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National Drug
Research Institute

Preventing harmful drug use in Australia

INDIGENOUS AUSTRALIAN ALCOHOL AND OTHER DRUG ISSUES:

Research from the National Drug Research Institute

Edited by
Dennis Gray and Sherry Saggers

Funded by the National Drug Strategy
and the Office of Aboriginal and
Torres Strait Islander Health

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Indigenous Australian Alcohol and Other Drug Issues: Research from the National Drug Research Institute

Edited by

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National Drug Research Institute
Curtin University of Technology
Perth

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Foreword

This collection of journal articles and book chapters on Indigenous Australian drug and alcohol research by the National Drug Research Institute (NDRI) at Curtin University of Technology represents a timely and crucial contribution to the debate about substance misuse directions for Indigenous Australians, services and governments.

The NDRI has had a long and positive relationship with Indigenous people in regards to issues surrounding substance use. This book highlights the importance of linking national research centres such as NDRI and community-controlled Indigenous organisations across rural, remote and urban areas of Australia. Without commitments from centres such as NDRI, there would be a paucity of research into the structural determinants and positive outcomes in relation to Indigenous substance use.

This book brings together a range of findings: from liquor licensing restrictions to what works. Recently NDRI also completed a study mapping Indigenous drug and alcohol projects across Australia in 1999—2000. This was the first attempt to give a view as to what is happening across the country.

The NDRI's commitment and track record in relation to Indigenous substance use issues is beyond par. I would like to recommend this collection as a continuation of that commitment, and I look forward to it adding to informed decision-making by Indigenous organisations, academics and the government sector.

Scott Wilson
Chairperson
National Indigenous Substance Misuse Council Inc.

5th April 2002

Contents

Foreword v

Contents vii

Acknowledgments ix

1. Introduction
   Dennis Gray, Sherry Saggers 1
2. Beating the grog: an evaluation of the Tennant Creek liquor licensing restrictions
   Dennis Gray, Sherry Saggers, David Atkinson, Brooke Sputore, Deirdre Bourbon 17
3. Indigenous Australians and Liquor Licensing Restrictions
   Dennis Gray 29
4. Aboriginal wellbeing and liquor licensing legislation in Western Australia
   Dennis Gray, Mary Drandich, Lisa Moore, Ted Wilkes, Rob Riley, Sandy Davies 35
5. Evaluation of an Aboriginal health promotion program: a case study from Karalundi
   Dennis Gray, Brooke Sputore, Jill Walker 53
6. What works? A review of evaluated alcohol misuse interventions among Aboriginal Australians
   Dennis Gray, Sherry Saggers, Brooke Sputore, Deirdre Bourbon 63
7. The use of tobacco, alcohol and other drugs by young Aboriginal people in Albany, Western Australia
   Dennis Gray, Brooke Morfitt (Sputore), Kathleen Ryan, Sam Williams 79
8. The Northern Territory's cask wine levy: health and taxation policy implications
   Dennis Gray, Tanya Chikritzhs, Tim Stockwell 93
9. Regional variation in alcohol consumption in the Northern Territory
   Dennis Gray, Tanya Chikritzhs 99
10. The effective and culturally-appropriate evaluation of Aboriginal community alcohol intervention projects
    Dennis Gray, Brooke Sputore 109
11. Evaluating government health and substance abuse programs for Indigenous peoples: a comparative review
    Dennis Gray, Sherry Saggers, Mary Drandich, Dawn Wallam, Paul Plowright 123
12. Alcohol in Indigenous Australian communities
    Sherry Saggers, Dennis Gray 137
13. Supplying and promoting 'grog': the political economy of alcohol in Aboriginal Australia
    Sherry Saggers, Dennis Gray 151
14. Explanations of Indigenous alcohol use
    Sherry Saggers, Dennis Gray 169

Index 191

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Dennis Gray
Sherry Saggers

3rd March 2002

1. Introduction

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Over the past twenty-five years our research on Indigenous health and substance misuse issues, while focused on Western Australia and the Northern Territory (NT), has involved consultations with Indigenous and non-Indigenous people throughout Australia. Whether talking to community members, service providers or policymakers, a common question has arisen: 'What is the use of all this research, and how is it relevant to our attempts to make a positive contribution to Indigenous wellbeing?' Some people are very sceptical about the contribution academic research can make to improvements in health; others have neither the time nor the resources to access material that they might otherwise use. This volume of collected papers attempts to address both these concerns.

The chapters in this volume describe the results of some of the collaborative research into Indigenous substance misuse conducted by staff from: the National Drug Research Institute at Curtin University of Technology; the Institute for the Service Professions at Edith Cowan University; the Centre for Aboriginal Medical and Dental Health at the University of Western Australia; and a number of Indigenous community-controlled organisations. We have brought together the chapters, which have been published previously in various journals and books, to make them more readily accessible, and to highlight the themes that have guided, and emerge from, the research.

The National Drug Research Institute's Indigenous Australian Research Program

The National Drug Research Institute was established as the National Centre for Research into the Prevention of Drug Abuse in 1986, as part of the National Campaign Against Drug Abuse (now the National Drug Strategy). The Institute's

Indigenous Australian Research Program was initiated in late 1991, in response to Recommendation 66 of the Royal Commission into Aboriginal Deaths in Custody that:

> … appropriate steps be taken to ensure that the NCADA (National Campaign Against Drug Abuse) national research and training centres at the University of New South Wales, Curtin University, and the Flinders University of South Australia establish mechanisms to encourage new graduates, researchers from other fields and Aboriginal people to conduct research in this area and identify research priorities and methods to implement them.[1]

The aim of the Institute's Indigenous Australian Research Program is to identify strategies to reduce substance misuse and related harm among Indigenous Australian peoples. The specific objectives of the program are the:

- identification of risk factors for the misuse of alcohol and other drugs by Indigenous peoples, and strategies that might help prevent it;
- development of culturally-appropriate means for measuring the extent and consequences of Indigenous alcohol and drug misuse—including appropriate means for program and project evaluation; and
- dissemination of information about Indigenous alcohol and drug misuse, and measures for its prevention.

The Institute's program research is based on recognition of the diversity among Indigenous peoples, and the fact that much research has provided little direct benefit to Indigenous communities. Accordingly, the program—which is conceived as a resource for Indigenous community organisations—is based on the following principles:

- Indigenous Australians should make the decisions about what research is to be conducted in their communities;
- research should be practically-oriented;
- Indigenous people should be involved at all stages of the research process;
- the research process should include training of Indigenous people; and
- research should be directed towards providing Indigenous people with information that empowers them in their quest for self-determination and the provision of appropriate services.

In the ten years since the program's establishment, staff have undertaken 20 major, and several smaller, research projects. Based on these, they have written a book, 17 journal articles or book chapters, 18 technical reports and 22 conference papers on Indigenous substance misuse. These publications account for 17% of all Australian publications on these issues between 1992 and 2001, and 30% of research publications in that period.[2]

In conjunction with Tangentyere Council, Julalikari Council, and Waringarri Aboriginal Corporation, staff have also developed a computer package for the monitoring and evaluation of night patrols and warden schemes.[3] This package can be

customised to suit the needs of any local night patrol, and is available free of charge to any organisation that wishes to use it.

In order to disseminate information about Indigenous substance misuse issues, and the work that is being undertaken to reduce misuse and related harm, staff have developed a web-based database.[2] This database includes an annotated bibliography with details about more than 700 articles on Indigenous Australian substance use, and a project database that provides information on approximately 300 intervention projects for Indigenous people (most of which are conducted by Indigenous community-controlled organisations).

About this collection

The 13 chapters in this volume include: six papers on primary research projects that involved the collection of new data; and seven on secondary research projects—the latter papers review the results of other studies and discuss their implications. These 13 papers were selected because they highlight a number of themes that run through, or have guided, our work:

- monitoring changing patterns of Indigenous alcohol and other drug use;
- a focus on the political and economic context of Indigenous substance misuse;
- the importance of supply reduction strategies;
- the importance of culturally-appropriate evaluation in determining which intervention strategies work; and
- the continuum of practical collaboration between researchers and Indigenous communities.

Although the chapters cover a ten-year period, all include issues that are of continuing relevance.

The six primary research chapters deal with: patterns of substance use among young Aboriginal people in Albany, Western Australia (Chapter 7); patterns of alcohol consumption in the NT (Chapter 9); evaluations of liquor licensing restrictions (Chapter 2) and a health promotion program (Chapter 5); the use of liquor licensing legislation to promote Aboriginal wellbeing (Chapter 4); and the effect of a levy on the sale of cask wine in the NT (Chapter 8).

Of the seven secondary research chapters, four deal with evaluation of intervention projects (Chapters 3, 6, 10, 11). One of these chapters is a review of the small number of projects for which formal evaluations have been conducted (Chapter 6). Another reflects on the effectiveness of interventions aimed at limiting the supply of alcohol (Chapter 3). The other three chapters reflect on: the relationship between individual and community 'rights' in the context of treatment and controls over the availability of alcohol (Chapter 12); the supply and promotion of alcohol in Indigenous communities

(Chapter 13); and the theories that have been employed to explain why some people in Indigenous communities (in New Zealand and Canada, as well as Australia) consume alcohol at levels that are harmful to the wellbeing of themselves, their families and their communities (Chapter 14).

Patterns of Indigenous substance use

When confronted by someone who misuses alcohol or other drugs, most people's immediate response is to characterise that misuse as a fault of the individual. Only when we become aware of wider patterns of misuse is it possible to see that what we might otherwise regard as only an individual problem is a public issue. There is considerable evidence to demonstrate that substance-related problems are not randomly distributed within populations. For example, in a study conducted among Aboriginal communities in western New South Wales, Gray and Hogg found varying rates of death (including alcohol-related deaths) that were associated with characteristics of the communities rather than individuals.[4] Similarly, the 1994 survey of Indigenous Australians conducted by the National Drug Strategy found higher rates of alcohol use among those who were unemployed and those who had lower levels of education.[5] Therefore, when attempting to address problematic substance use, we need to focus on the social factors with which it is associated rather than seeing these behaviours as either individual frailties or behaviours common to Indigenous peoples as a whole.

The baseline: National Drug Strategy findings

The context of the research projects on which we report in this volume is the well-documented pattern of substance use among Indigenous Australians. The largest study of the patterns of Indigenous Australian substance use was undertaken in 1994 as part of the National Drug Strategy. On behalf of the Commonwealth Department of Human Services and Health (now the Department of Health and Aged Care), the firm ABG McNair conducted a household survey of 2993 Indigenous people.[5] The survey was conducted in urban areas (defined as population centres of more than 1000 people) and included people aged 14 years or older. The results of the survey were similar to those of other regional and local studies that have been conducted before and since.[6–9] The results of the 1994 survey were compared to those of a similar survey conducted among the general population, and the main findings included the following.

- A smaller proportion of urban Aboriginal and Torres Strait Islander peoples drank alcohol (62%) compared to the general population living in urban areas (72%).
- Those who did drink alcohol, however, consumed much higher quantities of alcohol than the general population.

- Males tended to have more hazardous drinking patterns than females, as was the case in the general population.
- More than half (54%) of urban Aboriginal and Torres Strait Islander peoples were current or regular smokers, compared to only 29% of the general population.
- Illicit drug experimentation and use were more widespread among the Aboriginal and Torres Strait Islander urban community than in the general urban population—50% had tried at least one illicit drug (compared to 38% in the general community), and 24% were current users (compared to 15% in the general population).
- Much of this higher incidence of illicit drug use, however, was accounted for by widespread use of marijuana. Nearly half (48%) of the Aboriginal and Torres Strait Islander urban community had tried marijuana, and 22% were current users. These rates were higher than in the general urban population, where 36% reported they had tried marijuana and 13% reported they had used it in the previous 12 months.
- Of the other illicit drugs, there was greater similarity in the use patterns among Aboriginal and Torres Strait Islander peoples and the general community.[5]

As the largest-ever survey of its type, this survey provides the best baseline estimate of patterns of substance use among Indigenous Australians.

Important similarities and differences

Three important points should be made regarding the findings of the 1994 survey—and they are addressed, or partly addressed, by papers in this volume. The first is that, among Indigenous Australians, the patterns of alcohol use were remarkably similar to those found among Indigenous peoples in New Zealand and Canada.[10] Given the diversity among these peoples, this might be considered surprising. We address the reasons for it in Chapter 14, and discuss them below (see the following section 'The political economy of Indigenous substance use').

Second, the percentages reported for both Indigenous and non-Indigenous people in the survey are national averages and, like all such averages, hide considerable variation. We address this in Chapter 9. The international and general Australian literature clearly demonstrates that, as average per capita consumption of alcohol in a population increases, so do indicators of harm such as acute hospital admissions, motor vehicle accidents and assaults.[11] In 1992–93 average per capita consumption of pure alcohol among Australians aged 15 years or older was estimated to be 9.71 litres; and it was estimated that in 1992 the total net cost of alcohol abuse in Australia was $4494.5 million.[12, 13]

Variation on a state/territory basis which is hidden in the national averages is demonstrated in Chapter 9. That chapter shows that average annual per capita consumption among those aged 15 years or more was 14.87 litres in the NT over the four years 1994–95 to 1997–98 compared to 9.67 litres in Australia as a whole in

1996–97. That is, per capita consumption in the NT was about 1.54 times the national average—with, it should be anticipated, commensurately higher costs. Despite suggestions that 'the drinking problem' in the NT is an 'Aboriginal drinking problem', the data in this chapter show that, even though average consumption among Indigenous people was higher than among non-Indigenous Territorians, consumption among non-Indigenous people was still 1.43 times that of the Australian population as a whole.

Chapter 9 also shows that there were considerable regional differences in the level of per capita alcohol consumption and variation in levels of consumption through time. Reductions in consumption were shown to reflect both tighter restrictions on the availability of alcohol in the Barkly regional centre of Tennant Creek (the subject of Chapter 2), and a Territory-wide levy on the sale of cask wine imposed by the NT government (the subject of Chapter 8). We discuss both subjects below (see following section 'The political-economy of Indigenous substance use').

The third point to be made about the patterns of substance use described in the 1994 survey is that they are not static. This is discussed in Chapter 7. Previous studies among Indigenous people aged 15 years and older found that the frequency of alcohol use among females was less than that among males.[5, 7] However, we found that among youths in Albany, Western Australia, females were consuming alcohol as frequently as males. Although no comparative data were available, also of concern was the large percentage (48%) of people described as 'frequent polydrug users' in the 15- to 17-years age group. They were frequent users of two, and occasional users of one, of the three commonly-used drugs (tobacco, alcohol and cannabis), and some had also used volatile substances or other drugs.[14]

The political economy of Indigenous substance use

Both a casual search of the annotated bibliography in the Indigenous Australian Alcohol and Other Drugs Databases and an extensive review of the literature show that most efforts to explain substance misuse among Indigenous people have been written by non-Indigenous people and that, generally, they focus on the characteristics of Indigenous people and/or their societies.[2, 10] In Chapter 14, we review the main theoretical approaches to the explanation of patterns of alcohol use among Indigenous peoples in Australia, New Zealand and Canada. These 'explanations' include:

- the biological characteristics of Indigenous peoples;
- alcohol dependence as 'disease' or individual dysfunction;
- the loss of culture and/or culture change;
- cultural explanations, including the characteristics of traditional Indigenous cultures, drinking patterns learned in the context of contact with representatives of

non-Indigenous cultures, and the role played by alcohol in contemporary Indigenous cultures; and

- political and economic factors, including colonialism, dispossession, economic exclusion and poverty, and drinking as protest against non-Indigenous society.

In Chapter 14, we argue—as do other papers in the book from which this chapter was taken—that there is no evidence for the view that there are biological differences which explain differences in patterns of alcohol consumption between Indigenous and non-Indigenous people. We also argue that the cultural diversity among Indigenous peoples is considerable, and thus unable to account for the common patterns of alcohol misuse found among them. What is common to Indigenous peoples in Australia, New Zealand and Canada (and elsewhere in North America) is their common historical experience of colonialism, dispossession and exclusion, and it is this that explains the common patterns of alcohol misuse. This is not to argue that individual and cultural factors do not play a role. However, these must be situated in their political and economic context. The implication of this is that, although people and communities may need help, it is not Indigenous peoples and cultures that need 'fixing' but the political and economic inequalities between Indigenous and non-Indigenous societies.

This issue is also taken up in Chapter 13 where we review common explanations of alcohol misuse and, following the work of Singer,[15] we argue that what is missing from these explanations is an analysis of the political economy of alcohol. We argue that attention needs to be directed away from Indigenous people towards the network of relationships in which their lives are lived—in particular, towards the ways in which demand for alcohol is created and its supply promoted. In Chapter 13, we argue that a political economy of Indigenous alcohol use must include consideration of: the role of profit-seeking by the alcohol industry; the role of governments in supporting the alcohol industry; and the history of Indigenous affairs policies that have created the conditions which have led to increased demand for alcohol among Indigenous people.

Supply reduction strategies

It is an economic truism that the level of consumption of a product is a result of both the demand for it and its supply. Consideration of the political and economic context of Indigenous substance misuse directs attention to the supply side of this equation. Although, until recently, non-Indigenous writers on the issue largely ignored supply-side issues, it has long been a concern of Indigenous people in communities affected by excessive consumption. This concern is reflected in a saying often heard in rural and remote Australia: 'Behind every blackfella getting drunk, there's a whitefella getting rich'. The theoretical concern with supply reduction raised in Chapter 13 is

given specific practical focus: Chapter 2 examines the effects of supply restrictions in Tennant Creek; Chapter 3 gives an overview of restrictions, potential barriers to their effectiveness, and lessons that can be learnt from them; Chapter 4 provides some of the legislative background to alcohol restrictions; and Chapter 8 examines the effects of the imposition of a levy on the sale of cask wine in the NT.

The experience of restrictions

After considerable lobbying by a coalition spearheaded by Julalikari Council and Anyinginyi Congress, the NT Liquor Commission imposed a number of restrictions on the availability of alcohol in Tennant Creek.[16] These restrictions included: a ban on the sale of wine in casks of more than two litres, closure of hotel 'front bars' on Thursdays, a ban on takeaway sales on Thursdays and limitations on the hours in which takeaway sales could be made on other days. Over a two-year period, the restrictions resulted in a 20% reduction in per capita consumption of alcohol, and reductions in alcohol-related hospital admissions, the proportions of people taken into protective police custody and offences committed on Thursdays. Furthermore, it was shown that a majority of Tennant Creek residents—both Indigenous and non-Indigenous—supported the restrictions. The Tennant Creek case—and similar examples elsewhere in Australia—highlight the effectiveness of concerted community action and controls on the supply of alcohol.[17] However, as we note in Chapter 3, there are a number of potential barriers to the effectiveness of such restrictions. These include: counter-pressures, which are largely industry-driven, for the liberalisation of restrictions on the sale of alcohol; the use of restrictions by politicians and bureaucrats as a 'quick fix' for Indigenous alcohol problems; and the danger that they may be pursued by well-meaning public health workers without the support of Indigenous people, thereby further disempowering them.

The ability of communities such as that in Tennant Creek to have restrictions imposed on the availability of alcohol is, in large part, dependent upon the provisions of liquor legislation passed by state or territory parliaments. Among other things, these Acts of parliament specify who can or cannot consume alcohol, when and where it may be consumed, who can sell alcohol and when and where they can sell it. The Acts also specify the purpose or objectives of the legislation. The research reported on in Chapter 4 took place in the context of a review of the Western Australian Liquor Licensing Act by a government-appointed committee. It highlights the recognition by Indigenous people that the objectives of the Liquor Licensing Act were biased in favour of the alcohol and tourist industries, did little to ameliorate the harm caused by alcohol, and provided insufficient opportunity for communities to have a say on the availability of alcohol. The research included the development of a number of recommendations for changes to the legislation, and various Indigenous community-controlled organisations lobbied for these. Of the 26 recommendations made, the

review committee addressed five and partly addressed seven. There remains much to be done, in both Western Australia and other jurisdictions, to make liquor licensing legislation more responsive to community needs. Many of the recommendations made in Chapter 4 continue to provide a blueprint for change.

A key element of the Tennant Creek restrictions was the ban on the sale of wine in casks of more than two litres. The ban on cask wine is effective not because it focuses on wine, but because it is effectively a control on price. Wine in larger casks is cheap to produce, package and transport; and, because the tax on wine is calculated on these costs, the tax on cask wine itself is low. Banning this low-cost drink forces people to turn to other beverages, of which they cannot purchase as much.

Opponents of such a ban often argue that it does not reduce the amount of alcohol consumed, but forces people to pay more for it and, hence, that people have less money to spend on other items such as food. The results of the Tennant Creek study show that this is not the case. Although there was some increase in the sales of other beverage types, this was much less than the reduction in the sale of cask wine. An earlier study of the initial trial of the restrictions in Tennant Creek showed that not only was there a decline in alcohol consumption but there was no decline in the amount of money spent at the town's only supermarket.[18]

Chapter 8 shows a similar effect across the NT as a whole. In this case, sale of wine in casks was not banned but the price of cask wine was increased by the imposition of a $0.35 per litre levy. The resultant increase in the cost of alcohol was not as significant as that consequent on the localised ban in Tennant Creek, but over the two-year period it was in place, the levy resulted in a 4% reduction in alcohol consumption. This was due almost solely to a reduction in cask wine consumption with no significant shift to the consumption of other beverages.

Unfortunately, along with similar levies and state- and territory-based alcohol taxes, the cask wine levy was declared unconstitutional. In the adjustments made by the Commonwealth to reimburse the states and territories for the loss of this revenue, the cask wine levy was effectively removed and consumption again increased. However, the research shows the important role that taxation—as a means of increasing the cost of some alcoholic beverages relative to others—can have in reducing consumption.

Culturally-appropriate evaluation of substance misuse interventions

There is no doubt that substance misuse among some sections of Australia's Indigenous population is a problem and, clearly, Indigenous people are themselves

concerned about this. This concern is reflected in: their attempts to change liquor licensing legislation; their attempts to obtain restrictions on the availability of alcohol; the declaration of some communities as ‘dry’; and the large number of substance misuse intervention projects.[2, 19] In the 1999–2000 financial year, a total of 277 intervention projects were directly targeted at Indigenous people and, of these, 226 were conducted by Indigenous community-controlled organisations.[20] One of the questions most commonly asked, by members of Indigenous communities and by the representatives of the government agencies that fund most of these intervention projects, is: ‘What works?’ Unfortunately, however, the answer is not simple, because there have been few formal project evaluations, and there are disputes about the criteria by which success is to be judged and the evaluation methods that should be used.

Chapter 6 provides a review of alcohol intervention evaluations. The surprising thing about this review is that, at the time it was conducted in 1999—after a thorough search of the Indigenous Australian Alcohol and other Drugs Databases[2]—we were able to identify only 14 published evaluation reports. Since our review was undertaken, there have been some additional evaluations of alcohol projects—including some by members of our own research team[21, 22]—but the number remains small. Similarly, d’Abbs and MacLean found that very few petrol-sniffing interventions had been adequately monitored or evaluated.[23] The same is true with regard to the evaluation of interventions for other forms of substance misuse.

There are several reasons for the paucity of project evaluation reports. First, although funding agencies require various financial and activity reports from the organisations conducting projects, little of this data is of the kind that enables evaluation of the processes involved in conducting the projects or project outcomes. Second, evaluation can be a costly exercise and often funds are not available for collection of any but the most basic data. Third, many of the staff in either community organisations or funding agencies do not have the training to decide what is the most appropriate data to collect or how to make the best use of it. Fourth—as the results of evaluations and reviews are sometimes used to reduce or cut services rather than to strengthen them—there is considerable distrust among Indigenous people of the motives of politicians and bureaucrats who call for more evaluation. Finally, there is often disagreement between funding agencies and Indigenous organisations about what criteria should be used to measure success, and the methods to be employed in that measurement.[24] These issues are addressed in Chapters 10 and 11—chapters that were originally aimed at non-Indigenous bureaucrats and researchers.

Chapter 10 examines some of the reasons that Indigenous intervention projects have been poorly evaluated or not evaluated at all, and suggests ways in which evaluations might be made more effective and culturally appropriate. In it, we call for: recognition of the political context in which evaluation takes place; negotiation of program

objectives in ways that include recognition of the social accountability of Indigenous service providers to their own communities; use of evaluation strategies that are effective but minimise costs and do not detract from service provision; strengthening and supporting community organisations so that they are able to undertake their own evaluations; and strengthening funding agencies so that their staff have the expertise to assist community organisations to develop their own evaluations and make use of the findings arising out of the evaluation of community-based projects

Chapter 11 is based on a review of the Australian and Canadian literature conducted for the Western Australian Aboriginal Affairs Department (now the Department of Indigenous Affairs of Western Australia). The aim was to identify a culturally-appropriate model for the monitoring and evaluation of programs conducted for Indigenous people by government agencies. We concluded that there are no such ideal models. However, evaluation should be based on a number of underlying principles that must be contextualised within a framework of self-determination, in which Indigenous peoples negotiate with government agencies to decide what programs they need, how the programs might be implemented, the outcomes they believe are desirable, and how those outcomes can be evaluated. These issues are political as well as financial, and require negotiation within Indigenous communities and between those communities and funding agencies.

We go on to conclude that evaluation methodologies have to incorporate a wide and flexible array of qualitative and quantitative techniques that are sensitive to the social and cultural differences existing in Indigenous communities and to the paucity of administrative, technological and information infrastructure to support evaluation. Indigenous peoples must be consulted at each stage of the evaluation process, from the determination of objectives to the interpretation of evaluation results. Finally, we need to be sure that Indigenous health and substance misuse programs are not unfairly bearing the brunt of evaluation attention while programs for healthier, non-Indigenous communities escape the bureaucratic gaze.

In Chapter 5, we highlight the problems that can arise when inappropriate methods are employed in the evaluation of a community-based intervention project. The results of the evaluation itself were inconclusive. However, in highlighting the problems that arose in the evaluation process, we were able to make a number of specific recommendations for improving the evaluation of Indigenous intervention projects. These recommendations included providing Indigenous community organisations with greater support and assistance in development of grant applications. In turn, this requires training for the staff of granting bodies to enable them to review more constructively the evaluation component of applications.

Although there is still a long way to go before we can unequivocally state ‘what works’, the evaluations that have been undertaken point the way. As we show in Chapters 2

and 8, restrictions on supply—although they are not the solution to the problems of alcohol misuse—can certainly be an effective part of any strategy to reduce excessive consumption and related harm. These points are reiterated in the review of alcohol interventions presented in Chapter 6. Although the number of evaluations reviewed was small, they do enable some tentative conclusions to be drawn. Of the interventions evaluated, restrictions on supply have produced the most tangible results. Evaluations of both treatment and health promotion projects have produced only modest gains and are most effective when they are part of a broader intervention strategy.

Importantly, the effectiveness of some interventions is limited by lack of expertise among, and limited support for, staff. This, in turn, is likely to be related to the broader issue of inadequate and uncertain provision of funding by government agencies. Elsewhere we have reported that, in the 1999–2000 financial year: there was considerable disparity in the funding of intervention projects; almost half of all prevention projects received only non-recurrent funding; and less than 3% of total expenditure on intervention projects was spent on staff and program development.[20]

In Chapter 6, we also conclude that there is a need for more evaluative studies of Indigenous intervention projects. These need to be undertaken cooperatively with Indigenous community organisations—the objective being to improve service delivery, not as a means of exercising bureaucratic control. Attention to enhanced, well-resourced and coordinated intervention projects does have the potential to make significant inroads into excessive drinking (and other drug use) among Indigenous people. However, in the interests of both greater public health gains and social justice, there is a need to redress the fundamental inequalities faced by Indigenous people.

Collaboration between researchers and Aboriginal communities

In 1991 the National Health and Medical Council (NH&MRC) issued a set of guidelines for research on Indigenous health issues.[25] These guidelines grew out of Indigenous people's concerns over the way in which some research projects were conducted, and frustration about their lack of involvement in, and control over, health research in their communities. Although Indigenous health research was increasing, there appeared to be few direct benefits—health or social—to the Indigenous communities involved. These NH&MRC guidelines are not as strong as many Indigenous people and health services would wish. However, they set out what should be a minimal set of standards that outline the means by which researchers should involve Indigenous people—from the initiation of research to the decisions over the ownership of research data and publication. In each state and territory there are Indigenous health research ethics committees established to review Indigenous health research in terms of its

adherence to these guidelines. However, not all proposals for Indigenous health research are referred to these committees, and much research is still conducted outside of these ethical guidelines.[26] We think it is important, therefore, to make explicit the types of research collaborations that underpin our work.

It is possible to see collaboration with Indigenous communities on a continuum:

- from work which has formal Indigenous approval but with which Indigenous people are not actively involved;
- to work which is initiated by Indigenous people, involves Indigenous researchers and allows for Indigenous feedback before dissemination.

It is research at the latter end of the collaboration continuum which is more likely to have direct, practical relevance for Indigenous people and their communities because it addresses their needs, not those identified by outsiders. As can be seen in the examples below and in the collection of chapters as a whole, our work can be located right along this continuum. We are not arguing that we have been wholly successful in our attempts to make our research meaningful to the Indigenous participants—merely that we are trying to make it increasingly so.

Our study of substance use by young people in Albany, Western Australia (Chapter 7) provides an example of the most intensive form of collaborative research. Members of the Albany Aboriginal Corporation (AAC) initiated this study. They were concerned initially about a perceived increase in the use of volatile substances, and later about the use of illicit drugs, among young people. Following their request for help, we worked with them to refine the research topic. We employed local Indigenous people as research associates on the project and provided them with Technical and Further Education-accredited research training. The Indigenous research associates conducted all interviews, and assisted in the analysis and interpretation of the results. Throughout the project, the research team reported regularly to the AAC executive committee and presented the final report to the committee for approval before its release. On the project's completion, we worked actively with members of the AAC to lobby the Western Australian Ministry of Education and the Health Department of Western Australia to implement a broad-based intervention program based on the findings of the study. Unfortunately, despite strong support from local primary and high schools, the Ministry of Education provided only a short-term Aboriginal support worker who was not in a position to effect wider change, and no further action was taken by government in support of the community on this issue.

The research project on liquor licensing in Western Australia (Chapter 4) was conducted as a collaborative project between the Aboriginal Legal Service of Western Australia, Perth Aboriginal Medical Service (now Derbarl Yerrigan Health Service), the Royal Commission Reference Group (set up by representatives of Indigenous organisations to monitor implementation of the recommendations of the Royal Commission into Aboriginal Deaths in Custody), and the National Centre for Research

into the Prevention of Drug Abuse (now the National Drug Research Institute). Each of these organisations had intended to make independent submissions to the committee established to review the Western Australian Liquor Licensing Act, but decided that a stronger submission could be made if they worked together. Accordingly, a joint steering committee consisting of representatives from each organisation was established to oversee the project. The steering committee agreed that our research team would conduct interviews with representatives of Indigenous community organisations in regional centres and review the literature on the subject. We conducted preliminary analyses of the data, which were then discussed with members of the other collaborating organisations before being reviewed and approved by the joint steering committee and finally submitted to the Liquor Licensing Review Committee.

In Tennant Creek, we were contracted by the 'Beat the Grog Sub-Committee' to conduct an independent evaluation of liquor licensing restrictions there (Chapter 2). Although we did not report directly to any Indigenous organisation, representatives of Julalikari Council and Anyinginyi Congress (along with representatives of Territory Health Services, the NT Police and liquor licensees, among others) were on the committee which oversaw the evaluation and to which we reported. In this project, we also recruited and trained a number of Indigenous people from Tennant Creek to conduct a survey of community attitudes to the restrictions. On the basis of this evaluation, the NT Liquor Commission agreed to leave the restrictions in place for a further two years, at which time they were again reviewed.

At first glance, our work on the effects of the cask wine levy (Chapter 8) and regional variation in alcohol consumption (Chapter 9) in the NT might seem somewhat removed from the grassroots concerns of Indigenous communities. However, although there was no formal Indigenous involvement in the research itself, the work was a response to requests for information on these topics by the staff of Central Australian Aboriginal Congress (Congress). At the time we undertook the research, Congress—along with other organisations—was seeking to have tighter controls imposed on the availability of alcohol in Alice Springs. Congress and the other organisations were able to use the results of these studies to mobilise wider support and argue their case more vigorously. In addition, at hearings held by the NT Liquor Commission, one of us (DG) gave evidence on the results of these and other studies in support of Congress and its allies.

The National Indigenous Substance Misuse Council also took up and used the results of the study on the impact of the cask wine levy (Chapter 8). The council is part of a coalition which is arguing in favour of our recommendation (and that of others) that, as a public health measure, alcoholic beverages be taxed on the basis of the amount of alcohol they contain—not on the cost of producing them.

As well as work along the continuum of collaboration, we have conducted research that involves no direct collaboration with Indigenous people or organisations. This kind of research does not involve the collection of new data, or other forms of imposition on Indigenous communities. It involves reviewing our own work and that of others to draw broader conclusions about the meaning of research results and their implications for addressing the harm caused by alcohol and other drug misuse. Chapters 13 and 14 provide examples of this type of research. We do not claim that the results of such research represent the views of Indigenous people. We do, however, believe that our research experience in Indigenous communities means that our views are informed by those of Indigenous people and, as such, our views can contribute to the broader debate between and among Indigenous and non-Indigenous people about the best way of reducing the harm caused by substance misuse.

Conclusion

Throughout Australia, Indigenous people identify substance misuse as one of their primary concerns. We hope the research papers presented in this volume demonstrate the practical ways in which collaboration between Indigenous communities and researchers can document the harms associated with such use and suggest strategies to deal with its consequences. In addition, we hope the volume may encourage Indigenous organisations to start working on similar collaborations in their own communities. It is these local community-controlled actions, in conjunction with broader strategies addressing Indigenous inequality, that will have the most impact.

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2. Beating the grog: an evaluation of the Tennant Creek liquor licensing restrictions*

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Abstract

Objective To review the effectiveness of, and community attitudes towards, increased restrictions on the availability of alcohol in Tennant Creek.

Method Estimates of quarterly per capita consumption of pure alcohol by persons aged ≥15 years, admissions data from the local hospital, women's refuge and sobering-up shelter, and police data on detentions in custody and common offences were compared for the 12 months prior and 24 months subsequent to the introduction of the restrictions. A random sample survey of residents aged ≥18 years was conducted to ascertain attitudes towards the restrictions.

Results Over the two years following the introduction of the restrictions, there was a reduction of 19.4% in annual per capita consumption of pure alcohol. This was accompanied by declines in: hospital admissions for acute alcohol-related Diagnostic Related Groups; and persons taken into police custody and the proportions of offences reported on Thursdays. A majority of survey respondents was in favour of retaining or strengthening the existing restrictions.

Conclusions The restrictions were effective in reducing alcohol consumption and acute related harm, and had the support of the majority of people in Tennant Creek. On the basis of this evidence, the NT Liquor Commission made a decision to retain them. Restrictions do not provide a simple answer to the problems associated with excessive alcohol consumption. However, they can be an effective part of a broad public health strategy to deal with such problems.

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More than a decade ago, a coalition—spearheaded by Julalikari Council Aboriginal Corporation and Anyinginyi Congress—commenced a campaign to 'Beat the Grog' in Tennant Creek, Northern Territory (NT).[1, 2] As a result, between August 1995 and February 1996, the NT Liquor Commission conducted a trial of increased restrictions on the availability of alcohol in the town. According to the Commission Chairman:

> The conclusion to be drawn from the evaluation (of the trial) is that … there has been an improvement in the area of police incidents, public order, health and welfare.[3]

Consequently, in March 1996, the Commission amended the licences of Tennant Creek hotels and takeaway outlets (but not licensed clubs) to include the following restrictions.[4]

- Takeaway outlets from hotels and liquor stores to be closed on Thursdays.
- Sales of all wines in casks >2 litres volume prohibited.
- Sales of all wines in casks ≤2 litres restricted to one transaction per person per day.
- No wine to be sold in glass containers over one litre volume.
- No third party sales to taxi drivers.
- Hotel front bars to be closed on Thursdays.
- Lounge bars not to open before noon on Thursdays and Fridays.
- Lounge bars to make food available.
- On weekdays other than Thursdays, takeaway sales limited to between noon and 9 pm.
- In front bars, wine only to be sold with substantial meals.
- In front bars, light beer to be the only alcoholic beverage sold between 10 am and noon.
- Takeaway sales of fortified wines restricted to containers of ≤1.125mL.

The restrictions were given particular effect on Thursdays because this was the day on which most social security entitlements, and Community Development Employment Program wages, were paid.

Two years later, in the face of assertions that they were not working, the Commission agreed to a review of the restrictions. As part of this, the Commission conducted public meetings, received written submissions, and—after some lobbying—agreed to allow a short period of time for an independent evaluation. The broadly representative 'Tennant Creek Beat the Grog Sub-Committee' was formed to facilitate the evaluation, the objectives of which were to report on:

- the continuing impact of the restrictions on the community;
- the effectiveness of the restrictions; and,
- the ongoing response of the community to the restrictions.

Methods

Given Liquor Commission deadlines, a period of only nine weeks was available to conduct the evaluation. This imposed severe restrictions on the data that could be collected and analysed. Both qualitative and quantitative data were used in the evaluation. Qualitative data included written submissions on the restrictions made to the Liquor Commission and semi-structured interviews with 38 representatives of stakeholder organisations. These data were analysed to identify issues related to the restrictions, and to develop an interview schedule for a random sample survey of Tennant Creek residents. Quantitative data included results of the survey and various statistical collections.

The Liquor Commission provided data on purchases of alcoholic beverages by outlet type for the four quarters prior to the introduction of the trial restrictions through to the first quarter of 1998. These data were converted to litres of pure alcohol using methods described elsewhere, and estimates of per capita consumption were made using as a denominator the population of the Tennant Creek Statistical Local Area aged ≥15 years at the 1996 Census.[5, 6] (Data from the Tennant Creek Town Council indicate this population remained stable over the period under consideration.) The data were:

- subjected to time series analysis using SPSS 6.1 to identify changes in the level of consumption;
- analysed to identify any changes in the types of beverages purchased and the places in which they were purchased; and
- used to test assertions that the restrictions were being circumvented.

The health, welfare and law-and-order impacts of the restrictions were assessed using a simple pre-test post-test design. The following data were compared for periods of 12 or 24 months prior to (depending on availability of data), and 24 months subsequent to the introduction of the trial restrictions:

- all hospital admissions for those aged ≥1 month;
- admissions of those aged 18 to 35 years (those most likely to consume large amounts of alcohol);
- admissions for Diagnostic Related Groups (DRGs)—a categorisation based on diagnosis, severity, presence of complications and patient age—to which alcohol was potentially a significant contributor;
- admissions to the women's refuge and sobering-up shelter; and
- police data on detentions in protective custody and the most common offences.

These data were analysed using Microsoft Excel, SPSS 6.1 and Statview 512+.

DRGs were used because they are coded for all admissions and are reliably recorded by the NT Health Service. All common potentially alcohol-related admissions (these included all DRGs for alcohol-specific diagnoses, all DRGs for acute injuries and

DRGs for acute gastrointestinal conditions likely be associated with harmful levels of alcohol consumption) were included. Broad categories were used to reduce the potential for any changes in classification over time to influence results.

A random sample survey of persons aged ≥18 years was undertaken to ascertain community views on the restrictions. The structure of the interview schedule and the sampling methods were similar to those employed by d'Abbs et al.—on advice from the Australian Bureau of Statistics—in evaluation of the trial restrictions.[3, 6] The sample was comprised of 271 persons (approximately 10% of the population). In terms of age, sex and Aboriginality, there were no statistically significant differences between the sample and the population of Tennant Creek as enumerated in the 1996 Census. Interviews were conducted by three members of the evaluation team, and by two non-Aboriginal and four Aboriginal people recruited locally and trained by the evaluation team. Using SPSS 6.1, responses to the survey questions were simply tabulated, and frequencies, proportions and 95% confidence limits calculated.

Results

Alcohol consumption

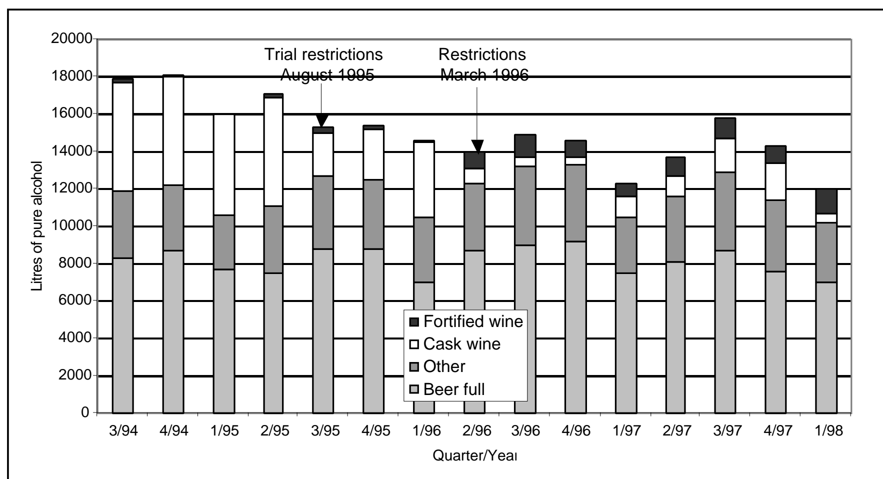
Quarterly data on the purchase of pure alcohol show seasonal fluctuations with peaks occurring in the third quarter of each year. The data presented in Table 1 and Figure 1 begin on one of these peaks and fall to the second quarter of 1995. In this 12-month period, mean quarterly purchases totalled 17 577 litres. In the third quarter of 1995, when the trial restrictions were introduced, there was a marked fall

Table 1: Liquor purchases (litres of pure alcohol) by Tennant Creek licensees by beverage

Type	3/94	4/94	1/95	2/95	3/95	4/95
Beer full	8331	8676	7714	7519	8789	8775
Cask wine	5873	5843	5376	5791	2289	2716
Spirits	1984	1761	1340	1873	1997	1763
Beer low	1164	1372	1258	1211	1339	1480
Bottled wine	372	386	269	507	575	482
Fortified wine	214	95	69	173	309	141
Cider full	163	202	173	241	209	252
Spirits mixed	108	103	67	82	163	122
Total	18208	18437	16268	17396	15671	15730

in purchases. From that point to the first quarter of 1998, there was a continuing decline—albeit marked by seasonal fluctuation. In this latter period, mean quarterly purchases declined by 17% to 14 575 litres. Time series analysis of these data indicates that prior to the third quarter of 1995 there was actually an upward trend in purchases (masked by seasonal variation) and since that time a downward trend. Statistical testing indicated these trend lines are significantly different (p = 0.001).

Figure 1: Liquor purchases (pure alcohol) by Tennant Creek licensees by beverage type, third quarter 1994 to first quarter 1998



There was decline in per capita consumption of pure alcohol among persons aged ≥15 years: from 25.3 litres in 1994–95 to 21.8 litres in 1995–96, and to 20.4 litres in 1996–97 (Table 2). Given the stability of the Tennant Creek population, this cannot be attributed to a population decline nor, as Table 2 shows, can it be attributed to a decline in consumption in the NT as a whole.

type, third quarter 1994 to first quarter 1998

1/96	2/96	3/96	4/96	1/97	2/97	3/97	4/97	1/98
7040	8656	9034	9187	7512	8145	8725	7642	7015
3981	788	475	407	1051	1121	1780	2002	418
1754	1852	2132	1902	1512	1869	2220	1838	1579
1278	1351	1443	1696	1204	1176	1484	1463	1268
472	483	626	494	311	373	483	424	378
107	919	1231	936	665	997	1125	891	1372
157	157	246	206	147	200	208	184	134
72	104	111	99	65	117	136	112	187
14862	14309	15297	14928	12469	13997	16161	14555	12350

Table 2: Licensee purchases of pure alcohol and per capita consumption, Tennant Creek and the Northern Territory 1994–5 to 1996–97

Location	Measure	1994–95	1995–96	1996–97
Tennant Creek	Litres of alcohol	70,309	60,572	56,691
	Litres per capita	25.3	21.8	20.4
Northern Territory	Litres of alcohol	2,144,278	2,100,873	2,184,364
	Litres per capita	15.0	14.3	14.8

A factor which did contribute to the decline was the NT government's levy of $0.35 per litre on cask wine—introduced in July 1995. In the NT as a whole, in the two-year period in which the levy was in place, mean quarterly per capita consumption of pure alcohol was 4% lower than in the previous and following four quarters.[7, 8] However, given that sales of casks >2 litres were banned in Tennant Creek, the levy only affected sales of smaller casks and the contribution of the levy to the decline there was less than elsewhere in the NT. The limited impact of the levy in Tennant Creek is also indicated by the fact that consumption there continued to fall while elsewhere it increased following the lifting of the levy.

Circumvention of the restrictions

It was alleged in some submissions to the Commission that the restrictions were being circumvented by: a shift to consumption of fortified wine; increased purchases from licensed clubs that were not subject to the restrictions; and increased purchases from licensed premises outside the town. Mean quarterly purchases of fortified wines in the period following the introduction of the trial restrictions increased by 573 litres (570%) over the mean for the previous four quarters (Table 1). However, this offset only 14% of the mean quarterly decline of 4173 litres of pure alcohol purchased as cask wine.

In the period following the introduction of the trial restrictions, mean quarterly purchases by licensed clubs were 2801 litres of pure alcohol compared to 1799 for the previous four quarters—a 55.7% increase. This offset the decline in purchases by other licence types by 25%. In the four quarters prior to the introduction of the restrictions, purchases by out-of-town premises averaged 2313 litres of pure alcohol per quarter. In the period following the introduction of the trial restrictions, this increased to 2899 litres per quarter (25%). However, this increase was only 20% of the mean quarterly decline of 3002 litres that occurred in Tennant Creek itself.

Health and welfare effects

General admissions, and admissions of those aged 18–35 years of age, to Tennant Creek Hospital increased over the years 1993–94 to 1997–98. However, in the latter age category, there were statistically significant declines in admissions for potentially alcohol-related DRGs ($X^2df_4 = 45.96$, $p<0.0001$) and in admissions of males ($X^2df_4 = 16.0$, $p<0.003$). The decline in these admissions began in 1995–96 when the trial restrictions were introduced. A second decline occurred in 1997–98 (see Table 3) and was probably related to an increase in persons being taken into protective custody by the police in that year (see Table 4, over). In the two years prior to the introduction of the trial restrictions, the mean number of admissions for potentially alcohol-related DRGs was 177.5, and in the three subsequent years it was 126.3—a decline of 28.8%. In the same periods, males comprised 36.7% and 31.7% of admissions in the 18–35 year age group—a reduction of 5.0%.

Table 3: Admissions of persons 18–35 years for possibly alcohol-related and all other diagnostic related groups, Tennant Creek Hospital 1993–94 to 1997–98

Diagnostic Related Group	1993–94	1994–95	1995–96	1996–97	1997–98
Alcohol-specific DRGs	9	5	8	10	1
Injuries					
Head Injuries	32	32	14	11	21
Other injuries	91	88	71	86	64
Gastrointestinal DRGs possibly related to alcohol					
Oesophagitis, gastroenteritis (GI) and miscellaneous GI conditions	29	22	18	19	5
Pancreatic disorders	12	17	9	11	2
GI haemorrhage	6	7	3	2	2
Unclassified GI conditions	2	3	11	6	5
All alcohol-related DRGs	181	174	134	145	100
Other DRGs	450	458	539	545	553
Total	631	632	673	690	653

Alcohol is a factor in the majority of admissions to the Tennant Creek Women's Refuge and a factor in all admissions to the sobering-up shelter. Unfortunately, in both agencies, changes occurred independently of the licensing restrictions that made it difficult to draw conclusions from their admissions data. Admissions to the Women's Refuge in 1997 and 1998 returned to 1994 levels after a decline that preceded the restrictions. This was probably related to changes in both management and record keeping in the intervening period. There was, however, a slight reduction in the mean number of admissions to the Women's Refuge on Thursdays. During the

period under consideration, the sobering-up shelter experienced large fluctuations from one of its main sources of referrals—the police. These fluctuations were related to changes in policing policy, rather than to the restrictions. However, since the introduction of the restrictions, the sobering-up shelter has been closed on Thursdays.

Impact on public order

The number of people taken into protective custody by the police increased substantially in the two years following the introduction of restrictions. However, there was a reduction in the numbers taken into custody on Thursdays. In interviews, the police—and other informants—attributed this to increased police activity and improved police performance. In addition, the police suggested that the apparent increase may have been due to improvements in their recording procedures. Prior to the restrictions, the police had three 'busy' days per week; subsequently, this was reduced to two. Fridays and Saturdays continued to account for just over 50% of protective custodies—a percentage similar to that before the trial. However, the percentage of detentions on Thursdays declined from 20.4% to a mean of 8.5% and it became the second quietest day of the week. Also, following the initial trial of restrictions the ratio of Aboriginal to non-Aboriginal people taken into protective custody declined from over 3:1 to about 2.5:1. This may reflect a real effect on the drinking behaviour of Aboriginal people attributable to the restrictions.

Table 4: Numbers in protective police custody, numbers of offences reported, and percentage of each on Thursdays, Tennant Creek

Reported offences	Pre-trial year 1/4/94–31/3/95		Trial—6 months 14/8/95–11/2/96		First year post-trial 1/4/96–31/3/97		Second year post-trial 1/4/97–29/3/98*	
	n	% Thu	n	% Thu	n	% Thu	n	% Thu
Protective Custody	633	20	343	15	960	9	1169	7
Offences								
Assault	95	19	67	4	116	9	108	9
Unlawful entry to buildings	72	8	27	4	67	9	51	11
Unlawful entry to dwellings	69	13	25	8	151	13	59	10
Criminal Damage	188	12	63	8	195	11	170	6
Total above offences	424	13	182	8	521	11	396	9

* Data provided by Police Dept only up to 29/3/98, not 31/3/98.

The numbers of the most commonly reported offences showed relatively small changes over the period under consideration. The exception was a significant increase

in unlawful entries to dwellings between April and June 1996—in the first year after the introduction of the restrictions. Reports of this offence subsequently returned to around pre-trial levels. The number of all offences in the year to March 1998 was about 7% lower than in the year to March 1995. As with detentions in protective custody, there appears to have been a marked reduction in the percentage of assaults and lesser reductions in the percentages of other offences reported on Thursdays. Again—given more intensive policing—there may have been a real decrease in the total number of offences committed as opposed to those recorded.

Community attitudes

In the survey, each restriction was listed and respondents were asked whether they thought the restrictions should be 'dropped altogether, eased, remain the same, or be strengthened'. In Table 5 responses to these questions are ranked according to the

Table 5: Respondent attitudes to the future of current restrictions (n = 271)

Restrictions	Attitude			
	Strengthen % 95% CI	Retain % 95% CI	Ease % 95% CI	Drop % 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 litres	24 19.1–29.3	51 44.9–56.8	2 0.7–4.0	15 11.2–19.7
Takeaway sales limited to between noon and 9 pm on weekdays	14 10.3–18.5	57 50.9–62.6	7 4.4–10.5	18 13.8–23.0
Lounge bars not to open before noon 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 am and noon bar sales limited to only light beer	9 5.9–12.7	56 50.1–61.9	2 0.7–4.0	29 23.9–34.8
Takeaway 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 two-litres 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 closed on Thursdays	9 5.9–12.7	46 40.9–52.8	4 2.2–6.9	35 29.5–40.9

level of support for each restriction. Those with the least support were: closure of takeaway outlets on Thursdays; the ban on the sale of wine in casks >2 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 these positions did so because they thought the restrictions were not working rather than because they were opposed to them in principle. Nevertheless, those who believed that the restriction with the least support—the closure of hotel front bars on Thursdays—should be dropped or eased made up only 39% of the sample and, overall, there was a majority in favour of retaining or strengthening all of the restrictions.

Respondents were also asked whether or not they were in favour of other restrictions that had been suggested to the Liquor Commission. Three of these suggestions each had the support of more than half the sample: discouraging the sale of alcohol in glass containers (71%); limiting the sale of high-alcohol content drinks to one bottle per person per day (57%); and extending the restriction on Thursday takeaway sales to licensed premises within a 50 kilometre radius of Tennant Creek (56%). With regard to a fourth suggestion—extension of Thursday restrictions to licensed clubs—opinion was almost equally divided, with slightly more people opposed to it (48%) than in favour (46%). The majority of respondents opposed other suggestions, including banning all alcohol sales on Thursdays.

Conclusions

The evidence indicates that, over the two years following the introduction of the restrictions, there was a reduction of 19.4% in annual per capita consumption of pure alcohol. Nevertheless, consumption in Tennant Creek remained more than twice the national average.[9] Hospital and police data provide evidence that this reduction in consumption was accompanied by a reduction in acute alcohol-related harm—particularly on Thursdays—and there is also some support for this in data provided by the sobering-up shelter. It may have been the case that the majority of people in Tennant Creek was opposed to the restrictions when they were first imposed by the Liquor Commission. However, the results indicate that, when they had experienced their operation and effect, the majority was in favour of them. A majority of the population had also come to favour some additional restrictions.

The evidence for the effectiveness of, and support for, the Tennant Creek restrictions which is summarised in this paper was accepted by the NT Liquor Commission. On the basis of this, on 19th November 1998, the Commission handed down a decision that 'All existing restrictions shall be retained' subject to a further review commencing in November 2000.[10]

For several years now, Aboriginal communities throughout Australia have sought to include licensing restrictions in their strategies to 'beat the grog'.[11–13] As d'Abbs et al. argue, in isolation, restrictions do not provide a simple answer to the problems associated with excessive alcohol consumption. Attention to both the demand for, and supply of, alcohol is crucial. However, restrictions can be an effective part of a broad public health strategy to deal with alcohol-related problems. Despite flying in the face of commercial and ideological pressures for deregulation of the alcohol industry, the Tennant Creek experience demonstrates that—when shown to be effective—both Aboriginal and non-Aboriginal people are prepared to support restrictions as an important means of reducing alcohol-related harm. To end on a less sanguine note, however, a change to the Department of Social Security payment cycles—that came into effect on 1st July 1999 and which allows for the payment of benefits on days other than Thursdays–has the potential to undermine this and similar interventions in other communities.

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3. Indigenous Australians and Liquor Licensing Restrictions*

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In Australia, laws relating to the sale and consumption of alcohol are the prerogative of state and territory governments. Until the 1960s, in all jurisdictions, laws were in place which prohibited the sale of alcohol to, or the consumption of alcohol by, Indigenous Australians. Following the repeal of those laws, there was a rapid increase in consumption by some sections of the Indigenous Australian population. Recent research has shown that the proportion of Indigenous Australians who consume alcohol on an occasional or frequent basis is lower than that among the non-Indigenous population. However, in aggregate, those Indigenous Australians who do consume alcohol do so at levels greatly in excess of levels among non-Indigenous people, resulting in a variety of harms at both the individual and community level. This pattern of consumption and harm—reflected to varying degrees among the Indigenous populations of countries such as New Zealand, Canada and the United States—is rooted in the legacy of European colonialism. As the Royal Commission into Aboriginal Deaths in Custody has made clear, this legacy continues and is reflected in poverty, marginalisation and discrimination, and their consequences. The Race Discrimination Commissioner has linked the disadvantage faced by, and neglect of, Indigenous Australians to the infringement of their human rights by the wider Australian society. In this context, much excessive consumption is: a response to dispossession and grief; a response to boredom as a result of exclusion from the mainstream economy and its benefits; one of the few cheap recreational activities available; and a protest at the imposition of a range of bureaucratic controls. [1–3]

Some efforts are being made to redress the fundamental inequalities faced by Indigenous Australians from which the patterns of consumption found among them arise. In addition, Commonwealth and state/territory governments fund a number of programs aimed specifically at addressing the harms arising from, or associated with,

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excessive alcohol consumption among Indigenous Australians. Some of the services funded under these programs are delivered by government agencies but, more importantly, a large number have been developed, and are provided by, Indigenous community-controlled organisations. As well as such programs, in recent years some Indigenous community-controlled organisations have attempted to use liquor licensing laws to restrict the supply of alcohol and, hence, to reduce consequent harm.

Liquor licensing restrictions

As well as general provisions relating to all liquor licences, state and territory liquor laws contain provisions that allow licensing authorities to impose specific conditions on individual licences. Over the past decade, the amendment of most licensing acts to include harm minimisation objectives has strengthened the ability of authorities to impose such conditions, and it is these which some Indigenous community organisations have sought to exploit.[4]

Usually at the instigation of Indigenous community organisations, licensing authorities have imposed restrictions in a number of localities in remote and rural Australia. All of these localities have small populations—generally about 5000 people—and have either a majority, or a large minority, of Indigenous people. These restrictions—appended to existing liquor licences—have sought to reduce the supply of alcohol by reducing trading hours and limiting the amount and the types of beverage that can be sold. In particular, the restrictions have had two foci. First, they have sought to reduce takeaway sales because of the unfettered manner in which much off-premises consumption occurs. Secondly, they have aimed to reduce the sale of cask wine which is consumed in large quantities because of its low cost per standard drink—stemming from both economies of scale in its production and distribution, and a taxation regime that is favourable to it.[5] These restrictions are often popularly portrayed as new, draconian measures which infringe upon the 'rights' of individuals to consume alcohol.[6] Despite this portrayal, however, they are not new. Rather, they are an extension of existing restrictions on who may sell alcohol, and under what conditions, that are already part of various state and territory liquor laws.

Evaluation

Evaluations of the effect of additional restrictions have been conducted in a number of localities, and these have been reviewed in comparison with each other and in comparison with other interventions.[7–14] While there has been some variation in their impact, in general, it has been found that: they have led to reductions in per capita

consumption and key indicators of harm such as hospital admissions and police incidents; and that—at the local level—they have had a greater measurable impact than interventions such as treatment and health promotion programs. Where they have been most effective, they have been initiated by Indigenous people, conducted as part of broader strategies to address alcohol-related harm, and have had wide community support. The latter is particularly important because, in most situations, restrictions impact on non-Indigenous as well as Indigenous people.

Licensing restrictions have a significant advantage over licensee 'accords' which have been implemented in other locations, and which have purportedly similar objectives. Under such accords—which are generally negotiated between licensees and concerned community groups and/or government agencies such as police and health—licensees in a locality voluntarily agree to limit supply in ways similar to those included in licensing restrictions. However, licensee accords are not enforceable at law (one reason that at least some licensees are willing to enter into them) and can break down as a result of commercial pressure on individual licensees. Although they have an advantage in this regard, licensing restrictions do share a disadvantage with licensee accords. That is, they are piecemeal in application and because they have been implemented only in small population centres, to date, their impact on state- or territory-wide consumption and indicators of harm has been limited.

Barriers to the effectiveness of additional restrictions

Given the demonstrated local success of additional restrictions on availability, there is increasing interest in them in other communities. However, there are at least five interrelated barriers to their continued success. The first of these barriers arises from the view, common among large segments of the population, that alcohol problems—including drinking problems among Indigenous Australians—are problems of individual drinkers at whom interventions should be directly targeted. Although by no means unchangeable, this view means that Indigenous community organisations and their supporters face a difficult challenge in even getting population-based strategies, such as additional restrictions, on the agenda.

The second barrier—to some extent related to the first—is a contradiction inherent in current alcohol policy and legislation. At the same time that governments have moved to enshrine harm minimisation principles in liquor licensing legislation, most have also sought—to varying degrees—to reduce legislative and administrative restrictions on the supply of alcohol.[4] At the macro level, such liberalisation is likely to increase the aggregate levels of consumption and related harm that additional licensing restrictions are designed to reduce at the local level.

The third barrier to increased use of additional licensing restrictions comes from the liquor industry. Where they are effective, restrictions have reduced alcohol sales and hence impacted on the profitability of licensed premises. This has not been accepted passively by licensees. One of the country's largest liquor chains successfully challenged the imposition of restrictions in a Western Australian town—although, in the face of a public outcry, it later agreed to adhere to the proposed restrictions under a licensee accord.[9] The same liquor chain has subsequently challenged the imposition of restrictions on takeaway trading hours in a town in the Northern Territory.[15] It is likely that there will be more such challenges in the future based on the provisions of commercial and competition law.

A fourth barrier is misinformation about the effects of additional restrictions. At the local level, individuals and groups opposed to restrictions for ideological reasons or because of vested interests have actively sought to distort the results of the assessments of the impact of restrictions. This activity has included editorials and articles in local newspapers and has had at least some success.

Ironically, a fifth barrier may arise from the success of restrictions. On the one hand, there is a danger that they may come to be seen by politicians and bureaucrats as an inexpensive 'quick fix' to problems of Indigenous drinking and/or be imposed in response to calls by non-Indigenous sections of communities seeking to restrict the access of Indigenous people to alcohol. The latter is a particular danger in localities where non-Indigenous people define 'the alcohol problem' as 'an Aboriginal problem'—despite excessive, though less readily observable, levels of consumption by many non-Indigenous people in remote and rural Australia.[15, 16] On the other hand, there is a danger that well-meaning public health workers may pursue the implementation of restrictions without the support of Indigenous people, thereby further disempowering them. Research suggests that restrictions imposed in isolation and without the wide support of both Indigenous and non-Indigenous people are likely to be circumvented and limited in impact.[13] If they are applied under such circumstances, additional restrictions in general may come to be perceived as ineffective and less likely to be considered as part of a broader solution to the problems associated with excessive consumption among Indigenous Australians.

Some lessons

The lessons to be learnt from the Indigenous Australian experience with additional liquor licensing restrictions, and the obstacles to their more widespread adoption, relate to measures to address alcohol problems both in general and among Indigenous people in particular. The lessons are not new, but they are worth re-stating, and they are broadly applicable to other countries with Indigenous populations.

The fact that additional restrictions on availability have been shown to be effective in reducing alcohol consumption and related harm in some areas of rural and remote Australia does not mean that they are the solution to the problem. It does demonstrate, however, that they can be an effective part of a broader strategy to deal with the problem. It also teaches that effective action is possible at the local level—often in the face of countervailing policy and powerful vested interests. Importantly, it also highlights the need to consider carefully the impact of policies that aim to liberalise the availability of alcohol.

Research on the economic costs alone demonstrates that excessive alcohol consumption and related harm is a problem for all Australians.[17] Similarly, given the underlying factors, alcohol misuse and related harm among Indigenous Australians is also a problem for all Australians. Demonstration of these facts, however, is not enough. That they are not recognised or acknowledged by large segments of the Australian population reminds us that public opinion can severely constrain what is achievable both locally and nationally. Clearly, those of us working in the field need to renew our efforts to better inform that public opinion.

The final lesson is perhaps the most important of all. Although the alcohol problems of Indigenous Australians are rooted in both their past and present relations with the wider Australian society, any solution to those problems requires Indigenous people themselves to acknowledge them and to initiate action to address them. Their efforts in working towards the introduction of restrictions, plus numerous intervention projects around the country, demonstrate that they have done this. As researchers, educators, and practitioners we need to work with, not on behalf of, Indigenous people to further these efforts. Indigenous people need assistance, not to be assistants. For many of us, this will involve an unfamiliar role—playing second fiddle.[18]

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4. Aboriginal wellbeing and liquor licensing legislation in Western Australia*

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Abstract

This paper is based on the results of a project undertaken as the basis for a submission to the committee established to review the Western Australian *Liquor Licensing Act 1988*. It reports on key issues relating to liquor licensing as identified by members of regional Aboriginal organisations. Among these issues are the promotion of alcohol consumption and misuse, discriminatory practices by licensees and the police, and the need for greater community involvement in liquor licensing decisions. To address these issues, members of the participating organisations proposed: inclusion of a harm minimisation objective in the Act; education and training programs for the public, licensees and the police; and industry funding for harm minimisation programs.

Alcohol misuse is both a consequence and cause of many of the social and health problems Aboriginal people face, and it is exacerbated by the continuing legacy of dispossession, disadvantage and discrimination.[1] Although there is still no definitive study of the epidemiology of Aboriginal alcohol use, it was found that, in the seven days prior to the 1989–90 National Health Survey, 62.4% of Aboriginal men and 38.4% of Aboriginal women—compared to 73.5% of men and 51.8% of women in the non-Aboriginal population—reported having had an alcoholic drink. However, while fewer Aboriginal people consumed alcohol, 22% of Aboriginal males did so at levels

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likely to be injurious to their health. This is more than twice the rate among non-Aboriginal men.[2] Although there is some difference in the proportions, this overall pattern among Aboriginal people is similar to that found by Watson et al. in the Northern Territory and Hunter et al. in the Kimberley.[3, 4]

Various health and social consequences result from, or are associated with, the misuse of alcohol among Aboriginal people. The mortality rates among Aboriginal people in Western Australia have been documented most recently by Veroni et al.[5] Overall, they found that all-cause standardised mortality rate ratios were 2.6 for Aboriginal compared to non-Aboriginal men and 3.0 for Aboriginal compared to non-Aboriginal women in Western Australia. The causes of Aboriginal mortality are complex. However, it has been estimated that alcohol is responsible for 8% to 10% of Aboriginal deaths.[6, 7] In another report, Veroni et al. found that, although there were wide regional variations, hospital admission ratios for conditions solely caused by alcohol were 8.6 for Aboriginal compared to non-Aboriginal men and 12.8 for Aboriginal women compared to non-Aboriginal women.[8]

The social consequences of alcohol misuse among Aboriginal people include family breakdown, child neglect, and absenteeism from school. Of particular concern is the association between alcohol misuse and violence in the home, and other forms of intra- and interpersonal violence.[9] There is also a strong association between alcohol and crime. As Wilkie has stated, in Western Australia no statistical data is recorded on whether or not any offences for which prisoners are convicted were committed under the influence of alcohol. However, she cites a survey of Aboriginal prisoners in Roebourne, Broome and Wyndham prisons in which:

> Nearly three-quarters (74%) of the prisoners answered that they were 'really drunk' when they offended and a further 18% said they had been drinking but were not drunk.[10]

The causes of the alcohol misuse which result in such problems are complex, and any strategies to deal with them must be multifaceted.[11, 12] Importantly, Aboriginal people themselves have undertaken a number of initiatives to minimise the harm associated with excessive alcohol use. Among these are:

- night patrols, such as the Kullari Patrol in Broome, which pick up intoxicated people;
- the provision of treatment and referral and general health and welfare services, such as those provided by the various Aboriginal medical services;
- rehabilitation centres, such as Milliya Rumurra Alcohol and Drug Centre;
- comprehensive substance abuse programs such as that conducted by Noongar Alcohol and Substance Abuse Service;
- preventive programs such as the Albany Aboriginal Corporation's program to provide young people with alternatives to the harmful use of alcohol;
- the establishment of outstations; and
- the declaration of some discrete communities as 'dry'.

Despite the rhetoric surrounding the concept of Aboriginal self-determination, when Aboriginal people take the initiative to deal with issues such as alcohol misuse, they often receive little support from the wider society and its institutions. Liquor licensing is a state or territory responsibility, and in Western Australia (as in other parts of the country) Aboriginal people also find that the Liquor Licensing Act and its administration are obstacles to their efforts to address the problem of alcohol misuse.[13]

While legislation alone will not reduce the harm caused by alcohol misuse, it is important as one of many strategies which can be used in concert to minimise alcohol-related harm. This was recognised by the Royal Commission into Aboriginal Deaths in Custody, the recommendations of which included a number specifically related to liquor licensing legislation.[12] Successive Western Australian governments have taken little action to implement these recommendations.[14] However, the opportunity to pursue them recently arose as a result of a statutory requirement that the Liquor Licensing Act be reviewed.

Consequently, a proposal was developed to prepare a submission and make recommendations to the committee established to review the Act. This was undertaken jointly by the Aboriginal Legal Service of Western Australia, the Perth Aboriginal Medical Service, a reference group established by the State's Aboriginal Advisory Council to oversee implementation of the recommendations of the Royal Commission into Aboriginal Deaths in Custody, and the National Centre for Research into the Prevention of Drug Abuse.

The objectives of the project were to document the concerns of key Aboriginal organisations and individuals relating to existing liquor licensing legislation, to elicit suggestions for change from them, to identify initiatives in other states and territories and overseas in response to similar problems, and from this to develop a set of recommendations for amendments to the Act. These recommendations were also to give effect to the liquor licensing recommendations of the Royal Commission into Aboriginal Deaths in Custody[12, 15–17] and various other reports which had involved extensive consultation with Aboriginal people.[18–20]

Method

A steering committee was established to oversee the project. It comprised the authors as representatives of their respective organisations. The project was undertaken using a qualitative methodology which included group and individual interviews with key informants; these were analysed in the light of liquor licensing initiatives elsewhere in Australia and overseas.

The Liquor Licensing Review Committee, established by the Minister for Racing and Gaming, allowed only six weeks from the announcement of the review until the final date for submissions. This placed severe limitations on the consultations that could be undertaken by the project team. To ensure a broad range of Aboriginal perspectives, a decision was made to conduct interviews in the regional centres of Albany, Kalgoorlie, Carnarvon and Broome, as well as within the Perth metropolitan area. Within each of those centres, the regional office of the Aboriginal Legal Service and one key community-controlled organisation which had a particular interest in alcohol-related issues was selected. Telephone contact was made with the chairpersons or administrators of those organisations to explain the review of the Act and the joint submission that was being prepared, and to seek their assistance in arranging group discussions with members of their and other Aboriginal organisations.

These telephone contacts were followed up by a letter containing a package of materials so that the various organisations to be consulted could review the issues and give them consideration prior to meeting with members of the research team. The package included the terms of reference for the government-appointed Liquor Licensing Review Committee (see Table 1), a plain-English summary of the existing Act, the liquor licensing related recommendations of the Royal Commission into Aboriginal Deaths in Custody, and an article from the magazine Yarranma, which outlined some of the liquor licensing initiatives taken in the Northern Territory.[21]

Table 1: Terms of reference of the Liquor Licensing Review Committee appointed by the Western Australian government

The review panel shall report on whether:

1. Section 5 of the Act should be expanded to include control over the supply and sale of liquor, with the aim of contributing to the reduction of alcohol abuse so far as that can be achieved by legislative means.
2. An industry-funded program should be established to educate the public in respect of health issues and for compulsory training of licensees, managers and staff involved in the sale and supply of liquor.
3. The administration and enforcement of the Act can be simplified. In particular, whether the number of regulatory authorities (for example, local authorities, Health Department, fire brigade, police and town planning authorities) is necessary.
4. To continue the provision of a special facility licence and extended trading permit.
5. A licence rationalisation scheme is needed—including consideration of the number of licences, the criteria by which they may be obtained or cancelled and how such a scheme could operate.

The panel shall also examine and, if thought fit, make recommendations about the operation of the licensing authority.

Source: Terms of reference review of the *Liquor Licensing Act* [32]

The group discussions included representatives from nine regional Aboriginal community organisations as well as the Aboriginal Advisory Council's Royal

Commission Reference Group (which itself is composed of Aboriginal representatives from throughout the State). These group discussions involved about 50 people. The group discussions were supplemented by individual interviews with some of the participants, as well as unstructured interviews with key informants from government agencies. Both the group discussions and interviews were conducted by two of the authors (Gray and Drandich) and focused upon identification of alcohol and liquor licensing related problems and proposed solutions to those problems.

Analysis of the transcripts of group discussions and interviews focused upon how the data related to the objectives and provisions of the existing Act and the terms of reference established for the Review Committee. Information on licensing legislation in other states/territories and overseas—particularly as this affects Indigenous peoples—was reviewed to identify possible solutions to problems raised in the discussions and interviews. On this basis, a comprehensive set of recommendations was developed which met the needs identified by the organisations and individuals consulted. Recognising the workload of committees of review, and the difficulties they often experience in translating general principles into legislative practice, many of the recommendations included suggestions as to the specific wording for proposed amendments to the Act. The proposed recommendations were reviewed by the project steering committee and, with approval of the members, the final submission prepared and submitted to the Liquor Licensing Review Committee. Copies of the submission were also circulated to the organisations which participated in the project.

Results

In the group discussions and interviews, participants identified a number of problems related to the Act and proposed a number of solutions to them. By far the majority of problems related to activities which were either designed to promote or had the effect of promoting alcohol consumption and misuse among Aboriginal people. Other problems identified were either contingent upon this excessive consumption or the way in which it was promoted, or were concerned with discrimination both on licensed premises and the way in which the law appears to be enforced.

There was a clear recognition by most participants that, in an environment that promotes alcohol misuse, liquor licensing legislation will not of itself address the problems of excessive alcohol consumption by some members of the Aboriginal population and the related harm. It will not address the underlying causes of that excessive consumption and the resultant demand for alcohol. Liquor licensing legislation was, however, seen as a means by which local communities can address issues relating to the control of supply, can contribute to the reduction of harm and can, through the revenue-raising provisions of the legislation, be used to fund harm-reduction strategies and to reduce discrimination against Aboriginal people.

Promotion of consumption

There was widespread feeling that many licensees, particularly in rural and remote areas, see Aboriginal people as a source of profit which is vigorously exploited by a variety of strategies aimed to maximise consumption of alcohol. For Aboriginal groups attempting to minimise alcohol-related harm, control over the availability of alcohol is a key issue. Two factors were identified as contributing to the excessive availability of alcohol: the number of licensed premises (both on- and off-licences); and the wide range of hours over which they trade.

Based on 1991 Census population figures, the number of licensed premises per 1000 persons in Carnarvon and Kalgoorlie/Boulder was 2.1 and 2.2 respectively—compared to 1.2 per 1000 persons for Western Australia as a whole. Representatives of Aboriginal organisations in these towns considered these numbers too high and in their view the number of premises contributed to high rates of alcohol consumption. As well as increasing the availability of alcohol, the high number of licensed premises means that some licences are less profitable and that, in order to make a return on their investments, licensees often resort to strategies such as selling to juveniles and intoxicated persons and inadequate maintenance of premises, which further contribute to alcohol-related harm.

In Kalgoorlie and Carnarvon concern was also expressed over licensed premises, (including liquor stores) opening as early as 6 and 8 a.m. Similar concerns have been expressed to the Aboriginal Affairs Planning Authority by Aboriginal people from Port Hedland, and there have been reports in the press about similar concerns by Aboriginal groups from Halls Creek and Roebourne. Again, it is perceived that these extended trading hours encourage the excessive consumption of alcohol by sections of the Aboriginal population. As well as contributing to the frequency of drunkenness, consumption of alcohol over such extended periods has other consequences. These include the effects on personal health, as well as the neglect of children and other family responsibilities.

Particularly among those who are alcohol-dependent, there is a demand by for low-cost, high-alcohol content beverages such as cask wine and fortified wine. Consumption of such beverages facilitates high levels of intoxication and its attendant physical consequences. Such consumption was perceived as being promoted at two levels: by the liquor licensing fee structure; and by the active promotion of high-alcohol beverages by individual licensees.

At present liquor licensing fees for retail licences are assessed upon 7% of the gross amount paid by the licensee for low-alcohol liquor (defined as less than 3.8% alcohol by volume) and 11% of the amount paid for high-alcohol liquor. Representatives of some of the Aboriginal agencies were of the view that the differential retail price provides little price incentive for the purchase of low-alcohol beverages by consumers

nor a disincentive to purchase those beverages with a higher alcohol content than 3.8%.

Among individual retailers the sale of low-cost, high-alcohol beverages is further promoted by discounting and by displays encouraging their purchase. It was felt that where communities were attempting to reduce alcohol-related harm, and general consensus had been reached, it was reasonable for them to have some say in the type of beverages offered for sale. This has been achieved in the town of Halls Creek, where residents—most of whom were Aboriginal—were successful in petitioning the Director of Liquor Licensing to restrict the sale of wine in casks and flagons to between the hours of 4 p.m. and 6 p.m. and to limit the amount sold to any individual.[22, 23] Although this is regarded by many as an important step forward, such action might still be open to legal challenge, and the procedures necessary to obtain such restrictions—should a community so desire—are regarded as a major obstacle.

Among all the Aboriginal groups consulted, particular concern was expressed about the serving of intoxicated persons and juveniles. Although both of these practices are offences under the Act, they are reputedly widespread. The intent of the sections of the Act prohibiting these practices is clearly to protect those who, either because of their physical state or their age, are in need of such protection. However, in the interests of higher profits, some licensees and/or their employees commonly disregard the law.

Transportation, supply and sale of alcohol (particularly by taxi drivers) has long been a source of concern to many Aboriginal people. In small rural towns and adjacent areas, Aboriginal people, who often do not have their own motor vehicles, constitute a major client group for taxi services. In some instances, taxi drivers promote the use of their own services, and the consumption of alcohol, by selling and/or transporting liquor. There are two interwoven issues involved here: the sale of alcohol; and its transportation. Under the Act, it is illegal for a person not holding a licence to sell liquor or carry it for the purpose of sale. Under this provision, it is against the law for a taxi driver who is requested by a customer to do so to purchase alcohol on behalf of the customer, deliver it to the customer and then accept payment for the alcohol. Nevertheless, the practice is reportedly widespread. It was reported to us that in one town children of the age of 13 had called a taxi service and had had alcohol delivered to them at the home of one child's parents. Although reports of this practice are common, there are few convictions for the offence—largely because of the difficulty of obtaining evidence and possibly because of discriminatory enforcement of the law.

Although on-sale of alcohol is clearly illegal, transportation of alcohol paid for by the consumer is more problematic. Some sections of Aboriginal communities are completely opposed to any transportation of alcohol by taxis, whereas others regard it as a legitimate amenity. In urban areas or areas in which the use of alcohol is not

prohibited, this is not likely to be resolved. However, there was a strong consensus that, where discrete communities have declared themselves ‘dry’, transportation of alcohol onto or into their vicinity should be specifically prohibited under the Act, which should thus complement similar provisions (that are more difficult to enforce) in the Aboriginal Communities Act.

The sale of liquor on credit is also a source of concern to Aboriginal people. Under the Act (except in the case of business accounts), it is an offence to sell liquor unless it is paid for before, or at the time, it is sold. However, in some towns licensed premises and/or taxi drivers are reported to provide alcohol to Aboriginal people on credit. It was also reported that some licensees and/or managers and taxi drivers either act as agents for individuals and manage their bank accounts or accept social security cheques from individuals and cut the amount out by the provision of services and/or alcohol. Given the conflict of interest involved, these are viewed as a pernicious practices which again promote the consumption of alcohol and often trap individuals in a cycle of debt.

Contingent problems

Aboriginal informants identified (as well as those factors which promote the use of alcohol) other problems which are contingent upon the promotion of Aboriginal drinking or attempts to maximise profits from it. Although they are eager to keep Aboriginal custom, some licensees provide little in the way of service or amenities. In some premises, the facilities provided for Aboriginal patrons, or which Aboriginal patrons are ‘encouraged’ to use, are clearly below the standard of facilities provided for non-Aboriginal patrons. Often comfortable seating is not provided, and at times large numbers of patrons are crowded into confined spaces. In extreme instances, facilities consist of little more than a shed with a cement floor and galvanised iron roof. Not only is the provision of such facilities viewed as discriminatory but the facilities are seen as contributing to other problems. These include violence and drinking in public places as people look for more congenial locations.

In some locations, concern has been expressed about the high levels of injury from broken glass beverage containers as a result of accidents and interpersonal violence. As a consequence of such concern, several years ago in the town of Wiluna the local Aboriginal community was successful in negotiating with the local licensee not to sell alcoholic beverages in glass containers. In a town which has been notorious for high levels of alcohol consumption and related accidents and violence, this has had some effect in reducing alcohol-related harm. However, implementation of this strategy was dependent upon the goodwill of the licensee. If glass containers are to be banned in other communities, the Act will have to be amended.

Discriminatory practices

For many Aboriginal people, discrimination is a daily fact of life.[12] With regard to liquor licensing issues, such discrimination was identified as frequently occurring from two sources: licensees and the police. The provision of substandard drinking facilities by some licensees has already been mentioned. In other instances, licensees target a non-Aboriginal market, and view Aboriginal people as being likely to discourage attendance by non-Aboriginal patrons. Dress requirements are often used to exclude Aboriginal patrons from licensed premises or sections of them. Of concern here is not such requirements themselves, but their discriminatory application. For those aggrieved, legal procedures for seeking redress are complex and beyond the means of many. Several of those interviewed thought that there is a need for local dispute resolution procedures to adjudicate complaints against unfair exclusion.

As pointed out by an officer of the Aboriginal Legal Service, in the past liquor control legislation has been used as an instrument to control Aboriginal people rather than a means of promoting their interests. This continues to apply as a result of discriminatory enforcement of the present Act and other legislation to the detriment of Aboriginal people. An important concern here centres on the way in which Aboriginal people appear to be singled out for offences such as underage drinking and other alcohol-related street offences, whereas few prosecutions are brought against licensees for serving alcohol to juveniles or to intoxicated persons.

In Western Australia, public drunkenness was decriminalised in 1989 (after many years of calls for its abolition).[24] Aboriginal people were charged with public drunkenness disproportionately compared to non-Aborigines; the offence was used to get Aboriginal people off the streets. Following its decriminalisation, Commissioner Dodson reported that 'it is apparent that the use of the offences of park and street drinking is coming into vogue'.[17] That is, rather than being charged with public drunkenness, Aboriginal people were being charged with drinking in parks or on streets—offences under the Liquor Licensing Act which still remain in force. Although there are no comprehensive statistical data available, officers of the Aboriginal Legal Service have reported that, rather than there being a simple substituting of these charges for drunkenness, there have been small increases in a broad range of charges, including the charge of being 'disorderly'—the offence that replaced 'drunk or disorderly' in the Police Act. In the absence of sobering-up shelters in most locations, Aboriginal people continue to be detained by the police but not charged. Although drunkenness has been decriminalised, Aboriginal people continue to experience adverse effects of law enforcement and higher rates of detention.

Community involvement

The heterogeneity of Aboriginal populations, their autonomy, variation in the alcohol-related problems they face, and the importance of community involvement in

addressing those problems was often stressed. Those interviewed were of the view that local Aboriginal people are best placed to define alcohol-related problems and to develop strategies to deal with them. To this end it was believed that the Act should be amended to ensure that all local communities (not only discrete Aboriginal communities) have a far greater say in licensing decisions which affect them. In fact, in terms of licensing decisions, the issue of local community involvement was seen as the key factor in minimising alcohol-related harm.

Under the present legislation, one avenue for community involvement in licensing decisions is the provision for members of the public to make objections to the granting of new licences. However, in a survey conducted in Perth among a sample of 1160 non-Aboriginal people, Lang et al. found that fewer than 2% were aware of this provision.[25] Similarly, McCallum found that, in the Kimberley Region, most Aboriginal people were unaware of this right.[20] Even if these provisions were more widely known, the procedures by which the public is notified of licence applications are themselves problematic. They require the applicant to advertise the application in a daily newspaper and on the site of the proposed premises, and the Director of Liquor Licensing to advertise it in the government gazette and at the office of the clerk of the local court. These procedures assume a high standard of literacy, access to newspapers and their relevance to people's daily lives, and a familiarity with bureaucratic structures and procedures. As such, they are culturally biased, are inappropriate for seeking Aboriginal input, and disadvantage Aboriginal people compared with the applicant.

Procedures for lodging complaints about licensed premises present similar difficulties. These include the requirements that complaints be authorised by no fewer than ten people, that they be made first to the licensee, and that they be lodged with the Director of Liquor Licensing in Perth. Representatives of the Aboriginal Legal Service and one of the Aboriginal medical services pointed out that these provisions create major obstacles for community involvement in licensing decisions. Furthermore, it was felt that the Act is too restrictive with regard to the type of complaints that can be made under it (as opposed to other Acts) by the public. Complaints are restricted to noise and the behaviour of individuals on, or in the vicinity of, licensed premises. The Act needs to be amended to widen the range of complaints that members of the public can bring under it (particularly to include offences such as serving juveniles and intoxicated persons) and the procedures need to be simplified to facilitate the lodging of complaints and, where possible, to enable them to be dealt with locally. As well as procedures for dealing with complaints about breaches of the Act, there is also a need for procedures for resolving at a local level justifiable community complaints about practices which are not illegal. Such practices include the promotion of low-price high-alcohol beverages, the sale of liquor in particular types of container, and discriminatory use of serving policies and dress requirements.

Community involvement in licensing decisions is a key issue. Community organisations want the information to make informed decisions about the problems they face and are aware that this is complicated by disputes between non-Aboriginal 'experts' about what strategies are or are not effective. However, it was strongly argued that rather than waiting, perhaps interminably, for the resolution of such disputes, liquor licensing decisions should support the strategies proposed by local communities. This is important because, in itself, the ability of community organisations to exert controls over the availability of alcohol sends a message that it is not acceptable to drink alcohol in an unrestrained manner. The need here is for the Liquor Licensing Authority to actively seek community opinion on extension of trading hours and to make provision for communities to seek variation in the conditions imposed on particular licences.

Objectives of the Act

It was clearly the view of the community-controlled organisations that liquor licensing legislation should be an instrument which supports and facilitates the efforts of all people to reduce alcohol-related harm. The present Act does this to the extent that it contains sections which give the Liquor Licensing Authority the power to grant or refuse a licence application on any ground that the Authority considers in the public interest, and empowers the Authority to impose conditions on a licence for similar reasons. Unfortunately, as the Act stands, there is no requirement that the Authority must, as a matter of course, consider public interest and community opinion when making a decision. Instead, the interest of the public is subordinated to the primary objects of the Act. These are set out in Table 2. As the added emphases in that table indicate, the main aims of the Act are to promote the interests of the liquor and tourist industries. It was acknowledged that these industries are a major source of economic benefit to the state. However, these interests must be balanced against the harm caused by the misuse of alcohol, the burden of which is borne by all Western Australians. Accordingly, the community organisations supported the notion that a harm-minimisation objective be included in any amendments to the Act and that explicit account of this objective should be taken in all licensing decisions.

Table 2: Objects of the *Liquor Licensing Act 1988*

The objects of this Act are

1. to regulate and *contribute to the proper development of the liquor, hospitality and related industries* in the State
2. to *cater for the requirements of the tourism industry*
3. to *facilitate the uses and development of licensed facilities* reflecting the diversity of consumer demand
4. to provide adequate controls over, and over the persons directly or indirectly involved in, the sale, disposal and consumption of liquor
5. to provide a flexible system, with as little formality or technicality as may be practicable, for the administration of this Act

Note: Emphases added

Source: *Liquor Licensing Act 1988*

Education and training

The second of the terms of reference for the Review Committee was to report on whether:

> An industry-funded program should be established to educate the public in respect of health issues and for compulsory training of licensees, managers and staff involved in the sale and supply of liquor.

Again, there was strong support from the community organisations for this idea. The need for greater education about alcohol and its effects has been demonstrated by Brady and d'Abbs.[26, 27] The need for preventive and public awareness campaigns was also considered essential by the National Aboriginal Health Strategy Working Party,[28] and, in her review of the Aboriginal Communities Act, McCallum recommended that more education programs about the effects of alcohol and strategies to deal with alcohol-related problems be provided.[20] However, educational programs for Aboriginal people developed by mainstream agencies were generally viewed as having been culturally-inappropriate and ineffective in reducing excessive alcohol consumption and related harm among Aboriginal people. For these reasons, the community-controlled organisations were strongly of the view that any allocation of resources for educational and other health promotional programs should be directed to Aboriginal organisations.

As well as supporting the need for educational programs directed at the public, there was also support for the establishment of a compulsory training program to ensure that licensees and their staff are aware of their responsibilities under the Act, and that such training be a condition of holding a liquor licence. As well as a host-responsibility component, such training should include a component—developed and delivered by Aboriginal organisations—on working with Aboriginal people, part of which should be aimed at reducing discriminatory practices by licensees.

As Patrick Dodson pointed out in his Royal Commission report, some of the practices which are of concern to Aboriginal people (such as the serving of juveniles and intoxicated persons) are illegal and what is required is the simple enforcement of the legislation'.[17] However, the prospect of unqualified enforcement was a matter of some concern to the Aboriginal Legal Service. There is a strong view that the law is administered in a discriminatory fashion and more enforcement is likely to simply result in more discrimination. The community organisations argued that there was a need to go beyond proposals for educating the general public and licensees to more training for police officers on enforcement of the Act. Such training should include a component, developed by Aboriginal organisations, on working with Aboriginal people aimed at ensuring there is no discrimination in the enforcement of the Act.

Funding harm minimisation

While it was acknowledged that liquor licensing legislation cannot directly address the demand for alcohol by segments of the Aboriginal population, there was recognition

that its revenue-related provisions could be used to raise funds to finance initiatives including those proposed above. As indicated in the introduction, Aboriginal people themselves have developed a number of interventions directed at minimising alcohol-related harm. However, a major constraint on the further development of such initiatives is the availability of funding. Given the need for an increase in such funding, and the strong feeling that those who profit from the misery caused by alcohol misuse should bear some of the cost of dealing with the problems it creates, there was general support for the view, being canvassed as part of the review, that public education and training programs be industry funded.

Although there was unanimous support for industry-based funding, there was some disagreement about how such funds should be raised. Most organisations were in favour of following the Northern Territory example of increasing licensing fees payable on full-strength beverages and decreasing those on low-alcohol drinks, and using the net increase in revenue to fund education and training programs. However, members of one of the medical services expressed the concern that the resulting increase in the cost of full-strength drinks would have the effect of diverting an even greater proportion of the incomes of some people to pay for alcohol. However, in light of the fact that this does not appear to have been a major problem in the Northern Territory, the steering committee supported increasing the differential between licensing fees payable on low- and high-alcohol beverages.

Recommendations

Arising from the problems identified and solutions proposed by the community-controlled organisations, a total of 26 recommendations were made in the submission to the Liquor Licensing Review Committee.[29] Space precludes discussion of all these recommendations, but they are presented in summary form in Table 3.

The main thrust of the recommendations aimed at increasing community involvement in liquor licensing decisions with the goal of reducing alcohol-related harm. Recommendations were made to require that applications for extended trading permits must be advertised, and that these and licence applications be advertised in a more appropriate manner. To facilitate this, it was proposed that a senior Aboriginal person be appointed within the Liquor Licensing Division. The role of that person should be to identify Aboriginal groups likely to be affected by licence applications and/or applications for extended trading permits, and to provide guidance and active support to those organisations wishing to make submissions.

Table 3: Summary of recommendations to the Liquor Licensing Review Committee

1.	The Act should include a harm-minimisation objective.
2.	A senior Aboriginal person should be appointed within the Liquor Licensing Division to identify Aboriginal organisations affected by licensing applications and to provide *active* support to organisations wishing to make submissions.
3.	The Act should be amended to enable the public to make any complaint about breaches of the Act.
4.	The Act should be amended to enable the public to lodge complaints *directly* with the police, the police should be *required* to investigate them, and if substantiated take appropriate action.
5.	Local inspectors should be given the authority to negotiate disputes between the community and licensees.
6.	Given the decriminalisation of public drunkenness, street and park drinking provisions of the existing Act should be repealed.
7.	Local community workers should be appointed as inspectors with the power to ensure that premises conform to proper standards.
8.	The Act should include a new definition of drunkenness which incorporates behavioural signs.
9.	Licensees should be liable if intoxicated persons consume alcohol on licensed premises.
10.	Serving intoxicated persons should be among the offences for which an infringement notice can be issued.
11.	To reduce the sale of alcohol to juveniles: use of ‘pub cards’ should be promoted; there should be more active prosecution of those supplying alcohol to juveniles; and penalties for such supply should be increased.
12.	Minimum standards of patron amenity should be prescribed.
13.	Provisions against unlicensed sales and transport of alcohol should be more vigorously enforced.
14.	Transport of alcohol to, or into the vicinity of, ‘dry’ communities should be prohibited.
15.	Prohibition of the sale of alcohol on credit should be vigorously enforced.
16.	Provision of banking facilities, including automatic teller machines, on licensed premises should be prohibited.
17.	*Specific provision* should be made for communities to seek variation of licence conditions.
18.	An industry-funded program should be established to educate the public, train licensees and managers, and train the police.
19.	The differential in licensing fees on high- and low-alcohol beverages should be increased, and additional revenue thus raised should be used to finance education and training programs.
20.	Provision of education and training programs on Aboriginal alcohol issues should be contracted to an Aboriginal organisation.
21.	Training of licensees and managers should be conducted by an *independent* organisation.
22.	Granting of a licence should be contingent upon knowledge of the Act and completion of a training course.
23.	Any amendments to simplify administration of the Act should promote increased community involvement.
24.	Extended trading permits should be retained and community comment on applications should be *actively* sought.
25.	A rationalisation scheme should be introduced to reduce the number of licensed premises.
26.	In granting or transferring licences, priority should be given to Aboriginal groups seeking to reduce harm.

Note: Emphases added

Source: Aboriginal issues and the *Liquor Licensing Act 1988*—a submission to the review committee *Liquor Licensing Act 1988*.[29]

To support Aboriginal community-based organisations (as well as the wider community) to address alcohol misuse and its consequences, it was recommended that a harm-reduction objective be introduced into the Act. Licensing fees should be increased to 16% of the gross amount paid for full-strength liquor and reduced to 2% on low-alcohol beverages (as in the Northern Territory). The increase in revenue thus obtained should be used to educate the community about issues related to alcohol misuse, to train licensees and managers in responsible serving practices, and to train police in non-discriminatory enforcement of existing provisions of the Act. Importantly, it was recommended that the development and delivery of educational programs be contracted to Aboriginal community-controlled organisations, and that training for licensees and the police include a cross-cultural component.

Other recommendations included: the decriminalisation of street and park drinking; the development of minimum standards for the provision of amenities on licensed premises, particularly aimed at reducing alcohol-related violence; strengthening the law to facilitate prosecution of licensees serving juveniles and intoxicated persons, and those transporting liquor onto or into the vicinity of 'dry' communities; simplification and development of more appropriate complaint procedures; and appointment of local inspectors to ensure that licensed premises comply with the law and to negotiate local resolution of disputes.

Aboriginal community organisations view changes to liquor licensing laws as an essential part of a broad strategy to address the issue of alcohol misuse and associated harm. However, implementation of these recommendations would not only assist in the reduction of alcohol-related harm and some improvement of the health of Aboriginal people. It would also go some way towards implementing some of the more fundamental recommendations of the Royal Commission into Aboriginal Deaths in Custody and empower Aboriginal people to make decisions about the kind of communities in which they live. The recommendations made as a result of this project were straightforward and can easily be implemented. It now remains to be seen whether the Review Committee and the Western Australian government positively respond to the challenge put forward by Aboriginal people.

Postscript

The Liquor Licensing Review Committee presented its report to the Minister for Racing and Gaming in April 1994 (at about the same time that this paper was prepared).[30] Approval to print the report was not given until September 1994, at which time Cabinet called for comments on it by the public and government agencies.

In its report the Liquor Licensing Review Committee made some positive recommendations. These included proposals to: include harm minimisation as an

object of the Act; train liquor industry personnel; promote community awareness, including support for sobering-up shelters and Aboriginal community patrols; and, raise additional revenue from liquor licensing fees to fund training and community-based project.

However, the Liquor Licensing Review Committee failed to adequately address Aboriginal issues. The Liquor Licensing Review Committee's recommendations do little to ensure that local communities (be they Aboriginal or not) will be able to exercise any real influence on liquor licensing decisions. Incredibly, while noting that the majority of submissions to it were against the extension of trading hours, and that pressure for such extension was 'largely industry generated', the Committee recommended extensions of trading hours for hotels and liquor stores. Although a particular focus of the Liquor Licensing Review Committee's report was upon juvenile drinking, the emphasis was largely upon measures directed at juveniles rather than the adults who supply them. Of particular concern is that the Liquor Licensing Review Committee, with no experience in Aboriginal affairs, rejected all but one of the recommendations of the Royal Commission into Aboriginal Deaths in Custody pertaining to liquor licensing—the exception being to prohibit the transport of alcohol to 'dry' communities.

Of the 26 recommendations made in our joint submission (see Table 3), the Liquor Licensing Review Committee addressed five (1, 8, 10, 14, 19), and only partly addressed seven (2, 11, 17, 18, 21, 22, 24). Through the Western Australian Aboriginal Justice Advisory Committee (formerly the Royal Commission Reference Group of the Aboriginal Advisory Council) the organisations which conducted this project have made a formal response to the Liquor Licensing Review Committee's report.[31] As of October 1994, Cabinet had not decided what action it will take on the report and responses to it. However, it is our fear that the opportunity to frame liquor licensing legislation so that it supports action to minimise alcohol-related harm among Aboriginal people (as well as the wider population) will be missed.

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Corporation, the Yanji Aboriginal Corporation, Kuwinywardu Aboriginal Resource Unit, the Kalgoorlie Aboriginal Medical Service, Kullari Patrol and Milliya Rumurra Alcohol and Drug Centre in Broome, and officers from the Aboriginal Legal Service in Perth, Carnarvon and Kalgoorlie. The project was funded by a grant from the Aboriginal Affairs Planning Authority.

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5. Evaluation of an Aboriginal health promotion program: a case study from Karalundi*

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Abstract

Issue addressed This paper describes the evaluation of an Indigenous health promotion program aimed at enhancing self-esteem and reducing drug use among Aboriginal students.

Methods The processes and outcomes were evaluated using qualitative data and a quantitative questionnaire developed for a similar project conducted among non-Indigenous students in New South Wales (NSW).

Results The results were compromised by problems with the evaluation design, with the inappropriateness of the questionnaire, and because of the unsystematic nature of qualitative data collection. While the qualitative data suggests some positive outcomes of the program, on the basis of the data at hand it was not possible to formally demonstrate these.

Conclusions Although the results of the evaluation were inconclusive, this should not be interpreted as a failure of the program, but as a consequence of the design and implementation of the evaluation strategy. Through no fault of the community organisation which conducted the program, the evaluation methods employed were technically, culturally and financially inappropriate.

So what? The problems raised are not unique to this particular program. They lay with the inadequate assessment of project and program proposals by funding agencies, and the lack of support provided to Aboriginal community-based organisations. We propose a number of steps that can be taken to address these problems and, in so doing, can help to better identify strategies for promoting the health and wellbeing of Aboriginal people.

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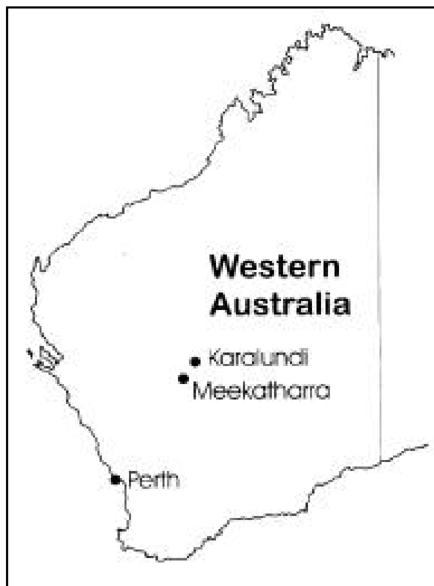
Introduction

This paper describes the evaluation of the Karalundi Peer Support and Skills Training Program. It includes a description of the program, the evaluation methods and results, and their broader implications for evaluation of Indigenous health promotion and substance abuse programs.

Map 1: Karalundi, Western Australia



Karalundi is located 1000 km north-east of Perth and 60 km north of Meekatharra. Between 1954 and 1974 it was a Seventh Day Adventist mission. In 1986 it was reopened as the Karalundi Aboriginal Education Centre (KAEC), owned by the community and managed by a board with an Aboriginal majority. Primary, high school and TAFE (Technical and Further Education) students aged 10 to 20 years from isolated traditional, rural, and town-based communities are boarded at the KAEC.

The peer support and skills training program was modelled on the Elizabeth Campbell program and adapted to suit the needs of Karalundi students.[1] It aimed to reduce or delay the uptake of smoking, drinking and other drug use by providing students with positive communication and decision-making skills that would enable them to recognise and resist social influences to use drugs.[2]

Peer support and skills training program

The program was initiated by the KAEC management board. As a first step, an informal needs assessment was conducted by the community nurse (later the program coordinator). This identified a range of drug use and general health problems. On the basis of this assessment, a review of the literature, and consultation with other organisations, the peer support and skills training program was developed. The aim of the program was to increase student self-esteem and reduce drug use by means of a variety of strategies including: provision of a supportive environment; improving communication between staff and students; developing leadership and communication skills; guiding students away from experimentation with drugs; early

identification of personal and drug-related problems; and developing culturally-appropriate health promotion media.[3]

The project was funded by two grants. A National Drug Strategy education grant of $15 300, from the Department of Health, Housing, Local Government and Community Services (DHHLGCS—now the Department of Health and Aged Care), included a small component for the salaries of community members ($4500), administration ($1750) and materials costs ($4046), and provision for program evaluation ($5000). A Healthway health project grant of $2000 contributed to the cost of producing a newsletter and videos. The greatest cost, however, was borne by the community, volunteers and various support agencies. These costs were not systematically recorded but, conservatively, they are estimated to total $32 100. The biggest single contribution was the salary of the coordinator who worked half-time without pay on the project for a total of 58 weeks ($18 400). The cost of time contributed by three other volunteers from the community is estimated to be $5600, and that of personnel from other agencies $3400. In addition, travel and accommodation costs totalling $3750, and materials totalling $950 were donated to the program. It is important that these costs be acknowledged, because without access to such resources the program could not be replicated in other communities.

In the original proposal, it was planned to conduct the program over the 1994 school year. However, due to delays in obtaining funding, the program did not commence until July 1994; and it was extended from one to two years, completed in June 1996. In the course of this time, a range of additional strategies was included in the program, and it was expanded to include 10 sub-programs, each of which was designed to address one or more of the original program objectives. These sub-programs were as follows:

- Peer support and skills training sub-program—aimed to develop students' interpersonal, problem-solving and decision-making skills.
- Quit Now education sub-program—covered fitness, long-term effects of smoking, and strategies to quit.
- Drug education and solvent sniffing awareness—aimed to provide an overview of drugs and their effects, and the health and social consequences of solvent sniffing.
- Excursion to Milliya Rumurra Alcohol and Drug Centre in Broome—aimed to provide an insight into the long-term effects of alcohol use, and the services available to Indigenous people with alcohol dependence problems.
- Media and health promotion plays and videos—created by students and volunteers, aimed to promote Aboriginal achievement and healthy lifestyles.
- Sex education workshop—aimed to promote safe sex practices and awareness of HIV/AIDS.
- Fabric painting—used to explore pathways to health, and to develop health promotion messages.

- An annual newsletter, entitled Karalundi Wangka—written by the students, published articles that dealt with alcohol and other drugs, and how misuse of them had affected their lives.
- Trachoma, ear and nose care sub-program—aimed to reduce the high incidence of ear, eye and nose infections.
- Natural medicine, alternative remedies and bush medicines workshop—aimed to encourage the use of alternative remedies in place of analgesics to relieve minor symptoms.

Evaluation

An evaluation, including quantitative and qualitative measures, was designed by the program coordinator who collected data with some assistance from teachers and program educators. At the completion of the program, assistance with data analysis was sought from the National Centre for Research into the Prevention of Drug Abuse (NCRPDA).

Methods

For the purposes of the program, the community members who developed it identified the participating students as the target population (rather than attempting to select a sample of students from the wider Aboriginal populations of the region). As indicated previously, the commencement of the project was delayed until July 1994. The pre-intervention survey was conducted among 27 students one week prior to the commencement of the program; and post-intervention surveys were conducted among 15 students in July 1995, and among 29 students in June 1996.

This compromised the usefulness of the questionnaire data because the student population is transient—particularly from year to year—and not all students participated in all activities, and not all students completed each questionnaire. Furthermore, because no means of identification was included on the completed questionnaires, it was not possible to ascertain which students participated in the pre-intervention and at least one of the post-intervention surveys.

The questionnaires and instructions for their administration were posted to the school teacher in the control community, and were completed by 12 students. However, the pattern of responses indicated that the instructions were not followed, and that the students had copied answers from each other. Given this, and as resources were not available to enable the coordinator to visit the community, plans to conduct the control component were abandoned.

The questionnaire was based on one developed by Reilly to evaluate a similar program among non-Indigenous students in NSW.[4] It included four sections. In the first, students were asked to indicate how often they had used alcohol, tobacco, cannabis and volatile substances, and how often they had been drunk or consumed more than five drinks in a row. In the other three sections, they were asked to indicate their level of agreement with: 14 statements about attitudes to drug use (for example, 'You can be friendly without drinking alcohol'); 10 statements about self-esteem (for example, 'I feel good about myself'; and 14 statements about how they felt about school (for example, 'School is a place where I feel worried').

Unfortunately, direct comparability of the results was compromised by three factors. In both post-intervention surveys two statements about self-esteem, and in the second post-intervention survey one statement about school, were not included. In each of the surveys, the points on the response scales were differently labelled because of concerns about the ability of students to understand them, and 'don't know' options were included in some but not others. The surveys were also administered under different levels of supervision.

In addition to the major outcomes to be assessed by questionnaire data, a number of intermediate aims were to have been evaluated qualitatively. However, the aims were not operationalised, and data were not systematically collected. Nevertheless, observational data and unstructured interviews with staff and community members were used to improve each stage of the program, and provided some insight into the effects of the program. More details on the methods, and the results, are available in a technical report on the program.[5]

Results

Due to the transient nature of the student population, the small number of students involved, and the way in which it was constructed and administered, it was not possible to ascertain from the questionnaire data whether the program had any effect on patterns of drug consumption, attitudes to drug use, students' self-esteem or their feelings about school. Furthermore, interpretation of the results within each survey was problematic. First, the lower proportion of students disagreeing with the negative statements indicates that some did not understand the tasks; because, as the school principal commented, mixing of positive and negative statements in such questionnaires is confusing to some Aboriginal students. This highlights the inappropriateness of the presentation and format to students whose first language is not English.

Even if this problem had been overcome, it would not have dealt with a more fundamental issue—that is, at least for the students from the remote communities,

the questions themselves were culturally inappropriate. In various Indigenous Australian cultures it is not appropriate to express self-esteem by comparing oneself favourably with others, as the students were asked to do by indicating their agreement with statements such as ‘I’m as good as others’ and ‘I can do things as well as others’.

In each of the surveys, 70% to 100% of students strongly agreed or agreed with eight of ten statements about the use of drugs; and more than 48% agreed with the other two statements. Again, from these data, it is not possible to identify changes consequent upon the intervention program. However, it appears that most students were relatively well-informed about drug use prior to the intervention. While not demonstrated by the survey data, the qualitative data suggest that the program probably re-enforced existing attitudes among most students and resulted in positive changes among at least some. It also appears that the high proportion in each survey (more than 80%) who agreed with the statement ‘Only use painkillers when pain is severe’ facilitated a reduction in the prescription of analgesics and use of alternative remedies. This was instigated by the community nurse.

As indicated previously, qualitative data were not collected in a manner which enabled systematic evaluation of the program. Nevertheless, they did provide some indication of positive outcomes. These include:

- Enhanced self-confidence among students as a result of the promotion of Aboriginal achievement through an entertaining media, and as reflected in their active involvement in selection of activities and their unselfconscious performance in front of small groups.
- Greater empowerment of female students, as demonstrated by participation in decision-making processes and successfully undertaking activities which they had designed.
- Increased awareness of health and substance use issues, as demonstrated by the ability of students to produce plays, paintings and newsletter articles with strong health promotional messages.
- Re-enforcement of existing positive beliefs about health matters, demonstrated by students volunteering to help at the nursing station and by an observed increase in hand washing and nose blowing at school (although little change was evident among the younger students after school hours).
- Reduced use of analgesics within the community, as observed by the community nurse.
- Provision of an outlet for student creativity.
- Provision of an opportunity for volunteers and staff to develop skills in program implementation, potentially enabling them to independently conduct similar programs in the future.

Discussion

At the most general level, the evaluation highlights the difficulties faced by Indigenous communities when attempting to address a range of needs from a limited pool of resources to which various strings are attached. As the results indicate, it is difficult to demonstrate the positive outcomes of the program in a formal manner. This should not be interpreted as a failure of the program itself. It is, rather, a consequence of the design and implementation of the evaluation strategy—a problem common to many projects in the Indigenous health field. This is not raised as a criticism of the KAEC, but as an exploration of the context of Indigenous program evaluation and a search for ways in which the process can be improved.

Reflecting demands for greater accountability in expenditure of government funds, evaluation proposals are an integral part of National Drug Strategy education grant applications. In principle, few Indigenous organisations are opposed to such a requirement. They are—like the KAEC—concerned to demonstrably improve the health status of their members and to do so in the most effective, culturally-appropriate manner. The difficulties arise in practice, as evaluation of this program and others clearly highlights.[6]

None of the KAEC board members or staff had any practical evaluation experience and, to meet DHHLGCS evaluation requirements, the coordinator simply adopted the framework used to evaluate the NSW program. Implicitly acknowledging this lack of experience, the grant application stated that evaluation would be contracted out to a university-based consultant.

Although the usefulness of evaluation was acknowledged, lack of experience led to it being conceptualised as an 'add on'—rather than an integral part of program planning. This had a number of unfortunate consequences. First, apart from some broad measures, no specific indicators were identified which would have enabled unambiguous assessment of program effectiveness. As a result, there were no guidelines for the collection of much essential data.

A second consequence was that no consideration was given to either the technical or cultural appropriateness, in the Karalundi situation, of the evaluation methods developed for the NSW program. Technically, given the transient nature of the school populations, and the timing of the intervention, the chance of obtaining complete data on students at Karalundi and in the control community before and after the intervention was small. Even if it had not been, there were so few students in each school population that, using the survey data, it would not have been possible to determine whether any small change in drug use was a consequence of the intervention or simply due to random variation. Culturally, some of the questions, their wording, and their format were inappropriate.

The DHHLGCS provided a set of nine criteria against which National Drug Strategy education grant applications were to be assessed. One of these dealt with evaluation, but the emphasis was clearly upon the relevance of the project to the National Drug Strategy, project planning, and the production of educational resources. The Karalundi proposal was assessed by officers from the DHHLGCS and from the Aboriginal and Torres Strait Islander Commission (ATSIC)—none of whom appear to have had any particular expertise in evaluation. The comments made by the reviewers focused largely on program implementation and issues pertaining to community involvement—although the ATSIC officer recommended tendering of the evaluation component to groups with some expertise.

It might be argued that insufficient information was provided in the grant application to clearly highlight the issue of the cultural inappropriateness of the strategy. However, it is reasonable to expect that the issue of technical inappropriateness should have been identified as part of the application assessment process. This suggests that—at least at the time this particular application was assessed—the procedures were inadequate. The ATSIC officer's recommendation that the evaluation be conducted by a group with appropriate expertise suggests an awareness of the complexity of the evaluation process. However, that this was to take place at a later stage suggests that, for the reviewer also, evaluation was perceived as an 'add on' rather than an integral part of the program.

The lack of expertise on the part of Karalundi community members and staff also had unfortunate consequences for data collection. Some of these arose from the fact that the questionnaires were not pre-tested prior to use. Thus, the fact that the meaning of some statements was not clear to the students was not detected until the completed questionnaires were analysed. In regard to other sections of the questionnaire, after the pre-intervention survey, it was decided that response options to some statements might not be comprehensible to the students, and these were changed. This limited the comparability of data from each survey—as did deletion of some questions in the post-intervention surveys, and the differential degrees of assistance and supervision provided in the various surveys.

The grant application stated that 'Simple bookkeeping techniques (that is, qualitative techniques) will be used to record student responses to program activities', and to this end the coordinator kept notes regarding program implementation. Again, due to lack of training, this data was not recorded in a way that enabled systematic analysis of program processes and outcomes.

In addition to the problems identified above, for the strategy proposed, the evaluation component of the program was considerably under-resourced. In particular, insufficient time and funds were allocated to enable the coordinator to plan and conduct evaluation activities. As a consequence, data collection in the control

community had to be abandoned, there were no resources to train teaching staff in administration of the questionnaire, there was inadequate time for the collection of qualitative data (even had there been sufficient expertise to do so), and no resources were available to recompense the coordinator for her time in assisting the evaluators at the completion of the program.

Comprehensive evaluation is a costly process. The total amount of money sought from the DHHLGCS was only $15 300; yet $5000 of this was allocated to evaluation of program components funded from that grant. This raises the question of whether expenditure on evaluation at this level for such a small program was warranted. We argue that it was not. Not only were elements of the evaluation strategy technically and culturally inappropriate; but its consumption of 33% of available resources also made it financially inappropriate. Again, this is partly a failure of the grant assessment process. We believe that the application should have been reviewed by someone with sufficient expertise to: identify the inappropriateness of the evaluation strategy and its cost; and advised the applicant on a more suitable approach. However, a larger part of the blame for this must be laid at the feet of those politicians, their constituents and others whose demands for ever greater accountability have often been made with little or no consideration of the practicalities or costs of evaluating the plethora of government-funded projects.

On the basis of this case study, and our experience as grant application assessors and as consultants to or employees of Indigenous organisations, we believe that some of the problems we have identified could be addressed if granting agencies adopted the following recommendations.

1. Grant applicants should be provided with more detailed information about the purpose of evaluation and the specific requirements of the granting agencies.
2. This information should be supplemented with lists of persons with appropriate expertise who would be willing to assist Indigenous organisations, at no or minimal cost, to develop appropriate evaluation strategies that are integral to particular projects.
3. Comprehensive guidelines and procedures for the evaluation of projects should be developed which take account of their different size and complexity. Such guidelines would be of assistance to both applicants and grant application assessors, and would help to ensure that evaluation strategies were matched to particular projects.
4. As part of the assessment process, grant applications should be reviewed by at least one person with evaluation expertise and some experience in working with Indigenous organisations.
5. Most importantly, we need to ensure that Indigenous service providers themselves develop the expertise to evaluate their own projects. In a collaborative project undertaken by the Albany Aboriginal Corporation and the NCRPDA, and funded by the Department of Health and Family Services, we entered into an arrangement

with the Department of Employment, Education and Training whereby community members were funded to undertake TAFE-accredited training in basic research methods.[7] Similar arrangements relating to the provision of training in basic evaluation techniques could be formalised with relative ease, and offered as part of a standard package to Indigenous organisations undertaking health care interventions.

All these recommendations have some cost implications. However, their implementation could improve the work being undertaken by Indigenous community organisations and should be viewed as an investment in the future of Indigenous health.

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6. What works? A review of evaluated alcohol misuse interventions among Aboriginal Australians*

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Abstract

Aims To identify which intervention strategies have been effective in reducing excessive consumption of alcohol, and related harm, among some segments of Australia's Aboriginal population.

Design Items dealing with 'alcohol' and 'evaluation' (27) were identified from the comprehensive electronic database on Aboriginal alcohol and other drug issues, maintained by Australia's National Centre for Research into the Prevention of Drug Abuse (NCRPDA). From these were selected all reports (14) dealing specifically with evaluation of particular intervention projects. These were grouped and systematically reviewed under the broad categories of treatment, health promotion education, acute interventions and supply reduction.

Findings A broad range of intervention strategies has been employed. However, few systematic evaluations have been undertaken, and the methodologies employed have been generally insufficient to allow robust generalisation. The impact of most interventions appears limited but, in part, this may be a function of inadequate resourcing and program support.

Conclusions Despite the limitations of the evaluation reports, several conclusions can be tentatively drawn. It appears there is a need to employ a broader range of treatment models and complementary intervention strategies. Interventions are generally inadequately resourced. There is a suggestion that supply reduction interventions may be effective. Most importantly, there is a pressing need for more rigorous evaluation studies in cooperation with Aboriginal community-controlled organisations.

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Introduction

Over recent years, various reports have shown that, while fewer Aboriginal than non-Aboriginal Australians drink alcohol, those Aboriginal people who do drink are more likely to do so excessively.[1–4] Several reports also demonstrate the significant contribution this pattern of consumption makes to ill-health and social disruption.[5–8] This paper reviews the few formally evaluated interventions among Aboriginal people, with the aim of identifying their potential contribution to the reduction of excessive consumption and related harm.

It should be noted at the outset that evaluation of alcohol intervention projects among Aboriginal people is not a simple matter. Among the complex issues to be considered are the broader political context in which evaluation takes place, including issues of self-determination and financial and social accountability, the costs of evaluation, the abilities of both community organisations and government agencies to conduct adequate evaluations, and the use of culturally-appropriate methods.[9, 10] To these, we must also add the absence of comprehensive longitudinal data for monitoring change, and the methodological difficulty of linking particular interventions with changes in consumption or harm indicators when those indicators are also influenced by a host of other factors. Given these issues, it is perhaps not surprising that so few programs have been evaluated.

The National Drug Research Institute has the most extensive library on Aboriginal alcohol and other drug issues in Australia. We have also compiled—from numerous sources—a comprehensive, computer-based, key-worded and annotated bibliography on these issues. At the time of writing, the bibliography includes details of 622 books, book chapters, journal articles, technical reports and manuscripts. For the purpose of this review, we searched the bibliography and identified all those items dealing with alcohol (444), and selected from them those involving evaluation (27). Of these, we selected for review all of those which specifically evaluated particular intervention projects (14). The remainder were general items, and reference is made to them only where they contain material of direct relevance to the review.

In this review, the evaluations are grouped according to intervention type, and include brief summaries of methods and key findings related to process and/or outcome. Reference is also made to our own experiences and those of workers on some of the 284 projects included on our National Data Base on Aboriginal and Torres Strait Islander Alcohol and Other Drug Projects.[11]

Treatment

Since the 1970s, treatment has been the most common form of intervention, and the Office for Aboriginal and Torres Strait Islander Health acknowledges a continuing bias towards this type of intervention in the Commonwealth government's current funding program.[12] On our National Data Base on Aboriginal and Torres Strait Islander Alcohol and Other Drug Projects, we identified 79 treatment services specifically for Aboriginal clients. A wide range of counselling options—in both residential and community settings—forms the basis of all these projects, but the majority are based on Alcoholics Anonymous or abstinence principles.

An evaluation of treatment/rehabilitation services provided by 14 Aboriginal organisations was conducted by O'Connor and Associates for the Western Australian Alcohol and Drug Authority in 1988.[13] It was based on semi-structured interviews with program staff, and collection of statistical data on workloads and client characteristics. They found that few clients achieved the goal of continuing abstinence. Importantly, however, programs that included residential facilities or 'dry camps' gave clients 'time out' from drinking, enabling them to improve their health status. The impact of all programs was limited to a greater or lesser degree by administrative problems and lack of staff expertise.

d'Abbs evaluated three programs—two residential and one non-residential—and a community-based field worker program conducted by the Council for Aboriginal Alcohol Program Services in the Northern Territory (NT).[14] It was based upon a review of documentary data, program records and comparisons of the drinking status of ex-clients and samples of community members. He identified needs for improved record keeping systems and for governments to ensure adequate and regular funding. He found:

> … a suggestion that attendance at (one family oriented program) has modest but real effects on drinking behaviour … (p 5).

However, outcomes at other locations were equivocal, and he concluded that the effectiveness of all services was limited because they were based on a narrow range of treatment options. He also concluded that '… community-based field workers constitute an essential complement to residential programs' (p 7).

Results of an evaluation of the Central Australian Aboriginal Alcohol Programs Unit's (CAAAPU) residential program, undertaken by Miller and Rowse, was similarly equivocal.[15] They conducted a review of client registration and discharge forms, conducted interviews with staff and residents, and followed up 25 ex-clients. They found that there were no agreed criteria against which success could be measured and—even if there had been such criteria—CAAAPU was inadequately funded to obtain necessary follow-up data on ex-clients. The evaluation identified problems in the administration of CAAAPU which, in part, led to its subsequent closure. However, it has since re-opened.

Health promotion

After treatment, health promotion programs have been the most common intervention. Some of these are based on the assumption that people misuse alcohol because they simply lack knowledge, others aim at changing specific drinking behaviours. Evaluations of these have focused on either program processes or short-term outcomes, rather than longer-term impact on consumption patterns and related harm.

In Victoria, the Koori Alcohol and Drug Prevention Project was initiated in 1985. It began with a broad set of treatment and prevention objectives to be implemented by Aboriginal alcohol and drug workers in four regional locations. However, due to a change in funding arrangements, the project was required to limit its focus to the provision of health promotion services—including education classes, sporting and recreational activities, and support for homeless people. Evaluation of the project was based on unstructured and semi-structured interviews with staff, clients and community members.[16] It focused upon describing the services, impediments to their delivery and their acceptance by the community. The evaluators found that, although the services were well received, they were compromised by lack of support structures for the alcohol and drug workers. Also—because Aboriginal people did not generally use mainstream services—considerable pressure was placed on the alcohol and drug workers to provide a wider range of services (including counselling) for which funding was not provided.

In 1993, the Commonwealth government funded a campaign in the NT targeting Aboriginal adolescent alcohol abuse. It consisted of a bush tour by the Aboriginal band Yothu Yindi and an associated television commercial. It was evaluated by Milne et al. on the basis of qualitative data on perceptions of the impact of, and response to, the campaign message, and quantitative data on exposure.[17] They claimed that the tour was effective in reaching the target group in those communities visited, and highlighted existing anti-alcohol abuse agendas, although people's perceptions about the likely impact of the message were mixed. Exposure to the television commercial varied depending upon local viewing habits; responses to it were generally positive, but interpretations of its message varied. Importantly, Aboriginal health workers and teachers expressed a need for supporting information and project material. However, the campaign was the subject of some criticism in a report prepared for the Central Australian Aboriginal Congress by Maher and Tilton.[18] This argued that the campaign was compromised by its 'top down' approach, and the fact that, while some Aboriginal groups in the Top End of the NT were consulted, those in Central Australia were not and, as a consequence, it was culturally inappropriate for people living in the latter area.

In the same year (1993), the Queensland Department of Education, in cooperation with an Aboriginal community, developed a school-based alcohol education package called 'When You think About It'. It focused on issues such as drink-driving and the

disruptive effects of excessive consumption. Attempts at quantitative evaluation were thwarted by high absentee rates and small numbers of students completing pre- and post-intervention questionnaires.[19] On the basis of qualitative data, the evaluators concluded that while students responded positively to the locally developed package:

> The effect of the teaching program on the student's attitudes and beliefs seemed limited which is not surprising given the already strong anti-alcohol attitudes of the sample group (p. 217).

They concluded that, in implementing such projects, there is a need for in-service training of teachers that focuses on informal group work, group exercises and activities, role play, community involvement and community-based promotion.

A local drug education program for Aboriginal children aged nine to 16 years was also developed on Palm Island in Queensland. Based on social learning principles this program sought to: help children identify the reasons for alcohol consumption, and the physiological and social effects of harmful use and peer pressures to drink; and provide them with enhanced self-esteem and skills to resist pressures to drink. The evaluation included pre- and post-intervention surveys of participants (n = 26) and a control group (n = 38).[20] Students were found to have responded positively to the content and methods of program delivery, and the questionnaire data suggested '… that the programme succeeded in making the children more aware of the influence of peer pressure'. The evaluators also claimed that:

> … there is some evidence that the programme may have caused fewer children to take up drinking than otherwise would have been expected (p 37).

However, they urged that the finding be treated cautiously.

Recently, we assisted staff from the Karalundi Aboriginal Education Centre in Western Australia to evaluate a similar small-scale program.[21] The program was designed to be evaluated using qualitative data, and pre- and post-intervention questionnaires to be administered to participants and a control group in a neighbouring community. The former provided some indications of limited positive changes in knowledge and behaviour. However, the evaluation as a whole was compromised by methodological difficulties stemming from the lack of expertise on the part of program staff, and lack of support for them. It did, however, raise a resourcing issue with important implications. Although the community received project grants of $17 300, implementation of the program cost an additional $32 000 in donations of time and resources!

Acute interventions

In the past decade, Aboriginal organisations have developed a number of 'acute interventions' aimed at reducing the immediate harm associated with excessive drinking. These include night patrols, sobering-up shelters and personal injury prevention initiatives. Of these, only sobering-up shelters have been subject to any

evaluation. The impetus for the establishment of sobering-up shelters came with the decriminalisation of public drunkenness in various jurisdictions. There are now more than 24 of them in diverse locations throughout the country. Their aim is to provide a temporary haven for, and supervision of, intoxicated people at risk of causing harm to themselves or others. Importantly, they provide a more appropriate alternative to placing intoxicated people in police custody, and the Royal Commission into Aboriginal Deaths in Custody urged the establishment of more shelters as one of many strategies for reducing such deaths.[8]

Daly and Gvozdenovic attempted to elicit attitudes to the decriminalisation of public drunkenness and the establishment of sobering-up shelters through the conduct of unstructured interviews with an unspecified number of Aboriginal people, police and others.[22] The study was conducted in three towns in Western Australia that had established sobering-up shelters and one that had not. They found that the shelters had generally been well accepted by both clients and the police (who reported that diversion of apprehended persons to shelters reduced their administrative workload).

While this has been the only focused evaluation of sobering-up shelters, other reports provide information relevant to judgements about their effectiveness. As indicated, a prime objective has been diversion of intoxicated people from police lockups. An early report by McDonald on the operation of sobering-up shelters in Darwin and Tennant Creek found that 60% of intoxicated persons detained by police were diverted to them.[23] In Halls Creek, Western Australia, in the first 15 months of its operation 78% of persons detained for public drunkenness were diverted to the sobering-up shelter.[24]

McDonald also noted that provision of sobering-up shelters was not cheap.[23] Subsequently, Alexander reported that in 1985–86 the mean cost per admission at the Darwin shelter was $94 and at Tennant Creek it was $146 (because of similar basic costs but fewer admissions).[25] In its first six months of operation, the mean cost at Alice Springs was $74. This compared with prison costs of between $82 and $93 per day in NT prisons and hospital bed day costs of between $290 and $350. Sobering-up shelter costs appeared greater than the cost of detaining prisoners in police cells—estimated at $50 per day—but the costs were not directly comparable because the latter did not include cell staffing costs. Although the cost of detaining people in sobering-up shelters appeared to be higher than detaining them in police cells, Alexander argued that the shelters provided a number of qualitative gains including more comfortable and dignified treatment and, for a small number, entry to other services. Midford, Daly and Holmes, and Daly and Maisey also reported that the establishment of sobering-up shelters in Halls Creek and other areas in Western Australia has been a catalyst to further local actions to address alcohol misuse and associated harm.[24, 26]

Supply reduction

Supply reduction is not a new strategy for reducing alcohol consumption among Aboriginal people. From the early 1800s through to the 1970s, various Australian colonial and state/territory governments sought to prohibit the supply of alcohol to Aboriginal people. This was only partially successful and—as part of moves to grant equal rights to Aboriginal people—was abandoned. Nevertheless, in recent years, various Aboriginal community organisations have called for the reimposition of prohibitions or other supply reduction measures at the local level.

In response to calls from some Aboriginal communities for total prohibition, and attempts by non-Aboriginal people to force Aboriginal people from drinking in public places, some governments have passed legislation enabling the declaration of 'dry' or restricted areas.[27] This legislation varies between jurisdictions and its impact has only been evaluated in the NT—where communities can apply for restricted area status under provisions of the Liquor Act. The evaluation, by d'Abbs, was based on documentary sources, official statistics and informal interviews. It included four case studies on the effect of 'dry' status.[28] He concluded that:

> … the restricted areas provisions should be adjudged a qualified success. They are a success insofar as they are shown to have been accompanied by an improvement in the 'quality of life' in several communities. The success is qualified on at least two counts: firstly, the beneficial effects of dry area status are not to be found in all dry areas; secondly, some of the procedures used in the declaration and enforcement of dry area provisions are cumbersome and/or inefficient, while others smack so much of a heavy-handed prohibitionist stance that they do little to foster responsible community control over alcohol consumption (p. 7).

He went on to say that the provisions themselves did not guarantee community control over alcohol. For this to be achieved, communities need to have a coherent strategy for dealing with alcohol, restrictions must have community support, and there must be clearly-agreed roles for controlling liquor consumption on a day-to-day basis.

These latter concerns were echoed by Hedges and McCallum, both of whom conducted reviews of the Western Australian Aboriginal Communities Act 1979—which includes provisions for communities to declare themselves dry.[29, 30] McCallum reported that, although the Act made provision for communities to enforce their dry area status, such provision was later found to be invalid and enforcement remained the domain of the police. As the police have no permanent presence in the communities and as the communities are not able to enforce the by-laws independently of them '… alcohol continues to flow more or less freely'.

In November 1992, in Halls Creek, restrictions imposed on licensees: prohibited takeaway sales before 12 pm; restricted sales of cask wine to the hours between 4 pm and 6 pm; and limited cask wine sales to one cask per person per day. The restrictions were evaluated by Douglas, who compared levels of alcohol consumption and crime and health indicators prior and subsequent to the introduction of the restrictions.[31] He found that the restrictions led to a reduction in wine consumption of 39% and a reduction in overall alcohol consumption of 7.5%; but that it was not possible to link this directly to a decline in other indicators.

Table 1: Summary of studies reviewed

Study	Intervention	Methodology
O'Connor[13]	Review of 14 treatment/ rehabilitation programs in WA.	Semi-structured interviews with program staff. Collection of statistical data on workloads and client characteristics.
d'Abbs[14]	Reviews of 2 residential and 1 non-residential treatment programs, and the role of community-based fieldworkers.	Review of documentary data and program records. Comparisons of drinking status of ex-clients and samples of community members.
Miller, Rowse[15]	Residential treatment program based on 12 steps approach.	Review of client registration and discharge forms, interviews with staff and residents and follow-up of 25 clients. Found no agreed criteria against which success could be measured—sobriety too crude.
Alati[16]	Process evaluation of range of preventive activities.	Unstructured and semi-structured interviews with staff, clients and community members.
Milne, Josif, Lynn[17]	A tour of 8 remote communities by an Aboriginal band and a television commercial.	Qualitative data on perceptions of the impact of, and response to, the campaign message. Quantitative data on exposure.
Sheehan, Schonfeld, Hindson[19]	A locally produced video and set of 6 lessons for high school students with the theme of controlling alcohol consumption.	Pre- and post-test student survey. Informal interviews with students. Interviews with teachers and community members. Only 27% of students completed both questionnaires and attended 5 lessons.
Barber, Walsh, Bradshaw[20]	An eight lesson alcohol education program among children aged 11 to 14 years.	Static group pre-test post-test design. 26 children in intervention group and 38 in control group. Multivariate analysis of covariance.
Gray, Sputore, Walker[21]	Health promotion program.	Qualitative data and pre- and post-intervention questionnaires. Compromised by poorly designed evaluation strategy.
Daly, Gvozdenovic[22]	Impact of decriminalisation of public drunkenness and establishment of sobering-up shelters.	Qualitative data including unstructured interviews and focus groups with Aboriginal people, police and others. No details of numbers interviewed .
d'Abbs[28]	Restricted areas.	Uses documentary sources, official statistics and informal interviews. Four case studies on the effect of dry status. Use of police and health statistics to compare communities before and after declaration of dry status and comparisons of restricted and non restricted areas.
Douglas[31]	Restrictions on the hours in which packaged liquor could be sold and restrictions on the sale of cask wine.	Pre- and post-intervention comparisons of alcohol consumption, criminal charges, alcohol-related presentations to hospital, and comparison with consumption in a similar community.
d'Abbs, Togni, Crundall[32]	Trial of two sets of restrictions on availability.	Comparison of law and order, health and welfare and economic (including alcohol consumption) indicators during the trial periods with corresponding periods in the previous year. Community survey of attitudes.
Gray, Saggers, Atkinson et al.[33]	Restrictions on trading hours and the sale of cask wine.	Pre- and post-intervention comparisons of alcohol consumption, acute hospital admissions, police detentions and offence reports.
d'Abbs, Togni[34]	Restrictions on trading hours and sale of cask wine.	Pre- and post-intervention comparisons of alcohol consumption, selected police offences, injuries recorded at hospital. Community survey of attitudes to restrictions.

Process	Outcome
Identification of administrative problems, and lack of expertise among staff.	Few clients achieved goal of abstinence but there were improvements in health status of clients.
Need for improved record keeping. Need for governments to ensure adequate and regular funding. Community-based fieldworkers are an essential complement to residential programs.	No statistically significant outcomes. Suggestion that one residential program had modest effects on drinking behaviour. Limited effectiveness in part due to inadequacy of the 'family disease model' on which the programs are based.
Need to improve administration. Respond to need of sub-groups of clients.	Results inconclusive.
Identified impediments to service delivery and difficulties of need to provide services not provided elsewhere.	No outcome measures.
Effective in reaching target group. Highlights need for supporting information and project material.	Claimed to have highlighted existing anti-alcohol abuse messages—though perception of message mixed. Findings contested.[19]
Need for broad in-service training of teachers presenting such packages.	Qualitative data suggests impact limited—but not surprising given already strong anti-alcohol attitudes in sample group.
Students responded positively to contents and methods of delivery.	No significant difference between intervention and control group in perceptions of, attitudes to, or beliefs about use of alcohol or drinking behaviour.
Highlights problems with inadequate assessment of projects by funding agencies and lack of support provided to community organisations.	Results inconclusive.
Makes various recommendations for working with Aboriginal people.	Aboriginal people are being diverted from police custody but no statistical data. Diversity of views among Aboriginal people. Supported by police.
Procedures for declaration and enforcement provisions cumbersome and inefficient.	Qualified success—benefits not found in all communities.
	Restrictions implemented in context of other interventions but there were significant reductions in all indicators—including 7.5% reduction in consumption.
	Consumption reduced by 2.7%. Reduction in police incidents, hospital and women's refuge admissions.
	Over the 2 years following introduction of the restrictions, per capita consumption declined by 20% and there were significant reductions in all indicators.
	Reduction in police offences. Otherwise, results inconclusive. Aboriginal people felt problems too complex to be adequately addressed by restrictions.

In 1995, the NT Liquor Commission agreed to a trial of alcohol restrictions for a period of six months in the town of Tennant Creek. The trial was conducted in two 13-week phases. Combinations of restrictions in each phase varied, but included restrictions on: Thursday trading (the day on which social security payments were made); the hours in which takeaways could be sold; front bar trading; and cask wine sales. The evaluation included comparison of law-and-order, health-and-welfare and economic indicators during the trial period with those for the corresponding period in the previous year.[32] These showed that the trial had resulted in reduced police incidents and disturbances to public order, and fewer alcohol-related hospital presentations and admissions to the women's refuge. A downturn in alcohol sales in the town itself was partly offset by increases in sales at roadside inns and, while wine sales fell, purchases of full-strength beer increased. Nevertheless, there was reported to be a 2.7% reduction in total consumption.

Consequently, the Liquor Commission amended the licences of hotels and takeaway outlets in Tennant Creek to include: a ban on sales of wine in casks of >2 litres; closure of front bars on Thursdays; and other restrictions on both takeaway and bar trading hours. Gray et al. evaluated these based on the methods of d'Abbs et al.[33] For the 12 months prior, and the 24 months subsequent, to introduction of the restrictions, they compared alcohol consumption, hospital admissions for alcohol-related diagnostic groups, police detentions and offences, and other indicators. They also conducted a random sample survey of residents (n = 271) on attitudes towards the restrictions. Over a two-year period: per capita consumption decreased by 19.4% (although it still remained twice the national average); there were significant declines in admissions for acute alcohol-related conditions; and the proportion of offences committed on Thursdays declined. Furthermore, all of the restrictions were supported by a majority of both Aboriginal and non-Aboriginal residents.

In 1997, d'Abbs and Togni conducted an evaluation of restrictions on alcohol availability in Derby, Western Australia.[34] The restrictions were part of a voluntary 'accord' between licensees and the Derby Alcohol Action Group, reached after similar restrictions imposed by the Director of Liquor Licensing were declared invalid by the Licensing Court. They included: no sales of packaged liquor on Thursdays; restriction of packaged liquor sales on other days to the hours of 12 to 10 pm; and no sales of four litre casks of wine. It was found that the trial may have resulted in a small fall in alcohol consumption (0.2%), but this may also have been part of a pre-existing trend. There was drop of 37% in the incidence of assaults, sexual offences, damage and threatening behaviour. However, there was insufficient evidence to indicate whether there had been reductions in other harm indicators. Responses to the measures were mixed, but among members of the Aboriginal community:

> There appears … to be a widespread belief that the problems associated with alcohol-misuse are too pervasive, and too complex, to be adequately addressed by imposed restrictions (p. 11).

Discussion

Clearly, on the basis of so few formal evaluations, any conclusions about what works can only be tentative. Too few intervention programs have been evaluated and the methodologies involved in some of those that have—particularly those of treatment and health promotion programs—are not sufficiently robust to allow generalisation. Nevertheless, there are lessons to be learnt from the studies reviewed—some of these relate to specific intervention types and others are of more general application.

The three evaluations which covered some 18 treatment programs were either inconclusive or suggested only modest gains.[13–15] Given both inter- and intra-community diversity, the narrow range of treatment models—identified by d'Abbs and on our National Data Base on Aboriginal and Torres Strait Islander Alcohol and other Drug Projects—is probably one limiting factor in this.[11, 14] Given this, there have been calls to broaden the range of treatment objectives and strategies.[35] Controlled drinking has been advocated as an alternative to abstinence. However, this has been resisted by representatives of many Aboriginal organisations who argue that it is not a realistic option in communities where heavy drinking is endemic. Also, given the high cost of the apparently slight gains from residential treatment programs, there have been calls for the trialing of brief intervention strategies. Although the feasibility of conducting a trial at Alice Springs has been explored, to date there have been no evaluations of brief interventions among Aboriginal people.[36]

As with treatment programs, those health promotional programs that have been evaluated have not yielded impressive results.[16–21] Again, this may in part be due to a lack of robustness in the methodologies employed. However, the limited efficacy of such programs in other populations—especially when conducted in isolation—should be borne in mind.[37] Sobering-up shelters have been shown to be an acceptable intervention strategy to both community members and police, and there is evidence that they provide a cost-effective means of diverting intoxicated persons from police lockups.[22–26] As yet, however, there is no quantitative evidence of their impact on indicators of alcohol-related harm.

Of those interventions evaluated, restrictions on the supply of alcohol appear to have produced the most tangible results.[31–34] This may be because the results are more easily demonstrable. Nevertheless—even here—the evaluation reports show considerable variation in their effect, and the authors of all these reports emphasise that, alone, restrictions are not likely to provide any long-term solution. Certainly, however, restrictions on cask wine have played a significant part in their success. Cask wine has been a particular focus of restrictions because of its low cost per standard drink—a function of economies of scale in production and resulting low wholesale tax imposition. In all instances where its sale has been restricted or, in the NT, when an additional levy of $0.35 per litre was imposed on its wholesale price, there has been substitution of other beverages. However, because of the price

differential, this substitution has not resulted in total replacement but has led to a reduction in total alcohol consumption.[38, 39]

Importantly, all three treatment evaluations showed that, at least in part, the effectiveness of the programs was circumscribed by administrative deficiencies and/or lack of staff expertise.[13–15] Similarly, the evaluations of four of the health promotion programs highlighted the need for greater staff support and the provision of supporting educational resources.[16, 17, 19, 21] These factors themselves are likely to be related to the inadequate and uncertain provision of funding by government agencies highlighted by d'Abbs and Gray et al.[14, 21]

d'Abbs' identification of community-based field workers as an 'essential' part of residential treatment programs has both specific and general implications. On the one hand, it highlights the lack of after-care which representatives of many Aboriginal treatment agencies have identified as a significant impediment to the effectiveness of their programs. More broadly, it highlights the synergistic effects that interventions can have upon each other. This is reflected in those reports which indicated that sobering-up shelters were either a point of entry into other programs or a catalyst to other community action.[24–26]

These few studies suggest that—as among other populations—there is no simple solution to the problem of excessive alcohol consumption among Aboriginal people. The gains from any particular intervention are likely to be limited, but can be enhanced when they form part of a broader intervention strategy. Indeed—though it has yet to be evaluated—this is the approach taken in the NT's Living With Alcohol Program.[40] The studies also suggest that the effectiveness of programs can be compromised by inadequate resourcing. This underlines the view that transfer of service delivery to community-controlled organisations should be undertaken with the objective of ensuring appropriateness and accessibility of services—not as a cost-cutting exercise.[9] The review also highlights the need for more evaluative studies of Aboriginal intervention programs. Again, however, this needs to be done cooperatively with Aboriginal community organisations with the objective of improving service delivery and not as a means of exercising bureaucratic control.

Focus on effective alcohol intervention programs should not lead us to ignore the broader context in which Aboriginal drinking takes place. While by no means the only reason for excessive drinking among them, Saggers and Gray have argued that the elevated rates to be found among Indigenous peoples are attributable to political and economic inequalities stemming from colonialism and dispossession.[41] Attention to enhanced, well-resourced and coordinated intervention programs does have the potential to make significant inroads into excessive drinking and related harm among Aboriginal people. However, in the interests of both greater public health gains and social justice, there is a need to redress the fundamental inequalities faced by Aboriginal people.

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7. The use of tobacco, alcohol and other drugs by young Aboriginal people in Albany, Western Australia*

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Abstract

This paper describes patterns of tobacco, alcohol and other drug use among Aboriginal people aged eight to 17 years in the town of Albany, Western Australia. Out of a total of 110 young Aboriginal people residing in the town at the time of the study, 105 were interviewed by two trained Aboriginal research assistants using interview schedules that included questions based on the national guidelines for the comparability of studies of drug use among young people. The most commonly used drugs were tobacco, alcohol and cannabis. Use of other substances was usually experimental. The majority (57%) of this population had not used any drugs, 13% made some use of alcohol and/or tobacco, 15% were polydrug users and 15% were frequent polydrug users. Use of drugs increased with age so that 48% of those aged 15 to 17 years were frequent polydrug users. Tobacco consumption was greater and alcohol use less than that reported among Western Australian secondary school children of comparable age.

This paper documents the patterns of psychoactive substance use by young Aboriginal people aged 8–17 years in the town of Albany, Western Australia. Albany, located on the south coast, is the centre of the Great Southern region and has a total population of about 16 000 people—approximately 3% of whom are Aboriginal. The study was initiated by the Albany Aboriginal Corporation—a community-based organisation which is involved a range of cultural, social and economic activities. The

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study is part of a larger project to document: patterns of drug use; knowledge about, and attitudes towards, drugs; educational, vocational and recreational activities; and the aspirations of these young people. This collaborative project grew out of the Corporation's concern about the level of drug use among young people and a desire to provide alternatives to it. As well as providing baseline data and information for the development of appropriate intervention programs, the project aimed to address the absence of systematic studies of drug use among young urban Aboriginal people.[1, 2]

In a study of Aboriginal mortality in Western Australia for the period 1983–1989, it was reported that the age standardised mortality rate per 100 000 person years in the Great Southern health region (of which Albany is the major urban centre) was 2714.8 (SE 552.85) for Aboriginal males and 1522.1 (SE 234.73) for females. Conservatively (that is, assuming that the lower end of the confidence interval is closer to the actual rate), these rates are 20% and 60% higher than for Aborigines throughout the State. They are between three and four times the mortality rates for non-Aborigines in the Great Southern health region and are between six and seven times the rates for non-Aboriginal men and twice the rate for non-Aboriginal women in the State as a whole.[3]

The mortality data are reflected in hospital admissions. For both Aboriginal males and females, the Great Southern health region has the highest age standardised admission rates in Western Australia for conditions wholly caused by alcohol. They are 3.2 and 2.7 times those for all Aborigines in the State and 40 and 56 times those for non-Aboriginal men and women in the region.[3] Some of this difference might be accounted for by coding biases, hidden morbidity in non-Aboriginal people, and over-reporting for Aboriginal people. Nevertheless, the real differences are likely to be significant and they are a cause for great concern.

In a random sample survey conducted among 265 Aboriginal people in the region, Knowles and Wood found that more than 60% of both males and females aged 15–29 years, and almost 50% of those aged 30 years or more smoked. They also found that alcohol was consumed by: 64.7% of males aged 15–29 years, 57.8% of males aged ≥30 years, 45.9% of females aged 15–29 years, and 33.3% of females aged ≥30 years. Of 90% of drinkers who answered questions about the amount of alcohol consumed, 30% of males and 20% of females drank at harmful levels.[4] It was against this background, and because of community concern about the use of these and other drugs by young people, that this project and the Albany Aboriginal Corporation's broader aim of reducing drug-related harm were developed.

Method

The study was a descriptive, cross-sectional survey conducted within the Albany local statistical area. At the commencement of the study, two local Aboriginal research assistants identified all Aboriginal households and developed a list of household members. This list was then circulated among other members of the Corporation for cross-checking and the addition or deletion of individuals as necessary. On this basis, a list of 426 people who identified themselves as Aboriginal, distributed as in Table 1, was developed.

Table 1: Aboriginal population of Albany Western Australia, by age and sex

Age group (years)	Male n	Female n	Total n
0–7	48	40	88
8–12	30	27	57
13–14	11	13	24
15–17	15	14	29
≥18	100	128	228
Total	204	222	426

Members of the Corporation's committee decided the survey should include all of the 110 young people aged 8–17 years. This range was selected because in the past children as young as eight had been observed 'sniffing' volatile substances, and persons over the age of 17 years are legally entitled to consume alcohol.

Separate interview schedules were developed for those aged 8–12 years and 13–17 years. These included questions related to education and employment, recreational activities, aspirations for the future, drug use, and knowledge about and attitudes to drug use. In contrast to those in the older age category, those aged 8–12 years were asked only about those drugs they could identify without prompting, and they were not asked to recall the amounts of particular drugs they had consumed. Within the constraints imposed by the cultural context of the study, the different data eliciting techniques and the age of the participants, questions about drug use were based on the guidelines for ensuring comparability between studies developed by Drew et al. and Jones and Mugford.[5, 6] The schedules were pre-tested in the neighbouring town of Mount Barker.

Consent to participate in the study was obtained in a two-step process. First, the aims of the project were explained to the parents or guardians; they were given a simply worded sheet describing the project, and were asked to sign a form giving their consent for their children to participate. Second, the study was explained to the young people themselves, and their consent to participate was also obtained.

All but five of the 110 young people were interviewed. One family refused to allow their children (two males aged 8 and 10 years, and one female aged 16 years) to participate, one female (aged 16 years) declined to be interviewed, and one male (aged 14 years) was in juvenile detention.

Interviews were conducted by two local Aboriginal research assistants, who received training in research methods and an introduction to addiction studies conducted by the chief investigator and accredited through Technical and Further Education (TAFE). To maximise participation and obtain more valid data, they were assigned to interview participants from their own broad kinship networks. Interviews were generally conducted at the homes of the young people or at the Aboriginal Centre. To compensate them for their time, those aged 8–12 years were paid $10 and those aged 13–17 years were paid $20 for the interviews.

Answers to most questions were coded by the interviewers at entry. Responses to open-ended questions were compared and coded on the completion of the survey. Data were punched and verified by a professional key punch operator and were analysed using SPSS.[7] Responses to questions about the use of various drugs were combined to create indices of frequency of use. Relationships between these and the demographic variables of age and sex were analysed using simple cross-tabulations and the chi-square test of significance or, where appropriate, calculating Kendall's tau-b rank order correlation coefficients.

Payment of participants was an important, although not the only, factor in ensuring the high response rate. The familiar surroundings in which the interviews were conducted and the fact that the interviewers were known and trusted facilitated frank discussion. The latter consideration also enabled the interviewers to compare the answers given with behaviour they had observed and to question discrepancies. As a further check on the validity of answers about drug use, the older participants were asked if they had ever used 'elixanol' (a dummy drug). None answered affirmatively. Together, these factors suggest the results are an accurate reflection of the pattern of drug use among young Aboriginal people in Albany.

Results

Tobacco use

Of the three drugs most commonly consumed (tobacco, alcohol and cannabis), tobacco is the one which is usually the first used. On the basis of both the number of cigarettes they estimated having smoked and time periods in which those cigarettes had been smoked, the population was classified by whether they had never smoked

tobacco, or whether they were occasional or frequent smokers. The majority of young people (64%) had never smoked tobacco (Table 2).

Table 2: Tobacco use, by age, among young Aboriginal people in Albany, Western Australia

	Age group			
Frequency of use	8–12 n	13–14 n	15–17 n	Total n
None	47	13	7	67
Occasional	6	7	8	21
Frequent	2	3	12	17

The 21 occasional users included those who had ever smoked a cigarette or part of a cigarette and had done so infrequently. Most (16) estimated that they had smoked fewer than ten cigarettes in their lifetime and only eight had smoked at any time in the previous 12 months. Of the five who had smoked in the four weeks prior to interview, all estimated they had smoked fewer than 20 cigarettes in that period.

Frequent smokers were those who had smoked on the day prior to interview, and at other times in the previous week and previous four weeks. There was a total of 17 (16%) young people in this category, 15 of whom were aged 13–17 years. Of those in this latter age category, six estimated they had smoked ≥10 cigarettes on the day prior to interview and 11 that they had smoked ≥40 cigarettes in the previous week.

There was no difference in the proportions of males and females in each of these categories. However, the frequency with which tobacco is used strongly correlated with age (Kendall's tau-b = 0.641 $P<0.001$). Among those aged 8–12 years, 85% were non-smokers and 11% occasional and 4% frequent smokers. Among 13- to 14-year-olds the proportions of nonsmokers, occasional smokers and frequent smokers were 57%, 30% and 13% respectively; and among those aged 15–17 years the respective proportions were 26%, 30% and 44%.

While frequent smokers were concentrated in the 15- to 17-year age category, the majority had their first cigarette at a much younger age. The mean age at reported first use was 9.7 years (mode 13), with 24% reporting first smoking before the age of eight, and 71% before the age of 13 years.

Alcohol use

As with cigarette smoking, the population was classified by whether they had never drunk alcohol (apart from an occasional sip), or whether they were occasional or

frequent drinkers. As with tobacco, the majority of young people (61%) had never drunk alcohol (Table 3).

Table 3: Alcohol use, by age, among young Aboriginal people in Albany, Western Australia

	Age group			
Frequency of use	8–12 n	13–14 n	15–17 n	Total n
None	49	12	3	64
Occasional	6	8	11	25
Frequent	0	3	13	16

Occasional drinkers included those who had ever consumed alcohol but did so infrequently. There were 25 individuals (24%) in this category. However, of these, 13 had not had a drink in the previous year; and another two, although having had a drink in that period, did not consider themselves to be drinkers. Furthermore, none of the 25 had consumed alcohol in the week prior to interview.

The 16 (15%) frequent users were those who had drunk on at least one occasion in the week prior to interview, more than once in the month prior to interview, and on other occasions in the previous year. Of these, 9 had consumed alcohol on one or two occasions in the previous week; and 7 on three or four occasions. In the previous month, 5 reported drinking on two occasions; 8 on four or more occasions; and 3 could not recall the number of occasions—although the occasions on which they consumed alcohol in the week prior to interview were in excess of two or three.

Frequency of alcohol consumption was not associated with sex but was correlated with age (Kendall's tau-b = 0.641 $P<0.001$). Of those aged ≤12 years, 89% had not consumed alcohol at all and a further 5% had not consumed alcohol in the previous 12 months. Among those aged 13–14 years, 52% had never consumed alcohol and 26% had not done so in the last year. In the 15- to 17-year age group, 48% consumed alcohol frequently and only 11% had never consumed alcohol.

Frequent drinking is not common among younger Aboriginal children in Albany. Up to the age of 14, apart from an occasional sip, most had not consumed any alcohol, and among those who had, use was largely experimental. However, by the age of 15 there was an important shift, and more consumed alcohol frequently. This is reflected in data on the age at which they first drank—the mean age of which was 11.5 years (mode 13). Ten (24%) had had their first drink (not counting sips) as young as 6–9 years of age. However, the majority (54%) first drank between the ages of 12 and 14 years.

The classification of the population into non-drinkers, occasional drinkers and frequent drinkers does not indicate the amounts consumed. The 16 frequent drinkers and three occasional drinkers (11 males and 8 females) aged 13 to 17 years who had consumed alcohol in the past month were asked: what they usually drank; how many drinks they usually had on a day on which they drank; how many days they had a drink in each of the past week and the past four weeks; and on how many days in the last two weeks they had consumed more than five drinks in a row in one drinking session.

All 19 reported that whisky was their usual drink. Eight (7 males and 1 female) of the 19 reported that they also usually drank full-strength beer, two females low-alcohol beer, and four females wine cooler. Of those who consumed beverages in addition to whisky, all but one were in the frequent-drinker category. Those who drank beer said they only did so if there was not enough money to buy whisky.

The preferred way of drinking made it difficult to estimate precisely the usual number of drinks consumed. Three estimated that they consumed 10–12 drinks per session, but the other 16 said they did not know or pointed out that they usually shared a 700 ml bottle of whisky (about 37% alcohol by volume) with three or four friends. However, on this basis, it is reasonable to estimate that they consumed between 6.5 and 9 standard drinks each per session. Of these 19 people, six estimated that they had consumed alcohol at least once and ten twice per week in the previous month. Three of the 19 had not had a drink in the previous week. However, of the remaining 16, six said they had a drink on one occasion and ten said that they had a drink on two to four occasions during that week.

Of the latter 16, only two reported that they had not consumed more than five drinks in any one session in the past two weeks, and 11 that they had consumed more than five drinks on between one and six occasions in the past two weeks. The other three said they did not know on how many occasions in the past two weeks they had consumed more than five drinks in a row. However, given that these three also indicated they usually shared a bottle of whisky at a drinking session, it is probable that in each of the drinking sessions in the previous two weeks they also consumed more than five standard drinks. This indicates what discussion with them also reveals; that is, among the frequent drinkers most drinking is done to get intoxicated.

Cannabis use

After tobacco and alcohol, cannabis was the most frequently used drug. Those who had used cannabis eight or more times in the previous month and twice or more in the previous week were arbitrarily classified as frequent users, and those who had used cannabis less frequently as occasional users. On this basis, there were

16 occasional and 15 frequent users (table 4). Among the 15 frequent users, five had used cannabis on four to six occasions in the week prior to interview and nine had used it on seven to 15 occasions during the same period.

Table 4: Cannabis use, by age, among young Aboriginal people in Albany, Western Australia

Frequency of use	Age group 8–12 n	13–14 n	15–17 n	Total n
None	52	17	5	74
Occasional	3	3	10	16
Frequent	0	3	12	15

There was no significant difference in the proportions of male and female users of cannabis, but again there was a strong correlation between cannabis use and age (Kendall's tau-b = 0.611 P<0.001). Among the 8- to 12-year-olds, 95% had never used cannabis and the remaining 5% had used it on fewer than ten occasions. In the 13- to 14-year age category, the number of occasional users had risen to 13% and another 13% were using it frequently. Among 15- to 17-year-olds, 44% were frequent and 37% occasional users. The mean age at which cannabis was first used was 12.4 years and, as with alcohol and tobacco, the modal age of first use was 13 years.

Volatile substance use

The population was divided simply into those who had never or ever used or sniffed volatile substances. Seventeen individuals (16%) reported having sniffed a variety of substances (Table 5). In order of frequency of use these were glue (10), toluene (8), spray cans (7), petrol (6), correction fluid (5), and paint thinners (2). As with the use of tobacco, alcohol and cannabis, use of volatile substances was not associated with sex but was associated with age. Only one person (2%) in the 8- to 12-year age group had used volatile substances. Among those currently in the 13- to 14-year age category, the percentage who had ever sniffed rose to 13%, and it was 48% among the 15- to 17-year olds.

Most (11) of those who had ever sniffed first did so between the ages of 12 and 14 years (mean 13, mode 12); the range was between eight and 16 years, with four of those in the 15- to 17-year age category not having sniffed until they were at least 15 years. Only five people had sniffed in the month prior to being interviewed and only three of these in the week prior to interview. Of these, three were in the 13- to 14-year age category.

Table 5: Use of volatile substances, by age, among young Aboriginal people in Albany, Western Australia

Use of substances	Age group 8–12 n	13–14 n	15–17 n	Total n
No	55	20	14	88
Yes	1	3	13	17

During the six-month study period, it was observed that sniffing among young people ceased altogether. This reflects previous observations that, in Albany, sniffing is a cyclical phenomenon. An outbreak occurs when it is introduced to a small group of novices, either by a visitor from another town or by someone who was at the tail end of a previous outbreak who again takes it up. The outbreak runs for two weeks or so and then dies down as the young people lose interest. In unstructured interviews, some said that their sniffing had been a ‘passing phase’, and others that when money was scarce they had sniffed as an alternative to using cannabis.

Use of other drugs

In addition to alcohol, tobacco, cannabis and volatile substances, 15 persons reported using a number of other drugs (Table 6). Again, use of other drugs was not associated with sex but was with age. However, in this case—with one exception—use was confined to the 15- to 17-year age category.

Table 6: Use of drugs other than tobacco, alcohol, cannabis and volatile substances, by age, among young Aboriginal people in Albany, Western Australia

Use of drugs	Age group 8–12 n	13–14 n	15–17 n	Total n
No	55	22	13	90
Yes	0	1	14	15

Amphetamine was the most commonly used of these other drugs; a total of ten young people (10%) reporting its use. It was the only other drug used by anyone from the 13- to 14-year age category (one person), and it was the only drug injected (by four males and three females). It is not, however, frequently used. Only three people reported using it more than ten times and only one in the month prior to being interviewed.

Eight people reported using pharmaceutical drugs for recreational purposes—seven using analgesics, and six using central nervous system depressants. Most said that

they had used them only once and had added them to alcoholic drinks to give them a 'boot'. Use of hallucinogens was reported by six people; only one of whom reported having used them more than once or twice. Four people reported using opiates—in this case morphine. This had been obtained from a seriously ill relative for whom it had been prescribed, and it had been used on just one occasion at a party. Similarly, the one person who reported using 'cocaine' had done so only once when visiting Perth. (It is likely that this youth was given amphetamine, but was told or thought that it was cocaine.)

Patterns of drug use

The most commonly used drugs were tobacco, alcohol and cannabis with smaller numbers having used volatile substances or other drugs. With regard to each of these categories of drugs, there was a substantial proportion of young people who had not used them. Overall, apart from an occasional sip of alcohol, a total of 60 (57%) young people had not used any drugs at all. For another 13%, drug use was limited, being confined to experimentation with, or occasional use of, alcohol and/or tobacco (Table 7). The other 30% fell into two categories.

Table 7: Patterns of all drug use, by age, among young Aboriginal people in Albany, Western Australia

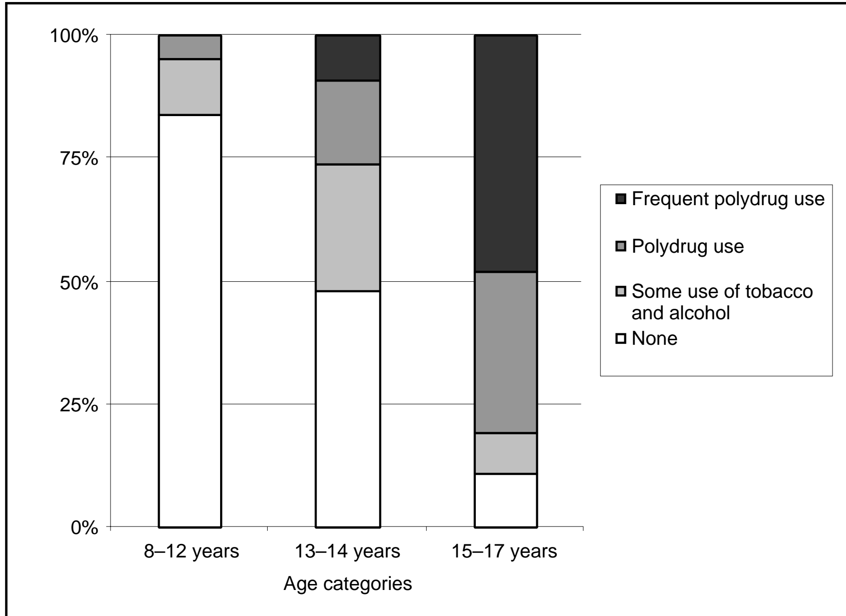
	Age group			
Type of use	8–12 n	13–14 n	15–17 n	Total n
None	46	11	3	60
Some use of tobacco and/or alcohol	6	6	2	14
Polydrug use	3	4	9	16
Frequent polydrug use	0	2	13	15

Polydrug users were generally occasional users of some combination of tobacco, alcohol and cannabis. Included in this group of 16 were three who had not used tobacco and one who had not used alcohol. The group also included some individuals who were frequent users of either tobacco or alcohol or cannabis. In addition, five had experimented with volatile substance use and two with the use of other drugs.

The fourth category—frequent polydrug users—consisted of 15 young people who were frequent users of two, and occasional users of another of the three commonly used drugs. Additionally, all but one of them had used volatile substances or other drugs, and most (11) had used both of these categories of drugs. In the week prior to interview, nine had smoked ≥40 cigarettes, consumed alcohol at least once, and used

cannabis on four or more occasions. While this group is not a large proportion (14%) of the population as a whole, it comprises 48% of those aged 15 to 17 years (Figure 1).

Figure 1: Percentages using drugs by age, among young Aboriginal people in Albany, Western Australia. Age groups: 8–12, n = 55; 13–14, n = 23; 15–17, n = 27.



Comparative proportions of users

There are no studies of non-Aboriginal people that are directly comparable with the study undertaken in Albany. In 1990, Clark et al. conducted a survey of tobacco and alcohol consumption among secondary school children in Western Australia.[8] That study probably underestimates the proportion of users in the 12- to 17-year age group because it excludes those who have left school, among whom such proportions are thought to be higher. However, to place tobacco and alcohol use in Albany in a broader perspective, the proportions of users of alcohol and tobacco among all those who were in secondary school or who had left school were compared to those among secondary school children in the study by Clark et al.

Although similar proportions reported having smoked in the previous year, a higher proportion of Albany respondents reported smoking in the previous month and in the previous week (Table 8). This indicates that those from Albany were more likely to smoke on a frequent basis than their non-Aboriginal counterparts.

With regard to alcohol, this situation is reversed. A smaller proportion of Albany respondents than secondary school students asserted that they had consumed alcohol in the previous year. However, the proportions consuming alcohol in the previous month and previous week were closer. Although, overall, higher proportions of secondary school students reported more frequent alcohol consumption than the Albany respondents, this was largely the result of lower levels of consumption among 12- to 14-year olds in Albany. Among those in the 15- to 17-year age category, the proportions of users were closer. Of secondary students aged 15 to 17 years, 96% reported consuming alcohol in the previous year compared to 87% of young Aboriginal people from Albany in the same age range. Comparative proportions for the previous month and week were, 59% to 63% and 48% to 47%.

Table 8: Use of tobacco and alcohol among young Aboriginal people in Albany, Western Australia, compared with Western Australian secondary schoolchildren

	Age group			
Period in which used	Albany %	WA[a] %	Albany %	WA %
Not in the last year	58	59	50	26
In the last year	42	41	50	74
In the last month	38	25	38	47
In the last week	36	21	32	35

Note: (a) Derived from tables in Clark et al.[8]

Discussion

This is the first reported study which examines the use of tobacco, alcohol and other drugs among a total population of young Aboriginal people. However, Aboriginal communities are not homogeneous and caution must be exercised in extrapolating the results to other Aboriginal populations.

The majority of young Aboriginal people from Albany had not used any psychoactive substances. However, with age, use—particularly of tobacco and alcohol—increases rapidly. Those of comparable age to Western Australian secondary school children consumed tobacco more frequently but, overall, frequency of alcohol consumption was less (and was no greater among those aged 15–17 years).

Among those people using psychoactive substances, few use one drug exclusively. Most are polydrug users. This is true whether use is occasional or frequent. Among those aged 8–14 years, this is largely confined to tobacco and alcohol. However, with an increase in age, many also use cannabis and others also make use of volatile substances and/or other drugs. Typically, tobacco is the first drug to be tried,

followed by alcohol, often while young people were still of primary school age. In some cases, use of these substances was followed a little later by the use of cannabis and volatile substances—often around the time of the transition from primary to high school. When it occurs, the use of other drugs does not usually take place until the age of 15 years or later.

It is important to stress that most use of volatile substances and other drugs is experimental. Most use them on one or two occasions or, in the case of volatile substances, over a short period of time. Use of these drugs is, however, of particular concern to parents and other members of the community. While the long-term health risks to these experimental users are not great, in the short term, users are observed to behave in ways that disrupt family activities, heighten the risk of accidents or violence, and that are likely to bring them into contact with the police.

In the long term, the greatest risk to the future health of these young people is from tobacco and alcohol. The proportions of 15- to 17-year-olds who use tobacco and alcohol are greater than among 15- to 29-year-old Aboriginal people in the Great Southern health region as a whole.[4] This suggests that in the immediate future there is likely to be a rise in the number of adult Aboriginal smokers and drinkers in the region, with associated longer-term implications for tobacco and alcohol-related morbidity and mortality.

At this point, a word of warning with regard to potential interventions is apposite. From an epidemiological perspective, reduction in the uptake and use of tobacco is of high priority. However, discussions in Albany and other communities suggest that this is not the priority of many Aboriginal people. Of greater concern than the long-term health consequences of tobacco use are the immediate social consequences of the misuse of volatile substances and amphetamines and, to a lesser extent, alcohol.

Much of the community development and international health literature is a testament to the truism that, without community support, public health interventions frequently fail. Accordingly, public health zeal to rush in and tackle the problem of tobacco use per se must be tempered. Given the concerns of the community and the patterns of polydrug use among young Aboriginal people, the most appropriate intervention strategy will be one which deals with the use of all drugs in a manner appropriate to the expressed needs of young Aboriginal people themselves and which is conducted in conjunction with the Albany Aboriginal Corporation.

Acknowledgments

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8. The Northern Territory's cask wine levy: health and taxation policy implications*

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Abstract

Objective To examine the effect of the application, and removal, in the Northern Territory of a levy on the sale of cask wine—a beverage shown to contribute disproportionately to alcohol-related harm.

Method Using data on licensee purchases of alcoholic beverages and ABS population data, estimates were made of per capita consumption of pure alcohol by beverage type. Time series variables were analysed using multiple linear regression analysis.

Results Prior to the introduction of the levy, quarterly per capita consumption of cask wine among persons aged ≥15 years was 0.73 litres, during the levy period this fell to 0.49 litres, and following removal of the levy it rose to 0.58 litres. Imposition of the levy had no significant effect on the consumption of other beverages.

Conclusions Taxation is an effective means of reducing excessive alcohol consumption and related harm.

Implications In the interests of public health, support should be given to the introduction of a tiered tax based on alcohol content.

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Introduction

In June 1999, the Australian Senate passed a series of bills paving the way for the introduction of a Goods and Services Tax (GST). Among these was the Wine Equalisation Tax Bill. It aimed to maintain wine prices and revenue collection from wine sales—which would have fallen with the abolition of the Wholesale Sales Tax—at then current levels.[1] In the lead-up to passage of the Bill, debate focused upon whether the new tax should be levied on an ad valorum basis (i.e. be another sales tax) or on a 'volumetric' basis so that tax was levied according to the amount of alcohol in a beverage. The ad valorum method was adopted, resulting in the continuation of taxation arrangements which greatly favour cheap bulk and fortified wine products such as cask wine. The volumetric approach would have raised the floor of alcohol prices currently occupied by these products and thereby reduced their consumption. The outcome of this debate thus had the potential to make a significant public health impact by reducing the burden of alcohol-related harm, and the research on which this report is based was undertaken in that context.

The price of alcoholic beverages has a significant impact on consumption levels.[2, 3] Until 5th August 1997, the price also included state/territory liquor licensing fees. At that time, the High Court ruled that the licensing fees were de facto excise duties and, hence, that it was unconstitutional for the states/territories to levy them. Following that decision, the Commonwealth government increased Wholesale Sales Tax (WST) on alcoholic drinks by 15% to reimburse the states/territories for lost revenue. The current system of excise and taxation, of which the WST is a part, has grown up on an ad hoc basis and contains significant anomalies. For example, the 'total tax payable per standard drink' (i.e. one containing 10 g of alcohol) is approximately $0.28 on regular strength beer, $0.38 on light beer, $0.40 on bottled wine, and $0.08 on cask wine.[4]

In Australia as a whole, annual mean consumption of pure alcohol is estimated to be 9.67 litres per person aged ≥15 years.[5] However, in some parts of Australia, it is often twice, and sometimes approaches three times that level. In these areas, much alcohol is consumed as cask wine which—because of economies in production, packing, and lower taxation levels—has enjoyed a considerable price advantage. This price advantage has led to its purchase for cheap binge drinking, and it has been shown that a significant proportion of night-time assaults and acute alcohol-related hospital admissions are linked to its consumption.[6]

Excessive consumption of cheap cask wine has been of concern to members of both Aboriginal and non-Aboriginal communities in which it takes place. In towns such as Tennant Creek, communities have used the provisions of liquor licensing legislation to have restrictions imposed on cask wine sales. In towns such as Derby, they have used 'accords' between licensees to similar ends. It has been shown that such restrictions

have been effective in reducing consumption and related harm. [7, 8] However, while they certainly have a role to play, they are piecemeal in application. A more efficient means of curbing excessive consumption and related harm is through price—which can be significantly modified by taxation policy.

Excessive consumption of cask wine has also been a concern of the Northern Territory government which—in July 1995, in addition to existing liquor licensing fees—introduced a $0.35 per litre levy on the sale of cask wine. The aim of the levy was to reduce consumption and to raise revenue for the NT's Living With Alcohol Program. Replacement of liquor licensing fees by a Commonwealth WST effectively removed this levy. These changes provide a 'natural experiment' for studying the effect of taxation on levels of consumption.

Method

The Northern Territory Liquor Commission provided quarterly data on licensee liquor purchases (the best estimate of consumption[9]) by beverage type by volume for the period July 1994 to September 1998. Purchases made during the period in which the cask wine levy was in place (July 1995 to June 1997) were compared to purchases for the periods July 1994 to June 1995, and July 1997 to September 1998. To enable comparisons to be made between purchases of cask wine and other beverages, they were each converted to estimates of litres of pure ethyl alcohol using the following conversion factors:

- cask wine—0.119
- bottled wine—0.119
- high beer—0.048
- low beer—0.025
- straight spirits—0.385.[10]

Estimates of licensee purchases of pure alcohol were divided by Australian Bureau of Statistics estimates of the Northern Territory residential population aged ≥15 years for each financial year, producing estimates of per capita consumption of pure alcohol.

Examination of auto-correlation plots and Durban Watson statistics for cask wine and high alcohol content beer revealed no evidence of significant auto-correlation, thereby allowing the application of multiple linear regression. As indicated by the SPSS seasonal decomposition procedure, seasonal factors in each series reflected peak tourist seasons occurring between April and September. Both beverage variables were deseasonalised and transformed by utilising seasonal weights generated by the SPSS seasonal decomposition procedure and transformed by natural log prior to analysis. Other beverage types were similarly examined.

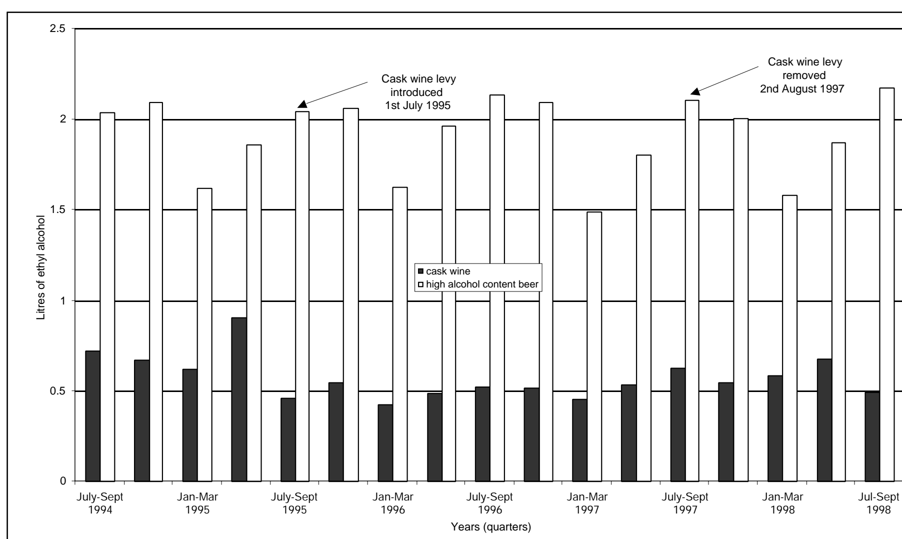
Results

Table 1 and Figure 1 show that, during the period the cask wine levy was in effect, estimated per capita consumption of cask wine in the Northern Territory was significantly lower than that occurring during the non-levy periods (beta = -0.71, p = 0.001). A test of df beta did not implicate the unusually high level of cask wine consumption in the second quarter of 1995 (see Figure 1) as an influential point (df beta >2); i.e. this point did not unduly influence the slope of the regression line. In the period prior to the introduction of the levy, mean quarterly per capita consumption of cask wine was 0.73 litres per person aged ≥15 years. After the introduction of the levy, this dropped to 0.49 litres per person aged ≥15 years. In the period after the removal of the levy, estimated mean quarterly per capita consumption rose to 0.58 litres. No similar association was found for high alcohol content beer or any other beverage type.

Table 1: Association between the presence/absence of the NT cask wine levy and per capita consumption of ethyl alcohol for cask wine and high alcohol content beer, estimated by multiple linear regression.

Beverage variable	Adjusted R^1	Standard beta coefficient	beta estimate	95% CI for beta Lower	95% CI for beta Upper	t	p
Cask wine	47%	-0.709	-0.257	-0.397	-0.116	-3.896	0.001
High beer	0%	-0.074	-0.004	-0.036	0.028	-0.286	0.779

Figure 1: Trends in per capita consumption of ethyl alcohol for cask wine and high alcohol content beer among persons aged ≥15 years, NT, July 1994 to September 1998



Discussion

Introduction of the cask wine levy in the Northern Territory led to a significant reduction in per capita consumption of cask wine, without any corresponding shift to the consumption of other beverage types. In the year following removal of the levy, there was a drop in the average retail price of cask wine[11] and a return to higher levels of cask wine consumption—although not to pre-levy levels. This natural experiment suggests that increasing the tax on cask wine to a level which is more closely in line with that on other alcoholic beverages had the effect of reducing consumption of a beverage which has been clearly implicated as disproportionately contributing to levels of alcohol-related harm. Together with previously cited work, it provides a strong public health argument for reforming the alcohol taxation system.

In passing an ad valorum based WET (Wine Equalisation Tax) bill, the Senate missed this chance for reform. Nevertheless the opportunity remains, in the spring session of parliament, to amend existing alcohol excise legislation and to move Australia towards a tiered volumetric tax system which will:

- create a new volumetric tax on bulk wines, as recommended by the 1995 National Inquiry into the Wine and Winegrape Industry;
- remove present anomalies in the taxation system that allow wine-based 'designer' drinks to be taxed at a significantly lower rate than spirit-based drinks of identical beverage strength;
- tax beverages on the basis of their contribution to harm; and,
- promote the consumption of lower strength beers through lower rates on these products.

Acknowledgments

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9. Regional variation in alcohol consumption in the Northern Territory[*]

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Abstract

Objective To identify any regional variation in per capita consumption of pure alcohol, and the types of beverages consumed in the Northern Territory (NT); and, to estimate the relative contributions to consumption by Aboriginal and non-Aboriginal people.

Method Estimates of per capita consumption were based on wholesale purchases of alcohol by licensee and Census population data. Mean levels of per capita consumption, and the percentages of each beverage type consumed, were compared between regions and through time. Estimates of per capita levels of consumption between Aboriginal and non-Aboriginal segments of the population were based upon reports of the proportion of frequent and occasional drinkers in each group and the ratio of consumption among Aboriginal and non-Aboriginal drinkers.

Results Mean quarterly per capita consumption was higher in both the Lower Top End (4.22 litres) and Central NT (4.04 litres), and less in the Barkly (3.44 litres) than in the Top End (3.55 litres). Over the four-year period, there was a rise of 6.4% in consumption in the Top End and a decline of 22.5% in the Barkly. In the Lower Top End and the Central NT, a larger percentage of alcohol was consumed as cask wine than in the Top End. Prior to the introduction of licensing restrictions, this was also the case in the Barkly. In the NT, per capita consumption among Aboriginal people is approximately 1.97 times, and among non-Aboriginal people about 1.43 times, the national average.

Conclusions In the NT, alcohol consumption is greater than in Australia as a whole and there is significant regional variation. The problem is not simply an Aboriginal problem, and a broad range of strategies—which include a component to address regional variation—is required to reduce it.

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Excessive consumption of alcohol continues to be a major public health problem in Australia.[1] For the country as a whole, annual mean consumption of pure alcohol is estimated to be 9.67 litres per person aged ≥15 years.[2] However, there is considerable variation in consumption patterns, including the levels of consumption, types of beverage consumed, and the temporal pattern of consumption. The aim of this paper is to describe some of that variation in the Northern Territory (NT).

Recent articles have highlighted the limitations of approaches that focus solely upon per capita consumption as an indicator of harmful consumption, and on intervention strategies that simply aim to reduce aggregate levels of consumption.[3–5] Nevertheless, where other data are not available, per capita consumption remains an important crude indicator of use that is generally well correlated with measures of harm.[6, 7]

On this measure, it has long been known that alcohol consumption in the NT is considerably greater than in Australia as a whole. In recognition of this, in April 1992, the NT government introduced a levy on the sale of all alcoholic beverages and, in July 1995, introduced an additional levy on the sale of cask wine. The purpose of these levies—which, along with other state and territory liquor licensing fees, were declared unconstitutional by the High Court in August 1997—was to fund the NT's Living With Alcohol Program. This program was a major public health initiative aimed at reducing alcohol-related harm. Despite the positive impact of both the levies themselves and the Living With Alcohol Program, per capita consumption remains high.[8, 9] In this context, there is currently a vigorous debate within the NT on both the nature of 'the alcohol problem' and measures to address it.

Unfortunately, much of this debate has been conducted in the absence of basic descriptive epidemiological data. For example, while there is some evidence of regional variation, little published data is available, and in various public forums widely conflicting claims have been made regarding levels of consumption. In the same forums, again in the absence of real evidence, it has been claimed that 'the problem' is simply an 'Aboriginal problem'. This paper contributes to this debate by seeking to identify any regional variation in per capita consumption of pure alcohol and the types of beverages consumed; and to estimate the relative contributions to consumption by Aboriginal and non-Aboriginal people.

Methods

The NT Liquor Commission provided quarterly data on wholesale purchases of alcohol by licensees by beverage type by Australian Bureau of Statistics' statistical subdivision (SSD) for the period 1 July 1994 to 30 June 1998—the beginning of this period coinciding with the establishment of the Commission's current method of data

collection. Data on the volume of each beverage type purchased were converted to estimates of pure alcohol content using methods reported on elsewhere and used as a proxy measure of consumption.[10]

For the purpose of comparison, four regions were delineated. These are:

- Top End, consisting of the Darwin Statistical Division and the Darwin Rural Areas, Bathurst-Melville, Daly, Alligator, and East Arnhem SSDs;
- Lower Top End SSD, centred on Katherine;
- Barkly SSD, centred on Tennant Creek; and,
- Central NT SSD, centred on Alice Springs

Quarterly per capita levels of consumption of each beverage type were calculated for each region. Population denominators were based on the total counts of persons aged ≥15 years in each statistical subdivision at the 1991 and 1996 Censuses of Population and Housing, with extrapolations for non-Census quarters based on the rate of change between the two Censuses. Total counts were used, rather than visitor-adjusted estimates of usual resident population because the data necessary to adjust for an Aboriginal component were not available. However, because the time of the Census coincides with the peak in the tourist season, use of the total count provides a conservative estimate of per capita consumption which does not vary greatly from the visitor-adjusted estimates of population.

Data were analysed using SPSS 6.1. Several independent t-tests for the equality of means were used to compare mean quarterly levels of pure alcohol consumption between the Top End (where about 65% of the NT's population resides) and each of the other regions. Durban Watson statistics for the measures of consumption revealed no evidence of significant auto-correlation, thus allowing the application of multiple linear regression to examine trends over time. Seasonal factors in each series reflected peak tourist seasons occurring between July and September, and consumption variables were deseasonalised prior to analysis. Multiple linear regression was used to test for trends in quarterly levels of per capital consumption. Direct comparison was made between the percentage contribution that each beverage type made to quarterly per capita consumption in each region.

Estimates of per capita consumption among Aboriginal and non-Aboriginal populations were made on the assumption—based on national survey data—that 62% of the Aboriginal population and 72% of the non-Aboriginal population are either regular or occasional drinkers.[11, 12] In rural areas of the NT, the proportion is actually lower—thus Aboriginal consumption is likely to be over-estimated to some extent.[13] The 1.6:1 estimate of the ratio of alcohol consumed by Aboriginal to non-Aboriginal drinkers was based on two sources that provided similar results. The first was regression modelling of data from a 1995 survey by the Health Department of Western

Australia.[3] The second was unpublished findings from two surveys conducted by Peter d'Abbs and his colleagues from the Menzies School of Health Research. These latter surveys were conducted in the West Kimberley region of Western Australia (a region similar in many respects to much of the NT). These surveys found that, in the week prior to interview, the median consumption of alcohol by Aboriginal drinkers (n = 194) was 237.9 mL, and of non-Aboriginal drinkers (n = 1826) was 148.2 mL—a ratio of 1.6:1 (d'Abbs personal communication 1999). Estimates of Aboriginal and non-Aboriginal per capita consumption of pure alcohol for each quarter were calculated using the formula:

$$AC + nAC = TC$$

$$[(Ap * Ad) * (r * nAdc)] + [(nAp * nAd * nAdc)] = TC$$

where—

AC = Aboriginal consumption
nAC = non-Aboriginal consumption
TC = total consumption
Ap = estimated Aboriginal population
Ad = proportion of the Aboriginal population that consumes alcohol
r = ratio of Aboriginal to non-Aboriginal per capita consumption
nAp = estimated non-Aboriginal population
nAd = proportion of the non-Aboriginal population that consumes alcohol
nAdc = per capita consumption of pure alcohol among non-Aboriginal drinkers, and
nAdc = TC/[(Ap * Ad * r) + (nAp * nAd)

Results

During the four-year period, in the Top End, mean quarterly per capita consumption of pure alcohol among those aged ≥15 years was 3.55 litres (14.2 litres per annum). Per capita consumption in the Lower Top End was 18.9% higher, and in the Central NT was 13.8% higher (Table 1). That there was no significant difference between the Barkly and the Top End is a consequence of the averaging out of a higher level of consumption in the Barkly in 1994–95 and a fall to a significantly lower level in 1997–98. For comparative purposes, mean consumption is summarised on an annual basis in Table 2.

Table 1: Mean quarterly per capita consumption of pure alcohol by region, Northern Territory, 1 July 1994 to 30 June 1998

Region	Mean	SD	SE of mean	t	df	Sig
Top End	3.55	0.431	0.108			
Lower Top End	4.22	0.624	0.156	-3.52	30	0.001
Barkly	3.44	0.484	0.121	0.70	30	0.491
Central NT	4.04	0.366	0.091	-3.41	30	0.002

Table 2: Annual per capita consumption of pure alcohol by region, Northern Territory, 1994–95 to 1997–98

Region	1994–95	1995–96	1996–97	1997–98
Top End	14.02	13.71	14.20	14.92
Lower Top End	17.67	15.85	17.00	17.03
Barkly	16.10	13.86	12.61	12.47
Central NT	16.55	15.60	15.99	16.44
Northern Territory	14.98	14.32	14.79	15.37

In all regions, there was a drop in per capita consumption between 1994–95 and 1995–96 (Table 2). With the exception of the Top End, this reduction was sustained in 1996–97. However, in 1997–98, in all regions but the Barkly, consumption returned to levels similar to, or higher than, those in 1994–95. Despite the reduction in 1995–96 and 1996–97, in the Lower Top End and the Central NT—apart from seasonal variation—trends in the level of per capita consumption remained relatively constant (Table 3). However, in the Top End on a seasonally-adjusted basis, there was an increase in consumption of 6.4%; and in the Barkly there was a decline of 22.5% in annual per capita consumption from 16.10 to 12.47 litres per person aged ≥15 years.

Table 3: Variation in trends associated with regional per capita consumption of pure alcohol

Region	Model Adj R^2	Stdsd B coeff	B estimate	95% CI for B Lower	95% CI for B Upper	t	Sig
Top End	0.344	0.623	0.020	0.006	0.035	2.978	0.010
Lower Top End	0.000	-0.026	-0.001	-0.033	0.030	-0.096	0.952
Barkly	0.760	-0.881	-0.078	-0.102	-0.054	-6.973	0.000
Central NT	0.000	0.122	0.004	-0.016	0.025	0.458	0.654
Northern Territory	0.088	0.387	0.012	-0.004	0.028	1.569	0.139

On a mean quarterly per capita basis, in the Top End most alcohol was consumed as full-strength beer (46%), followed by spirits (15%), low-strength beer (13%), cask wine (11%) and bottled wine (9%). None of the other categories of beverage (full-strength cider, fortified wine, mixed spirits and low-alcohol cider) exceeded 2% (Table 4).

When compared to the Top End, in the other regions more alcohol was consumed as cask wine and less as low-strength beer. This was most marked in the Central NT, where cask wine consumption was double, and low-strength beer almost half, that in the Top End. While, in the Lower Top End and the Barkly, the percentage of alcohol sold as cask wine was not as high as that in the Central NT, the percentage of alcohol sold as full-strength beer was greater.

Table 4: Mean quarterly per capita consumption of pure alcohol by beverage type by region, Northern Territory, 1994–95 to 1997–98

Region	Beer: full strength	Beer: low strength	Wine: cask	Wine: bottled	Spirits	Other
Top End	1.64 (46%)	0.47 (13%)	0.39 (11%)	0.31 (9%)	0.55 (15%)	0.19 (5%)
Lower Top End	2.33 (55%)	0.48 (11%)	0.69 (16%)	0.13 (3%)	0.44 (10%)	0.15 (4%)
Barkly	1.93 (56%)	0.29 (8%)	0.52 (15%)	0.10 (3%)	0.40 (12%)	0.21 (6%)
Central NT	1.82 (45%)	0.30 (7%)	0.91 (23%)	0.34 (8%)	0.49 (12%)	0.18 (4%)

The figures on mean per capita consumption by beverage type conceal some variation. In the Barkly Region, in 1994–95, the proportion of alcohol sold as cask wine was the highest in the NT (28.4%) but in 1997–98 it was the lowest (9.6%). In the Top End, Lower Top End and Central NT in the 1995–96 and 1996–97 financial years, less alcohol was sold as cask wine than in the previous and subsequent years. In fact, in the NT as a whole, this reduction in cask wine sales led to a seasonally adjusted decline in mean quarterly consumption of all alcohol of 4% ($t = -2.625$ $p = 0.020$) during this period.

Estimates of the range of per capita consumption among Aboriginal and non-Aboriginal people aged ≥15 years for each region for the four-year period 1994–95 to 1997–98 are presented in Table 5. Per capita consumption among Aboriginal people in the NT as a whole was 1.97 times, and among non-Aboriginal people was 1.43 times, the national average. Consumption among both Aboriginal and non-Aboriginal people in both the Lower Top End and Central NT was considerably higher than these estimates. Even in the Barkly—where per capita consumption was the lowest in the NT—Aboriginal consumption was 1.70 times and non-Aboriginal consumption 1.23 times the national average.

Table 5: Estimates of mean annual per capita consumption of pure alcohol by Aboriginality Northern Territory, 1994–95 to 1997–98

Region	Aboriginal	Non-Aboriginal
Top End	18.50	13.42
Lower Top End	21.01	15.25
Barkly	16.45	11.94
Central NT	20.26	14.70
Northern Territory	19.05	13.83

Discussion

Throughout the NT, per capita consumption of pure alcohol is considerably greater than in Australia as a whole. However, the results of this study indicate that even within the NT there is considerable variation—with levels of consumption being significantly higher in the Lower Top End and Central NT than in the Top End. The results also indicate that, during the period under consideration, there was some temporal variation. This has three components: a 4% overall reduction in consumption in the 1995–96 to 1996–97 period; a reduction of 22.5% in the Barkly; and an increase in consumption of 6.4% in the Top End. Elsewhere, we have shown that the first component was associated with the imposition of the NT government's cask wine levy.[9] This levy had most effect in the Lower Top End and Central NT regions. In the Top End, where less alcohol is consumed as cask wine, the levy was apparently less effective. In the Barkly, the cask wine levy also had less effect. In this case, however, it was because—about the same time the levy was introduced—licensing restrictions were imposed which, among other things, banned the sale of wine in casks of >2 litres. It was these licensing restrictions that account for the second component of the temporal variation described above.[10] With regard to the third component, it is not clear what caused the increase in consumption in the Top End, and this requires further investigation.

The significant regional variation in per capita consumption is associated with variation in the types of beverages most frequently consumed. In the Lower Top End and the Central NT, a higher proportion of alcohol is consumed as cask wine; in the Lower Top End, a higher proportion is consumed as full-strength beer—a pattern similar to that in the Barkly before the introduction of the Tennant Creek licensing restrictions. In part, it would appear that this pattern is associated with the higher percentages of impoverished Aboriginal people living in these regions (approximately 29%, 43% and 25% respectively in the Lower Top End, Barkly and Central NT compared to 16% in the Top End). Our own observations and those of others suggest that Aboriginal people in such circumstances often seek to purchase high-alcohol low-price beverages—of which cask wine is the best example.[14]

In part, the estimates of per capita consumption among Aboriginal and non-Aboriginal people highlight what has already been well documented. That is, among some sections of the Aboriginal population, consumption levels and associated harm are extremely high. However, these estimates clearly indicate that the problem of excessive alcohol consumption is not confined to the Aboriginal population. Consumption levels among non-Aboriginal people in the NT as a whole are estimated to be 43% greater than among Australians as a whole. Thus, even if some magic solution was found to reduce the harmful levels of consumption among Aboriginal people, the NT would still have a significant alcohol problem.

The results of the study indicate that there is a need for renewed effort to reduce per capita levels of alcohol consumption in the NT. Studies from both Australia and abroad make it clear that there is no one simple solution to problems of excessive alcohol consumption.[15–17] Although the impact of the NT government's cask levy and the Tennant Creek liquor licensing restrictions provide some indication of measures that can be effective, the solution to the problem of excessive alcohol consumption in the NT requires a broad range of strategies. These should include both 'broad brush' strategies which aim to reduce aggregate consumption, and strategies that focus on high-risk consumption and drinking situations.[18] Importantly, such strategies need to include a component that addresses the regional variations in consumption identified in this study.

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10. The effective and culturally-appropriate evaluation of Aboriginal community alcohol intervention projects*

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Abstract

In the past decade, the harm to Indigenous people caused by excessive alcohol consumption has been increasingly acknowledged. A wide range of projects aimed at reducing such consumption and associated harm has been initiated by both Aboriginal community-controlled organisations and government agencies. Unfortunately, for the members of Aboriginal communities and for policymakers who want to know 'what works?', many of these projects have been poorly evaluated or not evaluated at all. This paper examines some of the reasons for this and suggests ways in which evaluation of Aboriginal projects might be made more effective and culturally appropriate, and thus provide a guide for further efforts to reduce excessive alcohol consumption and related harm.

Introduction

The purpose of the symposium at which this paper was first presented was to examine what can be learned from the results of various local, national and international trials of different policies for dealing with the harm caused by drug use. At the symposium, a number of eminent researchers presented papers on the results of work that they had undertaken in this area. Unfortunately, when we looked at strategies that had been successfully employed to reduce excessive alcohol consumption and related harm among Aboriginal Australians, few studies suggested the clear directions for policy provided by many of the other papers presented.

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In this paper, we want to explore some of the reasons for this. For the benefit of our overseas colleagues, we will begin by providing a brief overview of the pattern of alcohol consumption among Aboriginal people and the harm caused by excessive consumption. We will go on to review the range of strategies that have been employed to address these problems—focusing particularly on those conducted at the community level. As we will show, few of these strategies have been adequately evaluated. We will canvass the reasons for this and make a number of suggestions as to how the evaluation of interventions among Aboriginal people could be improved.

Aboriginal alcohol consumption and related harm

A number of studies—including a major survey undertaken by the Commonwealth Department of Human Services and Health—has shown that, at the population level, the pattern of alcohol consumption among Aboriginal people differs from that in the non-Indigenous population.[1]

The data in the following tables are for urban dwellers, but a subsequent survey conducted by the Australian Bureau of Statistics indicates that the proportion of drinkers found in urban areas is similar to that found among Aboriginal and Torres Strait Islanders throughout the country.[2] Table 1 shows that, among urban dwelling Aboriginal and Torres Strait Islanders, approximately 62% were either regular (33%) or occasional drinkers (29%)—defined, respectively, as those drinking on at least one occasion per week; and those drinking less than once per week. Of the remainder, 22% had been drinkers but no longer drink, and 15% had never been drinkers. When compared to the results of the survey of non-Indigenous urban dwellers, this indicates that there is a significantly lower proportion of regular drinkers among Indigenous people (12%) and a significantly higher proportion of people who have given up drinking (13%).

Table 1: Alcohol use among urban dwelling Aboriginal and Torres Strait Islanders and the general urban population

Levels of alcohol use	Proportion of all urban Aboriginal and Torres Strait Islanders (1994 survey)	Proportion of urban general population (1993 survey)
Current regular drinker (at least once a week)	33%	45%
Current occasional drinker (less than once a week)	29%	27%
No longer drink	22%	9%
Never had more than one glass of alcohol	15%	13%
Don't know	1%	6%

Source: Department of Human Services and Health 1996[1]

These results are reflected in Table 2 which shows that, among those who reported that they were current drinkers, the proportion of Aboriginal and Torres Strait Islanders who drink on either a daily or weekly basis is less than among non-Indigenous drinkers.

Table 2: Frequency of drinking among urban dwelling Aboriginal and Torres Strait Islanders and the general urban population

Frequency of drinking	Proportion of Aboriginal and Torres Strait Islander peoples who have had a drink in the last 12 months (1994)	Proportion of the urban general population who have had a drink in the last 12 months (1993)
Every day	8%	11%
At least once a week	41%	50%
At least once a month	29%	22%
At least once a year	14%	15%
Less often/no longer drink	8%	2%

Source: Department of Human Services and Health 1996[1]

Tables 1 and 2 show that among Aboriginal and Torres Strait Islanders there were fewer drinkers, and those who did drink did so less frequently than non-Indigenous people. However, Table 3 shows that, when they do drink, Indigenous people usually consume greater amounts than do non-Indigenous people. Thus 68% of Indigenous people reported that, when they did drink, they usually consumed alcohol at what are considered harmful levels—defined by the Australian National Health and Medical Research Council (NH&MRC) as ≥41 g of alcohol per day for women and ≥61 g per day for men—whereas only 11% of non-Indigenous people reported drinking at those levels.

Table 3: Amount usually drunk when alcohol consumed among urban dwelling Aboriginal and Torres Strait Islanders and the general urban population

Amount usually drunk when alcohol consumed	Proportion of urban Aboriginal and Torres Strait islanders who currently drink (1994 survey)		Proportion of urban general population who currently drink (1993 survey)	
	Males	Females	Males	Females
1–2 drinks	9%	16%	44%	68%
3–4 drinks	9%	17%	31%	20%
5–6 drinks	11%	18%	14%	7%
7–8 drinks	10%	11%	5%	3%
9–12 drinks	18%	17%	2%	1%
13 or more	42%	21%	3%	0%

Source: Australia, Department of Human Services and Health 1996[1]

The Department of Human Services and Health report from which these data are drawn states:

> When analysis is restricted only to regular drinkers (i.e. those drinking at least weekly), the health risk of alcohol among the Indigenous community is more noticeable with 79% of regular drinkers consuming at harmful levels, compared with only 12% of regular drinkers among the general community.[1]

Observers from New Zealand and Canada will note that this pattern of consumption is remarkably similar to patterns among Indigenous peoples in their own countries.

The high rates of health and social problems consequent upon this pattern of consumption have been well documented. Data from various states consistently show that a significantly greater proportion of Aboriginal people die from alcohol-related causes than do non-Indigenous Australians. Overall, it has been estimated that 8–10% of Aboriginal deaths are alcohol related, and that this is at least three times that among non-Aboriginal people.[3–7] This pattern is also reflected in morbidity data. A Western Australian study has shown, for example, that Aboriginal men were at least eight times and Aboriginal women at least 12 times more likely to be admitted to hospital for alcohol-related conditions than were non-Aboriginal men and women.[8] As the Royal Commission into Aboriginal Deaths in Custody reported, the consequences of alcohol misuse impact right across Aboriginal society.[9]

Intervention

This pattern of alcohol consumption and its consequences is of increasing concern to both Aboriginal and non-Aboriginal Australians. The Commonwealth and the various state and territory governments have all developed programs of intervention. These programs include the provision of services, or the funding of Aboriginal community-controlled organisations to provide services, or both. In addition, some Aboriginal communities have undertaken the provision of services without such funding, and/or have taken action under various state or territory laws to control the supply of alcohol.

In a previous paper, we described the broad categories of initiatives being undertaken.[10] Among these are the following.

Acute interventions

Acute interventions are those that aim to prevent intoxicated persons from harming themselves or others. They include patrols, sobering-up shelters, refuges and detoxification facilities. Some communities provide only one of these services while others employ some combination of them.

Counselling/treatment

Most Aboriginal agencies conducting alcohol intervention projects make a distinction between counselling and treatment. However, almost all Aboriginal treatment programs are based on some form of counselling—both therapeutic and life skills counselling. In the Aboriginal context, the term 'treatment' is commonly used to describe those counselling-based programs that are conducted in a residential treatment facility. What distinguishes this 'treatment' from other forms of counselling is the fact that clients are removed from drinking environments and have the opportunity to physically recuperate from the ravages associated with alcohol misuse.

Support Services

Support services aim, without directly addressing alcohol misuse, to improve the lifestyle and health of Aboriginal people who are currently experiencing, or are at risk of experiencing, alcohol-related problems. Such services include health and medical services, accommodation, after-treatment care, and other crisis care and support.

Prevention

The preventive strategies undertaken by Indigenous organisations fall into a number of categories. These are personal injury prevention, health promotion, the provision of alternatives to alcohol use, cultural initiatives, supply reduction, and broad-based programs aimed at preventing abuse by improving socioeconomic conditions.

Personal injury prevention

Personal injury prevention strategies are exemplified by those initiatives in which communities have reached agreement with the operators of licensed premises to sell alcohol only in safe, or non-glass, containers. The aim of this is to minimise the number of accidental injuries caused by broken glass or injuries due to violence when glass containers are used as weapons.

Health promotion

Health promotion aims at changing the behaviour of individuals by giving them the knowledge to make informed choices about the use of alcohol. Aboriginal groups are making extensive use of both media campaigns and health education to promote positive health and to increase awareness of alcohol issues at local, regional, state and national levels.

Alternatives to alcohol use

A number of projects aim to provide a range of recreational, educational, training, employment and cultural activities as alternatives to alcohol use. Some of these activities are conducted as projects in their own right and may or may not include health promotion or educational activities related to alcohol use.

Cultural initiatives

Culturally-based initiatives are varied but include efforts to re-assert traditional law, and to strengthen family and culture.

Supply reduction

Supply reduction has been a prominent part of recent Indigenous initiatives to reduce alcohol-related harm. A variety of strategies has been employed to achieve this end. They include the declaration of 'dry areas', and the use of local by-laws and liquor licensing regulations to restrict trading hours and impose limits on the volume of alcohol that can be purchased. A more far-reaching, though as yet unsuccessful, strategy employed by Aboriginal organisations in Western Australia has been to seek to change liquor licensing legislation so they can gain greater control over the availability of alcohol at the local level.

Broad-based socioeconomic interventions

A small number of Indigenous organisations are currently seeking government funding to conduct programs that explicitly aim to minimise the use of alcohol by improving the overall social, political and economic wellbeing of Aboriginal people. Among these broad-based strategies are attempts to regain land, 'return to country', establish business enterprises, create employment opportunities, and re-assert control over their own lives. A large number of similar initiatives is not directly linked to alcohol problems, nor funded from government allocations for such projects (and sometimes they not funded by government at all). Nevertheless, they are perhaps the most important component of Aboriginal initiatives to minimise alcohol misuse and related harm, for it is these that go to the heart Aboriginal alcohol misuse.

The need for evaluation

It is only in recent years that comprehensive national data on Aboriginal alcohol consumption have been available and, as yet, we do not have the longitudinal data that would enable us to accurately describe whether or not changes are taking place in Aboriginal patterns of consumption. However, in aggregate, based on anecdotal evidence, there is little reason for optimism. Given this situation, there is a pressing need for both government and community agencies to be able to determine which of

the broad categories of intervention—and within them which particular strategies—are most effective. Unfortunately, however, there are few published, good quality evaluations which would enable such determination to be made.

In a review of the evaluation literature we conducted for the Western Australian Aboriginal Affairs Department in 1995, we identified only a handful relating to alcohol intervention projects.[11] More recently, a small number of well-conducted evaluations has been reported upon—such as that, by d'Abbs and his colleagues, of the effectiveness of alcohol control measures in Tennant Creek—but overall the number remains small.[12]

A review of South Australian projects conducted by the Aboriginal Drug and Alcohol Council of South Australia found that:

> … little data is collected by programs to enable any meaningful assessment or evaluation of service delivery and that which is collected reflects the priorities of the funding agencies.[13]

Similarly, in a database of 284 Aboriginal alcohol and other drug projects being conducted in 1996, we found that only 65% reported conducting any formal evaluation and, of these, 26% were only collecting data related to the administration of the projects.[14] The reality is that most projects have either not been evaluated or have been evaluated poorly. However, most Commonwealth and state/territory funding agencies now require as a condition of funding that some formal evaluation be undertaken.

At least among those working in the area, there is increasing recognition that a large part of the reason for the lack of success in evaluating Indigenous alcohol projects has been the cultural inappropriateness of the approaches employed. In 1995 we were contracted by the Western Australian Aboriginal Affairs Department to identify culturally-appropriate models for the evaluation of Aboriginal projects. As we have reported elsewhere, no such simple model exists. Given the heterogeneity of Aboriginal communities, if programs and their evaluation are to be culturally appropriate they must be flexible enough to address that heterogeneity, and must take account of the broader setting in which Aboriginal programs are conducted.

The political context of evaluation

At the outset, it must be recognised that the difficulties in evaluating Aboriginal alcohol projects are not simply methodological. Evaluation is not a politically or ideologically neutral activity—what is to be evaluated and how it is to be evaluated are political decisions. The issues regarding the evaluation of programs are related to, and inseparable from, both the broader context of Aboriginal affairs policy—as variously determined by both Commonwealth and state/territory governments—and issues relating to the planning and implementation of the programs under which most Aboriginal community projects are funded.

Officers of government agencies charged with the implementation of health policy, members of Aboriginal community organisations and researchers are usually interested in evaluation of projects for practical and sometimes mundane reasons. However, at the political level, much of the demand for evaluation is the result of a perception in the wider community that excessive amounts of funding are being allocated to Aboriginal programs for few tangible results.

This is wrong on two counts. First, the real benefits that programs deliver to Aboriginal people are often overshadowed by the overall slow pace of change. Second, and arguably more important, is the myth of overspending. In 1987, the then Labor government introduced the Community Employment Development Projects Scheme—CDEP as it is known. Under CDEP, Aboriginal communities were given the option of working on community-based projects for unemployment benefits (which are an entitlement of all Australians, regardless of skin colour). In an accounting sleight of hand, the funds for those communities participating in the scheme were transferred from the Department of Social Security to what is now the Aboriginal and Torres Strait Islander Commission or ATSIC. In one stroke, this enabled the government to claim that it had increased spending on Aboriginal affairs by more than 30% and that it had reduced the level of unemployment. In the current ATSIC budget, these funds comprise 27% of the total budget of about $1.25 billion.[15]

In 1986–87 total Commonwealth expenditure on Aboriginal programs amounted to approximately $2380 per person. Since that time, this expenditure has approximately trebled. However, as Saggers and Gray have argued, such an amount was, and still remains, insufficient to bring about significant change in the economic position of Aboriginal people.[16] The inadequacy of the Aboriginal affairs budget was highlighted by allocations for the National Aboriginal Health Strategy. When this program was introduced in 1990, a government-appointed working party estimated that an injection of $2.5 billion dollars was required immediately to address Aboriginal health needs. However, the Commonwealth government budgeted less than 10% of that amount to be allocated over five years, with equal contributions to be made by the states and territories. A subsequent review of the strategy concluded that there was little evidence of its effectiveness and that the amounts spent were small in relation to need.[17]

Furthermore, in the 1996–97 financial year, the Commonwealth government made a significant cut to ATSIC funding. It is in this environment of limited funding, and the threat of cuts to that funding, that there is a suspicion among Aboriginal people that project evaluations might be used to justify further spending cuts rather than to improve the quality of services to communities. Among some, this suspicion is accompanied by a reluctance to participate in program and project evaluation. This suspicion cannot be easily overcome, but it must be recognised and funding agencies must genuinely work towards its alleviation.

Program objectives and social accountability

The fact that for most Aboriginal communities their needs exceed the resources available to them creates another problem, which in turn poses a threat to culturally-appropriate project evaluation. Aboriginal communities are often dependent upon government funding programs. In this situation, quite apart from the services such programs are designed to provide, project funding provides jobs and resources that can be used, in part, to meet other community needs.

This can be extremely problematic for community office bearers and/or employees. On the one hand, they are required to be accountable to the funding agency—both financially and for outcomes that are constrained by the broad objectives of funding guidelines. On the other hand—and more importantly—they are socially accountable to members of their own communities. Such conflicting responsibilities can often place them in an untenable position.

The solution to this lies partly in greater flexibility in the application of funding guidelines by government agencies. This is not to argue that the statutory responsibilities of government agencies should be disregarded. Rather, it is to suggest the open negotiation of realistic, achievable project goals, which are responsive to the needs of Aboriginal communities as they define them, instead of forcing them into the mould of uniform program objectives. Negotiation of such goals would ensure that projects are evaluated in a way that takes account of their broader impact—which, often, may be greater than intended by program planners.

The costs of evaluation

The cost of project evaluation is a real issue for many Aboriginal agencies. In a political and economic environment in which they are starved of resources, the priority is on the delivery of services, and it appears wasteful to allocate resources to project evaluation.

This is not to argue that Aboriginal organisations are not interested in the effectiveness of the services they provide. As the chairperson of an Aboriginal organisation which conducts several alcohol projects recently told us, ‘We wanna be sure we’re on the right track’. Rather, formal evaluation is often considered unnecessary because committee members and staff of organisations informally monitor projects and receive feedback from people about whether or not projects are meeting their needs.

The perception that evaluation is costly is not entirely unfounded. We were recently asked to assist in the evaluation of a small Aboriginal alcohol and other drug misuse

education project in which evaluation had been budgeted to cost a third of the project grant, and was still insufficient to adequately do so.[18]

Levels of excessive alcohol consumption and related harm are determined by many factors, and assessing the impact of intervention projects is often a complicated, time-consuming and costly undertaking. Given this, it seems to us that—rather than seeking to assess the outcomes of all projects, and doing so badly—it might be more appropriate for funding agencies to negotiate the selection of a small number of projects within various intervention categories and to rigorously subject them to both process and outcome evaluation. Other projects could then be subject only to simple monitoring and process evaluation. In our view, this would both reduce the overall cost of evaluation and provide a far better appraisal of the strengths and weakness of various strategies.

Obviously, the informal methods of monitoring and evaluation that communities use are not infallible. However, it would be useful to try to identify those methods with a view to negotiating their use as the basis for the less intensive evaluation of projects. There are several attractions about such an approach, not the least of which is that it would not entail the imposition of methods considered inappropriate by community members, and if successful should prove to be a relatively inexpensive means of project evaluation.

Strengthening and supporting community organisations

A project conducted on behalf of the NH&MRC found that an inadequate research base, and lack of training and support have contributed to the current state of Aboriginal health program evaluation.[19] A key to making the evaluation of Aboriginal alcohol intervention projects more culturally appropriate and effective is to strengthen the ability of community organisations to conduct their own project evaluations and support them to do so.

Although there is much distrust of the motives for project evaluation which is orchestrated from outside, there are many organisations which are keen to undertake their own evaluations of their projects. However, they often lack the necessary skills, and those which attempt to do so often produce data which is unreliable and of little use.[20, 21]

When interviewing representatives of community organisations for the development of our database on Aboriginal alcohol and other drug intervention projects, many talked about the difficulties of conducting projects with inadequately trained staff, and complained about the lack of opportunity to obtain training. This was seen as a major obstacle to the successful implementation of all aspects of projects, not only their

evaluation, and as contributing to a less than optimal use of available resources. The provision of such training would obviously be both long term and expensive. However, we believe it should be seen not as a cost but as an investment in the country's health infrastructure.

More immediately, we believe that funding agencies should support community organisations by providing grant applicants with more detailed information about the purpose of evaluation and the specific requirements of the granting agencies. This information should be supplemented with lists of persons with appropriate expertise who would be willing to assist Aboriginal organisations, at no or minimal cost, to develop appropriate evaluation strategies that are integral to particular projects. Provision of such guidelines and support should supplement more detailed discussion between officers of funding agencies and representatives of Aboriginal community organisations aimed at ensuring that the latter are adequately resourced to undertake planned intervention strategies and their evaluation.

As indicated above, providing the support and training to enable communities to adequately monitor and evaluate their own intervention projects will both go a long way to ensuring the cultural appropriateness of such evaluation and, in the long term, should lead to some reduction in the cost of project evaluation.

Strengthening funding agencies

Many of the suggestions we have made regarding additional support for community organisations envisage a greater role for Commonwealth and state/territory funding agencies. It is our view that strong funding agencies with well-trained staff are essential partners in efforts to reduce excessive alcohol use and related harm. They need the expertise to give adequate scrutiny to project proposals, the skills to assist in their development and evaluation, and the opportunity to review and make use of the findings arising out of the evaluation of community-based projects.

Clearly, in a period when public service staffing levels have been, and are being, reduced, many agencies would not be in a position to provide the level of support required. Such support should not be provided at the cost of curtailing project funding. In our view there is clearly a need for all Australian governments to increase expenditure on both; and we strongly support recent calls by the Australian Medical Association and the Public Health Association of Australia for the Commonwealth government to increase its spending on Aboriginal health.

Methods

So far, we have said little about the methods of culturally-appropriate evaluation. This is because we believe that methodological issues are more tractable and amenable to solution than the broader political and economic dimensions of project evaluation.

Given the heterogeneity of Aboriginal communities and the diversity of the objectives and strategies of their alcohol intervention projects, we believe that the only viable approach is a methodological eclecticism. Methodology should not drive the evaluation of Aboriginal alcohol intervention projects. Methods should be selected on the basis that they can best provide answers to the questions posed—not on the basis that they are judged 'best' a priori.

Given the diversity of communities and projects, funding agencies need to be wary in their selection and advocacy of standardised performance indicators. Although they can be useful, they can also constrain the strategies communities employ and can result in the expenditure of much energy in collecting data that is of little practical value.

Again, methods are more likely to be appropriate when selected by members of the communities in which projects are conducted. In these circumstances, they are better able to take account of cultural practices and the constraints on data collection imposed by living conditions, especially in rural and remote areas.

Conclusions

Evaluation is an essential part of the planning, implementation and improvement of Aboriginal alcohol intervention projects but it is not a substitute for them. In our concern with evaluation, we must bear in mind that its purpose is to improve the effectiveness of the services that are provided to Aboriginal people, and we must not get bogged down in its technicalities.

We believe that the greatest single obstacle to the culturally-appropriate and effective evaluation of Aboriginal alcohol intervention projects is the mistrust engendered by the political environment in which it takes place. The concerns that many Aboriginal people have about the use of evaluation is one that can only be worked out at the political level. Nevertheless it cannot be ignored by researchers and government officers, as it provides the context within which they must work.

Despite that, we believe that the evaluation of alcohol intervention projects and their effectiveness can be enhanced and the way forward shown by:

- implementing funding programs in a manner that accommodates the heterogeneity of Aboriginal communities and gives due consideration to the need for social accountability;
- minimising the cost of evaluation for community organisations;

- providing support and training to enable Aboriginal organisations to monitor and evaluate their own projects; and
- strengthening funding agencies so that they are able to provide a more supportive role to those Aboriginal organisations conducting alcohol intervention projects.

On the basis of our experience in Aboriginal communities, we believe that the type of intervention projects we have discussed in this paper are important and that it is necessary to demonstrate their relative effectiveness. However, it is important to recognise that, alone, they are likely to have limited impact on the problem of excessive alcohol consumption and related harm among Aboriginal people.

As we mentioned in the introduction and have shown elsewhere, the pattern of alcohol consumption among Indigenous Australians is not unique to them.[22] It is remarkably similar to that found among Indigenous peoples in New Zealand and Canada. The cause of this similarity must not be sought in the particularities of community and culture, but in what is common to the experience of Indigenous peoples in all of those countries. That commonality is the historical and continuing impact of non-Indigenous colonialism, and the political and economic inequalities that it has produced. Unless those inequalities are addressed in a more systematic and concerted manner, the impact of measures that focus on alcohol use per se will remain limited.

Acknowledgments

This paper is based on lessons we have learnt from a number of studies, including a review of culturally-appropriate evaluation methods funded by the Western Australian Department of Aboriginal Affairs, and an evaluation of the Karalundi Peer Support and Skills Training Program and the Indigenous Australian Alcohol and Other Drugs Databases (<http://www.db.ndri.curtin.edu.au>) funded by the Commonwealth Department of Health and Family Services. It is also based on work we have conducted on behalf of various Aboriginal community-controlled organisations. The paper has been informed by work and discussions with numerous Aboriginal community workers and our colleagues Sherry Saggers from the School of Social and Cultural Studies at Edith Cowan University and Deirdre Bourbon at the National Centre for Research into the Prevention of Drug Abuse.

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11. Evaluating government health and substance abuse programs for Indigenous peoples: a comparative review*

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Abstract

Most health and substance abuse programs for Indigenous peoples in Australia are funded by government. Over the past decade there have been calls for greater accountability in the conduct of these programs. Initial attempts focused on the development of standardised performance indicators, an approach that has been roundly criticised on both political and methodological grounds. Recently, some government agencies have sought to identify culturally-appropriate models for the evaluation of programs for Indigenous peoples. In a comparative review of the evaluation of Indigenous programs in Australia and Canada, conducted for the Western Australian Aboriginal Affairs Department, the authors were not able to identify any generally applicable models. However, this literature review and our own research and experience in working with Aboriginal community organisations have identified a number of principles that should be an essential part of any attempts to evaluate health and substance abuse programs for Indigenous peoples. Underlying these principles is the realisation that evaluation is not a politically or ideologically neutral activity. Theoretical and methodological considerations of the evaluation process must take into account the very real differences between the agendas of Indigenous peoples and those who seek to evaluate programs for them.

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Introduction

Despite considerable government expenditure over the past two decades and significant improvements in particular areas, the health of Indigenous Australians remains well below that of other Australians, and a high proportion consumes alcohol at harmful levels.[1, 2] Concern has been expressed that resource allocations are insufficient, services are inappropriate, and resources are used less than optimally, and there have been calls for increased program monitoring and evaluation. These calls have come from different quarters, including: Indigenous peoples who feel they are not being adequately served; Indigenous affairs departments critical of the performance of mainstream agencies; technocrats who appear to believe that rational management techniques are the solution to all social problems; and conservative politicians seeking to reduce government spending and specialised services for Indigenous peoples.

The present review was undertaken in this context. It aimed to identify culturally-appropriate models for the monitoring and evaluation of government health and substance abuse programs for Indigenous peoples, and builds upon a previous project undertaken for the Western Australian Aboriginal Affairs Department.[3] There is little in the literature dealing specifically with health and substance abuse programs for Indigenous peoples. Therefore, of necessity, the review draws on the wider literature on evaluation of programs for Indigenous peoples, as well as the general literature on health and substance abuse program evaluation, and the experience of two of the authors as members of Indigenous community organisations (MD, DW).

Self-determination

Indigenous peoples in Australia and Canada are insisting that governments deliver on their promise of self-determination, ensuring local community control and participation.[4] The extent to which demands for self-determination are accepted by various levels of government determines how well Indigenous peoples are enabled to: formulate policy and programs, participate in delivery of services that meet their perceived needs, and themselves evaluate the effectiveness of those programs and services.

The Australian and Canadian literature on self-determination and Indigenous-government relations contains an implicit view that from self-determination will flow the development and implementation of effective policy and programs.[5, 6] In support of this view, a comprehensive United States review found that real improvements in the socioeconomic status of Indigenous Americans are directly attributable to political changes of the 1970s leading to ‘increased Indian control over, and participation in,

the formulation of Indian policy', including agenda setting, and policy development, implementation and evaluation.[7]

Canadian and Australian federal governments have both made greater concessions to Indigenous demands for self-determination than provincial and state governments. In both countries, Indigenous peoples are concerned that, even where provincial governments have made 'in principle' concessions to self-determination, often this is not reflected in the program objectives and activities of mainstream government agencies.[4, 8] Thus monitoring such programs should ensure that they are consistent with government commitments to Indigenous self-determination.[9]

Accountability

Self-determination is closely related to accountability. At the political level, much of the demand for evaluation of Indigenous health and substance abuse programs is driven by concerns about financial accountability.[10] While not discounting the importance of financial accountability, Indigenous peoples are more concerned with the broader issue of 'social accountability'.[11] This includes the demand that program providers be accountable directly to program recipients. In Australia, as in Canada, government officers are only indirectly accountable to the public; while they are directly responsible to their ministers, who in turn are responsible to parliament and to the law.[12] This system severely limits the influence of minority populations, and stringent terms and conditions on how funds can be spent imposes constraints on self-determination.[13, 14]

Canadian federal legislation has given some Indigenous bands greater responsibility and autonomy, and Sanders argues that the Australian government's Aboriginal and Torres Strait Islander Commission (ATSIC) legislation is an attempt to reconcile public accountability and Aboriginal self-determination.[12, 15] Clearly, enhanced program effectiveness is dependent upon responsiveness to local needs and circumstances. The challenge is to build in some measures of local accountability while meeting broader accountability requirements.

Program Planning and Implementation

Appropriate evaluation is only one aspect of, and not a substitute for, the planning and implementation of programs that respond effectively to the needs of Indigenous peoples. As a consequence of differences in culture, history, social environment and access to resources—even within national boundaries—these needs are not uniform, and to be effective programs must respond to this heterogeneity.[16, 17] The National

Aboriginal Health Strategy Working Party concluded that there is no single solution to Indigenous substance abuse problems, and the review of the Healthy Aboriginal Life Team's petrol-sniffing prevention program highlights the difficulties in applying a standardised approach in heterogeneous communities.[18, 19]

Effective program outcomes are dependent upon the setting of objectives that are unambiguous; although, as revealed in evaluations of ATSIC's Enterprise Program and the Department of Employment, Education and Training's Training for Aboriginals Program, this is not always achieved.[20, 21] At the same time, however, programs need to retain the flexibility to incorporate changed objectives. Such changes in objectives need to be carefully documented, and evaluation strategies themselves must be flexible enough to take account of them.[22]

Program goals need to be attainable, and the ability of agencies to implement and resource them must be monitored.[23, 24] In Canada lack of field experience by Department of Indian and Northern Development personnel was identified as creating difficulties for program design; and in Australia, reviews of ATSIC programs found that staffing and other resources were often well below that approved for similar government programs elsewhere.[20, 23, 25, 26]

Where they have responsibility for implementation, the ability of communities to undertake programs should also be monitored. A comprehensive review of Canadian programs found that effectiveness and efficiency would be improved by giving Indigenous communities more responsibility for program management.[16] However, it must be recognised that few communities have the necessary levels of support to achieve desired program outcomes, and provision should be made for this in the program planning process.[22, 23]

In the experience of the Aboriginal authors of this paper, program administrators assume that Indigenous community members are familiar with bureaucratic processes. The Office of Evaluation and Audit notes the consequences of this assumption, and its evaluations of ATSIC programs emphasise the need to document program procedures and make communities aware of them.[20, 23, 26] A review of community enterprise programs for youth in South Australia, for example, found that this was an essential ingredient of successful programs.[27]

Evaluation and monitoring procedures must be an integral part of program planning. This axiom has implications for the monitoring and evaluation of programs by third parties such as Indigenous affairs departments. Such departments do not have the resources to evaluate the outcomes of the many government Indigenous programs; nor is this desirable, given the need for integrated program development and evaluation. To oversee Indigenous programs most effectively, Indigenous affairs departments should provide other agencies with best practice guidelines for

Indigenous program planning and evaluation, and monitor their compliance with those guidelines. Given the importance of self-determination, such monitoring should include review of:

- Indigenous participation in policy formulation;
- the match between program objectives, and the needs and priorities of Indigenous peoples;
- the extent to which Indigenous peoples are involved in the delivery of services, including the contracting of service delivery to community organisations; and,
- the opportunity for Indigenous peoples to participate in the evaluation of program effectiveness.

The Politics of Program Evaluation

Evaluation is not a politically or ideologically neutral activity.[24, 28] Definitions of the 'problems' programs are designed to address and the perceptions of the underlying causes are inherently political. In part, political differences in problem definition between representatives of government agencies and Indigenous peoples are also based on cultural differences. Generally, Indigenous peoples do not compartmentalise aspects of their experience, and insist that their needs be addressed in a holistic fashion and evaluated accordingly.[11, 29] However, government 'departmentalism' (fragmentation of roles) and lack of coordination works against this, and evaluators rarely consider the impact of a program in one sector upon another.[30]

Also, analysis of the underlying causes of social problems (on which program development is based) is particularly unsophisticated, and based on what Chen and Rossi have described as 'the current folk-lore of the upper-middle-brow media'.[31] The ideological assumptions that underlie such analysis are rarely questioned, and they carry weight because of the political power of those holding them rather than any inherent explanatory value.

On the ground, the political differences over program outcomes are compounded because: Indigenous peoples often have no choice but to use government programs to achieve their own ends; agencies sometimes provide services in response to gaps in the delivery of services by other organisations; and, during program implementation, unintended positive outcomes emerge.[13, 22, 32]

For these reasons, it has been argued that evaluation of programs for Indigenous peoples must incorporate Indigenous assessments of both the programs and their broader effects, using criteria that reflect the broad range of Indigenous social needs.[4, 33–35] In Canada, Indigenous people have taken the initiative in this regard; attempting

to construct development indicators that can be used to measure the wider effects of new programs at the community level.[29]

Just as political and ideological assumptions underlie decisions about what is to be evaluated or monitored, they also underlie the choice of methodology. Again such assumptions are rarely openly discussed or questioned. Debates such as that between Garbutcheon Singh and Keefe over the relative merits of economic rationalist and culturalist approaches to evaluation are rare.[34, 36] However, in reports such as the Office of Evaluation and Audit review of ATSIC's Community Infrastructure Program, it is possible to identify an implicit economic rationalist drive for financial accountability that contrasts with broader social development approaches to program evaluation.[26] Such assumptions must be made explicit because they reflect differences not only between non-Indigenous evaluators but also between them and the Indigenous people for whom programs are intended, and they can be a source of conflict and mistrust.[8, 37, 38]

Another major political consideration has to do with the use that is made of program evaluation research. Writing particularly about organisational decision-making, Hennessy and Sullivan point out that much of the evaluation literature is based on an inaccurate rational decision-making model. which assumes a stable environment, clear program goals and sufficient resources for consideration of all relevant information.[39] In the real world, they argue, decisions about programs are based on the interaction of group coalitions within organisations, and evaluation research is used to protect the interests of these coalitions. In the wider political arena, too, it has been shown that evaluation research has had little demonstrable effect on the policy-making process.[24, 40, 41]

Indigenous organisations are concerned that evaluation is used by program funding agencies to impose unreasonable accountability requirements on them, or to justify political and/or bureaucratic decisions to cut funding. Some believe that the performance of Indigenous organisations is subjected to more scrutiny than other programs of the funding agencies.[42, 43] This is not to argue that program evaluations are of no practical value. In the right hands, they can improve service delivery and inform public debate about political processes. However, ultimately, major program decisions will be based on political considerations and relative power—not on the basis of evaluation reports alone.

Evaluation methodology

Although many professional evaluators believe that programs can only be properly evaluated using experimental (or quasi-experimental) research designs, various

difficulties in their use have been identified. These include: ethical objections to the allocation of potential program recipients to experimental and control groups; cost in both time and resources; and the dependence of outcomes on variables such as the choice of the control group and the time selected as the benchmark for measurement. Apart from these difficulties, the results of experimental evaluations are often not replicable in whole populations or other environments.[21] Furthermore, the canons of experimental design exclude participation of Indigenous stakeholders and preclude the flexibility of considering other criteria of program effectiveness that might emerge during the program implementation phase.[44]

A comprehensive review of standardised instruments for the evaluation of substance abuse prevention programs in the United States found that none were sensitive to cultural difference between populations.[10] To overcome the limitations of experimental approaches, 'naturalistic' and 'fourth generation' approaches to the design of Indigenous program evaluation have been advocated.[9, 45] Such designs employ a more descriptive approach and rely on qualitative techniques of data collection and analysis—such as participant observation and in-depth interviews—used to good effect in cross-cultural research by anthropologists and sociologists. Although some evaluators demonstrate a relatively unsophisticated understanding of qualitative techniques,[45] others have shown how they can be rigorously and successfully used in evaluation research.[46, 47] In Australia, some reports recommend on-site visits, allowing observation of programs in action and discussions with participants, for the most reliable and valid data.[23, 27, 48]

Some proponents of qualitative techniques have advocated that they are the only appropriate techniques to use in the evaluation of programs for Indigenous peoples. Hébert, for instance, claims that quantitative techniques involving surveys and sampling are not appropriate to the group consensus mode of decision-making of many Indigenous groups.[9] However, the appropriateness of the techniques employed depends upon the Indigenous community involved. For example, even telephone surveys have been reliably used among some Indigenous groups in the United States, and technologies such as teleconferencing have been useful in both urban and rural settings and may reduce considerably the cost of consulting with distant groups.[49, 50] The point is that rigorous evaluation requires a pluralistic methodology that includes a range of techniques and data sources (documentary, interviews, questionnaires, group discussions, participant observation, case studies, and so on) and as many stakeholders as practicable.

The selection of performance indicators requires careful consideration. They should realistically reflect the impact of the program and the processes involved—from the viewpoints of both administrators and recipients. However, the literature abounds with examples of where this has not been achieved. For example, simple counts of

patient visits, proposed in the past as one measure of the performance of Aboriginal health services, provides no information about outcomes achieved by particular services, says nothing about the severity of problems dealt with, is too general to be of any use in process evaluation, and the collection of the data is wasteful of resources.[43] Furthermore, when data from individual health services are aggregated they provide no information on either the efficiency or the effectiveness of the program as a whole.

Given the difficulty of developing appropriate performance indicators and the costs involved in the collection of data, the use of existing data collections for program evaluation has obvious attractions.[51] However, their utility is often limited. First, most routine departmental data collections are designed for specific purposes and do not adequately reflect the impact of particular programs.[52] Second, many of the macro-level health indicators such as Census, mortality, and morbidity statistics reflect the outcomes of complex social and political processes, not just the effects of particular programs. Furthermore, they take no account of the adequacy of the resources allocated.[4, 18]

These limitations have been widely recognised and there have been various calls for the establishment and maintenance of specialised databases.[16, 23, 26] However, while they are clearly necessary, establishment of such databases needs careful consideration. In terms of both resources and time, they are expensive to establish and maintain. Given the costs and a desire for concise data sets for the purposes of both planning and evaluation, there is often pressure to establish single multi-functional databases.[53] The danger in this approach is that the database will suffer from the same limitations as existing collections and will not provide a comprehensive measure of the impact of particular programs.

Expanded data collection systems are needed to facilitate evaluation of programs for Indigenous peoples. However, the effects of these must be considered carefully. Sackett has been critical of the call by the Royal Commission into Aboriginal Deaths in Custody for the collection of more data on Aboriginal and Torres Strait Islander peoples.[54] He has argued that the response to this by the Commonwealth and state governments will extend bureaucratic control and scrutiny of Aboriginal lives, with little likelihood of benefit to them. For these reasons, the Canadian Development Indicator Project Steering Committee has argued that performance indicator development and data collection should be undertaken by Indigenous communities themselves, thus promoting Indigenous autonomy and responsibility, and responding to community heterogeneity.[29]

Cultural appropriateness

For Indigenous peoples, a key consideration in monitoring government agency programs is the cultural appropriateness of the programs themselves and of the means by which they are evaluated. While its own reviews highlight the need for the cultural appropriateness of program evaluation, the Office of Evaluation and Audit's evaluation handbook provides no specific guidance on this.[55] As with program development, the best way of ensuring that program evaluation is culturally appropriate is to involve Indigenous stakeholders in the evaluation process. Such inclusion is more likely to occur in Canada and the United States than in Australia. In North America Indigenous peoples have more power, in part because of their organisation at the tribal and national level.[7, 38, 56]

The need to involve Indigenous peoples in program development and the collection of evaluation data has already been stressed. However, the results of any research or evaluative data collection do not speak for themselves; they must be interpreted. When data have been collected, a range of competing hypotheses about the findings should be generated and assessed in terms of the available evidence. If this is not done, rather facile conclusions about the impact of a program can be reached.[23] Indigenous people must be involved not simply in data collection but also the interpretation of those data and the conclusions and recommendations that are drawn from them.[22, 33, 57] What is a desirable outcome for one group of stakeholders may not be so for the Indigenous recipients of the program. Even within Indigenous communities, there will be debates about what is culturally true and untrue and what should be accepted and implemented.[9, 38]

Related to the issue of community involvement is the question of representativeness. If evaluation is to include Indigenous stakeholders, and the community is too large to include all members, this can be a vexing problem.[9] In Australia, Canada and the United States, representation may have more than one meaning; and for Indigenous communities it may be neither possible nor desirable.[58] Evaluators have to balance the ideals of cultural relativity, which entail recognition that in some Indigenous communities not all are authorised to speak, and more universal concerns about democratic representation.

Stakeholders are not equally powerful. Evaluators need to acknowledge and attempt to account for this at all stages of the evaluation process.[28] Whether setting program objectives, deciding upon data collection techniques or interpreting the data, unequal positions of power may have an influence. Evaluation guidelines must articulate ways in which Indigenous peoples can have their views heard at each stage of the evaluation process.

Inclusion of all stakeholders is seen as important to best professional practice in mainstream evaluation.[59, 60] However, it is essential in Indigenous communities where power-holding is more diffuse and where exclusion of some can cause social disruption. Among the advantages accruing from community involvement in evaluation are the identification of unforeseen problems, improvements in both program efficiency and effectiveness, and the allaying of community suspicion and hostility that can undermine evaluation.[4, 22, 35]

Although Indigenous stakeholder involvement is essential, it will not ensure cultural appropriateness of program evaluation if there is not recognition of the cultural chasm that often separates non-Indigenous evaluators and Indigenous peoples. Central to this are issues of language and communication. Misunderstandings result from non-Indigenous people's lack of knowledge of the varieties of non-standard English spoken and the range of non-verbal communication used by Indigenous peoples.[61, 62] Without such knowledge, the integrity of the evaluation process can be compromised. Non-Indigenous evaluators need to be aware of and sensitive to culturally-appropriate ways of communicating with Indigenous peoples, and this itself should be monitored.

Conclusion

Evaluation discourses are ubiquitous among government-funded health and substance abuse program personnel. Over the past decade or so, evaluation theory and practice have been a boom industry as conservative politicians and bureaucrats demand greater accountability for publicly-funded programs, particularly those in politically sensitive areas. There can be no argument against evaluation in principle, either for financial and activity monitoring or assessment of outcomes. What is at issue is the uncritical application of evaluation theories and methodologies to programs for Indigenous peoples. Indigenous groups are too heterogeneous, program and evaluation issues too complex, and methodological weakness of much evaluation too apparent for this to continue.

Our analysis of the literature, and our research and community-based experiences indicate a chasm between the expectations of funding agencies and Indigenous peoples about health and substance abuse program evaluation. While there are no ideal, culturally-appropriate models, principles must be contextualised within a framework of self-determination in which Indigenous peoples negotiate with government agencies to decide what programs they need, how the programs might be implemented, the outcomes they believe are desirable, and how those outcomes can be evaluated. These issues are political as well as financial, and require negotiation

within Indigenous communities and between those communities and funding agencies.

Evaluation methodologies have to incorporate a wide and flexible array of qualitative and quantitative techniques that are sensitive to the social and cultural differences existing in Indigenous communities and the paucity of administrative, technological and information infrastructure to support evaluation. Indigenous peoples must be consulted at each stage of the evaluation process, from the determination of objectives to the interpretation of evaluation results. Finally, we need to be sure that Indigenous health and substance abuse programs are not unfairly bearing the brunt of evaluation attention while programs for healthier, non-Indigenous communities escape the bureaucratic gaze.

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12. Alcohol in Indigenous Australian communities*

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This chapter examines two of the strategies employed by Indigenous Australian communities to deal with harmful consumption of alcohol and the risks it poses to them. Such an examination highlights: the balance that all societies must strike between the 'rights' of individuals and the collectivity; some of the processes by which non-Indigenous society dominates Indigenous Australians; and the resistance of Indigenous peoples to those processes.

Available evidence indicates that the pattern of drinking among Indigenous peoples differs significantly from that found in non-Indigenous populations. In Australia, for example, although a greater proportion of the Indigenous population does not consume alcohol, among the proportion that does, more people do so at harmful levels.[1–4]

The deleterious health and social consequences of excessive Indigenous alcohol consumption—that is, consumption at levels which causes harm to both individual drinkers and those around them—are well documented. Indigenous peoples in Australia experience significantly higher rates of alcohol-related illness such as alcoholic cardiomyopathy, alcoholic gastritis and alcoholic liver cirrhosis, as well as traumatic injuries, road accidents, suicide and violent death.[5–8] Excessive alcohol consumption also contributes to unemployment, family breakdown, child neglect and school absenteeism.[6] In addition, there is widespread concern about the association between excessive alcohol consumption and violence in the home and other forms of intra- and interpersonal violence.[9]

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Indigenous communities themselves recognise the harmful health and social consequences of excessive drinking. For many Aboriginal Australians, alcohol is unambiguously implicated in 'too much sorry business'.[10] Aboriginal people strongly expressed their concerns about the impact of excessive alcohol use to the Royal Commission into Aboriginal Deaths in Custody, and three-quarters of those interviewed for the National Aboriginal and Torres Strait Islander Survey identified it as a health problem.[6, 11] However, such a view is not universally held. For other Indigenous people alcohol consumption is pleasurable, a means of social exchange, and a means of protest against the wider society in which they are encapsulated.[12–14]

There has been a broad range of responses by both Indigenous and non-Indigenous people to the problem of excessive alcohol consumption. These responses have been implemented at community, state and national levels. Specific responses have included acute interventions, treatment, prevention, supply reduction, provision of alternatives to use and broad-based socioeconomic interventions.[15] These responses are not value free. Embedded in each are philosophical understandings and ideological constructions of the risks that alcohol poses to individuals and society, and the way in which a democratic society should 'properly' respond to those risks.

There is a longstanding tension between sociological theories which emphasise the institutional and structural constraints upon individual behaviour, and those in which individual agency is paramount.[16] Over two decades, in most of our analyses of Indigenous health, we have pursued what are often seen as unfashionable notions of political economy—not simply because they reflect our ideological predilections, but because they still appear to be powerfully valid.[17–20] Like many contemporary observers, however, we see the need not simply to '… formulate the global systematic theory which holds everything in place, but to analyse the specificity of mechanisms of power, to locate the connections and extensions, to build little by little a strategic knowledge'.[21] For Foucault, as cited by Seidman, social control 'operates less through a system of legal, state, or economic repression than through the application of technologies of discipline that spread from the military to prisons, factories, schools, hospitals, asylums, and virtually all organisations'.[22]

Interwoven throughout these technologies of discipline are medico-scientific discourses that control what people desire, how they express themselves and what they do, by establishing norms of belief and behaviour. Analysis of these discourses heightens our understanding of the links between the structural factors underlying much behaviour and micro-level psychosocial interactions.

In Australia, colonialism established widespread institutions of control that provided surveillance over most aspects of the lives of Indigenous peoples—including missions, segregated schools and prisons. The dominant discourses that rationalised this

approach were imbued with racist notions of biological and social difference, cloaked in Christian goodwill. The way in which problems associated with alcohol misuse are conceived, and the interventions proposed, illustrate colonial legacies of control, Indigenous resistance to them, and ongoing changes within Indigenous societies and cultures. Managing the risks alcohol misuse poses within acceptable limits to individual and community liberty requires theoretical attention to both structure and agency. In the past we have stressed the need to focus on the structural determinants of alcohol use. However, it is also clear that these have to be linked to the shared understandings of individuals and communities, for it is upon these that successful interventions must be based.

Risk and liberty

In Western industrialised societies, the 'rights' of individuals have been generally accorded greater priority than those of the collectivity. In those societies, among the key medico-scientific discourses which establish norms of belief and behaviour are those surrounding the autonomy of the individual and the liberal values arising from them. These values arose with the development of industrial capitalism and emphasised the 'right' of individuals to pursue their interests (particularly economic interests) unfettered by the intrusion of the state. This philosophy has been most clearly articulated by John Stuart Mill.

In his essay On Liberty, Mill argued that mature people should neither be forced to do anything because it might be good for them, nor prohibited from doing anything because it might be bad for them.[23] For Mill, drug use was simply the act of independent people rationally exercising their 'tastes and pursuits', and he argued that intervention in this exercise by the state was not warranted.

Against the argument that state intervention could be justified because the exercise of individual 'tastes and pursuits' might have consequences for others, Mill responded that such harm should have actually occurred or be at least a definite risk. It was not sufficient to posit indirect or possible harm in order to justify state intervention. The only people requiring the paternalistic protection of the state, according to Mill, were children or immature adults; although, some whole societies—so-called 'savages' and 'barbarians'—were deemed to be immature, and required paternal intervention to realise their historical potential.

Such liberal discourse represents the dominant ideology in Anglo-Western societies. Liberal ideology attributes the misuse of alcohol and other drugs to the weakness or susceptibility of individuals—whether biological, psychological or moral—and denies or minimises the role of political and economic factors in such misuse. However, as

with all ideologies, it has been contested, and its dominance has not been exclusive. In addition to this ideology, assessment of the risks posed by alcohol and other drugs has been strongly influenced by cultural preference and economic interest—rather than objective appraisal. In Australia, non-medical use of opiates and stimulants such as cocaine—which have never been used by a majority of people and of which there is no significant domestic production industry—has been regarded as high-risk activity and generally has been proscribed. On the other hand, there has been a downplaying of the risks associated with the use of alcohol—the most commonly-used recreational drug, and one in which there is significant capital investment in production and distribution. Control of alcohol use has been viewed as more properly based on the education of individuals rather than on state intervention; and there has been considerable resistance—justified in terms of Mill's notion of individual liberty—by consumers, suppliers and producers to any but limited regulatory measures to control consumption.[24]

In what follows, we examine the relationship of these liberal views to the ways in which alcohol-related problems are defined, and to the intervention strategies employed to deal with the risks and consequences of alcohol misuse. First, however, it is necessary to consider Indigenous notions of individuality or selfhood, and their implications for alcohol misuse and strategies to deal with it.

Indigenous notions of selfhood and community

As indicated previously, all societies must strike a balance between the rights of individuals and the collectivity (although this is often shifting). The level at which this balance is struck has important implications for patterns of alcohol consumption, and its resolution will determine whether interventions are most appropriately directed at individuals, groups of problem drinkers or wider communities. However, in the case of Indigenous Australian communities, the ethnographic literature provides no clear-cut answer to this problem.

There are several descriptions of Indigenous communities in which drinking is the norm, and which suggest that the collectivity takes clear precedence over the individual.[14, 25, 26] In such communities 'The choice is simple: drink and belong, or abstain and remain outside'.[26] This style of drinking has been described as 'contingent drunkenness', because it is intimately connected to a communal drinking lifestyle rather than any particular individual susceptibility to alcohol. Such drinking defies conventional descriptions of alcohol addiction or dependence, as individuals seem able to control their drinking while apart from the collectivity.

On the basis of such studies, it is argued, interventions that target individuals are misdirected because they fail to differentiate between drinking in Indigenous communities where heavy drinking is the norm, and drinking in other settings where the problem drinker is an alienated outsider. When individuals return to their communities, newly-sober after having undergone treatment, the struggle to maintain a transformed way of life proves too difficult for most. Accordingly, it is suggested there is a need for intervention programs that identify and strengthen group processes which will control the level of alcohol consumption.

Tempering such optimism about the use of endogenous social control mechanisms to reduce alcohol misuse, however, are ethnographic descriptions that highlight the limits to the collectivity and articulate a strong sense of individual autonomy where people are ‘bosses for themselves’.[27–30] Brady has documented the ability of individuals to give up the grog despite being members of drinking communities. However, she claims that traditional social controls may actually facilitate drunkenness, and that individual autonomy more often than not allows individuals to maintain their drinking rather than enabling them to stay sober.[30]

Rowse cautions against such generalisations, pointing to the places where non-drinking is normative—like the ‘dry’ communities where alcohol is prohibited, and in places where mostly senior women choose not to drink.[31] Diverse Aboriginal subcultures where drinking is not part of everyday life provide a possible place for hard-drinking individuals who want to give up the grog—a place where both individual autonomy and the strength of the collectivity can be expressed in mutually supportive ways.

The differences described in the literature are probably a function of the perspectives of the anthropological observers, the diversity of Indigenous communities, and the changes that have taken and are taking place in those communities. Nevertheless, this debate about notions of Indigenous selfhood and the way in which they impact on drinking patterns and intervention options brings into question the simple applicability of liberal notions of individuality to Indigenous societies.

Strategies of intervention

Indigenous people can access alcohol and other drug programs provided by state, territory and private agencies, and some do so. Increasingly though, there has been recognition that these programs cannot provide the type of support that many Indigenous people want. The first Indigenous alcohol intervention program, an Aboriginal Alcoholics Anonymous (AA) program, was established in Redfern in 1972, and currently about 120 community organisations conduct alcohol and other drug-

related intervention programs.[15] In this section, we review two of the intervention strategies—treatment and use of liquor licensing-related legislation—employed by Indigenous Australians to reduce excessive alcohol consumption and the risks it poses. It is our contention that these strategies reflect, on the one hand, the colonial discourse of control of Indigenous peoples and, on the other, Indigenous resistance to such control.

Treatment

Clearly, people who are using alcohol to such an extent that they are harming themselves and/or others require some kind of help, and the most common response is to advocate the provision of treatment. Application of the term 'treatment' to describe measures used to address alcohol misuse implies that the problem to be addressed is a biological or psychological disease or disorder—located in individuals—which is amenable to cure or amelioration.

Some treatments are pharmacologically based. For example, use of the drug disulfiram inhibits the metabolism of acetaldehyde (a toxic metabolite of alcohol), thus inducing illness when alcohol is consumed. The purpose of this treatment is to induce aversion to alcohol and its consumption. However, most treatments are based on some form of 'counselling' in which individuals are encouraged to identify dysfunctional behaviours or psychological conflicts that are then addressed through behavioural modification, psychotherapy or some form of self-help. The aim in some of these treatment modes is abstinence, in others it is controlled drinking. Such treatment is provided on a non-residential basis, and/or in rehabilitation or treatment centres where access to alcohol is denied and where counselling activities can be conducted on an intensive basis.

When provided by mainstream agencies, such treatment programs have not been well utilised by Indigenous peoples, and dropout rates among participants have been high. Accordingly, there have been calls to acknowledge that program models developed for White, mostly middle-class males may not suit Indigenous clients, and there has been a push to make treatment more 'culturally appropriate'.[32]

All of the treatment services conducted by Indigenous organisations are based on some form of counselling. Currently, 86 programs provide such services. In distinction to our usage, many Indigenous people reserve the term treatment for services conducted in a residential facility (of which there are 38 across the country), and refer to non-residential services as counselling. Some non-residential programs are conducted in prisons or detention centres by Indigenous organisations. Treatment in such latter settings is often conducted in fulfilment of court orders—a process

which itself reflects the definition of Indigenous alcohol misuse by non-Indigenous society.

More than any other intervention strategy, the treatment programs conducted by Indigenous organisations reflect either an explicit or implicit acceptance of liberal definitions of alcohol misuse. As indicated previously, the first Indigenous AA group was started in 1972 by Val Bryant.[33] Currently, of the 86 Indigenous treatment programs, 49 are based exclusively on the AA model—a model that defines alcohol misuse or 'alcoholism' as an incurable disease against which an individual must struggle throughout his or her life.

In addition, the AA model provides the basis for another 29 programs. In some of these programs, the AA approach to treatment is supplemented with strategies such as life-skills counselling. In others, while the liberal discourse of AA has been accepted, attempts have been made to modify it so that it is more congruent with Indigenous cultural practice and/or includes some elements of Indigenous healing.

Perhaps the most well-known example of the latter type of program was that conducted by the Central Australian Aboriginal Alcohol Programs Unit (CAAAPU). CAAAPU was based on an Indigenous Canadian program developed by Poundmaker's Lodge—itself based on the philosophy and guiding principles of the Nechi Training Research and Health Promotions Institute. The Nechi Institute's mission statement includes a list of beliefs which make clear its roots in the Alcoholics Anonymous approach to alcohol use, including the statement that: 'Alcoholism, drug, and gambling dependencies, like other addictive/dependency behaviours, are diseases which can be treated and from which recovery is possible'.[34]

In the Poundmaker's program, this liberal philosophical approach underlies a treatment program which incorporates many Indigenous Canadian healing symbols such as the sweatlodge, drum, sweetgrass, eaglefeather, and the natural elements of fire, rock, air and water. All staff are required to be abstinent—in their terms to not only 'talk the talk' but also 'walk the walk'—and most staff are Indigenous, many of them having been previously alcohol or drug dependent.

Although not without its Indigenous Canadian critics, Poundmaker's Lodge has attracted enthusiastic attention worldwide, and leading figures such as Eric Shirt have been brought to Australia to facilitate development of Indigenous alcohol and drug programs. In 1991, using the message of 'Let's beat the grog together', CAAAPU launched an outreach program. Initially, Eric Shirt and other workers helped to train people from Central Australia to run an alcohol counsellor training program. This was followed by a 28-day treatment program, based on the Poundmaker model. Two years later, in 1993, CAAAPU received funding from the Northern Territory Department of Health and Community Services to run a full-time alcohol treatment program, under

the Territory-wide Living With Alcohol Program. Subsequent evaluation of the program found inadequacies in its staffing and the inappropriateness of some of the treatment curriculum but made no findings about its overall effectiveness.[35] For a variety of reasons, the Centre ceased its activities. (However, it has since re-opened.)

It is not known how effective most of these treatment programs are, as very few have been subjected to systematic evaluation.[36] Although most programs claim they are successful, the literature gives little cause for optimism. For instance, a review of several evaluations of alcohol treatments utilising a wide range of therapies (hypnosis, group therapy, drug therapy, aversion treatment, incarceration and probation) found, after controlling for treatment setting, no statistically significant differences in results, a finding confirmed by more recent studies.[37, 38]

One of the reasons posited for the lack of success of AA programs among Indigenous people is that such programs are not culturally appropriate, in that they ascribe to individuals greater autonomy and freedom of choice than they actually possess within Indigenous societies. However, the heterogeneity of Indigenous communities and variations of belief and behaviour within them necessitates caution in subscribing to such generalisation.

Although AA-based treatment programs have not generally been successful, through these type of programs or on their own individuals have dramatically reduced or completely curtailed their use of alcohol and consequently transformed their lives.[39] Our argument highlights the limitations of liberal notions of individuality but does not negate the importance of the actions that individuals can themselves take. It is clear that, when attempting to reduce the misuse of alcohol, individual motivations and actions are integral. However, they are not sufficient.

Legislation and regulation

As indicated previously, the libertarian position with regard to availability of alcohol has never had total ascendancy. From the time of colonisation, there have always been some legislative controls over the production, sale, supply and consumption of alcohol; both because taxes and levies on these have been a significant source of revenue for the state and because it has been perceived as a drug whose unfettered use poses some risks to society. These controls have included: conditions under which licences to produce or sell alcohol are granted; restrictions on hours of trading; prohibitions on supply to minors and intoxicated persons; and prohibitions against public drunkenness. Up until as late as the 1970s in some jurisdictions, they also included prohibitions on the supply of alcohol to Indigenous persons. Nevertheless, the liquor industry has argued—and governments have generally agreed—that the misuse of alcohol is an individual problem, not to be addressed through restrictions

on availability and individual liberty, but one to be dealt with by education and health agencies.[40]

In a review of state and territory liquor licensing legislation, Craze and Norberry identify four broad objectives: public order or public good; revenue-raising or profitability; public health; and regulation of the industry. Summarising the thrust of legislative activities, they write:

> A noticeable development during the current century has been the shift by legislatures away from the social purposes of the restriction of liquor sale, supply and public consumption to the purposes of deregulation, the reduction of State interference [sic] within the liquor industry, the encouragement of diversity in services and facilities and the promotion of tourism and economic prosperity.[41]

Even recent inclusion, or proposals for inclusion, of harm minimisation objectives in some jurisdictions has been accompanied by greater deregulation of the industry.

Despite the fact that liquor licensing legislation has generally favoured the interests of the industry, there are provisions in the various Acts to limit these interests, thereby supporting some Indigenous groups who reject the notion that misuse of alcohol is wholly or largely the problem of the individual consumer. Either explicitly or implicitly, such groups have identified what much research demonstrates—that is, the availability of alcohol is a key factor in the level of alcohol-related harm—and they have taken various steps to reduce such availability.[19]

Northern Territory legislation provides an option for discrete Aboriginal communities to declare themselves ‘dry’—that is, to prohibit the distribution and consumption of alcohol within those communities. In Western Australia, similar provisions are contained within the Aboriginal Communities Act. Many Indigenous communities have taken advantage of such legislation, affirming that the interests of the community as a whole have precedence over the rights of individual drinkers. The effect of such action has been mixed. Generally, community members comply with such prohibitions, which are sometimes backed up with local sanctions. However, some disaffected individuals have moved more-or-less permanently to nearby towns, although others often go to nearby towns on ‘binges’—thus transferring the problems associated with excessive consumption from the home communities to nearby population centres.

Where restrictions on availability have been confined to discrete Indigenous communities, they have tended either to have attracted little widespread attention or to have been applauded by paternalistic Whites. They have been much more contentious where Indigenous groups have successfully applied for restrictions on the sale of alcohol in communities consisting of both Indigenous and non-Indigenous people. One recent example is Tennant Creek in the Northern Territory where, in July 1995, the Northern Territory Liquor Commission agreed to a trial restriction of the sale and supply of alcohol for a period of six months.[42]

Trial restrictions, introduced in two 13-week periods, included restricted trading on Thursdays ('pension day'), variations to trading on days other than Thursdays, and restrictions on front bar sales and takeaway sales.[42] The restrictions provoked intense debate both before and during the 26-week trial because of fears of the economic costs to local businesses, perceived infringements of individual rights, and heightening of racial tensions as some non-Aboriginal people perceived themselves to be disadvantaged because of the drinking excesses of Aboriginal people. While most people in the town acknowledged the social disruption caused by excessive drinking, some were unhappy with the proposed solution. An evaluation found that the trial had resulted in improvements in terms of fewer police incidents, reduced disturbance to public order, and improved health and welfare in terms of fewer alcohol-related hospital presentations and admissions to the women's refuge. The economic impact of the measures was varied, with a downturn in alcohol sales in the town of Tennant Creek offset to some extent by increases in sales at roadside inns. After reviewing the evidence, the Liquor Commission found that, although liquor controls could not solve alcohol problems in the town, there was general community support for limited restrictions.

Not all such actions by Indigenous peoples have been successful. Indeed, as Gray et al. indicate with regard to Western Australia, the bureaucratic procedures entailed in actions such as objecting to the granting of new licences or extended trading permits, or lodging complaints against licensees severely curtail their chances of success.[43] Difficulties with existing legislation in Western Australia led a number of Indigenous organisations to make a detailed submission to a committee established to review existing liquor licensing legislation. In this submission, the groups actively sought to have legislation amended to give local communities much greater control over the availability of alcohol, and made recommendations for the inclusion of a harm reduction objective in the Act and greater, non-discriminatory enforcement of existing provisions of legislation such as those dealing with sales to minors and intoxicated persons.[43] Unfortunately, to the extent that these recommendations conflict with the government's objective of increased deregulation of the liquor industry, it appears that their success will be limited.

In spite of the threat that such controls pose for individual liberty, many small Indigenous communities are showing they are prepared to sacrifice some freedoms for a reduction in alcohol-related harm. Their position has recently been supported by the Race Discrimination Commissioner, who favours amendments to the Racial Discrimination Act 1975 recognising community rights and public health concerns.[44]

Conclusion

For many people, Indigenous and non-Indigenous alike, alcohol is central to what Mill referred to as our 'tastes and pursuits', providing a pleasurable focus for much of social life. Among many Indigenous communities, however, in the past 20 or 30 years, excessive consumption and related harm have become so great that concerned individuals and organisations are demanding that action be taken to address these problems.

Indigenous societies themselves are changing in response to the ongoing colonial process. Within some, there has been an acceptance of aspects of the liberal model which have been accommodated within their world views. In some cases this has been facilitated by Indigenous views on the nature of personal autonomy. This can be seen in the AA-focused treatment programs which 'require the subordination of the particularities of the drinking self to the ideal universal, sober self which AA promotes and sustains'.[31]

In other cases Indigenous people have promoted interventions that theoretically confront Western ideals of individual liberty and autonomy. These have been most controversial where they include attempts to assert disciplined drinking regimes in communities of both Indigenous and non-Indigenous people. It is these contexts where conflicting notions of risk and liberty are most problematic. But, on balance, it appears that there is general community support for local-level structural interventions that may reduce some of the health and social consequences of excess. Ideological justification for this includes the 19th century notion espoused by Mill that Indigenous people require paternal intervention to realise their historic potential. Indigenous justifications have been both philosophical and practical. For some, regulating supply constitutes Indigenous attempts to gain some control over a problem created by colonisation and maintained by unequal power relations. For others, it is simply the most obvious and direct method to curb excessive drinking.

Structural interventions such as the regulation of supply have been more successful than attempts to treat alcohol-affected people. Our research indicates that Indigenous alcohol programs have increased in number over the past several years but they are patently too few to deal with a problem acknowledged as a primary contributor to Aboriginal ill-health and social disruption.

It is these circumstances that reinforce our belief that theories of both structure and action are required to understand the problems of and potential solutions to Indigenous alcohol abuse. Understanding the way in which the political economy of alcohol operates at the global and local level to influence the supply of alcohol is crucial, and Indigenous communities have shown they are prepared to tackle this issue by lobbying liquor licensing authorities so that they will consider health and

community concerns in their deliberations. They are demonstrating too their belief that local, Indigenously-controlled treatment programs and support services are necessary, but most are woefully under-resourced and there are simply too few to provide for the numbers of people requiring them.

Social scientists can contribute in two important ways to Indigenous attempts to deal with alcohol and its consequences. We need to critique and evaluate the models used to explain alcohol misuse, and the intervention programs either in place or planned, resisting monolithic solutions to what are very complex problems. More importantly, however, we have to use our knowledge of Indigenous communities and the wider societies in which they are located to refute the current outrageous lie that Indigenous health in general, and problems with alcohol in particular, are the consequences of personal choice.

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13. Supplying and promoting 'grog': the political economy of alcohol in Aboriginal Australia*

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Abstract

The deleterious effects of alcohol misuse among Aboriginal Australians have been well documented and are widely acknowledged by Aboriginal people. However, most academic discussion has attempted to explain the demand for alcohol by Aboriginal people. In this review we argue for an analysis of the political economy of Aboriginal alcohol use that also focuses on the supply and promotion of alcohol. Our own research and that of others demonstrates the utility of such an approach and the practical benefits it offers for harm minimisation strategies.

'Behind every blackfella getting drunk, there's a whitefella getting rich' (anonymous).

Introduction

Over the past few years, we have tried to explore the way in which the ill-health of Aboriginal Australians can be explained by their position within the political economy of Australia.[1–4] In the process it has become increasingly clear that alcohol plays a very significant role in Aboriginal ill-health.

Available evidence indicates that the pattern of drinking among Aboriginal peoples differs significantly from that found in the non-Aboriginal population (although perhaps not from some segments of it that occupy a similar social place in Australian society). Generally, the proportion of the Aboriginal population that does not consume

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alcohol is much larger than that among the non-Aboriginal population. However, among those Aboriginal people who do consume alcohol, more do so at harmful levels.[5–7]

The deleterious health and social consequences of excessive Aboriginal alcohol consumption—that is, consumption at levels which causes harm to both individual drinkers and those around them—are well documented.[8] It is responsible for an estimated 8–10% of Aboriginal deaths and contributes to high levels of morbidity.[9–11] For example, in Western Australia, it bas been shown that, in the period 1981–1990, hospital admission rates for alcohol-caused conditions were 8.6 times greater for Aboriginal men than for non-Aboriginal men, and 12,8 times greater for Aboriginal women than for non-Aboriginal women.[12] Although the relationship is not linear, excessive alcohol consumption also contributes to unemployment, family breakdown, child neglect and school absenteeism.[8] There is also widespread concern about the association between excessive alcohol consumption and violence in the home, and other forms of intra- and interpersonal violence.[13]

The problems associated with the excessive consumption of alcohol by some sections of the Aboriginal population are not only of concern to non-Aboriginal people. For many Aboriginal Australians alcohol is unambiguously implicated in 'too much sorry business'.[14, 15] Aboriginal people strongly expressed their concerns about the impact of excessive alcohol use to the Royal Commission into Aboriginal Deaths in Custody, and three-quarters of those interviewed for the National Aboriginal and Torres Strait Islander Survey identified it as a health problem.[8, 16]

Various strategies have been developed to treat, minimise or prevent the harm caused by excessive alcohol consumption among Aboriginal people, and much has been achieved.[8, 17] However, we suggest that these strategies have been constrained by the theoretical eclecticism of the analyses of Aboriginal alcohol use that largely have left unexplored the political economy of alcohol use.

Explanations of Indigenous alcohol use

Few dispute the evidence of excessive alcohol consumption by some segments of the Aboriginal population, and its direct and indirect consequences. However, as several reviews attest, there is little agreement on the cause of such consumption.[8, 13, 18–21] A variety of explanations for excessive consumption have been advanced. These include factors from one of four broad categories of determinants—biological, psychological, cultural and structural—or combinations of them.

Among Aboriginal Australians, the least research has been conducted into the role of biological factors. There are biochemical and physiological factors that influence individual responses to alcohol and its metabolites.[22] However, popular prejudice to the contrary, neither in Australia nor elsewhere among other Indigenous peoples is there evidence that such differences explain population differences in either patterns of alcohol consumption or its consequences.[23–25] Similarly, in the Australian literature, psychological explanations per se have not been widely advocated. Where psychological factors have been invoked, they are usually viewed as being consequential to other underlying factors. For example, Larsen sees alcohol abuse as reflecting 'a sense of maladjustment' as a result of non-Aboriginal discrimination.[26]

It is within the cultural realm that the broadest range of 'determinants' of excessive consumption has been identified. One of the most commonly advocated of these explanations of Aboriginal patterns of alcohol consumption has been the purported breakdown of Indigenous societies and cultures and consequent feelings of anomie and alienation.[27–29] However, studies that have demonstrated the changing but resilient nature of Aboriginal cultures have made this explanation untenable.[30, 31] Included in this category of cultural explanations are those that emphasise historical factors such as the purported absence of social controls on alcohol consumption in traditional societies; the learning of patterns of excessive drinking from the representatives of non-Indigenous society with whom they were most likely to come into contact, such as migratory workers; and the association of drinking and citizenship rights.[27, 32, 33] More recent cultural explanations emphasise factors such as the use of drinking as: a means of expressing Aboriginal values such as individual autonomy; a focus for group identity, solidarity and resistance to non-Aboriginal society; and a medium of social exchange.[34–37]

Structural explanations of excessive drinking emphasise the underlying importance of the dispossession of Aboriginal peoples and the continuing influence of colonialism, including poverty, exclusion from the mainstream economy and discrimination. Although there are numerous reports that cite the underlying importance of structural factors in the explanation of Aboriginal drinking, apart from a review by Khoury there are none that systematically explore their role.[38–41] Nevertheless, as Brady indicates, in support of broad structural explanations (as opposed to particularistic explanations focusing on the unique characteristics of Aboriginal peoples), similarities are often cited in patterns of consumption and alcohol-related harm between Indigenous peoples in Australia and those in other countries, such as the United States.[19]

These categories of explanation are often not exclusively invoked. Many employ models that explicitly theorise the relationships between particular sets of factors; others eclectically invoke a range of factors in loosely reasoned explanation.

Although biological and psychological explanations do not comprise a large part of the academic literature, they nevertheless inform much of both professional practice and popular views about Aboriginal alcohol consumption. This is most evident in the 'disease model'. In the variations of this model, 'alcoholism' or the 'alcohol dependence syndrome' is seen as a pathological state of addiction with physiological and/or psychological origins. This model, developed and elaborated in the United States and Britain, is ideologically underpinned by a liberal, individual-centred view of humankind and individual responsibility. Although the model has been subject to academic critique, particularly for its neglect of cultural and broader social factors, it continues to be influential.

Based on the critique of the disease model is the so-called 'public health model'. Following Zinberg, proponents of this model emphasise the need to consider the drug (in this case alcohol) and its biochemical effects, the psychological state of the person using it, and the environment in which use takes place.[42] In the area of Aboriginal studies, the most notable advocate of this approach has been Brady.[19] Clearly, attempts at a comprehensive explanation of Aboriginal drinking are to be applauded. However, the public health model suffers from the shortcomings of the general systems theory approach on which it is based. That is, it accords no theoretical priority to any one set of factors and hence provides no theoretically consistent explanation of the interrelationships between those factors, their relative importance, and excessive consumption.[43]

As anthropologists working from a political economy perspective, explanations giving primacy to structural factors are closest to our own. However, in our view these often share a serious shortcoming with the other approaches. That is, they usually seek to explain the reasons for the excessive demand for alcohol by some sections of the Aboriginal population. However, it is an economic axiom that the level of consumption is a function of both demand and supply.

Reviews of the general literature by Room, Single, and Holder demonstrate that, with increases in the availability of alcohol, per capita consumption within populations increases; and that, with increases in consumption, there is an increase in alcohol-related health and social problems.[44–46] Factors that affect the overall availability of alcohol include types of control systems, restrictions on distribution (i.e. trading hours/days, age limits, advertising), density of outlets, pricing and taxation; and these have been shown to have an impact on consumption not only by 'social' but also by 'heavy' drinkers.[45] Furthermore, density of outlets is not simply a response to demand but also acts to stimulate it.[47]

Few writers have addressed these issues in an Aboriginal context. When they are addressed, it is usually in the practical context of curbing Aboriginal demand, rather

than as an independent factor in a theoretical model of excessive consumption. An adequate political economy of Indigenous alcohol use needs to address the structural factors underlying both supply and demand, and to situate psychosocial factors within that explanatory framework.

The political economy of alcohol

The political economy perspective to which we have referred places individuals and social and cultural phenomena 'within an examination of the circumstances associated with getting a living and the structures of power that shape and constrain activity' (p. 179).[48] That is, while acknowledging the role of biology, individual psychology and culture in determining human behaviour, these are theorised as shaped and constrained by broader political and economic factors.

The first to apply such an approach to the study of alcohol use was Engels, who demonstrated the political and economic determinants of heavy drinking among the working class in 19th century England.[49] Singer identified six specific insights in Engels' work:

- abusive drinking is both a health and social problem;
- alcohol consumption is influenced by social conditions;
- social drinking can be an act of class solidarity;
- consumption rates and the level of related problems are linked to availability of alcohol;
- the state either promotes or facilitates the availability of alcohol; and
- producers view the alcohol market as an expandable arena for profit-making.[50]

In a review of the anthropological and related social science literature, Singer argued that failure to address the range of issues raised in this political economy approach was a serious impediment to understanding excessive alcohol use, especially among Indigenous peoples and in Third World countries. He also argued for the need to go beyond Engels, and to look at issues such as the use of alcohol as a labour control mechanism and the focus on 'alcoholism' in biomedical and related treatment. According to Singer, a political economy of alcohol use should be concerned with:

> … the larger structures, patterns and processes that create the settings, bring into being social groups, produce and promote the intoxicants, and generate the motivations for prodigious consumption (p. 116).[50]

These understandings have informed alcohol studies among the general population in Australia.[51] However, while non-Aboriginal researchers have parenthetically referred to the role of multinational alcohol corporations in the supply and marketing of beer and cheap wine,[17] there has been no sustained examination of this and related issues.

Nevertheless, some Aboriginal people are demonstrating a broader understanding of the issues. In New South Wales (NSW) the Aboriginal Legal Service, on behalf of three Aboriginal 'alcoholics', mounted a claim against the Commonwealth government and Australian alcohol companies on the basis that the companies had encouraged them to drink alcohol and that the Commonwealth had failed to properly control its manufacture and distribution.[52] The case was subsequently rejected by the NSW Supreme Court in May 1992. However, similar cases are exploring the fiduciary duty of care the Commonwealth has to Aboriginal people, and they reflect a growing consciousness among Aboriginal people that drinking is part of a wider network of political and economic relationships that need to be made explicit.[53]

The political economy approach we advocate directs attention away from Aboriginal people to the wider network of relationships in which their lives are lived. It directs attention from a focus on Aboriginal demand for alcohol towards questions of how demand is created and how supply of alcohol is promoted. In the following sections, we focus on two aspects of this: the role of both the alcohol industry and the state in promoting alcohol consumption; and attempts to reduce excessive consumption through limiting the availability of alcohol. In doing so, we highlight a growing number of studies—some acknowledging many of the core understandings of a political economy of alcohol—which can contribute to such an approach.

Profit seeking by the alcohol industry

Marcia Langton sees the focus on the misuse of alcohol by Aboriginal people in Australia as part of a colonial construct of the 'drunken Aborigine' that:

> … glosses over the economic facts of the distribution of alcohol. The icon also deprives the set of problems involved in the misuse of alcohol by Aboriginal people of the contradictions, ambiguities and subtleties to do with the social use of alcohol in Aboriginal and non-Aboriginal societies. The 'drunken Abo' does not require that the economic and political factors which lead to and perpetuate the misuse of alcohol be understood or that any theoretical approach which might include such questions as 'Who benefits from the distribution of alcohol to Aboriginal people? Who profits?' be developed. Such questions are quite simply unnecessary to the discourse of racial superiority.[53] (p. 199)

Clearly, although they are not the only ones to do so, those who profit most directly from the sale of alcohol to Aboriginal people are those who produce and those who sell alcohol, and increases in those profits are primarily dependent upon increases in consumption.

It is in the interest of national and multinational producers of alcoholic beverages to increase consumption of their products in all segments of the market. However, as Aboriginal people comprise only a small segment of the national market they are not directly targeted in alcohol promotions. Rather, it is at the regional and local levels,

where Aboriginal people represent a larger market segment that direct promotion, by retailers, takes place.[†]

A study of the use of sex shows to sell alcohol in Tennant Creek provides some answers to Langton's questions.[54] A decline in the town's economic fortunes following the closure of the meatworks and downturns in mining in the mid-1980s led to increased promotion by local licensees to attract a share of the reduced market. The Tennant Creek Hotel, historically a place for Aboriginal drinkers, was bought out in 1987 by Australian Frontier Holidays, which had previously used sex shows to promote alcohol sales elsewhere in Australia. Sex shows in the Tennant Creek Hotel included live sex acts, audience participation and the presence of underage drinkers. Although there is little evidence that the shows targeted Aboriginal people specifically, the presence of only one other hotel and the large Aboriginal patronage of the Tennant Creek Hotel led many Aboriginal people to believe they were the objects of a concerted campaign.

An anti-sex show coalition of local politicians, Aboriginal elders, public health practitioners, Anyinginyi Congress (the local Aboriginal-controlled health service) board members and others were pitted against miners, cattlemen, hotel owners and others who wanted the shows to continue. Hotel owners bowed to public opinion only after adverse publicity seriously affected the national image of Australian Frontier Holidays and led to local boycotts of the hotel. Subsequent changes to the Liquor Act:

> … made it compulsory for licensees to warn the public that the shows were on, to conduct them behind closed doors, not to allow audience participation and to keep a specific distance between the strippers and audience.[54] (p. 363)

The importance of the action, for our purposes, is the clear connection made by Aboriginal and other participants between the availability of alcohol and alcohol-related problems, and the perceived need to identify those instances where the profit motives of the liquor industry are opposed to the public interests of Aboriginal individuals and groups. Subsequent to this action, an interagency group formed a 'Beat the Grog' campaign and resolved to: oppose new liquor licences and alcohol sales promotion; demand strict enforcement of laws on underage drinking and sale of alcohol to intoxicated people; and support grog-free concerts, further reduction in trading hours, and the declaration of more alcohol-free living areas in communities.[54]

The sex show debate was part of broader concerns over alcohol in Aboriginal communities. In response to this wider debate, the Northern Territory government established a Sessional Committee on the Use and Abuse of Alcohol by the

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[†] A complicating factor here is the increasing purchase of liquor outlets by Aboriginal groups who may then contribute to excessive consumption by providing easy access to alcohol in order to increase profits that come to the community. This issue requires detailed analysis of the ways in which Aboriginal communities are linked to the broader structures of alcohol supply and promotion, both at the macro and micro levels.

Community. The Committee's recommendation that a special liquor tax be introduced was adopted by the Northern Territory Legislative Assembly, raising $10 million annually for alcohol prevention, rehabilitation and treatment programs. Aboriginal and other community groups have subsequently benefited from these funds.[54]

Recent research by one of us (DG) and our colleagues in Western Australia with Aboriginal community-controlled agencies identified a number of other strategies used by local suppliers of alcohol to increase their market share among Aboriginal patrons. These included sales to minors and intoxicated persons, credit sales, promotion of low-cost high-alcohol beverages, early trading, and reduction of costs by not providing appropriate levels of amenity on their premises.[55] These practices were not investigated in detail, and there is a real need for local-level studies of the way in which alcohol is promoted and sold to Aboriginal patrons.

The role of the state

The role of the state (that is, the legislative, judicial and administrative arms of the Federal and state/territory governments) with regard to the consumption of alcohol among Aboriginal people cannot be considered apart from its broader roles. From colonial times, the Australian state has 'mobilised public resources for private gain' (p.15).[56] That is, the state has acted to promote the interests and development of the private sector. Despite the rhetoric of aggrieved or extreme advocates of private enterprise, no government has acted in a contrary manner. However, it has not done so in an untrammelled way. In order to maintain its legitimacy, the state must be seen to be responsive to the concerns and welfare of a broader constituency.

Since the establishment of the first British colony in Australia, the state has provided encouragement and support to the alcohol industry (or sections of it). It has done so in the interests of the industry itself and because of the revenue the state obtains through various forms of taxation, licensing fees and excise duties. Nevertheless, the state has had to balance competing interests and, at various times, has acted to curb levels of alcohol consumption. Such restrictions have been put in place when levels of consumption and its consequences have been perceived by sections of the private sector as threatening the productivity of workers, as being a disproportionate cost to government and/or taxpayers, or as being disruptive of social life. When such threats have receded, restrictions have been relaxed.[57]

At times such as the present, when the service industries are increasingly dominating the economy, the support by the state for the liquor industry has been particularly explicit. For example, the objectives of the Western Australian Liquor Licensing Act 1988 include:

- to regulate and contribute to the proper development of the liquor, hospitality and related industries in the State;

> • to cater for the requirements of the tourism industry; (and)
> • to facilitate the use and development of licensed facilities …[58]

Such legislation provides a framework that facilitates efforts by various segments of the alcohol industry to vigorously promote and sell their products. The thrust of this legislation is to regulate the industry per se (rather than the impact of alcohol on the community) and to ensure its economic viability. Furthermore, various provisions of the Western Australian legislation purportedly designed to facilitate community input actually serve to hinder community attempts to restrict the availability of alcohol. Such provisions include measures for advertising licence applications that are inaccessible to particular groups, especially Aborigines, and cumbersome procedures for the lodging of complaints.[55]

Aboriginal affairs policy

As well as its policies with regard to the promotion of the private sector in general and the alcohol industry in particular, when examining the role of the state with regard to Aboriginal alcohol consumption it is also necessary to consider specific policy towards Aboriginal alcohol consumption and broader Aboriginal affairs policy. In the past 200 years the state has had, and continues to have, a significant role in the lives of Aboriginal people—even attempting to define who is and who is not Aboriginal, and the degree of Aboriginality. While not completely successful in its aims, for most of this period the state has sought to impose limitations on the availability of alcohol to Aboriginal peoples.

In the 19th century, it was the official policy of the British colonial governments that the interests of Aboriginal people should be 'protected' (although the meaning of this was limited). Part of this protection included prohibition of the supply of alcohol to Aboriginal people, and various pieces of legislation were passed giving effect to this.[17, 57, 59] Such prohibition was not all altruistic; in part it was a response to the colonists' fears and sensibilities about the behaviour of intoxicated Aboriginal people.

Despite official policy, however, Langton has shown how alcohol was used:

> … unconsciously or consciously as a device for seducing Aboriginal people to engage economically, politically and socially with the colony.[53] (p. 201)

Brady also cites accounts of early colonial life where Europeans enticed Aborigines with alcohol so that they would fight or provide sex.[17] Furthermore, again in the interests of the private sector, in Western Australia early prohibition on the supply of alcohol to Aboriginal people specifically excluded employers, who were permitted to pay Aboriginal employees with alcohol rather than wages.[60]

From the 1920s through to the 1960s, access to alcohol was a potent symbol in the attempt by various governments to assimilate Aboriginal people. Among the benefits

of citizenship granted to those who limited their contact with other Aboriginal people and who adopted a European lifestyle was the 'right' to purchase and consume alcohol. Conversely, withdrawal of citizenship was a sanction imposed on those who were frequently inebriated or who used their right of citizenship to purchase alcohol for others.[17, 61]

In the 1960s, as a consequence of Aboriginal resistance to assimilation, increased international scrutiny and dominance of liberal ideology, Australian governments began the repeal of legislation that restricted the rights of Aboriginal people and adopted the policies first of integration and then self-determination/self-management. These legislative and policy changes included the: provision of the right to vote in 1962; constitutional amendment to count Aboriginal people as Australian citizens in 1967; and relaxation of restrictions on the availability of alcohol to Aboriginal people. (It should be noted, however, that at least in Western Australia there remain in force legal provisions against street and park drinking which impact disproportionately against Aboriginal people.[55]) Given the historical connection between citizenship and the right to consume alcohol, and the temporal juxtaposition of these legislative changes, many Aboriginal people came to regard alcohol consumption almost as an obligation of citizenship, and is itself an important factor in Aboriginal consumption patterns.[17]

Elsewhere we have argued that, despite attempts at amelioration, the ill-health of Aboriginal people is a direct consequence of Aboriginal affairs policies and practice.[1, 3] Similarly, the excessive consumption of alcohol and resultant harm among Aboriginal people is a consequence of the same policies. Those policies have created the social groups and the conditions which have had the indirect consequence of promoting consumption through the stimulation of excessive demand for alcohol.

The excessive demand for alcohol among sections of the Aboriginal population is recognised by both Aboriginal and non-Aboriginal people as linked to colonial relations of dependence, and powerlessness,[20, 34, 35] experiences shared by Indigenous peoples the world over.[19, 62]

> Tangentyere [Council] recognises that alcohol abuse is only a symptom of an even more profound distress in contemporary Aboriginal life which flows directly from people's experiences of colonisation, their brutal dispossession and removal from traditional lands and from continuing assaults on their culture and community.[63] (p.14)

Apart from the dispossession of Aboriginal people and their marginalisation from the dominant economy, colonialism in Australia created different levels of Aboriginal sociality, and these creations have exacerbated the consumption of drinking and its control. For example, Aboriginal people from different language and clan groups were herded into government settlements run by welfare authorities or missionaries, and subsequently came to be known as 'communities'.[64] Most of these settlements were marginalised economically, socially and politically from mainstream society.

Aboriginal people from these so-called communities in Western Australia, South Australia and the Northern Territory subsequently formed the nucleus of heavy drinking camps with associated high levels of alcohol-related harm.[34, 36, 65]

Control of availability

Although Aboriginal affairs policy has had the presumably unintended consequence of promoting alcohol consumption and, over the past three decades, legislative change has had the effect of increasing the availability of alcohol to Aboriginal people, some sections of Aboriginal communities have sought to reduce excessive consumption through controls on the availability of alcohol. These attempts highlight ideological differences within both Aboriginal communities and the wider society, and the ambiguous role of the state.

The issue of the rights and responsibilities associated with alcohol and citizenship have been thoughtfully addressed by Rowse. Using a Foucauldian perspective, he illustrates how:

> … the content of 'citizenship' is not only variable historically (through time) and culturally, but is also subject, in any one time/jurisdiction, to disjoint logics (or 'rationalities') of government.[66]

He shows that the 'progressive liberalism' which, in the 1960s, sought to improve the conditions of Aboriginal peoples by arguing for an end to legal inequalities between Aboriginal and non-Aboriginal Australians, now 'constitutes a new conservatism' which opposes Aboriginal attempts to control availability of alcohol and reduce its harm on the same grounds.

Counter to this, political progressives have proposed an alternative construction of rights based on notions of the rights of cultural groups. This would allow Aboriginal community groups to control the availability of alcohol on the grounds that non-Aboriginal drinking patterns are:

> … neither culturally suitable nor sufficiently accessible to be put into practice by most Central Australian Aborigines.[66] (Memmott cited in Rowse p. 395)

The Race Discrimination Commissioner has taken the matter of the collective rights of groups further in the Alcohol Report and recommended changes to the Racial Discrimination Act 1975 to ensure that collective rights in areas such as alcohol distribution have legal status (p. 154).[67] This would enable community interest to be defined more narrowly in terms of the health and social consequences for people living in specific areas. However, such a definition is problematic. This approach challenges a widely-asserted view of the autonomy of the individual in Aboriginal communities (based on both traditional values of being one's own 'boss' and the

historical link between citizenship and the right to drink), and the consequent difficulties in controlling drunken behaviour.[17]

This ideological conflict is reflected also in the non-Aboriginal community. As Lyon notes, in the Northern Territory there has been a fluctuation between an economically 'wet' approach supporting increases in government control over the availability of alcohol and, to a lesser extent, spending on programs; and a 'dry' approach, favouring individual responsibility, free enterprise and small government.[63] In Lyon's view, the extent of alcohol-related problems in the Territory warranted the former approach. It is a view shared by many Aboriginal people. In the words of Iamampa:

> The Liquor Commission is not interested in us and is not listening to us ... We have been talking for too many years and too many people are dying, and still nobody wants to make the hard decisions to help our people' (in Lyon, p.13).[63]

At the same time as these philosophical and political debates are occurring, Aboriginal and non-Aboriginal groups have been pragmatically attempting to limit the sale and consumption of alcohol by legislative means. d'Abbs has identified three approaches aimed at restricting the consumption of alcohol within certain areas:

- The community control model, embodied in Western Australia's Aboriginal Communities Act 1979, enables some Aboriginal communities to establish their own by-laws to regulate alcohol consumption (among other things), but provides little support for enforcement of those by-laws.
- The statutory control model is exemplified by provisions of the South Australian Liquor Licensing Act 1985, which enables local councils to apply to have certain areas declared 'dry', and by provisions of the Northern Territory Summary Offences Act (the 'Two Kilometre Law'), which make it an offence to consume alcohol in a public place within 2 km of a licensed premise.
- The complementary control model combines both community and statutory control. It is exemplified by provisions of the Northern Territory Liquor Act 1979, which enables Aboriginal communities to apply for various restrictions on availability and provide for enforcement of those provisions.[68]

Important philosophical differences underlie these models. While the community and complementary control models aim to give varying degrees of control to Aboriginal people, most commentators see the 'Two Kilometre Law' as a transparent attempt to clear the streets of Aboriginal drinkers while doing nothing to address the underlying problems. Designated alcohol-free zones in NSW have apparently served a similar purpose.[69]

In reviewing the success of these models of control, d'Abbs stresses the need to separate concerns about public drunkenness from those of prevention of alcohol abuse. Policies to deter public drunkenness should not impede individuals or groups from acting against alcohol-related harm. He claims that restricted area policies will

be successful only if they promote the capacity of Aboriginal individuals and groups to control the use of alcohol, and that they require support to enforce restrictions, given the vested interests in the sale and promotion of alcohol and widespread desire for drinking. For these reasons, d'Abbs supports the complementary control model, particularly the restricted area provisions of the Northern Territory Liquor Act (p. 32).[68]

There are a number of studies describing attempts at restricting alcohol consumption under these legislative arrangements.[63, 68–71] The general consensus appears to be that they have been a qualified success. Reviewing Northern Territory initiatives in the early 1980s, Larkins and McDonald cite the improved standards of licensed premises, easier public access to the licensing and review process, restricted areas designation, and restrictions on trading hours for takeaway sales as well received by Indigenous people and health and welfare agencies, if not the liquor industry.[70]

Attempts to restrict the availability of alcohol under various liquor licensing legislation have been pushed even further by community groups. In November 1992, as a result of petitioning by the Halls Creek Alcohol Action Advisory Committee in Western Australia, the Director of Liquor Licensing placed restrictions on the sale of packaged alcohol in the town. Under the new regulations, the sale of packaged alcohol is prohibited prior to midday on any day, and flask and cask wine may only be sold between 4 pm and 6 pm with a limit of one cask or flagon per person.[72]

A 13-week trial of 'grog-free days', which will prohibit trading in hotel front bars and bottle shops on Thursdays in Tennant Creek, has also been announced recently. It is the first time bans have been imposed on non-Aboriginal as well as Aboriginal people in an Australian town with a majority of non-Aboriginal residents (3000 total population with about 35% Aborigines). They result from an appeal to the Northern Territory Liquor Commission by women from the local Julalikari Association. The bans have been opposed by alcohol retailers in the town, one of whom estimated that the ban had cost her $5000 or half her week's earnings in the first week of operation. Local Aboriginal women, however, had no reservations:

> We are pretty happy with it and the old people too. It's the first time they have had decent sleep.[73]

Aboriginal attempts to restrict alcohol sale and consumption demonstrate an understanding of the link between availability and excessive consumption and the need:

> … to remove alcohol from an everyday item and return it to its position as a special substance, a drug which must be treated with caution.[15] (p.23)

Implications for prevention

What then are the practical implications of a political economy approach to alcohol in Aboriginal Australia? We are not suggesting that current attempts to limit the demand for alcohol at an individual and community level should be de-emphasised. Individual and group acknowledgment of alcohol-related harm, and willingness to accept responsibility for it are crucial. The development of a wide range of Aboriginal-controlled treatment programs throughout Australia reveals an acknowledgment of that responsibility. But this alone is not sufficient.

A focus on the question of supply and promotion provides immediate limits to the availability of alcohol, and it is something pragmatic that Aboriginal groups can achieve. Throughout Australia, Aboriginal groups have shown their willingness to control the supply of alcohol in order to minimise its harmful effects and to take action to limit its promotion.[14, 17, 54, 55] What they need are more clearly defined targets for their energetic responses.

The focus on supply also spreads the responsibility for alcohol-related harm more equitably within the Australian community. Aboriginal people and health and welfare advocates are insisting that the state and its agencies, such as Liquor Licensing Commissions, accept the responsibilities they have with respect to the supply and promotion of alcohol to Aboriginal people. Aboriginal community organisations such as the Aboriginal Justice Council in Western Australia have suggested measures which include all of the following: the increase of licensing fees for full-strength alcohol and corresponding reductions for low-strength drinks; decriminalisation of public drunkenness; the provision of minimum standards for amenities on licensed premises; stronger laws to facilitate prosecution of licensees serving juveniles and intoxicated persons, and those transporting liquor onto 'dry' communities; simplification and development of more appropriate complaint procedures; and appointment of local inspectors to ensure that licensed premises comply with the law, and to negotiate local resolution of disputes.[55]

Much of the effort to control the availability of alcohol in Aboriginal communities has focused on the need to reduce the demand for the substance. This necessarily means that attention is directed to Aboriginal drinkers rather than to the alcohol producers and promoters who aggressively seek to increase their market share when health authorities the world over are arguing for moderation, and to the agencies of the state that have the legislative authority to limit market expansion but which, for ideological reasons, may prefer the excesses of the free market. These are the kind of relationships a political economy of alcohol in Aboriginal Australia needs to explore.

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14. Explanations of Indigenous alcohol use*

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Stereotypes such as those of the 'drunken Aborigine' or the 'drunken Indian'—stereotypes that have been described as 'firewater myths'—are simply not tenable.[1, 2] Not all Indigenous people are heavy drinkers, and significant proportions either do not drink or do so moderately—although, at the aggregate level, larger proportions of Indigenous populations consume alcohol in a harmful fashion.

In this chapter, we will examine some of the various, and sometimes contradictory, perspectives on Indigenous alcohol consumption. In doing so, we—though not all of those whose views we discuss—are not trying to explain why Indigenous people drink. Like people in many societies, Indigenous people drink for a variety of reasons: to become intoxicated to some degree or other, as part of social interaction, to relieve stress. What we are trying to explain is why there are higher rates of harmful alcohol consumption and related harm among Indigenous peoples than among non-Indigenous people in the societies of which they are both a part.

Some have seen this as a fruitless task. For example, Storm (cited in McKenzie p. 61) has written:

> Sorting out cause and effect within this complex of social problems is difficult and may not be worthwhile.[3]

We strongly disagree with this position. The problem of explanation should not be shied away from simply because it is complex; and, more importantly, to do so means that we are ill-equipped to find adequate solutions to the misuse of alcohol and its consequences.

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Biology

In the 16th century, Western European powers began a series of conquests aimed at the colonisation of the far corners of the globe. The conquerors came in search of luxury goods and wealth, and later for raw materials and markets for the products of their industrial revolutions. The conquered peoples were regarded variously as savages, barbarians, heathens, and even as less than human; and the conquests were rationalised in terms of civilising or Christianising these 'inferior' peoples. The notion of European 'superiority' was characterised initially in terms of morality; but in the latter half of the 19th century this became wedded to a bowdlerised version of Darwinian evolutionary theory which attributed it to biological fitness.

The notion that Indigenous peoples were biologically inferior struck a chord with European notions of ethnocentrism and gained widespread popularity. It also complemented 'upper'-class notions of superiority and was used to 'explain' and justify inequalities within European societies. It gave rise to the eugenics movement and, in its most extreme form, was a pillar of the ideology of Nazism. Among significant segments of popular opinion, this biological reductionism is still used to 'explain' differences between ethnic groups, including different patterns of alcohol use and their consequences.

In the 1970s, a number of attempts were made to examine whether or not there were genetic differences that affected the response to alcohol. Attention in these studies focused on differences in the rate at which alcohol is metabolised. Underlying these studies was the notion that, if they consumed an equivalent amount of alcohol—when controlling for other factors such as body size and body composition—groups which metabolise alcohol more slowly should maintain and/or build up higher levels of blood alcohol, thus becoming and remaining intoxicated for longer than those who metabolise it more quickly.

Among the first of these studies was one undertaken by Fenna, Mix, Schaefer and Gilbert.[4] They administered similar doses of alcohol to Whites, Eskimos and 'Indians', and calculated that the amount of alcohol in grams metabolised per kilogram of body weight per hour in each group respectively was 0.1449, 0.1098 and 0.1013. However, a similar study of alcohol metabolism in Whites, Chinese, and Ojibwa 'Indians' by Reed, Kalant, Gibbins et al. produced contradictory results.[5] They found that the 'Indian' group metabolised alcohol at significantly greater rates than both Chinese and Whites: 182.7 mg/kg/hour versus 136.6 and 103.6. In a study conducted in Hawaii among Whites, Chinese and Japanese, Hanna found that both Chinese and Japanese subjects (who are genetically more closely related to Indigenous Americans than to Whites) metabolised alcohol more rapidly than Whites,[6] thus lending some support to the finding of Reed and his colleagues.

A similar study was conducted in Australia among a small group of Aboriginal and non-Aboriginal prisoners by Marinovich, Larsson and Barber.[7] They found that, although there were wide differences in the rates of alcohol metabolism between individuals, there was no significant difference in the mean rates in each group, which were 17.7 mg/100 ml blood/hour for Whites and 18.1 for Aborigines. They wrote that:

> Considering these factors we must conclude that there appears to be no genetically determined difference in blood alcohol degradation between Aboriginals and whites.[7]

In recent years, attention to the biological basis of 'alcoholism' (alcohol dependence) has shifted from rates of alcohol metabolism to the role of genetically-determined variation in dopamine D_2 receptors in the brain.[8, 9] Dopamine is a neurotransmitter, the release of which is stimulated by alcohol (among other chemical compounds). It has various effects, one of which is to induce feelings of pleasure when it attaches to D_2 receptors in certain brain cells. The number of these receptors is determined by one of two alleles (variants of a gene). In brain samples from deceased persons, Noble and his colleagues found that the allele which genetically codes for fewer receptors was more common in deceased 'alcoholics' than in non-alcoholics, and that there was no difference between Caucasian and Black subjects.[9] They hypothesised that people with a lower number of receptors '… may need a very strong stimulation of their fewer receptors' (emphasis added) and thus seek the stimulation provided by alcohol.

As Karp has pointed out, while some research groups have conducted similar studies that appear to confirm this result, others have failed to find an association.[10] Forgetting the major issue of what constitutes 'alcoholism', as Saunders and Phillips point out, the relationship between 'alcoholism' and the presence of the D_2 receptor remains simply an association—that is, no causal relationship has been demonstrated.[11]

It is important to emphasise here that we are not denying that there are biochemical and physiological factors which influence individual responses to alcohol and its metabolites. Clearly there are.[12] However, popular prejudice to the contrary, there is no firm evidence that these differences cause the misuse of alcohol or that they explain differences between populations in patterns of either alcohol consumption or its consequences.

Alcohol dependence as 'disease' or dysfunction

The rise of industrial capitalism in Western Europe and the United States was accompanied by the growth of the values and ideology of liberalism. As we have written elsewhere, liberalism emphasises the 'right' of individuals to pursue their

interests (particularly economic interests) unfettered by the intrusion of the state (see chapter 12 in this volume).[13] It is the now the dominant—though not un-contested—ideology in Anglo-Western societies.

For John Stuart Mill, perhaps the most articulate proponent of liberalism, the use of alcohol and other drugs was simply the act of independent people rationally exercising their 'tastes and pursuits'.[14] This view was congruent with an older one in which the excessive use of alcohol was perceived as being a moral problem. That is, individuals who used alcohol excessively were seen as doing so from choice, and were held to be morally culpable for that choice.

In the early decades of this century, a change occurred in the way excessive alcohol use was viewed. On the one hand, there were novel elements in this view. Individuals with alcohol problems came to be viewed as 'sick' rather than 'immoral'. On the other hand, observations that the problem of alcohol misuse is not evenly distributed across all segments of populations—as it would be if the problem was an individual phenomenon—were disregarded. In accord with the underlying liberal ideology, the problem remained located at the individual level.

This sickness or disorder was characterised by a craving for alcohol and loss of the ability to control the level consumed. Two explanations of this approach emerged. The first saw this loss of control primarily as the manifestation of a physical disease, 'alcoholism'. Although there are some variations in definition, generally those who view it as a disease characterise it as occurring among individuals who, among other things: are genetically predisposed; are physiologically dependent upon alcohol (that is, they are so accustomed to its intake that they suffer withdrawal symptoms on cessation of drinking); and suffer alcohol-related brain damage which further impairs their ability to control their level of consumption.[15] The second approach viewed the excessive consumption of alcohol as a psychological disorder characterised in terms of an uncontrolled craving for alcohol, which was often a manifestation of underlying psychopathology. It should be noted, however, that these are primarily differences in emphasis, for proponents of both views usually acknowledged elements of the other approach.

These concepts of alcohol misuse are not uncontested. In 1970s, the term 'alcoholism' was removed from the International Classification of Diseases because no agreement could be reached on its definition. It was replaced by 'alcohol dependence syndrome', defined in terms of observable physical aspects and separating these from behaviour and affective factors whose ætiology is more controversial.

As indicated previously, the evidence for a genetic predisposition to alcohol abuse is equivocal. Some genetic markers have been identified which are associated with 'alcoholism' but a causal link remains to be clearly demonstrated. The issue of

establishing such a causal relationship is further complicated by the lack of agreement on what constitutes 'alcoholism'.

Except where they are linked specifically to notions of population-based genetic differences, the concepts of 'alcoholism' and 'alcohol dependence' are rarely invoked to explain differences in the frequency of excessive alcohol consumption between population groups. This is because, as indicated previously, they are explanations which focus on the causes of excessive drinking in individuals, and in these approaches broader social differences in the patterning of excessive alcohol consumption are largely ignored. Nevertheless, as we will discuss later, these approaches have been particularly influential in Indigenous treatment programs.

In a widely cited paper, O'Connor has argued that excessive alcohol consumption by Indigenous Australians cannot be explained by the same theories used to explain alcohol dependence in the non-Indigenous population.[16] He reports that, depending on the social environment in which they are located, individuals who might be classified as heavy drinkers demonstrate an ability to abstain from or control their drinking in ways that are inconsistent with the behaviours of persons who are alcohol-dependent in terms of the criteria discussed above. This is consistent with our own observations in a town in the north-west of Australia where individuals who were referred to as 'alcoholics' by medical and nursing staff were able to completely abstain from drinking for periods of weeks, and sometimes months, when they went to work on pastoral stations. It is also consistent with Levy and Kunitz' findings among the Navajo people that:

> … most of the individuals in this study who did become aware that alcohol consumption is more costly than it is worth were apparently able to stop drinking with little difficulty, regardless of whether they were in a treatment program and whether intensive follow-up treatment was provided. This indicates to us that excessive drinking amongst most Navajos does not originate in the same pathological motives as it does among Anglo alcoholics. The behaviors are labelled the same because they look the same, and often produce the similar end results.[17]

The application of the disease model to Indigenous societies has also been criticised on the basis of its ethnocentrism, a point made above in terms of the liberal ideology which underlies it. In this regard Heath has written:

> … although drinking—and even heavy drinking—is widespread among North American Indians, with episodic drinking being both commonplace and condoned in many groups, the concept of alcoholism, or even problem drinking is relatively rare. … it is not banal to underscore the crucial—and often ignored—fact that problems are in the eye of the beholder.[18]

While we strongly contest the view that excessive alcohol use is a 'disease', we are not denying that among some Indigenous people problem drinking is a manifestation of psychopathology or a response to psychological trauma. However, to view the observed patterns of excessive alcohol consumption among Indigenous peoples as simply the sum of individual differences is to tear them from the social contexts in

which they occur. Much of the psychological trauma among Indigenous people is a consequence of the continuing legacy of colonialism, and although the trauma requires treatment the underlying causes must be addressed.

Loss of culture and culture change

By the early years of this century, the Indigenous populations of Australia, New Zealand and Canada were again increasing in size after the devastation wrought by early colonisation. No longer could they be regarded as remnants of dying populations, to which the only responsibility of governments was to 'smooth the dying pillow'. As in the United States, the response of governments in all three countries was to seek to assimilate Indigenous peoples.

But assimilate them to what? All three countries had been British colonies, most migrants to each had come from the British Isles, and each was dominated by a political and economic elite that was British or of British descent. The culture of this group was held up as the ideal which all members of society should seek to attain in a process leading to homogenous societies. Of course, this ideal did not reflect reality. In Canada, there was a sizeable French population and, in all three countries, migrants also came from other parts of Europe. These groups were variously integrated into the political and economic life of the three countries and maintained important cultural differences. Nevertheless, the ideology of homogeneity prevailed.

This ideology was reflected in the functionalist anthropological and sociological theory of the day. Societies were conceived as organic wholes, in which institutions and values functioned to preserve the integrity of society. Those groups that did not behave like, or subscribe to the beliefs and values of, members of the wider society presented an anomaly, and various studies were undertaken to explain these 'deviant' subcultures.[17]

Inevitably, similar perspectives were applied to the study of Indigenous peoples. Central to this was the notion that, with few exceptions, Indigenous peoples had 'lost' their cultures. According to this perspective, there were two aspects to this loss: Indigenous people were in a state of 'anomie' (or normlessness), or were in a state of stress as a consequence of difficulties acculturating (or assimilating) to the supposedly homogenous wider society.

The concept of anomie was first developed by the French sociologist Emile Durkheim.[19] Durkheim used it to describe a 'pathological' state of society in which consensus on social norms had broken down as a consequence of industrialisation and modernisation, and increasing individuation. As Merton noted, later writers

extended the term to include the state of mind of individuals living in such a society.[20] Subsequent writers applied the concept and related theory in analyses of the state of Indigenous peoples. As a result of colonisation, Indigenous cultures were regarded as having irretrievably broken down and been lost. As a consequence, Indigenous people were seen as having lost traditional roles, and as having no social rules to guide their behaviour, nor institutions which could exercise effective social control over behaviour. It was argued that this supposed breakdown of culture was manifested psychologically in loss of individual autonomy, identity and self-esteem, and alienation from both traditional and colonial cultures.

Related to the notion of anomie is that of acculturative stress. In this conceptualisation, Indigenous peoples were seen as accepting the goals and values of the wider societies and attempting to assimilate into them. However, their attempts were restricted by a variety of factors including discrimination, poverty and lack of skills. As McKenzie has written:

> Only about two generations of Aboriginal Canadians have made contact with the mainstream population. To some extent, their integration with the population has met with great frustrations because Aboriginal Canadians need to acquire certain skills to adapt to the patterns of the larger society. This situation placed certain stressors on Aboriginal communities.[3]

Various writers have argued that high levels of alcohol consumption among Indigenous peoples are a means of dealing with the psychological distress caused by either anomie or the frustrations arising from not being able to achieve the goals they have adopted from the wider societies.[21–24]

This explanation of higher levels of alcohol consumption among Indigenous peoples has been criticised from two perspectives. First, extensive field research undertaken among Navajo people in the United States by Levy and Kunitz found that the explanation was not supported by the pattern of consumption among subgroups of the population. In contradiction to the theory:

> … the highest intensity of involvement with drinking and the greatest use of alcohol was found among the most traditional and least acculturated group, while the lowest use and involvement was found in the most acculturated off-reservation group.[25]

Second, research that has documented the life of contemporary Indigenous peoples—as opposed to attempting to reconstruct 'traditional' patterns of culture—has demonstrated that they do not live in a cultural vacuum. The cultures of Indigenous peoples, like all cultures, change through time in response to the broader social, political and economic environment. In the course of such change, older patterns are discarded—sometimes by choice, sometimes by force. Nevertheless, the people maintain living cultures which are both distinct from and share characteristics with 'traditional' Indigenous cultures and the cultures of the colonising societies.

This is not to deny that some Indigenous people feel considerable pain and a sense of great loss as a consequence of not being acquainted with the cultures of their

forebears. The report by the Aboriginal Legal Service of Western Australia on the experiences of Indigenous Australians who were removed from their families as children make this poignantly clear.[26] Again, however, this alone cannot explain patterns of Indigenous alcohol consumption.

Cultural explanations

For much of the first half of this century—in the face of the changes wrought by the spread of industrial capitalism, 'modernisation' and attempts to assimilate minority populations—a great deal of anthropological effort was expended in trying to document the ways of life of 'other' peoples before they disappeared. Much of this effort involved trying to re-construct 'traditional' ways of life (disregarding the fact that all of them had been affected one way or another by colonial expansion for long periods of time), and little attention was focused on contemporary Indigenous cultures, which were often implicitly, and sometimes explicitly, devalued. It was assumed that Indigenous cultures were rapidly disappearing and that policies of assimilation were succeeding. As two prominent Australian anthropologists wrote in the early 1960s:

> Generally ... the majority of these people [Aborigines in remote areas] are becoming more and more like those in the south—who are already, both in appearance and in manner of living, European in all but physical characteristics, and often very largely so in that respect as well.[27]

However, such views were not based on extensive first-hand experience among 'non-traditional' peoples. From about the 1960s, a number of ethnographic studies appeared that highlighted the fact that, although they were not 'traditional', Indigenous peoples had distinct cultures which demonstrated continuities with the past, which had adapted to present circumstances and which had incorporated for their own purposes elements of the culture of the colonialists. This realisation was accompanied by a turning away from explaining Indigenous drinking as a consequence of cultural breakdown to attempts to explain it in terms of Indigenous cultures themselves. In this approach, three strands of explanation can be identified: those that focus on the characteristics of 'traditional' cultures; those that focus on aspects of contemporary Indigenous cultures; and those that emphasise the adoption and incorporation of drinking styles learned from non-Indigenous peoples.

Characteristics of traditional Indigenous cultures

A commonly-cited explanation for excessive alcohol consumption among Indigenous peoples has centred on its absence in pre-contact societies. According to this line of argument, because they did not have access to alcohol (or other psychoactive

substances), no social rules or conventions were developed to control its use. Thus, when it was introduced, consumption was largely unregulated and people drank, and continue to drink, excessively.

This position has been refuted on two grounds. First, there is clear evidence that at least some groups did have access to psychoactive substances, including naturally-fermented alcoholic drinks; and there is no evidence to indicate that the response to the introduction of large quantities of alcoholic beverages was any different between those who did and those who did not have prior access to such substances. Second, it sees culture as relatively unchanging, a view clearly contradicted by archaeological studies of traditional Indigenous cultures and by studies of contemporary Indigenous cultures, both of which demonstrate a long history of successfully incorporating a range of ideas and material goods.[28, 29] Furthermore, various recent studies demonstrate that Indigenous peoples have incorporated the use of alcohol into their societies in regulated ways, if not the ways which some non-Indigenous people would prefer.[30, 31]

Some Indigenous cultures, such as those of the North American plains, particularly valued and actively sought 'altered states of consciousness' often as a means of obtaining personal power from the supernatural. This has led some commentators to claim that alcohol was consumed as a means of achieving such states.[32] Although there might have been some truth in this in an early contact situation, it has been suggested that people soon learned that any such gain was illusory. More importantly, however, there are no ethnographic records of Indigenous people drinking alcohol to achieve religious ends—as the Native American Church did with peyote[33]—on a scale that would explain contemporary patterns of consumption.

Another attempt to explain Indigenous patterns of drinking in terms of continuities with traditional cultures sought to link it with the nature and consequences of the social organisation among some peoples. It has been argued that the small-scale nature of Indigenous communities required members to suppress their emotions and personal feelings in the interest of social harmony to an extent not required in larger-scale societies, and that excessive drinking provided an opportunity to escape from such restrictions.[34] In a similar vein, Rubel and Kupferer attributed patterns of alcohol consumption among the Inuit of northern Canada to traditional patterns of social relations.[35] These approaches grew out of the 'culture and personality' school of anthropology which was prominent from the 1940s to the 1960s and which sought to link 'modal personality' types to particular cultural forms. However, as Harris has written, this approach has largely been discredited because it failed to adequately account for the wide range of personality types occurring in any particular society.[36]

An alternative approach, which linked contemporary patterns of alcohol consumption and 'traditional' society, was taken by Levy and Kunitz. They viewed drinking less as a consequence of the pathological aspects of Indigenous culture and more as a reflection of positively valued forms of expression. They have written:

> We maintain that drinking behavior is mainly a reflection of traditional forms of social organisation and cultural values instead of a reflection of social disorganisation

and

> … it is important to make the distinction between people who drink excessively because they are normal young men in Navajo terms and people who drink because of pathological processes, whether these processes derive from the stresses of acculturation or from more personal difficulties. Our findings indicate that the former group—normal young men—is the vast majority and accounts for what is regarded as Navajo problem drinking.[17]

Although it is not seen as a factor which explains drinking patterns per se, the emphasis placed on the value of personal autonomy in Indigenous Australian societies has been the subject of some attention. In some circumstances this is seen as facilitating excessive consumption, because individuals are loathe to impose on the personal autonomy of others and thus the excesses of individual drinkers are not curbed.[37, 38]

Learned behaviour

In a well-researched and widely-cited book, MacAndrew and Edgerton point out that there are two aspects to the ways in which people respond to alcohol.[2] The first of these is the impairment that alcohol causes to sensorimotor skills. This is fairly uniform and is clearly attributable to the toxic effects of alcohol itself. The second is the manner in which people behave, or 'comport' themselves after consuming alcohol. They cite numerous examples—many from Indigenous American societies—demonstrating that such behaviour is so varied that it cannot be attributed to the effects of alcohol itself. They go on to show that such behaviour is learned and is culturally determined.

This is a theme taken up by a number of observers in Australia, Canada and the United States to explain Indigenous drinking patterns.[32, 39, 40] It has been argued that Indigenous people in each of these countries learned their drinking behaviour from the Europeans with whom they first came into contact on the 'frontier'. These people were variously convicts, traders, soldiers and itinerant farm and pastoral station workers, who drank excessively and in 'binges' and responded to it in a relatively uncontrolled manner. It is argued that this pattern has been incorporated into the cultures of Indigenous peoples and continues to be the way in which they drink and respond to alcohol.

In a similar approach, it has been argued by some that the way in which Indigenous people drink is based on patterns which were established during the years in which

they were prohibited from drinking liquor.[32, 41] Under these circumstances, people would have to obtain alcohol illegally and consume it rapidly to avoid detection by the police and confiscation of their drink. Again, it is maintained that this pattern of drinking has become part of Indigenous cultures and remains so.

While there is certainly an element of truth in such explanations, alone they imply a rather static view of Indigenous cultures, in which, once they have been adopted, patterns of behaviour remain unchanged. Such explanations do not stand alone, and they need to be linked to others which show how and why such patterns have been maintained.

Alcohol in contemporary Indigenous cultures

Particularly in Australia, in the last 20 years, there have been a number of studies which examine the role alcohol plays in contemporary Indigenous communities. These studies emphasise the valued nature of drinking within those communities, which is seen by the drinkers themselves as an opportunity for socialising and enjoyment and as a means of relieving boredom.[41–43] Some observers have suggested that activities focused on drinking serve as a substitute for traditional ceremonial and ritual life, an observation that has also been made with regard to Maori drinking.[44, 45]

The detailed accounts of Indigenous Australian drinking by Sansom and Collmann, as well as others, also highlight the elaborate but unwritten rules surrounding alcohol consumption.[30, 31, 46] In doing so, they act as a refutation of the view that Indigenous people misuse alcohol because they had, or developed, no mechanisms to control its use. The examples provided by these researchers clearly demonstrate that Indigenous people have developed their own set of rules governing consumption. As we remarked earlier, it is simply that these rules do not accord with non-Indigenous, middle-class notions of appropriate behaviour.

These accounts which stress the normative nature of Indigenous drinking have been subject to some criticism by both Indigenous and non-Indigenous observers. Following Room, it is argued that such accounts ‘deflate’ the problems associated with excessive alcohol consumption.[47] To some extent, such criticism is not warranted. For example, Sansom lists the problems associated with alcohol misuse, including acts of violence and traffic accidents.[31] However, this was not the objective of his study. Nevertheless, it is important to note that while some Indigenous people might claim that ‘being Aboriginal is being a drinker’ this is certainly not the case for a large proportion of the Indigenous population; Gilbert (cited in Brady) and Langton, among other Indigenous people have spoken out against this notion.[40, 48]

Political and economic factors

As well as the psychosocial and cultural explanations discussed above, various political and economic explanations of Indigenous drinking patterns have also been invoked. The most common of these is the dispossession and consequent political and economic marginalisation of Indigenous peoples. As Kahn, Hunter, Heather and Tebbut have written:

> … the majority of attempted explanations implicate factors connected in some way with the subordinate position of Aborigines in Australian society over the last 200 years.[49]

The role of dispossession in explaining Indigenous alcohol misuse and related harm has been most cogently argued by Hunter.[50] In a well-researched book, he situates the position of Indigenous peoples in the Kimberley region of Western Australia in a historical context. He shows how the process of dispossession and subsequent eviction of Indigenous peoples from their land has left them in a relatively powerless position, and he convincingly demonstrates how alcohol misuse, suicide and other forms of violence are a consequence of that powerlessness. This is a theme echoed in a review by Moore who has argued that, to reduce the incidence of alcohol-related problems:

> Aboriginal people need to be supported in their struggle for self-determination, the shaping of contemporary Aboriginal identities and in the attainment of power to make decisions affecting their lives.[51]

It is not surprising that Indigenous people are generally more likely to invoke dispossession and its consequences as an explanation than are non-Indigenous people—especially in a climate in Australia where the Liberal-National Party coalition government is unwilling to acknowledge past injustices to Indigenous Australians. The Australian National Aboriginal Health Strategy Working Party reported that:

> … there is a consensus in the Aboriginal community which understands the 'alcohol' problem … as a symptom (ultimately a symptom of dispossession) of alienation which leads to loss of self-esteem.[52]

In Auckland, New Zealand, Maori themselves cited '… the stress of unemployment, unsatisfactory jobs, poverty and the experience of racial discrimination' among the reasons for heavy alcohol consumption.[53] Similarly, Health and Welfare Canada notes that among Indigenous peoples, high rates of alcohol use and abuse are correlated with low income, education and occupational status.[54]

In Australia:

> In general terms, poverty, the economic disparity between Aborigines and whites, lack of education and job skills are mentioned by many writers.[49]

Despite this recognition, there are few studies that directly link patterns of alcohol use to specific social and economic indicators. However, our own research and that of our colleagues has clearly linked such inequalities to alcohol and other drug use among young Indigenous people in Albany, Western Australia. There we found that among 15- to 17-year-olds, those who were unemployed were 13.5 times more likely

to be frequent users of some combination of alcohol, tobacco, cannabis or other drugs than those who were employed, in training or still at school.[55]

The role of broader socioeconomic factors has been taken up in Canada by Brody, who has argued that Inuit and Dene communities are subject to the same negative impacts of industrial expansion as non-Indigenous people, with similar results including high rates of alcohol misuse.[56] Going further, Graves claimed that patterns of alcohol misuse among Navajo people in Denver, in the United States, were similar to those among Whites of similar social class, and were a consequence of the same social structural factors acting on both, rather than being a consequence of their identity as Navajo.[24]

Although we do not agree that drinking among Indigenous peoples can be explained without any reference to their histories and cultures, we do believe that the similarities between Indigenous drinking patterns and those in some segments of non-Indigenous populations requires further investigation. In Canada, for example, Smart and Ogborne note that heavy drinking is not confined to Indigenous people in the north, and suggest similarities with drinking patterns among sections of the non-Indigenous population.[32] However, as we have highlighted elsewhere—when comparing studies of alcohol use in Indigenous communities with data from aggregated non-Indigenous populations—there is a paucity of studies on comparable non-Indigenous communities.[57] In the words of McKenzie:

> We don't know if non-Aboriginal populations and poor people show the same level of problems as Aboriginal populations.[3]

How do dispossession, political and economic marginalisation, and discrimination 'cause' alcohol misuse? Here, a variety of mechanisms have been suggested. Perhaps most prominent of these is the use of alcohol to ease the psychological pain caused as a result of a barrage of assaults including rejection, the break-up of families, institutionalisation and consequent loss of self-esteem. Excessive alcohol use is also seen as making bearable the impoverished conditions in which people are forced to live, and in communities that lack access to other recreational activities it is one of the few means of 'having fun'.

It should not be thought that Indigenous people have been helpless pawns in the process of colonisation, and that excessive alcohol consumption has simply been a passive response to it. There are various well-documented accounts of Indigenous resistance and protest. In Australia, for example, this includes armed resistance, strikes against working conditions and the appropriation of land, the establishment of a 'tent embassy' to draw attention to the condition of Indigenous peoples, and legal actions to re-claim land.[58–60] Alcohol has also been used by Indigenous people to make statements of protest. Indeed, Lurie has described the drinking patterns of Indigenous peoples in North America as 'the world's oldest on-going protest demonstration'.[61]

Writing about a desert fringe community in Western Australia, Sackett has said that Indigenous people drink to '… express their antipathy to the idea and practice of others administering their lives'.[62] Similarly in Australia, others have described excessive Indigenous drinking as an alternative to compliance with the existing power structure, and as a way of 'kicking back' at non-Indigenous administrators and institutions.[21, 63] As Brady notes, however, such a mode of protest takes a toll on Indigenous people themselves.

As well as protest, drinking has also been used to make other political statements. It has been employed as a means of asserting Indigenous identities opposed to those of non-Indigenous peoples.[18, 61, 64] It has also been used as a statement of equality with non-Indigenous people.[57, 65]

Despite acknowledging its historical role, some writers have expressed ambivalence about invoking colonialism and its economic consequences to explain contemporary patterns of alcohol consumption. For example, Brady has written:

> In the circumstances surrounding Aboriginal uses of alcohol in Australia, these causes are most commonly attributed to Aborigines' history of colonisation and oppression and contemporary socioeconomic deprivation, unemployment and marginalisation. These somewhat global postulated causes for the misuse of alcohol (among those Aboriginal people—apparently in a minority—who drink) … mean that public health models stressing prevention and personal responsibility are left, somewhat uneasily, unresolved.[42]

The implication of this statement is that if all Indigenous people have experienced the effects of colonisation then the misuse of alcohol should be more widespread among them and not confined to a minority. However, we believe that this is a simplistic way in which to view the effects of the political and economic forces of colonialism. These forces provide the overall framework for the interaction between Indigenous and non-Indigenous societies, but they have differential impacts on Indigenous societies and/or sections within them, and individuals and communities have responded to those forces in different ways. For example, it is likely that fewer Indigenous women than men drink excessively because their roles in domestic economies have been far less disrupted than those of men. They have obligations to family and children which entail considerable responsibility and leave them with both less inclination and time to become involved in heavy drinking groups.

In Canada, also, some observers who favour culturally-based explanations of Indigenous drinking patterns have sought to minimise the role of political and economic factors. Smart and Ogborne do so based on their assertion that, before traditional cultures were undermined, 'Indians' still had problems with alcohol.[32] We suggest that this view is untenable for, although some of the more obvious trappings of traditional cultures remained in place, the economic base of traditional cultures had already been undermined by the involvement of Indigenous people in the fur trade. Storm (cited in McKenzie) discounts the role of broader political and economic factors by arguing that, contrary to his expectations, problems of alcohol and

substance use continue despite increasing political awareness among Indigenous organisations.[3] However, as various Australian studies demonstrate, political awareness is necessary but not sufficient to bring about change in the absence of an economic base.[66, 67]

Eclectic approaches to the explanation of Indigenous alcohol use

Most of the categories of explanation that we have discussed are not mutually exclusive, and many writers have invoked some combination of them in their work. For example, most observers have cited the role of colonialism and dispossession, at least as a background to their explanations. In Australia, writers such as Larsen and Ward have attempted to situate psychosocial approaches within the context of a broader socioeconomic framework.[68, 69] Others, such as Albrecht in Australia and Smart and Ogborne in Canada attribute Indigenous drinking patterns to an eclectic assortment of historical and cultural factors.[21, 32] This eclectic approach is also evident in several review papers on Indigenous drinking, in which various approaches are canvassed, some rejected, most accepted as containing some element of explanatory value, but not presented in any consistently coherent framework.[18, 49, 70]

Some observers have not seen this as problematic. For example, Heath, writing about Indigenous North Americans, has said that:

> … it should be obvious that … no single theory can reliably and parsimoniously explain such cross cultural diversity [in 'Indian' alcohol-related beliefs and behaviour].[18]

Like Heath, Brady eschews 'the search for unified "causes" for drug and alcohol abuse'.[37] Unlike him, however, she has attempted to place explanations for Indigenous alcohol misuse in an inclusive framework which gives priority to none. To do this, she has employed the model elaborated by Zinberg, who has argued that to understand any drug use it is necessary to consider the interaction between drug, set, and setting—that is, the physiological effects of the drug itself, the state of mind of the person using the drug and the environment in which the drug is used.[71]

From our perspective, although this model usefully draws attention to the broader context of alcohol and other drug use, it suffers from the same weakness as the systems theory on which it is based. That is, like the more particularistic approach of Heath, it provides no theoretical basis for establishing the priority of the explanatory factors included in the model. In failing to do so, it ignores the vast empirical literature which shows that political and economic structures impose a constraining influence on human behaviour, and it thus provides no guide to an optimal strategy of intervention.[36, 72, 73]

The political economy of Indigenous alcohol use

Most of the approaches to the explanation of patterns of Indigenous alcohol consumption that we have reviewed appear to shed some light on the phenomenon. However, each has its limitations, as do most attempts at combining some or all of them. As we said at the beginning of this chapter, we do not believe that this should lead us to abandon the search for a comprehensive explanation.

In our previous work on the health of Indigenous Australians, we have employed a 'political economy' approach.[74, 75] Although this approach is not popular—largely because of its materialist emphasis—we believe that it is best able to explain the difference in health status of Indigenous and non-Indigenous peoples, and is best able to help in the identification of strategies that will bring a reduction in that inequality. Similarly, like Singer, we believe that it is the approach best able to explain differences in patterns of alcohol consumption and related harm between Indigenous and non-Indigenous peoples, and that directs our attention to the ways best able to reduce that harm.[76]

What is a 'political economy' approach? It is an approach to the explanation of human social behaviour which takes as its starting point the complex web of political and economic relations that constitute the environment in which individuals and social groups exist.[73] These relations, and the way in which they allocate resources and the fruits of economic production, set greater or lesser constraints upon the life chances of individuals and groups, and the power they have to choose the ways in which their lives are lived. These relationships are not 'determinative' in any absolute sense; they and their effects are shaped by history and by the ability of individuals and groups to change them. We do not claim that this approach can explain all human social behaviour. However, it does provide a basic framework for understanding the context in which social behaviour takes place and the constraints upon it.

The political economy approach is similar in some respects to others which emphasise the role of political and economic factors. However, it differs from such approaches in that it does not treat those factors as discrete variables; and it treats current political and economic systems not as given, but as shaped by history and differential power relationships. Thus, for example, differences in the distribution of wealth between Indigenous and non-Indigenous peoples are not viewed as the outcome of abstract 'market forces', but as the outcome of differential power relations between those peoples.

Within anthropology and comparative sociology, there has always been a tension between those approaches which have emphasised the unique character of particular societies and those aimed at developing theoretical frameworks which identify the commonalities of human experience. Many of the studies we have reviewed in this

chapter clearly fall into the former category. That is, they have sought to explain patterns of Indigenous alcohol consumption in terms of the characteristics, cultures, or histories of particular individuals, groups or Indigenous populations. However, a review such as this highlights a number of interrelated problems with such approaches. The first of these is the commonality of drinking patterns and the broad similarity of experiences that become evident when they are compared.

A second problem arising from seeking an explanation for drinking patterns within the culture of particular groups is that it ignores the fact that such groups do not exist in a vacuum. Indigenous societies are not social isolates. Most have been in contact with Europeans for at least 150 years (and often longer) and, even where direct contact has been more recent (as late as the 1950s in parts of the Australian desert), they have been indirectly affected by colonisation. The environments in which they live and the social organisations and cultures of Indigenous peoples in Australia, New Zealand and Canada have all been shaped in response to colonial societies, and they cannot be adequately understood apart from that.

A third consequence of particularistic approaches to the study of Indigenous alcohol consumption is a focus on demand. That is, by looking inward, such studies usually seek to explain why there is an inordinate demand for alcohol by some segments of Indigenous populations. However, levels of consumption are a function of supply as well as demand, and an increase in supply can increase consumption. Although, at a practical level, several Indigenous Australian community groups have sought to limit the supply of alcohol, few studies address this issue in any detail.

As we have indicated—although there are gaps in it—material we have presented elsewhere reveals a remarkably similar pattern of alcohol consumption among Indigenous peoples in the countries under consideration.[57] Given this similarity, it is unlikely that it has arisen from unique circumstances within Indigenous societies. In our view, explanation of this phenomenon requires consideration of what is common to them all—that is, the experience of colonialism, the destruction of traditional economies, exploitation and marginalisation, the loss of power entailed in these processes, and the responses of Indigenous peoples to them. A model of Indigenous drinking must take this as the starting point, and other factors need to be considered in the context of these political and economic relationships.

Colonisation was a disaster of catastrophic proportions for Indigenous societies in Australia, New Zealand and Canada. Although there were differences in pattern and timing between and within countries, the results were essentially the same. The combination of the appropriation of the most valuable land and resources, and the decimation of populations due to violence and introduced diseases undermined the economic basis of traditional societies. With the influx of significant numbers of non-

Indigenous migrants, Indigenous people became largely irrelevant to the labour market. The remnants of Indigenous populations were herded onto reserves or reservations, or left to congregate on the fringes of European towns and cities. They were provided with only meagre education, or denied access to it altogether, and their access to vocational training was similarly restricted. Non-Indigenous people regarded them as inferior, took their impoverishment as evidence of that supposed inferiority, and actively discriminated against them. Indigenous people were regarded as a ‘problem’; and when that ‘problem’ did not disappear as anticipated, an attempt to solve it was made through policies of assimilation. In the attempt to assimilate Indigenous people, children of mixed descent were taken from their Indigenous parents and placed in institutions and foster care, causing untold psychological trauma for both parents and children.

Indigenous people have not been helpless victims in this process of colonisation. They have struggled and resisted, and it is not to detract from that continuing struggle to acknowledge that European victory has generally rendered them dependent and relatively powerless. This is so even in those remote areas where cultural continuities with traditional societies—in the form of language and religion, for example—are more evident and sometimes obscure the political and economic realities. The effects of colonisation have been particularly devastating for men. Women’s social roles in the domestic economy have largely remained intact. However, for men, their exclusion from the labour market has meant that there has been little to replace their traditional economic roles. This has heightened their sense of dependence upon the wider societies—and, often, on their own women—and their sense of powerlessness.

Alcohol has always played a role in the process of colonisation. In the pre-contact Indigenous populations with which we are concerned there was little, or more commonly, no demand for alcohol. As we have shown elsewhere, such demand had to be created.[57] Once it had, alcohol was used as an item of trade, as a means of intoxicating Indigenous people in order to obtain more favourable terms of trade or to enter into sexual relations, as a means of securing indebtedness which could be redeemed for land, and in exchange for labour (in some times and locations). In periods when the sale of alcohol to Indigenous people was legally prohibited, there were always non-Indigenous people prepared to break the law to reap the profits of illicit sales. As Kahn and his colleagues note with regard to Indigenous Australians:

> … the exploitation of Aborigines as an economic resource, through alcohol certainly continues, via sale and taxation, via ‘grog-running’ to remote communities, and perhaps the growth of bureaucratic structures set up to service alcohol-affected Aborigines.[49]

In the context of colonisation and its continuing consequences, excessive alcohol consumption plays many roles. In the absence of other meaningful employment and recreational activities it is simply a means of ‘having fun’. For many young men, it is one of the few ways open to them to express their masculinity. As we have seen, for

some Indigenous people, it is a symbolic statement, a protest against their powerlessness. Many people have been psychologically scarred, and for some of them it is a means of coping with that trauma. Being drunk also helps to make deplorable living conditions bearable. Because it serves so many purposes, it is little wonder that the excessive use has become institutionalised among some segments of Indigenous societies and has become a self-perpetuating activity.

It is at this level that excessive alcohol consumption may be seen as having many 'causes' and, clearly, at this level various interventions may be required by Indigenous groups that wish to address the problem. Nevertheless, these reasons for drinking are themselves a function of relationships between Indigenous and non-Indigenous societies within the broader web of political and economic relationships. That is, they are symptoms of underlying inequalities. However, interventions aimed solely at these symptoms—while alleviating some of the pain—will not address the underlying cause, and the symptoms will continue to re-emerge.

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Index

This is an index to the subjects discussed in this book, although three prominent authors (d'Abbs, Brady and Hunter) have also been included. Most topics refer to Aboriginal people and alcohol, even if they don't explicitly say so (eg 'hospital admissions' refers to hospital admissions of Aboriginal people).

A

Aboriginal Advisory Council, 37–39, 50

Aboriginal and Torres Strait Islander Commission (ATSIC), 116, 125, 126, 128

Aboriginal Communities Act 1979 (WA), 41–42, 69, 145, 162

Aboriginal Justice Council, 164

Aboriginal Legal Service, 37–38, 156

Aboriginal people, see Indigenous Australians

abstinence, 65, 73, 142

accountability, 117, 125

acculturative stress, 175

adolescents, see young people (juveniles)

Albany Aboriginal Corporation, 13, 79–80. 91

Albany (WA), drug use, 79–91, 180–181

alcohol consumption, 152–156, 169–187, see also interventions; per capita consumption of alcohol; supply reduction strategies
- Australia, 35–36, 80, 89–90, 94, 110–112, 137–148
- behaviour after drinking, 178–179
- dependence, 170–174
- individual nature of abuse, 4, 31, 139–140, 144, 145, 162
- patterns of, 4–6, 110–112, 169, 173, 185
- promotion of, 40–42, 151–164
- pure ethanol calculation, 95
- regional differences in the NT, 99–106
- in traditional cultures, 176–177
- type of beverage and, 105
- young people, 83–85, 90–91

alcohol industry, 156–159, see also licensed premises
- funding for training from, 47
- licensing restrictions and, 31–32, 45, 163

alcohol supply, see licensed premises; supply reduction strategies

Alcoholics Anonymous (AA), 65, 141, 143–144, 147

Alice Springs, see Central NT SSD (NT)

amphetamines, 87, 91

analgesics, 56, 58, 87

'anomie' (normlessness), 174

Anyinginyi Congress, 18, 157

arrests, see law-and-order issues

assimilation, 174–175, 186

ATSIC (Aboriginal and Torres Strait Islander Commission), 116, 125, 126, 128

autonomy (selfhood), 140–141, 147, 161–162

availability, see supply reduction strategies

B

Barkly SSD (NT), 101–105, see also Tennant Creek

'Beat the Grog' campaign, 18, 157

beer, 103, 105

biological determinants of alcohol misuse, 153–154, 170–172

Brady, Maggie, 46, 141, 153, 154, 159, 182, 183

C

Canada, 124–126, 130, 174–175, 182
  traditional healing, 143

cannabis use, see marijuana (cannabis) use

cask wine, 40, 94–95, 103–105
  NT government levy, 22, 73–74, 93–97
  restrictions on sale of, 8–9, 18, 25–26

Central Australian Aboriginal Alcohol Programs Unit, 65–66, 143

Central NT SSD (NT), 101, 102–105

children, see young people (juveniles)

cigarettes, 5, 79–91

citizenship, 160–162

collectivity, 139–141, 146, 161, see also community input

colonialism, 29, 138–139, 153, 160–161, 174–176, 180–182, 185–187
  Aboriginal affairs policy, 159–160
  early settlers, 178

community input, 12–15
  data collection, 131–132
  field workers, 74
  licensing decisions, 38–39, 43–45, 47–50, 159
  liquor restrictions, 25–26, 30, 32, 161
  program management, 126–127

controlled drinking, 73, 142

costs, see also funding
  alcohol abuse, 5
  programs and evaluation, 55, 61, 74, 117–118
  sobering-up shelters, 68

counselling, 113, 142–143, see also treatment

cultural determinants of alcohol misuse, 153, 176–179, 182
  loss of culture, 174–176

culturally-appropriate evaluation, 9–12, 109–121
  data collection, 58, 59, 129, 131–132
  government programs, 124
  holistic evaluations, 137

D

d'Abbs, Peter, 10, 27, 46, 74
  consumption surveys, 102
  evaluation, 65, 69, 73
  liquor restrictions, 72, 115, 162, 163
  survey methods, 20

Darwin, see Top End (NT)

data collection, 129–132
  project evaluation, 10, 53–62

databases, 63, 73, 121

Derbarl Yerrigan Health Service, 37

Derby Alcohol Action Group (WA), 72

discrimination, see racial discrimination

disease model of alcohol dependence, 154, 171–174

dispossession, see colonialism

drinking, see alcohol consumption

drug use, see substance use

'dry' communities, 69, 141, 145, 162
  transportation of alcohol, 41–42, 50

E

economic factors, see political economy; socioeconomic factors

educational programs, 46, 47, 49, see also health promotion; training
  evaluation of, 66–67

evaluation, 53–74, 114–119, 120, 123–133, 144
  costs of, 117–118
  culturally-appropriate, 9–12, 58, 59, 109–121, 137
  liquor licensing restrictions, 17–27, 30–31
  political factors, 115–116, 127–128

F

fees, see taxation and levies

financial accountability, 117, 125

fortified wine, 25, 40, 43

funding, 12, 46–47, 116, 117, see also costs
  evaluation and, 55, 60–61, 74, 119
  from taxation, 47, 49, 158

G

gender differences, 6, 182
  colonialism impact, 186

genetic predisposition to alcohol, 172–173

glass beverage containers, 25–26, 42, 113

glue sniffing, 86–87

government policies, 31, 158–161, see also political factors

grant applications, 55, 59–62, 119

grog, see alcohol consumption

group processes, see collectivity; community input

H

Halls Creek licensing restrictions, 41, 69, 163

harm minimisation strategies, 30, 45–49, see also interventions

health effects, 36, 80, 112, 137–148, 151–152, see also hospital admissions
  education about, 46
  restrictions and levies and, 19–20,

health promotion, 113, see also educational programs; harm minimisation strategies
  evaluation, 53–62, 66–67, 73, 74, 123–133

health research, see research

historical background, see colonialism; political economy

hospital admissions, 19–20, 23, 36, 80, see also health effects

hotels, see licensed premises

Hunter, Ernest, 36, 180

I

illness, see health effects

Indigenous Australians, 1–3, see also colonialism
  Aboriginal affairs policy, 159–161
  attitudes to drinking, 138
  political statements through alcohol use, 181–182
  representation in data collection, 131–132
  views on community, 140–141

Indigenous peoples, 5, see also Canada
  alcohol consumption, 169–187
  self-determination, 124–125

individual nature of substance abuse, 4, 31, 139–140, 144, 145, 162

individual rights, see rights of individuals

injuries from broken glass, 42, 113

interventions, 63–74, 112–115, 141–144, see also evaluation; health promotion; supply reduction strategies
  Indigenous initiatives, 36–37, 163

interviews, see surveys

intoxicated people, liquor served to, 41

J

Julalikari Association, 18, 163

K

Karalundi health promotion program, 53–62

Koori Alcohol and Drug Prevention Project (Vic), 66

L

land, see colonialism; self-determination

law-and-order issues, 36, 43
  liquor restrictions and, 19, 24–25, 72

learned behaviour, 178–179

legislation, 159–160, see also liquor legislation

levies, see taxation and levies

licensed premises, 42–44, 46
  alcohol promotion, 157–158
  liquor restrictions and, 18, 25–26, 163
  opening hours, 40, 50

licensee accords, 31, 32, 72

licenses, see licensed premises; liquor licensing restrictions

Liquor Act 1979 (NT), 69, 162

liquor industry, see alcohol industry

liquor legislation, 144–146, 162, see also liquor licensing restrictions
  enforcement of, 46
  history of, 29

Liquor Licensing Act 1985 (SA), 162

Liquor Licensing Act 1988 (WA), 8–9, 13–14
  review, 35–50, 146
  support for alcohol industry, 158–159

liquor licensing fees, see taxation and levies

liquor licensing restrictions, 29–33, 35–50, 144–146, 163, see also cask wine
  Halls Creek, 69
  Tennant Creek, 17–27, 72, 145–146

Liquor Licensing Review Committee (WA), 38–39, 47–50

liquor tax, see taxation and levies

Living With Alcohol Program (NT), 74, 95, 144

low-alcohol liquor licensing fees, 40–41, 47, 49

low-strength beer in NT, 103

Lower Top End SSD (NT), 101, 102–105

M

marginalisation, see colonialism

marijuana (cannabis) use, 5
  young people, 85–86, 90–91

Mill, John Stuart, 139–140, 147, 172

minors, see young people (juveniles)

monitoring, see evaluation

morbidity, see health effects

mortality, 36, 80, 112

N

National Aboriginal Health Strategy, 116

National Drug Research Institute, 1–2, 63

National Drug Strategy, 1, 4–5, 55, 59–60

National Health and Medical Research Council guidelines, 12

National Indigenous Substance Misuse Council, 14

Northern Territory, see also Tennant Creek
  alcohol consumption, 6, 99–106
  cask wine levy, 22, 73–74, 93–97
  liquor tax used for treatment, 158

O

offences committed, see law-and-order issues

opiate use, 88

P

Palm Island (Qld), alcohol education, 67

park and street drinking, 43

patterns of substance use, 4–6, 88–89, 184–185

pay days, liquor restrictions on, 18, 27

peer support programs, 54–56

per capita consumption of alcohol, 5, 21–22, 94, 96, 100–106, see also alcohol consumption

performance indicators, 120, 129–130

Perth Aboriginal Medical Service, 37

pharmaceutical drugs, 56, 58, 87–88

pharmacologically-based treatments, 142

physiological determinants of alcohol misuse, 153–154, 170–172

police officers, see also law-and-order issues
  attitudes to sobering-up shelters, 68
  training in liquor act enforcement, 47, 49

political economy approach, 7–8, 138, 180–187
  interventions, 114
  supply of 'grog', 151–164

political factors, see also government policies
  in evaluation, 120, 127–128

polydrug use, 88–91

population-based strategies, see political economy approach; supply reduction strategies

Poundmaker's Lodge program, 143

poverty, see structural determinants of alcohol use

preventative strategies, 113–114, see also education; harm minimisation strategies; interventions; supply reduction strategies

problem drinking, see alcohol consumption

prohibitions, see supply reduction strategies

project evaluation, see evaluation

project planning and implementation, 125–127

promotion of alcohol, 40–42
  political economy, 151–164

protective custody, see law-and-order issues

psychoactive substance use, see substance use

psychological determinants of alcohol misuse, 153–154, 172, 174–175, 181

public drunkenness, 43, 68, 163

public health models, 4, 183, see also disease model of alcohol dependence

pubs, see licensed premises

Q

questionnaires, see surveys

R

racial discrimination, 43, 46, see also colonialism

Racial Discrimination Act 1975, 146, 161

racial predisposition to alcohol, 172–173

regional differences in alcohol consumption, 5–6, 99–106

regulations, 144–146, 162, see also liquor legislation

rehabilitation services, see treatment

research, 1–4, 12–15, see also evaluation
training in, 62, 82

residential alcohol programs, 65, 73, 142

resources, see costs; funding

restricted area status, 69, 162–163, see also 'dry' communities

restrictions, see liquor licensing restrictions

rights of Aboriginal people, 160

rights of cultural groups, 161

rights of individuals, 30, 139–140, 145–146, 147

Royal Commission into Aboriginal Deaths in Custody, 29, 37–39, 138
on data collection, 130
recommendations, 2, 37, 38, 49, 50, 68

S

school students, see young people (juveniles)

self-determination, 124–125, 180
support for Aboriginal initiative, 37

self-esteem programs, 54, 57–58, 67

selfhood (autonomy), 140–141, 147, 161–162

settlements, 160–161

sex shows for alcohol promotion, 157

smoking, 5, 79–91

sobering-up shelters, 23–24, 67–68, 73

social accountability, 117, 125

social consequences of alcohol misuse, 36, 137–138
liquor restrictions and, 19, 23–24

social control, 138, 141

social organisation, see community input; traditional cultures

social security pay days, 18, 27

socioeconomic factors, see also political economy
approach to Indigenous health, 138
interventions, 114
patterns of substance use, 4, 181

spirits, 85, 103

street and park drinking, 43

structural determinants of alcohol use, 153, 155–156, see also political economy

students, see young people (juveniles)

substance use, 2, 4–8, see also alcohol consumption; tobacco use
individual nature of, 4, 31, 139–140, 144, 145, 162
program evaluation, 123–133
young people, 54–58, 79–91

supply reduction strategies, 7–9, 114, 161–164, see also liquor licensing restrictions
evaluation, 69, 72–74

surveys, 4–5, 35–36, 129
collaborative research, 13–14
Karalundi program evaluation, 53–62
liquor licensing restrictions, 19–20
young people's drug use, 81–82

T

takeaway alcohol restrictions, 18, 25–26, 30

taxation and levies
- cask wine levy, 22, 73–74, 93–97
- health funding from, 47, 49, 158
- low-alcohol liquor, 40–41, 47, 49, 94

taxi drivers, 18, 25, 41–42

teenagers, see young people (juveniles)

Tennant Creek, 14, see also Barkly SSD (NT)
- alcohol promotion, 157
- alcohol restrictions in, 8–9, 17–27, 72, 145–146, 163

Thursdays, liquor restrictions on, 18, 24–26

tobacco use, 5, 79–91

Top End (NT), 101–105

Torres Strait Islanders, 110–112, see also Indigenous Australians

traditional cultures, 174–178
- healing, 143

training, see also educational programs
- community projects, 54–56, 62, 82, 118–119
- of licensees, 46, 47, 49

transportation of alcohol, 18, 25, 41–42

treatment, 65, 73, 113, 142–144, see also interventions

U

under-age drinkers, see young people (juveniles)

unemployment funding, 116

urban areas, 4–5, 110–112, see also Albany (WA)

V

violence, 36, 42, 72

volatile substance use, 86–87, 91, 95

W

welfare, see social consequences of alcohol misuse

Western Australia, 6, see also Albany (WA)
- Liquor Licensing Act 1988, 8–9, 13–14, 35–50

Wiluna, glass containers not sold in, 42

wine, 18, 25, 103, see also cask wine
- Wine Equalisation Tax, 94, 97

women's refuges, 19, 23

Y

Yothu Yindi campaign, 66

young people (juveniles), 79–91
- alcohol education, 66–67
- Karalundi program evaluation, 53–62
- liquor served to, 41, 50

Z

Zinberg’s model of drug use, 183