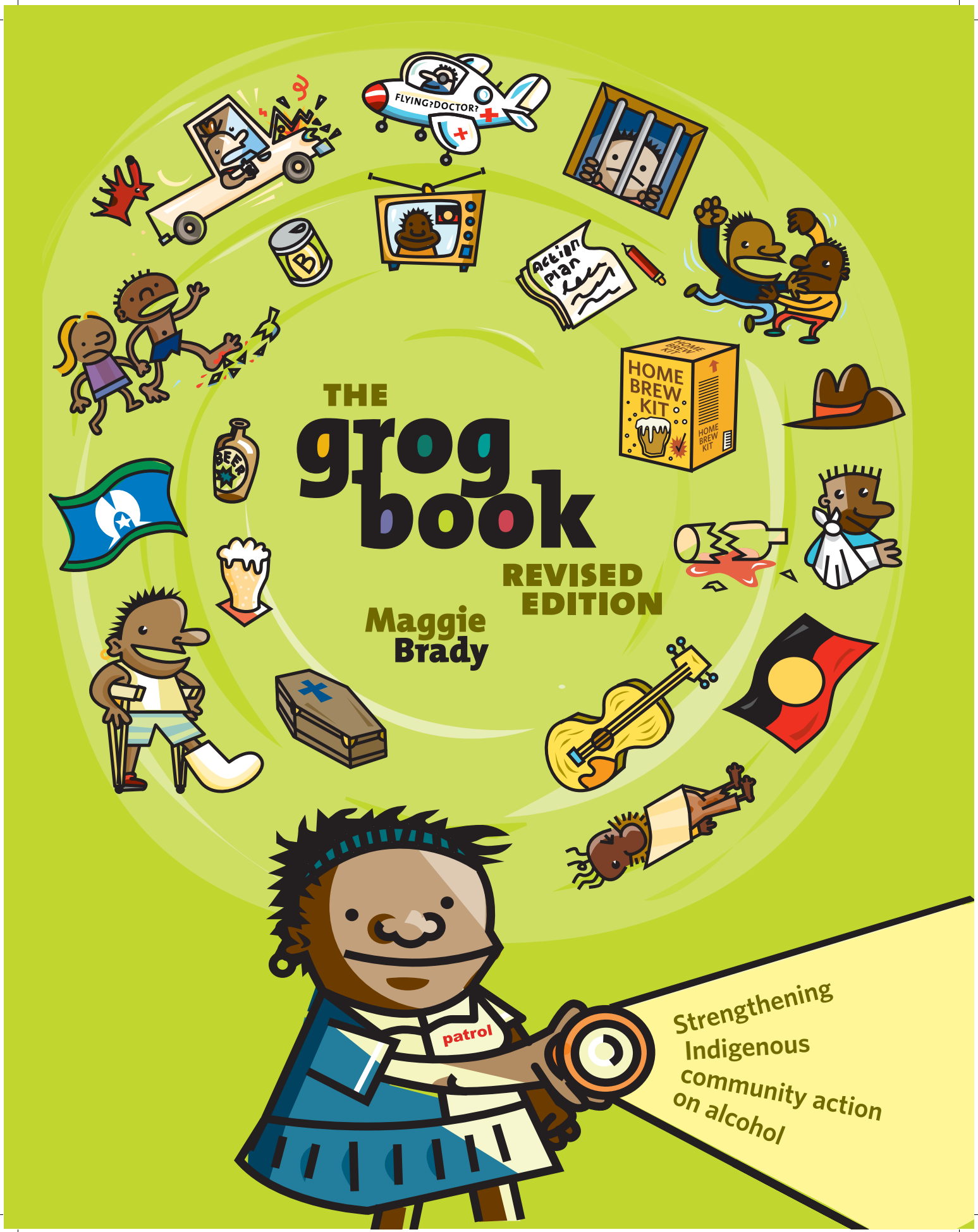

THE grog book

REVISED EDITION

Maggie Brady

Strengthening Indigenous community action on alcohol

A message from Prof. Marcia Langton, AM

The aim of this book is to provide Indigenous people in Australia, whether they are living in remote communities, rural towns or urban areas, with ideas and strategies for managing alcohol. It tries to widen the choices people can make. It aims to set out the advantages and disadvantages of different courses of action.

The book is not meant to be a complete collection of all the actions that are taking place. Instead it provides a selection of case studies of what Indigenous people themselves have been doing, in order to share ideas and solutions across a wider audience. So the book is both based on the work of Indigenous people and is written for those in our communities and neighbourhoods who are concerned about alcohol-related harm to our people. The book takes its name 'Strengthening Indigenous Community Action' from one of the guiding principles of the Ottawa Charter.

Dedicated to

Jane Lloyd, the NPY Womens' Council,
Greg Telford and all those working
on family violence.

THE grog book

REVISED EDITION

Strengthening Indigenous community action on alcohol

Maggie Brady

Australian Government

Department of Health and Ageing

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The views expressed in this publication are those of the author, and not necessarily those of the Department of Health and Ageing.

Disclaimer
Several commercial companies are mentioned because they have been recommended by others and you need to judge them for yourself. Any such reference is not intended as an endorsement of the resources or services.

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Contents

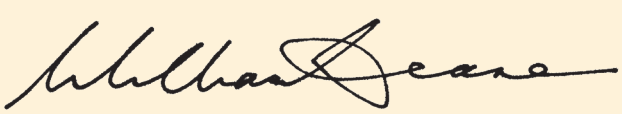
Message from The Honorable Sir William Deane

I am very pleased to be associated with the publication of this new edition of *The Grog Book*, and to commend it to all whom its message is addressed. The first edition was published in 1998 and has been widely acclaimed.

The Grog Book Revised Edition: Strengthening Indigenous Community Action on Alcohol is a practical guide to community strategies for dealing with alcohol misuse, and is designed for Aboriginal and Torres Strait Islander peoples, their organisations and advisors. The case studies and ideas in the original book have prompted many Aboriginal and Torres Strait Islander people and communities to take action, and to try out new approaches to contain harms caused by alcohol misuse.

Like its predecessor, this new, updated edition is a book of 'best practice' ideas that are illustrated and brought to life by grass roots examples and case studies. These have been contributed by Aboriginal and Torres Strait Islander groups and individuals, as well as other health professionals around Australia.

I congratulate the author Maggie Brady of the Australian National University, the Office for Aboriginal and Torres Strait Islander Health and the Drug Strategy Branch of the Department of Health and Ageing, all of which supported the project.
I have no doubt that the book will continue to strengthen and encourage all those whom it is designed to assist.



Sir William Deane

Thanks to these people

The original *Grog Book* (1998) was based on an idea from Professor Marcia Langton, and was produced with the support of the Australian Institute of Aboriginal and Torres Strait Islander Studies, Dr Bill Jonas, the Council for Aboriginal Reconciliation and OATSIH in the then Department of Health and Family Services. The book was launched by Professor Mick Dodson in November 1998 and won a category award in the 1999 Australian Awards for Excellence in Educational Publishing. This new edition has built on an evaluation of the first book, together with experience gained as a result of the development, writing and testing of a similar book designed for community workers in South Africa, a project supported by AusAID.

This revised edition has had the support and help of many people. I am indebted to Carol Watson who has worked closely with me on the research and writing of case studies for this book, Anne Mosey for contributions based on her evaluation of the book, and Ruth Nicholls for research assistance. I appreciate the support given by Professor Jon Altman and the Centre for Aboriginal Economic Policy Research at the Australian National University where I am a research fellow. The production of the revised *Grog Book* has been funded by the Department of Health and Ageing. I appreciate the enthusiastic support and commitment to the project given by many departmental staff including Romlie Mokak and Jill Turner (OATSIH), Margaret Cox and Megan Donnelly (Drug Strategy Branch). Internationally, Andrew Ball (at WHO) and Maristela Monteiro (at PAHO) have each been supportive of the first and second editions of *The Grog Book* and their potential adaptation for other indigenous groups.

Numerous Indigenous and non-Indigenous organisations, programs and individuals have contributed case studies and updates on progress for this new edition for which I am extremely grateful. Particular thanks are owed to: Donna Ah Chee, Steve Allsop, Stuart Anderson, Carol Atkinson, John Boffa, Mike Bowden, Chris Burke, Wendy Casey, Helen Caine, Kevin Coombs, Tim Cooper, Craig Edwards, Patricia Fagan,

Christine Fougere, Anthony Franks, Vicki Gillick, Kate Gooden, Dennis Gray, Ernest Hunter, Sue Laird, Jane Lloyd, David Nash, Fiona Nichols, Paul Maher, Coralie Ober, Tristan Ray, David Reilly, Debra Reid, Barb Shaw, Greg Telford, Helen Travers, Huti Watson and Scott Wilson. The design and contents of the original book were tested with Aboriginal health workers and students in Alice Springs and Goulburn (with the help of Marg Hampton, Helen Liddle, Marilyn Pittman and Gwen Walley). My thanks to all those who took part in the evaluation of the first *Grog Book*; many ideas and comments that emerged from the testing and evaluation processes have been incorporated into this new edition. We greatly appreciate the positive feedback from readers' comments on order forms for the first *Grog Book*, and invite you to tell us what you think of this new edition (see feedback form at the end of the book).

The success of *The Grog Books* rests to a large degree on how inviting and interesting they look and how easy they are to use. For her brilliant conceptual development and design skills and for the testing methodology, I am again indebted to Mouli MacKenzie of M Squared Design, and to Alex Tyers for the illustrations.

Who is this book for?

The book is for Aboriginal and Torres Strait Islander peoples, for those who work with them, and for community members who ask '*How do we start? Where do we start? We know our community or town has a problem with alcohol but what can we do about it*?' Workers say '*How do we talk to people? What's the best treatment?*'

People can feel overwhelmed by how difficult it all is and some are disempowered: they have no confidence. They are often a minority who are non drinkers or who only drink a little. They are the ones who often take on many extra responsibilities, but they are nervous about taking a leading role to deal with grog problems. They do not want to antagonise others too much. We hope that this new updated *Grog Book* will show what is possible and how even small actions can make a difference.

- *If you want to organise an action group*, work for an Indigenous organisation or are a concerned community member, there is guidance here to show you how to encourage and mobilise community based action. You can read about what other communities are doing.
- *If you are a frontline worker* in health or alcohol and other drugs programs, you can learn about alcohol and its effects as well as finding out what you can do to help and how to speak with people about their drinking.
- *If you teach in a high school or tertiary institution*, or run training for community workers, there are discussion topics and workshop activities for you to use.
- *If you simply want to understand more* about what is happening on the ground in Indigenous communities, there is information for you here.
- *Those in police and prison services,* in criminal justice and liquor licensing will find here practical case studies of community strategies aimed at controlling the supply and consumption of alcohol.

The actions and interventions that have been tried over the last few years have each worked a little, in their own way. Maybe you can learn something from the trials, mistakes and successes that Aboriginal and Torres Strait Islander peoples share with us all in this book.

What is in each chapter?

This second edition contains lots of new material including information about homebrew, alcohol-related birth defects, local restrictions and their evaluation, permit systems, alcohol management plans, cultural protocols, guides to counselling and workshop handouts. The chapters are arranged like this:

History

This chapter looks at Indigenous drugs and alcohol in the past and nowadays. It tells you about early laws, prohibition, citizenship and their effects. This chapter also looks at the costs and benefits of alcohol to the country, pricing and taxation and different kinds of alcohol policy.

Alcohol

In this section we give facts and information to answer questions people usually ask about alcohol. It explains 'standard drinks' and what different drinks contain. You can find out how alcohol affects the body and the mind and the guidelines for reducing health risks. An illustration shows the parts of the body affected by heavy drinking. You can find out how the social and physical environments affect the way people drink.

Action

This chapter is a guide to community motivation and local action with real examples to inspire you. It shows how you can start a community-based action or campaign, how to get people going and how to do local action research. If you want to collect and make use of statistics, and identify problems and needs around alcohol issues, this chapter is for you.

Prevention

Read about The Ottawa Charter on Health Promotion and other ideas for health promotion in this chapter. You can learn about how to avoid mistakes in health education, and about new ideas in raising awareness and prevention activities. There are ideas on running workshops, using puppets, targeting hotels and culturally secure training in AOD.

Controls

This chapter shares ideas from across the country about getting restrictions going, mistakes to avoid and making drinking places safer. Controls over drinking are illustrated with examples of the latest

strategies for local alcohol-free areas, the use of permits, the costs and benefits of social clubs and policies for safe service of alcohol.

Strategies

This chapter gives examples of strategies for managing drinking trouble from many different communities in cities, country towns and remote areas. You can learn about managing behaviour Aboriginal way as well as how to set up a women's shelter and a night patrol. Read about the importance of cooperative relationships with the police and be inspired by stories of working with men and protecting women around family violence problems.

Care

This chapter is for frontline workers and for families dealing with alcohol problems. It covers what service providers, relations and friends can do to help people change and support each other. Learn about brief interventions, and screening. Understand better the differences between 'detox', 'rehab', and 'treatment'.

Handouts

There are 12 handouts for you to photocopy or make into overheads to use in workshops, with action groups or students. You can use them for role plays, for staff training and some are for the clients of services. They include a list of key resources, and a glossary of terms and phrases.

The idea behind the book is that of 'strengthening community action' on alcohol, a key principle of The Ottawa Charter on Health Promotion (1986). The five areas for action to improve health set down in the Charter are as follows:

- Building healthy public policy
- Creating supportive environments
- **Strengthening community action**
- Developing personal skills
- Reorienting health services

Each of these five areas for action is relevant to the ideas and strategies discussed in the book, which is designed to show practical examples of people at the grass roots putting these principles into action.

How to find your way around this book

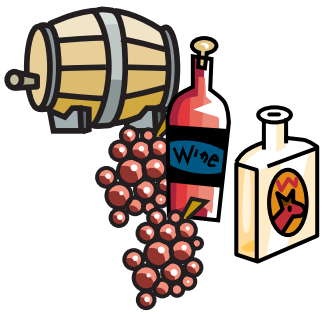
- *Contents*
  At the beginning of the book (on pages iii–v) there is a list of contents for the whole book.
- *Chapter contents*
  Each chapter has its own detailed list of contents
- *Tabs*
  You can find your way quickly to each chapter by using the key words on the tabs. Once you get there you can find exactly the topic you want by using the chapter contents
- *Colour coding*
  If you prefer to flip through the book rather than looking up topics on contents pages, the chapters are colour coded, and you can scan the headings to tell you in more detail what is on each page.
- *Pictures*
  You can also find your way around by looking at the pictures. The pictures relate and connect to what is written next to them.
- *Cross references*
  The arrows are colour coded to each chapter, and link you to other parts of the book dealing with the same issue, like this:
  See page 75 **Action** Motivating the community
- *Resources*
  At the end of each chapter there is a list of resources relevant to that chapter, with web addresses and contact numbers. The handout on page 246 lists key resources for your library.
- *References*
  The end of each chapter also has a list of articles and books used to write that chapter. Look them up in the library!
- *Handouts*
  To help you pass the information on to others in different group settings. The handouts can be photocopied or put on overheads.
- *Index*
  At the very end of the book is an Index. With this you can look up the main subjects and places mentioned in the book, and find the exact page number to find out more.
- *Now read on!*

What's in the 'history' chapter?

The old days

Where did alcohol come from?

People all over the world have been making drinks with alcohol in them for thousands of years. This started among people living on the edges of the deserts in the Middle East who made a wine from date palms and grew barley. They brewed up a kind of thick food-drink. Women soaked barley seeds in water to make them sprout. Then they dried the sprouts and mixed them with other cereals, soaked them in water and let the mixture sit and ferment. They mashed and sieved the mixture. The liquid that came out now contained alcohol. The Greeks, Egyptians, and Chinese peoples brought this knowledge to Europe where the Germans called it *bior;* the English called it beer and ale. They also made an alcoholic drink from apples, called cider. But beer was the number one drink in England for a long time. In the 13th century English people drank it for breakfast, dinner and tea instead of bad water. Africans use sorghums and millets for beer; some American Indians brewed beer from corn. Wines were made at least 6,000 to 7,000 years ago in the Middle East from grapes, figs, and dates.



Different countries in Europe used (and still prefer) different kinds of alcohol. The French, Spaniards and Italians liked wine. In Scotland and Ireland people preferred whisky. In Britain, people drank beer and gin. Now there are new kinds of alcoholic drinks being made. There are mixtures of wine and fruit juice, and spirits with fruit flavours ('alcopops'). There is low-alcohol 'light' beer that tastes like beer but has less alcohol in it.

Before the invasion

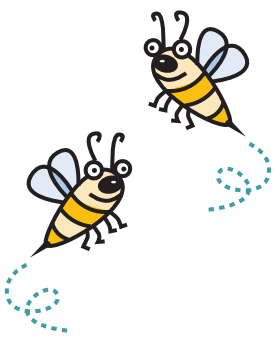
traditional alcoholic drinks

Did any Aboriginal or Torres Strait Islander people make alcohol? Some early writers tell us that people in many places made sweet drinks from flowers, honey and water. These were drunk before they fermented into alcohol. But some say that a few of these drinks were intoxicating. Early observers described which indigenous plants and trees were used. They said that the drinks 'seemed to make people drunk'. This is different from what is usually believed.

In Tasmania, the sap of a gum tree (*Eucalyptus gunnii*) was collected by Aborigines and by early white settlers. GA Robinson reported in 1831 that it made them 'drunk'.

> *'The sweet, saccharine juice or liquor, tasting like molasses, flowed plentifully from the apertures, and was collected in a hole at the foot of the tree. When allowed to remain for a length of time, it underwent a natural process of fermentation and settled into a coarse sort of wine or cider, which was rather intoxicating if drunk to excess. In the early days of Tasmanian settlement, it was in great demand both by the natives and stockmen. In 1825 the Lake Arthur blacks indulged in a great orgy, drinking it.'*
>
> (J MacPherson, 1921)

In Queensland, people made drinks from bauhinia flowers and wild honey. Alice Duncan-Kemp, a white woman who lived in the area, wrote in 1933 that when the bauhinias came into bloom, the local Aborigines picked coolamons full of blossoms. These were pounded and the liquid drained off and mixed with sugar-bag or ant honey. This was left to ferment for 8 or 10 days, and made a semi-intoxicating drink.



In the south of Western Australia, Aboriginal people made a drink from banksia cones they called *mangaitj*:

> *'The vat was next filled up with these cones and water, in which they were left to soak. The cones were subsequently removed and replaced by others until such time as the liquid was strongly impregnated with the honey, when it was allowed to ferment for several days. The effect of drinking this 'mead' in quantity was exhilarating, producing excessive volubility. The aboriginals called the cones and the fermented liquor produced there from both by the same name — the mangaitch'.* (WE Roth, 1904)

In the Northern Territory, Basedow reported in 1929 that Roper River Aborigines made what he called a 'mild pandanus cider' from a pandanus plant. He said that people became excited and talkative, merry, and 'drunk'.

Islanders in some parts of the Torres Strait made drinks — some intoxicating, some not — from the juice of coconut tree buds. The juice was called *tuba*, and it could be distilled into a strong spirit that the islanders called 'steamed *tuba*'. We do not know when this started; the knowledge probably came from the Philippines.

Indigenous and introduced drugs

pituri

We also know that Aborigines used different kinds of drugs that changed their mood. The Aboriginal drug *pituri* was made from a plant found in the desert regions of Australia, (the botanical name for the plant is *Duboisia hopwoodii*). People mixed *pituri* with wood ash to make it sweet and juicy, and to increase the effects of the nicotine. They chewed it like chewing tobacco. Aboriginal people had much knowledge of nicotine as a drug. The *Duboisia* plants from one small area (the Mulligan River in south-western Queensland) were selected to make *pituri* because these plants were very high in nicotine. These plants were traded over hundreds of kilometres.

Pituri had strange effects: from feeling high to stupor (drunk). Donald Thomson wrote in 1939 that *pituri* was a 'powerful stimulant'. Isabel

Terrago, a Queensland Aboriginal woman, told Pamela Watson that she remembered *pituri* from her childhood, saying that it had to be used properly by older people.

I remember Mum getting angry with somebody who left a big bag of pituri *at my cousin's house in Mount Isa. Mum said it was too dangerous to leave lying around. She didn't like to see young people using* pituri *and getting drunk on it, so she took it to the police and they burnt it... I know that my father belonged to the group that had the right to distribute it [*pituri*], but I don't know the whole story.* (Isabel Terrago)

Other Aboriginal groups used different drug plants. In New South Wales, people made a 'stupefying' drink using corkwood trees; and Murray River people ate an 'intoxicating root'. Aboriginal societies used tobacco from different sources: some tobacco was traded into Australia from Papua New Guinea and Sulawesi, some came from local plants. This bush tobacco is not *pituri*, it comes from different plants (the botanical name is *Nicotiana* sp.) Aboriginal people use these tobaccos differently to Europeans: they mix tobacco with ash. The ash helps to free up the nicotine in the tobacco. Aboriginal people sometimes keep the chewed wad behind their ear (this way, some of the nicotine from the tobacco goes into the body through the skin behind the ear).

In the old days Aboriginal people made their own drinks and drug substances; they knew their plants, and controlled how they were produced and shared around. (For example *pituri* was distributed only by those with rights over country and Law). When other people started visiting and settling in Australia, they brought large supplies of alcohol and other drugs such as opium with them.

tobacco and nicotine

The Macassans (Indonesian seamen) visited the north coast each year from at least the 18th century, long before European settlement. They came to hunt trepang (sea slugs) and brought with them palm wine and gin; tobacco and tobacco pipes. Some Arnhem Land people still make and use long 'Macassan' pipes for smoking their tobacco.

'A final item of consumption carried on the praus [Macassan boats] was a quantity of spirits... Most of the bottles found on Macassan campsites originally contained Dutch gin, but of course that does not mean that they necessarily contained this when brought to Australia... The word remembered by Aborigines on Groote Eylandt for liquor is anija.'
(C MacKnight, 1976)

Aboriginal languages have words which are used to refer to different types of alcohol. The linguist David Nash looked for them in dictionaries of Aboriginal languages. He found that some words used to describe alcohol mean 'sweet' or 'delicacy', while others refer to 'salty', 'bitter' or 'burning', or simply use the term for water. The table on the next page gives some examples from different languages:

Indigenous words for alcoholic drinks

Language	Term	Meaning
Adnyamathanha	*ngaldya*	spittle, beer
Alyawarr, e.Arrente, Kaytetye	*ngkwarle*	nectar, alcoholic drink
Arabana	*kutha-karldi*	bitter water, alcohol
Torres Strait Creole 'Broken'	*adstap*	hard stuff
Guugu Yimidhirr	*buurraay gaga*	salt water, beer
Jaabugay	*biri*	fire, spirits
Maung	*kurrula*	sea, liquor
Pitjantjatjara/ Yankunytjatjara	*wama*	sweet substance, liquor
Pintupi/Luritja	*tjurratja*	delicacy, beer
Tiwi	*winga*	salt water, beer
Wajarri	*gurulhu*	'Swan', beer
Warumungu	*kurlppu*	sweet, alcohol
Wik-Ngathan, Wik Mungkn	*ngak way*	salt water, grog
Yindjibarndi	*kari*	poison, alcoholic drink
Yolngu Matha, Gupapuyngu	*nganitji*	aniseed, alcohol, from Dutch/ Macassan

Europeans brought easy supplies

In 1788 the First Fleet brought rum and wine to Australia. People in England then drank huge amounts of alcohol. In fact in 1750, (just before the first settlement started in Sydney), there was a gin epidemic — 3 million people managed to drink 11 million gallons of gin! The rich and the poor people all drank a lot. Because the drinking water in England was often dirty and polluted in those days, beer was safer than water. In Australia, the Europeans soon got started growing hops for beer and grapes for wine, and making distilleries for spirits. People's wages were paid in rum. The government tried to limit the number of licensed premises. But there were soon breweries in many country towns.

The first alcohol controls

'In case you should find it indispensibly necessary to grant licenses for retailing spirituous liquors, it will be your duty to confine such licenses to as few persons as possible; if to two or three, their conduct would be more easily watched and controuled, and the first instance of irregularity should deprive them of the license'.
(Hobart to King, 14 February 1803, *Historical Records of Australia*)

learning to drink

Aboriginal people learned to drink heavily from the English and Irish. The bush pubs were full of fighting, swearing and dead drunk Europeans who drank up their money when they came in after months of working out bush. Licensees gave Aboriginal people the leftovers from bottles and glasses and what they called 'bull', the liquid from washing out the rum casks. Missionaries and temperance groups (organisations trying to persuade people to stop drinking alcohol) worried about the welfare of Aboriginal drinkers. They tried to get prohibition for Aborigines, and in some places, for European Australians too.

Prohibition

Because of this 'welfare' concern—but also to keep the white settlers quiet (who thought drunken Aborigines were dangerous)—the first laws were passed prohibiting the supply of alcohol to Aborigines by each State or Territory. These are the dates when this happened: NSW in 1838; WA in 1880; Vic in 1864; SA (and NT) in 1869; Qld in 1885; Tas in 1908 and the ACT in 1929.

The laws covered people of mixed descent and (in Queensland), Pacific Islanders and Polynesian people. What happened after this, everyone knows. The States introduced laws that exempted some Aboriginal people from these rules, which meant if they mixed with 'good' company and did not live in the camps, they had a form of 'citizenship' (Albert Namatjira was a famous example). It meant that they could legally buy alcohol. But Aboriginal people could always get grog if they wanted it. People used to give their money to whites they knew ('bullockies') who would buy it for them on the side. Publicans sold grog illegally round the back of the pub while the police looked the other way. Some people think that the prohibition laws, and drinking out the back meant that Aboriginal people got into the habit of drinking a lot while they had the chance.

All the blackfeller drinking beneath the tall gum tree.
When he sees the policeman come you'll see him split the breeze.
Many's the time I've tried it but running does not pay.
Because when they get in those cells, ten pounds, or twenty days.
(Wilcannia Song, collected by Jeremy Beckett 1957)

The Aboriginal singer-songwriter, Dougie Young, wrote songs about those days. He was born in Mitchell, Queensland, but lived in Wilcannia and other parts of New South Wales in the 1950s and 1960s. Jeremy Beckett collected his songs onto a CD. See page 23 Resources

In the country style, his songs were based on the experiences of Aboriginal and white country people. Grog shows up in most of these songs. There are songs about flagons of wine, about punch-ups, good laughs, hangovers and the horrors. There are songs about the white people in town who spoiled all the fun, such as the magistrate and the police. The Aboriginal people in his songs are not victims. They are independent characters who choose themselves how they will live or die.

I'll drink and roam till the cows come home
If it will give my poor heart ease.
I don't care who know, I work for my dough,
And I'll spend it as I please. (Dougie Young)

Changing the prohibition laws

citizenship

After the Referendum in 1967, Aboriginal people could be counted in the census, and the Commonwealth government, as well as the State governments, could now make laws on behalf of Aborigines. Aboriginal people were able to vote in elections from 1962 onwards. Some older people remember the Referendum as 'citizenship' that gave them the right to drink. But it is not true that the Referendum changed the drinking laws. These were State or Territory laws, separate from the Referendum. Prohibition was repealed in each State in these years: Vic 1957; Tas 1959; Qld 1961; NSW 1963; NT 1964; ACT 1965; SA 1967 and WA 1972.

I bin first drink when I bin thirty. Thirty. I was a grown-up. Because I didn't involve when I bin a young one because it wasn't agreement for Aboriginal people to go into a pub and when I bin thirty years of age and people said we legal to go into a pub like a European and drink. Yes, citizenship came in and that's the reason I had to go and drink. (Jack Little)

Now we think this was discrimination. It was humiliating, a shame job, not to be able to go into a pub and buy a beer alongside white people, or to have a policeman smelling your breath to see if you had been drinking alcohol. Many people believed that drinking gave them equality with whites. **See First Taste in Resources page 23** ⇢ ⇢ ⇢

I got picked up here in Ceduna, took me a long time to wake up to myself but old sergeant at the time, he used to get on the windy side of me to get the smell and he'd have me up for drinking grog. But I woke up this time, he came around, and every time he'd walk on the windy side, I'd walk away from him. So he done that a couple of times, and his comment was — I remember his comment — he said 'what? you woke up to my trick! Took you a long time!'. So he didn't bother me after that. (Archie Barton)

The shame of these old laws still lives on. When communities are trying to work out what to do, and suggest changing the licence conditions at a local pub, older people sometimes say they should not, because of the past. They say they have a right to drink, that they won that right to drink, and no-one should take it away from them. This is an example of how powerful the history of discrimination and prohibition has been, and how the past can influence what happens today.

Nowadays

Drinking in Australia generally

statistics

Drinking alcohol is an Australian tradition. Alcohol has been the most popular drug in Australia from the time of the First Fleet. Now, Australians are 23rd in world ranking for alcohol consumption (2002 figures for pure alcohol consumption per capita) and 9th in the world for beer drinking. On average each Australian drinks 7.8 litres of pure alcohol each year. Overall, people in Australia are drinking less now than they were 20 years ago. But one out of every six Australians visiting his or her local doctor is probably drinking enough to cause physical damage to his or her body. Now people drink more wine and more low alcohol beer than they used to, and more young people are using 'ready to drink' mixes (spirits and mixers). All alcohol sales provide tax money to the Australian government but the benefits of this income have to be weighed up against the damage caused by alcohol.

See Economic costs and benefits of alcohol page 17 ⇢ ⇢ ⇢

Differences in the way people drink

Surveys show differences in alcohol consumption between Indigenous and non-Indigenous people. As a proportion of each population, more Indigenous than non-Indigenous people do not drink alcohol at all (37% as against 22%, NDS 1994). But those Indigenous people who do drink alcohol, drink enough to cause some harm. For example, the NDS 1994 survey (still the best one) of Indigenous people living in cities and towns showed that 70% of men who drink usually drank more than six standard drinks at a session, and 67% of females usually drank more than four standard drinks. Twenty-four per cent of non-Indigenous males (and only 11% of females) drank this much.

See page 32 **Alcohol** Standard drinks

See page 231 **Handouts** Standard drinks

In some small populations of Aboriginal people (in the Northern Territory and South Australia), heavy drinking is a direct cause of about half of all deaths. About one-third of the Aboriginal population lives in small rural communities where even a few heavy drinkers can affect everyone. When non-Aboriginal people are heavy drinkers, it is more hidden inside the home.

> *On my payday I used to leave hundred dollar Curtis drive-in, hundred dollar in the pub, and my takeaway I used to take two cask, or four wine, smoke. I used to get up four o'clock in the morning, that's when I used to start drink. Till six o'clock, I used to go to Wallaby camp, or Wave Hill camp, to get more grog. Used to get drunk before ten. Over to the pub for one or two or three can, and then after that used to walk out, walk around in the pub, friend used to buy me a grog, more beer. I had money but I didn't bother about eating. Nothing.* (Chappy Robinson)

While people in both remote and urban areas consume large amounts, there are those who drink moderately—one survey in NSW found 20 per cent of Aboriginal men and 10 per cent of Aboriginal women drank 'responsibly' (according to standards set by the National Health and Medical Research Council; Perkins et al 1994).

Now the boys and me at the old gum tree were havin' a drink of wine.
We were feelin' bad cause we only had one lousy flagon of wine.
Old Hunter Bert with his eyes alert said 'Hey, steady on with that brew!
You hungry lout, when the grog runs out, what the heck we goin' to do?'
So pass him the flagon boys, and let him drink it down.
Hey, whoa, don't let 'im drink too much, you gotta make it spin around.
You better steady on for when the grog's all gone,
It's the end of a good day's fun
And it'll be a tarpaulin muster to get the price of another one.
('Pass him the flagon' by Dougie Young)

Maybe Aboriginal ways of drinking have changed?

'See, before, we only had Aboriginal "alcoholics"; Aboriginal people in their late thirties or forties that had drunk heavily for many years. Their health had been affected; their family life had been destroyed and the only choice they had left was to stop drinking for good. In the last ten years, things have changed. We now have younger lads. They have personality problems they haven't got to terms with; but maybe they haven't got an addiction, yet. They 'binge' with their mates. Some of them use other drugs too. You know, marijuana; but not only marijuana, also pills, speed and smack. And they mix them with the alcohol'.

(Drug and alcohol counsellor from Victoria, quoted in Alati 1996)

The economic costs and benefits of alcohol

liquor industry

From the time of the early settlements, Australians made and sold alcohol. In Western Australia it only took six years for there to be a licensed pub for every 75 people!

Alcohol has been part of the story of government control over Aboriginal people for many years

Governments allowed Aboriginal people to drink. Then Aborigines were forbidden to drink. Then they allowed some Aborigines to drink and not others. Then prohibition for all Aboriginal people ended. By this time drinking had become a symbol of equality and 'citizenship'. This history makes it hard now for communities deciding on what kind of restrictions to apply.

Aboriginal people help keep profits up in particular local areas

In certain areas, Aboriginal people are very important to the profits made by licensees. In some places licensees stock cheap fortified wine (port) in bottles or casks specially for Aborigines. Few others drink this 'monkey blood'. Some have it wrapped up in brown paper ready to go. In other places hotels keep keycards belonging to Aboriginal people making it easy for people to pay for grog – the Northern Territory and Western Australian governments have outlawed this practice.

In one Aboriginal community a closed-door meeting of the council voted to have a licensed club. Within 24 hours a plane-load of eager brewery executives arrived, delighted at the new market opportunity opening up before them. (D'Abbs, Hunter, Reser and Martin 1994)

Governments and the liquor industry have always been connected. The liquor and tourism industries employ lots of people who have influence with the government. Governments have to bear the costs of alcohol-related harm, but they also make money through alcohol sales and taxes.

alcohol taxes

Pricing issues

Alcohol taxes are an economic benefit to the country. The government uses this income to contribute to infrastructure costs such as hospitals, schools and roads. In 2001 the Alcohol Education and Rehabilitation Foundation (AERF) was set up with $115 million from the over-collection of beer excise. In that year, Australian federal and state governments raised about $3.1 billion in alcohol taxes.

People complain about taxes but they will support a tax being used to fund treatment services and community education. Research around the world shows that paying more tax (which increases the price of alcohol to the consumer) helps to decrease the amount that people drink. Some alcohol is quite cheap.

Cask wine has twice the alcohol content of beer but sells for the same price per litre as lemonade! It is only taxed at 64c a litre compared with $3.28 a litre on a bottle of wine.

Benefits of the Living with Alcohol Program

Between 1992 and 1997 the Northern Territory placed a small extra charge on alcohol drinks (stronger than 3%). The money from this 'levy' went into a special fund for community education, alcohol campaigns and treatment services to help reduce alcohol harm. This was the Living with Alcohol Program. The first year of the tax made $7 million to go into the special fund. When it started, people in the Territory were drinking 70% more than the rest of Australia and one out of two road deaths were alcohol-related. An evaluation found big drops in alcohol-related harm, especially road crash injuries. It also found the Program saved $124 million in the cost of alcohol-related harm. The Program and the levy, sparked greater public support for harm minimisation and community-based actions.

(National Drug Research Institute & Lewin Fordham Group 1999)

Health and taxes

volumetric tax

Cutting down on the amount people drink helps to prevent injuries and illnesses. Some kinds of alcohol are involved in more harm than others (cask and flagon wine for example). Because of this, public health researchers encourage governments around the world to tax drinks according to how high the alcohol content is. This is called a 'volumetric tax' — a tax based on the volume of alcohol. A low-alcohol beer should cost less than full strength beer.

See page 135 **Controls** Restrictions and product substitution

BENEFIT

Making alcohol (and tobacco) more expensive is a good public health strategy: it cuts consumption.

DRAWBACK

If alcohol is more expensive, some people argue that drinkers will spend even less money on things such as food.

Cost of alcohol misuse

Although making and selling alcohol contributes to the economy, alcohol misuse costs the Australian economy $7.5 billion each year (2002 figures) from deaths, illnesses, accidents, health care costs, crime, and lost productivity.

In 1997, 23,000 Australians lost their lives because of alcohol or other drugs and 3,668 of these deaths were alcohol-related. About one-third of all driver and pedestrian deaths on our roads are alcohol-related (1990–1997).

Alcohol and tobacco are responsible for 90 per cent of the deaths and disabilities from drugs, but in 2004 the Australian government only allocated $4.2 million over four years for the continuation of the National Alcohol Harm Reduction Strategy. This is a very small part (less than 1%) of the $439.6 million allocated under the National Illicit Drug Strategy over four years.

The majority of Indigenous people identify alcohol as a serious problem in their communities. Alcohol is associated with 75 per cent of homicides among Indigenous people, with most family violence and with high imprisonment rates. Alcohol misuse shortens the lives of Indigenous people, who live up to 20 years less than other Australians.

Aboriginal singer-songwriter Dougie Young imagined what it would be like if all the boys knocked off drinking in Old Balranald Town:

The local lockup is empty, there's no prisoners there now.
While they finally got sick of the old gaolhouse chow.
There's no white feller runnin', supplying darkies with grog,
And the cops in Balranald, they're all out of a job.
Now the publican, he went broke. He's now walking the track
Since the boys gave up sneakin' all grog 'round the back.
The old gum trees are all leanin', any day they will fall.
The big pub's full of cobwebs and dust on the wall.

('Old Balranald Town' by Dougie Young)

Alcohol policy development

Countries around the world have become more aware of alcohol as an important factor in public health. Many countries have adopted 'health for all' policies, and alcohol fits into these. So alcohol policies are being discussed and written in many countries. They guide action and provide advice about the best ways of controlling the sale and supply of alcohol, and caring for people with problems, so as to cut down on deaths, illnesses and injuries.

policy advice

Alcohol policies are useful internationally, on a large scale; at the national and state or territory level; and in local organisations, right down to having small scale policy for community-owned liquor outlets.

World Health Organisation (WHO) policy

At the international level, a WHO alcohol policy team has made recommendations for countries around the world to follow. It says that policy measures that affect all drinkers will have an impact on problem drinkers too. The WHO team advises that policy should:

- Have broad targets and not be limited to 'alcoholism'.
- Take notice of alcohol-related problems and alcohol dependence.
- Prioritise acute and accident problems as well as long-term illness.
- Deal with small and common problems as well as major ones.
- Be concerned with the impact of drinking on the family as well as the drinker.

Teams of WHO experts have written major publications on alcohol policy, public health, and developing societies.

See page 23 Resources this chapter for details

Australian alcohol policy

Australia has adopted a public health approach to alcohol policy. It has a National Alcohol Strategy that builds on the National Health Policy on Alcohol (1989). The major strategies are harm reduction, demand reduction and supply reduction. Its goal is:

harm reduction

> *'To build a healthier and safer community by minimising alcohol-related harm to the individual, family and society, while recognising the potential social and health benefits from alcohol'.*

Linked in with these mainstream policies and strategies in Indigenous health, there's an *Aboriginal and Torres Strait Islander Peoples Complementary Strategy,* drawn up through consultations by the NDS Aboriginal & Torres Strait Islander Reference Group chaired by Ted Wilkes.

Local policies

Policies can cover regions, local communities and can be made to deal with much smaller environments, such as workplaces, and licensed premises such as community-controlled clubs. An example of local policies are the Alcohol Management Plans.

See page 145 **Controls** Alcohol Management Plans
See page 156 **Controls** Making policy for clubs
See page 54 **Alcohol** Making policies for the workplace

Policy myths

'Heavy drinkers are a group of people so different from everyone else that they will not be influenced by ordinary restrictions and constraints'.

'Drinking only has a negative effect on a small minority of the population'.

'The amount of alcohol and the style of drinking in a population have no influence on the number of drinking problems'.

Research has shown that all these statements are wrong!

Resources for chapter 1 History

First Taste. How Indigenous Australians Learned about Grog

A set of six resources by Maggie Brady (2008) order from www.aerf.com.au

The Songs of Dougie Young. CD produced by AIATSIS and the National Library of Australia (with accompanying notes by Jeremy Beckett). Phone 02 6246 1111 Contact www.aiatsis.gov.au

National Alcohol Indicators Bulletins

Short bulletins of Australia-wide statistics for each state and territory on youth, road accidents, mortality etc. Bulletins on Indigenous statistics are planned. www.ndri.curtin.edu.au/publications

An electronic version of Australian Alcohol Indicators, Patterns of Alcohol Use and Related Harms for Australian States and Territories (order no. AG21) is available at www.alcohol.gov.au

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National Alcohol Strategy (2001–2004) www.alcohol.gov.au

National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2006 www.alcohol.gov.au

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What's in the 'alcohol' chapter?

Introduction

Alcohol is a substance that changes how the body works – it is a 'drug'. When you drink something with alcohol in it, like beer, wine or spirits, the drug (alcohol) changes the way you think, act and feel. It slows down the nervous system (a depressant). Where you drink and who you are with also affect you. For many people this is OK—after all alcohol is drunk by people all over the world. It helps us to relax with friends, enjoy ourselves, to be friendly to visitors. In some parts of the world, alcohol is used in traditional ceremonies; some Christians have wine when they take communion in church.

Think about these three things to help you understand the ways in which drinking alcohol or using a drug affects people differently:

- **The drug, alcohol itself** — what kind of alcohol, how strong it is.
- **The drinker or user of the drug** — the person's size and weight, whether male or female, the person's personality and history.
- **The environment** — everything else going on around the drinker, friends, how they share alcohol, drinking places and availability.

This is the framework we use in this chapter.

Alcohol, the drug

So first, alcohol itself.

- Alcohol is a powerful drug and is toxic. It can poison the human body if taken in large quantities, or if taken with other drugs.
- In small amounts, alcohol can give people a feeling of wellbeing. It can make them feel more confident, talkative and relaxed.
- A moderate amount of alcohol does not harm most people. But regular heavy drinking can cause health and other problems.

Beer is all froth and bubble,
Whisky will make you moan,
Plonk is another name for trouble,
But the metho* is out on its own.

*methylated spirit

Alcohol content

Alcoholic drinks are made in different ways. All of them contain water, ethyl alcohol and sugars.

Beer is made by fermentation of grains and malt, and hops (a vegetable) are added to give flavour. The fermentation process produces ethyl alcohol. Most beers contain between 4–7% alcohol; light beer contains about 2.7% alcohol.

Home brew produces beer that contains around 4.5% alcohol. It uses a lot of sugar (1 kg). Bottles and containers must be clean and hygienic to make this beer safe to drink.

Wine is made by fermentation of grapes or other fruit. Wine contains between 9–14% alcohol. Fortified wines (port and sherry), contain much more, between 18–21% alcohol. Sweet wine contains a lot of sugar.

Spirits or hard liquor (whisky, gin, rum, vodka) are made by distilling a fermented mix of grain, fruit or molasses. Spirits contain a lot of alcohol, between 40–50%. Spirits have fewer additives in them than wines and beer, and less sugar.

Some people worry that some kinds of alcohol are more 'dangerous' than others. In fact, it is not 'safer' to drink a lot of beer, rather than a lot of wine. Makers of commercial beer and wine put additives in them to stop the drink from going 'off', such as sulphur dioxide. Sulphur dioxide can give an asthma attack to people who have asthma. A lot of any alcohol can harm a person's health. It is ethyl alcohol that causes all the alcohol-related health problems — it is that simple!

What do we know about homebrew?

In some newly restricted (dry) areas, people have been getting around restrictions by buying homebrew kits to make their own beer and selling it illegally. Homebrew can undermine any positive effects of restrictions. The Queensland government has responded by amending the legislation to allow communities to ban these kits. This is not a blanket ban; decisions can be taken by each community.

What are the dangers of homebrew?

Some people are drinking homebrew before the beer has finished fermenting. This will produce a thick, sickly sweet unfermented drink that will taste bad. As far as we know, drinking this too soon is not dangerous in itself. If it has not had time to ferment, it will not contain any alcohol, or only very little.

The dangers of homebrew are: risk of bottles exploding if instructions are not followed; making beer in dirty containers. All bottles must be sterilized (or else people risk infections such as *E.coli*), and be properly stored. (Thanks to Dr Tim Cooper, Cooper's Brewery)

Illegal to sell homebrew

'A 59 year old man has been busted by police for selling home brew in Tennant Creek on so-called Thirsty Thursday. When police raided his Peko Road home they found two 20 litre tubs of beer in the kitchen. They also discovered dozens of coke bottles that had been filled with drink and were allegedly ready to be sold. Senior Sergeant Chris Smith said the man had allegedly taken advantage of the 'dry' day to sell his home brew. But he said regardless of the day the activity was still illegal. It's not illegal to brew your own but it is illegal to sell it'.

(*NT News* 21 August 2004:2)

Methylated spirit

'Metho' or 'goom' is nearly all ethyl alcohol (95% is alcohol). It has additives in it to make unattractive. Metho is cheap (less than $4 a litre). Metho is poisonous because of its high alcohol level. Workers in detox centres say that metho drinking is 'slow suicide'.

See page 141 **Controls** Sales of methylated spirits

'I left Perth and came up to the north—drinking all the way of course. I'd done my hitchhike right from Perth to Broome and Darwin. Of course it was the goom camp set, which I found quite easy in Darwin. Goom, we call the metho goom. Well, after I'd gotten to Brisbane, after being pretty heavily into the metho, my legs had started to go on me. I couldn't walk in the mornings. I was losing my sense of balance. The old brain was getting very foggy. That sort of got to me'.

(Lindsay N)

Standard drinks

The Australian Government has been teaching the public about how people can drink alcohol without harming their health. They wrote guidelines based on the idea of a 'standard drink'.

A standard drink is any drink containing ten grams of alcohol.

All alcoholic drink bottles and cans are labelled by law saying how many 'standard drinks' they contain. Look on the can or bottle to see how many standard drinks are in it. Here is an example of the new label.

What is a standard drink?

1 can of mid strength beer	=	**1** standard drink
1 can of full strength beer (4.8%)	=	**1.4** standard drinks
1 small glass of red wine (100mls)	=	**1** standard drink
1 nip of spirits (30mls)	=	**1** standard drink

Or you can think about the number of standard drinks like this

1 slab full strength beer (cans or stubbies)	=	**34** standard drinks
1 x 4-litre cask of white wine (11.5%)	=	**36** standard drinks
1 soft drink bottle (750mls) filled with red wine	=	**7.7** standard drinks

Guidelines to reduce health risks

lifetime risk

For healthy men and women, drinking no more that two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury.

For healthy men and women, drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion.

Refer to the *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* and the *Alcohol Treatment Guidelines for Indigenous Australians* (see page 57).

Binge drinking is bad for your health

binge drinking

The health people recommend that people should not 'save up' their drinks — or their money — for a binge every week or fortnight. Drinking up big (irregular heavy drinking) is more likely to end in an accident or a fight, and makes sudden heart attacks and coronary heart disease more likely. No more than 4 drinks at a time!

Blood alcohol level

Many traffic accidents (including pedestrians being killed) are caused by alcohol. It is an offence to drive with a blood alcohol level, BAL (or blood alcohol concentration, BAC) of over .05. Breaking this law carries heavy penalties. Anyone under the influence of alcohol or other drugs who kills or injures another person while driving can be sentenced to a term in prison.

drink-driving

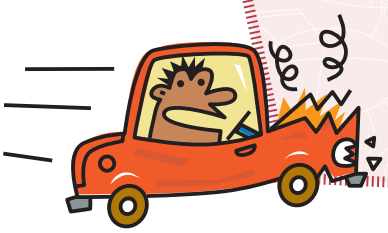
To keep under .05 blood alcohol level—so that you can drink and drive safely—you need to drink slowly, and not much. The NSW government campaign has as its slogan 'Enjoy a few—not a few too many'.

Drinking and driving

Men should have no more than two standard drinks in the first hour of drinking if they want to drive.

Women should have only one standard drink in that first hour.

Both men and women should have only one drink each hour after that if they want to stay below the .05 limit (but remember the recommended levels for low risk drinking!)



Is alcohol good for you?

Research shows that drinking small amounts of alcohol regularly cuts down on the risk of heart disease in people who are middle-aged or older. There is a lot of talk about what 'small amounts' means and so it is hard to say exactly, but probably about one small glass of wine or beer each day. That's all. You can get the same benefit by starting to exercise or by eating more vegetables. Drinking large amounts of alcohol in binges actually increases the risk of heart disease. All we can say is that, if a person drinks, it is better for health reasons to take it easy.

Women and alcohol

Women are different to men

- Women's bodies are more vulnerable to alcohol.
- Even if a woman is the same size and weight and drinks the same as a man, the concentration of alcohol in her blood will be higher.
- Some research shows that women who drink a lot have a greater chance of developing breast cancer.

Alcohol and pregnancy

FAS

If a woman drinks heavily in the early days of her pregnancy, she risks the health of her baby. Babies born from drinking mothers can be retarded in their physical growth and are slow to learn. They will find it hard to remember things as they grow up. When a baby is like this it is called 'foetal alcohol syndrome', or FAS for short. FAS affects the way the baby grows, learns and behaves. Doctors in the USA first described FAS in 1973. Since then it has become recognised as a worldwide issue. Health workers in Australia are very worried about the number of women who drink and may not know they are pregnant, or may not know about FAS and carry on drinking while pregnant.

For women who are pregnant or are planning a pregnancy and for women who are breastfeeding, not drinking is the safest option.

Harmful drinking when pregnant

Problems for the mother:

- Complications like miscarriage, stillbirth, babies born too early.
- Poor nutrition.
- Low blood sugar/glucose (hypoglycaemia).
- Diabetes when pregnant, high blood sugar/glucose.
- Withdrawal from alcohol while giving birth.

Problems for the baby:

- Poor growth and development, especially the brain
- Breathing trouble when born.
- Weak sucking.
- Can't sleep well.
- Weak muscles, not so active.
- Slow to grow and learn.
- Behaviour problems later.

See page 97–98 **Prevention** (for more on FAS)

See page 57 Resources this chapter

See page 239 **Handouts** Talking with women about their drinking

The drinker

The effects of alcohol on people depend on how fast people drink, whether they have eaten anything, whether they are male or female, and how big they are. The effects also depend on whether they are used to drinking or not, and what they expect to happen when they drink. You don't have to be an 'alcoholic' to get into trouble with drink! For example, it is not just a question of how often and how much a person drinks, but how high his or her blood alcohol level goes and what the person is doing at the time.

Why does alcohol change people?

alcohol effects

Alcohol goes into the bloodstream through the walls of the stomach and the gut (small intestine). Alcohol travels quickly around the body in the blood. It begins to affect the brain within five minutes. Alcohol slows down the activity of the brain. It depresses all parts of the brain. For example, it affects your balance, so that people can't walk straight when they are drunk.

See page 107 **Prevention** Are YOU fit to drive?

Alcohol is an anaesthetic which means that it makes you less sensitive to pain. It also increases heat loss from the body. When you feel that 'warm glow' it is because you can feel the heat leaving your body more quickly. This heat loss can be dangerous if people fall asleep in the cold. They can suffer from hypothermia and die.

The liver has the job of cleaning out the alcohol from the bloodstream—it detoxifies or breaks down the alcohol in the body. It takes one hour for the liver to clear one standard drink from the bloodstream. Nothing will speed this up.

'I was watching you know. I was sitting down, you know just watching them. Men they told me "hey! you want to get warm? try this!" Uwa [yes] it was really cold too, and I bin try em you know. First [time], got really drunk. Yes I couldn't walk. I gotta crawl to the camp. I was really headache then. Boss of me then'. (Young Mr May)

Tolerance and dependence

If people think they can drink a lot without feeling much effect, this may be because they are becoming tolerant to alcohol.

Tolerance means that your body is used to alcohol, so you have to drink more to get the same effect. You have a problem! Tolerance is lost after a period of abstinence.

Dependence on alcohol means that alcohol becomes the number one thing in a person's thoughts, feelings and activities. The dependent person thinks about it all the time. A dependent person finds it very hard to stop drinking.

Alcohol and health

Signs of trouble in a drinker's body and mind

Drinking heavily over several years (all the time, or binge drinking) can cause different physical and mental problems.

short term effects

In the short term, heavy drinkers can suffer from:

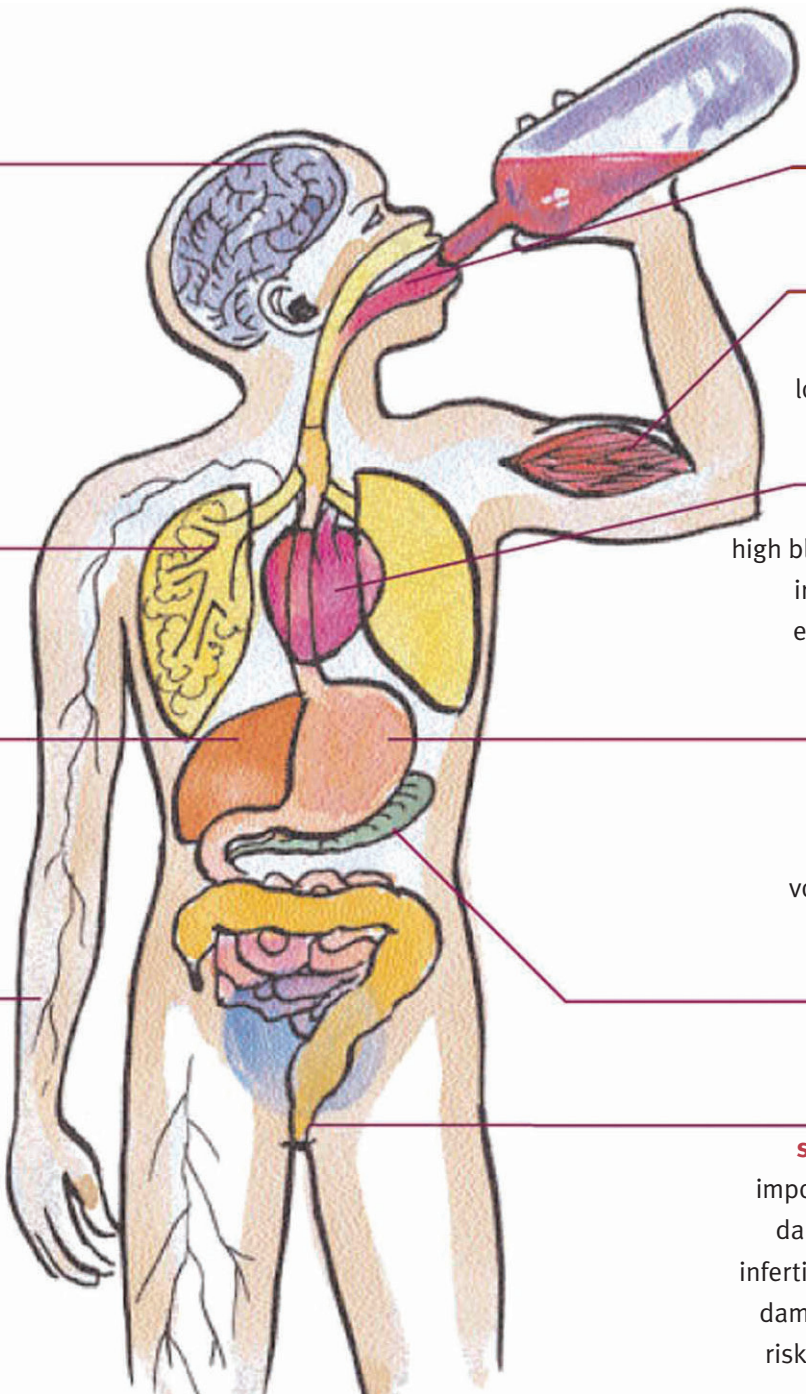
- **Stomach problems** (gastritis and ulcers) causing pain, vomiting including vomiting blood.
- **Liver problems** (alcoholic hepatitis) causing pain, vomiting and jaundice (yellow skin).
- **Pancreas trouble** (acute pancreatitis) that makes the drinker very sick with pain and vomiting.
- **Brain problems** like loss of consciousness, fitting, going off. These things may happen during withdrawal (the horrors) or to people who are still drinking (hallucinosis—being scared, paranoid and hearing things), and may make existing mental health problems worse.

long term effects

In the longer term, heavy drinkers can get:

- **Liver cirrhosis** and liver failure—these often kill drinkers
- **Malnourishment** from loss of appetite and malabsorption from the gut. This can lead to serious brain damage with no short term memory (called 'Korsakoff's psychosis'), and to paralysis of the eye muscles and difficulty with balance (called 'Wernicke's encephalopathy').
- **Brain problems** and dementia, causing a person to be forgetful and unstable. People with dementia often believe that others are picking on them.
- **Nervous system problems** — nerves to the arms and legs do not work properly; pins and needles, and numbness.
- **Chronic pancreas and intestinal problems** causing malabsorption, and diabetes in some cases.
- **Heart problems** where the heart muscle does not work so well any more (cardiomyopathy and heart failure).

The effects of alcohol on the body



brain
brain damage
loss of memory
hallucinations
fits
confusion
dementia

lungs
risk of chest infection
TB

liver
swollen liver
cirrhosis
hepatitis
liver cancer

nervous system
tingling nerves
numbness
tiredness
loss of feeling

throat
coughing

muscles
weakness
loss of muscle

heart
high blood pressure
irregular pulse
enlarged heart

stomach
inflammation
ulcers
vomiting blood

pancreas
pancreatitis

sexual organs
impotence in men
damaged sperm
infertility in women
damage to foetus
risk of STI / AIDS

'Oh, real weak on the two knee, and arm you know and I couldn't pick em up anything. Couldn't even hold the tea. No – real weak. Couldn't see from here to that motor car. Just see the country, [like] smoke. That's what happened from the grog. Yeah. I bin tell them all, you know, I can't take it my grog. I can't see too far. I can't feel my stomach, and I can't get myself clean, and I got no good bed...' (Claude Manbulloo)

Other health problems commonly associated with heavy drinking include:

- Sexual problems (men find it harder to get an erection).
- Infertility and menstrual problems among women.
- Obesity — getting fat.
- High blood pressure and ischaemic heart disease.
- Anxiety, sleeplessness, loss of appetite.

While some of these problems improve if the person stops drinking, others do not.

'It was in '88 I gave up drinking, on account of my foot. I'm diabetic and [the] more alcohol I drank .... being a diabetic, if you get any cut or anything you sort of break out, infection breaks out. That's what happened to me'. (Mr Singh)

Poly drug use

This refers to people who drink alcohol and use other drugs as well. People who use more than one drug together are more at risk of toxic drug interactions, severe intoxication and suicide.

A coroner's inquest report on suicides

'At the vanguard of the need for change, is the need to address alcohol and marijuana abuse. If the evidence of this inquest suggests anything, it is that alcohol and marijuana abuse are destructive of all current attempts at ameliorating the unacceptable suicide and attempted suicide statistics'.
(CR McDonald QC)

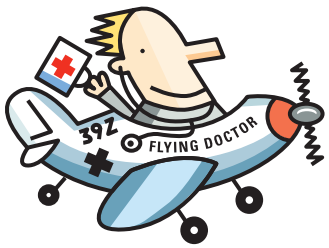
How can drinking make people sick?

Alcohol can make people sick for a number of reasons.

Toxicity Alcohol itself, in large amounts, is toxic, poisonous to the body. If a person drinks heavily, either drinking a lot every day, or drinking cartons and casks one after the other every weekend or every few weeks, the liver just cannot clear out the alcohol quickly enough.

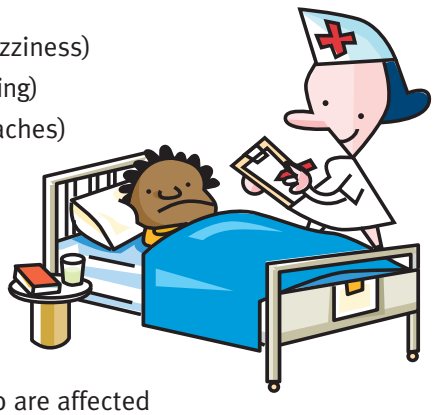
Allergies Some people are allergic to the additives that are put into alcohol when it is made by the breweries, wine-makers or distillers.

Medicine Alcohol can affect people badly if they are taking some kinds of medication or tablets for another illness. This means that if they are taking prescribed drugs (drugs given by a doctor or a nurse) and drink alcohol as well, they can become sick. Drinking alcohol can also stop the prescribed drug from doing its proper work.



This includes the medicines for:

- diabetes
- high blood pressure, angina (can cause dizziness)
- strokes (can affect the control of blood clotting)
- antibiotics for infections (can cause headaches)
- arthritis (can cause upset stomach)
- epilepsy (can cause sleepiness)
- mental illness; anti-psychotic drugs.



'Addicts' or 'abusers'?

These two terms are often used to describe people who are affected by alcohol. Drinking or taking a drug does not mean the person will become addicted. This has to do with the way the drug, the person and the environment around the person all interact.

addiction

'Addict' or 'alcoholic' are words used by many people to describe a person who can't seem to stop drinking. But these terms can sound bad, like a put-down, as if the person's situation is hopeless and nothing can be done about it. This is not true, there is always help. It is better to say that someone has 'drink problems' or is 'dependent'. This describes a person who feels that he or she needs to keep on drinking or finds it hard to give up. Drink is the most important thing for someone like this, and he or she will carry on even when drinking is causing major problems.

withdrawal

People who have been drinking heavily for a long time can feel very sick when they stop. This is because the body has to get used to not having alcohol again — it is called **withdrawal**. A person like this is dependent on alcohol and can have fits and very bad shakes (the DTs) when he or she stops drinking. The DTs can be fatal, especially if someone has been drinking for many years. A person like this needs a doctor's care or a detox unit in order to stop drinking safely. Many feel a craving for alcohol after they stop; there are medications that can help with this.

See page 205 **Care** What is detox?

See page 244 **Handouts**
Terms and phrases which may be misunderstood

abuse

Abuse/misuse is something different to addiction. It is important not to confuse the two. Abuse or misuse can describe a person who drinks heavily from time to time, getting intoxicated, having bad hangovers, getting into fights or car accidents. Most people who misuse alcohol or drugs at some stage in their lives grow out of it; some with help, some on their own. Lots of Aboriginal and Torres Strait Islander people give up drinking altogether in their 40s.

Is alcoholism a disease?

The idea that alcoholism is a disease started about 200 years ago in America. People who found it hard to stop drinking were said to have a 'disease of the will'—no will-power to stop themselves from craving alcohol. From this came another idea, that the only way to cure this addiction was not to drink alcohol at all.

Now many people think differently about problem drinking; these ideas change from country to country as well as over time. In Australia it was common in the 1950s to refer to alcoholism as a disease. Now this has changed. But in the US, for example, there are still many programs based on the idea that alcoholism is a disease. The World Health Organisation (WHO), which looks at what experts are thinking around the world, cut out the word 'alcoholism' from the International Classification of Diseases in 1977. WHO talks of 'alcohol-related problems' and the 'alcohol dependence syndrome'.

Theories about addiction have changed over time—they are influenced by historical, social and political factors. If you do NOT believe in the disease idea, you can try to see someone who drinks a lot as a 'hard drinker' who has learned to drink that way. The person has got stuck in that habit and can change the way he or she drinks — not someone who has an illness making them drink that way.

There is no evidence to prove drinking problems are the result of a disease. But experts agree that heavy drinking can *cause* disease (as we have already shown), and alcohol-related problems seriously affect individuals, families, and society. Experts agree that people with a long history of alcohol and health problems need to stop drinking altogether.

Debate these two points of view

People have strong views about the idea of alcoholism as a disease:

> *'Smoking, drinking, and quitting, like eating and dieting or excercising and being a couch potato, are matters of free will and personal choice. Yes, habits may cause disease—but habits aren't diseases in and of themselves. Cancer is a disease. Smoking is a habitual behaviour. Likening a behaviour to a disease seems especially cruel to people with real diseases. A person cannot choose to quit or moderate diabetes.'* (JA Schaler 1997)

> *' Alcoholism is a disease and should be treated as such. The old method of treatment, of punishment, control and media campaigns, did not work. Would cancer respond to punishment or advertisements? No. Our society is structured to keep alcoholics in denial. How many times have you heard 'if you really wanted to, you could give it up?' Alcoholism is a disease. Can you give up cancer?'* (E Shirt 1994)

Do alcohol problems run in families?

'Yes, it is often the way. But in many cultures, so does being a tinker, tailor, soldier or sailor. Children follow in their parents' footsteps, mostly because of role modelling and opportunity, not because of genetics. Perhaps drinking runs in families not because of anything written into peoples' genes, but because of home influences.' (Griffith Edwards)

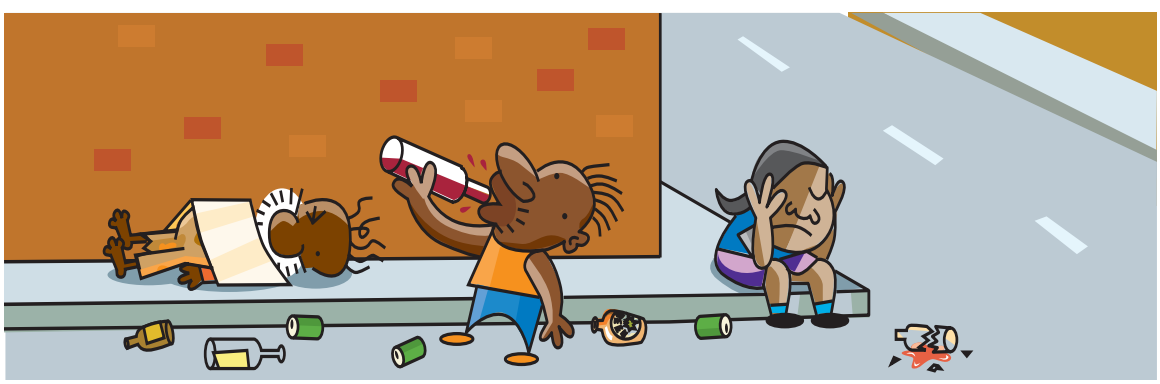
Benefits and drawbacks of thinking of alcoholism as a disease

Benefits

- A person might not feel blame for what has happened in his or her life. The individual can explain this by saying 'I have a disease'.
- A person can then try to 'recover' (as if the person is ill).

Drawbacks

- A person might feel hopeless. He or she might think 'this thing will always be inside me. I can never take another drink'.
- If a person believes that having one drink will send him or her downhill again, having a drink could make the person feel a failure and be an excuse for drinking more. This means that person takes less responsibility for his or her actions.
- The more people believe that they cannot cut down on their drinking, that they are are powerless, the more they are likely to act in a powerless way. This is called a 'self-fulfilling prophesy'.
- It is very difficult to persuade young people who are heavy drinkers that they have an illness, and that they must become completely sober for the rest of their lives. They might be persuaded to slow down though.



See page 232 **Handouts**
Questions and answers about alcohol

See page 237 **Handouts**
Let's get straight about harm reduction

The environment

Social, cultural and physical influences

Health professionals have come to realise that alcohol problems are not caused by individual weakness or by the powerful effects of alcohol. They are also the result of the environment in which the person drinks. The social, cultural and physical environments are very important influences on how we drink.

There is a famous study of alcohol use that looks at many different societies around the world (*Drunken Comportment* by C MacAndrew and RB Edgerton). The book describes how in different societies people behave in different ways when they drink. It shows that people behave according to the customs for drunken behaviour in their particular cultural group. It shows that people 'learn' styles of drinking and how to behave when drunk. It shows that these change according to the situation and drinking environment.

Think about this: How many people do you know who will get full drunk when they are with their usual mates, it is payday, and the mood is right? They are out in the open, sharing a carton or a 'green suitcase'.* There will be arguments, people get angry, maybe a fight develops. Then maybe someone from that same group goes to a meeting in town the next week and has a meal somewhere in a restaurant. The place is quiet, people talking and laughing a bit, and that person might just have one beer or one glass of wine with a meal. No problem! This is what is meant by the influence of the environment.

*cask of wine

The environment influences the way people drink, how much, who with, how they behave, how other people deal with them — everything about drinking itself. The environment includes things such as what people think and believe about alcohol and what are OK ways to behave; what are the local rules and role models. It includes how much grog there is around (how easy is it to get hold of), and what sort of drinking goes on — quiet drinking or bingeing. The physical environment

means drinking places and the surroundings, how comfortable or crowded they are. The environment makes all the difference—it makes it easier or harder to become a problem drinker in the first place, or to go from being a heavy drinker to being a light drinker or a non-drinker.

Some Indigenous people say 'whites never showed us how to drink properly — they never gave us the story for grog'. By saying things like this, people are recognising that the way we all drink is something we learn. In the early days, Aboriginal and Torres Strait Islander people were watching the wrong kind of drinking by whites! They saw those frontier men, hard men, pearlers, squatters and gold-diggers, timber-getters and stockmen — they all drank hard.

'Those clever white men always try to teach us poor, dumb Indians something new. I sure wish they'd teach us how to drink. When you buy a camera or a tape recorder, it always comes with a little booklet which tells you how to use it, but when they brought us in the white man's whisky, they forgot the instruction book. This has caused us no end of trouble.' (Lame Deer, Sioux Medicine Man)

social environment

When Aboriginal people lobby for residential rehab centres and 'dry' bush camps, they acknowledge how important the social environment is. They know that the social pressures on people to drink are very strong, and that people need a quiet place where they are protected from drinking mates and family. Drinkers who want to change need a place where they do not see the people, places, and situations that are associated with heavy drinking.

I spent the day in jail and they paid my bail
when they opened the big iron door.
Then I shook my head as I sadly said,
'Well, I'll never get drunk no more'.
And I made a vow I'd give it up somehow,
but as I strolled down the lane,
I met a friend of mind who had a flagon of wine,
so we turned it on again. (Dougie Young)

Availability of alcohol

access to alcohol

The experts say that controlling *access* to alcohol affects how much people drink. Access means how easy or hard it is to get hold of alcohol. That's what licensing laws are there for — the rules that say how a pub or a takeaway should operate, the hours it can open, who it is allowed to sell to, what sort of alcohol is sold. Different countries have had experiments to see what effects different rules can have. We also know from the scientific research that controlling access to alcohol makes it harder for problem drinkers —they find it hard to think ahead, save up grog or money for later.

There are many examples across Australia of Aboriginal and Torres Strait Islander groups being involved in these controls over the availability of alcohol. When the supply of alcohol is cut down, the alcohol-related problems are cut down too.

See page 132 **Controls** Women lobbying for restrictions

See page 145 **Controls** Alcohol Management Plans

See page 130 **Controls** Restrictions on sales in Tennant Creek

If you are planning an alcohol strategy or running a workshop, look at the experiences from other places and think about the environmental influences listed below. Workshop participants can discuss these influences on drinking behaviour:

discussion topics

Cultural background

Is alcohol part of the traditional culture? How do people learn to drink; their childhood and growing up; parents' roles; the role of religion/spirituality; how is alcohol drunk (Alone? In groups? With meals? In secret?)

Community attitudes

Are these tolerant? Do people accept drunken behaviour? Is there a split between drinkers and non-drinkers? Between men and women? Are young people allowed to drink, who teaches them and at what age?

Social controls

Are there local rules about drinking? When do people decide enough is enough? Who decides this? How do people express disapproval? How do people refuse to have a drink?

Social groups

Who drinks with whom? Are there role models for heavy or light drinking?

Local beliefs about alcohol and drinking

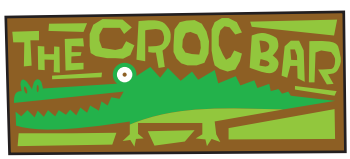
Do people use alcohol as an excuse? Do they blame the grog or the drinkers or the grog sellers?

Drinking places

Is there a choice of places to drink? Do people drink anyhow, in the open? Do people drink at home, in front of the kids? Are there other things to do without grog?

Licensed premises

How easy is it to buy alcohol? Are the pubs pleasant or unpleasant places? Are there distractions from drinking? Do they serve food? Play loud music? Do licensees target Aboriginal drinkers? Are there poker machines? How do the pokies affect drinking?



See pages 78–85 **Action** Planning action

'When you watch, you follow, you know? When somebody do things, see them, and you follow their example. They drink—well, you drink too! You get in there with them, they share you. "Hey, come on come on here, drink, here!". And you drink. That's it'. (Keith Peters)

gambling

Drinking and the pokies

Community groups and service providers are getting worried about the effects of poker machines on the social, economic and emotional wellbeing of Indigenous people. Australia has 21% of the world's poker machines and they are now appearing in pubs, clubs and hotels all over the country. Apart from taking large amounts of cash off people who are already poor, playing the pokies can mean trouble for drinkers. Poker machines are usually in licensed premises so alcohol is being sold as well. Drinking alcohol affects decision-making and can make it easier for gamblers to risk all their money on the machines. Drinking alcohol means that people are more likely to keep on playing, even when losing — their minds are not thinking straight.

Many Aboriginal people might say that gambling with cards has been going on for a long time, it is part of life in many communities — so what's the problem with poker machines?

Playing cards in the community is one thing:

- Cash tends to go round inside the community.
- Card playing is very public and sociable.
- Everyone can see who wins or loses.
- It does not always include drinking.

But playing poker machines is different:

- Pokies are more individual, no family around.
- Pokies are in drinking establishments.
- No one is there to witness wins or losses.
- When you lose, your money goes to the hotel (and the government!)

Gaming machine licences are administered by Gaming and Liquor Licensing boards in each state or territory.
Communities have rights to object.

See page 159 **Controls** for Licensing Board contacts

Black communities fend off pokies

Two remote Aboriginal communities have won a fight to ban poker machines from a hotel on South Australia's far west coast. The landmark decision also means that issues such as the socio-economic impact of gaming machines on 'extremely dependent people' can now be taken into account when deciding whether or not to grant poker machine licences.

Maralinga Tjarutja administrator Archie Barton said the decision would give the west coast Aboriginal communities 'the protection they need against the effects of poker machines'.
(*Weekend Australian* 31 October 1998)

The work environment

The workplace can be an important part of social and cultural life. Employers can show leadership by taking alcohol problems seriously and having standards. For example, the Institute for Aboriginal Development (IAD) in Alice Springs has a policy that no alcohol is served at official functions such as book launches. Making a policy shows that your staff are setting an example, and makes it clear that drinking or using drugs in the workplace are not acceptable. Land councils, resource agencies, health services can all decide to take a stand and make their own policies.

Making policies for the workplace

workplace

A workplace policy is about:

- Making the workplace safe and healthy.
- Promoting the safe use of alcohol.
- Helping people who have problems.
- Helping people take the right action with others who are intoxicated.
- Helping to protect jobs.

A policy is not about:

- Stopping people drinking.
- Forcing people to 'dob in a mate'.
- Forcing people into treatment.
- Shaming people.
- Giving people a bad name.
- Getting people sacked.

Organisations may need to make decisions and policies about:

- Staff members who miss work through substance use.
- Staff turning up drugged or charged up.
- How to deal with intoxicated clients.
- How to deal with requests for cash from drinkers.
- Use of alcohol and fundraising, social events and meetings.

A workplace policy in an Aboriginal health service, Tennant Creek

This policy applies to all Anyinginyi Health Aboriginal Corporation's personnel and is designed to ensure the health and safety of employees at work. It covers alcohol and other drugs in the workplace.

The objectives of the alcohol policy are:

- To support the AHAC Mission Statement
- To cut out the dangers and problems associated with people affected by alcohol in the workplace
- To create an awareness among employees that it is not acceptable to come to work under the influence of alcohol
- To identify persons who may have alcohol dependency problems and to provide them with assistance in overcoming these problems.

The policy covers these issues:

- All staff to have a blood alcohol content of zero during working hours
- All drivers of AHAC vehicles to have zero blood alcohol content
- Vehicles should not be parked at liquor outlets or carry any alcohol during or after work hours
- The responsibilities of Section Heads for decisions on whether their staff are breaking these rules
- No lunchtime drinking
- Providing support and assistance to staff with drug or alcohol problems
- Possession, sale or supply of drugs or alcohol at the workplace.

The policy also sets out the procedures for dealing with any breaches. These include the Section Head giving informal counselling, and warnings. The ultimate sanction is dismissal.

(Thanks to Anyinginyi Health Aboriginal Corporation; their policy is currently in the process of being revised, 2004)

See page 57 Resources this chapter, Workplace issues ⇢ ⇢ ⇢


Ease up!
Buy food first!
Slow down!
Worry for kids!
safe way
Have a spell!

Resources for chapter 2 Alcohol

Alcohol in general

See also pages 231, 232 **Handouts**

Alcohol Treatment Guidelines for Indigenous Australians, available from www.alcohol.gov.au

Alcohol and Other Drug Council of Australia *ADCA News*. www.adca.org.au

Alcohol Resources from the Department of Health and Ageing (free).
Australian Guidelines to Reduce Health Risks from Drinking Alcohol
www.alcohol.gov.au
health@nationalmailing.com.au

Alcohol handbook for frontline workers (2004) Far West Area Health Service, NSW.
Available from: Department of Rural Health
Phone 02 8080 1210 www.drh.med.usyd.edu.au/library/index.php

Booklets and fact sheets on alcohol, local government alcohol policy, responsible service, alcohol and the workplace etc. available from Drug and Alcohol Office, WA at www.dao.health.wa.gov.au

FAS resources

(Australian) National Organisation for Foetal Alcohol Syndrome and Related Disorders (NOFASARD).
Download brochures at www.nofasard.org

Workplace issues

National Centre for Education and Training in Addictions (NCETA) provides useful workplace resources. See www.nceta.flinders.edu.au

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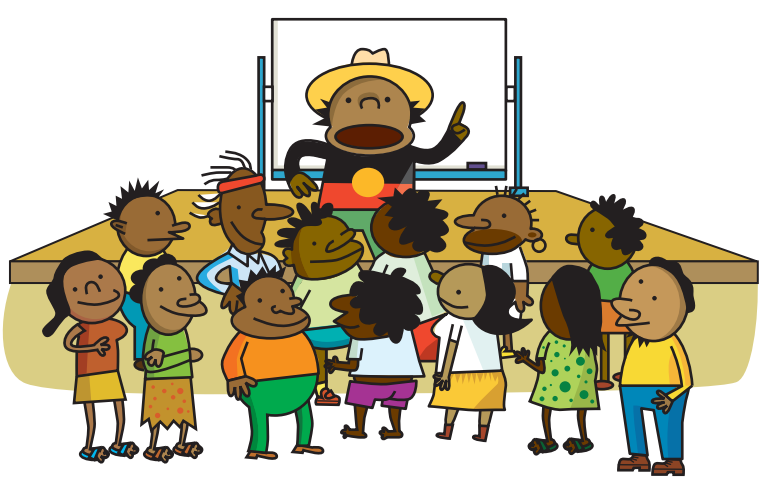
What's in the 'action' chapter?

Getting people going

It can be hard for Aboriginal or Torres Strait Islander people living in a small community to take strong action about alcohol. They might be accused of being bossy, or poking their noses in other peoples' business, trying to take away their 'rights'. So, how do they overcome this and mobilise people to take action? Overall, there are two main methods of getting people going. The first is by using a crisis or an event that really upsets people. We call this a **spark topic** — something that gets people fired up. The second way of getting people going is to organise **local action research** to identify needs and get a good picture of the situation.

Spark topics — what are they?

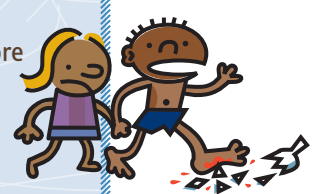
Spark topics are the things that upset people, the things they get worked up about. An incident — like a fatal car accident or an assault on an elder — can be a spark topic that can push people to act. Usually things around alcohol that upset people are to do either with peoples' behaviour or the effects on health. Many people would not worry about others' drinking if they did not drink so much and hurt other people. They would not mind people drinking if their health and wellbeing was still OK. Once you start talking with people in a community about drink, spark topics are the issues that come up. You can help a community to use this energy in a practical way. Here are two examples of how spark topics led to action among a First Nations group in Canada and among Aboriginal women in Australia.



One person can start action: Alkali Lake, Canada

A Shushwap Indian reserve in Canada called Alkali Lake, has become famous because of the actions the community took to control drinking. One woman and one incident started it off. This Indian woman Phyllis Chelsea, her husband Andy and nearly everyone in the community were drunks. People were selling sly grog and the community was troubled. In one year, 16 people from the population of 400 died from alcohol-related causes. The white people called the place 'Alcohol Lake'.

One day in 1971, Phyllis realised that her daughter was too scared to come home because of drunken arguments and fights. Phyllis was so shocked that she decided to stop drinking and to persuade others to do so too. Five days later, her husband joined her. He had met two small children walking to school one day who were bruised and dirty, and had no breakfast. They said there was nothing to eat at home. This shook him up. The couple started to have meetings with a local alcohol counsellor. Morning time, Andy walked through the community smiling and feeling good, looking healthy, talking to people. The others were stumbling around, feeling bad, with sore heads. But after three years, only two more people joined them in the meetings.



Then Andy became Chief of the Shushwap Tribe and he started to speak up strongly about drunkenness. He clamped down on sly grog, confronted the local priest who was a heavy drinker, and made public drinking illegal. He organised the social security cheques so that the drinkers could only get their money in the form of food vouchers. People started joining the meetings then. They began thinking about traditional culture and formed a youth dance group. They started looking after each other, caring for each other. Fifteen years later, nearly everyone in that community had given away the grog. They made some videos about what they did, called 'The Honour of All'. These have been shown all around Australia and in other countries as well.
Andy's motto was: Never give up trying.

See page 157 **Controls** Resources for how to order this film

Aboriginal women taking direct action

Aboriginal women in some regions have spoken out strongly about their worries over what alcohol is doing to their sons and daughters, the peace and wellbeing of their communities and the future for their grandchildren. These are some of the things they have done.

In November 1988 a hundred men and women non-drinkers destroyed the licensed club at Wadeye, NT. Ten of these women, mostly Aboriginal health workers, wrote a letter to the Liquor Commissioner. They said they would do the same again if the club re-opened. In 1989 the mothers' club on Bathurst Island demanded that the drinking club should be closed down.

In 1988, Pitjantjatjara and Yankuntatjara-speaking women in the north of South Australia led objections to the sale of alcohol from a roadhouse called Curtin Springs. Takeaway sales from this outlet found their way hundreds of kilometres into the Lands. In July 1990, in frustration, these women marched to Curtin Springs, and had a women's council meeting there and gave a letter to the licensee. In May 1991 the women from Aurukun, Cape York, sent a delegation to the premier to complain about illegal grog in their community.

In March 1993 a group of 30 women from Hermannsberg marched on a delicatessen in Alice Springs to support objections to its liquor licence. One man had just been killed and six injured in a drunken fight. The community had suffered repeated violence, stabbings, bashings and rape. A month later, 300 women and children (and some men) from five communities marched against grog through the streets of Alice Springs. The women were painted up, wearing ceremonial headbands, and looking strong.

These actions attract publicity. They make people take notice. They show licensees and governments that Aboriginal people really are concerned. They also show that people will only put up with so much.

Local action research

Doing some local action research means just that — finding out about what is going on locally in order to decide on what action to take. The value of collecting information from the local area is that, although individuals or families have their own troubles and tragedies, the community as a whole might not realize how many tragedies are connected to alcohol. It is only when you collect local data and make them known to everyone, that the community as a whole can have a new understanding.

The process of local action research

local data

- You collect information about alcohol-related harm related to the people concerned.
- You find out more about the problems, collect information, feed it back to the community, analyse it.
- You get a bigger picture of how serious the problems are.
- You can use this material like a mirror. The community looks into the mirror to see itself more clearly. Once people realise how many young people are getting injured or killed on the roads, or how many middle-aged people are getting sick from drinking, they get fired up.
- Research results can be useful to lobby for change. They provide evidence to convince the community, the liquor commissions or the government that action should be taken.

Action sparked by a tragedy

At Yalata, SA in 1990, there was a car accident in which five people from the community lost their lives. This tragedy shocked the community so much that the council demanded that the Liquor Commissioner should visit to discuss uncontrolled sale of takeaways. It also led to some local action research to write down the numbers of alcohol-related injuries, evacuations and deaths. With the evidence from this research, the liquor commissioner decided to ban takeaways from three local outlets. The local action research team continued to collect information. The results showed that deaths and injuries dropped over the next ten years (1991–2000). (See Brady, Byrne, Henderson 2003)

A good way to work out what should be done is to make an overall assessment of the situation. One way of doing this is using 'rapid appraisal methods' which help to get a picture of what is happening.

Rapid appraisal methods

Rapid appraisal methods (RAMs) are ways of collecting information that can help to draw up a plan of action. They can be used to make a program work better. The methodology of rapid assessments has been used by the WHO, United Nations and other aid agencies as a way of planning health programs in many countries. These are some rapid assessment methods:

- *Case studies*
  description of one person's or one group's experience with the issue.
- *Observation*
  recording what you see around you.
- *Focus groups*
  a mediated discussion on a fixed topic among 6–10 people.

- *Key informant studies*
  series of interviews with several experts on a topic.
- *Narrative research method*
  a story about the events is created during a workshop, and transformed into a questionnaire.
- *Surveys*
  questionnaires or interviews of people.
- *Documentary sources*
  Analysis of available written material like newspaper articles, other reports, experiences of NGOs and communities.

research methods

Focus groups

One way of doing a rapid assessment is to use a focus group. It is an organised discussion among 6 to 10 individuals. It is usually on a single topic for a limited amount of time. It is particularly useful for finding out peoples attitudes and opinions about a particular topic.
The group leader guides the conversation by asking open-ended questions on the issue. The idea is to encourage easy discussion among the group, including differences of opinion. One person makes notes of what is discussed. The group leader keeps everyone on track, thinking about just a few questions.

Focus groups are not useful for getting information that is private or might bring criticism — people are not usually willing to share this sort of information in a group situation. With open-ended questions though, you can follow the issues raised by people in the focus group. You can choose appropriate questions from a basic 'menu' — some questions might be culturally inappropriate and need re-wording. You might decide that a group situation is not a good idea and talk instead to people in private.

Finding the gaps

Questions for a focus group of service providers

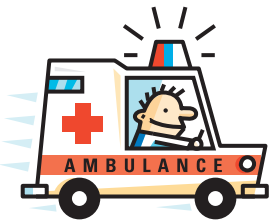
- **Stresses experienced by community members**
  (major life events, everyday stresses, what kind of major changes or traumas have happened to them?).
- **Drugs**
  (attitudes to different drugs, whether they are tolerated, influence of family and peer group).
- **Effects on the community of substance use**
  (main problems, risks taken, greatest worry).
- **Community skills and resources**
  (what coping skills do people have, what services are available, community agencies, access to training).
- **Main health issues** of the drinkers/drug users.
- **Risk behaviours** of drinkers/drug users.

Collecting information

To help with your thinking and planning here are some practical examples of finding and using data and statistics, and how to make them part of local action research. You need to find out where you can collect local statistics.

- *Health centre records*
  Does your local health service count the number of alcohol-related cases? Number of medical evacuations?
- *Hospital records*
  Negotiate for access to information through the health department.
- *Police records*
  Ask local police for any information they can give on alcohol-related events (drink-driving, assaults).
- *Sobering up shelter* and women's refuge usage.

- *Road Traffic Authority*
  The State Road Traffic Authority should have figures on alcohol-related motor vehicle and pedestrian accidents.
- *Alcohol sales* figures from licensing board or outlets.



Working with health centre and hospital records

Most community health centres have a book or database with causes of death or injury and whether alcohol or drugs were involved. If not, encourage your local sisters or health workers to keep this information.

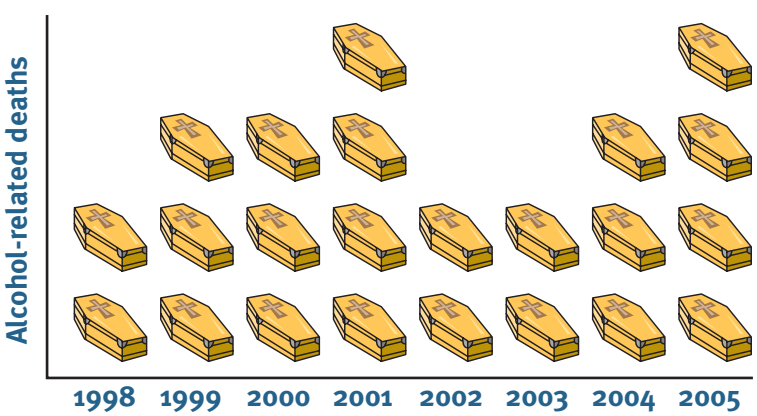
Work with the health service to set up a simple data collection sheet to be filled out for every alcohol-related visit to the clinic. No names of individuals are involved. Negotiate with the health staff to see if they will help a local project by completing the sheets.

making charts

Count up the number of injuries or deaths associated with substance use (including motor vehicle accidents, drownings, illness, assaults) over a period of years.

Make up simple diagrams to show the number of cases for each year.
You can draw stick figures or coffins to show the numbers. Keep entering the information in each year — it gives an idea of progress over time.

Put these charts on public display.
Charts like this are examples of spark topics. They can be put up in the health centre, clinic, administration offices or school, and used to get people thinking. Use them to educate the community!



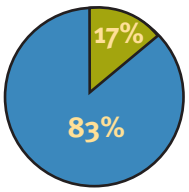
Mortality data

Dealing with mortality data is always sensitive. The board of the health service and the community Council will need to feel comfortable about the death records being looked at.

In order to find out whether people died from alcohol-related causes, the researcher might need to look up files or talk with health workers or local hospital staff who know the details. Because it is a sensitive issue, an outside researcher might be best for this type of work.

Collecting basic facts and figures means that a community Council, or a health service, can have an annual progress report. Showing changes over time can give people positive feedback after an intervention, such as what happened after a restriction on alcohol sales or declaration of a dry area. It helps a community to stay strong and motivated.

Information sharing



Our Town Police records Feb 2001–3, 83% of all offences were related to alcohol.

In western NSW, a partnership between the State government, the Aboriginal Land Council and ATSIC has been working to improve service delivery. People in the communities said they wanted access to local information about alcohol problems because the lack of available information had led to some poorly informed decisions.

What did they do?

The Alcohol Community Development Project (based in Broken Hill) negotiated for access to the available data from local government and non government agencies (police, education, health, night patrol, women's safehouse). They made up simple packages of documents on alcohol-related harm for each town, with one graph or illustration on each page and a sentence explaining the graphic. The type of information in the packages included:

- Alcohol-related assaults.
- Most common alcohol-related problem presenting at hospital.
- Place where alcohol-related problems are occurring.
- Days and times when problems occur.
- Qualitative data — people's concerns and what they are already doing.

Deciding what information to include from each agency was one of the hardest tasks: they did not want to overwhelm people with too much information. Each community group was asked for feedback on the type of information in the packs.

How were the packages of information used?

- One town used its information sheets to start a point of sale project. A grant was obtained to allow the graphs and illustrations from the package to be printed on the paper bags used by the bottle shops.
- Some information packages told a story different to popular belief. In one town, public drinking was thought to be the main issue, resulting in people being encouraged to drink at home. But the police statistics showed that most alcohol-related incidents were already happening in people's homes. As a result of the information sharing, it was decided that it was safer to encourage people to drink in the more controlled environment of the hotels.

Problems faced by this project

- Service providers did not think that community members would be interested in this information. (They *were* interested!)
- Agencies suffered from lack of coordination, staff turnover, and different data collection regions.
- Agencies were reluctant to share their information due to fear that it could be misused or misinterpreted.
- The need for someone with the time and skills to collate the data.

(Thanks to Kate Gooden)

See page 88, References, Burns and Gooden (2005) ⟶ ⟶ ⟶

122, 256, 2700, 690, 1952, 53 1000

The figures make you think

'Having the statistics is a big help — they help with funding as well. It's all good stuff. A wake-up call for people themselves... it's so important, that knowledge and information and support. It's vital that it goes on, that it is available to communities... Aboriginal people live with [the effects of alcohol misuse] everyday. It made them realise how serious it is. They got a shock. Aboriginal people have to see it for themselves... I'd like other communities to have access to stats so they can have a rude awakening!'

(Member of the Brewarrina Community Working Party, 2004)

ethical research

Research capacity and ethics

Dealing with statistics can be difficult, and your community or resource agency may not have the resources to do this kind of data collection and analysis. One way around this is to form partnerships with people who do have the skills, such as researchers or public health groups in universities or larger non government organisations. PhD or Masters students can be helpful if you work closely together and make sure that the research they do is what you want.

For a successful and ethical outcome there must be trust among the stakeholders in research — the participants, the researchers, the research partners, the scientific community. Unethical behaviour can cause this trust to be lost. By looking at research proposals and making sure agreed guidelines are followed, ethics committees can give some protection against blatantly unethical research. You can also write up an MOU ('memorandum of understanding') between your organisation and the researcher or student.

See page 87 Resources *Community Guide to the Ethics of Health Research* NHMRC publication

See page 246 **Handouts** Key resources for your library

Identifying problems and needs

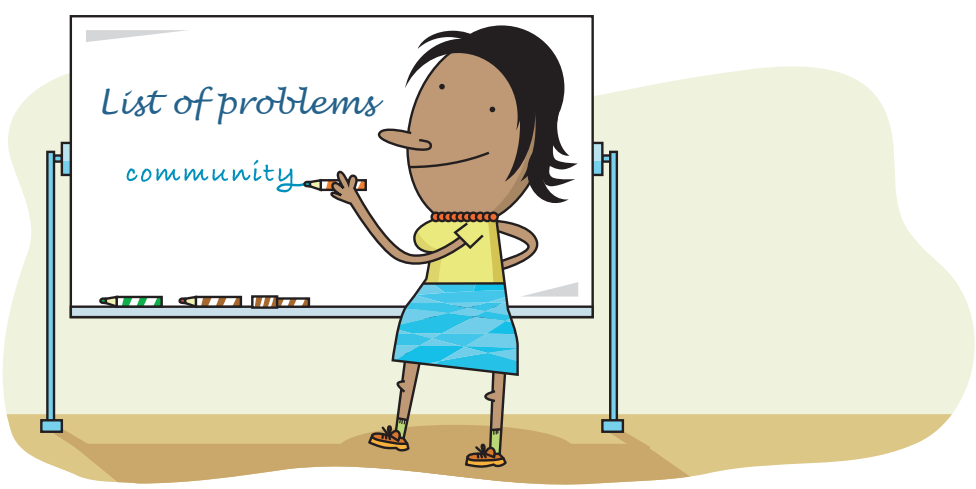
If you are working with a local action group, you need to find out what people get upset about and what actions they will support. Knowing about local attitudes helps to avoid just criticising the drinkers. The focus should be on the wellbeing of everyone. Sometimes people who drink are not included on committees or action groups trying to cut down on problems. You should make sure that both sides have their say — drinkers and non-drinkers. People who drink also know what the problems are!

Make a list of the things people identify as problems with drink

- Physical effects, illness?
- Neglect of economic activities?
- Neglect of families?
- Affecting young children?
- Spending too much money?
- Getting ripped off?
- Noise associated with drunks, no sleep?
- Violence? Family violence?

Identifying these things helps to focus problem solving onto something achievable within the community.

See page 102 **Prevention** The good and bad things about drinking



When there is conflict between people

Unresolved conflicts between people in a community or in an action group can undermine many activities. Without a person willing to take on a leadership role, action group members can end up arguing with each other at meetings. These arguments are usually not about the work people are doing, they are about private family matters. Group members can find it hard to leave their differences with each other at the front door. In some cases, an outside person can see things more clearly, and can be useful because he or she is not already part of any one group. Someone who is a skilled conflict resolution worker can help to resolve things. If you are in a position to give advice about these difficulties, here are some ideas about what to do:

Talk about the potential for conflict from the beginning

When a group forms, talk with group members about the potential for conflict:

- ★ Ask people to think honestly how they feel about working with each other.
- ★ Ask people to think about not joining the group if they do not feel they can work cooperatively with other group members.
- ★ Set out group rules from the beginning; rules about communication and what to do when there is a disagreement.

Keep a look out for conflict

Ask all group members to be on the look out for early signs of conflict:

- Ask people to be aware of their feelings and talk with someone if they find it difficult to work with another group member.
- If conflict is seen happening, name the conflict with those people involved. Ask people to talk about what is going on for them and to think about what needs to happen to deal with their concerns.

When conflict impacts on the whole group

- If conflict flows over into the group, raise it early on with the whole group. Be upfront.
- Ask people if they are willing to try and work through the conflict.
- If people say they want to address the conflict, put in place a formal conflict resolution process. Invite someone with conflict resolution skills to the group to assist. Think about inviting an independent person because sometimes people can be more open with an 'outside' person. (Thanks to Kate Gooden)

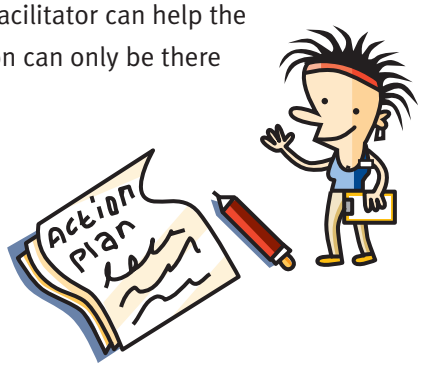
Motivating the community

An outside facilitator can help to draw the 'big picture' and help to identify the different problems. He or she can encourage people to improve their life conditions by taking notice of their worries.

outside facilitator

Listen out for local concerns

A counsellor usually works with an individual, listening and helping the person to see his or her life more clearly. A facilitator works with a community in the same way. The facilitator must be sympathetic to people in the community and listen to them. The facilitator can help the community to see itself more clearly. Such a person can only be there by invitation.



Hold up the mirror

In individual counselling, a counsellor helps someone to think about the results of his or her actions and tries to act like a mirror, to reflect back to the person what is going on. It is the same with a community. A facilitator needs to do the same thing so that community members can take a look at themselves. To get a picture of what is going on, people might need to do some local research, a survey, or gather existing information. Holding up a 'mirror' so that the community can look at itself can be hard. People might not like what they see. So this needs to be done sensitively, without judging.

Deal with myths or mistakes about the issue being discussed (such as stereotypes of the drunken Aborigine, wrong ideas about what is in alcohol). No individual should be given a negative label, and participants should be discouraged from making accusations against each other. Talk should not be personal, and should help everyone to analyse the problem as equals.

Decide on action

Once the 'mirror' is held up to the community, people can be encouraged to look for solutions. They might need options to choose from and ideas from other places. People from outside can help here by searching out examples from programs elsewhere (because they probably have better access to these resources). To decide on the best course of action you need to weigh up the benefits and drawbacks of change and to air different points of view.

(Adapted from May, Miller and Wallerstein 1993)

Evaluation

This can be done by repeating earlier surveys to measure changes; write up notes taken of progress (who came to meetings and what happened), or follow-up interviews with different stakeholders.

Once you have worked out what you have and what is needed, service providers should join in with planning. These are the people from the different departments and agencies dealing with the area.

See page 68 Finding the gaps — Questions for focus groups

See page 86 Resources, Evaluation

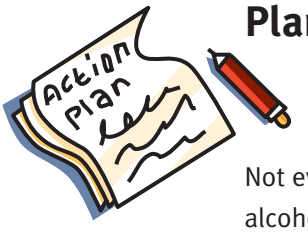
Collecting personal stories

Another way of finding out about the problems and needs is by interviewing people who have given away the grog. You can find out what made it hard or easy for people. Writing down success stories like this is also a good way of keeping the energy going, because positive stories can be a motivating and empowering influence on people. The idea is that people tell their stories in order to help others. Their experiences tell you about whether the person had particular individuals or agencies that gave support, and if the person had a safe place to go after stopping drinking. If you know more about about the gaps in services or networks, you can try to do something about them.

See page 234 **Handouts** How to collect personal stories

Giving Away the Grog is a book of personal stories collected like this. It has been used by people working with Aboriginal prisoners in gaols, with trainee AOD workers, as a resource book for primary health care centres, and as reading material for Indigenous people after alcohol screening and in hospital. (See Brady 2004)

'I hope whoever's going to hear [my story] will take note, and really it's up to the person, up to the individual. Himself or herself, to make up their mind, because we've got a will. God has given us a will. To do, or not to do. To be, or not to be'. (Peter Idai, *Giving Away the Grog*)



Planning action

Ready for action?

Not every community will be ready to receive information about how alcohol is harming people, or be ready to 'look at' itself in the mirror.

See page 233 **Handouts** Is the community ready for action?

Some basic steps to follow when you have an action group together:

1. Do local action research to identify problems and needs.
2. Share the information with others in the community.
3. Work out together what are the main problems and targets.
4. Find out what help you have got, and what existing resources are.
5. Determine the gaps in resources.
6. Draw up suggestions for action, list the choices you have.
7. Discuss the benefits and drawbacks of different options.
8. Make some decisions on action and write these down to show what you hope to achieve.
9. Decide who will do what, and when.
10. Make a note of what happens, and watch for changes.
11. If things are not going as planned, think about other actions you might take.
12. Invite the media to take an interest.

Keep people informed all along the way!
You need to tap into the concerns and support of community leaders, influential people and ordinary people.

Find out what the community will support

Members of an action group need to have options to choose from.
You can set these out for people either at a public meeting (see next page) or you could have a secret ballot (see page 80).
You need to think about the benefits and drawbacks of different choices and air these ideas.

Public meetings

In Alice Springs, a People's Alcohol Action Coalition (PAAC) started in 1995*. It is made up of a broad coalition of Aboriginal organisations, health professionals, churches, businesses and community leaders. This is an announcement for an early meeting:

* originally called People's Alcohol Action Group

Public notice: People's Alcohol Action Group

(PAAG) invites the community of Alice Springs to a public meeting under the sails of Todd Mall at 12 noon this Sunday 9th June.

The People's Alcohol Action Group was formed by Alice Springs citizens from all walks of life, both Aboriginal and others, out of concern about the effects that alcohol is having on our town. Our prime aim is to work to reduce the incidence of alcohol-related harm so that all Central Australian people can live in a more humane and healthy environment.

PAAG is primarily focussed on investigating strategies aimed at reducing the availability of alcohol.
Reducing availability includes:

- Decreasing the number of outlets
- Decreasing the hours of sale, including the days of sale
- Special restrictions, such as limiting the amount of alcohol that any person can buy
- Changing the price and location of alcohol
- Increasing the price of alcohol
- Voluntary restrictions

The public meeting will be chaired by Ted Egan and Wenton Rubuntja (members of the Aboriginal Reconciliation Council). Guest speakers will include: John Maley, Chairman of the NT Liquor Commission; Paul Ruger, Mayor of Tennant Creek; and David Curtis, General Manager of Julalikari Council Tennant Creek. The Menzies School of Health Research will present an evaluation of the alcohol control measures trialed in Tennant Creek.
A sausage sizzle will be available to all who attend.

See page 135 **Controls** Restrictions and product substitution

opinion poll

Taking a vote is one way of finding out what the community will support. But the voting, and the results, can cause divisions and antagonism. Members of a community may find it difficult to attend meetings and speak out loud about what they think about alcohol. In some places, people are scared that others will threaten them. Having a **secret ballot** (an 'opinion poll') is a good way around this. Everyone's views are collected privately. No-one knows who said what. And when the majority agree on something, it is hard for others to argue against that. An example of a simple survey of opinion comes from Elliott, NT where people were deciding what to do about alcohol-related problems. They held an opinion poll to find out everyone's views.

The Elliott secret ballot on local liquor rules

In 1994 the local Aboriginal council (Gurungu Council) asked a health promotion team from Tennant Creek to help them decide on the design of a survey to find out what decisions people would support. They decided on these questions:

How much takeaway alcohol should people be allowed to buy?

Should children be allowed in the public bar?

Should there be any take-away sales on Sunday?

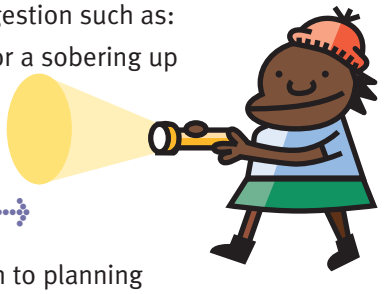
The survey: A simple ballot type paper was used and the voting process was explained to everyone, Aboriginal and non-Aboriginal. Community members marked appropriate boxes to simplify adding up the data. People could choose to take part in the survey or not, but it covered a broad group of people and included both drinkers and non-drinkers. In the end, about 65% of people on the electoral roll participated in the survey. The data were analysed by people elected by the community, with representatives of major groups (school, local government, Gurungu etc) present for the counting.

The outcome: Results were posted up on noticeboards and sent to the Liquor Commissioner. As a result, the licences for two outlets were changed so that there was a limit of one six-pack takeway; no underage children allowed in the bar; and no takeaways on Sundays. This was for a six month trial period.

What happened years later? Elliott community was surveyed again eight years later and agreed to continue with the changed licence conditions.

(Adapted from Walley and Trindall 1994)

As a result of the needs assessment, a community might look at the gaps in services and programs, and come up with a suggestion such as: 'We need a night patrol', or propose a treatment centre or a sobering up shelter.



See page 209 **Care** Residential programs

See page 182 **Strategies** Sobering up shelters

How can we learn from others' experiences and get down to planning the details? A lot has been happening in the last few years from which to learn. For example, we now know a lot more about setting up night patrols and the things that will help to make them successful:

patrols

- You need a community of over 100 people to have a night patrol. If your community is smaller than this, half the group will be policing the other half.
- The first meeting about a patrol needs to involve as many men and women of all age groups as possible. Patrols need wide support across all families, not just among a few concerned people.

See page 164 **Strategies** Patrols

Give people responsibility for tasks

When there is agreement on the action to be taken, you need to write down what you hope to achieve: your objectives. You may want to form sub committees to work on different objectives or have particular people take responsibility for them. Make it clear what each person will do and when each should report back. Keep notes of these discussions.

Funding and support

This book reinforces the need for ideas and local action to come from the people, rather than be imposed from the 'top down'. You may need funding and other supports to back up a community-based project. Government departments have resources too, but some communities resist the idea of government-driven programs. The knack is to make *use* of government programs and resources. Work out how to make the funding work for you locally and do projects that support your community's plans, while fitting in where you can with government agendas. Examples of this include government programs (with access to funding) for things like crime prevention, 'Community Harmony' programs, family violence and youth issues — alcohol can be linked to all of these as underlying issues.
With a little creative thinking you can do this!

⇦ ⇦ ⇦ See page 72 Research capacity and ethics

See page 86 Resources, Funding ⇨ ⇨ ⇨

Watch for changes — evaluation

You need to know whether your activity has had an effect, and this is what monitoring and evaluation are for. To find out if anything has changed means that you need to choose indicators (signs) that will show up easily. For example, if you are using health records to see whether alcohol restrictions have improved health, it is no good looking at illnesses such as cirrhosis of the liver. These illnesses take years to develop and will not be affected in the short-term. It is better to choose indicators such as numbers of cuts and lacerations, tooth-knuckle injuries (from fighting), or medical evacuations. These are called quantitative indicators: numbers, statistics.

It is just as important to collect qualitative indicators (that is, not just numbers or statistics) about an intervention. People's opinions, attitudes and experiences about an intervention are also essential to take account of.

indicators

To make evaluation easier, think about three kinds of indicators:

- *Public order*
  Public drunkenness, fighting, assaults, vandalism.
  Do the numbers go down?
- *Health and wellbeing*
  Alcohol-related injuries, expenditure on food, school attendance.
  What do people say about these? Do they improve?
- *Economic activities*
  Liquor sales, absenteeism from work, impact on tourism.
  Are more people turning up for work?

Evaluations can also tell us things we weren't expecting to happen — both negative and positive.

See pages 131–132 **Controls** Some positive outcomes

See page 135 **Controls** Restrictions and product substitution

An evaluation of a moselle ban in Brewarrina

The Brewarrina Community Working Party took fast action after reports in the Daily Telegraph of young people injecting moselle wine. They asked the police to support them in banning the sale of cask moselle from licensed premises. The ban started on 1 January 2003. In March the Working Party agreed to let Far West Area Health Service (FWAHS) evaluate it to see what had happened as a result of the ban. A community development worker and a public health officer collected two types of information: people's thoughts and opinions on the ban and its effects, and figures from the hospital, police and licensees (on sales of flagons and big bottles of whiskey and vodka). The workers collected what figures they could for the two years before the ban as a comparison.

The evaluation was repeated a year later as well.

continued on next page

What did they find out from the evaluation?

There is only limited evidence to show that the moselle ban has been helpful [in changing people's drinking or stopping the reported injecting]. However, the ban does not seem to have created any problems. The moselle ban has a number of positive effects not associated with drinking:

- The Working Party is perceived in good light as they are seen to be taking action by enforcing the ban.
- Community members are well informed of the ban, which suggests that people were talking about the problems associated with alcohol.
- By seeking feedback on the moselle ban the Community Working Party will have information available which may be useful in informing future alcohol strategies.
- The evaluation process has also encouraged a number of service providers to work together and share information...It has also highlighted the importance of sharing local information in order to support the implementation and evaluation of local alcohol initiatives.

The really positive thing about this case study is that it shows how a community group took action and even though their action did not have the effect (changing peoples' drinking) they had hoped for, the group was willing to look at and learn from this experience.

(From Kate Gooden & Pippa Burns, FWAHS, 'An evaluation of the ban on the sale of cask moselle in Brewarrina 2003', compiled for the Brewarrina Community Working Party, 2004).

continued from page 83

Keeping a watch on indicators helps to give everyone a sense of progress and movement (to keep up the energy) and it supplies the community with useful facts and figures for further action.

See page 86 Resources, Evaluation — books by Wadsworth

The Aboriginal organisations that took the lead in changing the licensing arrangements in Tennant Creek and at Curtin Springs, had solid information behind them. They made sure they had good networks and links with research organisations and researchers who could do evaluation studies for them. These help to stop white-anting by those opposed to community actions. Also, if you have good evidence, then Magistrates, Licensing Boards and governments are more likely to listen!

See page 133 **Controls** Assess the impact of your restrictions

See page 236 **Handouts**
How to make a success of local action aimed at restrictions

Resources for chapter 3 Action

Evaluation

See the *Public Health Bush Book*
www.nt.gov.au/health/healthdev/health_promotion/bushbook

Y Wadsworth (1997) *Everyday Evaluation on the Run*. Allen and Unwin, NSW.
(Although this is not written for Indigenous contexts, it is in plain language with evaluation strategies and how evaluation can lead to change).
Available from www.allenandunwin.com ($24.95)

Y Wadsworth (1997) *Do It Yourself Social Research*. Allen and Unwin, NSW.
(A practical introduction to social research. It is a good reference book for research in the social sciences and human services). Available from www.allenandunwin.com ($24.95)

T Colin and A Garrow (1996) *Thinking, Listening, Looking, Understanding and Acting as You Go Along: Steps to Evaluating Indigenous Health Promotion Projects*. Council of Remote Area Nurses of Australia Inc. Alice Springs.
(A guide for anyone interested in evaluation. It includes practical ways in which to work together to develop project evaluation).
Available www.crana.org.au/store/view_product.php?product=TLL

Funding

Look at the Australian National Council on Drugs website www.ancd.org.au
under 'funding opportunities' for a list

The Foundation for Alcohol Research and Education (FARE)
Phone: 02 6122 8600 www.fare.org.au

Many NGOs are working in partnership with Indigenous communities including:
Caritas www.caritas.org.au
Fred Hollows Foundation www.hollows.org
World Vision www.worldvision.com.au

Planning action

E Stringer (1996) *Action Research: A Handbook for Practitioners,* SAGE Publications available through the agents for SAGE: Astam Books, Sydney. (This is a practical handbook aimed at people working in community and organisational contexts. Illustrations and examples are drawn from the author's work with Aboriginal people, with guidance on action-orientated research and development work.)

For how to set up action groups and many examples of community action in NSW, see www.communitybuilders.nsw.gov.au

On conflict and dispute resolution see http://ntru.aiatsis.gov.au/ifamp/links/links_frameset.html

Research ethics

Keeping Research on Track: a guide for Aboriginal and Torres Strait Islander peoples about health research ethics NHMRC, Canberra (2006) www.nhmrc.gov.au/publications/synopses/e65syn.htm

Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research by NHMRC (2003) www.nhmrc.gov.au/publications/synopses/e52syn.htm

Guidelines for Ethical Research in Indigenous Studies by AIATSIS (2000) www.aiatsis.gov.au/_data/assets/pdf_file/3512/EthicsGuideA4.pdf

Rapid appraisal methods

See World Health Organisation website at www.who.int/management/partnerships/community/en/index1.html

Krishn Kumar, Ed (1993) *Rapid Appraisal Methods.* World Bank. http://publications.worldbank.org/ecommerce/catalog/product?item_id=195170

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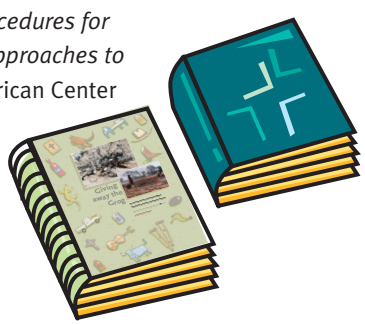

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Email order: nmm@nationalmailing.com.au
Phone: 1800 020 103 ext 8654

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Willie, E (1989) The story of Alkali Lake: anomaly of community recovery or national trend in Indian country? *Alcoholism Treatment Quarterly* 6(3–4):167–174

What's in the 'prevention' chapter?

Prevention and health promotion

preventing harm

Basic information

What is prevention? Are we trying to prevent people using drugs or alcohol? Or trying to prevent people from hurting themselves or others? We probably will not stop people from using alcohol and other drugs completely. We know that people from all over the world change their moods by taking different substances. We know this is true for Indigenous people in Australia as well. But we can try to prevent drinkers from harming themselves and others.

Preventing harm to people who drink alcohol or use drugs can mean taking people to sobering up centres instead of the police cells, giving out clean needles to people who inject themselves with illegal drugs so that they are less likely to spread HIV, and having night patrols which calm people down when they are angry and drunk. Aboriginal and Torres Strait Islander people across Australia are involved in programs which do all of these things. Preventing and reducing harm are strategies that are already endorsed and used by Indigenous people.

health promotion

Health promotion is how you help people to improve their health by increasing their knowledge and by their taking more control over their own health. It is not just what the health professionals do. Health promotion is the process of changing how people think and how they behave, and changing the environment. It can take years to do this. The basic document that laid out the key areas of health promotion is called The Ottawa Charter.

The Ottawa Charter

This came out of an international WHO conference in Ottawa, Canada in 1986. It has five basic strategies to deal with all areas of health promotion. As this book is dealing with alcohol, we give below examples of what these strategies include for alcohol problems:

1 *Building healthy public policy*

Includes having good liquor laws and policies of harm reduction; making laws work; taxing alcohol and tobacco; having alcohol advertising standards, codes of conduct for licensed premises, policies in schools and workplaces.

2 *Creating supportive environments*

Includes making liquor outlets safer; having food for drinkers; putting on alcohol-free events; providing information on alcohol; providing safe places for women and children; having sport and entertainment.

3 *Strengthening community action*

Includes supporting local communities to do action research; making funding available; raising alcohol awareness; planning strategies; getting people going on action and making choices about what to do; supporting people to speak up.

4 *Developing personal skills*

Includes having health education in schools, health centres and workplaces; providing lifeskills and peer support training; learning more about the effects of alcohol; questioning narrow views.

5 *Reorienting the health services*

Includes providing education and training to Indigenous health workers, nurses, community workers and others about how to care for people with alcohol problems; making alcohol issues part of primary health care, including AOD screening and brief interventions; collecting alcohol-related statistics.

Community development

Community development is a process of people finding out how to deal with and change their environment, their communities. They do this by working together, identifying problems and needs, deciding on goals and succeeding with these goals. The process will bring people together, build on local knowledge and skills, and bring change that is supported locally. Your role might be to help raise awareness of problems related to alcohol. You need to get people talking to debate the issues and follow the direction chosen by the community. You also have to think about the long-term. Will this community development project or action keep going if you are not there to push it along? This is what is called **sustainability**. Any community action needs to have strong support on the ground and plans for the future.

sustainability

Factors that support sustainability

★ *Community relevance*

The project must be relevant to the needs and concerns of the community. Then the community will find a way of carrying on a project without outside funding and guidance.

★ *Community and cultural values*

The project must take into account local values and culture. Community members must be involved in developing ideas, goals, use of language that reflect their values.

★ *Key leader support*

The support of community leaders is crucial. To make a project last, local leaders must give active and visible support.

★ *Local staff*

Action groups should have locally resident workers, who are respected and understand the community. They can keep projects alive after initial funding stops.

★ *Development of local resources*

Even if early resources come from outside, resources to continue the project must be developed locally. Write proposals to donor funding bodies.

★ *Flexibility*

A successful project must be flexible. Re-arranging existing programs to fit new needs is one way of doing this.

★ *Using early success*

Early good results will increase the chance of a project carrying on. Write down the early success and celebrate it — this will strengthen the project in the long term.

(Adapted from Holder and Moore 2000)

Health education

Many people ask for alcohol and other drug (AOD) 'education'. They hope that if people knew more about the damage caused by substances such as alcohol, petrol or tobacco, then they would not use/misuse them. Unfortunately it is not as simple as that!

Community or school-based education on its own about the harmful effects of alcohol and other drugs is not much help. To work at all, it needs to be part of other community activities.

But if a health worker or doctor talks with someone about what is happening to his or her own body and how alcohol is affecting that person's health, it is quite different. Personal advice can have a strong influence on the individual.

Many prevention and education activities can help to change what people know and think about alcohol. People have a right to be fully informed about what will happen to them if they misuse substances like alcohol.

Alcohol education in a treatment program — an expert view

Alcohol education or instruction using a film or lecture about the harmful effects of drinking too much is not recommended as a treatment strategy for people with alcohol dependence. This is because it is not personalised to the individual drinker. If this type of education is included in a treatment program it should be only a small part of the overall program.

(Adapted from Mattick et al 1993)

Avoiding mistakes in health promotion

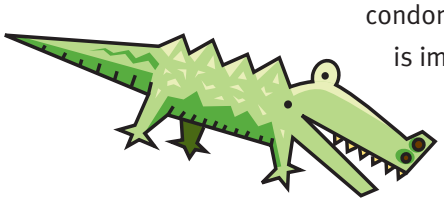
Community participation in health promotion is a basic, essential rule. Health promotion strategies that are designed from outside the community concerned and have no involvement with local people, can go badly wrong. But you also need professionals.

A story of no local involvement.

This story comes from the Pacific. The US Navy (during World War II) landed on a Pacific island. The health officer found that flies carried serious disease there, so he asked the chief to organise the community for a health lecture on diseases carried by flies. He had a model of a large fly about one foot long, to illustrate his talk. The chief said afterwards to him: 'I can understand your worry about flies in America. We have flies here too, but fortunately for us, they are only little ones'.

A story of no professional involvement.

This story comes from Australia. When everyone started to make posters and health education materials about HIV/AIDS in the 1980s, some of the early posters were not so good. One showed the AIDS virus as a green monster that frightened some Aboriginal people. Others simply said that 'AIDS is a killer' without informing people about using condoms or giving contacts for advice. Now we know that it is important to give people factual and practical advice, and not stress 'doom and gloom' messages.



USE THESE TWO EXAMPLES AS DISCUSSION TOPICS

Prevention of alcohol-related birth defects (FAS)

A very important topic for prevention and education activities is alcohol-related harm to unborn babies. Several different types of harm (defects) can happen to babies who are born to mothers who have been drinking during the pregnancy. The most serious of these is foetal alcohol syndrome (FAS). FAS is starting to show up in the Indigenous population here, as it has in other countries like Canada, the United States and South Africa. Children who have been affected in this way can have learning problems, behaviour problems, and delayed development as they grow. Preventing these problems in the first place is the priority!

Prevention means educating all women of child-bearing age about the dangers of drinking alcohol when pregnant. This can happen in many different ways such as:

- Raising FAS awareness of mothers attending play groups and women's centres.
- Making sure ante-natal care includes discussion about alcohol and a drinking question as part of check-lists.
- Educating Aboriginal Health Workers about the issue.
- Working with grandmothers — to increase their awareness.

Apunipima (in Cape York) is incorporating FAS education sessions as a core part of training for community-based workers as part of the Strong Families Project. Two levels of FAS training happen: the workers themselves receive FAS training to increase their awareness and knowledge of the issues, and then FAS education and awareness-raising takes place for community groups such as the mothers attending the playgroup.

Primary prevention of FAS

The public health experts tell us that most energy should be put into primary prevention — that is, informing and educating ALL women of child-bearing age about the harm that alcohol can do to an unborn child.

The message?

Whatever the mother drinks, the baby drinks too.

Not drinking alcohol is the safest option.

See page 239 **Handouts**
FAS: Talking with women about their drinking

Developing media and educational materials

We know that the most effective health promotion resources are those developed locally. They need:

- The involvement of interested local people and professional health staff.
- The pre-testing and evaluating of materials by a small group of local people before being distributed.

See page 235 **Handouts**
Evaluating health education resources

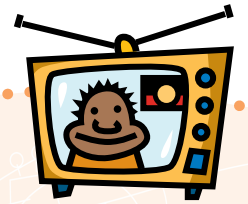
Often the best way to approach the development of a resource is to organise a workshop. The health team will have a chance to look at issues together with interested local people.

Health education messages should:

- Make people wake up and listen.
- Make people think 'this message is for me'.
- Be clear, so that people understand.
- Make people want to do what the message says.

(From *Public Health Bush Book*)

WATCH OUT! Education about some drug uses can be tricky. Solvent use is one example where education must be carefully designed to avoid making the activity seem more exciting and risk taking.

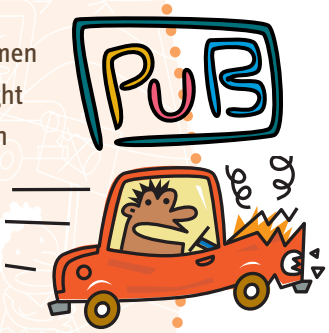


Making a TV ad

This is an example of making a health awareness ad for local TV.

1) Aboriginal facilitators ran community health promotion workshops in two Kimberley communities of about 200 people, so that people could list their concerns and needs.

2) Some women worried about young men getting injured or killed in alcohol-related motor vehicle accidents. The young men would drive into town to drink, and a car had rolled and caught fire — several people had been seriously burned. The women worried about the drinkers getting home, humbugging their relatives, stealing food and causing fights.



3)This idea was turned into a story and was filmed by a local Aboriginal film company: Five young men set out for town to drink. One of them chose not to drink and he collected money from the others for food, drove them back, tipped out leftover alcohol at the entrance to the community (which was 'dry'), and broke up a fight after they returned home. The message of the story was: 'if you drink and drive, take a skipper'.

4) Different community groups and the chairperson checked and approved the story and it was made into a short TV advertisement. Members of the local rock band acted the roles of the drinkers. The ads were shown on a commercial TV station over several weeks.

5) A follow-up evaluation tested the reactions of people in other communities in the region. About forty per cent of people could remember seeing the advertisement and remembered the messages were about 'drinking less', 'keeping alcohol out of the community', 'drink safe, don't drink and drive'.

(From Spark et al 1991)

Why did this TV project work?

- It used the right message. Community input meant that an appropriate message was created. The message did not try to dictate that there should be no drinking at all, or even that people should drink less. It simply said that drinkers have to be cared for but that they should not disturb others in the community. It also focused on the very real local problem of drink driving.
- It belonged to the local community. The posters, songs on the radio, ads, radio plays were developed by local Indigenous people and showed people and places, symbols and language that everybody knew.

WATCH OUT! This approach needed support in the form of an outside health promotion team to get things rolling; funding to buy time on TV and the resources to do the filming.

Raising awareness

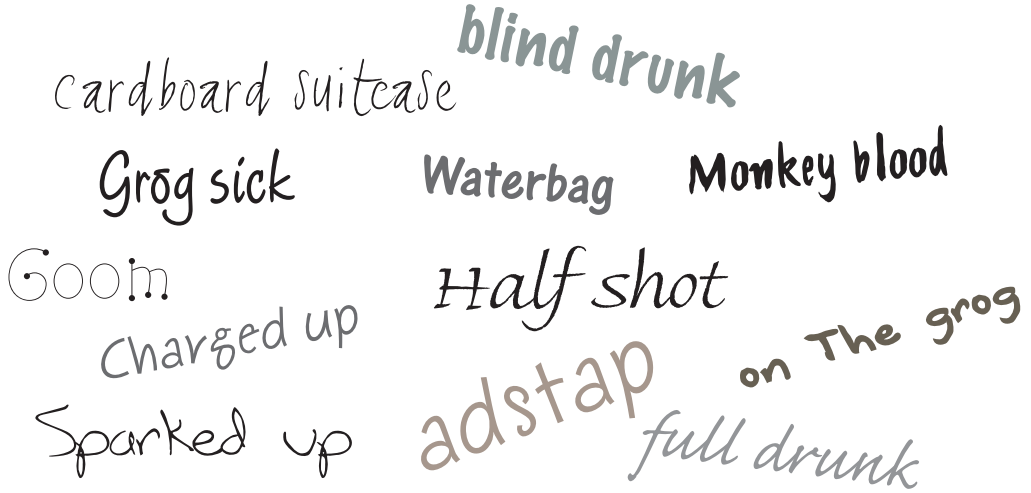
Community workshop activities

workshops

A workshop can get community members to talk about the problems of drinking and begin to air some issues. Guide the discussion along, and you can produce some great material. Here are some ideas.

Words for drink and drinking

Put people into groups of 4 or 5 people and ask them to brainstorm the words for drinking, for drunkenness, and different kinds of alcohol. Encourage people to give words from their own language, Kriol, Broken (in the Torres Strait), or slang 'everyday' words and ways of talking. Come together and write them up on a board.



Now discuss together:

- What do the terms about grog really mean?
- What do these words communicate about grog, and about attitudes to drinking?
- Look up the origin of the word 'grog' itself in a good dictionary and discuss what this tells you about Australia.

See page 9 **History** for some Indigenous language terms for alcoholic drinks

See page 230 **Handouts** Discussion topics

Debate the good and bad things about drinking

A very simple exercise is to get a group of people to write down (or say aloud) the positives and negatives of drinking. Divide into four groups and brainstorm answers to all questions. Share and debate the results:

- What are the good things about drinking?
- What are the good things about NOT drinking?
- What are the bad things about drinking?
- What are the bad things about NOT drinking?

What people said at a workshop in Wiluna

The bad things about drinking

Fighting. Stealing. Accidents. Family break-ups. No money. Hangover. Court. Prison. Hospital. Suicide. No job. Losing Law. Making enemies. Jealous. Losing respect. Losing licence. Getting sack. Losing culture. Wrong-way love. Stress. Blackout.

The good things about drinking

Making friends. Forget sorrows. Forget arguments. Tastes good. Feel open. Party. Helps leave lover. Guts to talk. Confidence.

Good things about not drinking

Look after family. Think clearly. Get job and money. No fighting. Happy kids. Nice clothes. Rent paid. Family together. Aware of others. No sickness. Get support. Happy. Money for travel. Good environment. Get respect. No one in lock-up. Self control.

Bad things about not drinking

Not so many friends. Left out. Lonely. People criticise you. No willpower. Pressure from drinkers. Can't get angry enough. No courage. Can't cut loose.

(Thanks to Yarranma, Duncan Graham)

Ideas like this from a brainstorming session can be great information to pass onto doctors or nurses working in health services with Indigenous people. They need to know the Aboriginal or Torres Strait Islander experiences and points of view about drinking.

Information technology

Computer technology is doing amazing things now. People are realising that computers and touch-screens are new ways to reach and teach Indigenous people in many different parts of the country. As usual, there are advantages and disadvantages to it. It is a form of health literacy (encouraging people to read and take in information); it is interactive (the user and the technology can 'talk' to each other); and it can include local faces and language to suit each area. On the other hand, it is expensive to develop, install and maintain; it depends on the high-tech knowledge of outsiders rather than being a truly grassroots action strategy. Here are some examples.

The touch screen kiosk that talks back

A team from the University of Queensland in Cairns have produced a new and simple way of presenting health information to Indigenous communities with some simple talking touch screens. They look like little TV screens, and you touch the questions on the screen and it talks back to you. There are pictures, sound, music, videos, animations, photos, questions and answers, test yourself quizzes and printouts — it is like an interactive game. Ernest Hunter, Helen Travers and their team have piloted the health information kiosks in Yarrabah (where the kiosk is in the Centrelink waiting room so everyone can find it) and Inala in Brisbane (who made their own material locally). The pilot testing showed that people WILL use this technology. Kiosks are now in health centres in Napranum, Lockhart River, Pormpuraaw and Kowanyama in Cape York and in AMSs in Woolloongabba, Cairns, Stradbroke Island, Bunbury and Port Hedland.

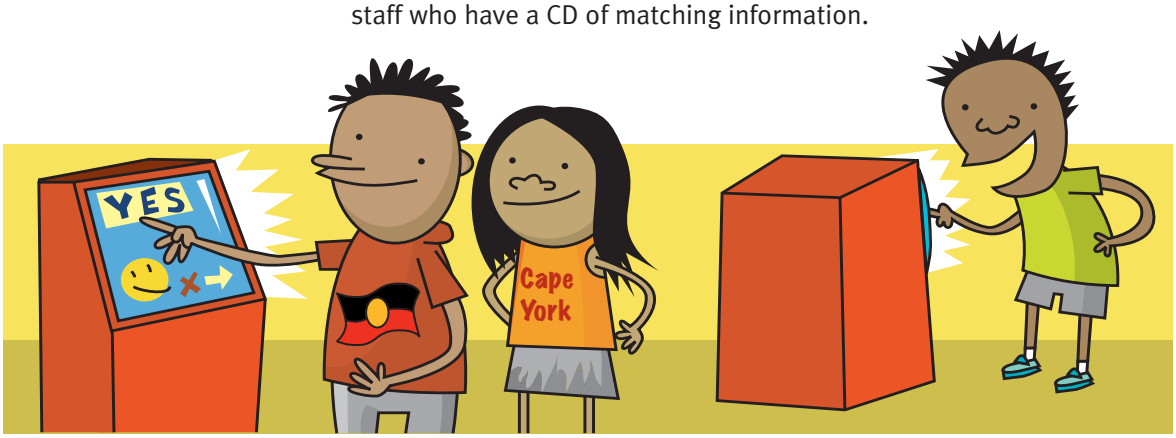
Touch and see (and hear)
TOUCHSCREEN TECHNOLOGY AND INDIGENOUS HEALTH

What is on the kiosks?

The kiosks provide health education modules for kids about keeping healthy and safe, and for adults about diabetes, alcohol and local community news and events. Local news and events can be updated regularly by local agencies to make the kiosks relevant, useful and fun.

There are three modules so far: diabetes, kids and health, alcohol. The alcohol module includes:

- *Learning* — health information about alcohol use for individuals, families and communities.
- *Screening* — find out if you have a problem, using a version of the AUDIT questionnaire.
- *Brief Intervention* — advice given by the kiosk itself or by health staff who have a CD of matching information.



For example, the alcohol screen asks if you are male or female, and if female, do you think you could be pregnant? If the answer is yes, then there are these FAS messages:

- If you're pregnant, don't drink alcohol.
- It's not too late to stop drinking.
- If you think you might become pregnant, don't drink alcohol.
- Both you and your baby are important and special.
- Strategies to cut down or quit drinking.

Practical implications of touch screens:

- People can see and easily understand the health information.
- Increases familiarity with technology.
- Increases the skills of health workers.
- Reinforces messages from other health interventions.
- Develops partnerships to help sustainability, making the technology available across the country.

Making local health messages on computer

New computer technology can also create animated characters that move and talk on a computer screen. The multi-award winning computer program MARVIN, developed in the NT in consultation with remote communities, features a host of animated Indigenous characters. The interactive program means that local communities can be involved in the creation of these characters and tell them what to say in the local language, as a way of communicating information. Communities need access to the computer program (which costs money), computers and CD burners to do this.

A number of government departments (such as FaCS) are making use of this technology as a way of publicising and promoting projects at a community level. For example in the Torres Strait, island communities have developed their own explanation of what the Longitudinal Study of Indigenous Children is all about, which will appear with local scenes and characters on screen.

Awareness campaigns in hotels

In towns and cities, people use pubs as a place to talk about problem drinking and improve awareness. These campaigns have different names such as **DrinkSense** and **DrinkSafe**. They involve cooperation between police, health and road safety workers and the licensees. Ernie Dingo launched the DrinkSafe campaign that ran in over a hundred hotels. Customers filled out a survey to check out whether their drinking was safe or harmful. The police offered people a free blood alcohol concentration test (BAC/BAL), using a breathalyser so that they could see for themselves how much alcohol was in their bodies.

The NT ran a program in pubs where customers were asked to drink either light beer or heavy beer and then have their blood alcohol levels measured at regular intervals. This showed people the difference in the effects on their bodies of drinking low alcohol beer versus high alcohol beer. Both these campaigns involved Aboriginal customers at the hotels.

Breathalyser: test yourself

* You can buy a breathalyser machine and have it in your licensed club or tavern. Lobby your local hotel to install one!

Machines to test how much alcohol is in your blood are already installed in some clubs and hotels. There are also units in mines and on tanker ships — as both these are very hazardous working places for anyone who is not completely sober. Some of the machines are small hand-held ones; there are large free-standing units. The units can be made to work free of charge, or to cost $1. You take a straw and blow down it. The blood alcohol concentration shows up on a display panel. If you have an over-the-limit reading (.05-.149) the message reads:

DANGER! ***It is illegal to drive in excess of .05. Your blood alcohol concentration (BAC) can rise for 1 hour or more after your last drink. Retest yourself in 30 minutes.***

See page 119 Resources this chapter, Breathalyser Services

See page 34 **Alcohol** Blood alcohol level

Free soft drinks for sober drivers

In one of the clubs in Tennant Creek, the Memo Club, where both Aboriginal and non-Aboriginal people drink and unwind, they did a sober driver campaign. To encourage people to drive home with a sober driver, and not drink and drive, the Club had a special promotion. Each nominated sober driver for a group of drinkers was provided with free soft drinks all night. To get their soft drinks, they present a special sober driver ID card, given out by the club.

Drink goggles: are YOU fit to drive?

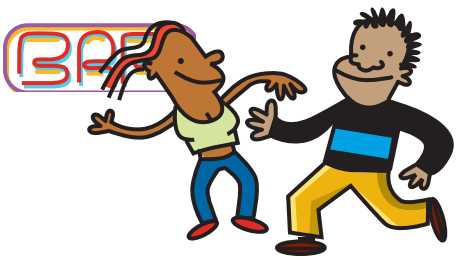
A community educator in Tennant Creek has discovered a great teaching aid. DW Eyes are special goggles that are designed to mimic what it feels like to have different blood alcohol levels. He has taken the goggles out to a number of communities and to rodeos and shows to demonstrate how strongly alcohol can distort senses and judgement. With the 0.2 goggles on, he gets people to try a couple of exercises. 'I get people to do the heel to toe line walk. They lose balance and about 99% drift to the right. I get them to pick up a ball and throw it at me — it goes about a meter to the right. It really gets people thinking about what can happen if they drink and drive!'

(Thanks to Lloyd Brooks and Carol Watson)

See page 119 Resources this chapter for DW Eyes (goggles) ⇢ ⇢ ⇢

Entertainment as prevention in drinking places

Certain types of entertainment can help to cut down on levels of intoxication and violence in pubs, hotels and clubs. Dancing, playing games, and listening to certain kinds of music all help to slow down the rate of drinking and keep people occupied.

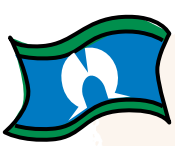


On the other hand, poker machines in pubs are not such a great idea because drinking affects decision-making.

See page 52 **Alcohol** Drinking and the pokies

The Mills Sisters — singing in the TI hotels

The three Mills Sisters — Cessa, Ina and Rita — are famous throughout the Torres Strait, Queensland and the rest of Australia. Sadly, Rita passed away in December 2004. They sang Island love songs, country and western, blues — and played tambourine, guitar and ukulele. They made several CDs. Before they retired they used to play in the pubs on Thursday Island. Ina tells how this helped to keep the lid on things:



'We got everbody's songs, as soon as we see someone walk in the door, if any country and western fella come in, we strike up a country and western song. Keep everybody happy in the bar. Instead of argument, we get everyone singing — we do requests too. Soon as there's a fight — "hey come on boys! That's enough!" If we walked in the street past a mob of drunks, "That's enough, you go home now". "Ok, ok".

(Thanks to Mrs Ina Titasey and Vic McGrath)

The atmosphere in a hotel or club can help prevent, or can contribute to, violence and heavy drinking. The tendency towards violence can depend on things like whether people are bored, how loud the music is, how crowded it is, the lighting and ventilation. Are there enough seats for everyone? It is important for people to be comfortable and have good quality entertainment. Other things to think about:

- Cups made from plastic avoid having broken glass.
- Use cans instead of stubbies.
- Have lots to do (pool tables, darts, juke box) and people do not drink so much or so fast.

See page 155 **Controls** Safer drinking places

See page 47 **Alcohol** The environment

Alcohol free social events

On the other hand, you can prevent trouble right from the start by putting in place short-term restrictions, or make special social events alcohol-free. Look at examples of the prevention strategies on the next few pages. They show that community organisations are getting much tougher on alcohol and drug misuse.

A safe sports carnival announcement

AP Sports Carnival

This is a family affair

NO GROG
NO DRUGS
NO MARIWANA
NO FIGHTING
NO SNIFFERS

In oval complex

If you bring grog or drugs your vehicle will be taken away

Police Aids and Night Patrol
will ban offenders from the Carnival

BY ORDER

Leonard Burton, Chairman of AP Sports Committee

(1997 Anangu Pitjantjatjatara)

Blue light disco on the move!

In the Torres Strait, the Queensland Police service has a blue light disco trailer — it is a mobile unit that allows them to run discos, movie nights and video games. The inter-island ferry service, *Sea Swift*, agreed to transport the trailer at no cost. They aim to visit each one of the Torres Strait island communities. The police run it as a crime prevention strategy—an alternative to drinking parties for young people under 18.

(*Torres News* 28 July–3 August 2004)

30th birthday party grog ban

The Central Land Council (CLC) had its 30th birthday in 2004 and it was a great family night — without the humbug and violence from drunks. Expecting large numbers of people in Alice Springs, the CLC approached the NT Licensing Commission to ban sales of port and four-litre casks for a three-day period during the celebrations. The Commission agreed, and police reported only one-third of their usual call-outs on the night of the celebration. An evaluation of the short-term ban is being done, to see whether this is the way to go for future special events.

Alcohol free arts festival

In August 2004, one of Tennant Creek's biggest social events went alcohol-free for the first time in its 15 year history. The Desert Harmony Arts and Cultural festival includes 20 events, with hip-hop bands. In the local paper, the mayor of Tennant Creek, Rod Swanson, said 'We are setting an example to help reduce alcohol consumption throughout our community. Alcohol-free events appeal to a wider range of community members and they are proof that good fun and entertainment are not dependent on the sale of alcohol'.

(Adapted from *ABC Online* www.abc.net.au 16/7/04)

Theatre and puppets for prevention

Several groups around the country use theatre and performance as a way of raising awareness and posing questions on all kinds of social issues: the use of alcohol and drugs, negotiating safe sex and dealing with family violence.

Moving Stories community theatre

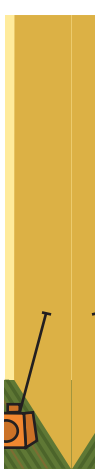
The Health Promotion Unit of the Kimberley Aboriginal Medical Services Council (KAMSC) in Broome makes resources with appropriate health promotion messages for Kimberley Aboriginal people. These include health music concerts, pamphlets in kriol, cartoon pamphlets and radio jingles for issues such as diabetes, smoking, and well adult screenings. The Health Promotion Unit also took theatre and performances out to the communities with prevention messages: Moving Stories, Desert Acrobats, No Prejudice (an HIV/AIDS play).

story telling

Moving Stories is a kind of community theatre for small groups. A person tells their story and the actors act it, mirror it back. It is a mix of theatre techniques adapted for local Aboriginal people. The act of telling a true story and having it played back allows for people to think objectively about their problem. This form of theatre can be used for counselling, dealing with community conflict, for sexual abuse and for alcohol-related issues. The Moving Stories team worked in parks, prisons, rehabilitation centres, schools, women's refuges and communities. (Thanks to Sue Laird, Kathy Hamaguchi)

Puppets

Puppets are a great way to communicate with kids and adults in a non-threatening way. Because puppets are not real people, but can tell real stories, they are able to say things that are hard to say in real life. They are a playful way of getting people to think about serious problems.



The Jannawi Kids is one example of using puppets (they were created by a puppeteer, Chris Burke). The puppets are very life-like, made of soft latex and you can sit a puppet on your lap and talk to it. There are three Aboriginal puppets: Tanika, Aubey and Birrilli. The puppets have been used in many Aboriginal communities: Ali Curung, Tennant Creek, Elliot, Nhulunbuy, Alice Springs, Cape York, Sydney. The stories told by the puppets are about how kids deal with violence and abuse in the home. One story narrated by Ernie Dingo tells about a woman deciding to leave a violent home and go to a refuge, getting legal protection. Chris Burke says: 'Puppets can do and say anything — it is not in print, or on video - they can become spokespersons on all sorts of things. They help people build empathy, to listen to the voice of kids, and their experiences of family life. Imagine the power of kids talking about grog!'

Jannawi Family Centre also has video resource kits (about overcoming the effects of family violence on children); it trains workers how to use the videos with children and adults; and trains people to become puppeteers. (Thanks to Chris Burke)

See Resources this chapter for contacts

See page 172 **Strategies** Managing family violence

Teenagers exploring alcohol issues through rap

In 2004 in rural NSW the Community Drug Action Team organised a series of workshops for young people with Hip Hop artist Morganics and supporting artist DJ Wire. These were linked to the promotion of harm minimisation behaviours and alcohol education. Rather than exploring 'gangsta rap' and lyrics associated with violence, they created rap songs exploring alcohol issues. A CD was made and distributed in the community. The workshops gave young people a way of expressing themselves and their culture, feelings and ideas.

In Wilcannia, the kids asked 'what are we gonna rap about?', and the answer was 'what do you do?', so they wrote this rap chorus:

When it's hot we go down river and swim
When we go fishing we're catching a brim
When the river's high we're gonna jump in
Then we go home and play didge

(Track from 'All You Mob', recordings of young Aboriginal hiphop from around Australia. www.morganics.info/)

Supporting parents in prevention activities

Another way of improving awareness about prevention is to work with parents — give them some skills. Adults need help so they can talk to young people about alcohol and other drugs. They need ideas about how to do this or else it is just too easy for them to close down the discussion by saying 'don't do it'.

Homework centres

In Launceston, Tasmania, a group of Aboriginal adults worked in homework centres, to help kids with their school work. These adults needed help to talk with the kids about their drug problems, so a group was started called 'Tarinna Circle'. Tarinna means 'albatross', the sea bird with a huge wing span. For Aboriginal workers in northern Tasmania, the image suggests Aboriginal people looking after the younger generation. Adults in the group shared information to educate themselves about AOD, to help their work in the homework centres. This has helped them to feel that it is OK to talk to young people about drugs and alcohol, not just say to them 'don't do it!'

Paul Maher, who helped to facilitate this group said:

> *'We gotta stop denying drugs exist in schools, particularly in Tasmania. The guys from the homework centre get together. It's interesting talking about their experiences with the kids who had drug problems and how it made them feel. Staff in the homework centres know the kids —some are even closer than their parents. The workers find ways to talk to the parents and get them working on the problem. Tarinna Circle is a mixture of grass roots, academic and others who are really interested. Most of Tarinna Circle are there not because they get paid, but to be there for the kids and to do something for the community'.*

Why this program worked:

- There was a committed local Aboriginal person with energy, acceptance in the community and who got meetings together and facilitated them.
- The group met regularly once a week in a neutral place. Everyone chucked in for a pizza, so it is a social get-together.

- The issues were about 'what was happening in kids' and adults' lives, not political rhetoric' said Paul Maher.
- The group was a vehicle for mainstream services to become more aware of Aboriginal needs — like a reference group.
- These are Aboriginal voices advocating for their children. The group met at its own cost and did all the activities-setting meetings, taking minutes, producing newsletters, organising guest speakers.

This case study shows that self-help groups can work. To get started, they need two main things: the spark of interest or concern from community members, and someone to take it on as a commitment.

Home influence

Families can help to prevent drug and alcohol harm because:

- Young people are introduced to alcohol mostly by parents and relatives.
- After shops and retail outlets, the most common way for young people to obtain cigarettes is from a friend or family member.
- Parents have an important part to play in modeling responsible drug taking behaviour.
- The home is an important setting for responsible 'real life' drug education.

(From www.communitybuilders.nsw.gov.au)

See www.cuzcongress.com.au — a great website for young people.

Training in alcohol and other drugs

Remember The Ottawa Charter for Health Promotion (page 93).
The 5th strategy of The Ottawa Charter is 'Reorienting health services'. This includes providing training for health workers, especially frontline workers and those in primary health care.

skills

Training courses for drug and alcohol workers have come and gone over the years. Certainly the old days are past when it was good enough to be an ex-drinker and have no other training. Now there is more evidence of what works and what does not. There is polydrug use, mental health problems, new drugs, blood borne viruses — things are more complicated now. New quality assurance projects and service agreements have also put more emphasis on properly trained Indigenous AOD workers in agencies and residential programs. It is essential to have learned the skills to counsel and motivate people with drinking and drug problems. Mainstream alcohol and drug services need to employ Indigenous personnel too, to break down the barriers that prevent Indigenous people from utilising them.

Along with the practice development team at the Drug and Alcohol Office in Perth, Wendy Casey has been involved in developing a curriculum for the Indigenous Alcohol and Other Drug Training Program (Certificate III, Community Services Work (AOD)). The training is for frontline Aboriginal workers in community controlled services, NGOs and government agencies. Trainee positions are also funded for Aboriginal people working in mainstream AOD services.

Culturally secure and evidence based training in WA

The training is block release, consisting of four one week training blocks over a year. At present the Drug and Alcohol Office runs the program once a year and there are waiting lists for future blocks. Most of the participants in the previous year have been able to gain ongoing employment in the sector.

The learning materials and methods have been developed by Indigenous professionals. The program uses evidence-based practice

for responding to people and communities affected by AOD. It has the best of both worlds! The training talks about new Aboriginal models inspired by existing Aboriginal models. It also adapts some mainstream models that fit in well with Aboriginal ways of working, such as social learning theory and motivational interviewing. It shows how an AOD assessment can use an Aboriginal Inner Spirit model that:

- Allows clients to assess how their AOD use is affecting their Inner Spirit and their connections to family, community and country.
- Supports clients to understand that Aboriginal ways of being healthy are to look after ourselves by making good choices, and to care for our family, community and culture.
- Promotes an understanding that AOD can tangle and weaken our spirit and mind. This can affect a person's emotional, social, spiritual and physical wellbeing, and weaken connections to family, community, culture and country.

(Produced by the Aboriginal Alcohol and other Drugs Program, Drug and Alcohol Office. The Aboriginal Inner Spirit Model (Ngarlu Assessment Model) was developed by Joseph 'Nipper' Roe. Thanks to Wendy Casey and Steve Allsop)

For information about training courses for Aboriginal and Torres Strait Islander workers in different States and Territories (in AOD services, counselling, sobering up shelters, community patrols, nursing, dementia, narrative therapy and the health sciences) see Resources.

Resources for chapter 4 Prevention

Equipment

Breathalyser Services
Phone 02 9972 9360 Fax 02 9972 9362 Email breathservices@ozemail.com.au
www.breathservices.com.au

DW Eyes Game Kit with Goggles (includes 2 pair of goggles) and *Fatal Vision Kit* (includes 4 pairs of goggles, at two different blood alcohol levels and for day and night vision) are available through Scientific Educational Supplies in Brisbane, QLD. Phone 1800 656 434 Email info@ses.com.au www.ses.com.au

Health education, health promotion

Public Health Bush Book A great resource written and developed in the NT
www.nt.gov.au/health/healthdev/health_promotion/bushbook

A website for young people with contacts for primary health care services, lifeline, kids help line, Healthy Vibes, and 'ask the doctor' www.cuzcongress.com.au

Rethinking Drinking. You're in Control (2004) Dept of Education Science and Training. An education pack for lower-middle secondary students in years 8–10 with Indigenous content. Available from: Australian Council for Health Physical Education and Recreation (ACHPER) www.healthylifestylesbookshop.com.au

The Indigenous Health Promotion Resources Guide, 5th edition (2005)
www.aihwj.com.au Email journal@aihwj.com.au

Information technology

Touchscreens — HITnet (Health Interactive Technology Network) University of Queensland, Cairns. www.hitnet.com.au

MARVIN — Interactive Communications Unit, NT Department of Health and Community Services. www. MARVIN.com.au

Puppets

Jannawi Resources — Phone 02 9750 0500 www.jannawi.com.au

Chris Burke Gracie Productions — Phone 02 9555 4030 www.gracieproductions.com.au

Training

For resources on alcohol and other drugs education, training and workforce issues see www.nceta.flinders.edu.au

Diploma of Narrative Approaches for Aboriginal People (Counselling, group and community work). Contact Nunkuwarrin Yunti of SA Inc Phone 08 8223 5217 or Dulwich Centre www.dulwichcentre.com.au

Indigenous alcohol and other drug training program (Western Australia) Contact: Drug and Alcohol Office (Wendy Casey) Phone 08 9370 0333 www.dao.health.wa.gov.au (see 'Practice development')

References chapter 4 Prevention

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Foster, G M (1965) *Traditional cultures and the impact of technological change.* Harper and Row, New York

Holder, H D and R S Moore (2000) Institutionalisation of community action projects to reduce alcohol-use related problems: Systematic facilitators. *Substance Use and Misuse* 35(1&2):75–86

Lander, A (1995) *Preventing Alcohol-related Violence. A Community Action Manual.* Eastern Sydney Area Health Service, Sydney (available from ADCA)

Lenton, S (1996) The essence of prevention. In C Wilkinson and B Saunders *Perspectives on Addiction. Making sense of the issues*. William Montgomery Pty, Perth

Mattick, R P and T Jarvis (1993) *An outline for the management of alcohol problems.* Quality Assurance in the Treatment of Drug Dependence Project. AGPS, Canberra

National Drug Research Institute and Centre for Adolescent Health (2004) *The Prevention of Substance Use, Risk and Harm in Australia: a review of the evidence*. Ministerial Council on Drug Strategy, Canberra www.nationaldrugstrategy.gov.au/publications/monographs.htm

Spark, R, R J Donovan and P Howat (1991) Promoting Health and preventing injury in remote Aboriginal communities: a case study. *Health Promotion Journal of Australia* 1(2):10–16

WHO The Ottawa Charter on Health Promotion www.euro.who.int/AboutWHO/Policy/20010827_2

What's in the 'controls' chapter?

Controls over supply

Liquor licensing laws

Licensing laws are some of the most powerful tools that can be used by governments and Indigenous community groups to reduce alcohol-related harm. The licensees, not only the drinkers of alcohol, are part of the problem and need to be part of the solution. All states and territories have licensing boards or commissions that make and enforce the rules covering where and how alcohol is sold. Their job is to take notice of the needs of the public and the needs of licensees, but balancing these two sides is not easy.

licensees

Licensees do a number of things to increase their sales to Aboriginal and Torres Strait Islander people.

- Selling on credit ('book-up').
- Promoting cheap high alcohol drinks.
- Opening early in the morning.
- Reducing costs by having few facilities in 'front' bars.
- Selling foodstuffs popular among Aboriginal people in licensed roadhouses (such as Weetbix, tinned meat).
- Installing poker machines in 'Aboriginal' bars.

Licensees usually object to attempts by community groups to limit their sales. They sometimes start petitions and lobby Aboriginal drinkers. They hire lawyers to appear for them at formal licensing hearings. Some licensees refuse to negotiate informal agreements with communities. But a successful regional strategy will need to involve and consult with licensees if possible.

The Royal Commission into Aboriginal Deaths in Custody recommended that:

Legal provision be available in all jurisdictions to enable individuals, organisations and communities to object to granting, renewal or continuance of licenses — and that they be provided with the resources to facilitate this (Recommendation 277).

See page 236 **Handouts**
How to make a success of a local action strategy

Getting access to liquor licensing authorities

Any community group trying to cut down on accidents or violence associated with drinking needs to know about the relevant licensing laws. They need to know how to make use of them, how to object to new licences, or complain about existing ones.

Most licensing laws have provision for community people to have input, but this can be difficult so it is important to get information to know how to do this. Many Aboriginal and community groups have been successful in putting their cases forward, in the southern states as well as in remote areas of WA or the NT.

Have your say!

- SEND FOR *Indigenous Australians and Liquor Licensing Legislation* by Bourbon, Saggers and Gray (1999).
  See page 157 Resources
- CONTACT your state/territory liquor licensing board and find out what you need to do to make changes to a licence, object to a new one, or make a complaint.
  All addresses listed on page 159 Resources
- INVITE the liquor commission or board to send a representative to come and inform your community or action group about the regulations in your state or territory.

Arranging a visit from the licensing authorities

In Brewarrina, community members did not know about the different options for restrictions or how to get these going. A visiting alcohol researcher presented a workshop to the local action group and suggested they should simply invite the Department of Gaming and Racing to come and talk to them. The group thought this was a good idea, so their facilitator contacted the Department. Several officers visited the Far West region and held community education sessions in Collarenebri, Walgett, Bre, Bourke, Dubbo and Broken Hill. This is the invitation sent out to the communities:

Invitation to an Information Session on Local Licensing

What's it about?

A representative from the NSW Department of Gaming & Racing will:

* Provide information about developing local liquor accords
* Identify other licensing issues community members are interested in learning more about during 2004

What is a Local Liquor Accord?

A liquor accord is an agreement between local police, licensees, council and community representatives. The agreement sets out practical strategies to minimise harm associated with alcohol use. The agreement can be formal or informal.

Outcomes for the community

A successful accord can bring about benefits such as:

* Reducing anti-social behaviour and crime
* Increasing compliance with the liquor laws
* Improving relationships between police, licensees, councils and residents

For more information

Contact Alcohol Community Development Project, FWAHS

(Thanks to Kate Gooden)

The sessions in the Far West area allowed Aboriginal community members to discuss local issues, suggest strategies and hear from the officers what is and is not possible under the liquor laws. The visiting officers also had a chance to check out reports of health, safety and discrimination issues involving local licensed premises.

Putting restrictions in place

We know from expert research that targeted restrictions do help to reduce harm. Even more importantly, we know that many Aboriginal drinkers are 'opportunistic' drinkers — they drink if and when the grog is available. For this reason, making alcohol harder to obtain can make a big difference. Licensing restrictions are now brought in very often at the request of Aboriginal and Torres Strait Island groups. Communities are getting to be less tolerant of drunken behaviour. Even so, when people in a community or town open up the grog issue for discussion all sorts of arguments start to fly! Below are some questions that often come up, and some answers to them.

Questions and answers on restrictions

What about the 'rights' of tourists?

tourists

Tourism often drives the supposed need for more alcohol outlets in remote areas. Why are drivers encouraged to buy grog like this? Are tourists visiting just to drink grog? In a licensing submission in 1990, the Pitjantjatjara Council wrote: 'We live here. We're not going away. It's the tourists who are passing through. Why are their needs and wishes greater than ours?' Tourists can buy their supplies in towns, not on the road.

What about tourists buying grog for Aboriginal people?

Have signs up that state clearly that the local Aboriginal community has made an agreement with the licensee and politely request that people not supply alcohol. These 'sympathetic' people are in fact going against a local initiative.

Why not have an informal arrangement?

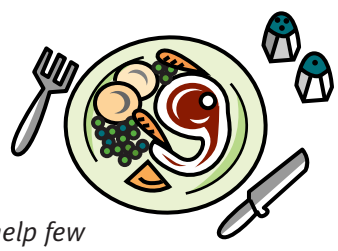
Managers and owners of licensed premises change over time, and change their minds. This means that what seemed to work OK with one manager may not necessarily work with another. A formal arrangement is better.

How is a licensee supposed to know who he can sell to?

There are ways around the problem of licensees not knowing who they can sell to and who not. Give them a list of names and involve local people such as the night patrol. If there's a limit on the number of cans or casks, the licensee can take the names of the people who buy and check driver's licences for ID.

What about loss of sales and profits?

Licensees are pushed along by financial interests and claim they will lose sales if there are restrictions. In fact, premises can make up any loss of income from grog by providing hot food (not just snacks), a range of cool and hot drinks or having entertainment (for a small charge).



Restrictions punish many and help few

The fact is that restrictions generally reduce how much everyone drinks. If everyone's consumption is down, then alcohol-related problems are fewer.

Restrictions for Aborigines are discriminatory

Licensees have used 'discrimination' as an excuse for not agreeing to restrictions, even when requested by local Aboriginal groups. Licensees say they worry about complaints against them for discrimination. A solution is to use certain words to describe the restrictions, so that they are non-racially discriminatory. Restrictions can apply to 'residents of, or travellers to or from [name of community]'.

Special Measures Certificate

The Race Discrimination Commissioner came up with a solution to claims of discrimination on racial grounds when restrictions are put in place. Communities or organisations could apply for a 'Special Measures Certificate'. These Certificates have been issued to communities in WA and the NT. One of the first was Wiluna, WA, where local Aboriginal people were not allowed to buy takeaways before 2pm and after 7pm on weekdays. The Race Discrimination Commissioner gave the Club Hotel (the only pub in town) a Special Measures Certificate.

Extract from a Special Measures Certificate

I, William Jonas, Acting Race Discrimination Commissioner, having considered

1. the application of the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council Aboriginal Corporation in relation to the Agreement dated May 2003 between the licensees of the Curtin Springs Roadhouse and the Aboriginal communities of the Anangu Pitjantjatjara Lands, Ngaaynyatjarra Lands, Docker River, Mutitjulu, Imanpa and Finke in respect of the sale or supply of alcohol by the Curtin Springs Roadhouse, its servants or agents to the residents of those communities....
2. the material furnished to me in support of restrictions on the sale and supply of alcohol by the Curtin Springs Roadhouse.

I am satisfied that conduct which conforms with the Agreement

(1) should constitute a special measure for the purposes of section 8(1) of the Racial Discrimination Act 1975 (Cth), being an agreement which is both necessary and imposed for the sole purpose of advancing those communities....

I am also satisfied that this agreement was adopted with the support of those communities generally and that it is for their benefit...

(Thanks to Vicki Gillick, NPY Women's Council)

To learn how to apply for a special measures certificate, see Resources page 157, The Human Rights and Equal Opportunity Commission is, however, planning to review the special measures process in 2005.

Restrictions on sales in Tennant Creek

Did you know that WHO and international researchers have taken note of the restrictions that are in place in Tennant Creek? The story of 'Thirsty Thursdays' is in some policy books sponsored by WHO.

See WHO publications by Babor (2001) and Room (2002) listed on page 23 **History** Resources

Thirsty Thursday—Development of the strategy

In 1993 groups in Tennant Creek raised concerns about alcohol misuse. There were meetings with the Liquor Commission, statistics collected, bans on 4 and 5 litre casks, a survey of town opinion and six month trials of two different restrictions.

The Liquor Commission organised an independent evaluation of the impact of the trial restrictions, that worked closely with Julalikari Council. During the trial period, when the front bars and bottle shops were closed all day Thursday, there were fewer alcohol-related injuries, violence and trouble. More than half the townspeople were in favour of the trial measures, 21% were against, and 16% had a mixed reaction.

Ten years later?

Centrelink payments are no longer only paid on Thursdays. Some drinkers get their payments on different days, so now there is always money for grog! The restrictions do not mean that you cannot buy alcohol on Thursdays. The lounge bars are still open. People can still get a drink with meals at licensed clubs and restaurants. The alcohol restrictions now in place indefinitely in Tennant Creek include:

- No front bar sales, no takeaways on Thursdays.
- Ban on the sale of casks of wine bigger than two litres.
- Limit of one container per person per transaction per day of wine less than 2 litre.

- Other than Thursdays, front bars open at 10am; only light beer before midday.
- Other than Thursdays bottleshops can open at midday.
- On-licence sale of wine only when accompanied by a meal.
- No off-licence sales to taxi drivers suspected of 'third party' sales.
- Exceptions for 'bush orders' made by customers who have an account.

Some positive outcomes in 2004 to the restrictions:

Thirsty Thursday is now called 'Boot Day': the only day that drinkers have to wear boots (and dress properly) if they want to have a drink!

- The pub is a more controlled environment than open air drinking.
- Police and Aboriginal Community Police Officers (ACPOs) visit pubs and talk to staff and drinkers.
- One pub is having 2 x 3 hour 'sessions' with a 3 hour break in between. In the afternoon session, people pay $10 for a cooked meal with their drinks. People say they enjoy themselves and behaviour is good.

- Protective custodies are down on Thursdays.
- People seem to be shopping at the Food Barn on Thursdays.

Not so positive outcomes:

- People are said to be buying 'top shelf' — more expensive drinks — so it is costing people more (but it could mean people are buying less alcohol altogether).
- Drinkers are playing the pokies which can be the end of money for the week.
- An ongoing problem is 750 ml bottles of port being sold, causing glass problems and use as weapons.

Read the book by Aboriginal writer Alexis Wright, which tells the whole story! See page 160 References

See page 52 **Alcohol** Drinking and the pokies

Women lobbying for restrictions

The Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council had a long struggle with Curtin Springs roadhouse on the Lasseter Highway, near Uluru, which started in 1988. After many complaints, letters, lobbying, collecting statistics and protest marches, things happened in January 1997. The Race Discrimination Commissioner negotiated an agreement between the NPY Women's Council and the licensee for a trial run of different restrictions.

- The first six months would have no takeaway sales (for Anangu) and sit down beer available from 1pm–4pm.
- The second six months involved no sit-down drinking, and takeway limited to one six-pack per person per day.
- The trial was evaluated in 1997 (d'Abbs, Togni, Duquemin 1999 report) See page 160 References

Currently (2003–5) there is an agreement between the licensee and the NPY Women's Council on behalf of a number of Anangu communities. The agreement states that there will be no sales of liquor from the roadhouse to Aboriginal people 'who are members of any of the communities who are party to this agreement or who stay in one or more of the communities from time to time'. The agreement is covered by a Special Measures Certificate issued by the Human Rights and Equal Opportunity Commission (see example on page 129).

Assess the impact of your restrictions

The community of Yalata in South Australia tried several times to negotiate with local licensees on the Eyre Highway. None were willing to cooperate. In the end, after a fatal vehicle accident, the Aboriginal council felt strongly enough to take action. Before this, it had always been difficult to do or say anything that affected the drinkers.

The council put up a strong case to the Licensing Court and, in 1991, it agreed to three local licensed outlets (one pub and two roadhouses) having restrictions on their licences. The changes said that the outlets could not sell takeaway full-strength alcohol to residents of, or travellers to or from, the community.

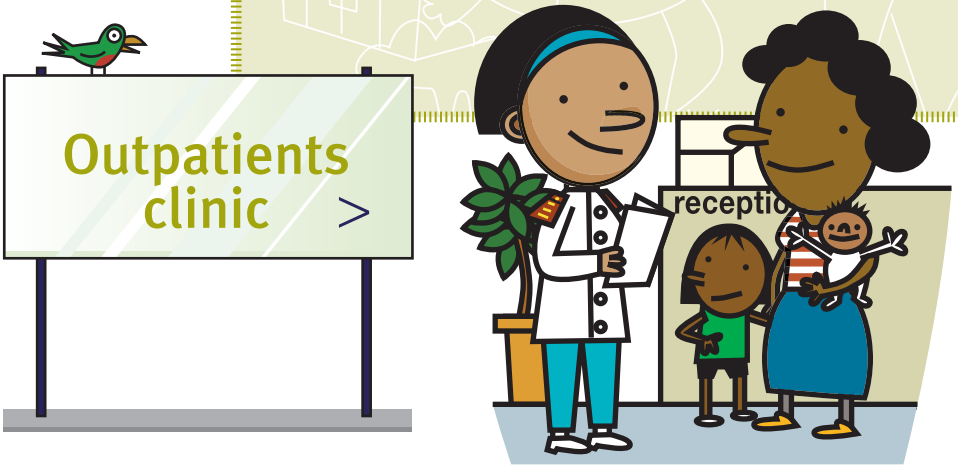
See page 65 **Action** Local action research

Health outcomes of takeaway restrictions

To see if the restrictions improved health, the community health centre set up a simple check sheet for staff to fill out. They did this for the six months before and six months after the restrictions. The check sheet listed alcohol-related causes including illnesses and child neglect and injuries such as bruise/laceration/broken bone/burn, and whether this was from an assault. Researchers working for the health service found:

* The number alcohol-related injuries dropped by more than half (55%)
* Assault injuries dropped by 43%
* Presentations at the clinic for burns dropped from 42 to 3
* Lacerations (cuts) dropped from 85 to 18
* There were decreases in violence, night disturbances, and everyone felt better
* The changes have not solved all problems but ten years later, the figures show a big drop in deaths from motor vehicle accidents, people drink more quietly, and daily life has improved for the community.

(Thanks to Yalata Maralinga Health Service, Joe Byrne, Graham Henderson)



Restrictions and product substitution

Remember the Peoples Alcohol Action Coalition (PAAC) in Alice Springs? see page 79 **Action** Public Meetings After many meetings, lobbying and surveys of town opinion, trial restrictions were introduced. Restrictions covered hours of trade, takeaway sales and size of casks (no sales of casks larger than 2 litres). However, the evaluation of the restrictions in 2003 had mixed results — there was a loophole in the restrictions that allowed for price-cutting.

There were significant reductions in assaults, sobering up shelter admissions and in selected presentations to the hospital and Congress health service. But there was no change in alcohol sales and consumption, which was disappointing. A negative outcome of the restrictions was a huge increase in sales of port. Drinkers substituted cheap port for casks of wine. The liquor sellers deliberately reduced their prices of 2 litre casks of port which made it even more attractive to drinkers! The PAAC had predicted that this might happen, knowing that people chose the cheapest alcohol to drink. Once 2 litres of port were as cheap as 5 litres of wine, that's what they chose.

PAAC organised a study of alcohol pricing around this time. It shows up the problem of prices not relating to the strength of the alcohol. They found these prices for takeaway:

- A standard drink of port (in 2 litre cask) cost 28c
- A standard drink of wine (in 2 litre cask) cost 57c
- A standard drink of full strength beer (in a 24 can pack) cost 72c.

This shows that port (the drink with the highest alcohol content) is the cheapest. This is not good public health practice!

(Thanks to Donna Ah Chee and John Boffa)

See page 19 **History** Health and taxes

Server responsibility

Duty of care

There is increased recognition that the sellers and servers of alcohol bear some responsibility for problem drinking, not just the drinkers themselves. This means paying attention to responsible serving practices. All licensees, including licensed outlets run by a community organisation, have to practise safe service or their licences can be temporarily cancelled.

- People who sell alcohol have responsibilities, called 'duty of care'.
- They must not put customers or staff at risk of harm.
- A licensee can be fined or closed down for irresponsible practices.
- Staff need to learn how to refuse service to someone who is drunk.
- Fresh water should be provided on the bar, at the tables.

Because of the 'duty of care' and because it is the law, a licensee is not allowed to keep on selling more and more alcohol to someone who is already charged up. If that drinker drives off and kills someone in his vehicle, the licensee can be sued by lawyers.

See report by Solomon and Payne 1996 in Resources page 157

How to get licensing laws enforced

We know that improving safe service of alcohol can cut down on service to intoxicated people and on the number of alcohol-related accidents. But how to persuade the police to target problem premises and enforce the laws that already exist? One way is to find out which outlets cause the most trouble, and then focus on them. Give them the hard word. Let them know that someone's watching them. The police can do this if they have hard evidence.

A 'linking project' in Newcastle, NSW, worked with the police and the licensees to do this.

The Newcastle linking project

The goals of the project were:

- To collect detailed reports about alcohol-related incidents.
- To provide feedback to liquor outlets on the number of times their premises were identified to be the last place of drinking alcohol by people picked up by the police for crimes.
- To evaluate effectiveness and let other police districts know about the project.

Police questioning

All police dealing with any alcohol-related incident (assault, family violence, stealing etc) had to write down four things about the person they picked up:

- Whether the person had drunk alcohol before the incident.
- What was the level of the person's intoxication.
- Where the person had last consumed alcohol.
- If it was at a licensed premises, the name and address.

Using this information, the police mapped the number of incidents and linked the incidents to the particular liquor outlets that had sold the alcohol.

The results

The results were pretty interesting. Out of 437 licensed premises in the district, only 54 were said to be the last place of drinking by people picked up for offences. Out of these 54 places, 4 premises accounted for 37% of the incidents! This gave the police the information they needed to target the problem outlets. Police gave the licensees feedback reports to show them first hand the role of their outlet in the crime. They should smarten up their serving practices or else!

As a result of the feedback intervention, alcohol-related assaults and damage went down in the district. The project was so successful that it started up across the whole of New South Wales and 9000 police are being trained to ask 'where did you last drink?' and collect the data.

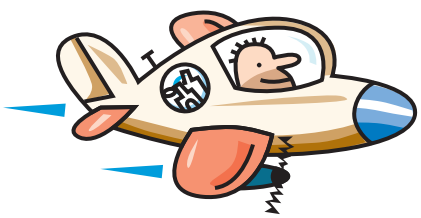
What can we learn from this?

- The Newcastle project found that only a few liquor outlets (out of hundreds) were responsible for selling alcohol to people who made trouble or committed a crime.
- Giving feedback to licensees of incidents related to drinking on their premises was effective. (This is also true for individuals. Letting individuals know how their behaviour hurts other people can help to change that behaviour).

(Thanks to John Wiggers, Hunter Centre for Health Advancement)

Sly grog and licensees

Sly grogging involves the licensees, not just the people who are buying up big to take back into a community. Drinkers drive into town, buy cartons of alcohol, take them back to the community and re-sell illegally, often on a 'dry' area. Aboriginal people are being ripped off twice — by the licensee selling in bulk and by their own people who are charging high prices. There are several ways of trying to deal with this: night patrols, locked gates and fences, searching utes, cars or aircraft, negotiated agreements with licencees, and prosecution.



Dealing with suppliers of sly grog: legal issues

All Liquor Acts make it an offence to sell liquor without being licensed to do so. This should solve the problem of sly grogging — people who re-sell grog illegally. But in reality, the police find it very hard to prove that money changes hands. It is not an offence for a licensee to sell large amounts of liquor. But if it was proved that the licensee knew the alcohol was going to be drunk in a restricted area, or re-sold to someone else, then he could be committing an offence. He would be an 'accessory before the act'.

The Royal Commission into Aboriginal Deaths in Custody (Recommendation 279) recommended that laws preventing sly grogging should be strengthened. In South Australia, the Liquor Licensing Act widened the definition of the word 'sell'.

'Sell' now includes:

a) to barter or exchange

b) to offer or expose for sale, barter or exchange

c) to supply or offer to supply, in circumstances in which the supplier derives, or would derive, a direct or indirect pecuniary benefit

d) to supply, or offer to supply, gratuitously but with a view to gaining or maintaining custom, or otherwise with a view to commercial gain.

(Thanks to Chris Charles, ALRM)

Taxis selling alcohol

In some areas, taxis are notorious suppliers of alcohol. In Tennant Creek, Julalikari Council was concerned about taxis selling alcohol to Aboriginal people and made this a part of their overall grog strategy. The NT Liquor Commissioner has included as a condition of the liquor licences in the town the following ruling:

'Sales of liquor to taxi drivers are prohibited where those taxi drivers are acting as purchasing agents for third parties or in circumstances that might reasonably lead you to believe the liquor purchased is not for the taxi-driver's personal consumption'. In other words, it is illegal for taxi drivers to buy alcohol and on-sell it to other people.

Getting rid of a sly grogger

In the Canadian film The Honour of All, *the community members at Alkali Lake caught the sly grog seller by marking the money. They set him up, then grabbed him as he got to his vehicle, seized the marked money notes, and kicked him off the community. 'But it's my way of life!' he said. 'Your way of life is our way of death' the community members replied.*

See page 157 Resources, for obtaining *The Honour of All* ⇢ ⇢ ⇢

Selling alcohol on credit: book-up

In many rural and outback locations, hotels allow people to 'book-up' — to buy drink on credit. Some hotels 'look after' people's keycards. This conveniently provides the stores with a captive group of customers. These activities have a negative impact on Aboriginal people. It means people can always buy grog, even when they are poor, and so they are always in debt.

How to deal with book-up

- Express your concern with the licensee about 'drinking on account'.
- In most cases it is up to the community council to take a strong stand on book-up and negotiate with storekeepers and licensees.
- Check your liquor licensing laws. In Elliott NT, pressure from the local Aboriginal council resulted in the banning of book-up as a condition of the hotel's licence, with the cooperation of the NT Liquor Commission.
- In WA it is not illegal for licensees to hold the keycards of patrons. But section 64 of the WA Liquor Licensing Act allows the authority to impose conditions on a liquor licence that prevent them from holding customers' cards.

See ASIC on book up in References page 160

Sales of methylated spirits

Methylated spirits is not supposed to be drunk. This means it is not defined as 'liquor' in the various Liquor Acts and the police cannot prosecute people who sell it for consumption. The only solution to easy access to metho is for community groups and the police to negotiate with shop keepers to keep it under the counter and take it off the shelves. In Mt Isa for example, the police Aboriginal and Islander liaison officer did this. Every shop agreed to keep metho out of sight; you have to ask for it. With Aboriginal ownership of the supermarket in Fitzroy Crossing, they had independent powers to restrict sales of metho. They keep spray cans behind the counter too, to stop kids from buying them to sniff.

You can use the same approach with retailers of methylated spirits that is used for the responsible sales of solvents. *A Retailer's Solvents Kit* is available from Tangentyere Council in Alice Springs (08 8951 4222).

Other laws used by communities

Alcohol-free zones

Both Aboriginal communities and non-Aboriginal town councils have made use of laws which allow for dry areas or alcohol-free zones. These can cover most of a town or a whole community, or specific areas such as a park or riverbank. Many Aboriginal people see these laws as 'cleaning up the streets' to promote tourism. This may be so in some cases, but the laws are usually designed to address uncontrolled drinking and broken glass — sources of potential harm. Dry areas can have both advantages and disadvantages. It is important to think about these before taking a stand.

Problems with a ban on public drinking: Coober Pedy

In August 1996 a trial ban was placed on drinking in public in Coober Pedy, SA. But Umoona Community was not declared dry. To do this, the Lands Trust Act would have to be amended. So the only places drinking could legally take place were in the homes of Aboriginal people at Umoona! There was increased violence and drinking problems in the Aboriginal community and in people's houses.

'I'm just writing about the Dry Areas. I know why you're having the Dry Areas but it's not fair to have it [the drinking] in the house. Why don't they have it in some other outside area place—somewhere else-not in the house? There will be a lot of things going on in the house—drinkers are likely to smash up whatever is in the house or cars in the yard. What about the young girls? Who's going to protect them, poor things? You can't just push drunks back into the houses. The kids won't be able to live in the houses — they'll just be scattered. The drinkers need to have an outside place somewhere else to drink'. (Resident of Umoona)

Problems faced by residents in Coober Pedy

* Drinkers forcing themselves into homes.
* Drinkers using and smashing up facilities — not paying.
* People fearful of having their houses taken away from them because of this.
* Older people and children at risk.
* High levels of general noise and disruption.
* Police 'too busy' to come.
* Dry area decision made with no follow-up or additional action.
* No broad strategy as originally recommended.
* Shift of responsibility away from the authorities onto (often elderly) Aboriginal residents without resources.

Solutions to these problems

The people affected by this dry area suggested some solutions:

* A women's shelter and a sobering up shelter.
* Basic facilities at camp for drinkers with a tap, a toilet, a shelter.
* A telephone.
* Resources directed to these solutions.
* More responsive policing and licensing regulation.

(Thanks to Michelle Madigan and Eileen Wingfield)

There are examples of positive outcomes from dry areas. In the NT most Aboriginal communities have made use of the 'restricted area' sections of the Liquor Act. This is because they know the difficulties of controlling violence and disorder. If people want to drink, they can go somewhere else. It does not affect the overall 'right' of someone to drink. Making an area dry simply puts the rights of a larger group of people before those of an individual. This is called 'the public good'.

People can also declare a dry area or a dry camp on a much smaller scale. 'No Grog' signs on houses (enforced by a community or town council) give people some powers to keep a safe and quiet home. A householder can use this public sign to give them back up to persuade drinkers not to come in and make trouble.

See page 171 **Strategies** Using the Trespass Act

Making your house and yard alcohol-free

In Tennant Creek, some Aboriginal people have put signs in front of their houses saying NO ALCOHOL ALLOWED ON THESE PREMISES. OFFENDERS WILL BE PROSECUTED. They were getting tired of drinkers bringing grog to their homes, getting drunk, making a mess and humbugging the householder. People can ask the Julalikari Council (through the housing section or a Council member) to have the big 'No Grog' sign on their fence. If people disobey the sign, they can be given a warning, and residents can ask Julalikari to serve a trespass notice. People say the signs do make a difference. Most of the 110 houses in the urban area managed by Julalikari have a sign now.

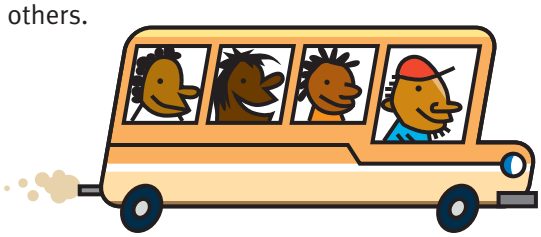
(Thanks to Tony Miles, Julalikari Council)

Avoiding mistakes with dry areas

When planning a dry area, a community action group needs to think about some side-effects. Taking one action can lead to other outcomes, by mistake. These are some possible problems and their solutions.

Problem—*Creating a dry area may mean more drink-driving.*
If supplies of alcohol are suddenly restricted, then drinkers may drive further to buy it and drink and drive. Repeat drink-driving offences carry heavy fines. People who cannot pay their fines can end up in gaol. And people in gaol get depressed. It is no good at all if genuine community efforts to deal with alcohol problems end up putting more Aboriginal people in gaol.

Solution—Have a mini-bus to drive people in and out of town. Choose a sober 'designated' driver who agrees not to drink and to drive all the others.



Problem—*Pressure on dry communities to have their own licensed clubs to keep people at home so as to avoid drink driving.*

Solution—Drink-driving needs to be dealt with as an issue in itself by having the police involved, and by raising community awareness.

See page 99 **Prevention** Making a TV ad

Alcohol Management Plans

Both Queensland and the Northern Territory are making it possible for individual communities to have their own local alcohol management plans, backed by the liquor licensing body. In the NT several Aboriginal councils approached the Racing Gaming and Licensing Division

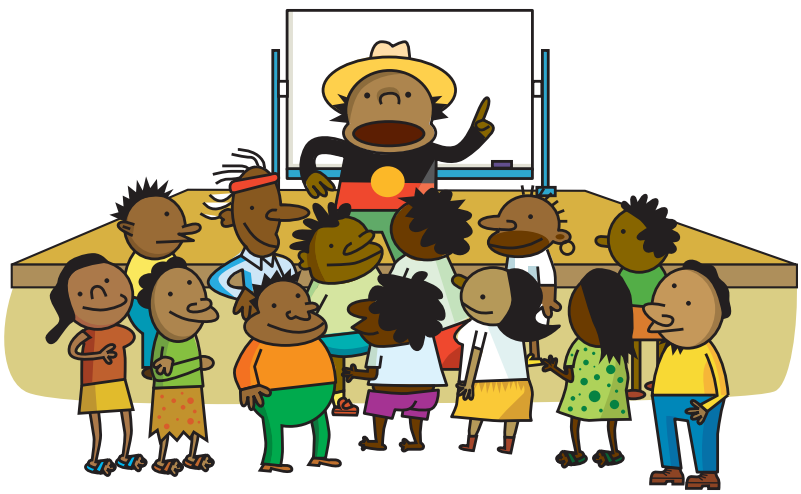
asking for support to develop these local plans. They cover different issues such as the way premises run, safe supply of alcohol, harm minimisation, and how and where takeaways are sold.

Queensland has brought in Alcohol Management Plans (AMPs) as a way of controlling the amount of alcohol in Indigenous communities that are run by their own council. These plans are developed by Community Justice Groups which are now recognised by the law and whose members are senior or respected members of the community.

An AMP can have a number of different ways of controlling alcohol supplies. A Community Justice Group can declare all or part of its community area dry. It can also make recommendations about how the community canteen should be run (if there is one), and about limits on alcohol that can be brought into the community. For example, in some communities alcohol can only be bought and drunk at the community canteen; no takeaway alcohol is allowed and no alcohol can be brought from outside into the community. The law says that the Justice Group should consult with members of its community before it makes decisions.

Are AMPs working? It is not easy to measure if the AMPs are working well or not. It is hard to get all the information from different government agencies like the police, hospitals and local health centres, to see whether people's health has improved, injuries from fighting are lower, and fewer people are being arrested for alcohol-related crime. In some places, people say that the community is quieter and better to live in after their AMP was introduced. However, there are many community members who strongly oppose AMPs, and not all of these are heavy drinkers. In some communities, the AMPs have not stopped sly grog or heavy drinking, and might even have increased it.

It can be really hard to get most of the community to agree about cutting down the amount of alcohol being sold or coming into a community. Sometimes the Community Justice Group feels that it has to take hard decisions about alcohol, which even their own family members are against. When this happens, Justice Group members need the support of Indigenous leaders and the responsible government agencies.



There is also the problem of drinkers from AMP communities spending more time and making trouble in town. You cannot solve all these problems at once, but Cultural Protocols are one of the new strategies to think about.

See page 169 **Strategies** Cultural Protocols

It is a long process: Remember, people have got used to drinking in a certain way over many years, and they will not change overnight. In north Queensland, people are not as experienced as communities elsewhere when it comes to liquor restrictions, limited hours or days of sale, and dry areas. An AMP is not a quick fix. It needs long-term commitment from the community and from government to slowly change attitudes and behaviours. (Thanks to Dave Martin)

See page 157 Resources for more information on AMPs

Permit Assessment Committees: who has earned the right to drink?

Under the Northern Territory Liquor Act, a community can apply to the Licensing Commission to have a restricted area declared. There are different kinds of restrictions such as no alcohol allowed in the restricted area; alcohol only available at a club; or alcohol being sold only to those people holding permits.

Communities that allow people to have permits to buy grog have 'permit assessment committees'. The Permit Assessment Committee may be composed of representatives from the Council, school, health centre, outstation resource centre, women's centre, CDEP, police and the shop. At Maningrida for example, the members meet fortnightly just after the barge bringing supplies and grog is unloaded. If a permit holder does the wrong thing when drinking (such as causing problems for the family or fighting), a family member or the police can ask for the permit to be cancelled. If the committee agrees, the message is sent to Licensing Commission in Darwin. The Liquor Commission cancels the permit the same day, so the person can't have any more grog shipped to Maningrida. People soon learn that they can't muck up when drinking and still have the right to a permit!

(Thanks to Peter Jones and Chris McIntyre)

Controls over drinking

Controlling drinking places

What about buying the hotel?

Over the years, several Aboriginal groups have bought into hotels or other licensed outlets. Examples include Finke, Oodnadatta, Mt Ebenezer, Fitzroy Crossing, and Tyeweretye Club in Alice Springs.

Buying a hotel brings up many complex issues for an Aboriginal organisation or group to consider. No research has been done that shows one way or another that buying a licensed premises is a good, or not such a good, idea. Maybe it is not that straightforward anyway. Some of the news is positive.

The Crossing Inn, Fitzroy Crossing

In the late 1980s, the supermarket, caravan park and the Crossing Inn in Fitzroy Crossing, all came on the market. The Bunuba people decided to build an economic future by buying into these enterprises. The cost of all enterprises was $1.7million. The money was raised by borrowing $1m from ADC and through grants of $700,000.

Aims The Fitzroy people saw the purchases as a development and participatory project. For the hotel purchase, the primary aim was to influence drinking and employment policies.

Process It took 18 months of consultations, bush meetings, negotiations with government departments and planning to come up with the final structure in 1990.

Management A proprietary company became the owner of the supermarket, caravan park and a share of the Crossing Inn. The company has a Management Liaison Group (MLG) that has representatives from local communities, and a Board of Directors which includes Aboriginal members, financial and legal experts.

Outcomes The enterprises are working profitably so far. The supermarket's pricing policy encourages people to buy nutritional food items. The hotel profits help to sponsor the football carnival.

No formal evaluation has been done to show whether owning a share in the Crossing Inn has helped cut down drinking problems, violence or alcohol-related illness. But in 2004 Maureen Carter, a director of the company, was positive about the control that the purchase has given the community:

> *'When the Fitzroy Crossing pub was purchased by the Aboriginal community we were able to implement restrictions on sales of alcohol before other towns did, because of the ownership. The restrictions are still in place in 2004. In 1996, people were able to say to the local directors 'we don't want the takeaways sold until midday. We want people to complete their CDEP work first'. They were able to have a good influence that way.*
>
> *The other part is that the community has the means to go to Leedal [the company] and ask it to implement restrictions, for example when the Garnaduwa carnival is on. What they do is only sell light alcohol during that time. The same for big sporting events or funerals: we can say no takeaways or only light beer'.* (Thanks to Emily and Maureen Carter)

Things to consider about buying a hotel

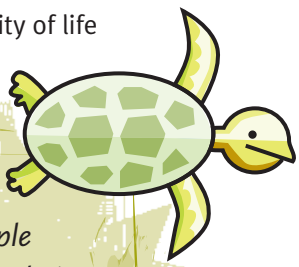
If your community is thinking of buying into a licensed outlet, you need:

- A long lead-in time (eg 1–2 years) allowing for plenty of discussion.
- Careful planning of management arrangements — maybe hire a consultant to help with this.
- Not just a loan from a bank, but commitment to the financial stability of the enterprise, some financial resources and the ability to make a contribution (eg through other enterprises).
- Good administration.
- A mixture of drinkers and non drinkers on management committee.
- Strong (preferably Aboriginal) staff who can be strict with rules over sales.
- Formal rather than informal restrictions on sales.

Social clubs and canteens

Licensed clubs in Aboriginal or Torres Straits communities are a controversial way of promoting responsible drinking. People affected by these clubs are either strongly for or strongly against them. Clubs also have economic implications because of the profits and revenues that come from them.

In Queensland (Cape York and the Torres Strait Islands) and the Northern Territory, they are quite common. Some communities had canteens at one time but closed them down later, such as Yalata and Wadeye. There are things to be said both for and against having clubs. Everyone will be affected by the presence of on-site alcohol, and you need to have straight talking when making a decision. If a community has a real desire to establish a licensed club and is willing to deal with all the organisational and social issues of running one, there is no reason why that community should not have a club. But pushing a club as a form of 'self determination' or as a way of getting rid of problems in town makes it hard for small communities to improve the quality of life for people.



Self determination does not mean allowing people with addictions to kill themselves, their children, their Aboriginal culture and their laws.
(Wadjularbinna, from Doomadgee, Qld)

If your community or local organisation is thinking about purchasing a liquor licence, you need to discuss the benefits and the costs of this. Here are some issues to think about.

The possible costs of a licensed club

MORE INJURIES.

A study in Queensland found that a community with a beer canteen had twice as many people being injured than in a community with no canteen. Injuries were from fights, accidents, and people harming themselves; children were injured by broken glass. More women were injured.

LESS MONEY ON FOOD.

When canteen takings go up, store takings on food go down (another Queensland study). People rely on fast food — not so healthy.

CHILDREN SUFFER.

Children can suffer when there is a club because parents and other adults are busy drinking and no-one is there to look after them.

MORE DAILY DRINKING.

Some people only drink when alcohol is easy to get; this is called opportunistic drinking. Having a beer club could mean that people drink every day. They might forget about going bush, visiting the land and looking after kids.

DOES NOT PREVENT IMPORTS.

Studies in South Australia and Queensland show that access to a canteen did not stop people bringing in more grog to the community, or going to town to drink.

FINANCIAL DEPENDENCE.

The council becomes financially dependent on the income from the canteen. The council likes the money and may be less interested in harm reduction and public health strategies that could cut down on sales.

DOMESTIC DISPUTES.

Canteens can mean more arguments between men and women. In one community, women tried to ban violent men

from using a canteen; their names were written up on a list. The drinkers took no notice, rubbed off their names, and threatened the women. No action was taken against them.

NON DRINKERS HAVE NO SAY.

Committees to run clubs are often made up of drinkers and others in the community have no say in running the place.

STRICT RULES DON'T ALWAYS LAST.

Community-run licensed clubs can start out with strict rules and good intentions. If management changes, these may become weaker over time.

On the other hand, you should also discuss the possible benefits of having social clubs or canteens.

The possible benefits of a licensed club

HELPS SOCIAL LIFE, SERVES MEALS.

If there are meals available this helps people to enjoy themselves. It is important to eat a meal before and while you drink, not drink on an empty stomach.

STAY IN COMMUNITY.

Some people might stay in the community instead of driving long distances to get grog, having car accidents and getting stuck in town.

SOCIABLE DRINKING.

With a good atmosphere (music, pool, proper food) and a code of conduct, there is a better chance that people will drink to be sociable, not to get full drunk.

AWARENESS CAMPAIGNS.

You can use the licensed club or canteen as a place to run alcohol awareness campaigns, such as showing people how a breathalyser works or running DrinkSafe demonstration.

RAISE USEFUL INCOME.

Income from a canteen can be used for community projects.

See next page Safer drinking places

See page 106 **Prevention** Breathalyzer

Community-owned licences and citizen rights

alcohol profits

If a community organisation buys into a hotel or receives the profits from a canteen, it is benefiting from the sales of alcohol. It might even become dependent on the income from sales of alcohol. This can raise ethical or citizen rights issues — you need to think about these.

In north Queensland and other communities with licensed taverns, the community councils receive the profits. The money made from selling grog is used to pay for community projects and infrastructure, such as upgrading housing and environmental health, school equipment. Sounds good? Wait a minute — it is the government's responsibility to provide a minimum standard of living for all its citizens! It is a problem if Aboriginal councils feel they have to sell grog to their own community members to earn money for these things.

Safer drinking places

If your community already has an interest in a club, hotel or sports complex — any kind of licence — there are things you can do to make it a pleasant and safer place for drinkers and their families. Make a profit AND have good serving practices. You can make money selling meals and soft drinks, not just alcohol! A club which relies on a small number of very heavy drinkers can become unpopular with other people in the community — it will put them off going there. A business will be more likely to do well if it attracts a large number of people. It can provide food (and non-alcoholic drinks for people who do not want to drink), entertainment, trained staff, and house rules or policy.

An example of safe service guidelines

Rules and policy

It is the responsibility of serving staff not to serve underage or drunk people.

Staff will know how to manage a crisis.

Some staff will be trained in first aid.

Communication of rules and policy

All staff and customers are made aware of the rules and policy.

Training and support

All staff are trained, to help them follow the rules and policy.

Serving practices

Food, low alcohol and soft drinks are provided.

Servers know how to keep an eye on customers.

Servers learn how to refuse a drunk customer.

Promotion of low risk drinking; sell soft drinks as well.

Intoxicated people are helped home safely — arrange a safe driver or taxi.

Environment

Avoid overcrowding. Crowding encourages trouble.

Good lighting is important.

See page 158 Resources, Safe Profit Manual

In order for a drinker to keep their 'right' to drink, they must respect the needs of children, neighbours, wife or husband, parents, grandparents, and all fellow community workers.

Making policy for clubs

We often think that policies are for governments, but there are policies at every level, right down to a workplace or club policy. A policy is simply a plan of action, written down for everyone to see. It outlines what your organisation wants in terms of safer drinking practices when alcohol is being served. A club policy needs to be practical and likely to work. The policy can be developed by the management committee of your club or tavern, by your Council or health service. It is important that there is wide agreement on the policy.

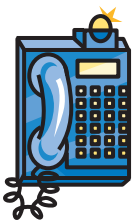
Policies are useful for several reasons:

- They are group decisions so no individual can be 'blamed' for a rule.
- They establish guidelines for everyone to watch out for.
- They help to control drinking places.

See Manaaki Tangata (Maori policy) in Resources opposite

Harm reduction at drinking camps

When liquor restrictions are placed in towns, or on whole communities, the drinkers often ask where they are supposed to go. Camps that are mainly used for drinking can be dangerous for those people. Try to make sure they have:



- Plenty of water available, so that people do not dehydrate.
- Firewood, so that they do not freeze in winter.
- Access to a phone or emergency help if possible.
- Regular visits from a patrol or health worker.

Resources for chapter 5 Controls

Alcohol Management Plans

For more information about AMPs in Queensland, contact the Department of Aboriginal and Torres Strait Islander Policy
Phone 07 3406 7987, or the Liquor Licensing Division on 1300 658 030.

For general information on AMPs in the Northern Territory, see 'Liquor Management Plans' www.nt.gov.au/ntt/licensing/liquor.shtml

Community action

Strengthening Community Action on Alcohol by Collie, C (2002) ALAC, Wellington NZ. Order free from Information Services, Alcohol Advisory Council of New Zealand, PO Box 5023, Wellington, NZ Download from www.alac.org.nz/CoreResources.aspx

*Video: The Honour of All (*Pt I 56 mins). See Filmwest Associates (USA & Canada) www.filmwest.com. Order from: Video Transfer Productions, PO Box 95, Kilkenny SA 5009 Phone 08 8447 7334

Liquor licensing laws

Special Measures Certificates. See *Alcohol Report. A Community Guide by the Race Discrimination Commissioner* (1995) Human Rights and Equal Opportunity Commission, Sydney. Available in hard copy and at www.humanrights.gov.au/racial_discrimination/publications.html (see 'Archive') or contact the Race Discrimination Unit at HREOC Human Rights and Equal Opportunity Commission, GPO Box 5218, Sydney, NSW 2001. Phone 02 9284 9600 Fax 02 9284 9611

Indigenous Australians and Liquor Licensing Legislation (a useful report) by D Bourbon, S Saggers and D Gray (1999) National Drug Research Institute, Perth. www.db.ndri.curtin.edu.au/publications.html

Alcohol liability in Canada and Australia: Sell, serve and be sued (report) by R Solomon and J Payne (1996) National Drug Research Institute, Perth. Available at www.db.ndri.curtin.edu.au/publications.html

Safe service

Manaaki Tangata Guidelines for Safe Alcohol Use (Maori, New Zealand) Alcohol Advisory Council of New Zealand.
Download from www.alac.org.nz/UnlicensedContent.aspx?PostingID=579

Safe Profit Manual (available on disc or photocopy): The Manager, Crime Prevention Unit, Attorney-General's Dept. Adelaide.
Phone 08 8207 1659 Fax 08 8204 9883

For research reports of studies on safer bars by Kathryn Graham see http://publish.uwo.ca/~kgraham/

Contact addresses for Liquor Licensing Boards

Tasmania
Department of Treasury and Finance
Liquor and Gaming Branch
PO Box 972
LAUNCESTON TASMANIA 7250
Phone: 03 6336 2261
Fax: 03 6336 2799
www.treasury.tas.gov.au

Western Australia
Department of Racing, Gaming and Liquor
PO Box 6119
EAST PERTH WA 6892
Phone: 08 9425 1888
Country Callers: 1800 634 541
Fax: 08 9325 1041
www.rgl.wa.gov.au

Queensland
Office of Liquor and Gaming Regulation
Locked Bag 180
CITY EAST QUEENSLAND 4002
Phone: 13 74 68
Fax: 07 3872 0957
www.olgr.qld.gov.au

Victoria
Consumer Affairs Victoria
GPO Box 123
MELBOURNE VICTORIA 3001
Phone: 1300 55 8181
www.consumer.vic.gov.au

Australian Capital Territory
Office of Regulatory Services
GPO Box 158
CANBERRA ACT 2601
Phone: 02 6207 3000
www.ors.act.gov.au

New South Wales
Office of Liquor Gaming and Racing
GPO Box 7060
SYDNEY NSW 2001
Phone: 02 9995 0300
Fax: 02 9995 0669
www.olgr.nsw.gov.au

Northern Territory
Department of Justice
GPO Box 1154
DARWIN NT 0801
Phone: 08 8999 1800
Fax: 09 8999 1888
http://www.nt.gov.au/justice/licenreg/index.shtml

South Australia
Consumer and Business Services
GPO Box 2169
ADELAIDE SA 5001
Phone: 131 882
Fax: 08 8226 8512
www.olgc.sa.gov.au

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Gladman, D, E Hunter, R McDermott, T Merritt and F Tulip (1997) *A Study of Injury in Five Cape York Communities,* 1997. AIHW National Injury Surveillance Unit, Tropical Public Health Unit, Cairns

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Walley, G and D Trindall (1994) Strengthening community action in the NT. *Health Promotion Journal of Australia* 4(1):60–61

Wiggers J, M Jauncey, R Considine, J Daly, et al (2004) Strategies and outcomes in translating alcohol harm reduction research into practice: the Alcohol Linking Program. *Drug and Alcohol Review* 23:355–364

Wright, A (1997) *Grog War*. Magabala Books, Broome

What's in the 'strategies' chapter?

Managing drinking trouble

Patrols

A number of Aboriginal and Torres Strait Islander organisations in cities, towns, in small bush and island communities have started day or night patrols to keep the lid on trouble. Usually these patrols work cooperatively or closely with outside agencies such as the police, other security agencies, and sobering-up shelters.

- If you have a problem in your town with kids or adults hanging out on the streets and getting into trouble with the police, using drugs and drinking, then a street patrol or outreach project might be the answer.
- If the problem in your community is too much fighting, keeping everyone awake, arguments and disturbance, then night patrols might be the answer.

Patrols in cities, towns and bush

There are patrols in rural towns such as Mildura and Shepparton in Victoria for example, linked into safe houses or Alcohol and Drug Resource Centres. The Adelaide Mobile Assistance Patrol (MAP) has been running in the city and suburbs for over 20 years. The patrollers cover a large area and visit hotels and parklands where people drink, empty houses and squats. MAP has a policy not to take people home if they are too intoxicated — that would mean encouraging family violence. People are usually taken to the Salvation Army dry-out hostel.

In Northern Australia, there are now over 50 night patrols operating in towns such as Alice Springs, Tennant Creek, Elliott, Hall's Creek, and in bush communities. The patrols have been set up to reinforce the views of what local people see as acceptable and unacceptable behaviour. They are examples of social control at work.

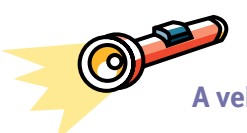
How to make a bush patrol work well

* **Night patrols need about 10 people.** It is good to have between 10 and 20 people who can take it in turns to be on patrol. You need to think about 'burn out' and allow people time for their other family activities.
* **Patrols need to have community support.** Members need to come from as many different families and age groups as possible. Try to have both men and women — either as separate teams or as husband/wife or mother/son units.
* **Patrols are voluntary** or receive CDEP 'top-up' wages. Some patrols have a funded coordinator position.
* **An administrative support person can help** with keeping Incident Records (what happens every night) and with rostering (also useful for writing funding applications or police accident reports).
* **Night patrols need to involve senior men or women.** In some places they are grandmothers and grandfathers. They say the drunks don't harm them.
* **Have two separate patrols, one for men and one for women,** dealing with different issues. See page 168 ⇢ ⇢ ⇢
* **Patrol members need to be non-drinkers or careful drinkers.** Heavy drinkers will have no credibility with the community.
* **Patrols need to set up written agreements** with other organisations: the police, the council, the health centre. You need to work out the rules for the night patrol, what their jobs are; and the rules for the police and what their jobs are.
* **Uniforms are essential.** They give a group identity to the patrol that is authorised by the community. They help people to step from their normal identity to that of a Patroller. You need a lot of them (for changing membership) and they need to be large sizes and cheap. T shirts with a printed label are fine. A padded, labelled jacket is good for the winter.

(Ideas from Anne Mosey)

What does a patrol do?

- Patrols are different in different places. Some walk around in groups of two or four people with torches and sticks. They can ask drinkers to drink quietly. If they see grog coming in, they ask them to leave, call the police or take them bush until they finish drinking.
- They also walk up and down to keep an eye on drinkers, or park the vehicle at a sports night to provide a presence and a radio base for emergencies.
- Patrols can bring in the sniffers too; they can take sniffers home to their families and give them a feed sometimes.
- Patrols are not a 'pick-up' service for drunks: the idea is to settle down disputes when they begin and not after they have spread to extended families and whole communities. This is in order to cut across the cycle of 'payback' arguments which often occur when people are intoxicated. If not stopped, these tit-for-tat disputes can go on for long periods.
- In town, night patrols take intoxicated people to the sobering-up shelter, another safe place or to medical help.



A vehicle or on foot?

- A vehicle can cause trouble. To avoid jealousy, it is better to buy a cheap, old vehicle rather than a flash new Toyota. It is less likely to be taken over for hunting trips. Or use private vehicles and get the council to pay for fuel.
- If you use a vehicle, you will need to make clear rules over its use.
- Patrollers (usually women) may stop working if they are excluded from the vehicle; some older women do not know how to drive. An all-woman patrol can employ a driver to work for it.
- Waiting to purchase a vehicle can stop the patrol in its tracks as people will want to wait until the vehicle arrives before they start the patrol. Instead, get going on foot in groups of two or three for support. Each can patrol a small area.

- Negotiate access to a community vehicle, eg CDEP, education department, health service for after hours/weekends.
- Radios can be difficult to manage in remote communities; they are more suitable for urban areas. UHF radios need to be locked onto the same channel; they need recharging, and need a 24 hour access base set in a vehicle or building.

REMEMBER

Uniforms are a motivator, an essential item to start a night patrol with. They help patrol members to take on a new identity and step outside their normal family roles in order to deal with drinkers.

Getting stuck in town: day patrol

Julalikari Council in Tennant Creek has noticed that sometimes people come into town, get stuck, and don't know what to do. This puts people at risk of getting into some sort of trouble. The Council is planning a Day Patrol to work with these people to link them up with supporting agencies like Centrelink and Anyinginyi Health. They will do assessments, brief interventions and referrals and look for ways of getting people home if necessary.

Night Patrols run by men and by women

Yuendumu has Men's and Women's Night Patrols, each dealing with different client groups. The Men's Patrol was established in 2003. It has up to seven patrollers working, both senior and younger men. The Justice Committee and Yuendumu Council members stated that the following changes have been noticed since the patrol was established, as noted in the minutes of 23–24 November 2003:

* A general perception that the levels of alcohol-related violence have dropped 'it's quieter and we're getting a better sleep' (a Yuendumu Councillor)
* Less alcohol is getting into Yuendumu
* Problems are being dealt with before police are involved
* Petrol sniffing is still absent from Yuendumu.

During the 2004 Yuendumu Sports Weekend, the combined Night Patrol services successfully contained all disputes and dealt with all alcohol-related incidents, without overt police assistance, as negotiated with NT Police.

(Thanks to Anne Mosey)

Problem behaviour

Alcohol abuse and anti-social behaviours are often the result of deeper problems and disadvantage. Tangentyere Council, representing people living on the Aboriginal Housing Association leases in Alice Springs, deals with these issues in a number of ways. The Tangentyere office is a central resource agency dealing with things like financial counselling, training people in the use of keycards, help with housing, repairs, services for old people and homemakers, and night patrols.
It also helps people living on town leases to show social disapproval when people cause problems. In general, Aboriginal organisations are getting much tougher on anti-social behaviour and public drinking. Here are some examples.

Cultural Protocols

Town councils are always complaining about 'itinerant' Aborigines or Islanders. They are really talking about Indigenous people who are visiting from out of town and who end up sleeping in the long grass or the parks, because there's nowhere else to go. Many of these people have serious grog problems and have had no help for these. There is often drinking, fighting and humbug. This spills over and affects life for everyone in town. The solution to these problems is to have a partnership between town councils and Aboriginal town organisations to improve social behaviour.

As part of the 'Community Harmony' strategy in the NT, several groups of traditional owners in Territory towns are educating and informing visitors to their country about courtesy and respect, Aboriginal way. They have written up Cultural Protocols, guides to behaviour. They respectfully remind people who are visiting that they cannot just camp anywhere, make litter, beg from tourists and give a town a bad name. As one Larrakia man said:

> *'We don't want to be too mean, or have signs up saying "Do not do this" — too many whitefella signs like this! We wanted to say "just think about your behaviour".'*

The Mala leaders, senior NLC elders, visit Darwin camping places a few times a year to encourage their people to go home. The Larrakia Information Referral Office helps by making travel bookings and arranging for costs to be taken out of Centrelink payments.

The Larrakia Nation Aboriginal Corporation in Darwin has produced pamphlets and a poster on its Cultural Protocol, metal signs for the foreshore area, and a video that will be sent to all communities with BRACS. Most of the shops in Darwin display the poster. Julalikari Council in Tennant Creek is also establishing protocols. These will be sent to community councils to display, and they plan to have signs about them on the roads coming into Tennant.

Cultural protocol poster

RESPECT LARRAKIA COUNTRY

Mala Elders ask people of Darwin and Palmerston to:

SAY NO TO HUMBUG
AND NO TO BEGGING

If you really want to help people, offer to buy them food. Otherwise please say NO.

All people have a right to visit town, but no person has a right to behave badly.

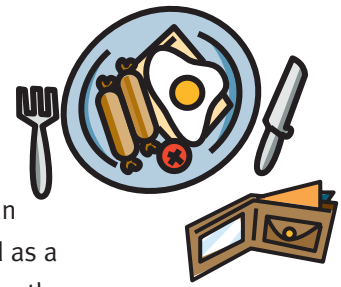
If people are behaving badly then please phone the Community Day Patrol or Night Patrol on 8948 0523. If it is a police matter, phone the police.

Using the Trespass Act

Tangentyere has been using existing trespass legislation to remove people who are causing trouble, to encourage people to return to their home communities, and take the pressure off people living in town. Each member of a housing association or committee at each camp signs an internal agreement with Tangentyere about this. How does this work?

- The owner of the land, an employee of the owner, or a police officer can give a direction (verbally or in writing) to someone to leave the area.
- Tangentyere keeps a record of who has been served with a direction and gives a copy of this to the police. If the person refuses to leave, the police have the power to move them on or arrest them. If this happens, they will end up before a Magistrate and maybe get a fine (although it usually does not get that far).

Solving food problems — managing money



Tangentyere Council has been registered as a Centrepay organisation. This is a facility of Centrelink which allows a direct debit to be taken out of a person's benefit. The money can come out of family allowance or any benefit. This is then issued as a cheque made out to a particular supermarket. The person makes the decision about how much will be taken out.

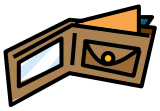
Can other places do this?

Any organisation across the country can register as a Centrepay organsation. This means that they can be authorised to make these kinds of deductions.

Centrelink deductions

Advantages

- This system allows choice. The money still belongs to the person, and that person decides how to spend his or her own money, by putting it straight to the supermarket to make sure there is food available.
- It is a flexible system. If someone is going out bush, deductions can be suspended for a while.



- If a person needs more cash (to buy a car for example), he or she can alter the amount deducted.
- The supermarket may not supply alcohol using this system.
- Tangentyere staff explain the system to people in their own language.
- Tangentyere has a special accounting package on its computers to keep track of money coming in and going out to each person.

Disadvantages

- If people move away from Alice Springs and do not tell Tangentyere, the deductions will continue to come out of their cheque. Sometimes a person might not realise that this has happened. However by law, Tangentyere must quarantine this money for collection by the owner at a later date, so that the money is not completely lost.
- There is a fee on each cheque that Tangentyere has to cover. It costs the organisation about $1200 a month to run this system.

Contact the Tangentyere switch for more information: 08 8951 4222

Managing family violence

Family violence is not always associated with alcohol. But it often is. One Aboriginal woman said 'he hits me drunk or sober'. In the wider Australian population, alcohol misuse is linked to about half of the reported family violence. Aboriginal and Torres Strait Islander women are vulnerable to violence for many reasons. They may be alcohol drinkers themselves. They may have close relatives who are problem drinkers, so that they are often in potentially harmful drinking situations. Women might sometimes not have the support of their families if they live in another community. Sometimes family members have passed away. Sometimes the legal system does not protect them enough. The behaviours experienced by Indigenous women are similar to those of other women, with men showing controlling behaviour ('*keeping me like prisoner*'); extremely jealous behaviour ('*getting jealous for me seeing family and going to work*'); and abusive

behaviour ('*swearing at me and calling me dirty names*'). In the past four years, seven women from the cross-border region (WA/SA/NT, pop. 6000) have been victims of family violence homicide — three of them were pregnant. Alcohol did feature in these homicides: the women were stabbed, beaten or kicked to death.

Jealous of a new baby

'This morning just before breakfast, Eddie started an argument for cuppa tea. He was getting angry with me to make him breakfast. Eddie started hitting me too many times to the head with a broomstick. We were in the house with his family. They told him to stop hitting me but he was still hitting me with the broomstick. Eddie was sober.'

(Thanks to Jane Lloyd, Manager Family violence Service, NPY Women's Council)

There are several ways of dealing with violence against women, and we give case studies of these below. The priority that dominates these is simple: the safety of the woman. One way is to set up a women's shelter, a safe place to stay. Another way is to support women by giving

information about how they can stay safe and how to access legal and other services. Men need help to manage their anger and jealousy.

Women's shelters

There are now a number of women's shelters or safe houses set up by Aboriginal or Torres Strait Islander groups across the country. There are shelters in Darwin, Alice Springs, Katherine, Walgett, Wilcannia, Palm Island and Thursday Island to name just a few. Some of these operate as a women's centre most of the time (with a laundry, kitchen, people get together to make scones etc) but which can become a shelter if and when necessary. Others are more organised Safe Houses. One example is the Safe House in Hall's Creek run by the Ngaringga Ngurra Aboriginal Corporation. Ngaringga Ngurra means 'Woman camp'.

A women's shelter in Hall's Creek

How did it start?

One woman asked people in the state Department of Community Welfare for a safe house. The Department set up a steering committee to look into the needs of women having trouble with family violence. The workers in this department were very supportive and were involved in committees right through.

How is it funded?

funding

The department seconded a worker to help the committee become incorporated, check out funding sources, and to draw up rules and goals. Ngaringga Ngurra was incorporated in June 1991. The building was jointly funded by Homeswest and the Lotteries Commission. Money for wages and running costs came from the Department of Family and Children's Services.

Was it hard to get going?

There were several times when it seemed the safe house would never be a reality. Committee members became discouraged. They needed to stay optimistic and to keep on working towards their goals, even though sometimes it seemed impossible. Having an employee to continue the work was a great advantage. In the end, the work and the waiting paid off. The safe house started up in 1995, four years after the group started.

How does it run?

The safe house has been running now since 1995. Every six months there are more people staying than before. The House is staffed by all Aboriginal workers, rostered for 24 hour care. Clients in the house are helped to contact the police, or hospital or other services they need. Assistance is given wherever possible. Ngaringga Ngurra sees itself as servicing all communities in Hall's Creek now with a vehicle for outreach work supplied by the Lotteries Commission.

The services include a Family Centre and an Art Centre. The Family Centre has a Family Support Worker and a Financial Support Worker. It provides help, support and organises craft and recreation activities for women and their families. The Art Centre has a retail outlet for arts and craft work produced locally.

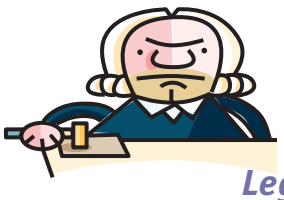
What are the problems faced by the safe house?

Training As Hall's Creek is a remote place, there are problems getting training organised for staff. Without formal training, many staff do not feel comfortable giving informal counselling

to clients. There is a variety of courses, seminars and conferences on family violence in Perth — but it is beyond the budget for people to attend these so far away.

Safety Staff safety is another important issue. Safety for staff as well as safety for clients is essential. A safe house will not function well if its staff are under threat. Clients who pose a threat to staff are not permitted in the safe house. Depending on each case, this ban is placed for a set period of time or permanently.

(Thanks to Elaine Gosztyoa and the women of Ngaringga Ngurra)



Legal advice

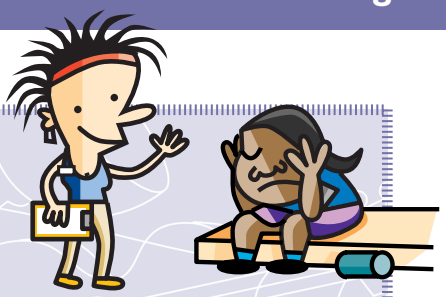
We know that Aboriginal women make up 16% of female murder victims in Australia, and that many Aboriginal women are survivors of violence. Alcohol is involved in about three-quarters of homicides among Aboriginal people. Many Aboriginal women have been denied legal assistance in the past, sometimes because the Aboriginal Legal Service is representing the partner who assaulted her, sometimes because in small towns there is only one solicitor. A solicitor cannot represent both parties. There are now legal services especially for women.

See page 189 Resources at end of this chapter ⇢ ⇢ ⇢

Family violence service in an Aboriginal organisation

The Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council (NPY Council) has an office in Alice Springs and a service that covers the borders between SA, WA and the NT. Good Protection for All Women (Atunypa Wiru Minyma Uwankaraku) began in March 1994 and is funded under the national SAAP program. Good protection for All Women has three main strategies:

- Assisting individual women who are victims of violence.
- Community education and development around family violence.
- Building links with other services and organisations.



Good Protection for All Women

What does the project do?

It manages individual cases:

* Over ten years the service has helped hundreds of women by giving them information on what they can do and what services are there to help. It gives information on family violence and sexual assault laws in the NT, SA and WA.
* It provides women with support to lay charges and go to court.
* It helps with emergency travel and accommodation and with family support for the victim.
* It liaises with the police, clinics, family violence service in town and helps to get a woman lawyer. It also works with the health services to develop plans for managing family violence.

The service provides community development and education:

* It distributes bilingual posters, information in newsletters and a video produced by CAAMA. As more women get stronger to come forward, the community has become more educated about family violence and protection orders.
* It conducts awareness raising workshops for health workers and police,
* It links up with diffferent services and communities, holding cross-border meetings giving people a chance to speak out about issues.

What outcomes are there?

* The police have observed an increase in reports of violence. This violence has always been there, but before it was never reported. Now victims know they do not have to put up with it.
* The men in communities have had to learn that, if they inflict violence on family members, they will be punished.
* It has given the victims a powerful weapon to use in an effort to break the cycle of violence.

(Thanks to Jane Lloyd, NPY)

Can this project be replicated in other areas?

There is no reason why not. The basic idea is easy to relate to: good protection for all women. The strategies of women's safety, community development around the issues of family violence, and links with other services have all been successful. With increased awareness, women start to take steps to deal with their experiences. The project works well because of these factors:

- The safety of women is the number one priority.
- There is a women's council, an umbrella organisation, that covers a large area across all three state/territory borders.
- People in this region speak similar languages.

'He gets cranky and hurts me when he is sober.
But I am really frightened of him when he has been drinking.
That is why I got a restraining order'

A men's group

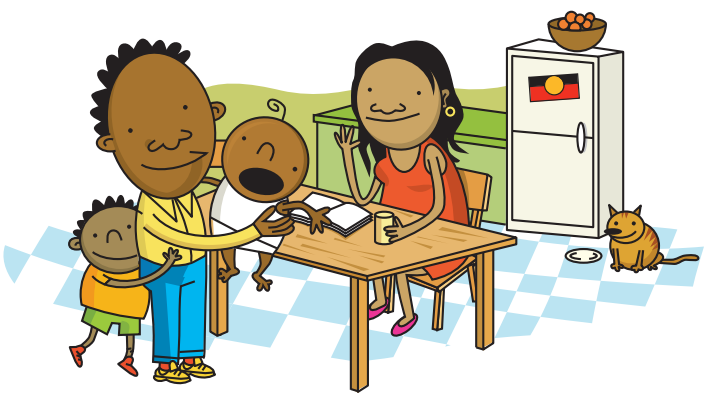
Another way to approach family violence is to work with men who have been violent. This idea is still quite rare in the Aboriginal community, although there are other types of contemporary men's group, such as the Elders' Justice Network based in Cairns, with branches in Cape communities.

In 1996, Greg Telford and Stuart Anderson from Lismore in northern NSW began a group to support Koori men to end their violence. This has grown into a program called Rekindling the Spirit.

men and violence

What happens at Rekindling the Spirit?

- Rekindling the Spirit runs groups for men that deal with drink, drugs, violence and parenting. They now have a female worker who works with partners of the men and with women who are referred.
- They also run a group for men attending Namatjira Haven, a rehabilitation centre. In the group, the men tell stories of their lives that are often full of traumatic and tragic events. From these stories, it becomes clear that violence has not got them what they want. Most of the men feel great shame about hurting their partners and kids. Greg says 'If we keep peeling the layers off, we get to the sadness and hurt underneath'.
- In the group they talk about ways of behaving differently when anger comes up. Huge changes in behaviour and attitudes have developed as a result. All the men are there for the same reason — they want better relationships in their families. This gives the group a kind of equality.



What problems does the group face?

- Funding. They need funding to pay for facilitators, rent, photocopies, transport, training and evaluation.
- Attracting Koori men to come to the groups and transporting them to and from the meetings. Greg shows other Kooris that he has experienced all that they have. Talking in this way encourages people to come. Without someone like him these groups would not happen.
- More prevention work is needed in schools. With more funding, Greg hopes to focus on young people aged 8–16 to 'plug this hole' in programs.

Is the men's group working?

- Many families are living without violence now. The success of the groups depends on the motivation of the people who attend. Some are very keen and put lots of effort into changing. Others are confused and find it difficult to make changes in their lives.
- Several men who have been through the program are now working in the area themselves. One man has become a qualified drug and alcohol counsellor at Namatjira; another is working on the Block in Redfern; another is doing voluntary work at a school. He's nobody's client now; he is his own man.

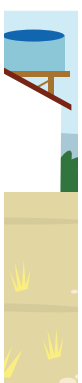
Advice on starting a men's group (Ideas from Greg Telford)

- The guts of the program should be 'responsibility without blaming'. The facilitators should not blame anyone who comes to the groups. Everyone should be treated with respect.
- The facilitators should be thoroughly trained in family violence issues, especially how low self-esteem and the desire to control others often lie underneath anger and violence. Allow plenty of time for training.
- Employ a female worker. If both partners are working together to change, there is a much better chance of success.

- Consider building linkages with mainstream services. This gives structural strength and creates bridges of reconciliation.
- Ending violence is a long-term effort.
- Greg is making a video as a resource in which he tells how the group got started and shows a group in action.

Kids and violence

CAAAPU in Alice Springs is a residential treatment and an outreach program. A staff member said this about helping kids who are living with alcohol at home:



'The day workers from CAAAPU visit Amoonguna School. We can only be a listening channel for those little kids. We only see them once a week. We have caring and sharing sessions. The CAAAPU workers sit in the circle with the kids, and the children talk about their feelings about violence and the effects of grog in the family. The workers take a small treat, such as oranges, to share with the children. This is part of sharing and caring. Some kids pour their hearts out to us.'

(Thanks to CAAAPU)

Dealing with intoxicated people

Five Australian states and territories have decriminalised public drunkenness: NSW, WA, NT, SA and the ACT. However public drunkenness is still an offence in Tasmania, Queensland and Victoria, despite the recommendations of the Royal Commission into Aboriginal Deaths in Custody. Decriminalisation means that the intoxicated can be taken to a shelter instead of to the police cells.

Sobering up shelters

The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) recommended that intoxicated people be taken to places other than the police cells. Special sobering up shelters (SUS) have been established in many parts of the country such as the NT, SA, WA and Victoria. Queensland has 'diversionary centres'. In NSW, drunk people are taken to a supported accommodation, a place that acts as a SUS as well as providing longer term accommodation for homeless people. Taking intoxicated people to a SUS or to police cells to sober up is a way of preventing people getting hurt or hurting others: a harm reduction strategy.

How do shelters work?

The SUS Program in the NT has been operating for about 20 years. There are now shelters in main urban centres run by community based organisations (non-government organisations) and funded by the

NT Government through the Department of Health and Community Services. In the NT, it is not against the law to be drunk in public. However there is a law that allows police to pick up drunk people. It is called 'apprehension without arrest', taking them into 'protective custody'. Police have the choice of taking people home, to the police cells or to a shelter.

When police take intoxicated people to a shelter, they release them into the care of shelter staff. Night patrols can also take people to a SUS. People go into the shelter of their own free will. If they agree to stay, they have to have a shower, a drink of water or cordial and go to bed to sleep off the grog. If a person causes trouble, shelter workers call the police to take the person to the cells. After people are sober, usually in the morning, they dress in their cleaned clothes, have a meal and get their possessions back before being discharged. In some shelters, alcohol and other drug workers visit people, talk about what grog is doing and ask whether they want to join an alcohol program for the day.

Things to think about if you want to start a SUS

Setting up a SUS needs the support and cooperation of several agencies as well as broad government support.

See page 189 Resources this chapter

Good things people say about sobering up shelters:

- People sober up in a safe and caring environment.
- People are treated respectfully. Some clients said that they appreciated not being given 'a hard time'.
- Keeping people out of police cells helps to avoid deaths in custody.
- People have a chance to get clean and have health problems attended to.
- People have a chance to talk to workers about their grog problems if they want to. They can ask to be referred to detoxification and treatment programs.
- Shelter workers have noticed that some repeat clients have shown

improved self-esteem and health. Some clients have reported cutting down on their drinking.

- When police or night patrol pick up intoxicated people, a drinking episode is stopped. People are being given the message that drunken behaviour is not socially acceptable. It is a type of 'brief intervention'.

DASA says that the process of being picked up and sobered up at the shelter helps to educate people about what is acceptable behaviour. People taken to the SUS have to follow the rules about showering, sleeping and not fighting. Over 90% of clients brought to the shelter in Alice Springs follow the rules and sober up there.

Shelters can also provide lots of valuable data such as: who is brought to the shelter, their sex and age (no names are used), where they come from, how many times people are brought to the shelter in a period of time. The information can be used to identify the needs of different groups of drinkers and help to plan strategies.

Concerns people have about shelters:

- *Rewarding drunken behaviour.* Clients get a warm bed and good food at the SUS while their families may go hungry. A few people have been known to stop a police car and ask to be taken to the shelter. Police say they would usually take these people to the police lock up.

- *The 'revolving door'.* From looking at their figures, DASA staff know that there is only a small number of 'high repeat clients'. DASA has just taken on two outreach workers who are going to work with this group of clients to help them overcome their grog problem.
- *Cost.* A SUS is expensive to run depending on the facility, the hours of operation and the number of staff employed.
- *Shelters do not stop people from drinking too much.* They provide 'care, not detention'. However, when people are sober and fed, they have a chance to think about their drinking. Some shelter workers have been trained in doing brief interventions.

How to extend the work of sobering up shelters:

- Have educational posters on the walls and other information available for clients to take away.
- Train shelter workers how to do a brief intervention with clients, particularly when they are leaving the shelter in the morning. This will encourage people to think about what they're going to do for the day, to only drink a little bit or give it a rest and buy food first.
- Set up a community outreach program to follow up high-repeat clients. An Outreach Worker assesses the person, finds out the client's story, strengths and needs. Each client will have a personal action plan for short and long-term goals. The worker's role is to support the client's decision about less harmful or no alcohol use. There will also be a chance to strengthen relationships with partners, family members, friends and the wider community and to link in with a range of programs and services.

outreach

(Thanks to DASA and Carol Watson)

See page 237 **Handouts**
Let's get straight about harm reduction

See page 189 Resources

Police cells and Justice panels

Deaths in custody have made everyone more aware of the need to keep Aboriginal people out of police cells and gaol. Sobering up shelters are one way of caring for people when they have had too much to drink. Another way is to have a community-run patrol or call-out system. This is what has happened in Geelong and Ballarat, the first places in Victoria to get Community Justice Panels going. Now there are 12 ACJPs across Victoria. The panels are groups of Aboriginal volunteers who are willing to work in with police and other agencies, to make sure Aboriginal people do not come to harm in police custody. They are involved in other parts of the criminal justice system, help if people go to court and visit people in gaol.

Aboriginal Community Justice Panels

trained volunteers

Wathaurong Aboriginal Community Justice Panel in Geelong is just one example. Two volunteer men are on call 24 hours a day. They have training in protocols, police procedures and child protection. The police call them up whenever they pick up an Aboriginal person. Most of the calls involve alcohol one way or another. If possible, the person is taken out of the cells to a safe house or a friend's/relation's house. Most times, the volunteers know the people involved. If there is nowhere for the person to be taken, the ACJP volunteer stays with the person at the police station.

What makes the Panel work?

- The Panel has some government funding and a mobile phone. Panel members saved up for their own vehicle.
- It has good working relationships with the police. Each group had to put aside their suspicions of the other.
- There is now a police liaison officer (a senior officer) at each police station, to liaise with the ACJP. In Geelong, the officer goes to community BBQs and committee meetings and gets to know the Koori community.
- It has a core of reliable, mature people to be volunteers.

What else does the ACJP do?

- It organises visits to the local prison, a maximum security gaol, and runs programs.
- Volunteer members play sport with Aboriginal prisoners, involve them in NAIDOC week activities, and are there to talk with people.
- It liaises with the Alcohol and Drug Resource Centre (a house where intoxicated people can recover for 24 hours, be assessed, have a feed, a sleep, a shower).
- The program owns a 17ft ski boat, Bullito Koorong ('seafaring boat'). It is designed to give young Kooris a chance to fish, ski, scoot around the Bay, learn about water safety and enjoy a recreation activity that is otherwise out of their reach financially.
- Even with limited funds, the ACJP can help out with buying shoes and outfits for sports.

As a symbol of the equal partnership forged by the ACJP and the Victorian police, Craig Edwards negotiated for the Wathaurong Eagle logo to go alongside the police logo on the jackets worn by patrollers on call. 'This showed it was dinkum to be working along side each other' he said.

See page 189 Resources this chapter for ACJP contacts

ACJP partnership in dealing with family violence

In one instance, the police ACJP liaison officer had a family violence call-out. It was a dicey situation, but because of his links with the community through the ACJP, the police officer knew the Koori man involved. Because of this he was able to negotiate a peaceful outcome. His links with the community really helped to defuse the situation. (Thanks to Craig Edwards)

Resources for chapter 6 Strategies

Cultural Protocols

Contact Larrakia Nation Aboriginal Corporation Phone 08 8948 3733
www.larrakia.com

Family violence

Australian Domestic and Family Violence Clearinghouse
www.austdvclearinghouse.unsw.edu.au

A Network Booklet with details of how to contact Australia-wide services with dedicated legal assistance to Indigenous women:
National Network of Indigenous Women's Legal Services
Network Co-ordinator Phone 08 9475 0755
Email Coordinator_NNIWLS@fcl.fl.asn.au

Rekindling the Spirit (Lismore) www.rekindlingthespirit.org.au

Night Patrols

Mosey, A (1994) *Central Australian Remote Area Aboriginal Night Patrols. A review.*
Drug and Alcohol Services Association, Alice Springs.
Available from: DASA, PO Box 3009 Alice Springs NT 0871
Phone 08 8952 8412 Fax 08 8953 4686

Sobering up

For more information about shelters, contact the Shelter Manager at DASA for a copy of '*Guidelines for the Establishment and Operation of a Sobering-up Shelter under the Northern Territory Sobering-up Shelter Program'* (February 2001). Drug and Alcohol Services Association Alice Springs Inc
Available from: DASA, PO Box 3009 Alice Springs NT 0871
Phone 08 8952 8412 Fax 08 8953 4686

Aboriginal Community Justice Panels (Victoria) contact:
The Manager, Aboriginal Advisory Unit,
Victorian Police Centre PO Box 415 Melbourne, Vic 3005
Phone 03 9247 6666

References for chapter 6 Strategies

Anon (1997) A better outlook for Indigenous women and the law. *Law Society Journal,* November:15

Bolger, A (1991) *Aboriginal Women and Violence*. NARU monograph, Darwin

Broom, D (Ed) (1994) *Double Bind. Women Affected by Alcohol and Other Drugs.* Allen & Unwin, Sydney

Langton, M (1991) 'Too Much Sorry Business'. *Royal Commission into Aboriginal Deaths in Custody National Report,* Volume 5 Appendix D(1). AGPS Canberra

Memmott, P, Stacey R, Chambers C and Keys C (2001) *Violence in Indigenous Communities.* www.ag.gov.au/agd/WWW/ncphome.nsf/D2801B61EABE80A2CA256809001328BA/3AF90A4576B81394CA256B430001AF24

Strang, H (1992) *Homicides in Australia 1990–1991.* Australian Institute of Criminology, Canberra

Strempel, P, Saggers S, Gray D, Stearne A (2004) *Indigenous Drug and Alcohol Projects. Elements of Best Practice.* ANCD Research Paper 8. www.ancd.org.au

Western Australia Drug and Alcohol Office (2003) Utilisation of Sobering Up Centres, 1999–2002. *Statistical Bulletin* No 17 September: 1–23

What's in the 'care' chapter?

Helping people change

Health and community services

The idea of looking after people who are in trouble goes deep down into Aboriginal and Islander cultures and ways of thinking about alcohol. This chapter is about caring for people with grog problems and for their families and friends too. All kinds of health care and other workers are trying to practice a holistic view of health and to make 'caring and sharing' real, not just a slogan.

'Health is a mixture of physical health with other kinds of health. It is wellbeing in body, mind and community. People live best in healthy surroundings, in a place where they can trust each other and work together to meet daily needs, share in times of difficulty and plenty, and help each other learn and grow and live, each as fully as he or she can'.

(David Werner *Where There Is No Doctor,* 1993)

If you are a service provider working in a health service or for a community organisation, you might think 'how can I do all this? How can I do anything about land and food and wellbeing?' The fact is, you can't do everything! Everyone fulfils his or her own part when and how the person can. Alcohol problems are influenced by many different factors: life difficulties, lack of options, being poor, grieving, despair or simply wanting to have a good time. The important thing to remember is that the words you say to someone, or the help you give them, might make a difference to a person's life and help that person turn the corner.

Raising awareness of alcohol problems

Community-controlled or state-run general health services already have a role in dealing with people with alcohol problems. However, they could all probably do much more about these issues. Often they are put in the 'too hard' basket. Sometimes the specialised organisations (like rehab centres) are just left to get on with things and have little contact with health services. But problem drinking affects different aspects of people's lives long before they end up in a rehab centre. Because of this it needs to be part of the normal everyday work of health and community services. If you work in such a service or you are on the board, here are some suggestions you could make about raising awareness of alcohol problems:

- Invite speakers to come and talk to staff to share new ideas.
- Organise a regular one-day in-service to raise awareness of, and teach skills in, how to identify problem drinking (especially for your frontline workers).
- Train staff in brief interventions.
- Work with staff on their attitudes towards people with drinking problems.
- Display Indigenous posters on AOD issues in the waiting area.
- Have pamphlets giving practical advice and copies of *Streetwize Comics* available in the waiting area.

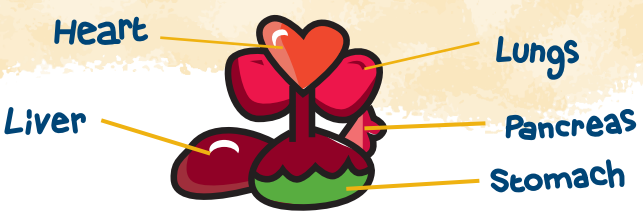
... And in health services:

- Employ an Indigenous AOD worker to keep in touch with problem drinkers and give them support and follow-up.
- Encourage all health staff (doctors, health workers) to be pro-active and ask clients about their lifestyle, alcohol and other drug use.
- Remind the health workers that it is OK to talk to people about harmful drinking. It is part of health and it is part of their job.
- Encourage the health workers to bring particular patients to the attention of the medical staff for a check-up for heavy drinking.

- Obtain a diseased liver specimen in a jar to show people what years of heavy drinking can do.

'When I go round to do a run...I take an example human liver from the Darwin hospital. I took 'em around and show the people what a good liver is and what the bad liver is and what happened with the bad liver. Well, lot of people, they like to see something in front of their natural eye. Because they cannot understand — when we try to educate our people, pretty hard for them to believe sometimes. They would like to see something...in Aboriginal way they used to do [that] , they saw things with their own eye'.

(Jack Little)



Supporting frontline workers

The reality is that Indigenous workers can find it very hard to talk with other Indigenous people about alcohol: it is thought intrusive; they know people too well; it is all too personal. Are these workers getting the support they need? Training and feeling more 'professional' help when staff have to raise difficult issues with clients. Having a policy in your service stating that questions about drinking, smoking and exercise are routine with all clients, is a way to back up your workers.

See page 117 **Prevention** Training in AOD

Many Aboriginal and Torres Strait Islander workers say that it is difficult for them to raise alcohol issues with elders or relations. It is not considered appropriate; it is a shame job. But perhaps there is a misunderstanding here. This is not about bossing someone, telling the person what to do! It is about giving some information so that the person can make his or her own decision.

If you work in primary health care....

Prevention Primary health care workers are in the front line when it comes to AOD problems. They are in a strong position to do prevention work as well as intervening in alcohol problems. Some examples of prevention work include getting to know about the drugs currently being used in the community; giving information and education; distributing material, talking to school groups; networking with other agencies. It can include helping people to find jobs or study courses as alternatives to heavy drinking.

Intervention includes finding the people and groups (through screening) who are high-risk: people who often drink and drive; who are on medication for a medical problem; who are already in trouble with drink; pregnant women. Brief interventions means talking directly about these things, reminding people of the damage they can do, getting them to think about themselves and their families. It includes giving people tips and advice on how to drink more safely.

Treatment might mean dealing with acute or emergency problems. These include DTs, fits, agitated and violent behaviour, self-harming behaviour or suicide attempts. Many kinds of workers need to be able to respond to these situations and make referrals to residential or day programs. Treatment in primary health care settings also includes dealing with long-standing health problems as a result of drinking: liver and heart problems, brain and nerve problems.

See pages 39–41 **Alcohol** Alcohol and health

What is a brief intervention?

Brief intervention means recognising a problem (as early as possible) and doing something to stop the harm it may cause. It means making the most of any opportunity to counsel people about their drinking. It involves asking and listening, giving information, and getting people to think about how they can cut down on the troubles they are having from alcohol.

All health and community workers have a role, not just the services with 'alcohol and other drugs' written on the door. They can help to identify people who are starting to suffer from their drinking, but who are not yet dependent on alcohol. Sometimes people will change after a health professional has talked with them about their own drinking story.

To learn more about brief interventions, see these items listed in Resources (at the end of this chapter):

- *Alcohol Handbook for Frontline Workers*
- *CARPA Standard Treatment Manual*
- *Drink-less Program*
- *Guidelines for the Treatment of Alcohol Problems*
- Flip Chart *Talking about Alcohol with Aboriginal and Torres Strait Islander Patients*

See page 240 **Handouts** A health worker gives a brief intervention
See page 238 **Handouts** Practical tips to drink more sensibly
See page 244 **Handouts** Terms and phrases often misunderstood

Doctors have a special role to play

giving advice

Many Aboriginal people say that nobody has the right to tell another to stop drinking; they say 'it's my way of living. You can't force people'. This is true. But health workers, especially doctors, have a responsibility to look after people's health. They have a special role because it is their job to advise their patients. They can speak with authority. Sometimes they can say things that are difficult for other people (like family) to say. A doctor can also write out and sign a 'safer drinking prescription' for a patient. Making it official helps in many ways.

Six good reasons why doctors can and should talk to their Indigenous patients about their drinking:

1. People expect doctors and health professionals to give advice.
2. Their advice is personal, directed to each individual's health.
3. Indigenous people are well aware that doctors have detailed knowledge of bodies and internal organs.
4. Doctors are respected for their knowledge and status.
5. The interaction with a doctor is private, it is not a shame job.
6. A doctor's advice can be used as an excuse by that patient when other people try to persuade him or her to drink.

Two Aboriginal people who took notice of advice:

'Then the doctor find out what's wrong with me you know. They told me "you gotta large heart". Doctor asked me "You drink a lot?". And I said "yes". And then he asked me "You only young, in your 30s. I'd like you to stop drinking. It is benefit for your body and for the future..." I've got to believe him, he's a doctor... I seem to have thrown it away from the time the doctor in Ceduna, and Sister Maria spoke to me. Sister Maria was working at health in Yalata and Oak Valley. She used to tell me to stay strong, don't fall from that road. No one else, only she. And I did'.

'I'm diabetic and more alcohol I drank it sort of got infection in my body, and being a diabetic, if you get any cut or anything you sort of break out, infection breaks out. That's what happened to me, and then I went to the hospital and the doctor said to me "you drink?" and I said yeah. "But for a start", he said "stop drinking". OK, I did, that was when I was in hospital'.

(Mr Williams and Mr Singh, in *Giving Away the Grog*)

Doctors can have a short training session to give some extra skills. This training helps doctors be sensitive and realise that their words can help people to change. Training can be arranged through the Divisions of General Practice around the country. We know from research in the general population that for some drinkers, a talk with their doctor or nurse is enough to get them to cut right down. We think this works in the same way for Indigenous people.

See page 224 Resources this chapter
See page 238 **Handouts** Practical tips to drink more sensibly

Giving advice

blood tests

Letting a patient know the results of different biological tests can help him or her to believe that alcohol can cause real damage. Your health service can offer these. For example, doctors do a test called 'GGT', a liver enzyme test. Having this 'proof' is useful if a person wants to explain to friends or family why he or she needs to stop drinking.

Doctors and health workers can also recommend that a person wears a MedicAlert bracelet for some serious conditions like diabetes and heart problems. The doctor can explain that, with some of these conditions, the person should not drink alcohol either. The person wearing the bracelet can use it as a kind of protection from being hassled.

Screening (giving everyone a check-up)

AUDIT test

There are different types of screening. You can do community screening, which is like a health check of everybody in the community. This usually includes alcohol and other drug use questions. Or there is individual screening. Screening helps a health service to focus on helping drinkers early on, before they get really sick. Nearly everyone comes to a health service for other reasons; they are not coming with an alcohol problem. You can still use the chance to check up on alcohol (and other drug) problems! There are set questions such as the Alcohol Use Disorders Identification Test (AUDIT). This only has ten questions, but be aware that some Aboriginal people have had difficulties with this questionnaire. The CAGE (another questionnaire) only has 4 questions

See *Guidelines for the Treatment of Alcohol Problems* in Resources

Or you can screen people by asking:

- Do you drink alcohol?
- Is it causing you any problems?

Early warning signs to watch out for:

- arguments with spouse about drinking and money
- 'stress'
- no sleep
- depression
- missing work
- losing a driving licence
- evidence of fights, wounds
- getting into trouble with the police
- not eating, weight loss
- sex life going downhill
- health problems (feeling crook, headache, gutsache, nausea, retching?)
- getting the shakes after stopping drinking
- frequent diarrhoea
- frequent infections.

Having trouble with the 7 L's?

LOSS Culture, family, grief, language.

LAW (Aboriginal) — Traditional practices, spirituality, cultural and social obligations.

LOVER Relationship problems with partner, family, friends, community.

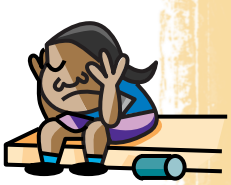
LAW (Western) Legal problems, gaol, losing licence.

LIVELIHOOD Work, unemployment, finances, housing, education, recreation.

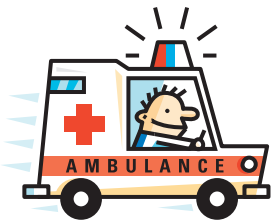
LIVER Physical health problems; emotional, spiritual and mental health

LAND Access to country, sacred sites, traditional land.

(Thanks to Wendy Casey)



See page 40 **Alcohol**
The effects of alcohol on the body (illustration)



Reaching Indigenous people in hospital

Hospitals are an important contact point between Indigenous people and the health system. More Aboriginal and Torres Strait Islander people use emergency and outpatient departments than do people in the general population. This means that hospital staff have plenty of chances to talk about alcohol or other drug use, either with people in a hospital bed or attending outpatient clinics.

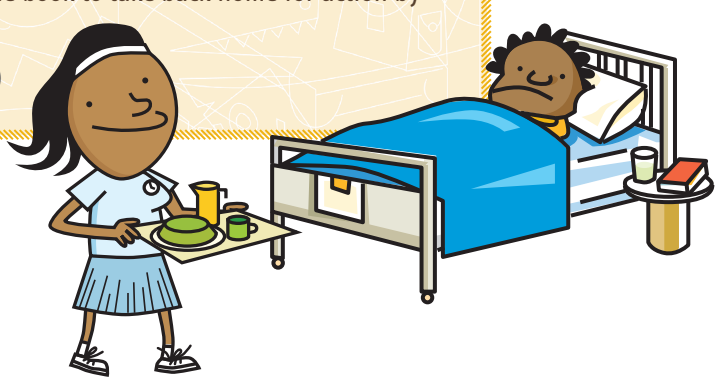
(Something an action group might do is to find out if local hospital staff are taking every opportunity to talk with all patients about alcohol).

Using a hospital setting to talk about grog

At Cairns Base Hospital, staff gave Indigenous patients copies of 'giving up the grog' stories — personal stories from Aboriginal or Torres Strait Islander people. Staff needed a way of relating to the people they were seeing as part of a hospital-wide screening and intervention for those drinking at unsafe levels.

The staff copied locally relevant stories from **Giving Away the Grog** and made them into small booklets. When a patient wanted to do something about his or her drinking, the staff gave them a copy of the stories. Indigenous people injured in alcohol-related assaults were also offered the stories to take back to their communities. A number of patients who were leaders in their communities asked for the book to take back home for action by the council.

(Thanks to Yvonne Nicoll)



assessment

Steps to treatment

Once you know that a person needs more help, that person needs to be properly assessed. This is really important if the person wants to do something about their drinking, to go for treatment. A good assessment will also find out about what the person's life is like, what other difficulties he or she has.

Doctors and/or nurses can do an alcohol assessment for you if your workers have not had any experience in doing one. An assessment helps to identify what kind of person a drinker is: a bender drinker? A heavy, regular, dependent drinker? This affects the kind of counselling you might offer. It shows whether the client needs more medical help (if they have serious physical effects of drinking), or ongoing mental health care (if they have a co-morbid psychiatric problem).

An assessment for treatment for dependence should measure:

- Level of drinking
- Level of dependence
- Physical effects of alcohol use
- Psychiatric co-morbidity
- and any other problems.

Once you have a good idea of how serious the problem is and whether the person wants to do something about it, there are several options: different types of counselling and different types of residential or day programs. In reality, Indigenous people often have very little choice of treatment programs. If the person does not want to do anything at the moment, do not give up! Give the client a card or contact number, and tell him or her that someone will be there if they need help later.

A person who is a dependent drinker may need to detox before treatment can begin, so that the body can get used to not having any alcohol. Ask for medical advice about this.

What is detox?

Detox is not treatment in itself. It is the first step towards treatment for dependent drinkers. It means managing the withdrawal process when coming off alcohol or another drug.

withdrawal

The level of dependence (how heavy a drinker and for how long) influences what type of withdrawal a person experiences. Mild to moderately dependent people can be withdrawn without medication in a quiet, safe and supportive place. They need kind talking, counselling and social supports from staff or family to help manage their symptoms (if they are doing it at home). The experts advise that for safety, you need to have ready access to medical care if the client has life-threatening complications. Heavily dependent drinkers will need medical supervision.

A detox unit in Lismore

The Northern Rivers Health Service has a 16 bed detox unit and methadone clinic. The employment of two Aboriginal staff members has encouraged more Aboriginal referrals from as far away as Taree. The purpose-built unit has incorporated an outside 'circle of healing', with a fireplace and benches around it to encourage Aboriginal clients to feel they have a place to go.

(Thanks to David Reilly, Mavis Golds and Leonie Jefferson)

Counselling

Non-residential counselling

The conversation between 'Ron' and a health worker (on page 240 Handouts) is an example of how to make the most of an interaction and give a brief intervention. Motivational interviewing is good for those people who need more of an in-depth talk.

Motivational interviewing

making changes

This is simply a way of counselling or talking with a person to help, but not force, him or her to make changes. Two researchers (Prochaska and DiClemente) came up with a way of understanding how people can go through changes in their ways of thinking about their substance use. They called it the 'stages of change model'. It is like this:

1. Pre-contemplation — that is, not really thinking about changing.
2. Contemplation — actually thinking about changing.
3. Preparation — making plans about how to change.
4. Action — deciding to do something and doing it.
5. Maintenance — keeping going once the decision has been made.
6. Relapse — drinking again (quite normal) — needs help to get back on track.

life stories

This is an idea based on the general population. But listening to Aboriginal people talk (or reading their stories) shows how real these stages of change can be. It is hard to get from just worrying about your drinking to actually making a change! Motivational interviewing helps people to move from one stage to another. It is based on the personal self determination of the client, who makes the decision about what to do. Aboriginal people who stop drinking say they do it themselves. But the health worker can still make them think, can give them a little push without being too bossy. They do this by discussing the good and not so good things about the person's drinking, avoiding argument, and helping to look at the behaviour and its impacts.

See page 242 **Handouts** What to say in a brief motivational interview

Narrative therapy

Narrative therapy is a form of counselling through story-telling which is being used for and by Aboriginal people. In Adelaide, a project linking up the Dulwich Centre, the Central Mission and Nunkuwarrin Yunti (the ACCHO), has trained Aboriginal workers in this type of counselling. It is not designed specially to deal with AOD problems, but covers issues which include grief and loss and dealing with deaths in custody.

'My first involvement was in 1994 when the Aboriginal Health Council of SA was granted some funding to address counselling for families who had experienced losses through deaths in custody (in its recommendations, RCIADIC said that counselling was urgently needed). Narrative Therapy offers a way for Aboriginal Counsellors to develop practices that are culturally sensitive and appropriate. Many Aboriginal people have had put on them negative stories about who they are. With Narrative, we can go through these journeys with them while they tell their stories, and acknowledge their strengths in a re-empowered way'.

(Barbara Wingard on her introduction to narrative therapy)

People have a story about their life, woven together out of all the things that have happened to them—their memories, their griefs and losses. For Aboriginal (and other Indigenous) peoples, the dominant story is often a negative one: separation from families; violence and abuse; gaol; drug and alcohol abuse; unemployment. They have felt racism, embarrassment, shame. These feelings can develop into a sense of 'not being good enough'. Narrative therapy helps people to turn these stories around, concentrate on the good things. It tries to get people to talk about the problem as if it is external to them, separate, not part of them.

See page 120 **Prevention** Training in Narrative Approaches

See page 224 Resources, for Dulwich Centre contacts

Whatever approach your counsellors are using, there are some basic features that contribute to good counselling.

A recipe for effective counselling:

- *Understanding and treating drinking in context.* Counsellors need to understand each individual's drinking in its social, environmental, spiritual and psychological context.
- *Problem-solving*. Divide up the different parts of the problem so the client has the chance to find solutions and feel in control.
- *More action — fewer words.* Some clients will not be thinking clearly. Treatment programs that use actions (social skills training, cooking, managing money, learning to be assertive) rather than just words, are more effective.
- *Family, friend and community involvement*. It helps the chances of success if a person has a supportive community and family.
- *Make it worth their while to change*. The client must see some reason to change. Family members are important here.
- *Getting on top of the triggers to drinking*. The counsellor needs to help the drinker to identify high risk situations or emotions that are 'danger times'.

- *Setting goals and self management.* Help the client to learn how to watch himself, have goals to achieve and find a way around the pressure from others.
- *Client choice.* The decision to aim for abstinence or cutting down is an example of client choice. Offer a choice of treatments and goals.
  (Adapted from Heather and Robinson 1989)

Treatment

Residential programs

Residential programs provide an essential part of the range of services needed. The research literature for the general population tells us that residential alcohol programs are good for:

- People who are homeless or on the streets.
- People who lack a supportive environment (surrounded by people who drink).
- People who are severely dependent on alcohol.
- People who cannot look after themselves.

rehab

(They also help ex-drinkers who work in them to stay sober).

Many Aboriginal residential programs have rules of abstinence, and most aim for the long term goal of giving up grog. Many places have adapted the Twelve Steps, introduced culturally appropriate features or been influenced by Canadian Indian programs. Others give people life skills, use motivational interviewing and talk about harm minimisation.

People often have high expectations of residential programs. In reality, only some of them manage to do what they hope to do. In a review of rehab programs in WA, Rory O'Connor found that many were unclear about the aims of their service and about the meaning of words used in treatment, such as 'rehabilitation' and 'detox'. He suggested that people need to look at their program and work out what it really is. Is it a rehabilitation program? Is it a recuperative program? Is it a dry camp?

A rehabilitation program

A rehabilitation program in the true sense of the word should have most of the following features:

- Detoxification — often under medical supervision or with access to such supervision.
- Rest and recuperation.
- Individual counselling (motivating people to change, helping their commitment).
- Group counselling.
- Therapeutic activities (artwork, making artefacts, working in the centre or garden).
- Advice on employment and education opportunities, job-finding.
- After-care and follow up by staff (a halfway house, home visits, phone calls).

If your rehabilitation centre has these seven positive features, the chances are that it will have a good chance of producing good outcomes. It is possible to call it 'a program'. If your service only has the first two features on this list, then it is not really a rehabilitation program. It is something else.

A recuperative centre

These centres are dry houses, halfway houses or supported accommodation. They usually provide rest and recuperation. Some may organise occasional meetings, but they do not provide an organised program of activities or interactions between clients and trained staff. Some clients do not want to be put through an intensive program and would probably not use such a program (see box opposite).

A dry camp

These are usually bush camps run by unpaid bosses who have strong personalities and lots of commitment. They take immediate action if alcohol is smuggled in or if intoxicated people turn up. They do not cost

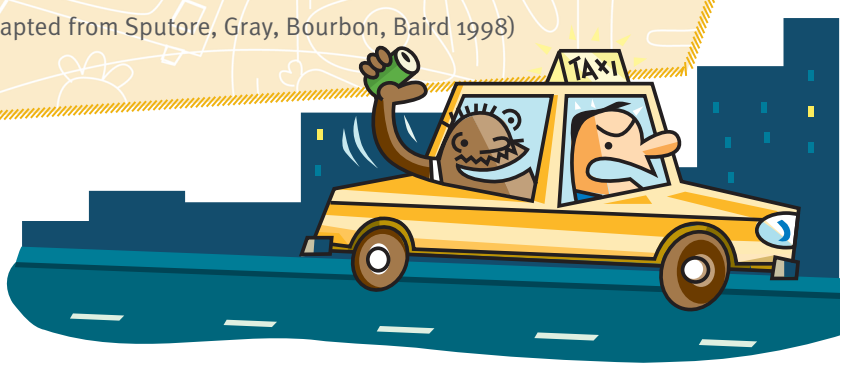
much money to run; they act as drying out facilities. Food is sometimes purchased by communal use of clients' Centrelink payments.

If what you really have is a dry house (that simply gives people a break from the grog), you will find it hard to show that you are achieving the aims of a treatment program! An evaluation will make your program appear to be a failure.

Unclear goals and mixed up clients

An evaluation of a residential program in Kununurra found that the clients were divided. One group wanted to take strong action to change and looked to the program to help them do this. The other group wanted to have a break from drinking, get away from grog for a while. Having both groups in the same program caused problems, as those not wanting to change were not interested in counselling or in a structured program. Those who DID want to change were frustrated because they wanted more formal and structured counselling.

(Adapted from Sputore, Gray, Bourbon, Baird 1998)



The needs of people in urban settings

These three basics are a starting-point for discussion if you live in a country town or metropolitan area:

- *A night shelter or sobering up shelter* — to get people off the streets, prevent them sleeping in the open and ending up in police cells.
- *A dry, recuperative facility* — preferably out of town, which could include bush trips, artefact making and encouragement to undertake counselling.

- *A counselling/youth worker service* to interrupt the cross-generational spread of problem drinking. Ideally this service should be attached to the recuperative facility and provide specific activities such as school visits to discuss Indigenous culture and history; evening youth groups, dry discos, sport.

See page 225 Resources, *Rethinking Drinking. You're in Control* ⇢⇢⇢

Networking residential programs with other services

In the past, the residential programs had limited funding and relied on ex drinkers to be workers. They were not usually linked to other agencies. The benefit of having links with other programs (such as mainstream Therapeutic Communities — see page 215) is that workers can learn from each other, have local support, and staff exchanges can be organised.

It is also essential to have a relationship with the nearest health service. This means that a doctor can check people before they go into treatment, keep an eye on them while they are there and do follow up after they leave. A GP that works closely with a residential program might be the only contact some clients have with the medical system. The GP has the only opportunity to find out whether a client has any physical or mental health problems (comorbidity) with harmful drinking. If a doctor does not take advantage of this opportunity, then the client will miss out on getting proper health care.

New ideas in a residential treatment program

CAAAPU in Alice Springs has been looking at its treatment program. Staff asked clients to give their ideas about how well it was going and what else they wanted to learn about. CAAAPU is now trying some different approaches. They are calling their program the 'Living Well Initiative' based on a holistic model.

* An individualised treatment program
* Counselling and client support
* Life skills
* Smoke ceremony
* Culture days
* Sharing circle
* After care

The program works with each client's strengths. It aims to give clients a better understanding of Indigenous history, what clients can do to prepare as future leaders of their communities and why they might have trouble with grog. While the program is still developing, some things are working well like the Story Book idea. While in the program, each person keeps an artbook about him or her self. Anything the person thinks important can go into the book, including what they learn in the program, memories, feelings, problems and ways to solve them. Some people write, some draw pictures or do collages — whatever they feel comfortable doing. It acts as a journal.

Throughout the Program, clients also do a group painting on a big piece of canvas about what was important for them during their stay. Then people talk about what they painted. Clients like doing the painting — it is a good way to say goodbye to the staff and each other: something to leave behind.

(Thanks to Karen Aucote and Huti Watson)

What approaches can be used in an alcohol program?

There are different approaches to therapy or counselling that can be used in residential programs: the Twelve Steps approach, cognitive behavioural therapy, motivational interviewing, narrative therapy and others. If you want to know more about these, send for free copies of an expert review of treatment and guidelines for treatment.

See page 225 Resources, *Treatment of Alcohol Problems* ⇢ ⇢ ⇢

What is AA?

AA is short for Alcoholics Anonymous. It is a self help organisation for people with drinking problems, not really a type of 'treatment'. It started in the USA in the 1930s when two white Americans started talking with each other about their personal drinking problems. They decided to help each other to stay sober and spread their message to other alcoholics. The Twelve Steps used in AA can be used in an abstinence based treatment program.

AA teaches that alcoholism is an illness which can never be cured. AA tells its members that to be an 'alcoholic' is to be a sick person. AA offers people a new way of life and is made up of people who have had similar problems who help each other. It relies on volunteers. At AA meetings, people tell their stories; there are no bosses. Because it pays attention to the spiritual side of life, AA appeals to some Indigenous people. Some rehab programs host AA meetings and people come in from the outside (both Aboriginal and non-Aboriginal people).

'With Alcoholics Anonymous, no matter where they are, they have a friend. We [in rehab programs] can't provide those follow-up services.' (Cyril Hennessy on AA)

What is a Therapeutic Community?

A Therapeutic Community is the name given to a certain type of residential program in the mainstream. Program participants live together like a community; they work to keep the whole unit going. Programs vary in length, from several months to much longer (a year or so), and in the approach they take. Some are based on a Twelve Steps program, others on family therapy or cognitive behavioural approaches. Around Australia there are about 25 residential communities like this who belong to a NGO peak body: the Australian Therapeutic Communities Association. Any Indigenous treatment program can become an associate member.

An Aboriginal man in a mainstream Therapeutic Community

A Victorian Aboriginal man completed the program at Odyssey House and is now at Deakin University. He goes back and talks to residents and helps any new Aboriginal participants (there are a few) to settle into the program. Another young man is in the program. He made a herb garden for the house and helped organise NAIDOC celebrations for the residents. He says it is OK being in the program, even if he is the only Aboriginal person there sometimes.
(Thanks to David Crosbie)

Staying sober

Doctors can prescribe drugs that are effective for treating people with alcohol dependence. These include drugs called acamprosate and naltrexone. They have to be part of a treatment plan between a person and his or her doctor. They are best used when the goal is maintaining abstinence. The client needs to know how the medication works, about the side effects, and to understand what the drugs can and cannot do to cut down on cravings.

For more information about these medications, see page 225 Resources, *Guidelines for the Treatment of Alcohol Problems* ('Relapse Prevention') ⇢ ⇢ ⇢

Informal helping strategies

How family and friends can help

Trying to cut down or trying to give up can be hard because of friends and relatives who drink themselves. They often cannot understand someone who wants to change and put pressure on that person to keep drinking. Those who give up often say they discovered who their real friends were. Sheila Miller from Katherine (whose story is in the book *Giving Away the Grog*) said:

'I think a lot of people drink because they think they've got friends. Whereas, you haven't got friends — you know it when you give it up. You're their friend when you've got the money and can afford beer, and you haven't got one ounce of friend when you really want their backing'. (Sheila Miller)

On the other hand individuals with drinking problems also find that the support of a partner or relative or a church group can make all the difference. Community members can help people with drinking problems and find Aboriginal or Torres Strait Islander ways of doing this. Families can discuss how to stop giving money for alcohol. This is hard, but ATMs and Centrelink deduction arrangements help vulnerable people to hang onto their cash.

See page 171 **Strategies** Solving food problems

Taking someone to an outstation, to another island or to stay with relatives (away from the normal drinking group) helps the person to change. Encouraging someone to get back onto the land, do more hunting, participate in ceremony or art production are other ways of helping.

You can set limits

'...like yesterday someone filled up a can with moselle and I asked him what he was drinking, and he said beer. So I said, "Let me smell it." I smelled it and it was coolibah, and I said, "I don't want you drinking this". And I tipped it out. Coolibah makes him [crazy]'. (Quoted in Orford et al 2001)

Talking strong and telling drinkers off are other ways of showing social disapproval. The women who campaigned against licensed outlets near the Pitjantjatjara Lands and in Alice Springs marched in the streets and gave speeches. They did this 'Aboriginal way' by linking the grog with their concern for their children and grandchildren: the future generations.

Putting coping strategies into practice

support group

An example of people supporting each other comes from urban Sydney. In 2000, a group of mothers and grandmothers formed the Family Support and Trainer Group as part of the Two Women Dreaming Program at La Perouse. These women are the family members and carers of alcohol and other drug affected people in the community. They meet weekly in the evening at La Perouse to talk about problems, share successes and to learn from each other and from invited speakers. They also go on weekend healing retreats a few times each year.
These healing retreat times are especially important for building strong relationships and trust.

La Perouse women talk about their family support group:

> *'We were stressed out with the world on our shoulders. Talking to one another relieved it. We came back laughing and smiling. Our families wondered what had happened to us ... We have more respect for each other. Now when we meet on the street we stop and have a good yarn ... we talk about things.'*

> *'You're there for one another. It lifts a big load off your shoulders.'*

'We have someone to turn to now when something happens ... Before, the shame would stop us. Privacy of the family ... traditionally we didn't talk about those things.'

Over the time they have been meeting, the La Perouse women have become more active in speaking out about what alcohol and drugs are doing to their community. Some members attended the NSW Alcohol Summit in 2003; they write to government departments and ministers on behalf of community members, becoming a 'voice' for the community. They keep going because 'it's the kids — the beauty and potential of the kids. We can't give in.'

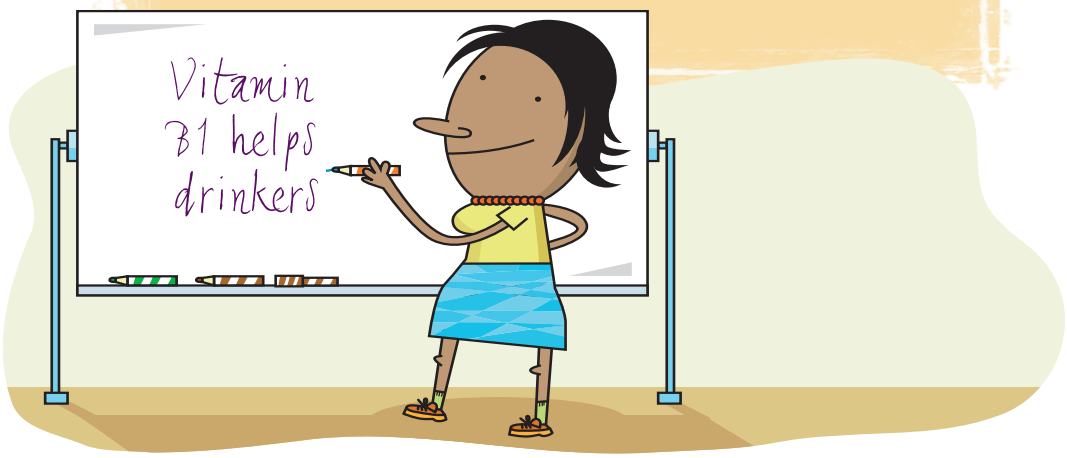
What makes it work?

- Community members are willing to come together, to trust each other and to learn about and experience new things. They take a chance and speak up strongly for their families and community. Coming together was crucial for their ability to carry on supporting others, particularly their family members.
- A psychotherapist who is experienced in community development and holistic psychology supports the group and helps organise healing retreats, speakers and conducts workshops on wellness. A doctor visits the community weekly, assesses people and gives health education talks. She speaks the 'truth' to them, face-to-face. Community members trust and respect them both.
- The Group is linked though the psychotherapist and a doctor to The Langton Centre, a mainstream AOD service. When people are ready to change their drinking or drug taking, the Group can help get them into treatment there and support them afterwards. The women have visited the service and given their ideas about how it can be made better for Indigenous people.

(Thanks to Family Support and Trainer Group La Perouse, and Esme Holmes The Langton Centre, and Aboriginal Health SEAH. The quotes are from *Evaluation of the Two Women Dreaming Project* (2003) by Hilary Armstrong and Peter Melser).

Some practical advice on thiamine

Did you know that drinking a lot of alcohol uses up a very important vitamin called 'thiamine' (Vitamin B1) from the body? Without this vitamin, a person's brain and nerves can be affected. To care for a heavy drinker, you need to give him or her foods with thiamine in them, like Vegemite on bread, Weetbix and Milo. People in sobering up shelters are sometimes given thiamine tablets to help to protect them from brain damage.



Indigenous ways

Going bush is one way in which many Aboriginal and Torres Strait Islander people deal with drinking. It is not just people living in the desert or Arnhem Land and Cape York who go bush! People in other parts of the country use their strong ties to the land and its resources as a way of dealing with grog. This is happening in Tasmania. Muttonbirding in the Bass Strait Islands is important for Tasmanian Aboriginal people, both culturally and economically. The birds are used for food, feathers and oil. Some old people drink the oil for colds. Muttonbirders go to Trefoil Island, the Walkers, Big and Little Dog Islands, Badger Island. The harvesting season lasts about five weeks, providing a lump sum of money at the end of the work.

Muttonbirding in Tasmania

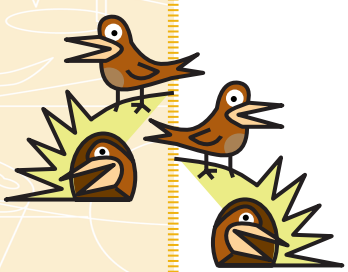
For Palawa, [the Aboriginal people of Tasmania] the muttonbirding is part of their culture. Young people are taken over to the islands by the Tasmanian Aboriginal Education Centre. It can be quite a test for young Aboriginal men to go for the first time; the burrows where the muttonbirds nest are also the homes of tiger snakes!

Some people will stop drinking a week before the season starts, to get ready to go to the islands without grog. On Trefoil Island, for example, the community decided that it would be dry; any alcohol brought in and that person would get sent away. On the other islands, the shed boss might have a ration of two cans of beer on Sunday, the rest day. People use the hard work and good food they have while muttonbirding as a way of withdrawing from heavy drinking. Each shed has a cook and people get more healthy eating regular meals. Everyone helps out with cleaning and gutting the birds. It is an opportunity for people to talk things over. Sometimes Aboriginal health workers go over to the islands to help out, to chat with people, be sociable and work with people in that low key way.

Issues that people still have to deal with:

* When the muttonbirders return to town, they are back in the same situation.
* They may have no other work for a year.
* The workers have earned a big cheque; it is easy to blow it at the pub.

(Thanks to Paul Maher)



Changing the culture around drinking

To end with, here are two positive stories about seeing the benefits of not drinking so much. In the first story, young men were rewarded for being good team members and for being great role models. In the second story, people found that drinking got in the way of things they wanted to do.

Helping footy players to keep out of trouble

Umagico Council (on Cape York) came up with an idea to help their footy team members keep out of trouble and become role models. They put together an incentive program. It meant that the 30 members of the Alau Eagles squad were paid for each game and each win, but only at the end of the season, and only if they stayed out of trouble. This meant no arrests, no charges and no reports of family violence. 'If any of the boys — and not all are angels — got into trouble, they would have been thrown off the team and without a cent' said Councillor Peter Lui. The community itself raised $36,000 for the program, by selling food at matches, collecting donations and having raffles. The team is one of the best performing rugby league teams in north Queensland, won the 2003 Torres Strait Cup and they stayed out of trouble! (From *The Courier-Mail* 26 November 2004)

Finding something more important than grog

Haasts Bluff (Ikuntji) is a small community of about 200 people, some 300 kms from Alice Springs. Although there were dry communities nearby, Ikuntji Council had always allowed alcohol to be brought into the community. Many people were heavy drinkers, and there was a lot of family violence. The new women's centre coordinator at Ikuntji was also an artist, and she started some of the women painting. After a while some of their husbands also started to paint. They soon decided that their drinking interfered with their painting and so they stopped drinking. Ikuntji now has a very successful art program and their paintings sell for many thousands of dollars. Those men still don't drink. The level of domestic abuse has gone right down.

(Thanks to Anne Mosey, 2004)

Resources for chapter 7 Care

Brief interventions

Alcohol Handbook for Frontline Workers
By Alison Laycock (2004). Far West Area Health Service, NSW
Sydney University Department of Rural Health
Phone 08 8080 1210 www.drh.med.usyd.edu.au/library/index.php

CARPA Standard Treatment Manual, 4th edition (2003) Central Australian Rural Practitioners Association, Alice Springs
www.crana.org.au (online store)

The Drink-less Program, Dept of Drug and Alcohol Studies, Royal Prince Alfred Hospital, Camperdown, NSW. General enquiries Phone 02 9515 7331
Drink-less materials Phone 02 9515 8650
www.cs.nsw.gov.au/drugahol/drinkless

Guidelines for the Treatment of Alcohol Problems (2009).
www.alcohol.gov.au

DVD *Brief Intervention Strategies for Aboriginal and Torres Strait Islander People*.
Clinical Skills Series: Effective Approaches to Alcohol and Other Drug Problems. DVD $92.40
Available from: Training Health and Educational Media Pty Ltd
Phone 03 5433 3854 www.themedia.com.au/

Narrative therapy

Telling our stories in ways that make us stronger, by B Wingard & J Lester;
What is Narrative Therapy? An easy-to-read introduction, by A Morgan.
Available from Dulwich Centre Publications Pty Ltd. $27.50 each
Phone 08 8223 3966 www.dulwichcentre.com.au

Residential programs and treatment

Australian Therapeutic Communities Association www.atca.com.au

Indigenous residential treatment programs for drug and alcohol problems: Current status and options for improvement by Maggie Brady (2002). Discussion paper 236, CAEPR, ANU, Canberra www.anu.edu.au/caepr/

Guidelines for the Treatment of Alcohol Problems (ref AAGO7) and Quick Reference Guide to the Treatment of Alcohol Problems (AAGO7A) both by P. Haber, N. Lintzeris, E. Proude and O. Lopatko (2009). www.alcohol.gov.au

Youth

Rethinking Drinking. You're in Control (2004) Department of Education Science and Training. (An education pack for lower-middle secondary students, years 8–10 with Indigenous content). Available from: Australian Council for Health Physical Education and Recreation. Phone 08 8340 3388. www.healthylifestylesbookshop.com.au

Cuz Congress website
www.cuzcongress.com.au

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Heather, N and I Robertson (1989) *Problem Drinking (2nd ed)*. Oxford University Press, Oxford

Lenton, S and R Midford (1996) Clarifying 'harm reduction'? *Drug and Alcohol Review* 15:411–13

Mattick, R and T Jarvis (1993) *An outline for the management of alcohol problems*. National Drug Strategy series no 20. AGPS Canberra

O'Connor, R (1988) *Report on the Aboriginal Alcohol Treatment/Rehabilitation Programmes Review and Consultation*. WA Alcohol and Drug Authority, Perth

Orford, J, L Templeton, A Copello, R Velleman and C Bradbury (2001) *Worrying for drinkers in the family: An interview study with Indigenous Australians in urban areas and remote communities in the Northern Territory*, Territory Health Services, Darwin

Prochaska, J O and C C DiClimente (1986) Towards a comprehensive model of change. In W R Miller and N Heather (eds) *Treating addictive behaviours: Processes of change.* New York, Plenum Press

Rollnick, S and A Bell (1991) Brief motivational interviewing for use by the nonspecialist. In W R Miller and S Rollnick (eds) *Motivational Interviewing. Preparing People to Change Addictive Behaviour*. Guildford Press, New York

Sputore, B, D Gray, D Bourbon, K Baird (1998) *Evaluation of Kununurra-Waringgarri Aboriginal Corporation and Ngowar-Aerwah Aboriginal Corporations Alcohol Projects.* NDRI, Curtin University, Perth

Strempel, P, S Saggers, D Gray, A Stearne (2003) *Indigenous Drug and Alcohol Projects. Elements of Best Practice.* ANCD Research Paper 8. www.ancd.org.au

Wright, G, T Graham and R Howsen (1992–3) Developing a partnership. A mainstream and an Aboriginal organisation. *Rapporter* Summer:18–19

What's in the 'handouts' chapter?

Discussion topics using this *Grog Book*

Use these questions as discussion/writing topics with students or participants in a workshop.

Questions to discuss from chapter 1 History

- How has the historical relationship between Indigenous people and alcohol affected attitudes to alcohol today?
- Are the costs of alcohol abuse greater than the benefits of the alcohol economy to Australia?

Questions to discuss from chapter 2 Alcohol

- Is the disease model useful or not, and why?
- Of all the different styles of drinking alcohol, which is the most damaging way to drink and why?

Questions to discuss from chapter 3 Action

- Suggest some ways of motivating community groups to take action on alcohol problems.
- What are the barriers to organising a successful community action?

Questions to discuss from chapter 4 Prevention

- What kinds of 'education' about alcohol can make a difference to how or whether people drink?
- How would you go about preventing alcohol-related birth defects?

Questions to discuss from chapter 5 Controls

- How could community-operated licensed clubs be organised so as to avoid a conflict of interest between fund-raising and community wellbeing?
- What are the benefits and drawbacks of having 'dry' communities?

Questions to discuss from chapter 6 Strategies

- What are the advantages of making use of the liquor licensing laws (rather than informal arrangements) to deal with the selling practices of licensees?
- Do sobering up shelters just reinforce drinking behaviour or do they offer a way out of heavy drinking?

Questions to discuss from chapter 7 Care

- Are relatives and friends a help or a hindrance to the problem drinker?
- Which health service providers have a role in giving brief alcohol interventions?

Standard drinks and safer drinking

The Australian Government has been teaching the public about how people can drink alcohol without harming their health. They wrote guidelines based on the idea of a 'standard drink'.

A standard drink is any drink containing ten grams of alcohol

1 can of mid strength beer	=	**1** standard drink
1 can of full strength beer (4.8%)	=	**1.4** standard drinks
1 small glass of red wine (100mls)	=	**1** standard drink
1 nip of spirits (30mls)	=	**1** standard drink

Or you can think about the number of standard drinks like this

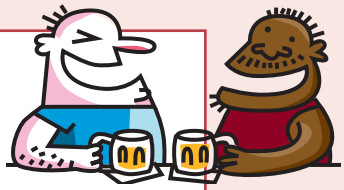
1 slab full strength beer (cans or stubbies)	=	**34** standard drinks
1 x 4-litre cask of white wine (11.5%)	=	**36** standard drinks
1 soft drink bottle (750mls) filled with red wine	=	**7.7** standard drinks

Guidelines to reduce health risks

For healthy men and women, drinking no more that two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury.

For healthy men and women, drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion.

See chapter 2 **Alcohol** pages 32–33



Questions and answers about alcohol

Do Aboriginal people have a genetic weakness for alcohol?

No study so far has proved any genetic difference between Indigenous and non–Indigenous people in the way their bodies absorb alcohol. All human responses to alcohol are influenced by a mixture of biological, psychological, social, environmental and cultural factors.

Why do Aboriginal people drink?

There is no one simple reason; perhaps for much the same reasons as everyone else. Proportionately more Indigenous people do not drink at all. The question is not why people drink, but why some people get stuck in regular heavy drinking that harms their bodies and relationships.

Aboriginal people only need a drop in order to get drunk, don't they?

On the contrary, any person who is a heavy drinker gets used to, and develops a tolerance for, alcohol. They need to increase the amount to get the same effect. Getting drunk depends on body size, gender, speed of drinking, food intake and individual differences.

Does alcohol keep you warm?

No. Alcohol cools down your body even though it gives a feeling of warmth.

Are all heavy drinkers 'alcoholics'?

No. Most people who drink too much are not dependent on alcohol. Some who drink heavily on paydays are sober on other days or for weeks at a time. They can still have many problems because of drink.

What's the best thing to sober you up?

Only time will sober you up. Stop drinking! Let your liver do the work.

Are harm reduction strategies any use to Indigenous drinkers?

These strategies save lives. Agencies like sobering up centres and pick up services give many marginal people a chance to talk with someone about their problems. This can increase interest in abstinence in the long term.

WORKSHOP ACTIVITY

- *Ask participants to answer these questions, then discuss responses.*
- *Show them the answers given here.*
- *Discuss the similarities and differences in the answers.*

See chapter 2 **Alcohol** pages 26–55

Is the community ready for action?

A check list for community development workers

Before starting work with a community, you need to make a list of indicators of community readiness and capacity to change. This includes leadership, community capacity and willingness to deal with priority issues. This will help you to choose communities in which to work. Even if people have identified priority issues, not every community will be ready to receive and act on information about itself (such as statistics on alcohol–related issues). The challenge is to work out where the community is in its thinking and how best to introduce people to research findings and other information. You need to mobilise informed discussion on what is possible and what might work.

Talk with community members and service providers and ask the following:

- Has the community clearly identified the issue as a priority?
- Are there community members prepared to take a lead role on the issue?
- Is there a formal commitment to work with you on the issue?
- Have those who are committed to take action looked at their capacity to bring about change as well as the possible consequences?
- Check to see if people work together at the community level. Ask people:
- *Is there any conflict?*
  - If there is conflict, are people willing/able to work with each other?
  - Can people separate the conflict from the work they will do togther?
  - If conflict is identified, it might be necessary to be 'up front'. Build in strategies to cut down the risk of the conflict growing and derailing the community's efforts.
- Check to see what other projects are being implemented in the town.
  - How many community committees are there?
  - Are the people you are working with also on these committees?
  - Can the town support another project /committee?
  - If people are already working together on various committees, talk to them about incorporating the activity into an existing project.

ACTION GROUP ACTIVITY

Copy, distribute and discuss these dot points with stakeholders before moving on to community action.

See chapter 3 **Action** pages 78–85

How to collect personal stories

- Collecting real life stories of success in overcoming drink or drug problems can tell you what helped (or did not help!) people to overcome their problems. Stories can help identify the needs of a particular community.
- Choose a group of people you know well, or people you have good contact with, who have given up the drink. Explain to the people concerned that the aim is to collect success stories to help others, to give them hope and inspiration. Make sure everyone understands and gives permission.
- Ask for formal approval and for direction and help from the local community. Is there someone there who can help you, a community health worker, or prominent person? These people may have a story of their own.
- You should document what people say. You can use a tape recorder, or you can write down what people say while they talk (if you can write fast!).
- Keep the interviews informal. Let the person tell the story in his or her own way, but ask everyone a few specific questions when the time is right (such as the age when they started and stopped drinking, physical symptoms at the time). How the person first learned to drink, what happened to make them stop and think, how did he or she deal with pressure from other people. You might be the first person to take an interest; give encouragement and support.
- Ask the person interviewed to suggest others. You might find everyone knows another person who has had a success, and you can follow them up.
- Write out the stories from your notes, or transcribe the tape. Give each person you interview a copy of his/her own story to keep. If people cannot read, revisit everyone and read the stories out aloud. Ask people if they are happy with the final version. Do they want to be identified or not?
- Produce booklets of stories for each community to keep. Distribute copies to the health clinic, the school, anyone who is interested.

ACTIVITY FOR LOCAL ACTION OR SCHOOL PROJECT

- *Distribute this handout as a guide for participants to use.*
- *Ask each person to find and interview at least one other person.*
- *Collect the stories; share with the group; make into a small booklet.*
- *Look at what is in the stories, what things helped or made it difficult for these people? How could this information be used to change things?*

See chapter 3 **Action** page 77

Evaluating health education resources

A checklist for making or choosing health education resources

- Is the information accurate and up to date?
- Is the resource suitable for the target group?
- Is it culturally acceptable? Will it upset or offend anyone?
- Can the target group understand the message?
- Does it make the person feel like it is 'talking' to them personally?
- Is the resource eye–catching and interesting?
- Are the diagrams/images clear in what they are trying to say?
- Are the photos or images acceptable to people in the community?
- Are the written words large enough to read easily?
- Can people understand the language, words and images?
- Does the resource use many technical words?
- Does it give clear directions to the reader or viewer?
- Is the message put in a positive way?
- Are there any hidden or conflicting messages that might confuse people?
- Is the resource worth the money it will cost you to make it?
- Can you afford to buy it or make it? Do you need extra funds for it?
- Can you share the cost with anyone else in the community or anyone in the health department?
- How many copies will you need, and how often will you be able to use it?
- How long will it last?
- Has another community got the resource? Can you borrow it from them? Can you adapt it?

WORKSHOP ACTIVITY

- *Look at an example of a health education resource and apply these questions to it.*
- *Split into groups and give everyone a copy of the handout.*
- *Brainstorm answers to these questions in groups and report back.*
- *Use the dot points as a guide when producing local resources.*

See chapter 4 **Prevention** pages 95–107

How to make a success of a local action strategy aimed at restrictions

- ★ Have plenty of widespread community support to start with.
- ★ Have a mix of Indigenous and non–Indigenous people in the action group.
- ★ Make sure the proposals respond to what the community wants.
- ★ Invite the public to participate and comment all along the way.
- ★ Don't exclude any one group. Everyone should be able to have a say.
- ★ Invite all the licensees from the start. It is important to show that you have tried hard to work things out on a local level before turning to outside intervention.
- ★ Have good facilities and good people, and time for organising action. It takes time to organise meetings, write and send notices, collect statistics and stories, talk things through, hold meetings, lobby, work out strategies and put them into practice!
- ★ Collect lots of reliable statistics, stories, observations and community opinion to support your case. Show how alcohol affects all sections of the population (not just Indigenous people).
- ★ Be aware of delaying tactics by people who do not want your group to succeed. If you cannot reach agreement by a set date and after a reasonable amount of discussion with all interested parties, do not be afraid to ask for outside help — contact the Director of Liquor Licensing.
- ★ Invite media interest when you have something solid to tell them. If you have a strong case, they can be helpful in publicising your attempts to deal with a big community problem.

ACTION GROUP ACTIVITY

- *Distribute to members of an action group if you are planning to have restrictions.*
- *Discuss each point early on and throughout your action project.*

See chapter 5 **Controls** pages 125–135

Let's get straight about harm reduction

Sometimes there is misunderstanding about what harm reduction is all about, and people get it wrong. So, it's a good idea to discuss it with students or community groups.

Harm reduction is meant to —

- ★ Cut down harms and social problems to the individual and the community resulting from the use of alcohol and other drugs;
- ★ Reduce or prevent harmful and risky drinking, especially by young people.

Harm reduction is NOT —

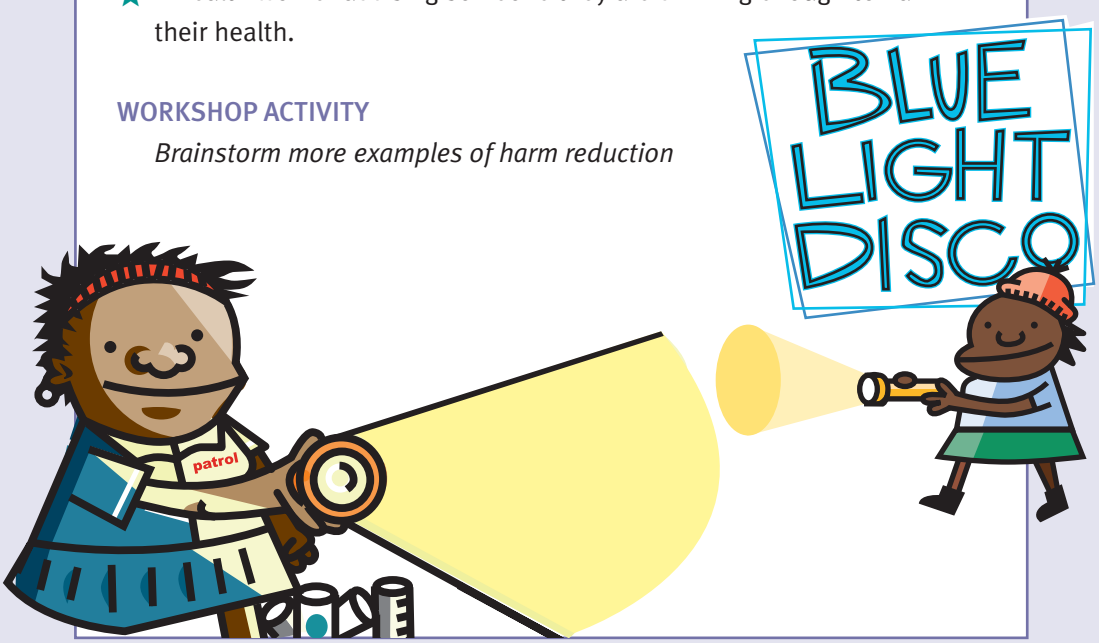
- * Trying to get non-drinkers to drink a little bit.
- * Against abstinence. Abstinence is a good way of cutting down harm!
- * Going soft on alcohol and drugs.
- * Going against Indigenous culture.

Examples of harm reduction

- ★ Having a sobering up shelter for drunk people instead of the cells.
- ★ Restricting sales at a local outlet.
- ★ Calming down people who are fighting.
- ★ Giving a blanket to a relation who turns up drunk
- ★ A health worker advising someone they are drinking enough to harm their health.

WORKSHOP ACTIVITY

Brainstorm more examples of harm reduction



See chapter 6 **Strategies** pages 164–170 and 182–187

Practical tips to drink more sensibly

Not everyone wants to give up the grog! But they might want to feel better in the body and not get into so much trouble. If you are helping someone who is having problems with drink and they want to go easy rather than give up, these tips might be useful:

Going easy on the drink

- Eat before and while you drink. This will help to avoid bad hangovers and be better for your health.
- Spread your drinks over several hours.
- Don't binge drink. You are more likely to have an accident or injury. Bingeing gives a shock to your body and is bad for your heart.
- Quench your thirst with water or try light beer.
- Set yourself a personal limit — be self-determining!
- Start drinking later in the day.
- Have regular days when you don't drink at all.
- Find other activities — play sport, go back to school, paint stories
- Avoid your usual mates; find some different friends.
- Spend more time with your family.
- Think about your grandchildren — will you see them grow up?
- Buy food for the family before you buy your grog.
- Think how much money you'll save!
- If you are under pressure to drink, say 'The doctor (or sister) has told me I should cut down'.
- Be boss of the grog, not the other way around!

WORKSHOP ACTIVITY

- *Brainstorm these suggestions.*
- *Are they culturally appropriate?*
- *Ask participants to suggest more ideas for advice.*
- *Design a leaflet of these practical tips to give to clients.*

See chapter 7 **Care** pages 194–201

FAS: Talking with women about their drinking

Identifying FAS

It is difficult to identify FAS in an adult, easier to identify in a child under ten, and easier still in a child under six. Remember, most children affected by alcohol before they were born only have MILD effects. Do not jump to conclusions! FAS must be properly identified by a medical practitioner or an expert who looks for: ☙ damage to the central nervous system — that is, learning or behavioural problems ☙ stunted growth ☙ a history of drinking in the mother ☙ special facial characteristics.

Talking with women

It is important to talk about alcohol use to all women of child bearing age or who are pregnant already. Talk to grandmothers as well – they can have influence. You need to talk to women carefully and kindly about this and not be confrontational. It is not helpful if a woman feels guilty and ashamed. To get honest answers about drinking, it is best to ask less direct questions.

Start by asking questions in the context of nutrition

'What are you eating? What are you drinking? Have you made changes in your habits since you got pregnant?'

Ask about other drinks as well as alcohol

'Do you drink coffee? Tea? Cool drinks? Beer? Wine?'

Ask about past use

'Have you ever drunk beer or wine? When was the last time?'

Ask about the alcohol use of a partner or spouse

'Does your husband/boyfriend drink? Do you ever drink with him?'

Ask about a friend's drinking to find out what a woman knows about alcohol's effect

'Do you have any friends who are drinking while they are pregnant? What could you tell them about alcohol and pregnancy?'

ACTIVITY

- *Distribute and discuss the handout with staff of health and other services.*
- *Workshop the questions, or use them in a role play exercise.*
- *Can participants suggest other ways of asking about these things?*

See chapter 7 **Care** pages 196–198 and 206–209

A health worker gives a brief intervention

This is an example of how a health worker can connect a health problem with a drinking problem. The people talking are an Aboriginal man 'Ron' and a health worker.

HW: Hi Ron, what can I do for you?

Ron: ***Oh, I've cut my arm a bit, it needs fixing up***

HW: OK, come and sit down, I'll take a good look at it. When did this happen?

Ron: ***Oh, a couple of days ago maybe, I don't really know***

HW: It looks infected — it shouldn't be like this already. I'll need to clean it up and put on a bandage for you. Hey — are you OK? you don't look good, are you sick anywhere else?

Ron: ***Oh, not really, just a bit sick in the guts maybe***

HW: You got pain in the guts?

Ron: ***Yeah***

HW: Where's the pain? Here lie down up here and show me. Then I can feel your stomach and take a proper look. Does it hurt high up about here? What about down there? Yeah, I can feel your liver a bit here too — does it hurt all the time?

Ron: ***Oh, it's bad in the mornings and it hurts on and off***

HW: I saw you mob all at the gate the other night — good party? How much grog did you have?

Ron: ***Well, I don't know really — I do feel pretty sick after I've been drinking sometimes–but another beer usually fixes me up***

HW: Was that how you cut your arm too?

Ron: ***I don't know — I think so — maybe***

HW: You know mate — this is between you and me, but I reckon you might be sick from the grog. It might be the grog that's giving you a pain in the guts.

Ron: ***Oh, I don't know, I've been drinking on and off for a long time–why is it making me sick now?***

HW: Well, you know your body can only take so much grog. Drink too much of it and it starts to make you sick. From what you say it sounds like it's making the inside of your stomach sick, that's why you've got pain, and that's why you vomit. It's your liver that gets rid of the grog — and I can tell from feeling it that yours is working pretty hard. Means you might be drinking too much. You know, it might be even that the grog's stopping your cut from getting better too. Too much alcohol in the body stops it from getting better.

Ron: ***Well, you fix it all up then OK?***

HW: I can bandage your arm and give you some medicine, but maybe you should start thinking about grog. Look, take this little book with you and have a look. Come and see me in a couple of days so I can have another look at you. And — if you want to — we can talk a bit more. Oh yes, best not to drink while you take that medicine. It'll give it a chance to work and make you feel better more quickly.

Later on...

HW: Ronald came back a few days later and his arm was getting better. He said he hadn't had a drink and I know that there wasn't any grog around anyway. We didn't talk much more about his drinking but he did feel a bit better after a few days without it. I gave him that booklet about drinking to take and look at later. I also said he should come and talk to me any time. So at least maybe he's thinking about it.

WORKSHOP ACTIVITY

- *Use this dialogue as a role play exercise.*
- *Split into smaller groups and have each one create or perform its own example of a brief intervention.*
- *Use it in staff training.*

See chapter 7 **Care** pages 198–203

What to say in a brief motivational interview

This is an example of a longer discussion between a health professional and an Aboriginal man 'Bill'

AHW You say you have been drinking for a long time, Bill. What do you like about drinking?

Bill ***I like the taste, and when I'm with my friends we have a good time drinking together. It makes me feel good.***

AHW What do you mean when you say it feels good?

Bill ***Well— more confident, talking and laughing.***

AHW Is there anything you don't like about drinking?

Bill ***It makes me feel sick sometimes, the next day you know. Hangover. Sometimes I've got no money left and my family gets mad.***

AHW So, Bill, what you're saying is, you like drinking because it makes you feel confident and you can join in talking and laughing, but on the other hand, you don't like drinking because it makes you feel sick and gives you a hangover. And it causes trouble with your family because you spend the money on grog. Is that right?

Bill ***Yeah, that's right.***

HW Does your family get upset with you for any other reason when you're drinking?

Bill ***What do you mean?***

AHW Well, tell me what you're like if you've been drinking too much.

Bill ***Sometimes I fight with them, shout at them. My kids, they get frightened.***

AHW Does that worry you?

Bill ***Well — yeah. I don't like my kids to be scared of me.***

AHW So, what are you like when you're not drinking?

Bill ***They're not scared then — I look after my family. We have good times, do things together, you know?***

AHW So, when you're drinking you get angry with them and fight, but when you're not drinking you have good times together. Is that right?

Bill ***Suppose so.***

AHW Which person would you like to be?

Bill ***I'd like to be happy with my family — but I like a drink too — guess it's hard to be both, hey?***

AHW What do you think you want to do about that?

Bill ***Maybe I should stop drinking.***

AHW What would be a good thing about that, if you stop drinking?

Bill ***My family would be happy with me. And I wouldn't feel sick.***

AHW What would be hard about giving up the drinking?

Bill ***I'd lose my friends, they're good friends you know. We've been drinking together for a long time.***

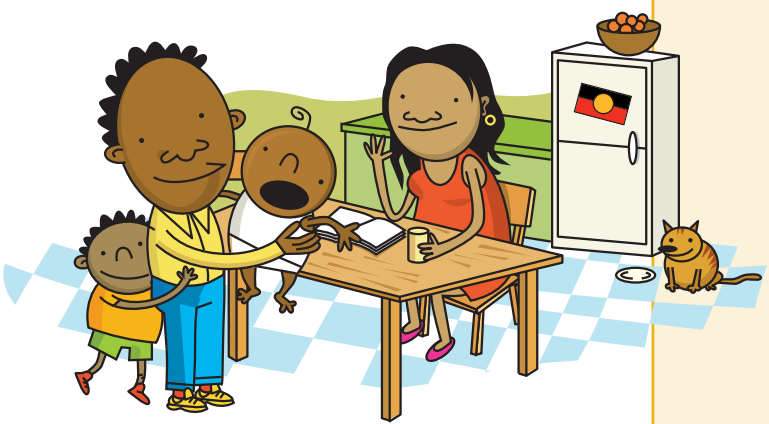
AHW So, what would you like to do?

Bill ***I need to think about it. I can see it's best for me to stop the drinking, but it's not that easy, you know?***

AHW I'm here to help you if you decide to stop or ease up. Or if you want to talk to me some more about this — or talk to someone else — here is some information about alcohol you might find useful, Bill, and some phone numbers...

WORKSHOP ACTIVITY

- *How is this discussion different from the one in the previous handout?*
- *How does the health worker help Bill to move from not thinking about change to thinking about change?*
- *Use this and the previous handout in role play exercises.*



See chapter 7 **Care** pages 206–207

Terms and phrases often misunderstood

Abstinence

When people decide not to use a substance at all.
People who abstain usually do not intend to use the drug again.

Addiction

- A strong desire to use a substance, so that the person cannot think about anything else, and finds it difficult to control the behaviour.
- He or she is uncomfortable or distressed when he/she cannot drink or stops drinking, and keeps using alcohol even when it is causing problems.

Alcoholism/alcoholic

Often used to describe someone with the 'disease of alcoholism' (common within the AA approach). A long term pattern of heavy drinking; someone who is dependent on alcohol, and whose life is taken over by drinking.

Binge drinking

Drinking alcohol quickly over a few hours until intoxicated and/or heavy and continuous drinking over days or weeks.

Blood alcohol level (BAL), blood alcohol concentration (BAC)

The amount of pure alcohol in the blood after drinking alcoholic drinks. The BAL is affected by how much is drunk, how strong the alcohol is, the weight and sex of the person, and whether they have had anything to eat. It is what the police test when you blow into a breathalyser.

Brief intervention

An intervention (talking, counselling) that takes very little time. It can take just a few minutes, or up to an hour, and involves a health worker asking about risky drinking and giving advice or information.

Comorbidity

When a person has two or more problems or disorders, like alcohol use problems *and* mental health problems.

Detox/detoxification

Coming off a substance, usually with medical supervision.
A process of reducing risks when an individual withdraws from any drug.

DTs, delirium tremens

A stage of withdrawal from heavy alcohol use when a person has serious symptoms such as the shakes ('grog shake'). The DT's can be life threatening and a person should have medical help.

Intervention

This means seeing that there is a problem (in a person or a community) and doing something about it. It is part of the daily work of service providers and frontline workers in health and welfare.

Metabolise

This describes a biological process in the body, when it digests and breaks down food and drinks inside. The body pulls out and uses the nutrition from what a person eats and drinks, and gets rid of the waste. The liver does this job with alcohol.

Recreational or social use

Using alcohol (or other drugs) on a casual basis as part of social life and to increase enjoyment of life.

Rehab/rehabilitation

Residential or day programs, to help people to change their drinking behaviour, that do client assessment, counselling, relapse prevention and after–care.

Tolerance

When the person's body gets used to having alcohol in the bloodstream.
When someone drinks regularly over a long period, this happens.
The person has to drink more in order to get the same effect.

Withdrawal

Describes a group of signs and symptoms that happen when a regular heavy drinker stops drinking. Symptoms can be mild or serious.

Key resources for your library

Alcohol Resources (free) from the Australian Government Department of Health and Ageing including several Indigenous–specific resources (eg *Giving Away the Grog. Aboriginal accounts of drinking and not drinking* by Maggie Brady). Available from health@national.mailing.com.au or www.alcohol.gov.au

Alcohol Treatment Guidelines for Indigenous Australians
www.alcohol.gov.au

Alcohol and other Drugs Council of Australia (ADCA) is a National Resource Centre on alcohol and other drugs.
Staff will send out copies of articles and loan books.
Email resource.centre@adca.org.au
www.adca.org.au

Australian Drug Information Network and Drug Information Clearinghouse
www.adin.com.au
www.druginfo.adf.org.au

Australian Indigenous Health InfoNet
www.healthinfonet.ecu.edu.au

National Drug Research Institute at Curtin University has an *Indigenous Australian Alcohol and other Drugs*
www.db.ndri.curtin.edu.au/index.php

Alcohol handbook for frontline workers, Compiled by Alison Laycock, 2004.
Department of Rural Health
Order from Phone 08 8080 1210
www.arh.med.usyd.edu.au/library/index.php

Brief Intervention Strategies for Aboriginal and Torres Strait Islander People (video) Training Health & Educational Media Pty Ltd Phone 03 5433 3854
Email front_desk@themedia.com.au

The Public Health Bush Book. A resource for working in community settings in the Northern Territory Department of Health and Community Services 2002.www.nt.gov.au/health/healthdev/health_promotion/bushbook/bushbook_toc.shtml

World Health Organisation publications
www.who.int/publications/en/

Sources for handouts

Is the community ready for action?

Adapted from *Alcohol Community Development Project: Review 1998–2004* by Carol D Watson with Kate Gooden, 2004. Population Health Unit, Far West Area Health Service, Broken Hill.

How to collect stories about giving away the grog.

Based on *Giving Away the Grog. Aboriginal accounts of drinking and not drinking* compiled by Maggie Brady (2004, 2011 reprint). Available from nmm@nationalmailing.com.au or www.alcohol.gov.au

Evaluating health education resources.

Excerpt from *The Public Health Bush Book*, Department of Health and Community Services, Darwin, 2002.

How to make a success of a local action strategy aimed at restrictions.

This information came from Dr Fiona Nichols, WA, and is in *The Grog Book* (1998:165).

FAS: Talking with women about their drinking.

This information derives from the work of Dona Tversky in Stellenbosch, South Africa, cited in Maggie Brady and Kirstie Rendall-Mkosi (2005) *Tacking Alcohol Problems. Strengthening Community Action in South Africa*. University of the Western Cape, Cape Town.

A health worker gives a brief intervention.

Thanks to the *Living with Alcohol Program*, NT for this text.

What to say in a brief motivational interview.

Extracted from *Alcohol Handbook for Frontline Workers* by Alison Laycock (2004) Broken Hill University Department of Rural Health.

Practical tips to drink more sensibly.

Compiled from different sources including *Yarranma*, and *The Grog Book* (1998).

Index

H refers to a Handout eg H244

Last words

No single idea discussed in this book will work on its own.

No single idea here will solve problems overnight, or even at all. These are not 'quick fix' ideas. They are long term strategies. If these strategies work, you are helping your mob live longer.

This book has been about how people have taken control and put their ideas into action. It has given you examples of how to strengthen the grass roots community spirit, in the hope that you too can build on these experiences.

the grog book

Feedback form

Available from health@nationalmailing.com.au or www.alcohol.gov.au

Let us know what you think of the *Grog Book (Revised edition)*. Maggie Brady (the author) and Mouli MacKenzie (the materials developer) would really like to have your comments.

Your name

Your address

Your occupation

Your work contact details

Please tell us what you think of the revised *Grog Book* (Design? Ease of use? Contents? Case studies? Ideas?)

What do you like best about the book?

What do you like least about the book?

Please tell us how and where you will use (or have used) the book?

What information that you need is missing from this edition?

Which sections were of most use to you?

Please give an example of how the book has influenced you/your organisation/community? Has it made a difference?

How might you use an interactive web-based version of this resource?

Anything else you would like to tell us?

Send your feedback form to:

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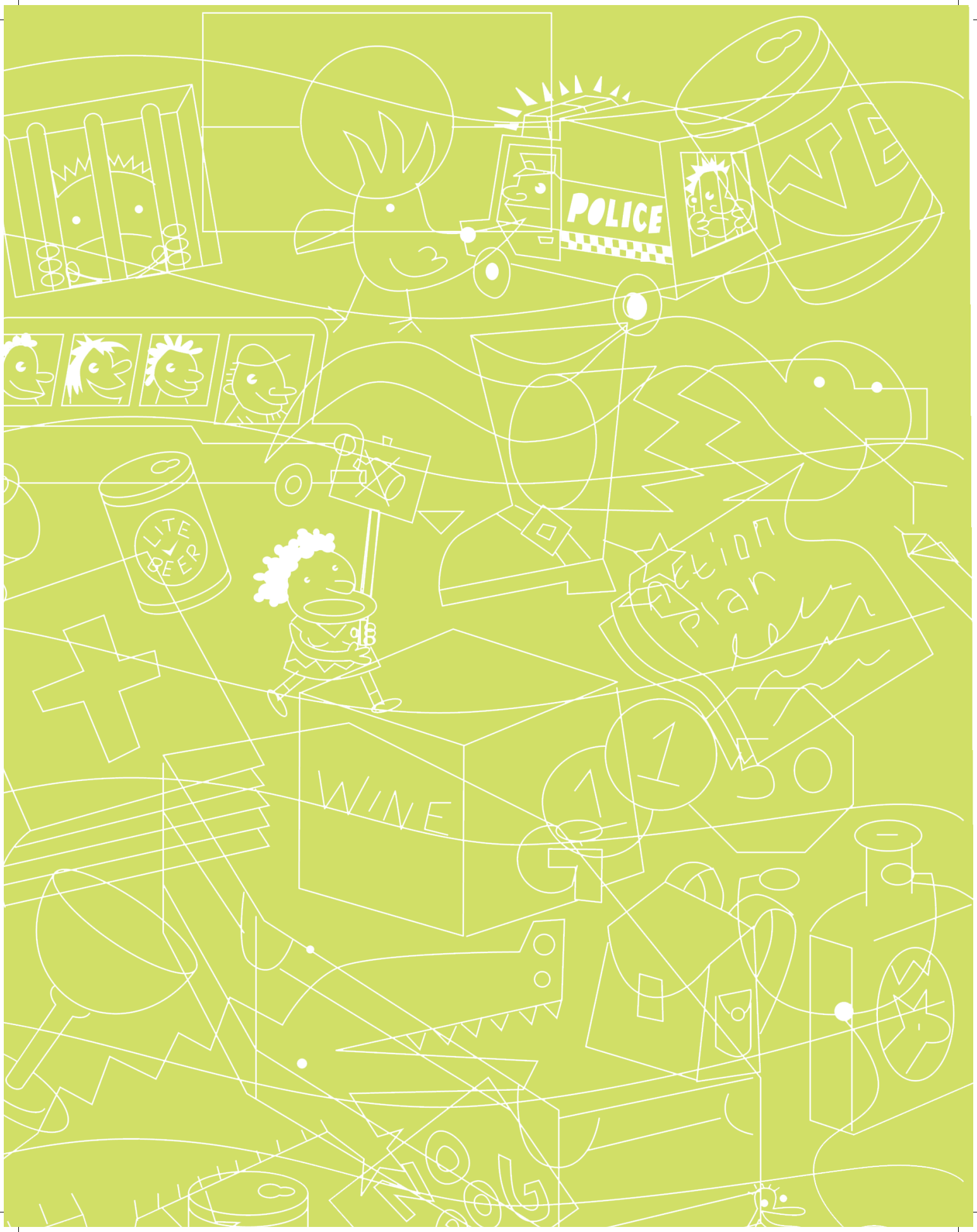
POLICE
LITE BEER
WINE

This revised edition of *The Grog Book* contains updated information and new case studies. The aim of this book is to let Aboriginal and Torres Strait Islander peoples know about ideas and strategies for managing alcohol consumption and problems from many different parts of the country. It is designed for all those who are able to encourage and mobilise community-based action, for frontline workers in health or alcohol and other drugs, and others such as police, prison and justice services, liquor licensing boards, schools and tertiary institutions. There are chapters on the history and economics of alcohol; the health effects of alcohol; how to stimulate, plan and evaluate action in Indigenous communities; ideas on prevention; strategies and case studies on controlling drinking places, restricting supplies of alcohol and managing drinking trouble; guidance for service providers, relations and friends who give care and advice; and a useful set of handouts for use in workshops or study courses.

'Like its predecessor, this new, updated edition is a book of "best practice" ideas that are illustrated and brought to life by grassroots examples and case studies. They have been contributed by Aboriginal and Torres Strait Islander groups and individuals, as well as other health professionals around Australia.' Sir William Deane

'I use [The Grog Book] as a teaching model on how to design and illustrate self-help health info. It is brilliantly adapted to the local culture in a way that draws in even the marginally literate. Excellent!'
David Werner, Author of *Where There Is No Doctor*

'I think the examples of what other communities have been doing are most useful. Acknowledging the communities is empowering for them and you can follow up with them if you want to.'
Coordinator, Community Drug Action Team

'I'm really looking forward to seeing the new edition of The Grog Book – the first edition has been a bit like a bible for me over the past five years.'
Linnell Barelli, Project Officer, Mindmatters

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