement entailed.

We wanted to make absolutely sure we were not coercing people in any way, shape or form. So we organised for a senior partner from Blake Dawson to travel with us to be an independent expert in consent and made sure he thought the way we were storing the data and gaining consent from people was the best practice we could have and there was nothing more we could do. It meant there was no risk of coercing people.[20]

When the researchers went out into the communities they would go in and have a barbeque and get introduced to the community by the navigators. With this issue [FASD and drinking alcohol during pregnancy] our people will not talk straight away, they have to get to know you. They have to have time to think about these things before they said yes or no to be involved in the research. We gave them time to think.[21]

As with any research project, the research team had to apply for permission from an identified human research ethics committee to conduct the study and to have the study design, parent information sheet, consent form, questionnaire and clinical assessment process approved.

In the case of the *Lililwan Project,* this involved not only the University ethics committee (University of Sydney Human Research Ethics Committee) but also the relevant committee in Western Australia (Western Australia Country Health Service Board Research Ethics Committee) and the Western Australian Aboriginal Health Information and Ethics Committee. In addition, all research conducted in the Kimberley must be approved by the Kimberley Research Subcommittee of the Kimberley Aboriginal Health Planning Forum. This committee was established in 2006 to ensure that research conducted in the region that might include Indigenous peoples was coordinated, that the people of the Kimberley would derive the maximum possible benefit from any research conducted there, and that any adverse impact of the research on either the community or its health services would be kept to a minimum.[22] Each part of the *Liliwan Project* will go through this arduous—but absolutely essential and extremely helpful—process.[23]

Data collection for Stage 1 was completed by the end of August 2010.

---

[16] E Elliott, Sydney Medical School, The University of Sydney, meeting with the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, Sydney, 25 October 2010.

[17] E Elliott, Sydney Medical School, The University of Sydney, meeting with the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, Sydney, 25 October 2010.

[18] M Carter, meeting with the Aboriginal and Torres Strait Islander Social Justice Commissioner, Fitzroy Crossing, 2 August 2010.

[19] J Latimer, meeting with the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, Sydney, 22 July 2010.

The success of the *Lililwan Project* so far is testimony to the careful investment in partnership, consultation, negotiation and consent.

> So now we have completed Stage 1 and we know that the entire population of children born in 2002 or 2003 across the Valley is approximately 138 children. Of these, we were able to access and contact 132 and 95% of them gave their permission to be interviewed. So we know that the data we will have is representative of the entire population.[24]

In addition to high participation rates, the research team reports that Stage 1 of the project has produced high-quality data.[25]

The community driven nature of the *Lililwan Project*, with consent processes embedded into its fabric, provides strong evidence that, when empowered to do so, Indigenous communities can address their most sensitive and difficult issues.

Postscript

As indicated earlier, the above account was written in 2011. Since then, the Lililwan project has received funding from philanthropic sources, the (then) Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and the National Health and Medical Research Council (NHMRC Project Grant 1024474). The Stage 2 study was conducted, and results have been reported in several publications including Fitzpatrick et al. (2015)*. Further information about the project, including links to other publications, is available at the following websites:*

- https://www.marulustrategy.com.au/pages/research-and-reports
- https://www.fasdhub.org.au/research-and-publications/research-projects/Lililwan-project-FASD0-prevalence-study/.

The Marulu Strategy is ongoing; it remains the most comprehensive, community-led intervention anywhere in Australia for preventing and managing FASD and providing support to families with FASD-affected children. As the Social Justice

---

[20] J Latimer, meeting with the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, Sydney, 22 July 2010.

[21] M Carter, meeting with the Aboriginal and Torres Strait Islander Social Justice Commissioner, Fitzroy Crossing, 2 August 2010.

[22] Kimberley Aboriginal Health Planning Forum (KAHPF), Kimberley Research Subcommittee, http://kams.org.au/research/kimberley-research-subcommittee/ (retrieved 30 January 2020).

[23] E Elliott, meeting with the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, Sydney, 25 October 2010.

[24] J Latimer, interview with the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, Sydney, 22 July 2010.

[25] J Latimer, interview with the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, Sydney, 22 July 2010.

Commissioner points out in the extract above, in many respects, it provides a model for other communities.

Among children completing Stage Two of the prevalence study, a diagnosis of FASD was made in 19.4% of cases. As the researchers note, this is comparable to findings from disadvantaged populations in South Africa and elsewhere, but far higher than prevalence levels estimated from other Australian studies that, as we have seen, have relied on passive surveillance methods (Fitzpatrick et al. 2017a). The study also found high levels of neurodevelopmental impairment, with 32% having impairment in three or more domains, including executive function, academic achievement and ADHD/sensory problems. Impairment was found in cases both with and without prenatal alcohol exposure, a finding that the researchers tentatively attributed to two factors: possible under-reporting of prenatal alcohol exposure, and the impact of other stress factors in the community. Notably, evidence of early life trauma was found to be 'almost universally prevalent' among study participants (Fitzpatrick et al. 2017a: 123).

The researchers consider the findings likely to be generalisable to other remote communities with similar patterns of alcohol consumption. On a more positive note, they also point out that prevalence of FASD in the Fitzroy Valley among younger children than those taking part in this study may have declined as a result of the restrictions on sales of take-away alcohol introduced under community leadership in 2007.

Apart from marking an important addition to the evidence-base about prevalence of FASD in remote Aboriginal communities, the *Lililwan* study has at least three other implications that warrant noting. Firstly, it demonstrates that research involving the methodologically rigorous collection of quantitative as well as qualitative data is not necessarily incompatible with respect for Aboriginal culture and Aboriginal ways of knowing, as is sometimes claimed. The key issues, in our view, are the *research procedures* through which the research is conducted and the *relationships* linking all of the participants involved in the project, including research subjects, community organisations and the researchers and the organisations with which they are affiliated. In the *Lililwan* project and the *Marulu* strategy of which it is part, community organisations have been actively involved in every stage of the project.

Secondly, the *Lililwan* project and the way in which its findings have been disseminated also demonstrate that 'bad news' does not have to be concealed or glossed in order to protect those to whom it refers. A FASD prevalence rate of 19.4% is, by any reckoning, disturbing, but the way in which it has been derived and 'owned' by the communities in the Fitzroy Valley has meant that it is not yet another statistic confirming poor Aboriginal health status, but rather evidence of communities having the courage to acknowledge a problem and set about collecting the information needed to address it in a sustainable way. Taking control of a problem in this way is arguably an act of self-empowerment. Elsewhere in this chapter we describe one of the strategies that has subsequently been developed in the Fitzroy Valley for managing challenges generated by FASD.

Finally, the high prevalence of FASD brought to light by the *Lililwan* project adds weight to the calls by the recent Senate inquiry, the AMA and numerous

other bodies for a properly funded national prevalence study using a case ascertainment method (Australian Medical Association (AMA) 2019; The Senate Community Affairs References Committee 2021).

Prevalence of FASD appears to be high in other subpopulations besides Aboriginal people. Popova et al. (2019) conducted an international systematic review and meta-analysis of studies of FASD in five subpopulations: children in care, correctional facilities, special education, specialised clinical populations and Aboriginal peoples. They estimated the prevalence of FASD in these subpopulations as 10–40 times higher than the global prevalence estimate of 7.7 per 1,000 population derived by Lange et al. and cited above (Lange et al. 2017; Popova et al. 2019).

In Australia, the prevalence of FASD in the justice system is unknown. However, a study of young people aged 10 to 17 years 11 months held in Western Australia's only detention centre found that 36% of study participants had FASD—the highest reported prevalence of FASD in a youth justice setting anywhere in the world (Bower et al. 2018). In this study, participants were clinically assessed by a multidisciplinary team following the Australian Guide to the Diagnosis of FASD (Bower and Elliott 2020). A total of 99 young people completed the assessment (60% of those originally approached to take part), 74% of whom were Aboriginal. All of those diagnosed with FASD were assessed as having neurodevelopmental impairment in three or more domains. Amongst those diagnosed in the study, only two had previously been diagnosed as having FASD. Even in the absence of more comprehensive prevalence data, these findings have significant implications for policing practices, legal processes and sentencing (Elliott and Bower 2019).

8.5   The Unknown Impact of FASD

In the absence of accurate prevalence data, the true impact of FASD in the community is difficult to determine. A study in Alberta, Canada, based on all inpatients, outpatients and practitioner claims on the provincial database from 2003 to 2012 found that the life expectancy at birth of people with FAS was just 34 years—about 42% of that of the general population (Thanh and Jonsson 2016). The leading causes of death were 'external causes' including suicide (15%), accidents (14%) and poisoning by illegal drugs or alcohol (7%).

In addition to the neurodevelopmental impairments associated with FASD, people born with FASD are at heightened risk of physical diseases including heart defects, kidney failure, hearing loss, gastroenteritis, pneumonia, bronchitis, epilepsy, sleeplessness, and bone and joint problems, and also at higher risk of dropping out of school, unemployment, homelessness, alcohol and other drug misuse, and involvement with the criminal justice system (Jonsson 2019).

In the remaining sections of this chapter, we look at community-based initiatives by Aboriginal communities and groups focusing on the prevention, diagnosis and support and management of FASD.

8.6 Preventing FASD in Aboriginal Communities

Since the damage wrought by FASD is irreversible, prevention must be a priority in any strategy addressing FASD. While this might sound like stating the obvious, the obvious in this case comes with three important qualifications. The first is that prevention is not simply a matter of providing educational resources and urging pregnant women not to drink alcohol. The roots of FASD in Aboriginal communities run deep, as Lorian Hayes' analysis, reprinted in Box 8.2, demonstrates. Secondly, because FASD is linked to broader issues, attempts to prevent FASD in Aboriginal communities must be situated in a broader strategy for reducing alcohol-related harms in the community, as the Alice Springs-based Central Australian Aboriginal Congress argued in its submission to the recent Senate Committee inquiry (Central Australian Aboriginal Congress 2019; The Senate Community Affairs References Committee 2021). Pregnant women are unlikely to heed calls to stop drinking if the sources of supply of, and demand for, alcohol around them remain unchanged, and they are pressured by friends and family to drink. Thirdly, strategies for preventing FASD must be led by communities or community groups. This is not to imply that communities on their own can be expected to prevent or manage FASD; on the contrary, addressing FASD, as examples in this section show, requires many kinds of expertise. At the same time, addressing FASD requires genuine community engagement, and that is unlikely to occur unless communities and their agencies have a lead role in defining and prioritising issues and devising interventions. Gonzales et al., writing about American Indian and Alaskan Native communities, argue that two common features of interventions aimed at preventing FASD are, firstly, low engagement by women of childbearing age and their partners and, secondly, limited community input into programs (Gonzales et al. 2021). They call for greater attention to the historical and structural precursors to harmful alcohol use, and greater acknowledgement of the protective powers of indigenous cultures.

In Canada, experts have developed a four-level framework for organising the resources and programs required to prevent FASD. The levels are

1. Awareness building and health promotion;
2. Conversations about alcohol use with all women of childbearing age, and their partners and networks;
3. Specialised support for pregnant women and
4. Postpartum support for new mothers (Poole et al. 2016).

Lorian Hayes' 'life cycle framework' for understanding the wellsprings of drinking during pregnancy in an Aboriginal community depicts the complex interplay of factors that give rise to intergenerational FASD. Dr Hayes is a Bidjara woman from central western Queensland who has spent several decades working with women and communities. She situates both early pregnancy and alcohol use within a culture permeated by collective intergenerational trauma. Her account is bleak and confronting, and it is important to be clear that it does not apply to all women (many of whom do not drink alcohol) or all communities. It might even

be argued that, given a long history of focusing on Aboriginal 'problems', there is nothing to be gained by publishing yet another graphic account of the consequences of alcohol misuse in Aboriginal communities. We believe that in this instance the potential gains from publishing her account are important. Hayes combines Western research frameworks with Aboriginal ways of knowing to show how historical, political and cultural factors intersect in the lived experiences of Aboriginal children and young people today as they navigate the world they have inherited.

Box 8.3 Aboriginal Women, Alcohol and the Road to Fetal Alcohol Spectrum Disorders

Edited extract from Hayes (2012)

> The girls don't drink much; 'bout the same as the fellas

I am an Aboriginal woman, with traditional connections to the Bidjara people from central western Queensland and extensive experience in working with Aboriginal women who consume alcohol during pregnancy.

During several decades of working in the health field, I have asked myself and others why Aboriginal people drink alcohol at such dangerous levels.

I believe that the historical and political background and the cultural aspects of drinking have been insufficiently considered. There is an entrenched expectation of Aboriginal community members that to drink is an expression of identity and culture.

It is unrealistic to expect that individuals can take responsibility for their own actions outside the context of their cultural environment. Programs aimed at changing individual risky behaviour fail to acknowledge the way in which the person is inextricably tied to the culture in which he or she exists.

In many communities, alcohol use is a familiar and embedded practice that spans generations as well as individual lifetimes, from before birth to death. Its consequences are difficult to escape, whether a given person actually drinks or not (Hayes 1998).

Some years ago, with input from a number of Aboriginal community members, I constructed a framework to assist in understanding the development of identity and the resulting changes of emotions and physical boundaries across the lifespan (Hayes 1998).

Using this framework, I have proposed an expanded view on the use of alcohol in Indigenous communities (Hayes 1998) formulated through interviews and discussions with members of remote, rural and urban Aboriginal communities in Queensland. This was originally done in the context of trying to better understand Fetal Alcohol Spectrum Disorders and Early Life Trauma.

In this essay I use a narrative format to display dialogue, because objectivity of the "interviewer" and distance from the respondents' responses is not

consistent with Aboriginal ways of knowing. Understanding the intersubjectivity between the author as an Aboriginal woman and the people whose input contributed to this report made possible the interactions and insights that follow. The impressions and conclusions should not be rejected on the grounds that the approach varied from more Westernised sociological research methods.

For many Aboriginal women, alcohol, like pregnancy, is a normal part of the life cycle.

During my research, young women and young men spoke honestly about the perceived relationship between alcohol and pregnancy, alcohol and drugs, and alcohol and crime, violence and abuse—all of which they associated with their families, relationships, friends and daily environment.

Within this life cycle the relationship between alcohol and pregnancy was revealed to be more complex than the physical effects of either. Young people strongly confirmed their connection with their toxic social environment and were aware of the hardships and disadvantages that confront them daily. The issues they identified were family breakdown; community disharmony; family and community dysfunction; alcohol and drug addiction; teenage pregnancy; peer pressure; violence within the home and community; unemployment; shame, pain and anger within; a sense of isolation and not belonging; lack of trust and respect from family, friends and peers; the high incidence of rape and sexual abuse; and the lack of opportunities to gain education and training within the community.

My proposed life cycle framework or model broadens the Western approach and integrates with cultural constructionist theories to give a clearer understanding of alcohol use (Hayes 1998).

The following story-lines provide examples of how interview respondents conceptualise their own or others' health status in terms of historical, cultural and systemic impediments.

Stamping the story on the kids (age 0–2 years)

The early years will shape the life's journey for many children who were not only exposed to alcohol in utero, but were also born into an environment that was awash with alcohol and violence.

If basic human needs are met through nurturing and responsible care, children will develop hopefulness, cheerfulness, trust, confidence and security. If children do not have caring experiences, they will develop insecurity, a feeling of worthlessness and general mistrust.

Although few individuals remember explicit stories from their lives before the age of 24 months, experiences within this period are generally accepted as having a significant impact on the development of emotional and psychological wellbeing.

The disappearing childhood (age 3–5 years)

It is during the ages of 3–5 years that children begin to retain strong memories that continue to provide background to their emotions in later life. Generally, children develop responsibility for self-sufficiency between the ages of 3 and 5. An important aspect of this is the development of trust. Trust in adults and their ability to ensure one's safety in a crisis is the earliest form of faith. If caregivers are inconsistent in satisfying a child's needs, the child will not develop this sense of trust, faith and hope (Erikson 1968).

Children whose needs are not met feel that they have been abandoned by their carers, as depicted in the story below.

Story 1. Small, alone and scared

When one is a tiny little boy and is sent to bed by his mumma, who is drinking noisily in the next room where the music is loud, then suddenly, all becomes very quiet and still. You pull the blankets up over your head and lie very still because you become really scared. Too scared to move. You lay there thinking "Is the bogeyman's gunna come an get me?" You call out to your mumma and dadda but there is no answer. You suddenly realise that you are all alone in the house. Thoughts wander through your little mind, wondering where is mumma and dadda? Where are they? Why don't they hear my call? They must know I am scared? What should I do now? Should I stay here or should I try and run to find my nanna's or auntie's place? It is very dark outside. I awake to hear a very loud crash and yelling — people fighting. My uncle then comes in and carries me over to my nanna's house. Here I know that I am safe. There is no reason to be scared anymore (Hayes 2001).

Interviewees reported feeling alone as a child, even when surrounded by adults drinking and partying, resulting in the child feeling unimportant as an individual. As these children grew older, they told of becoming more dependent on friends and peers for acceptance; their behaviour mimicking that of the adults around them and the peers for whose attention they aspired. Sometimes they reported an extraordinary sense of isolation related to what they perceived as a breakdown of their cultural identity, as well as the lack of mutual respect between older and younger community members, creating a sense of shame.

The "walk-the-talk" stage (age 6–8 years)

Between the ages of 6 and 8 years, the child develops a sense of responsibility for self-care and care of others. In crisis situations where the adult does not provide an environment of safety, a child may take on the responsibility of care for younger children.

Story 2. The protective older child

As a child who lived in a home where there is lots of violence, bashings and too much grog, because I was the bigger kid I used to get all the smaller kids in a room and we would lock the door and go into the corner and huddle together, we would cover our ears and cry and I would rock to try and silence the noise and screams from my mum asking my dad to stop. I am now in my early twenties and I don't rock anymore. Loud

noises still frighten us kids; we were so scared, so very, very scared. Why did our mum and dad do this to us? We had no one to come and take us away to somewhere safe; it was like nobody cared (Hayes 1998).

In addition to the impact on the child, I have observed that when a child takes on a parental role for children younger than him- or herself, including siblings and cousins, this relieves adults of their responsibilities and thus impairs the family's ability to provide nurturing and responsible care.

Feelings of failure (8–11 years)

During the mid-school-age years (8–11 years), children learn about their successes and failures from interactions within their environment. This can be measured in how strong a power base they have built over the younger children and who they control with financial rewards of lollies, drinks and take-away food. The following story depicts the sense of isolation and alienation this brings from a young age.

Story 3. Shame, failure and alienation

Jodie is four years old and has been outside playing with some older kids. Her sisters told her they had to hurry to school, but Jodie knows that they are going to the flats up the road. She wants to follow them and they scream back at her, "Get home you f... little so-and-so". Jodie stops in her tracks. She feels intense shame as she looks about to see if anyone has heard. A group of old men sit smoking in a front yard nearby and they show no sign of acknowledgement. Jodie knows they must have heard. She wanders back home to look for breakfast. As she enters the front door she can smell the stale grog from the night before. There is nothing in the kitchen for her to eat. She notices her mother lying quietly on the couch. Her mother mumbles something about a drink and Jodie climbs onto the kitchen bench to put the kettle on. She feels bad for her mother and worse for herself.

I'm clearin' out" (age 12–13 years).

By the time children reach the youth stage (11–13 years), they begin to mimic the behaviour of adults around them. Then, as young teenagers, they perceive themselves to be (and may be accepted by the community as) true adults.

Story 4. An empty belly

You go to bed quivering with fear and listening to drunks all night. You wake up and there are drunks everywhere, sleeping all around, and some still drinking. You search for food to fill your empty belly before you go to school. Most times there is none. Usually you go to school with an empty belly. You feel tired and you get a pain in your belly from lack of food. You become shy and embarrassed and begin to isolate yourself from others, especially those who have food. You run home at lunchtime hoping that there is some food waiting, but there is never any. When you come home from school, there are drunks still there. You go to bed and the drunks are still there — same old cycle. Eventually, after being exposed to alcohol year after year, you give up and join in, fill your empty belly with grog and become a drunk too (Hayes 2001).

The above account depicts the emotions of a child whose basic needs, such as food, are not met. As the child grows older, he or she begins to realise that survival depends on achieving independence.

The cycle continues (alcohol and pregnancy)

The reasons why women continue to drink alcohol while pregnant are varied and complex. The pregnancy itself is a validation of adult status, as is the consumption of alcohol. At the same time, the pregnancy, often at a young age, is an additional determinant of social disadvantage.

Story 5. A vicious cycle

> *She may have been raped. Especially being young girls, they're trying to heal their own problems. So they look for the first person to come along, looking for good faces. They drink beers an' wine, it is cheaper. Except when they really want to party out and look for a man, they get spirits. They get pregnant and then they forget to stop drinking. They have money problems, which leads to drinking, which leads to pregnancy, which leads to pension, which leads to drinking, which leads to more problems, which leads to more drinking, which leads to more pregnancies — then they can't look after their kids (Hayes* 2001*).*

The strategies described in such stories reflect both dependence and independence. Young women feel isolation and a desire to be loved. A man of their own and a baby can provide adult status, along with money gained through either the relationship or through social security payments. If the relationship becomes violent and/or the man is unsupportive, the drinking resumes and the cycle continues. Under these circumstances, the baby's dependency becomes overwhelming and burdensome.

Story 6. Violence causing harm

> *I don't think they know if anything can happen to the baby. Something might happen when they drink if they are pregnant. Drinking alcohol is a way women try to kill their babies. Some young women get drunk and even try to commit suicide, not just because they are pregnant — there is other abuse too. The person drinks alcohol — becoming angry — and then picks a fight with another woman or a man and becomes involved in a fight — killing the baby one time (Hayes* 2001*).*

In this example, fetal death removes full responsibility from the mother. A community elder told me that removing fault is common, with the woman claiming she does not remember or that it was beyond her control, as she was drunk. Members of the community will in turn come together to support the young woman go through grief at the loss of her child. Both young women and young men whom I interviewed felt that the practice of drinking alcohol when pregnant is seen as a way to kill the baby, either directly or indirectly (by initiating a cycle of violence in the hope that it will cause a miscarriage). They did not otherwise implicate or acknowledge toxic side effects of the alcohol

consumed, and the concept of fetal alcohol syndrome or other fetal alcohol effects was not of concern to them.

A whole range of factors contribute to a cycle in which alcohol is accepted as an inevitable part of life and death. The community does not perceive a special problem with women's drinking, either in amount or in the drinking patterns, manifestations and toxic side effects. Drinking is the expected community norm.

The girls don't drink much; 'bout the same as the fellas (quote from a community member)

Being a drinker is not equivalent to being an Aboriginal. When Aboriginal people enter into a drinking cycle, even the unborn child is affected.

If the cycle of drinking in Aboriginal communities is to be broken, a more effective model for health promotion would be to aim towards acknowledging children who are continually exposed to examples of the negative adult behaviour associated with alcohol. It should be designed to enhance skills in developing positive patterns of behaviour for later life and negating the effects of witnessing irresponsible adult behaviour.

At present, little is known about the effectiveness of preventive interventions for FASD in indigenous communities globally. Symons et al. (2018) conducted a systematic review, limited to studies published in English in peer reviewed journals and reporting results of interventions that examined prenatal alcohol exposure and FASD. Nine of the ten studies that met the review's selection criteria were conducted in the US and involved American Indian and/or Native Alaskan populations. The remaining study was a program developed in the Kimberley region of WA by the Ord Valley Aboriginal Health Service, described below in Sect. 8.6.2 (Bridge 2011). The authors found little evidence that any of the interventions examined were effective in reducing either prenatal alcohol exposure or FASD in the study populations. However, this conclusion was based largely on what the authors considered to be the poor methodological quality of the evaluations rather than the programs themselves (Symons et al. 2018).

The most comprehensive FASD prevention program developed in Australia to date forms part of the *Marulu* strategy referred to in Box 8.2. One component of the strategy, as we have already seen, was a decision to conduct the first case ascertainment FASD prevalence study to be carried out in Australia. Two other strategic priorities emerged from a series of leadership team meetings and community workshops held around the same time: one, a commitment to create a FASD prevention program through community consultation, education and prevention messaging. The program, led by Nindilingarri Cultural Health Services, delivered health promotion and prevention activities to local communities, schools and local liquor outlets. Activities to raise awareness of drug and alcohol issues in schools included inviting primary school children to write stories about the ways in which alcohol affected people's

lives, with the stories subsequently being used in other prevention activities (Fitzpatrick et al. 2017b). The other priority was to provide support to those living with FASD in families, schools and the justice system. Initiatives that emerged in this area are discussed below in Sect. 8.8.

More recently, the community has begun building on the *Lililwan* project by creating the *Bigiswun Kid Project*, aimed at understanding the needs of adolescents affected by FASD by working with participants in the *Lililwan* cohort when they reach the age of 17–18 years (Marninwarntikura Women's Resource Centre 2020).

8.6.1　Apunipima Cape York Health Council Fetal Alcohol Syndrome Project (2002–2006)

Another, early example of a community-based attempt to prevent FASD was the Apunipima Cape York Health Council's Fetal Alcohol Syndrome Project implemented throughout Aboriginal and Torres Strait Islander communities in Cape York, Queensland, between 2002 and 2006 (Apunipima Cape York Health Council 2006). The project was designed to be implemented at three levels: (1) in communities, by raising awareness of the links between alcohol, pregnancy and FASD and increasing the community's capacity to reduce harmful drinking; (2) among service providers in communities, particularly health service providers, by increasing their awareness and capacity to address FASD and (3) at regional and higher policy-making levels, by increasing awareness of, and resources for, preventing FASD.

Implementation was led by a mobile team of Aboriginal and Torres Strait Islander health workers trained in FASD—'the grog baby ladies in the blue shirts', as they reportedly became known (Apunipima Cape York Health Council 2006: 21)—who conducted workshops and small group discussions in communities, utilising a 'health literacy' model of health promotion and education. Health literacy has been defined as possession of literacy and numeracy skills and the ability to perform knowledge-based tasks, such as using health information, that are required to make sound health-related decisions (Nutbeam et al. 2017: 902). The project also used dolls that looked like live babies to demonstrate differences between a healthy baby and a baby born to a mother who drank during pregnancy, providing a concrete illustration that could be passed around among workshop participants. The project also established local FAS Action Groups in communities (Apunipima Cape York Health Council 2006). Although the Apunipima FAS project was evaluated, no outcome data have been published. A report on the project concluded that it increased knowledge about FAS and associated disorders and enhanced capacity both at an individual and community level to prevent FAS (Apunipima Cape York Health Council 2006).

8.6.2   Ord Valley Aboriginal Health Service FASD Program

The single Australian study included in Symons et al.'s (2018) systematic review of preventive FASD interventions in Indigenous communities, referred to above, reported on a program initiated in 2008 in the east Kimberley region of Western Australia by the Kununurra-based Ord Valley Aboriginal Health Service (OVAHS) (Bridge 2011). The initial aim of the program was to document drinking patterns among antenatal clients and identify the needs of these women and their families. A 5-point plan was developed targeting five groups, each of which received an intervention tailored for that group. These were

1. All Aboriginal antenatal women presenting at OVAHS;
2. All Aboriginal women aged 13–45 years in communities served by OVAHS;
3. OVAHS staff;
4. Local Aboriginal men and
5. Local, national and international interest groups and organisations (Bridge 2011).

Over the first 12 months of the FASD program's operation, 78 pregnant women were assessed, 74 of them more than once. Of these, 84.7% reported consuming alcohol at some point during their pregnancy. However, more than half of the women assessed (56.4%) reported abstaining from alcohol following their first FASD education session, and another 14.1% reported reducing their drinking.

One issue that came to be seen as particularly important during the first 12 months of the program's operation was the need to increase understanding of contraception among young women. Of the 78 antenatal women assessed during this time, 70.5% of the pregnancies were reported to be unplanned (Bridge 2011). The program's response is summarised in Box 8.4.

Box 8.4 Alcohol Awareness, Contraception and Preventing FASD
Extract from Bridge (2011: 5)[26]

Dialogue with young women in the community revealed that their knowledge of puberty, menstruation, pregnancy and contraception varied, with a significant number reporting little knowledge of contraception in particular. Given the incidence of early alcohol use among young women (and its resultant impairment of judgement), and their attitudes and norms around consumption, the program has placed considerable emphasis on the promotion of alcohol awareness, contraception and safe sexual practices as part of all brief interventions. Parental monitoring is also addressed separately. In an effort to encourage safer sex, female OVAHS clinic staff routinely ask female clients about their contraception use. A comprehensive puberty and contraception brief intervention resource and interactive contraception workshop was developed with input gained through OVAHS staff and community consultation with the local Aboriginal adolescent women. In addition, a brief intervention flowchart resource was developed

and is used as part of all clinic consultations where appropriate. This opportunistic education is viewed as critical to raising awareness in the community and encouraging higher levels of contraception use.

Another issue was the importance of engaging with men, as the authors explain in Box 8.5.

Box 8.5 The Role of Men in Influencing Maternal Alcohol Choices
Extract from Bridge (2011: 6)[27]

An additional challenge has been the role of men in the community. In some families, women report that men hold the power base and as such strongly influence the choices made regarding alcohol use in their pregnancies. Through conversation with antenatal clients, a number of women identified pressure from their partners as being significant in determining drinking behaviours during pregnancy. The women reported they would like to stop drinking, but were often pressured to stay with their partners in the 'drinking circle' as a show of family loyalty and their commitment and faithfulness to the relationship. Some female clients also report that to remove themselves from this social circle and 'sit' with non-drinking family members or friends, or spend time doing activities such as fishing, potentially results in relationship problems, arguments or even violence. The role men play in the decision-making of some clients was not initially anticipated, but it was recognised early on that the success of the program lay in part in the inclusion and education of men.

Overcoming the perception that pregnancy, and in turn prenatal alcohol exposure, was 'women's business' was challenging in the early stages of the OVAHS FASD program. Fortunately, following the request for FASD education by many male elders in the community, along with efforts to include men in program design and resource generation, the involvement of men in the program has greatly increased. Male focused FASD education workshops and outreach brief intervention are now regular activities of the program. To date, 6 male only workshops and 23 mixed gender workshops or presentations have been conducted locally. Like feedback gained from the women, the majority of men indicated that the FASD information was of great value to themselves, their families and the community. Along with the support of the male Social Support Unit staff, the program fosters FASD awareness and promotes fathering responsibility from conception. Men are also encouraged to take an active role in supporting their partners throughout the pregnancy by cutting down or abstaining from alcohol.

---

[26] The full text of this article is available for download from http://healthbulletin.org.au/wp-content/uploads/2011/10/bulletin_review_bridge_2011.pdf (retrieved 10 May 2021).

8.6.3 *Making FASD History: A Multi-site Prevention Program*

The success of the *Marulu* strategy provided a foundation for the *Making FASD History* multi-site prevention program implemented by Telethon Kids Institute in partnership with community organisations in Alice Springs, NT, and Newcastle, NSW over three years from 2018 to 2020. The aim of the program was to build capacity in local health services to enable them to lead FASD prevention activities into the future. Details of activities conducted in both settings are available at Making FASD History: A multi-site prevention program (telethonkids.org.au). In addition, the Newcastle project has generated a FASD Youth Justice Model of Care Handbook and other resources relating to youth justice and FASD as well as resources for dealing with FASD in the classroom. These too can be accessed at the above link.

Box 8.6 Online FASD Prevention Resources

An extensive range of resources designed to assist in preventing FASD, and suitable for use in Australian Aboriginal communities, is available from several websites. These include the FASD Hub (FASD Hub Australia | FASD Hub) a repository established in 2017 and maintained by a consortium of eight organisations.[28] The Telethon Kids Institute also maintains a website focusing on alcohol and pregnancy—Alcohol and Pregnancy & FASD: Research Subsite (telethonkids.org.au)—that provides links to resources for community groups, schools and health professionals. Further information and resources associated with the *Marulu* strategy in Fitzroy Valley are available at the Marninwarntikura Women's Resource Centre website *Marulu*Strategy—Marninwarntikura Fitzroy Women's Resource Centre (mwrc.com.au).

---

[27] The full text of this article is available for download from http://healthbulletin.org.au/wp-content/uploads/2011/10/bulletin_review_bridge_2011.pdf (retrieved 10 May 2021).

[28] Namely Telethon Kids Institute (Fund holder); University of Sydney; Menzies School of Health Research; University of Queensland; Curtin University; Griffith University; NOFASD Australia; Foundation for Alcohol Research and Education (FARE); Australian and New Zealand FASD Clinical Network; Murdoch Children's Research Institute (MCRI).

8.7   Diagnosing FASD in Aboriginal Communities

Diagnosing FASD is a complex, time-consuming and expensive process requiring multi-disciplinary assessments and specialist skills. Even with all specialists available, a single assessment can take several days. In rural and remote areas, if facilities are available at all, diagnosing FASD can take more than two weeks and require travel and extra support staff to arrange appointments and contact with families (The Senate Community Affairs References Committee 2021: 66). The Senate Community Affairs References Committee described access to FASD diagnostic services in Australia as 'fragmented, poorly-funded and lacking in a whole of government approach' (The Senate Community Affairs References Committee 2021: 84). As the Committee noted, timely diagnosis is an essential precondition for early intervention addressing specific areas of need. Conversely, delays in diagnosis can lead to an escalation of health and behavioural problems which in turn can generate problems at school and, in some cases, contact with the justice system (Public Health Association Australia 2019).

The National FASD Strategic Action Plan 2018–2028 identified access to screening and diagnostic services in rural and remote locations as a crucial issue, particularly for Indigenous communities, and envisaged primary health care providers as playing a key role in improving access (Commonwealth of Australia (Department of Health) 2018: 21). Two recent initiatives have sought to overcome the barriers of distance and remoteness by embedding FASD assessments in primary health care settings, reserving specialist services for the more complex cases. One is the Yapatjarrathati project in Queensland, a collaborative venture led by Griffith University and Gidgee Healing—an Aboriginal community-controlled health service in north west Queensland—and involving the University of Queensland, Gold Coast Hospital and Health Service, Sunshine Coast Hospital and Health Service, and North West Health.

The Yapatjarrathati project has three components (Shanley et al. 2019). The first involves the co-creation of a culturally sensitive neurodevelopmental assessment process composed of six tiers. The second covers the development of resources for training remote practitioners with varying levels of experience in using the tiered assessment process, and the third involves implementing the process in a remote Aboriginal community and evaluating outcomes (Shanley et al. 2019). The tiered process was co-created by project participants who combined material from FASD literature and practice guidelines with culturally appropriate materials and themes that emerged through 'yarning circles'. The tiers are

- Tier 1: A dreamtime story, created for the project, explaining the assessment process and support strategies and seeking informed consent to take part.
- Tier 2: A culturally sensitive developmental interview, which includes a measure of alcohol use during pregnancy (AUDIT-C), and physical measurements.
- Tier 3: Administration of the Rapid Neuro-Developmental Assessment (RNDA) (Kahn and Muslima 2012), an assessment that screens for vision and hearing

problems and seven of the ten neurodevelopmental domains required to assess FASD.

- Tier 4: Collecting collateral information from a caregiver and teacher about attention, executive functioning, affect regulation and adaptive functioning.
- Tier 5: Collating information for an initial case formulation and commencing planning of evidence-based intervention strategies.
- Tier 6: Where required, 'drilling down' to provide more in-depth assessment of any of the ten neurodevelopmental domains by specialists (Shanley et al. 2019).[29]

Tiers 1–4 are designed to be administered by community-based practitioners, including Aboriginal Health Workers, early childhood educators, youth workers and child safety officers, enabling the assessment process to begin in family homes and schools rather than specialised medical settings, and allowing specialist services to focus on the most severe and/or complex cases.

The Yapatjarrathati project was initially funded under a three-year grant commencing in 2018 and has since received further funding, under which it is expected to be implemented further in partnership with Gidgee Healing.[30] To date, an online 'train the trainer' course has been developed for instructing people in using the tiered assessment process. Additionally, the tiered assessment process itself has been integrated into a recently redesigned child health check, labelled the 'Share and Care Check',[31] that was co-designed by Gidgee Healing to combine clinical indicators such as neurodevelopmental checks with a holistic, culturally appropriate framework for assessing health and wellbeing (Reid et al. 2022). Through these actions, the team hopes to embed the assessment process into the local primary health care system in a sustainable way that enhances community involvement in preventing and diagnosing FASD.

The second initiative is located in Alice Springs, where Central Australian Aboriginal Congress (CAAC)—an Aboriginal community-controlled health service—in 2018 established a Child and Youth Assessment and Treatment Service (CYATS). The service provides early detection of neurodevelopmental conditions such as FASD, Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) (Central Australian Aboriginal Congress 2019). The multidisciplinary team consists of a Team Leader, Aboriginal Family Support Worker, two speech pathologists, an occupational therapist and two neuropsychologists. The team conducts specific assessments and multidisciplinary neurodevelopmental assessments for suspected neurodevelopmental disorders in children and young people. The program is based on a partnership with Alice Springs Hospital paediatric and other health and educational agencies (Central Australian Aboriginal Congress 2019).

---

[29] An illustrated depiction of the six tiers is at https://www.griffith.edu.au/menzies-health-institute-queensland/our-institute/epic-health-systems/yapatjarrathati-project (retrieved 10 March 2022).

[30] Dr Natasha Reid, University of Queensland, *pers. comm.*

[31] Also known as the MBS (Medicare Benefits Schedule) Item 715 Aboriginal and Torres Strait Islander Peoples Health Assessment.

8.8   Supporting Individuals and Families with FASD in Aboriginal Communities

As an incurable condition, FASD can generate a need for lifelong support; it is not, in other words, a problem experienced solely by children. A situational and gap analysis of research and policies relating to FASD conducted in South Africa found that FASD is associated with a range of problems among adolescents and adults, including mental health problems, disrupted school experience, trouble with the law, inappropriate sexual behaviour, alcohol problems, difficulties in independent living and employment difficulties (Rendall-Mkosi et al. 2008: 53–56). The Senate Community Affairs References Committee, in its recent report, cited evidence that the National Disability Insurance Scheme (NDIS), child protection systems, educational systems and youth justice systems were all inadequately equipped to manage or support people with FASD, causing hardships for carers and, in many cases, inappropriate treatment or management (The Senate Community Affairs References Committee 2021: 87–114). As the Committee also observed, families in remote Aboriginal and Torres Strait Islander communities face additional burdens because of a lack of culturally appropriate services (The Senate Community Affairs References Committee 2021: 115–130).

In recent years, two innovative projects that address some of these challenges have been generated under the *Marulu* strategy in Fitzroy Valley. One is the *Jandu Yani U* parent support program, and the other is a program to improve self-regulation and executive function among primary school children.

8.8.1   *Parent Support Program:* Jandu Yani U

Jandu Yani U—a Bunuba phrase meaning 'for all families'—arose out of a partnership between Marninwarntikura Women's Resource Centre (MWRC) and researchers from the University of Sydney and University of Queensland. Its purpose was to adapt an evidence-based family support program known as Triple P (Positive Parenting Program) for use as a community-led intervention in the Fitzroy Valley to help meet the challenges and complex needs associated with bringing up FASD-affected children (Andersson et al. 2019, 2020; Jandu Yani U Project Team 2020). In 2014, the National Health and Medical Research Council (NHMRC) awarded a project grant to fund the implementation and evaluation of the project (Andersson et al. 2020).

The Triple P program, on which *Jandu Yani U* is based, is a suite of interventions designed to strengthen the knowledge, skills and confidence of parents and thereby reduce behavioural and emotional problems in children and adolescents (Sanders 2008). A Group Triple P variant, developed in consultation with Aboriginal and Torres Strait Islander health staff and trialled in four community health sites in southeast Queensland (Turner et al. 2007), provided the foundation for the Fitzroy

Valley initiative. Group Triple P has also been adapted for use by Indigenous families in north-western Ontario, Canada (Houlding et al. 2012) and New Zealand (Keown et al. 2018).

In the Fitzroy Valley, following consultations to ensure that community members understood the range of interventions being offered, and that the interventions accorded with local cultural protocols, 38 local workers—named 'parent coaches' by the community—were trained and accredited to deliver the local adaptation of Triple P to all interested parents (rather than just those with FASD-affected children) free of charge. A variant of the program known as Stepping Stones Triple P was also made available for parents of children with developmental disabilities (Andersson et al. 2020).

The program was rolled out between 2017 and 2019, with participating families and caregivers completing questionnaires at baseline, post-program and at follow-up several months later (Andersson et al. 2020). Thirty participating families and caregivers consented to their results being shared. The evaluation found that parent coaches experienced an increase in skill, knowledge, confidence and sense of empowerment. Among participating families, the evaluation reported several benefits for parents and children, including a decrease in the proportion of parents reporting symptoms of anxiety from 56.7% prior to attending Triple P to 35% at follow-up, and a decline in the proportion of parents adopting 'over-reactive' parenting practices from 30% prior to attending Triple P to 5% at follow-up (Andersson et al. 2020: 3–5). The evaluators attributed the success of the program to its having been initiated and led by the community, implemented by a team with whom the lead community organisation had an established, trusting relationship, and supported with ongoing mentoring (Andersson et al. 2020). *Jandu Yani U* has since become an integral component of the programs offered by MWRC and serves as an entry point into engagement with other services. An interactive Positive Parenting booklet is available on the MWRC website at *Jandu Yani U*Program—*Marulu*—Making FASD history (marulustrategy.com.au).

8.8.2 School-Based Support

Children and young people with FASD encounter developmental, social, emotional, behavioural and other difficulties that in turn generate challenges for teachers and caregivers. At present, little is known about how FASD is recognised and managed in Australian school settings (Elliott and Bower 2019). In 2014, faced with a dearth of child health services in the Kimberley region (Dossetor et al. 2019), MWRC compiled a resource book for educators, which was revised in 2018 (Weston and Thomas 2018). The resource, which is available for free download,[32] proposes a

---

[32] Available at https://mwrc.com.au/pages/research-and-reports (retrieved 11 March 2022) and at http://www.fasdnetwork.org/uploads/9/5/1/1/9511748/fasd___complex_trauma.pdf (retrieved 26 May 2021).

strengths-based approach to educating and caring for children with FASD, while at the same time insisting on the importance of grounding strategies in an appreciation of the nature and effects of intergenerational trauma. It proposes a number of principles for interacting with children with FASD as well as classroom strategies for supporting children's cognitive and communication development, as well as behavioural, emotional and social development (Weston and Thomas 2018).

Another initiative generated under the *Marulu* Strategy is a trial of a school-based program designed to improve self-regulation among children in the Fitzroy Valley. The program was developed by a team of researchers in consultation with community members and Elders in response to community concerns that disruptive behaviour by some children—resulting in some cases from FASD—was harming learning outcomes (Wagner et al. 2018). Because of their remote location, neither schools nor families had ready access to paediatric services. The program adapted for the trial is known as the Alert program, and is designed to teach children about self-regulation by using the analogy of a car engine with its various gears corresponding to arousal states (Wagner et al. 2018). Following the successful implementation of a pilot program in one Fitzroy Valley school, the Alert program was rolled out as a self-controlled cluster randomised trial in eight schools (Wagner et al. 2019, 2020). Teachers received training to deliver eight one-hour lessons over eight weeks. Student outcomes were measured by both teachers' and parents' ratings of students' behavioural, emotional and cognitive regulation. No significant improvements were found in teachers' ratings, however parents' ratings recorded statistically significant improvements in executive functioning and behaviour (Wagner et al. 2020). The researchers describe the study as a useful first step in developing appropriate and effective school-based support for developmentally impaired students (Wagner et al. 2020).

8.9 Conclusions

Despite the attention that has been paid to FASD in Australia over the past two decades, it remains a major source of neurodevelopmental impairment throughout the community, the consequences of which can be seen not only in the families directly affected, but in health, education, child protection, youth and criminal justice systems. Some of these consequences, and the steps being taken to address them, are touched on above.

FASD is likely to be more prevalent in some Aboriginal communities than in the wider population, although the continuing absence of a national case ascertainment prevalence study makes it impossible to judge just how much more prevalent. Aboriginal communities, service providers and other agencies have taken a lead in developing innovative programs for preventing and supporting those with FASD. While much remains to be learned about what works under what circumstances, it is possible to identify a number of principles for effective FASD strategies. These are

- Community-led partnerships bringing together community groups, service providers and researchers;
- Approaches for addressing FASD that

  – Are embedded in broader strategies for reducing alcohol-related harm, including effective controls on alcohol availability;
  – Address social and cultural determinants of health as well as FASD itself and
  – Cover prevention, diagnosis and support.

- Adequate, consistent and culturally appropriate support—both in funding, professional services and enabling legislation—from governments.

Recent inquiries into FASD in Australia have shown that current services, legislation and funding are all inadequate for meeting identified needs in both Aboriginal and non-Aboriginal settings. The need in rural and remote Aboriginal communities is particularly acute.

References

Aboriginal and Torres Strait Islander Social Justice Commissioner. 2011. *2010 Social justice report*. Sydney: Australian Human Rights Commission.

Andersson, Ellaina, Cari McIlduff, Karen Turner, Sue Thomas, Jadnah Davies, Elizabeth J. Elliott, and Stewart Einfeld. 2019. Jandu Yani U 'For All Families' Triple P—positive parenting program in remote Australian Aboriginal communities: A study protocol for a community intervention trial. *British Medical Journal Open* 9: e032559. https://doi.org/10.1136/bmjopen-2019-032559.

Andersson, E., C. McIlduff, J. Davies, E. Cox, S. Thomas, M. Hand, E. Carter, J. Oscar, K.M.T. Turner, E. Elliott, and S. Einfeld. 2020. *Jandu Yani U ("for all families") project report*. Sydney: The University of Sydney.

Apunipima Cape York Health Council. 2006. *Creation of life: Fetal alcohol spectrum disorder report 2000–2006*. Cairns, Queensland: Apunipima Cape York Health Council.

Australian Institute of Health and Welfare. 2020a. *National Drug Strategy Household Survey 2019, priority population groups chapter, supplementary data tables*. Canberra: Australian Institute of Health and Welfare. www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/data. Accessed 12 Apr 2021.

Australian Institute of Health and Welfare. 2020b. *National Drug Strategy Household Survey 2019, drug use in geographic areas chapter, supplementary data tables.*Canberra: Australian Institute of Health and Welfare. https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/data?page=1. Accessed 11 Mar 2022.

Australian Institute of Health and Welfare. 2020c. *National Drug Strategy Household Survey 2019. Drug statistics series no. 32. PHE 270.* Canberra: Australian Institute of Health and Welfare. www.aihw.gov.au/getmedia/77dbea6e-f071-495c-b71e-3a632237269d/aihw-phe-270.pdf.aspx?inline=true. Accessed 12 Apr 2021.

Australian Medical Association. 2019. *AMA submission to Senate Community Affairs References Committee—Inquiry into effective approaches to prevention, diagnosis and support for fetal alcohol spectrum disorder*. Barton, ACT: Australian Medical Association. www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/FetalAlcoholSpectrumDi/Submissions. Accessed 12 Apr 2021.

Australian Medical Association (AMA). 2019. *AMA submission to Senate Community Affairs References Committee—Inquiry into effective approaches to prevention, diagnosis and support for fetal alcohol spectrum disorder.* Canberra: Australian Medical Association.

Bower, C., and E.J. Elliott. 2020. *Report to the Australian Government Department of Health: Australian guide to the diagnosis of fetal alcohol spectrum disorder (FASD): Updated February 2020.* Telethon Kids Institute and University of Sydney: Perth.

Bower, C., D. Silva, T.R. Henderson, A. Ryan, and E. Rudy. 2000. Ascertainment of birth defects: The effect on completeness of adding a new source of data. *Journal of Paediatrics and Child Health* 36: 574–576. https://doi.org/10.1046/j.1440-1754.2000.00575.x.

Bower, Carol, Elizabeth J. Elliott, Marcel Zimmet, Juanita Doorey, Amanda Wilkins, Vicki Russell, Doug Shelton, James Fitzpatrick, and Rochelle Watkins. 2017. Australian guide to the diagnosis of foetal alcohol spectrum disorder: A summary. *Journal of Paediatrics and Child Health* 53: 1021–1023. https://doi.org/10.1111/jpc.13625.

Bower, Carol, Rochelle E. Watkins, Raewyn C. Mutch, Rhonda Marriott, Jacinta Freeman, Natalie R. Kippin, Bernadette Safe, Carmela Pestell, Candy S C. Cheung, Helen Shield, Lodewicka Tarratt, Alex Springall, Jasmine Taylor, Noni Walker, Emma Argiro, Suze Leitão, Sharynne Hamilton, Carmen Condon, Hayley M. Passmore, and Roslyn Giglia. 2018. Fetal alcohol spectrum disorder and youth justice: A prevalence study among young people sentenced to detention in Western Australia. *British Medical Journal Open* 8: e019605. https://doi.org/10.1136/bmjopen-2017-019605.

Bridge, Penny. 2011. Ord Valley Aboriginal Health Service's fetal alcohol spectrum disorders program: Big steps, solid outcome. *Australian Indigenous Health Bulletin* 11: 1–8.

Burns, Lucy, Courtney Breen, Carol Bower, Colleen O'Leary, and Elizabeth Jane Elliott. 2013. Counting fetal alcohol spectrum disorder in Australia: The evidence and the challenges. *Drug and Alcohol Review* 32: 461–467. https://doi.org/10.1111/dar.12047.

Calhoun, F., and K. Warren. 2007. Fetal alcohol syndrome: Historical perspectives. *Neuroscience and Biobehavioral Reviews* 31: 168–171.

Central Australian Aboriginal Congress. (2019). *Submission to the Senate Community Affairs References Committee Inquiry into effective approaches to prevention and diagnosis of FASD and strategies for optimising life outcomes for people with FASD.* Alice Springs: Central Australian Aboriginal Congress.

Commonwealth of Australia (Department of Health). 2018. *National fetal alcohol spectrum disorder (FASD) strategic action plan 2018-2028.* Canberra: Department of Health.

Dossetor, Philippa J., Kathryn Thorburn, June Oscar, Maureen Carter, James Fitzpatrick, Carol Bower, John Boulton, Emily Fitzpatrick, Jane Latimer, Elizabeth J. Elliott, and Alexandra L. C. Martiniuk. 2019. Review of Aboriginal child health services in remote Western Australia identifies challenges and informs solutions. *BMC Health Services Research* 19: 758. https://doi.org/10.1186/s12913-019-4605-0.

Elliott, E.J., and C. Bower. 2004. FAS in Australia: Fact or fiction?. *Journal of Paediatrics and Child Health* 40: 8–10. https://doi.org/10.1111/j.1440-1754.2003.00281.x.

Elliott, E., and C. Bower. 2019. *Submission to the Australian Parliament Senate Inquiry into effective approaches to prevention, diagnosis and support for fetal alcohol spectrum disorder.* West Perth, WA: FASD Research Australia Centre of Research Excellence.

Elliott, Elizabeth J., Jan Payne, Eric Haan, and Carol Bower. 2006. Diagnosis of foetal alcohol syndrome and alcohol use in pregnancy: A survey of paediatricians' knowledge, attitudes and practice. *Journal of Paediatrics and Child Health* 42: 698–703. https://doi.org/10.1111/j.1440-1754.2006.00954.x.

Elliott, E.J., J. Payne, A. Morris, E. Haan, and C. Bower. 2008. Fetal alcohol syndrome: A prospective national surveillance study. *Archives of Disease in Childhood* 93: 732–737.

Erikson, E.H. 1968. *Identity: Youth and crisis.* Norton: New York.

Fitzpatrick, J., Jane Latimer, Manuela L. Ferreira, Maureen Carter, June Oscar, Alexandra L. C. Martiniuk, Rochelle E. Watkins, and Elizabeth J. Elliott. 2015. Prevalence and patterns of alcohol

use in pregnancy in remote Western Australian communities: The Lililwan Project. *Drug & Alcohol Review* 34: 329–339. https://doi.org/10.1111/dar.12232.

Fitzpatrick, James P., Jane Latimer, Heather Carmichael Olson, Maureen Carter, June Oscar, Barbara R. Lucas, Robyn Doney, Claire Salter, Julianne Try, Genevieve Hawkes, Emily Fitzpatrick, Marmingee Hand, Rochelle E. Watkins, Tracey W. Tsang, Carol Bower, Manuela L. Ferreira, John Boulton, and Elizabeth J. Elliott. 2017a. Prevalence and profile of neurodevelopment and fetal alcohol spectrum disorder (FASD) amongst Australian Aboriginal children living in remote communities. *Research in Developmental Disabilities* 65: 114–126. https://doi.org/10.1016/j.ridd.2017.04.001.

Fitzpatrick, James P., June Oscar, Maureen Carter, Elizabeth J. Elliott, Jane Latimer, Edie Wright, and John Boulton. 2017b. The Marulu Strategy 2008–2012: Overcoming fetal alcohol spectrum disorder (FASD) in the Fitzroy Valley. *Australian and New Zealand Journal of Public Health* 41: 467–473.

Gonzales, K.L., M.M. Jacob, A. Mercier, H. Heater, L. Nall Goes Behind, J. Joseph, and S. Kuerschner. 2021. An indigenous framework of the cycle of fetal alcohol spectrum disorder risk and prevention across the generations: Historical trauma, harm and healing. *International Journal of Ethnicity and Health* 26: 280–298. https://doi.org/10.1080/13557858.2018.1495320.

Harris, K.R., and I.K. Bucens. 2003. Prevalence of fetal alcohol syndrome in the Top End of the Northern Territory. *Journal of Paediatrics and Child Health* 39: 528–533.

Hayes, Lorian G. 1998. Children of the grog. University of Queensland.

Hayes, Lorian G. 2001. Grog babies: Where do they fit in this alcohol life cycle? *Aboriginal and Islander Health Worker Journal* 25: 14–17.

Hayes, Lorian G. 2012. Aboriginal women, alcohol and the road to fetal alcohol spectrum disorder. *Medical Journal of Australia* 197: 21–23. https://doi.org/10.5694/mja11.10390.

Houlding, Carolyn, Fred Schmidt, Susan B. Stern, John Jamieson, and Darcia Borg. 2012. The perceived impact and acceptability of Group Triple P Positive Parenting Program for Aboriginal parents in Canada. *Children and Youth Services Review* 34: 2287–2294. https://doi.org/10.1016/j.childyouth.2012.08.001.

Jandu Yani U Project Team. 2020. *Submission to Senate Standing Committee on Community Affairs inquiry into effective approaches to prevention, diagnosis, and support, for fetal alcohol spectrum disorder.* Fitzroy Crossing, WA: Marninwarntikura Women's Resource Centre.

Jones, Kenneth, and David Smith. 1973. Recognition of the fetal alcohol syndrome in early infancy. *The Lancet* 302: 999–1001. https://doi.org/10.1016/S0140-6736(73)91092-1.

Jones, K.L., D.W. Smith, C.N. Ulleland, and P. Streissguth. 1973. Pattern of malformation in offspring of chronic alcoholic mothers. *The Lancet* 9: 1267–1271.

Jones, Kenneth L., David W. Smith, Ann P. Streissguth, and Ntinos C. Myrianthopoulos. 1974. Outcome in offspring of chronic alcoholic women. *The Lancet* 303: 1076–1078. https://doi.org/10.1016/S0140-6736(74)90555-8.

Jonsson, Egon. 2019. Fetal alcohol spectrum disorders (FASD): A policy perspective. *The Canadian Journal of Psychiatry* 64: 161–163. https://doi.org/10.1177/0706743718773706.

Kahn, N., and H. Muslima. 2012. *Rapid neurodevelopmental assessment of children, a practical guide for health professionals.* Dhaka, Bangladesh: Bangladesh Protibondhi Foundation.

Keown, Louise J., Matthew R. Sanders, Nike Franke, and Matthew Shepherd. 2018. Te Whānau Pou Toru: A randomized controlled trial (RCT) of a culturally adapted low-intensity variant of the Triple P-Positive Parenting Program for indigenous Māori Families in New Zealand. *Prevention Science* 19: 954–965. https://doi.org/10.1007/s11121-018-0886-5.

Lange, S., C. Probst, G. Gmel, J. Rehm, L. Burd, and S. Popova. 2017. Global prevalence of fetal alcohol spectrum disorder among children and youth: A systematic review and meta-analysis. *JAMA Pediatrics* 171: 948–956. https://doi.org/10.1001/jamapediatrics.2017.1919.

Latimer, Jane, Elizabeth Elliott, James P. Fitzpatrick, Manuela Ferreira, Maureen Carter, June Oscar, and M. Kefford (eds.). 2010. *Marulu: The Lililwan Project fetal alcohol spectrum disorders (FASD) prevalence study in the Fitzroy Valley: A community consultation.* Sydney: The George Institute for Global Health.

Lemoine, P., H. Harousseau, J.P. Borteyru, and J.C. Menuet. 1968. Les enfants des parents alcooliques: Anomalies observees a propos de 127 cas (The children of alcoholic parents: Anomalies observed in 127 cases). *Quest Medical* 25: 476–482.

Lyall, V., L. Wolfson, N. Reid, N. Poole, K.M. Moritz, S. Egert, A.J. Browne, and D.A. Askew. 2021. "The problem is that we hear a bit of everything…": A qualitative systematic review of factors associated with alcohol use, reduction, and abstinence in pregnancy. *International Journal of Environmental Research and Public Health* 18. https://doi.org/10.3390/ijerph18073445.

Marninwarntikura Women's Resource Centre. 2020. *Background information. Submission to Senate Standing Committees on Community Affairs Inquiry into effective approaches to prevention, diagnosis and support for fetal alcohol spectrum disorder.* Canberra: Senate Standing Committees on Community Affairs. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/FetalAlcoholSpectrumDi/Additional_Documents. Accessed 1 Mar 2021.

May, Philip A., and J. Phillip Gossage. 2011. Maternal risk factors for fetal alcohol spectrum disorders: Not as simple as it might seem. *Alcohol Research & Health* 34: 15–26.

May, Philip A., J. Phillip Gossage, Wendy O. Kalberg, Luther K. Robinson, David Buckley, Melanie Manning, and H. Eugene Hoyme. 2009. Prevalence and epidemiologic characteristics of FASD from various research methods with an emphasis on recent in-school studies. *Developmental Disabilities Research Reviews* 15: 176–192. https://doi.org/10.1002/ddrr.68.

McBride, N., and N. Ward. 2019. *National Drug Research Institute's submission to the Australian Federal Parliament Senate Committee Inquiry into effective approaches to prevention, diagnosis and support for fetal alcohol spectrum disorders.* Perth: National Drug Research Institute, Curtin University.

National Health and Medical Research Council (NHMRC). (2020). *Australian guidelines to reduce health risks from drinking alcohol.* Canberra: National Health and Medical Research Council. www.nhmrc.gov.au/about-us/publications/australian-guidelines-reduce-health-risks-drinking-alcohol#block-views-block-file-attachments-content-block-1. Accessed 1 Apr 2021.

Nutbeam, Don, Bronwyn McGill, and Pav Premkumar. 2017. Improving health literacy in community populations: A review of progress. *Health Promotion International* 33: 901–911. https://doi.org/10.1093/heapro/dax015.

O'Leary, Colleen. 2002. *Fetal alcohol syndrome: A literature review.* Commonwealth Department of Health and Ageing: Canberra.

Poole, Nancy, Rose A. Schmidt, Courtney Green, and Natalie Hemsing. 2016. Prevention of fetal alcohol spectrum disorder: Current Canadian efforts and analysis of gaps. *Substance Abuse: Research and Treatment* 10s1: SART.S34545. https://doi.org/10.4137/sart.S34545.

Popova, Svetlana, Shannon Lange, Charlotte Probst, Gerrit Gmel, and J. Rehm. 2017. Estimation of national, regional, and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: A systematic review and meta-analysis. *Lancet Global Health* 5: e290–e299.

Popova, Svetlana, Shannon Lange, Kevin Shield, Larry Burd, and Jürgen Rehm. 2019. Prevalence of fetal alcohol spectrum disorder among special subpopulations: A systematic review and meta-analysis. *Addiction* 114: 1150–1172. https://doi.org/10.1111/add.14598.

Public Health Association Australia. 2019. Submission on effective approaches to prevention, diagnosis and support for fetal alcohol spectrum disorder to Senate Standing Committees on Community Affairs. Canberra: Public Health Association Australia.

Reid, Natasha. 2018. Fetal alcohol spectrum disorder in Australia: What is the current state of affairs?. *Drug and Alcohol Review* 37: 827–830. https://doi.org/10.1111/dar.12855.

Reid, N., N. Hayes, S.B. Young, L.K. Akison, and K.M. Moritz. 2021. Caregiver-reported physical health status of children and young people with fetal alcohol spectrum disorder. *Journal of Developmental Origins of Health and Disease* 12: 420–427. https://doi.org/10.1017/S2040174420000537.

Reid, Natasha, Marjad Page, Theresa McDonald, Erinn Hawkins, Wei Liu, Heidi Webster, Codi White, Doug Shelton, Mary Katsikitis, Andrew Wood, Bronwyn Draper, Karen Moritz, and Dianne C. Shanley. 2022. Integrating cultural considerations and developmental screening into

an Australian First Nations child health check. *Australian Journal of Primary Health*. https://doi.org/10.1071/PY20300.

Rendall-Mkosi, K., L. London, C. Adnams, N. Morojele, J.-A. McLoughlin, and C. Goldstone. 2008. *Fetal alcohol spectrum disorder in South Africa: Situational and gap analysis*. Pretoria: University of Pretoria.

Sanders, Matthew R. 2008. Triple P-Positive Parenting Program as a public health approach to strengthening parenting. *Journal of Family Psychology* 22: 506–517.

Shanley, Dianne C., Erinn Hawkins, Marjad Page, Doug Shelton, Wei Liu, Heidi Webster, Karen M. Moritz, Linda Barry, Jenny Ziviani, Shirley Morrissey, Frances O'Callaghan, Andrew Wood, Mary Katsikitis, and Natasha Reid. 2019. Protocol for the Yapatjarrathati project: A mixed-method implementation trial of a tiered assessment process for identifying fetal alcohol spectrum disorders in a remote Australian community. *BMC Health Services Research* 19: 649. https://doi.org/10.1186/s12913-019-4378-5.

Symons, Martyn, Rebecca Anne Pedruzzi, Kaashifah Bruce, and Elizabeth Milne. 2018. A systematic review of prevention interventions to reduce prenatal alcohol exposure and fetal alcohol spectrum disorder in indigenous communities. *BMC Public Health* 18: 1227. https://doi.org/10.1186/s12889-018-6139-5.

Thanh, N.X., and E. Jonsson. 2016. Life expectancy of people with fetal alcohol syndrome. *Journal of Population Therapeutics and Clinical Pharmacology* 23: e53–e59.

The Senate Community Affairs References Committee. 2021. *Effective approaches to prevention, diagnosis and support for fetal alcohol spectrum disorder*. Canberra: Parliament of Australia. www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/FetalAlcoholSpectrumDi/Report. Accessed 22 Mar 2021.

Turner, Karen M.T., Mary Richards, and Matthew R. Sanders. 2007. Randomised clinical trial of a group parent education programme for Australian indigenous families. *Journal of Paediatrics and Child Health* 43: 429–437. https://doi.org/10.1111/j.1440-1754.2007.01053.x.

Wagner, Bree, James P. Fitzpatrick, Trevor G. Mazzucchelli, Martyn Symons, Heather Carmichael Olson, Tracy Jirikowic, Donna Cross, Edie Wright, Emma Adams, Maureen Carter, Kaashifah Bruce, and Jane Latimer. 2018. Study protocol for a self-controlled cluster randomised trial of the Alert Program to improve self-regulation and executive function in Australian Aboriginal children with fetal alcohol spectrum disorder. *British Medical Journal Open* 8: e021462. https://doi.org/10.1136/bmjopen-2017-021462.

Wagner, Bree, Heather Carmichael Olson, Martyn Symons, Trevor G. Mazzucchelli, Tracy Jirikowic, Jane Latimer, Rochelle Watkins, Donna Cross, John Boulton, Edie Wright, Maureen Carter, Kaashifah Bruce, Sue Cherel, and James Fitzpatrick. 2019. Improving self-regulation and executive functioning skills in primary school children in a remote Australian Aboriginal community: A pilot study of the Alert Program®. *Australian Journal of Education* 63: 98–115. https://doi.org/10.1177/0004944119826206.

Wagner, Bree, Jane Latimer, Emma Adams, Heather Carmichael Olson, Martyn Symons, Trevor G. Mazzucchelli, Tracy Jirikowic, Rochelle Watkins, Donna Cross, Jonathan Carapetis, John Boulton, Edie Wright, Tracy McRae, Maureen Carter, and James P. Fitzpatrick. 2020. School-based intervention to address self-regulation and executive functioning in children attending primary schools in remote Australian Aboriginal communities. *PLoS ONE* 15: e0234895. https://doi.org/10.1371/journal.pone.0234895.

Weston, Jane, and Sue Thomas. 2018. *Fetal alcohol spectrum disorder (FASD) and complex trauma: A resource for educators*. Fitzroy Crossing, WA: Marninwarntikura Women's Resource Centre.

Chapter 9
Alcohol and Community Policing
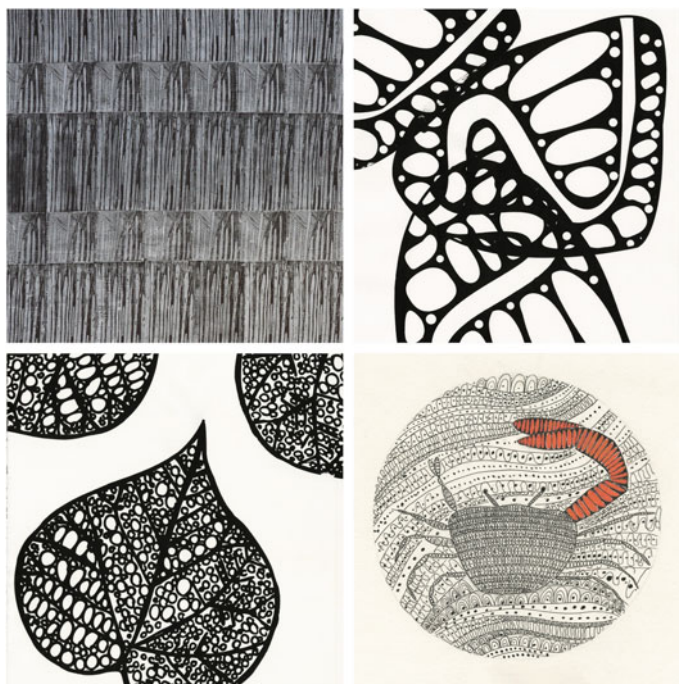
Artwork by Delvene Cockatoo-Collins

Abstract   This chapter describes the emergence and evolution of community patrols, warden schemes and social behaviour projects as community-led initiatives for promoting safety and preventing and resolving disputes, many of them associated with alcohol. The earliest reported community patrols date from around 1970 and refer to unfunded initiatives relying on Elders and other volunteers, often using their own vehicles and other resources. Patrols evolved in urban, regional and remote settings. They received increased attention following the Report of the Royal Commission into Aboriginal Deaths in Custody (RCADIC) in 1991, which recommended the use of community patrols as an alternative or complement to orthodox mainstream policing practices. Historically, many patrols and associated schemes have faced conflicting expectations. They draw on Aboriginal cultural authority to manage disputes in a way more culturally appropriate than mainstream policing practices. External authorities, however, including funding bodies, have tended to view them as extensions of state-based policing with primary roles of keeping drunks off the streets and crime prevention. We explore the emergence of these expectations and the responses of patrols to them and identify best practice principles for community patrols and associated measures.

9.1   Introduction

Community patrols or, as they are also known, night patrols or street patrols, have been described as 'the longest running form of Indigenous, community owned and designed harm prevention initiative in Australia' (Blagg and Anthony 2019: 280). In this chapter, we trace the origins and evolution of community patrols, exploring along the way the mixed blessings that have come with increased government support for what in many cases started out as grass-roots, unfunded initiatives. We also describe two related initiatives: community-based warden schemes and social behaviour projects.

Porter has described community patrols succinctly as 'locally-run justice initiatives with formal agendas that focus on improving safety within Aboriginal and Torres Strait Islander communities' (Porter 2018: 445). This description allows for a broad range of operational practices and organisational structures, in keeping with the diversity of settings—urban, regional, rural and remote—within which patrols operate. However, Porter suggests, a number of key functions are common to most patrols, including providing transport, promoting safety, preventing and helping to resolve conflicts and reducing confrontations between police and communities. Community patrols—along with warden schemes and social behaviour projects—are instances of non-state policing, but they are not extensions of state policing, although this distinction, as we show below, is not always recognised by those who would direct patrols along certain paths.

9.2 The Earliest Warden Schemes and Patrols

The origins of community policing in Aboriginal communities are probably unrecorded, as the first initiatives emerged not as funded programs but as actions by concerned volunteers in remote and other communities. Higgins (1997) describes the formation of a 'night duty' patrol in the Northern Territory community of Daguragu around 1970 in Box 9.1. Daguragu had been founded in the 1960s by Gurindji leaders in the course of their historical walk-off from Wave Hill Pastoral Station that effectively precipitated the Aboriginal land rights movement. It is located 7 km from Kalkarindji, the township originally known as Wave Hill after the cattle station on which it was located. Porter, in the course of conducting fieldwork with patrols in NSW, heard anecdotal reports of community self-policing initiatives in Redfern, Sydney, in the early 1980s and in other towns in the 1990s (Porter 2018: 452).

Box 9.1 Origins of the Daguragu, NT, Night Patrol

Extract from Higgins (1997: 36–37)

The original Daguragu scheme was developed by the Tribal Council over 25 years ago. The Elders shared responsibility for 'night duty' patrol at the native welfare camps at Kalkaringi and Daguragu.

One of the reasons for this was to ensure proper behaviour between the different family groups who settled at Kalkaringi and Daguragu after the Wave Hill Station walk-off. The other was because the Police did not know how to deal with traditional people and tribal customs. Night duty was introduced to reconcile the *Kartiya* (i.e. non-Aboriginal) and the *Gurindji* laws. The Police were locking people up who were doing the right thing in a tribal way. There was also the situation of Police being outnumbered, so the Police would back off, creating a vacuum for mainstream policing. There were also family problems, marriage problems, etc. which caused fights.

The Elders emphasised that the NP was all about the tribal way. NPs were tribal men and could deal with tribal disputes and resolve them. The main issue was tribal law. The NPs come out of this background and know about the tribal way of settling things. However, the Elders acknowledged that drinkers "have no brains" and hence were hard to deal with.

The Australian Law Reform Commission's (ALRC) inquiry into Aboriginal customary law that commenced in 1977 and reported in 1986 brought to light several examples of Aboriginal community-based policing, describing them in Box 9.2. As we show later in this chapter, many of the issues identified by ALRC in its descriptions of these early initiatives have continued to generate challenges for groups running patrols and warden schemes.

Box 9.2 Community Wardens and Other Forms of Self-Policing

Extract from Australian Law Reform Commission report *Recognition of Aboriginal Customary Laws (ALRC Report 31)*, (1986: Paras 858–863)[1].

858. *South Australian Wardens*. Several Aboriginal communities in the northwest of South Australia (including Amata, Ernabella, Fregon, Indulkana and Mimili) and Yalata in the west of the State have for some time used a system of Aboriginal wardens. Initially 20 persons were appointed and trained by the Police and the Department of Technical and Further Education for the Pitjantjatjara area and 10 for the Yalata community. A further 30 wardens were appointed and trained in June 1985. The system is not established nor regulated by legislation. Wardens are employed and controlled by the Community Councils and carry out an internal security role. Other functions include liaison between the community and visiting police. (Emergencies apart, South Australian Police are able to visit communities only weekly.) The wardens have no official uniform but in some cases wear khaki trousers and shirts (similar to uniforms worn by South Australian police in the outback) and have made their own badges. Some communities have requested an improved status for their wardens, which they consider would come from giving them proper training, uniforms, badges and greater powers (of arrest, etc.). It has been suggested that, at least if established by local initiative, such a status might free the warden from the kin relationships which, as discussed already, create real problems in many communities. Thus a warden in uniform and on duty might come to be regarded as exempt from kin obligations. The warden system, which was an Aboriginal initiative, has been operating with some success for several years. However, the South Australian Police Force has decided to introduce a system of police aides to replace it. It has been proposed that the Aide Scheme operate for a trial period of three years in Port Augusta, Amata, Indulkana, Fregon and Ernabella. The aim of the scheme is to enable specially trained Aborigines, working within their own communities, to assist the police to provide a police service which is suitable to the community. The South Australian Customary Law Committee opposed this change, principally because of the practical difficulties in making such a system work.

…

859. *Council-employed Peace Officers*. Other Aboriginal communities have sought to employ a local peace officer, similar to the wardens in South Australia. The Gurindji Community Council (NT) has advocated the appointment of a member of their community, chosen and dismissable by the Council, as a local policeman. He should be a member of the Council, be given proper training and a uniform, and would have the power to arrest, and if necessary lock-up overnight, local residents who commit offences on Gurindji land. The value of training and in particular a uniform was mentioned as creating an environment whereby the nominated person would be considered exempt from

kin obligations. Gurindji women considered there would be benefits in having an Aboriginal policewoman as well as a policeman. At Roper River (NT) the Council at various times has employed what are called security men to help police the community. These men, who have a uniform, are representative of the four different skin groups. There are also white police stationed at Roper River. The Lajamanu Council (Hooker Creek, NT) has also at times employed four 'nightwatchmen' as a supplement to the police. They are mainly older men who patrol the community each night. If offenders are found they are often dealt with summarily. The council and elders later decide if the police should be notified so that they may also pursue the matter. The development of the night patrol was a community initiative to reduce the very high level of disturbances and offending. It is apparently accepted by the members of the community. There is still support in some Aboriginal communities for nightwatchmen, especially among Aboriginal women.

860. *Policing by Council Members*. At Beswick Station (NT) the elected council performs a policing role. The Council relies on family leaders to help it. If trouble erupts a council member will request a member of the trouble-maker's family to assist. Specific incidents or matters of continuing concern are raised at Council meetings and families are requested to keep their members in order. The council is happy with the way this system operates and does not see any need for police aides. Other views expressed at the Commission's Public Hearings supported this method of policing because it prevented people from becoming resentful at a single person being given what were seen as arbitrary police powers.

861. *The 'Ten-Man Committee'*. The involvement of the 'Ten-Man Committee' at the Strelley Community (WA) has already been described.[2] Its role can extend to picking up offenders in Port Hedland and throughout the Pilbara, with the knowledge and support of the local police: those returned to Strelley by the committee are dealt with by the community at a public meeting.

---

[1] Footnotes citing details of information sources and other data have been deleted from this extract. They are available in the online edition of the full report (see References)

[2] The 'Ten Man Committee' was a group established by the community of Strelley Station, located about 40 km inland from Port Hedland, WA. Strelley itself was a distinctive settlement, having been created not by government policy but as a result of sustained political activism by Aboriginal people and their non-Aboriginal allies, beginning with a walk-off and strike in 1946 by Aboriginal workers on pastoral properties in the area protesting against their working conditions, treatment and other issues (for accounts of these events see McLeod (1984) and Hasluck (2018)). The Australian Law Reform Commission report described the Committee's role as apprehending and bringing wrongdoers before a community meeting, and administering the sanctions decided. These typically involved 'growling', shaming or ridicule, a fine, banishment and community work. The ALRC also noted that physical punishment—'a little bit of a hiding'—was sometimes administered, and raised a possibility that punishments meted out by the Ten Man Committee might sometimes contravene Australian law (Australian Law Reform Commission 1986: Paras 713–717). Blagg states that the

According to the local police the system works successfully. Apparently a similar committee operates at Noonkanbah (in the Kimberley area of Western Australia).

862. *Self-Policing in Urban Areas*. A system of self-policing first began operating unofficially among Aboriginal residents of Redfern in Sydney in April 1980. Two Aboriginal men were appointed as community liaison officers by the Aboriginal Housing Company to patrol the area and assist in local law and order. As a result of lack of funds, the system lapsed after six months. It was reactivated in April 1983 as an 'official' system with funding provided. Initially, two community liaison officers were appointed but this was later increased to four. Their principal function was to control behaviour involving vandalism and disruptive behaviour on Housing Company property. To this end they liaised regularly with the local police and with the Police Aborigine Liaison Unit, a special unit in the New South Wales Police Force. The four liaison officers wore identifiable clothing and carried ID cards. They generally worked shifts between 7 and 2 am. From time to time the Housing Company notified its tenants in the area of particular matters which the community liaison officers would be giving special attention: for example, drinking in the streets, loud music, smashing bottles, dumping rubbish and card schools. Apparently the system worked well and there was a marked improvement in local law and order. The Housing Company has temporarily discontinued the scheme although efforts are being made to resurrect it.

863. *Advantages and Disadvantages of Self-Policing*. Self-policing has advantages both for communities and the State and Territory police forces. Communities are able to deal with troublemakers in a more flexible manner which may be more appropriate to the circumstances, as well as more in accord with local customary laws. There may be as a result a de facto discretion to determine whether an apparent infringement of the criminal law should result in the police being called in and the matter pursued through the courts, or whether the matter can be dealt with locally. From the police viewpoint, self-policing can reduce the demands made upon them to service remote communities either with a permanent police presence or by regular visits. Police officers are understandably reluctant to live, with or without families, in remote localities. There may be no sufficient need for police in many smaller communities. Self-policing may reduce the overall demand on limited police resources, enabling a more efficient network of police services to be established. It may also, as the Redfern scheme demonstrated, be of value in urban areas. But of course it has its disadvantages, including the risk of unreliable provision of services, and the danger of partiality. Self-policing can also present real dilemmas, as the New South Wales Police pointed out. Some Aboriginal communities prefer to settle their

Committee, which ceased operating in the 1990s, drew criticism from welfare groups for being 'too aggressive' (2006: 33).

own disputes and if police are called, their presence is resented. But, if the police are called and do not attend, there are likely to be complaints that the police are not doing their job or are discriminating against Aborigines.

The first community patrol to gain national prominence, mainly as a result of its being promoted by the Royal Commission into Aboriginal Deaths in Custody (RCADIC) report as a model for other towns and communities, was the Julalikari Community Patrols in Tennant Creek, NT (Johnson, 1991, vol 5, Recommendation 220).

9.3 Julalikari Community Patrol

Like the initiatives described above in Box 9.2, the Julalikari Community Patrol emerged, not as a fully-fledged, funded program, but out of the voluntary commitment by members of Julalikari Council, using their own vehicles, money and other resources to patrol streets and town camps at night in order to offer a more satisfactory way of resolving disputes than the more confrontational approaches of mainstream police (Langton 1992; Curtis 1993). Julalikari Council, like Tangentyere Council in Alice Springs and Aboriginal-controlled bodies in other towns, services town camps occupied by Aboriginal people and performs functions and roles performed elsewhere by local government bodies. In 1992, the Julalikari Patrol won the inaugural Australian Violence Prevention Award by the Australian Institute of Criminology (Australian National Audit Office 2011).

In Box 9.3, David Curtis, an Aboriginal leader from Tennant Creek who was involved in establishing the Julalikari community patrol, offers a succinct account of what the patrol was in its early days—and, equally importantly—what it was not. In drawing attention to a predilection on the part of many people in the community to view patrols such as the Julalikari patrol as little more than a drunks' taxi service, providing policing on the cheap, Curtis highlights a misunderstanding that was by no means restricted to Tennant Creek. For Julalikari, as for other patrols, the chief purpose—especially in the early days of establishing community patrols—was to draw on culturally-grounded authority rather than mainstream police powers to resolve disputes before they escalated.

Box 9.3 Julalikari Council's Community Night Patrol

Extract from Curtis (1993: 73–76)

The purpose of this paper is to describe briefly some of the less known features of Julalikari's night patrol program and express a note of caution to communities thinking of adopting the scheme. In making these comments, it is hoped that communities can be helped to make informed decisions and avoid failures.

Over the last couple of years Julalikari's night patrol has gained considerable attention. Interest has been aroused by the Royal Commission into Aboriginal Deaths in Custody's detailed examination and recommendation that the program be adopted elsewhere. It has obvious relevance both to the current debate on Aboriginal/police relations and to those seeking to improve community management of alcohol problems. There is even international interest with Council members now discussing the program in Papua New Guinea.

Julalikari Council is a town camp organisation of about 900 Aboriginal people in the remote Northern Territory town of Tennant Creek; whose total population is approximately 3,000. With reduced mining activity, the town's economic base has contracted, enterprises have suffered, and the white population has declined. Alcohol abuse is a major problem in the community, both indoors and outside.

The night patrols have been operating since the mid-1980s. The starting date is not clear, for the community began the program without the tiers of bureaucracy and welfare assistance which would otherwise have recorded it.

The night patrol began because there was nothing else. While it was not obvious to government agencies, it was tragically clear to the Julalikari Community that something had to be done if the escalating violence, trauma and death in the town camps was to be halted. At the time there were no "Beat The Grog" campaigns, no suitable rehabilitation resources, no drive to improve community management of alcohol and little recognition that better relations between police and Aboriginal people were urgently needed.

What is The Night Patrol Program?

A senior Northern Territory police officer has provided the following description:

> The Council patrol operates a roster system of volunteer persons who conduct mobile patrols of the town area and camps at night. The patrol assists in removing intoxicated persons from the streets back to their residence and camps, as well as handling minor disputes that arise in the camps. As a general rule, councillors at each camp now contact the Council patrol in the first instance, however if the matter is serious, the police are called immediately.

This commonly held view is only partly correct, and in need of some elaboration. Five main points can be made about this description.

Firstly, while the patrols are based on a roster system, there are some important parameters. It is the Julalikari elected Council that makes the weekly roster, not the paid Council administrators. The rosters are not open to anyone. Participants must be approved by the Executive. Most of the Executive regularly participate and all of them take part in the camp meetings, even the elders.

Because the rosters include Executive members, the patrols are frequently led by some of the most influential and authoritative members of the town camps. Thus the Executive have a practical and intimate knowledge of the program. In a sense, the patrol is the Council and the Council is the patrol. So while the roster formalises who is doing service at any given moment, all the Executive are eligible for call-up.

Secondly, a basic principle of the patrols is their voluntary nature. This principle is vigorously held. It is argued that one does the job because one cares for the community. If it were paid work, some might do the job with the wrong attitude and for the wrong reasons.

For Executive, voluntary patrol work may exceed thirty hours or more per week. For some on roster, it may mean a full day's work on their normal job and then a twelve-hour night shift. This is a huge amount of effort and calls for immense dedication.

Camp leaders and Council Executive are now attempting to reduce the burden of work by encouraging younger members of the community to participate. It is hoped that not only will their participation relieve the older people but that it will give the younger ones a new perspective and show them what a pain in the neck they can be when drunk.

Thirdly, mobile patrols are often more patrol than mobile and that includes both tyre rubber and shoe leather. Patrols may consist of two women walking up and down the main street at sunset keeping an eye on some young drinkers or "rascals", as they say in Papua New Guinea. Patrol duty may be having the vehicle parked at the sports grounds on basketball night to provide both a Council presence and a radio base for all manner of reasons.

The patrol vehicle has a much wider function than police vans. It is constantly in use. With its communications radio, it is able to inform Executive members where each member is and can collect individuals and provide transport as necessary.

Fourthly, the object of the patrol is *not* to "assist in removing intoxicated persons from the streets". This is a frequent cause of misunderstanding for the police and the general public. The object is to resolve problems in town camps and special purpose leases; to settle disputes when they begin and not after they have exploded, drawing in extended families or entire tribal groups.

It is the Council's experience that by resolving disputes at an early stage the destructive cycle of alcohol-induced "paybacks", anger, guilt, misunderstanding and frustration can be short-circuited. By publicly discussing and

resolving these tensions the Council and community are able to spend more time on building rather than defence.

Lastly, the quote suggests that "serious matters" are the province of the police and the night patrol are junior helpers. This is quite incorrect. The community does not suspend its care or concern for its members because matters are serious; quite the reverse.

Where police have been required the immediate task of the patrol is to support the police and assist them and the community communicate with each other. Their role is also to collect information and provide a council presence that will be used later in community meetings. This is a serious task that complements the serious business of the police.

Public attention has been drawn to the program's attempts to overcome problems with police and policing, to reduce heavy-handed police surveillance and resolve conflicts in an Aboriginal way. What is less well known but equally important is the essential part community meetings play in the program and the way these meetings have come to affect the whole Council.

Community Meetings

Community meetings are held when there has been confrontation during the patrols or in the course of camp life. Camp meetings are called by the councillors and generally held on the following day. The aim of the meeting is to mediate the disputes. Outsiders are rarely permitted to attend.

The success of the patrols has strengthened and deepened the authority of the meetings. In turn the meetings have supported the patrol by promoting communication and understanding amongst a very diverse group of town campers and reaffirming the collective intolerance for unacceptable behaviour.

In the course of the meetings, the patrol's policy, protocols and rules are constantly under examination. Thus for instance, early in the life of the program, it was found that the productive efforts of single men and women on patrol was not what was wanted and had to be stopped. More recently, on a dark night, with little moon a "serious matter" that included the police ended with patrol members in gaol. Patrol workers now wear distinctive shirts while on duty and carry an identity card with their photograph.

At these meetings, unacceptable behaviour is condemned and offenders may receive a public dressing down. There may be some machismo in being given a hard talking to by the police or local magistrate. There is none in a community meeting of peers. The importance of this process cannot be understated. In communities that suffer from a high incidence of alcohol abuse one of the first things that disappears is frank, public, non-intoxicated discussion of the problem. With this disappearance comes a deepening of the problems. Julalikari is turning this process about through its community meetings.

Community patrols such as the Julalikari Patrol generate a need to define the respective roles of, and relationships between, the Aboriginal community patrol and local police. In Tennant Creek, this was codified in a protocol negotiated by both parties and signed in August 1991. The text of the protocol is reproduced in Box 9.4.

Box 9.4 Agreement on Practices and Procedures (Protocol) Between Northern Territory Police and Julalikari Council, Tennant Creek, NT
Full text of Agreement from Northern Territory Police Service and Julalikari Council Inc (1991)

Intoxicated person	Any person seriously affected by either alcohol or a drug
Member	Means a member of the Northern Territory Police
Mesne Warrant	A warrant issued by the court where a person fails to appear to answer his/her bail
Protective custody	Apprehension under Section 128 of the Police Administration Act (intoxicated persons)
Julalikari Council	The Governing Executive Committee of the body constituted as the Julalikari Council Incorporated
Patrollers	Means persons appointed by the Julalikari Council to uphold this agreement
Warrant of Apprehension	A warrant issued by the court where a person fails to answer his/her summons
Warrant of Commitment	A warrant issued by the court after a person has failed to pay a fine

Preamble
The following agreement is intended to establish a protocol between the Julalikari Council's Town Patrol and the Tennant Creek Police. It is not intended to provide a basis for legal rights or powers in the Night Patrol and must not be construed as giving any such rights or powers. The following provisions are to serve as a working guide only, subject to change upon mutual agreement.

Intoxicated persons
It is accepted where diversionary procedure or facilities are available persons should not be detained in Police custody for being intoxicated or held for minor offences unless that person is violent or an offence is likely to occur or continue. In cases of detention for offences, bail procedures are to be instituted as soon as possible unless the person is too intoxicated to be released.

Persons apprehended for Protective Custody under the provisions of Section 128 of the Police Administration Act and kept in the Police cells are to be released as soon as possible or as soon as that person can be placed into the care of a relative, or friend capable, in the opinion of the Police, of looking after that person.

The Barkly Regional Alcohol and Drug Abuse Advisory Group (BRADAAG) House, in Thompson Street is a special centre where intoxicated people can be taken and cared for. BRADAAG accepts intoxicated people who have been referred by the Police, Julalikari Council Patrol, church organisations and self-referrals.

When Patrollers locate an intoxicated person and cannot give that person to a friend or relative to mind, then they have the option of bringing the intoxicated person directly to the shelter. BRADAAG House holds 15 people and when it is full, any persons taken into custody must be lodged at the Police cells.

1. Julalikari Council will provide training for night Patrollers by negotiation with the Police, St John Ambulance and BRADAAG. Night Patrollers will receive training concerning their rights, obligations and first aid. Julalikari Council will provide Night Patrollers with a vehicle clearly identifiable by the reflector signs saying "Julalikari Night Patrol". The Patrollers must wear shirts authorised by the Council and carry identification cards.

2. When any disturbance involving Aborigines arises within the camps or town areas, the Patrollers, when possible will attempt to resolve the dispute in the first instance. If the Patrollers are unable to resolve the dispute, then Police will be called and the Patrollers will assist Police in resolving the dispute. On arriving at the scene of a dispute, Police should wherever possible, consult with the Patrollers as to the circumstances and the nature of the problem. Where it is agreeable to all parties, the Northern Territory Police may leave the situation in the care of the Night Patrol.

3. Following the Police intervention, the Police will, if possible, consult with the Patrollers as to the most appropriate action to take in the circumstances. The Police should give consideration to allowing the Patrollers to relocate persons involved if the Patrollers make such a request. Where necessary, Police will take the persons into Protective Custody and convey them to BRADAAG House. Persons will only be placed in the Police Cells as a last resort. Where Police and Patrollers are unable to agree on what action should be taken at the time, then the decision of the Police Officer will apply.

4. In circumstances where Police take action and the Council is not happy with that action or, Patrollers take action and Police are not happy with that action, a meeting will be held at the earliest opportunity between the Station Sergeant, No 3 Division, Tennant Creek Police Station and a nominated member of the Julalikari Council to resolve the dispute.

5. If more immediate action is required, it shall be pursued jointly by the Night Patrol Coordinator and the Senior Police Officer on duty.

6. It is agreed that intoxicated persons who, in the opinion of the Patrollers and Police, are violent or likely to be violent or likely to continue to re-offend should be placed in Police Custody until sober rather than released to family or Council members.

7. The Julalikari Council agrees that it will have community meetings to encourage all Aboriginal town campers to attempt to contact the Patrollers in the first instance when the Night Patrol is operating. If the Patrollers are unable to be contacted or the matter is urgent or serious, then the Police will be called. Police request that they be able to contact persons designated by Julalikari Council at each camp who can be called upon in the event of trouble at that camp.

8. Police will continue, where workload permits, to conduct mobile patrols of all the town camps. This will be to keep the peace and for the protection of persons living in the camps.

9. It is also agreed that the Patrollers, when possible, will try to assist the Police to keep the peace when they have time to meet such requests by talking to the people and try to sort out any arguments or differences. However, when the Police decide that a person should be taken into custody or arrested, then the Patrollers will assist by making the arrest as trouble free as possible.

10. Where Aboriginal persons have warrants issued for their arrest, then the following arrangements will apply:

    (a) If the warrant is a Mesne Warrant or Warrant of Apprehension, then the warrant will be executed and the person placed before a Magistrate as soon as possible.

    (b) If the warrant is a Warrant of Commitment issued for the non-payment of fines, then that person can pay the money or will be arrested and assessed for a Community Service Order at the first opportunity.

    (c) If the warrant is a Warrant of Commitment for forfeited bail or compensation and the person is unable to pay the amount, they will be taken into custody.

11. Any person in Police custody who exhibits signs of mental or physical distress, including alcohol or drug withdrawal symptoms, or is unconscious will be taken to the Tennant Creek Hospital.

12. If any person is unconscious or exhibits signs of distress or other symptoms which makes a member or Patroller become concerned about that person's welfare, that person is to be taken immediately to the hospital for assessment.

13. Wherever possible, Aboriginal persons arrested will be placed in multi-prisoner cells, preferably with another Aboriginal person or persons,

unless there is an identified danger or disruption to others by placing them together.

14. Patrollers and Police agree to work together and assist each other wherever possible. If disputes or misunderstandings occur at any time, then meetings will be called to resolve those problems, as soon as possible as per the provisions of paragraphs 4 and 5.

15. This agreement will be reviewed by all parties at meetings after having been in operation for a period of three months, in the first instance and six months thereafter or as required by either party.

Julalikari Council's patrol rapidly became a model for emulation, initially in the NT, later in other parts of Australia. In Alice Springs, the Tangentyere Council—a body serving a similar role to that of Julalikari Council in Tennant Creek—established a night patrol in December 1990 (Langton 1992; Tangentyere Council Patrollers with Catriona Elek 2007). Like the Julalikari patrol, the Tangentyere patrol was begun by volunteers with no external funding, and as in Tennant Creek, those involved saw their role as one of preventing disputes from escalating rather than reacting to offences (Tangentyere Council Patrollers with Catriona Elek 2007). In 1991, the Tangentyere patrol secured funding, and over the years that followed evolved into a larger, more complex organisation than the 'lean' outfit described by Curtis in Box 9.3. In 2003, the Tangentyere Night Patrol was selected as an example of 'best practice' in Aboriginal alcohol and other drug programs (Strempel et al. 2004). By this time, it operated between 5 pm and 1 am on five nights a week (from Tuesday to Saturday), with a team of seven patrollers, two referral officers, a database operator and two four-wheel drive vehicles. Patrollers attended weekly training sessions designed to enhance their skills in first aid, computing, legal issues and protocols for interacting with clients, police and other agencies (Strempel et al. 2004: 12). The patrol had also developed collaborative relationships with the sobering-up shelter, police, Alice Springs Town Council, St John's Ambulance, Alice Springs Women's Shelter, Central Australian Aboriginal Congress and other services.

Both the Julalikari and Tangentyere patrols continue to operate today.

9.4   Patrols in Remote Communities

Both of the patrols described above were designed for regional towns. In remote communities, the resources available and the nature of alcohol problems often differed from those in towns, but here too communities began forming night or community patrols at around the same time. In April 1991 the first women's night patrol was established in the Central Australian community of Yuendumu, 293 km northeast of Alice Springs. According to Anne Mosey, who was employed at the time as Coordinator of the Yuendumu Women's Centre, the patrol was created in response

to a series of five alcohol-related deaths in the community (Mosey 1994). Prior to these events, according to Mosey, women had not been involved in addressing alcohol problems, seeing them as 'whitefella' or men's business. The Yuendumu Women's Patrol initially consisted of five women selected from each of four camps in the community (Mosey 1994).

By 1994, thirteen remote communities in Central Australia had started their own night patrols, most though not all of them run by women (Mosey 1994). In a review prepared for the Alice Springs Drug and Alcohol Services Association (DASA), Mosey has described how patrols worked in different ways according to local conditions. In some, including Yuendumu, patrollers walked around the community at night with torches and sticks. If they saw people bringing in alcohol or drunkenly fighting, they would ask them to leave or drink quietly, or they would notify the police. Other patrols drove around the community using their own or council vehicles. Most of the patrols in the early years received no funding (Mosey 1994). In Box 9.5, taken from the DASA review, Mosey describes her experience working with community groups in helping to set up night patrols. Her approach, it should be noted, is markedly different from what too often passes for 'consultation' by government officers with their policy agendas for Aboriginal communities. Mosey also describes the obstacles and disappointments that are likely to be met along the way as a patrol grows into an institutionalised part of the community. She also lists conditions that she considers to be conducive to setting up a successful patrol.

Box 9.5 Establishing a Remote Area Night Patrols
Extract from Mosey (1994: 11–19).

How does a night patrol begin?
The process I have used is an invitation-led, community based-model.

It is better to wait for an invitation from a community rather than approach them. It is also important to make sure that the request does come from some members of the Aboriginal community and not from a concerned administrator. Several communities that have had severe problems with alcohol abuse have not wanted to start a night patrol or have chosen to after some years of problems (e.g. Nyirrpi). While a night patrol can seem like the cure for all ills, it will only work within a committed community.

My methodology has been to visit the community for several days, once I have been invited. I talk to them about the different formats worked out by other communities, then leave them to decide if they do want to form a patrol (there may be several months between the first and later meetings). If they decide to, then I return, and we discuss what kind of format they think is best suited to them, taking into account factors such as numbers of men and women, distance from the nearest police, present levels of drinking, presence of a police aide, etc.

I contact the council, the clinic and the nearest police to inform them of the community's decision if they are not already aware. If possible they should be at the early meetings. I role-play different situations so that the community are able to plan a strategy for each. If possible, members of established night patrols are at the early meetings to work through strategies with the community.

Once the community has decided to form a night patrol and planned a strategy, the police are involved so that they can suggest other aspects and can work with the community's plan as much as possible. This is essential so that both police and night patrol have 'ownership' of the strategy and avoid conflicts of interest.

Stages of growth

These are not set in concrete, and do not all apply. They are not to be read as definite but are based upon my observation of the longer-established night patrols. As all communities differ greatly, some may skip stages.

1st Stage (1–3 months)

Enthusiasm and fear from the members of the night patrol. Afraid of repercussions from male members of their families, but also keen to work together to deal with problems. Less fear if senior men are involved at the beginning.

Apprehensive of police support. Needs several meetings with local police and/or regional superintendent to plan procedures of call-outs, apprehension without arrest, etc. Important to plan this together, not ad hoc.

Usually large numbers of police call-outs for 1st 3–6 months as community and night patrol test out level of police support. Police overtime payouts increase, then decrease as community realise that police are being supportive to night patrol members.

Tends to be initially women that form the first night patrol, with many senior women, (aged 55–70), except in communities with low numbers of older women.

2nd Stage (3–6 months)

Numbers involved in night patrol drop away as members get tired or are undermined by the community.

Needs to be financial support for a few members who are keenest, and/or the main drivers, otherwise they drift into other jobs.

Most difficult time for night patrol. Problems recur and seem insurmountable.

Police call-outs drop right back as community adjusts to the continued presence of the night patrol by bringing in less grog or by drinking away from community.

The night patrol may collapse at this stage, due to the above pressures. There needs to be continued support from their council, NT Police, and organisations such as ADRES and Tangentyere Council.[3] However, they will usually revive again after a gap of some weeks or months.

Senior women recruit younger men as workers (sons/nephews/grandsons).

3rd Stage (6 months onwards)

Night patrol is recognised by all community members as an established presence. It is not likely to stop now, or if it has some lapses, will re-generate itself as necessary.

Will put forward delegates to go to speak at other communities, conferences, etc. to the media.

Will liaise easily and comfortably with local and senior police, and Correctional Services officers, and will initiate meetings if problems arise.

Will be interested in participating in community court.

Take an active and thoughtful role in law and order issues with both Aboriginal and European law. Initiate meetings within community on law and order issues.

Interest in further training for night patrol members.

More men become involved, as senior women stop work.

It is important for night patrol members to remember their initial objectives at this stage. While away from their community participation in meetings is one of the ways of maintaining patroller's interest, they need to balance this with their commitment to the actual work on the community.

…

What conditions are necessary for the formation of a night patrol?

The conditions below are not all essential and are based on personal observation. Patrols have started with much less than the requirements below.

The conditions that appear to be necessary for the initiation of a successful night patrol are

1. A community size of over 100 people. Smaller communities than this will involve almost every family grouping in the formation of a night patrol. Half the group would be policing the other half.
2. There needs to be a large group initially formed with a minimum of ten people. A practical size is ten-twenty people.

    a. The greatest obstacle is that the work is tiring and unrewarding, particularly for older people who are usually asleep at 8 or 9 at night and are required to stay awake till 3 or 4 am. People get sick, need to attend to family or ceremonial business, or are invited to travel to perform dances or attend meetings. There needs to be sufficient back-up numbers to maintain the night patrol when these people are absent or drop out.
    b. The other reason is that for night patrol to operate effectively, it needs to have full community approval, i.e. that there be representatives of each family grouping in its structure. Without this there is the situation of one family grouping disciplining other families, with the resultant friction in the community.

3. There needs to be several senior men or women involved initially even if these people delegate authority at a later date to younger people. It is the more senior members of the community, particularly those with strong

ceremonial authority as well, that are most able to be respected as members of a night patrol.

They are also, in the case of the women, usually widows and are not thus able to be threatened by husbands.

It is very important that it is the senior (grandmothers) women and men that are active in the night patrol, although of course they may recruit younger men and women themselves. Night patrols tend to have a short life if they are only composed of younger people (under 40). (Younger women have family responsibilities, are in demand for other jobs, and are under more pressure from other family members, who may be angry or jealous of their involvement).

However it is often the younger members of the community (30–50 year olds) that are in demand as paid representatives of the community, and yet they are the ones that do not yet have appropriate levels of ceremonial knowledge to be authorised to speak for all others. The Europeans system serves to promote those who are "educated", i.e. younger.

4. Patrol members need to be non-drinkers if possible. This is not totally essential but is certainly preferable, as obviously the drinkers are not likely to respect the authority of another drinker.

   However, if the person respects the Restricted Area boundaries or only drinks in Alice Springs it is possible that other drinkers may respect their authority.

   Kintore and Yuendumu have had drinkers as part of their patrol. The problem it can cause is that the drinking night patrollers will be much more lenient on other drinkers and will not take their role seriously. It can also cause fighting between members of the patrol, reducing the cohesion and effectiveness of the patrol.

5. The initial meeting in the community needs to be large with as many men and women of younger and older age groups as possible. It is very important that the idea of the patrol is not just dreamt up by a few concerned people, and that it has wide cross-family and community support. It may take a series of meetings to achieve this, with the idea of the patrol gradually gathering momentum and acceptance. Otherwise, there is the situation of a few concerned individuals (often the same ones as for several other issues) adopting the moral high ground against the rest of the community. Unless the patrol is seen as a positive move, one protecting and 'looking after' family members from the worst effects of alcohol abuse, it will not be maintained for long.

6. There needs to be involvement and consultation with all relevant bodies. The community council, the clinic and local police. Again, as above the intention is to gather wide community support.

7. There needs to be an understanding or strategy worked out with the local police. Both the night patrol and police need to be clear about each other's area of control before the night patrol starts.

   …

   There needs to be an attitude of generosity and flexibility on the part of the local police, as the requirements of the night patrol members do not always fit conveniently into police schedules, and perhaps a preparedness to do "that little bit extra" for the first couple of months. Of course, the night patrol members also need educating by the police as to the legal and practical parameters of their role. This may require several meetings to work out a set of procedures that is agreed upon by both the members of the night patrol and the local police unit. It is important that new or temporary police officers also be kept informed of the existence, names and procedures of the night patrol, particularly if the patrol staff do not have identifiable uniforms.

8. There needs to be a supportive administrative person on the community. The night patrol can flounder without the support of an enthusiastic administrator. This person can be a teacher, a clinic sister or council clerk, but needs to be prepared to assist with submissions, help with locating access to vehicles if wanted, and provide general interest and enthusiasm for the night patrol. Night patrols can of course operate without this but may be less effective.

   Community employees tend to be already over-extended, and are understandably reluctant to take on extra work, particularly something which may put them into dispute with senior (grog-running) men in the community or with the police.

   However in the long term the presence of an effective night patrol is of widespread benefit to the whole community, and may help that support person in their job.

9. Ideally, there would be a non-drinking council chairman, or at least some non-drinkers on the community council. These councillors could provide support for a night patrol. However in many communities it is the council members that are among the worst drinkers.

Brady expands on some of the points raised in the above extract with a useful discussion of practical issues relating to radios, vehicles and such like (Brady 2012: 164–167).

---

[3] 'ADRES' is an acronym for Alcohol and other Drug Resource Education Service, an NT Government service based in Alice Springs. It has since been replaced by the Alcohol and other Drug Services Central Australia (ADSCA). Tangentyere Council is an Aboriginal organisation based in Alice Springs that provides a range of services and programs for Aboriginal town camps in Alice Springs (Editors).

9.5 Extension, Expansion—and Evaluation

Throughout the 1990s and early 2000s, the number of community patrols expanded rapidly in rural, remote and urban settings. Blagg and Valuri (2004b) identified more than 100 patrols as operative in 2001–02. A review based on data collected from 63 patrols in WA, Queensland, NT, NSW, Victoria and Tasmania found that alcohol was the most frequently cited issue that patrols addressed, followed by anti-social behaviour, family violence and drugs (Blagg and Valuri 2002). The core functions of patrols were found to be providing safe transportation, diversion from contact with the criminal justice system and intervening to prevent disorder in communities. While many patrols focused on community safety, others—notably in urban programs in southern Queensland and NSW—grew out of youth outreach programs and focused on Indigenous youth (Blagg and Valuri 2002).

Little quantitative evidence is available regarding the impact of patrols on arrest rates, alcohol misuse, domestic violence or other indicators. Higgins, who evaluated seven night patrols and two community warden schemes in the NT in 1996, reported evidence of patrols in the communities of Ngukurr and Yirrkala, and the Tangentyere and Julalikari patrols in Alice Springs and Tennant Creek respectively, contributing to reductions in alcohol-related offences, health worker call-outs and community disturbances (Higgins 1997).

Sputore et al. (2000) evaluated the Halls Creek Night Patrol and Alcohol Centre, located in the East Kimberley, WA, at the request of Jungarni-Jitaya Alcohol Action Council Aboriginal Corporation, which managed both services. The Patrol had been established in 1994 in response to recommendations of the RCADIC, followed soon afterwards by the Alcohol Centre, which offered education and non-residential counselling services (Sputore et al. 2000). Formation of the Night Patrol and Alcohol Centre were preceded by the establishment of a Sobering-up Shelter in September 1992 and, in November of the same year, the introduction of restrictions on take-away liquor sales (Sputore et al. 2000).

The evaluation included a quantitative analysis of trends in alcohol-related arrests and alcohol-caused mortality and morbidity at Halls Creek Hospital by Aboriginality for the period 1990–1998. The analysis examined the impact of measures in two phases, the first being establishment of the Sobering-up Shelter and restrictions on take-away sales, the second being commencement of the Night Patrol and the Alcohol Centre. A time series analysis found that none of the measures had a statistically significant effect on the indicators of alcohol-related harm. Qualitative data gathered in interviews and discussions, however, revealed that the Night Patrol was well regarded and believed to have contributed to reducing alcohol-related violence. It was also reported to have a good working relationship with police and to be well managed (Sputore et al. 2000).

In a more recent review of evidence, Blagg and Anthony (2019) conclude that, where patrols operate within a strong community governance framework, they have been shown to reduce admissions to police lock-ups, youth crime, alcohol-related

crime and protective custody apprehensions. They are also widely supported within communities as community safety initiatives.

On the other side of the ledger, reviews have also identified challenges and chronic problems confronting community patrols. One of the most widespread is the presence of competing expectations about the role of patrols. Since their beginnings—as the 1993 paper by Curtis in Box 9.3 testifies—patrols have faced pressures to provide a 'street cleaning' or 'drunks taxi' service or play a police 'eyes and ears' role, thereby providing policing on the cheap. When patrols decline to define their role in the way demanded by funding bodies, police and/or other government agencies, they sometimes face defunding or other restrictions. Some patrols do become 'taxi' services. According to Memmott et al., in 2000 a night patrol operating in Darwin was neither strengthening community control nor helping to resolve disputes, but rather transporting people to the sobering-up shelter (Memmott et al. 2003: 14); it was said to have subsequently been modified. As Curtis, Blagg and others have argued, patrols are not an extension of police powers but rather an expression of a commitment of care for the community's own people, grounded in intervention and mediation by respected members of the community using culturally sanctioned procedures (Blagg 2003; Curtis 1993).

One example of a long-running, urban community patrol that has had to manage conflicting expectations and other challenges over the years is the Nyoongar Patrol Outreach Service in Perth, WA.

9.6 Patrolling Cities: The Nyoongar Patrol Outreach Service

The patrol was originally set up in 1998 as a volunteer-managed service conducting three patrols a week in the inner-Perth suburb of Northbridge in response to high numbers of Aboriginal children on the streets at night and high levels of involvement with the law and justice system. It has since grown into what a 2012 review described as 'an established leadership position within the human services sector in Perth' (John Scougall Consulting Services 2012: 20). Today, the Nyoongar Patrol Service (NPS) conducts day patrols and night patrols in the suburban areas of Vincent, Fremantle and Midland as well as Northbridge, and offers seven kinds of service:

- conflict mediation to defuse situations;
- street level assistance to homeless Aboriginal people;
- youth support and child protection;
- immediate street level health and wellbeing services;
- employment and training of Aboriginal people and
- policy advocacy.

From the outset, Nyoongar Patrol saw its role as working in concert with other bodies to address issues faced by young and homeless Aboriginal people in the

area, including anti-social behaviour but also including their risk of exposure to violence, drugs and involvement in the sex industry. It was primarily an *outreach* rather than a security program (John Scougall Consulting Services 2012). Other stakeholders, however, had other ideas. Media attention in the early years focused solely on the Aboriginal juvenile crime 'problem', which the Nyoongar Patrol was expected to solve by removing young Aboriginal people from the streets (Blagg and Valuri 2004b). Local retailers blamed Aboriginal people for a decline in patronage, overlooking other factors such as the area's sleazy reputation as a home to sex shops, brothels, drug users and drunken (non-Aboriginal) youths spilling out of local bars and clubs. In 2002 the Nyoongar Patrol won endorsement from a 2002 State Government inquiry into Northbridge as well as from a visiting Victorian parliamentary inquiry, but the Northbridge Retailers Association, the City of Perth and the state's peak crime prevention body—Safer WA—were all dissatisfied with Nyoongar's approach (Blagg and Valuri 2004b) and in 2005 the City of Perth ceased funding support (John Scougall Consulting Services 2012).

In the same year, Nyoongar renamed its service as an *outreach* service to clarify its function. Since then, it has attracted funding from other sources, including the Cities of Vincent and Fremantle—in and near Perth—and multiple governmental bodies as well as the corporate sector. An independent evaluation of the Nyoongar Patrol published in 2012 identified the achievements of the service in nine domains:

- mediating disputes: In 2009–10 the NPS defused a total of 516 incidents on the streets in Perth, and in 2010–11, another 337 incidents. In 2010–11, the main types of disputes involved were verbal (166), feuding (77), physical (53), health (35) and administration of first aid (5) (John Scougall Consulting Services 2012: 25);
- expanding the range of patrols to cover seven areas in metropolitan Perth;
- attracting increased funding from multiple sources, from corporate as well as government sectors;
- engaging at street level with vulnerable Aboriginal people (recording an average of 297 contacts per week in 2010–11);
- improving linkages with other services;
- implementing sound and stable governance and management;
- improving relations with the business community;
- creating employment and professional development opportunities for Aboriginal people and
- advocating policies.

The evaluation also identified five ongoing challenges:

- unrealistic expectations of the role and capacity of the service, including among some Aboriginal people who expect the patrol to provide a taxi service;
- inadequate shelter facilities for homeless people;

- the absence of an adequate youth policy framework in Perth;
- inadequate information sharing with other agencies and
- excessive access to alcohol in the area (John Scougall Consulting Services 2012).

The evaluation of the Nyoongar Patrol is one of the few independent evaluations that have been conducted of Aboriginal patrols. It was commissioned by the patrol service itself and funded jointly by the NPS and the WA Law Society. As an exercise, the evaluation probably holds lessons for other similar patrols. For example, the evaluator noted that, although the service was required to report regularly with respect to performance indicators set by the funding body—the WA Department of Indigenous Affairs (as it was then known)—it had no performance indicators of its own against which to measure progress with respect to its own objectives. The first recommendation in the evaluation report was that such indicators be identified and adopted (John Scougall Consulting Services 2012). The evaluation drew on five sources of data, listed in Box 9.6.

Box 9.6 Evaluating a Night Patrol Service

Extract from John Scougall Consulting Services (2012: 61)

Five kinds of data have been collected, analysed and brought together in this study to inform findings:

- Focus group meetings

    – NPS board
    – NPS staff
    – External Stakeholders.

- Surveys providing information about stakeholder perceptions of the service.

    – Internal NPS survey
    – government stakeholders
    – not-for-profit organisations
    – business community.

- Document review of information and reports held by NPS extending back over the life span of the organisation, e.g. program information, plans, monitoring data, progress reports, review reports, financial reports and some academic literature.
- Submissions in the form of invited written comments from key stakeholder organisations addressing the terms of reference.
- A brief literature review identifying recognised 'best practice' in this field.

The issue of accountability to funding and other bodies presents ongoing challenges for services that aim to prevent rather than react to incidents: a crime prevented is by definition an event that does not appear in statistical datasets.

9.7   Patrols and Policing in NSW

Porter (2016, 2018) has reported findings from an observational study in which she spent time with three night patrols in NSW, one in Redfern/Waterloo in inner-city Sydney, one in Bourke, a small town in far-western NSW and one in Dubbo, a provincial city in mid-western NSW. Her observations were also informed by earlier studies of other patrols in NSW. As noted earlier, community patrols in NSW have tended to focus on the safety and wellbeing of young people. Each of the three patrols in this study, she reported, was an expression of local Aboriginal control, exercised through a variety of bodies such as men's groups or women's groups, and through a variety of governance structures. In all instances, however, the need for community ownership was regarded as of primary importance:

> When asked 'what are the essential ingredients of a successfully run night patrol?', the term 'community' (in the sense of the local Aboriginal community), was the single most common response by patrol workers, residents, and management staff (Porter 2018: 456).

The patrols operated independently of state police, although often had arrangements in place to ensure police involvement in violent incidents, and in some instances, local police attended meetings of the patrol management committee (Porter 2016).

Porter identified four main activities as characterising everyday operations. The first was transporting young people from public places to home or an alternative safe place. The second involved building mentoring relationships with young people, and the third, caring for kids—looking out for kids in trouble and, when appropriate, engaging with them about their issues and referring them to available support services. The fourth activity Porter described as 'information sharing' which might on occasion involve making referrals on behalf of young people to another agency (Porter 2016). All of these activities, Porter suggested, were grounded in patrollers' own local networks and relationships. Unlike police, patrollers did not have formal authority to order young people to comply with directions.

Porter even questions whether it is appropriate to use the term 'policing' to describe the activities of patrollers, particularly in light of the fact that patrollers themselves explicitly rejected this term as a description of their roles. Moreover, the focus of patrollers' activity was not the maintenance of order but rather the safety and wellbeing of young people. Perhaps, she suggests, the term 'policing' in an Indigenous context is inextricably bound up with its colonising connotations as an activity *imposed on* Indigenous people rather than conducted by them. Others have suggested that, as grass-roots instances of self-determination, patrols such as these may contribute to decolonising policing practices (Blagg 2016; Blagg and Anthony 2014, 2019; Blagg and Valuri 2004a; Cunneen 2001; Porter 2016, 2018).

9.8   'The Intervention' in 2007

The 2007 'Intervention' by the Howard Coalition government—or, to give it its official title, the Northern Territory National Emergency Response (NTER)—radically altered the landscape in which community patrols operated, especially but not only in the NT. This was partly a direct result of some of the measures entailed in the NTER, and partly because, coincidentally, the measures were introduced at around the same time as the NT Government began rolling out a reform of local government across the NT, under which community councils were abolished and their functions absorbed into a smaller number of higher level bodies initially called shire councils, later renamed as regional councils. Up until this time, community patrols in remote communities were either run by community councils or operated with support from them. The local government reforms removed this level of community administrative capacity and accountability, while new alcohol restrictions imposed unilaterally under the NTER over-ruled existing alcohol control provisions negotiated between communities and the NT Liquor Commission. Although the NTER and the local government reforms were separate policies emanating from different levels of government, for many people in communities they were experienced together as yet another instance of disempowerment at the hands of 'the government' (d'Abbs et al. 2019).

The NTER covered 73 remote communities in the NT. At the time, community patrols operated in 23 of these as well as in the towns of Alice Springs, Katherine and Tennant Creek (Australian National Audit Office 2011). Under the NTER, the Commonwealth Government redefined patrols as a core component of a new community safety strategy and expanded the program to cover all 73 communities. This necessitated the establishment of new patrols in 50 communities—all within a timeframe of ten months (Australian National Audit Office 2011). Responsibility for implementing the expanded program was vested in the Commonwealth Attorney-General's Department (AGD), which adopted a single 'hub and spokes' service delivery model, under which all remote community patrols—new as well as existing—were to be managed by the newly established shire councils (Australian National Audit Office 2011). A review of AGD's performance in implementing the expanded patrol program found that, while the short time-frame and magnitude of the task probably necessitated a single service delivery model, there was little consultation or engagement with communities in the process, with a result that community priorities were given inadequate attention and community ownership declined (Australian National Audit Office 2011).

One observer who was uniquely placed to assess the impact of these changes was Jennifer Turner-Walker, who served as Remote Area Night Patrol Coordinator for Tangentyere Council in Alice Springs for nine years. In an unpublished thesis completed in 2010, Turner-Walker describes the operations of patrols in central Australian communities in the years preceding the NTER and the subsequent changes under the combined impact of the NTER and the local government reforms (Turner-Walker 2012). Many of the activities in which patrollers engaged in preventing

violence and mediating disputes, she argues, were largely invisible to governmental and other non-Aboriginal observers:

> To see a group of women sitting under a tree watching teenage girls play basketball looks like a peaceful scene of family relaxation. However, what is unseen is that the women under the tree are the aunties and grandmothers of the girls playing basketball, and that they are there to stop a jealous fight they know is occurring between two of the girls escalating to violence or turning into a family fight. Culturally specific forms of violence such as jealous fights have the potential to draw in much larger groups of family to support the disputants, and can continue to do damage to people and families for decades (Turner-Walker 2012: 18).

The NTER brought with it significantly increased funding to patrols in the NT, together with more resources for policing, community courts and other sources. But it also, according to Turner-Walker, undermined Aboriginal community ownership. Prior to the NTER, patrols had relied on the active engagement of community Elders, Traditional Owners and key family members. Subsequently, patrols were transformed into what Turner-Walker describes as 'a non-Aboriginal service model that prioritises administrative expedience over service delivery, and removes the basis of the patrols' legitimacy and effectiveness' (Turner-Walker 2012: 13). Patrols were required to reduce the range of their activities and focus on 'core business'; locally developed training programs were displaced by top-down programs; funds were expended not to meet the requirements of patrols, but of government budgetary cycles (Turner-Walker 2012). Blagg and Anthony (2014) describe an incident that illustrates the unintended effects of such changes, when a young man in one remote community was reported lost in the bush.

> The men's night patrol was prevented from searching for him because it was "off community"—and government funding prevented patrols from travelling off community. The patrol leader, a local Elder in a kin relationship with the young man, lost the respect of the boy's family and much of his authority

9.9   Warden Schemes and Social Behaviour Projects

While community patrols remain the most prominent expression of community policing in Aboriginal communities in Australia, they are not the only ones. Some of the earliest community policing initiatives, as the descriptions in Box 9.2 above attest, involved appointing community wardens, either in partnership with night patrols or as an alternative to them. Higgins, who evaluated two warden schemes in the NT in 1996, concluded that often there was no clear distinction in roles and responsibilities between wardens and patrols (Higgins 1997). In Alice Springs, a warden scheme was established several years after the night patrol, initially in the form of a top-down, government-imposed measure, but later brought under the control of Tangentyere Council, which developed it as a complementary service to the night patrol (Memmott et al. 2003: 14–15). While the patrol concentrated on preventing conflicts and disputes from escalating, wardens focused on working in a compassionate manner with itinerant visitors and campers (Higgins 1997). Strempel et al.

(2004: 17) described the Tangentyere wardens scheme as an early morning vehicular patrol designed to reduce illegal camping in the Todd River bed and elsewhere, and to help Aboriginal people who had become stranded in town return to their communities.

Another innovative program designed to strengthen Aboriginal social control over drinkers was the Mwerre Anetyeke Mparntwele (Sitting Down Good) Project, also known as the Social Behaviour Project (Memmott 1992). The program was developed by Tangentyere Council in the early 1990s and aimed to reduce binge-drinking and the conflict and violence associated with it by fostering more appropriate social norms, rules and behaviour through educational programs and strengthening Aboriginal law and authority. The program targeted three groups of people:

- Residents of the 19 established town camps in Alice Springs;
- Permanent and itinerant members of informal camps in the Todd River and Charles Creek in Alice Springs and
- Aboriginal people from outlying communities in Central Australia, who used Alice Springs as their regional centre (Memmott 1992).

The program had both pro-active and re-active components. The former involved promoting norms, values and conduct conducive to social cohesion; the latter, managing and mediating conflicts, sometimes in cooperation with the Tangentyere Night Patrol, and participating in judicial processes, for example, through helping to transfer offenders back to their home communities on completion of their sentences. All of these activities took place under the guidance of a Four Corners Council of Elders that was founded in Alice Springs in February 1991 and comprised about 50 initiated male Elders from town camps. A Women's Elders' Council was also established at the same time (Memmott 1992).

As part of the program, the Four Corners Council issued a set of rules prescribing expected behaviour on the part of 'bush mob' visiting Alice Springs, reproduced below in Box 9.7.

Box 9.7 Draft Rules for Bush Mob Visiting Town Camps: Social Behaviour Rules
Extract from Memmott et al. (2003: 22)

Produced by the Four Corners Elders Council, Tangentyere Council, Alice Springs, 1991.

1. Visitors coming in from bush should stay no longer than one week.
2. People shouldn't come into town to avoid ceremony business.
3. People coming out of gaol should go straight back to their community.
4. Bush Councils should help Tangentyere to get troublemakers out of town.
5. Bush Councils should worry about their people who are in town.
6. People shouldn't stay on a town camp unless they've got permission from the bosses of the camp first.

7. When people from the bush are asked to go back to their community they should do so as quickly as possible.
8. Bush visitors shouldn't chase after other people's wives and daughters in town.
9. People visiting Alice Springs should have full respect for Arrernte people and their country.
10. People visiting town for drinking should only stay one or two days and should learn to drink without fighting.
11. Visitors from bush should take notice of what Four Corners Elders, camp bosses and Night Patrol mob tell them.
12. Visitors should be careful where they camp in town.
13. People who are banned from drinking at road houses shouldn't come to Alice Springs for drinking.
14. People who make big trouble on camps and won't go home should expect to get into big trouble with the police and wind up in gaol.
15. People banned from town shouldn't break their parole or bond. They should stay out of town.
16. People from bush shouldn't camp with dialysis patients and pensioners, or make trouble for them or bludge off them.

Higgins described the program as a 'hub' linking with both the Tangentyere night patrol and the wardens program (Higgins 1997: 72–82). So far as we are aware, neither the implementation nor outcomes of the program have been documented. In at least one respect, however, it appears to have had an enduring impact. In December 2017, Tangentyere's Four Corners Men's Council, with several younger members now taking the place of others who had passed away, publicly renewed its endorsement of the rules, now labelled 'Going to Town Rules' (Hose 2017).

A similar approach that took the form of a set of 'Cultural Protocols' was subsequently adopted in Darwin by Larrakia Nation Aboriginal Corporation (LNAC), representing the traditional Aboriginal occupants of Darwin (Memmott and Fantin 2001). The protocols were first formulated in 2001, following a series of workshops and consultations in Darwin convened to identify solutions to a problem defined as one of homelessness among 'Indigenous itinerants'—that is, Aboriginal people who travelled to, and sometimes settled in, campsites scattered in and around Darwin. They were known as 'long-grassers', after the tall spear grass that sprung up in the area every monsoonal season, and had long been viewed, especially by non-Aboriginal residents of Darwin, as undesirables whose propensity to drink, fight, swear and 'humbug' in public places was an affront to good order and amenity.

The Cultural Protocols originated as part of a comprehensive and ambitious 'Indigenous Itinerants Strategy' that included a revamped and expanded community patrol, case management of individuals, assistance in helping individuals return to the communities from which they had come to Darwin, encouraging remote communities to establish licensed clubs and expanded accommodation options in Darwin

(Memmott and Fantin 2001). Much of the strategy never saw the light of day, but the Cultural Protocols formed a central part of what became known as the Community Harmony Project developed by the NT Government in partnership with LNAC (Fisher 2012). The protocols continue to be endorsed by LNAC today, with a few modifications to the original 2001 draft. Box 9.8 shows the current version.

Box 9.8 Larrakia Nation Cultural Protocols for Visitors
Source Protocol - Larrakia Nation

The Larrakia people have developed a set of cultural protocols for visitors to Larrakia land through the Community Harmony Project. These protocols apply to both Aboriginal and non-Aboriginal visitors and both temporary visitors and residents on Larrakia Country. They are as follows:

The Larrakia have always welcomed people to our lands, despite our ongoing struggle for proper recognition of our rights. The Larrakia aim to foster relationships according to our cultural protocols, which we ask you to respect.

1. The Larrakia people are the Aboriginal traditional owners of all land and waters of the greater Darwin area including identified Aboriginal living areas.
2. Aboriginal lore/law requires respect for the cultural authority of the traditional owners.
3. Larrakia speak for Larrakia country; other traditional owners speak for their traditional lands.
4. We have a mutual obligation to care for our country with our neighbours.
5. Visitors should be aware that we have a body of knowledge in our land and waters, which includes sites of significance.
6. Larrakia people expect visitors and service providers to be aware of Larrakia cultural obligations and to respect and acknowledge them.
7. Visitors have the right to be treated with respect and understanding.
8. All visitors are responsible for their behaviour and should respect guidance of Larrakia.
9. Learning about country is everybody's responsibility and it is also the responsibility of government and non-government agencies.
10. Inappropriate behaviour reflects badly on Larrakia people and we do not accept it.

The protocols, together with a specially commissioned painting and video by local Aboriginal artist Kootji Raymond, were widely disseminated throughout Darwin in shops, service stations, video stores, parks and along city walking trails (Fisher 2012). Fisher, an anthropologist who conducted fieldwork with LNAC in the early 2000s, describes the production and dissemination of the protocols, and the Community

Harmony Project of which they were part, as part of a broader political realignment involving the NT Government and LNAC, in which, in return for foregoing part of their native title claim to Darwin and its surrounds, LNAC gained a tangible stake in property and other corporate resources, and recognition as the traditional owners of the land on which Darwin stands (Fisher 2012). LNAC, in this context, had a common interest with the NT Government in minimising demands and disruption caused by Aboriginal visitors from outside Darwin. The Cultural Protocols in this context can be seen as serving a symbolic function of asserting a form of Larrakia sovereignty—one directed not only at non-Aboriginal residents of Darwin but also at other Aboriginal people.

The alignment has not gone uncontested. As Fisher notes, the portrayal of 'long-grassers' as homeless itinerants who belonged, by implication, back in their home communities was challenged by some Aboriginal activists who argued that for many people, living in the long-grass was a lifestyle choice rather than a product of homelessness, and that for some of these people, Darwin *was* home. In 2001, activists formed a Longgrass Association to press their case in the policy domain (Fisher 2012).

9.10 Summary and Conclusions: Patrols and Community Policing

For all the differences among them, the patrols, warden schemes and protocols reviewed above—as well as many others not described here—are instruments designed to enable Aboriginal communities and organisations to reclaim control over some of the drivers of order and disorder, safety and danger in their communities, and to draw on culturally appropriate ways of preventing and resolving disputes. They are not extensions of state policing or substitutes for good-quality policing.

In this chapter, we have traced the emergence of community patrols in the 1970s in several communities—most though not all of them remote—initially as unfunded, volunteer-staffed initiatives that sought to mobilise local, culturally grounded ways of preventing and resolving disputes, and the authority of respected Elders. Following the 1990 report of the Royal Commission into Aboriginal Deaths in Custody, community patrols took on a more prominent role as vehicles for a style of policing advocated by the Commission as preferable to more punitive policing practices. The number of patrols operating in remote, regional and urban settings grew, as did the flow of government resources to them.

At the same time, many patrols became subjected to conflicting role-expectations, with local authorities and other bodies viewing them as extensions of mainstream policing funded to keep drunks off the streets, rather than exercises in deploying Aboriginal authority to prevent and defuse conflicts.

The 2007 Intervention—formally known as the NT National Emergency Response—redefined the role of community patrols as vehicles for a government-defined community safety policy. Funding was increased and placed under the authority of the Commonwealth Attorney-General's Department. In the NT, where only 23 of 73 Aboriginal communities directly affected by the NTER had operating patrols, the Government decreed that all communities should do so—within a 10-month period. The result has been that community patrols today are better funded than in the past, but community control over how patrols operate has been undermined.

Two other control measures touched on in this chapter are warden schemes and cultural protocols formulated by traditional owners of a community or area defining acceptable and unacceptable behaviour by Aboriginal (and other) people residing in the area. Neither of these has been as prominent as community patrols in addressing harmful drinking. Warden schemes typically complement patrols, with wardens appointed by the community body to work with individuals towards ensuring their compliance with local community expectations.

While several descriptive accounts of patrols, warden schemes and cultural protocols exist, few have been evaluated, and it is not possible to assess their impact or outcomes. Anecdotally, most patrols and related measures enjoy strong community support, although the extent to which this has been maintained in the wake of declining community control is not clear.

All of the schemes considered in this chapter have operated within social and political contexts created, firstly, by dynamics within the host communities or organisations and, secondly, by government policies and practices. At various times, the latter have both enabled and undermined community policing of alcohol. The challenge today for governments remains what it has long been: to respect and support communities and community organisations working to control alcohol use, without making either of two errors to which governments are prone: (1) placing naïve expectations on the capacity of community organisations (and then penalising them when they do not meet those expectations) or (2) exercising excessive control as a price for providing support, as the federal government has arguably done in the wake of the 2007 Intervention in the NT.

In concluding this chapter, we reproduce seven principles for best practice in community patrols, advanced by Blagg in his review of patrols in Western Australia.

Box 9.9 Best Practice Principles for Community Patrols: Some Key Points
Extract from Blagg (2006: 4–5):

1. To operate effectively patrols need to be embedded in the local Aboriginal community. This does not mean that all workers and administrators need to be Aboriginal people; rather that patrols require the endorsement of the Aboriginal community to operate effectively, it requires cultural authority.

Amongst other things, this means that the patrol will need to acknowl-
edge Aboriginal customary law and culture. It will also need to respect
Aboriginal sensibilities around 'avoidance' where necessary and ensure
that protocols governing men and women's spheres of responsibility are
respected.

2. Patrols operate without police powers. Aboriginal patrols tend to see their
   role in terms of mediation rather enforcement, they should not be used as
   an alternative to the police or private security.

3. A patrol's primary role should be to divert Aboriginal people away
   from enmeshment in the criminal justice and related systems and, where
   necessary, into community owned systems of care, control and support.

4. They also have a key role in the early identification of potential victims of
   crime and should be viewed as having a victim support role.

5. Processes of capacity building are necessary to support patrols. There is a
   need for 'cultural' capacity building in non-Aboriginal agencies working
   with patrols. These should involve cultural training by local Aboriginal
   elders and people of significance.

6. Patrols should not be viewed in isolation as stand-alone para-policing
   initiatives, rather they need to be situated within an emerging sphere
   of Aboriginal-owned community justice mechanisms, supported by the
   Aboriginal domain.

7. Funding, training and appropriate forms of information gathering are
   crucial to the long-term viability of patrols.

As this chapter makes clear, the fundamental principle on which all the measures
considered here rest is that of community ownership—a term that is easily proclaimed
in policy rhetoric, but in practice, something that is complex, fragile and in need of
constant defence.

References

Australian Law Reform Commission. 1986. *Recognition of Aboriginal customary laws (ALRC
   Report 31).* Canberra: Australian Law Reform Commission. https://www.alrc.gov.au/public
   ation/recognition-of-aboriginal-customary-laws-alrc-report-31/. Accessed 8 Feb 2021.
Australian National Audit Office. 2011. *Northern Territory night patrols.* Canberra: Australian
   National Audit Office.
Blagg, Harry. 2003. *An overiew of night patrol services in Australia.* Canberra: Crime Prevention
   Branch, Commonwealth Attorney-General's Department.
Blagg, Harry. 2006. *Models of best practice: Aboriginal community patrols in Western Australia.*
   Nedlands: Crime Research Centre, University of Western Australia. http://www.crimeprevent
   ion.wa.gov.au/uploads/file/aboriginal_community_patrols_in_wa.pdf. Accessed 20 July 2010.
Blagg, Harry. 2016. *Crime, Aboriginality and the decolonisation of justice.* Leichhardt NSW:
   Federation Press.

Blagg, Harry, and Thalia Anthony. 2014. 'If those old women catch you you're going to cop it': Night patrols, indigenous women, and place based sovereignty in Outback Australia. *African Journal of Criminology and Justice Studies* 8: 103–124.

Blagg, Harry, and Thalia Anthony. 2019. *Decolonising criminology: Imagining justice in a postcolonial world*. London: Palgrave Macmillan.

Blagg, Harry, and Giulietta Valuri. 2002. *Profiling night patrol services in Australia*. Perth: Crime Research Centre, University of Western Australia.

Blagg, Harry, and Giulietta Valuri. 2004a. Aboriginal community patrols in Australia: Self-policing, self-determination and security. *Policing and Society* 14: 313–328. https://doi.org/10.1080/1043946042000286047.

Blagg, Harry, and Giulietta Valuri. 2004b. Self-policing and community safety: The work of Aboriginal community patrols in Australia. *Current Issues in Criminal Justice* 15: 205–219.

Brady, Maggie. 2012. *The grog book*. Canberra: Department of Health and Ageing.

Cunneen, Chris. 2001. *Conflict, politics and crime: Aboriginal communities and the police*. Sydney: Taylor & Francis Group.

Curtis, Dave. 1993. Julalikari Council's community night patrol. In *Aboriginal justice issues. Proceedings of a conference held 23–25 June 1992*, ed. Sandra McKillop. Canberra: Australian Institute of Criminology.

d'Abbs, P., Burlayn, and Jamijin. 2019. Aboriginal alcohol policy and practice in Australia: A case study of unintended consequences. *International Journal of Drug Policy* 66: 9–14. https://doi.org/10.1016/j.drugpo.2019.01.004.

Fisher, Daniel. 2012. Running amok or just sleeping rough? Long-grass camping and the politics of care in northern Australia. *American Ethnologist* 39: 171–186. https://doi.org/10.1111/j.1548-1425.2011.01356.x.

Hasluck, N. 2018. Don McLeod's unusual quest. *Brief*: 33–38.

Higgins, David & Associates. 1997. *Best practice for Aboriginal community night patrols and warden schemes. A report to the Office of Aboriginal Development*. David Higgins & Associates.

Hose, Nick. 2017. Central Australian men's council creates rulebook for remote Aboriginal residents visiting Alice Springs town camps. *ABC News*, December 13.

John Scougall Consulting Services. 2012. *Keeping people safe: An evaluation of the Nyoongar Patrol Outreach Service*. Perth: Nyoongar Patrol Systems Inc.

Langton, Marcia. 1992. *Aborigines and policing: Aboriginal solutions from Northern Territory communities, paper presented at the Wentworth Lecture*. Canberra: Australian Institute for Aboriginal and Torres Strait Islander Studies. http://www.aiatsis.gov.au/lbry/dig_prgm/wentworth/m0007677_a.rtf. Accessed 25 Apr 2008.

McLeod, Don. 1984. *How the West was lost*. Port Hedland, WA.: D.W. McLeod.

Memmott, Paul. 1992. Mwerre Anetyeke Mparntwele; A project by Tangentyere Council. In *Aboriginal justice issues: Proceedings of a conference held 23–25 June 1992*, ed. Sandra McKillop, 47–58. Canberra: Australian Institute of Criminology.

Memmott, Paul, and Shaneen Fantin. 2001. *'The long grassers': A strategic report on indigenous 'itinerants' in the darwin and palmerston area*, vol. 1. St Lucia, Qld.: Paul Memmott & Associates.

Memmott, Paul, Steve Long, and Catherine Chambers. 2003. *A national analysis of strategies used to respond to indigenous itinerants and public place dwellers*. Brisbane: School of Geography, Planning and Architecture, University of Queensland.

Mosey, A. 1994. *Central Australian remote area night patrols*. Alice Springs NT: A review on behalf of Drug and Alcohol Services Association Alice Springs Inc. (D.A.S.A.).

Northern Territory Police Service and Julalikari Council Inc. 1991. *Agreement on practices and procedures between the Julalikari Council and the Northern Territory Police concerning the Julalikari Council night patrol*. Tennant Creek, NT: Northern Territory Police Service and Julalikari Council Inc.

Porter, Amanda. 2016. Decolonizing policing: Indigenous patrols, counter-policing and safety. *Theoretical Criminology* 20: 548–565. https://doi.org/10.1177/1362480615625763.

Porter, Amanda. 2018. Non-state policing, legal pluralism and the mundane governance of "crime." *Sydney Law Review* 40: 445–469.

Sputore, Brooke, Dennis Gray, and Chris Sampi. 2000. *Review of the services provided by Jungarni-Jutiya Alcohol Action Council Aboriginal Corporation.* Perth: National Drug Research Institute, Curtin University of Technology. https://espace.curtin.edu.au/bitstream/handle/20.500.11937/13070/19192_downloaded_stream_284.pdf?sequence=2&isAllowed=y. Accessed 1 Feb 2021.

Strempel, Phillipa, Sherry Saggers, Dennis Gray, and Anna Stearne. 2004. *Indigenous drug and alcohol projects: Elements of best practice. ANCD Research Paper 8.* Canberra: Australian National Council on Drugs.

Tangentyere Council Patrollers with Catriona Elek. 2007. Relhe Marre Tnyeneme: Community patrols in Alice Springs: Keeping people safe. *Indigenous Law Bulletin* 24: 6.

Turner-Walker, Jennifer. 2012. Clash of the paradigms: Night patrols in Remote Central Australia. University of Western Australia.

Chapter 10
Conclusion: Outcomes and Issues

Artwork by Delvene Cockatoo-Collins

Abstract   This chapter summarises findings from the previous chapters addressing, respectively, primary prevention; secondary prevention or early intervention; treatment and rehabilitation; local restrictions on supply of liquor; community-controlled liquor outlets; liquor permit schemes; programs for preventing and diagnosing FASD and providing support to affected families, and community patrols and warden schemes. In most of these domains, there is little evidence with which to assess program outcomes; most of the limited data produced relates to implementation processes rather than outcomes. This enables us to identify key factors that enable or impede successful implementation. The chapter summarises these factors with respect to each of the program domains covered. It concludes with a brief discussion of three factors common to all domains: the importance of a high level of community control of programs; the importance of interpersonal relationships among key players, both within Aboriginal and non-Aboriginal domains and, especially, across these domains, and the need, in evaluating programs, to incorporate Aboriginal criteria and ways of knowing as well as indicators grounded in Western scientific frameworks.

This book began as a response to a dearth of evidence about the effectiveness of programs aimed at preventing or managing alcohol-related harms in Aboriginal communities or among Aboriginal people in Australia. The response has been informed by a belief that, after fifty years in which all sorts of programs and services have been established, there ought to be more by way of useful lessons that have been gleaned to date. We also suggested in the Introduction at the beginning of this book that at present we may not be availing ourselves of those lessons as well as we might, partly because relevant documents are fading into obscurity, and partly because a narrow understanding of what constitutes 'evidence' may result in potentially useful material being overlooked.

In the foregoing chapters, we reviewed documented evidence of programs and services in eight domains:

- Primary prevention;
- Secondary prevention or early intervention;
- Treatment and rehabilitation;
- Local restrictions on supply of liquor;
- Community-controlled liquor outlets in communities;
- Liquor permit schemes;
- Programs for preventing and diagnosing FASD and providing support to families impacted by Fetal Alcohol Spectrum Disorders (by FASD);
- Community patrols and warden schemes.

Almost all of these programs, it should be recognised, have been constrained by two limiting factors. The first is that alcohol interventions, virtually by definition, address symptoms rather than causes: the symptoms are various kinds of alcohol-related harms and the drinking patterns that give rise to them. The causal factors—poverty, marginalisation, intergenerational trauma and, behind all of these,

the ongoing legacy of colonisation—are rarely addressed, although healing programs aim to break the cycle of intergenerational trauma. To assert this point is not to deny that alcohol misuse in itself, once it becomes embedded culturally, is not a causal phenomenon in its own right, it is simply to acknowledge that alcohol programs themselves can only focus on a few components of large and complex causal chains. Other components, some of which are often conceptualised as the social, political and economic determinants of alcohol and other drug misuse, must be addressed in their own right. The second limitation is that few programs are established in a way conducive to adequate and appropriate monitoring and evaluation, either in terms of financial resources, program design or evaluation expertise.

It is not surprising then, that perhaps the most obvious outcome of our inquiry is confirmation that, as others have said before us, the evidence-base is thin (Gray and Saggers 2005; Gray and Sputore 1998; Loxley et al. 2004; Intergovernmental Committee on Drugs (Australia) 2014; James et al. 2018; Ministerial Council on Drug Strategy (MCDS) 2003). With the partial exception of local restrictions on supply and some descriptive studies of the prevalence of FASD (which have a potential to provide valuable baseline data for future programs), there is little evidence available to assess likely outcomes of most programs. Much of the limited and not very good quantitative data generated by programs tracks implementation processes rather than outcomes.

What we have also found, however, is a considerable amount of qualitative evidence about factors that tend to enable or impede successful implementation of programs, and this, we would argue, is of practical value not only to policy-makers and funding bodies but also to those involved on the ground in designing and implementing programs. By evidence here, we mean empirically supported observations of factors that enable or impede successful implementation and/or outcomes of programs.

Table 10.1 summarises the main findings from preceding chapters regarding enabling and impeding factors in each of the program domains listed above. These factors are discussed further in the relevant preceding chapters.

In addition to the factors identified in Table 10.1, many of which are specific to particular types of programs, we have identified three other issues that, we believe, are relevant to all of the program domains explored in this book, and that have implications for future initiatives. These are, firstly, the nature of community control; secondly, the importance of personal relationships, and thirdly, questions to do with defining relevant knowledge. We conclude this book by discussing each of these briefly.

Table 10.1 Summary of factors enabling and impeding interventions

Program type	Chapter	Factors conducive to implementation and effective outcomes	Factors that impede implementation and/or positive outcomes
Primary prevention (preventing or delaying uptake of harmful alcohol use)	3	• Community leadership; • Strategic partnerships between community organisations and both internal and external agencies; • Limited, clearly defined and widely supported objectives; • Data documenting both baseline and post-intervention indicators of problem being addressed; • A pathway to achieving selected objectives; • Regular rather than one-off initiatives; • A multi-component approach; • Cultural and recreational components promoting a sense of connectedness	Few interventions have been evaluated and, of those that have been evaluated, few have demonstrated positive outcomes
Secondary prevention/early intervention (preventing onset or continuation of harmful drinking among people already engaging in or at risk of harmful use)	3	• Strong evidence base for effectiveness of screening and brief intervention in primary health care settings among mainstream populations; • Training and support for service providers; • Defined referral pathways	• Competing demands on health practitioners' time, • Reluctance by health providers to question patients about their drinking; • A perceived (and often real) lack of referral options for patients requiring follow-up treatment

Table 10.1 (continued)

Program type	Chapter	Factors conducive to implementation and effective outcomes	Factors that impede implementation and/or positive outcomes
Treatment and rehabilitation	4	• Good governance (including clear distinction between roles and responsibilities of boards and managers); • Adequate resources • Trained staff with linkages to mentoring and professional development opportunities; • Participatory evaluation models based on partnerships between evaluators and service providers, rather than imposed evaluation models	• Inadequate and insecure funding; • Narrow range of treatment options offered by residential programs; • Difficulties in meeting governance requirements; • Sparsity of evidence of effectiveness; • Many clients have multiple needs requiring a broad range of treatments; • Inappropriate referrals to treatment, sometimes generated by criminal justice system
Community-based restrictions on availability	5, 6	• Restrictions tailored to local needs; • Local community leadership; • Attention to complementary measures to reduce demand, such as early intervention and treatment; • Flexibility in responding to changing needs • Evaluation to demonstrate outcomes and level of community support	• Opposition from liquor and hospitality industries; • Reluctance by politicians to impose restrictions; • Effectiveness fades over time; • Restrictions sometimes lead to unintended consequences such as 'grog-running' or drug substitution

Table 10.1 (continued)

Program type	Chapter	Factors conducive to implementation and effective outcomes	Factors that impede implementation and/or positive outcomes
Community-controlled licensed outlets	7	• Community support; • Imposition and enforcement of strict trading conditions by licensing authority; • Timely support from government agencies, especially police and licensing authorities; • Strong governance and management; • Appropriate physical amenities; • Responsible serving practices; • Clear eligibility rules (e.g. for suspending patrons for specified offences)	• Tension between objectives of fostering moderation and maintaining commercial viability; • Established drinking cultures favouring heavy consumption; • Challenges in governance and management—and failure of government agencies to support and strengthen local governance capacity
Liquor permit systems	7	• Adequate administrative support for local permit committees; • Geographic isolation; • Effective controls over illegal purchasing and supplying of liquor ('grog-running'); • Legitimacy in eyes of community	• Administrative burden on local permit committees; • Availability of alternative sources of liquor (or other drugs); • Community opposition or disinterest

Programs addressing Fetal Alcohol Spectrum Disorders (FASD)	8	• Community-led partnerships bringing together community groups, service providers and researchers;
		• Approaches for addressing FASD that
		  – Are embedded in broader strategies for reducing alcohol-related harm, including effective controls on alcohol availability;
		  – Address social and cultural determinants of health as well as FASD itself, and
		  – Cover prevention, diagnosis and support;
		• Adequate, consistent and culturally appropriate support—both in funding, professional services and enabling legislation—from governments
			• Lack of awareness or understanding of nature, determinants and consequences of FASD both in wider society and among many health professionals;
			• Difficulties in providing diagnostic and support services, particularly in remote communities;
			• Inadequate resources for prevention and diagnosis, and for supporting families impacted by FASD

Table 10.1 (continued)

Program type	Chapter	Factors conducive to implementation and effective outcomes	Factors that impede implementation and/or positive outcomes
Alcohol and community policing in Aboriginal communities	9	• Community ownership; • Adequate resources; • Clearly defined roles; • Mutually acceptable expectations with police; • Mutually acceptable expectations with other community stakeholders; • Authority of Elders or other senior persons; • Training and staff development	• Inadequate resources; • Conflicting expectations with/from funding bodies, police, other community stakeholders; • Pressure to function as a 'drunks taxi' rather than resolving disputes; • Excessive government control

10.1   Community Control

Most of the accounts of programs in this book, especially the more successful ones, have stressed the importance of control by the local community or its agencies. There are good reasons for this. Alcohol misuse is, at least in part, a product of personal and collective powerlessness, and is unlikely to decline as long as powerlessness remains pervasive. Individuals may stop drinking heavily, but others will take their place. (This is why law-enforcement based strategies targeting public drunkenness— which we have not reviewed in this book—achieve little other than new forms of resistance by drinkers). The culture of binge drinking that has long typified some Aboriginal alcohol consumption emerged in the first instance in a context where Aboriginal people were denied any rights to manage their encounter with alcohol— or many other aspects of their lives (Beckett 1964; Brady 2008). It has persisted to this day in part as a response to ongoing powerlessness (Brady 1990; Brady and Palmer 1984; Cowlishaw 1994; Sackett 1988). In this context, the act of asserting control over alcohol, whether by an individual, group or community, is to refuse to assent to powerlessness, to reclaim a degree of power.

Another reason is pragmatic. As numerous examples in this book demonstrate, dealing with alcohol-related harm is hard work that requires a sustained commitment. It often generates resistance, either from determined drinkers or the outlets that supply them—or both. As a result, in addition to the inherent difficulties in changing established drinking patterns, groups or communities intent on reducing alcohol-related harms face the challenge of maintaining ongoing support for their chosen programs. The kind of commitment required is unlikely to be maintained in the absence of a high level of community involvement from the outset in identifying problems and prioritising solutions.

The word 'community', however, has many connotations and uses, not all of them helpful in addressing alcohol-related issues. 'Community' can be a gloss, implying consensus where consensus does not exist. Individuals and groups will sometimes seek to advance their own interests by claiming to be speaking on behalf of the community. In such instances, it is prudent to ask: *who* is claiming to speak on behalf of the community, on what authority, and with what objectives? Whose voices, in these situations, are not being heard? Governments also use the term 'community' to pursue their own policy objectives. To insist that a particular issue is 'the community's responsibility'—as successive governments did through the latter twentieth century with regard to petrol sniffing in some Aboriginal communities—can be a justification for doing nothing or very little. At the other extreme, government agencies also sometimes use the rhetoric of community ownership to conceal the top-down nature of their own policies and programs. An example is the introduction of Alcohol Management Plans in Aboriginal communities in Queensland from 2002 (see the discussion in Chap. 5). The Queensland Government, in response to evidence of high levels of alcohol-related violence in some communities, was determined to divest local Aboriginal councils of control over beer canteens and reduce access to alcohol in many communities. By insisting that communities formulate their own

Alcohol Management Plans that complied with the government's objectives, it could claim that the AMPs were 'owned' by the communities concerned (Smith et al. 2019). For an illuminating case study of how this dynamic played out over time in one Cape York community, see Moran (2016: 15–28).

Finally, community control is also inherently fragile and easily eroded—even unintentionally—by the sheer strength of government political and economic power. The recent history of community patrols in many Aboriginal communities demonstrates this all too clearly. Following the 2007 Commonwealth intervention into Aboriginal communities in the Northern Territory, as we show in Chap. 9, the government significantly increased its funding support for patrols, but at the same time it also tightened its control over the roles and activities of patrols, with a result that community involvement ebbed away (Blagg and Anthony 2019).

10.2 The Importance of Relationships

One of the characteristics of successful alcohol programs at a community level—and one that is often overlooked in reports and other written descriptions—is the presence of strong interpersonal relationships among key players. Relationships marked by mutual familiarity, trust and respect, both within the Aboriginal and non-Aboriginal domains and, perhaps even more so, spanning both domains, facilitate the search for solutions and help to navigate the challenges, disagreements and disappointments that are part and parcel of alcohol interventions. These relationships are not part of programs, which helps to explain why their importance is not acknowledged, but in our observation they are often the foundation on which programs are built. Without them, many programs, however well designed, are likely to struggle for sustainability and impact.

10.3 Knowledge for Whom?

Within the world occupied by policy-makers, service providers and researchers, concepts such as 'evidence-based', 'best practice' and 'performance indicators' testify to a culture of rationality and transparency that is viewed as a self-evident good. From a different standpoint, however, as we suggested in Chap. 4, the same culture can be viewed as having in the past facilitated the colonial domination of Aboriginal people and, even today, as according scant respect to Aboriginal ways of ordering the world. In their 2019 report on an Alcohol Management Plan in the Cape York community of Pormpuraaw, Smith et al. question the value of past research on Indigenous alcohol issues, asserting that while it 'is sometimes of benefit to governments wishing to measure the performance of community groups funded by them, it has contributed little to increasing the capacity of individuals or groups to manage alcohol more effectively' (Smith et al. 2019: 12). They attribute the failure

to a reliance on biomedical and epidemiological analyses of drinking patterns and trends at the expense of research that reveals the complex interactions between social, cultural, economic and political factors that give rise to alcohol-related harms. We would go further, and argue that, as well as paying attention to these factors, research (including evaluation research) should accord greater respect than in the past to Aboriginal perspectives and priorities. As we noted in Chap. 4, some promising steps in this direction have been taken, such as Nichols participatory research project in the West Kimberley of WA, in which Aboriginal people worked with her in designing an evaluation framework that emphasised outcomes such as re-engagement with family and community rather than amounts of liquor consumed by participants (Nichols 2010). Shakeshaft et al.'s collaboration with a NSW treatment centre to produce a 'Healing Model of Care', also discussed in Chap. 4, attempts to integrate the logic of evaluation with cultural priorities of the Aboriginal-run program (Shakeshaft et al. 2018).

Differences in perspectives can also arise with respect to applying program models to local settings. Western scientific thinking moves constantly and easily between the particular and the general. Researchers, as a matter of course, think about the generalisability of their findings. Policy-makers and program funders keep a constant eye out for potential 'models'—that is, programs shown to be successful in one setting and therefore, it is hoped, replicable in others. Aboriginal community organisations, however, often show little interest in such models. Porter (2016), reflecting on fieldwork conducted with three Aboriginal community patrols in urban and regional centres in NSW, noted that those involved in patrols were frequently resistant to the idea that solutions developed elsewhere—regardless of whether or not by Aboriginal people—could be imported to their own communities. Patrols derived their legitimacy through addressing local conditions and being answerable to the local community.

> The often-heard claim that "Redfern is not Bourke", as voiced explicitly by research participants, reflects a sense that imposing general solutions is disrespectful to local Indigenous autonomy, to pre-existing local processes and to the community members in specific locales more generally. More than being disrespectful, the imposition of general solutions or pan-Indigenous programmes—without meaningful collaboration with the local Indigenous community—may have a recolonizing effect (Porter 2016: 563).

This might seem an odd note on which to close this book—which is, after all, about programs 'developed elsewhere'. We are not, however, advocating the 'imposition of general solutions or pan-Indigenous programs' on anybody or any community. At the same time, we believe that there are lessons to be learnt from the experiences of others. Creating programs that are both responsive to local conditions and informed by evidence about what is likely to be effective under these conditions is an art as much as a science. Our hope is that this book makes a useful contribution to both the art and science involved.

References

Beckett, J. 1964. Aborigines, alcohol and assimilation. In *Aborigines now: New perspectives in the study of Aboriginal communities*, ed. M. Reay. Sydney: Angus and Robertson.

Blagg, Harry, and Thalia Anthony. 2019. *Decolonising Criminology: Imagining justice in a postcolonial world*. London: Palgrave Macmillan.

Brady, M. 1990. Indigenous and government attempts to control alcohol use among Australian Aborigines. *Contemporary Drug Problems* 17: 195–220.

Brady, Maggie. 2008. The historical burden of prohibition. *Of Substance* 6: 7.

Brady, M., and K. Palmer. 1984. *Alcohol in the Outback*. Darwin: North Australia Research Unit, Australian National University.

Cowlishaw, Gillian. 1994. Policing the races. *Social Analysis* 36: 71–92.

Gray, Dennis, and Sherry Saggers. 2005. The evidence base for responding to substance use problems in Indigenous communities. In *Preventing harmful substance use: The evidence base for policy and practice*, ed. T.R. Stockwell, P. Gruenewald, J. Toumbourou, and W. Loxley, 381–393. Chichester, UK: Wiley. ISBN 0-470-09227-0 [CH128].

Gray, Dennis, and Brooke Sputore. 1998. The effective and culturally appropriate evaluation of Aboriginal community alcohol intervention projects. In *Drug trials and tribulations: Lessons for Australian drug policy*, ed. Tim Stockwell. National Centre for Research into the Prevention of Drug Abuse; Curtin University of Technology.

Intergovernmental Committee on Drugs (Australia). 2014. *National Aboriginal and Torres Strait Islander peoples' drug strategy 2014–2019.* Canberra: Intergovernmental Committee on Drugs. www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/natsipds2014-19d. Accessed 16 Aug 2018.

James, D., A. Shakeshaft, A. Munro, and R. Courtney. 2018. The need to move from describing to evaluating the effectiveness of Indigenous drug and alcohol residential rehabilitation services: A systematic review.*Current Drug Abuse Reviews* 11. https://doi.org/10.2174/1874473711666180404123904.

Loxley, Wendy, John W. Toumbourou, Tim Stockwell, Ben Haines, Katie Scott, Celia Godfrey, Elizabeth Waters, George Patton, Richard Fordham, Dennis Gray, Jann Marshall, David Ryder, Sherry Saggers, Lena Sanci, and Jo. Williams. 2004. *The prevention of substance use, risk and harm in Australia: A review of the evidence.* Canberra: National Drug Research Institute and the Centre for Adolescent Health.

Ministerial Council on Drug Strategy (MCDS). 2003.*National drug strategy Aboriginal and Torres Strait Islander peoples' complementary action plan 2003–2006*. Canberra: Commonwealth of Australia.

Moran, Mark. 2016. *Serious Whitefella Stuff: When solutions became the problem in Indigenous affairs*. Carlton, Victoria: Melbourne University Press.

Nichols, Fiona. 2010. Aboriginal recommendations for substance use program evaluation. *Aboriginal and Islander Health Worker Journal* 34: 17–19.

Porter, Amanda. 2016. Decolonizing policing: Indigenous patrols, counter-policing and safety. *Theoretical Criminology* 20: 548–565. https://doi.org/10.1177/1362480615625763.

Sackett, L. 1988. Resisting arrests: Drinking, development and discipline in a desert context. *Social Analysis* 24: 66–77.

Shakeshaft, Anthony, A. Clifford, D. James, C.M. Doran, A. Munro, T. Patrao, A. Bennett, C. Binge, T. Bloxsome, J. Coyte, D. Edwards, N. Henderson, and D. Jeffries. 2018. *Understanding clients, treatment models and evaluation options for the NSW Aboriginal Residential Healing Drug and Alcohol Network (NARHDAN): A community based participatory research approach.* Sydney: Prepared by the National Drug and Alcohol Research Centre (UNSW Sydney) for the Department of the Prime Minister and Cabinet, Canberra ACT. https://pmc.gov.au/resource-centre/indigenous-affairs/understanding-clients-treatment-models-and-evaluation-options-narhdan. Accessed 17 Oct 2018.

Smith, Kristen, M. Langton, Richard Chenhall, Penelope Smith, and Shane Bawden. 2019.
    *The Alcohol Management Plan at Pormpuraaw, Queensland, Australia: An ethnographic
    community-based study.* Melbourne: University of Melbourne and Foundation for Alcohol
    Research and Education.

Correction to: Learning from 50 Years of Aboriginal Alcohol Programs

Correction to:
P. d'Abbs and N. Hewlett, L*earning from 50 Years*
of Aboriginal Alcohol Programs,
https://doi.org/10.1007/978-981-99-0401-3

In the original version of the book a Disclaimer was missed to include. This has now been rectified and the Disclaimer has been included.

The updated original version for this book can be found at
https://doi.org/10.1007/978-981-99-0401-3

Index