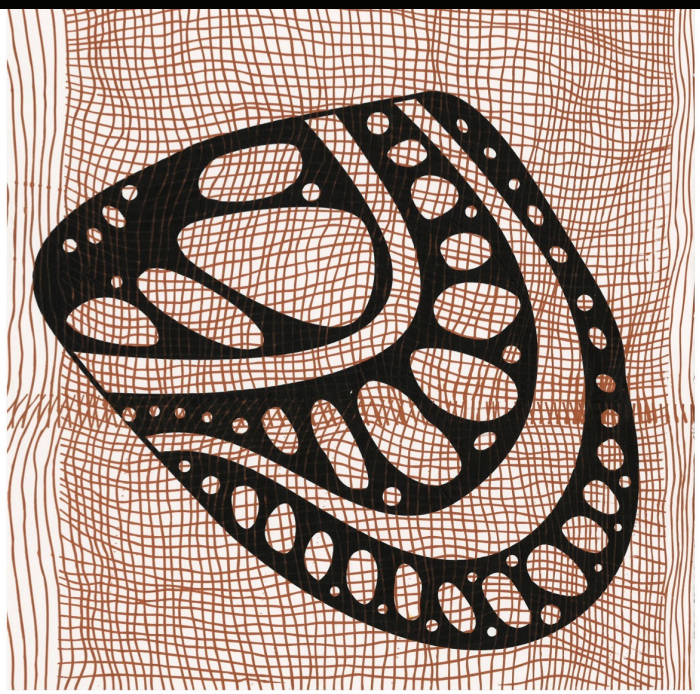
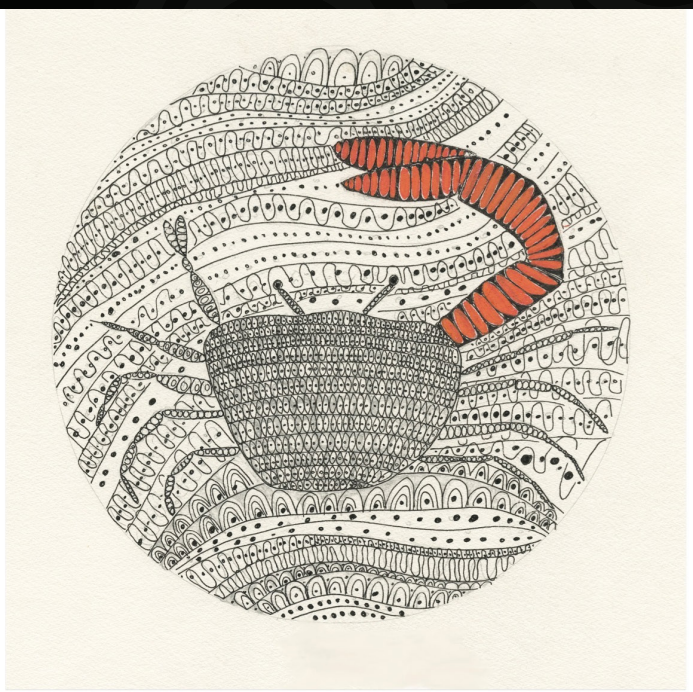
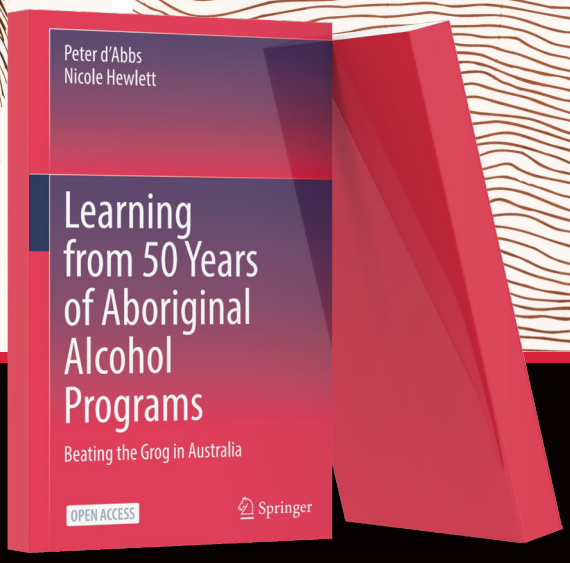
Australian Indigenous HealthInfoNet

Learning from 50 years of Aboriginal alcohol programs: a summary







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AUSTRALIA ECU EDITH COWAN UNIVERSITY

Australian Indigenous Health*InfoNet*

The mandate of the Australian Indigenous Health*InfoNet* (Health*InfoNet)* is to contribute to improvements in Aboriginal and Torres Strait Islander health by making relevant, high quality knowledge and information easily accessible to policy makers, health service providers, program managers, clinicians and other health professionals (including Aboriginal and Torres Strait Islander Health Workers and Health Practitioners) and researchers. The Health*InfoNet* also provides easy-to-read and summarised material for students and the general community.

The Health*InfoNet* achieves its commitment by undertaking research into various aspects of Aboriginal and Torres Strait Islander health and disseminating the results (and other relevant knowledge and information) mainly via Health*InfoNet* websites (https://healthinfonet.ecu.edu.au), the Alcohol and Other Drugs Knowledge Centre (https://aodknowledgecentre.ecu.edu.au), Tackling Indigenous Smoking (https://tacklingsmoking.org.au) and WellMob (https://wellmob.org.au). The research involves analysis and synthesis of data and other information obtained from academic, professional, government and other sources. The Health*InfoNet*'s work in knowledge exchange aims to facilitate the transfer of pure and applied research into policy and practice to address the needs of a wide range of users.

Recognition statement

The Health*InfoNet* recognises and acknowledges the sovereignty of Aboriginal and Torres Strait Islander people as the original custodians of the country. Aboriginal and Torres Strait Islander cultures are persistent and enduring, continuing unbroken from the past to the present, characterised by resilience and a strong sense of purpose and identity despite the undeniably negative impacts of colonisation and dispossession. Aboriginal and Torres Strait Islander people throughout the country represent a diverse range of people, communities, and groups, each with unique identities, cultural practices and spiritualities. We recognise that the current health status of Aboriginal and Torres Strait Islander people has been significantly impacted by past and present practices and policies.

We acknowledge and pay our deepest respects to Elders past, present and emerging throughout the country. In particular, we pay our respects to the Whadjuk Noongar peoples of Western Australia on whose Country our offices are located.

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Learning from 50 years of Aboriginal alcohol programs: a summary

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Further information

This summary is part of a resource package that includes a factsheet and video. These resources can be viewed at: aodknowledgecentre.ecu.edu.au/about/knowledge-exchange-products/

Artwork

Delvene Cockatoo-Collins

The art used on the front cover of this summary is by Delvene Cockatoo-Collins, a First Nations Quandamooka artist and designer who lives on Minjerribah (North Stradbroke Island, Queensland). Her work embodies a deep connection to Country, and shares in the stories, culture and techniques developed over thousands of years and passed down from generation to generation.

Featured icon artwork

by Frances Belle Parker

The Health*InfoNet* commissioned Frances Parker, a proud Yaegl woman, mother and artist, to produce a suite of illustrated icons for use in our knowledge exchange products. Frances translates biomedical and statistically based information into culturally sensitive visual representations, to provide support to the Aboriginal and Torres Strait Islander workforce and those participating in research and working with Aboriginal and Torres Strait Islander people and their communities.

Terminology

The term 'Aboriginal' in this summary refers to Aboriginal peoples in Australian communities and organisations unless it is clear from the context that Torres Strait Islander peoples are also covered by the meaning, in which case the term 'Aboriginal and Torres Strait Islander' is used. The term 'Indigenous' is generally not used unless it is used in the referred sources.

Contents

Introduction

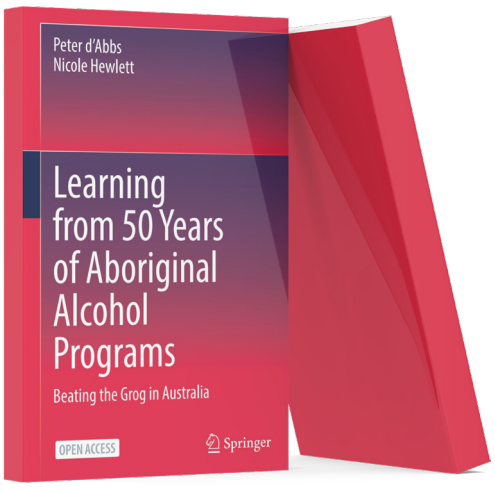
This publication is a summary of key messages from the book *Learning from 50 years of Aboriginal alcohol programs: beating the grog in Australia* by Peter d'Abbs and Nicole Hewlett [1]. The book provides a comprehensive overview of the many actions and measures taken over the last 50 years to prevent and reduce alcohol harms among Aboriginal peoples with a focus on actions led by Aboriginal communities. It provides a historical context for those actions and outlines successful initiatives as well as the lessons learned when approaches have not worked as intended. Notably, the book includes historical research into the harms from alcohol use and programs that have been developed to address these harms. This research should be understood in the context of the time in which it was produced, noting ongoing changes and innovations to community-informed and Aboriginal-led research. It should also be noted that some of the programs discussed in the book have not been formally evaluated. Nonetheless, the programs highlight potential principles of practice which could guide future work.

The need for a more robust evidence-base for reducing harmful alcohol and other drug (AOD) use has been identified previously [2, 3] . In the past, many programs have not been evaluated at all, or evaluated using methods that do not acknowledge Aboriginal priorities or privilege Aboriginal voices. Good quality data is notable by its absence. Nonetheless, the accounts that have been written, often in the form of 'grey' literature such as government reports that are largely inaccessible today, contain insights and observations that are valuable and relevant to those addressing similar issues today.

The aim of this publication is to provide an accessible synthesis of information and research outlined in the book and broadly summarise past efforts to inform future policy and practice focused on preventing and reducing harms from alcohol use. This summary and the accompanying video and factsheet highlight key information and invite deeper investigation of the evidence-base which is described in more detail in the book, *Learning from 50 years of Aboriginal alcohol programs: beating the grog in Australia.*

Methodology

The Health*InfoNet* routinely creates reviews and summaries of Aboriginal and Torres Strait Islander health research including information on AOD. The book, *Learning from 50 years of Aboriginal alcohol programs: beating the grog in Australia* was selected for publication as a summary given the breadth of knowledge contained about approaches in Aboriginal alcohol programs which have taken place in various communities across Australia over many decades. This summary highlights key parts of the book and was developed alongside the book's authors. The summary contains direct content reproduced from the book as well as key messages from each chapter, abbreviated by the Health*InfoNet* team, which can be found at the end of each section. Dot points and practice information that is directly relevant to the workforce are also included. This is a timely resource for community members, practitioners, educators and policy makers wishing to learn more about the types of programs that have been implemented in Aboriginal communities and the outcomes of these programs..



Explaining Aboriginal alcohol use: changing perspectives, hidden assumptions

Since the arrival of European colonisers, different frameworks have been used to interpret and explain harmful alcohol use by Aboriginal peoples. Most of these frameworks were put forward by non-Aboriginal peoples. The frameworks in turn have shaped policies and programs.

Frameworks include:

- A belief that there are biological differences between Aboriginal peoples and non-Aboriginal peoples in the way they metabolise alcohol.
  - There is no evidence to support this belief. Though prominent throughout the period when Aboriginal peoples were legally prohibited from possessing or consuming alcohol, this framework is no longer given credence [4-6].
- Alcoholism is viewed as a disease, as a result of which some people are unable to control their drinking [7, 8].
  - The Twelve Step and Alcoholics Anonymous (AA) models are based on this explanation and this model has been adapted by many Australian Aboriginal treatment providers. Under the current International Classification of Disease (ICD-11), alcohol dependence is one of three categories of alcohol use that are recognised, the other two being hazardous and harmful use [9].
- Psychological and social explanations for alcohol use.
  - Alcohol use is seen as a response to stress rather than an underlying disorder; drinking is seen as offering relief from personal distress as well as membership in a group [10, 11].
- Sociological and anthropological explanations for alcohol use.
  - From this perspective patterns of alcohol use are explained as an outcome of the interaction of historical, social, cultural and political contexts in which drinking occurs. These include the internal dynamics of drinking groups, inter-cultural relations in regional towns and social forces such as the legacy of colonisation and dispossession. These conceptualise drinking not as individual pathology but as a collective response to circumstances over which people have little control. While colonisation is conventionally portrayed as a historical event that began with the European invasion of Australia and ended with the cessation of frontier violence, an alternative view of colonisation sees it as an enduring structure that began with the appropriation of land and continues with processes of protection and assimilation [12]. The implication of this perspective is that programs targeting Aboriginal health and wellbeing today continue within this structure [13-15].

- Critiques of structural explanations.
  - Some Aboriginal leaders have argued that while colonisation provided conditions that enabled harmful alcohol use, alcohol itself is a primary cause of addiction. Langton et al [16, 17] identified four factors that interact with each other:
    - alcohol is a powerful addictive substance
    - Aboriginal societies did not have the social rules and cultural controls needed to manage alcohol effectively at a community level
    - the ready availability of alcohol in the Northern Territory (NT) catered to a heavy drinking culture and gave priority to commercial interest rather than community wellbeing
    - the introduction of drinking rights corresponded with the collapse of Aboriginal employment in the pastoral industry.

Pearson [18, 19] has argued that once excessive alcohol use becomes widespread and culturally normalised it takes on the characteristics of a psychosocial epidemic:

> *… the symptom theory of substance abuse is wrong. Addiction is a condition in its own right, not a symptom. Substance abuse is a psycho-socially contagious epidemic and not a simple indicator or function of the level of social and personal problems in a community [19, p.10].*

- Alcohol use as a public health problem.
  - This approach shifts the focus from treating the individual drinker to addressing alcohol-related harms at a population level (e.g. health effects, injuries and being absent from the workplace). As such, public health interventions are aimed at reducing harms by controlling the availability of alcohol (e.g. by price restrictions on trading) as well as reducing demand through education and health promotion [20].

Living with Alcohol Program

The most comprehensive example to date of a public-health based alcohol policy in Australia was the Living with Alcohol Program (LWAP), introduced by the NT Government as a ten-year program between 1992 and 2001. The objective was to reduce alcohol consumption and related harms for the total population in the NT to the national level. The strategy was based on a three-pronged approach: education, increased controls on availability of alcohol and expanded treatment and rehabilitation services. A new levy on alcohol and licence fees helped to fund the new policy. Independent evaluations indicated that it brought about significant reductions in alcohol-related harms, including a decrease in alcohol-caused deaths and a decrease in road crash injuries [21, 22].

- Alcohol and the social determinants of health.
  - This perspective draws on both the sociological and public health approaches [23-25]. In this model key factors influencing health are the social conditions in which people live. It is based on the observation that better health outcomes correlate with higher socio-economic status. The factors involved include stress, early childhood experiences, social exclusion, working conditions, social support, addiction, food quality and transport. It follows from this perspective that we cannot expect significant gains from improved alcohol treatment services as long as the major social determinants of poor health remain unaddressed.
- Alcohol use as a result of intergenerational trauma.
  - This approach explains harmful alcohol use as a product of unresolved collective and personal intergenerational trauma requiring healing. In this perspective Western models that locate the problems and solutions within the individual user are seen as inadequate [26]. Healing must be grounded in an Aboriginal understanding of health and wellbeing, one that is about relationships with family and community, with nature, and with ancestors. Healing is a process or journey to reconnect and restore the social, emotional and spiritual relationships that have been damaged through colonisation and its aftermath [27].

Key messages

Each of the frameworks described above offers an approach for defining and explaining various types of drinking by some Aboriginal peoples which influences how alcohol use is interpreted. This is important because the way alcohol use is thought about shapes how harmful alcohol use is addressed. These frameworks are not necessarily mutually exclusive, and some approaches combine aspects of different frameworks.

Prevention and early intervention

Prevention and early intervention are measures aimed at reducing the demand for AOD.

Demand reduction measures are usually categorised as:

- Primary prevention – preventing or delaying uptake of harmful alcohol use among healthy individuals, for example, through education and health promotion and providing alternatives to AOD use.
- Secondary prevention, also called early intervention – preventing the onset or continuation of harmful alcohol use among people who are already drinking or at risk of harmful use.
- Tertiary prevention, or treatment and rehabilitation – facilitating recovery from harmful use and/or alcohol dependence and preventing relapse.

Historically, prevention programs for Aboriginal peoples have tended to concentrate on primary prevention, mostly in the form of media campaigns and health promotion initiatives, and tertiary prevention in the form of residential treatment programs [28]. Secondary prevention was neglected for a long time, but more recent developments have attempted to address this gap.

Primary prevention

Primary prevention programs aim to educate people about the harms of AOD use, raise awareness, build resilience and/or enhance community capacity to prevent AOD problems.

The evidence for what works in primary prevention to address harmful alcohol use in Aboriginal communities is limited. Few primary prevention programs have been rigorously evaluated, and even fewer have demonstrated significant outcomes. However, some common elements for programs that have shown promising results have been identified [29-31].

These include:

- incorporating cultural activities
- ongoing rather than one-off initiatives
- programs that are developed with communities
- having more than one approach, such as education, recreational activities and supply control.

An international review identified four common components of beneficial programs to reduce substance use [32] :

- a high level of community involvement in developing the program
- cultural knowledge enhancement through activities such as ceremonies, storytelling and learning about traditional practices
- skills development such as problem solving, resistance strategies and interpersonal skills
- substance use education.

Principles of good practice in community-based prevention identified for American Indian communities are also relevant to communities in Australia [33]. These are outlined below.

Implementing community-based prevention: some guiding principles

- Define where your community is regarding knowledge, attitudes and opinions on alcohol policy and its readiness to work for change and improvement. A survey would be of tremendous value here.
- Develop generalisations that are held by the majority and around which a consensus can be formed.
- Based on the specific areas of consensus, select specific topics, policy options or techniques that can be pursued and accomplished through study, debate and work plans.
- Keep community-specific data and records on:
  - baseline indicators of mortality, morbidity (sickness and injury), public opinion and arrests related to alcohol
  - the process of intervention on problems
  - the outcome (both intermediate and final), or outcomes of positive action taken.
- Form explicit and positive ties between all stakeholders in the community who play a role in the problem. This includes the legal community, law enforcement, the media, business, government, schools, churches, service groups, families and others.
- Emphasise positive programs in the media to keep the public informed and invested.
- Fine-tune the programs and policies from time to time.
- Be creative. Public policy is not a science and cannot be completely fine-tuned so that it can be totally science directed. Seek new approaches that increase the *probability* of improvement; new, creative policies can be assessed retrospectively as to their effectiveness. Some detailed literature on local programs might be helpful.

Some pitfalls to avoid

- Deficit based approaches that blame and shame one type of individual or group. Alcohol harm is across all layers of Australian society and therefore, everyone's business.
- Championing one particular therapy, approach or ideology over other possible options.
- Looking for single case, one-size-fits-all magic bullet approaches.
- Polar arguments such as 'us versus them'.
- Being coercive with large segments of the non-drinking or light drinking population by enacting a policy that is radically different from the views of mainstream citizens.
- Focusing narrowly on the treatment of people with alcohol dependence.
- Expecting immediate success.
- Expecting someone else (people or agencies outside of the community) to provide solutions for the impacted community.

Source: adapted from May (1992) [33].

One example of a community-based initiative in the NT that implemented strategic partnerships with clearly defined objectives to reduce alcohol-related harm was a program led by Health Promotion Officers Gwen Walley and Darrin Trindall in the small town of Elliott [34]. In collaboration with the local Gurungu Council, they encouraged community members to voice their concerns and consider possible solutions. They helped the community to conduct a survey to determine support for strategies to limit alcohol use and reduce exposure to alcohol use among children.

Once these strategies were identified and had majority community support, the community negotiated with the Liquor Commission to formally adopt the strategies. The study found that strengthening community action gave people the confidence to further address AOD issues in the future.

In some instances the most effective action may be taken in the everyday routines and settings in communities [35]. Rather than focusing on an entire population, informal social contexts such as community-based night patrols, targeted health promotion messages aimed at young people, locally run drop-in centres and mentor programs for young people can be effective avenues for influencing behaviour and preventing harmful alcohol use.

Secondary prevention/early intervention

Secondary prevention or early intervention involves measures aimed at people who have begun to engage in harmful alcohol use, or are considered at risk of doing so, but who are not at a stage requiring intensive treatment or rehabilitation. The settings best suited to early intervention are hospitals, and even more so, primary healthcare centres, where health practitioners are more likely to become aware of possible harmful drinking and the opportunity to discuss this with patients [36].

Routine screening (including a series of questions to identify risky alcohol use when seeing clients as part of a regular health consultation) for harmful alcohol use in primary healthcare settings as part of early intervention has not always been given priority due to the immediate demands generated by serious health problems [37]. However routine screening has been shown to be an effective and credible tool for secondary prevention [38].

The most widely used screening instrument is the Alcohol Use Disorders Identification Test (AUDIT) [39]. In June 2017, the Australian Government introduced a requirement that all Aboriginal Community Controlled Health Services (ACCHSs) in receipt of Australian Government funding must screen patients for alcohol use, using a shortened version of AUDIT [40, 41].

Two barriers to screening have been identified. The first is the episodic pattern of drinking by some Aboriginal peoples, particularly those living in remote areas, making it difficult to identify a typical drinking pattern. Secondly, estimating the amount of alcohol consumed by an individual, and converting that into standard drinks, can be difficult where drinking is a group activity.

Brief intervention

Brief intervention or advice, is an early intervention measure that typically includes some, or all of the following:

- simple advice about drinking safely
- more personalised advice based on a presenting problem or screening result
- referral to a specialist alcohol or other service
- initiating a brief motivational interview
- discussing relevant, practical ways to reduce or cease drinking alcohol[38].

Brief advice from a range of health practitioners has been found to be beneficial in reducing heavy drinking. There is little evidence that longer, more sophisticated advice is better than shorter advice [42]. The benefit from brief advice appears to come from the interaction between provider and patient.[1]

Brief advice in primary healthcare on alcohol use is commonly 5–10 minutes in duration and can be guided by using the 'FRAMES' principles and the 'Five A's' [43, 44].

Brief advice in primary healthcare

FRAMES is an acronym summarising the key components of brief advice:

- **F**eedback (on the client's risk of having alcohol problems)
- **R**esponsibility (change is the client's responsibility)
- **A**dvice (provision of clear advice when requested)
- **M**enu (what are the options for change?)
- **E**mpathy (an approach that is warm, reflective and understanding)
- **S**elf-efficacy (optimism about the behaviour change).

The five As are:

- **A**ssess alcohol consumption with a brief screening tool, followed by clinical assessment as needed
- **A**dvise patients to reduce alcohol consumption to lower levels
- **A**gree on individual goals for reducing alcohol use or abstinence (if indicated)
- **A**ssist patients in acquiring the motivations, self-help skills or support needed for behaviour change
- **A**rrange follow-up support and repeated counselling, including the referral of dependent drinkers to specialty treatment.

Source: Anderson et al (2017) [43].

1 For more detailed guidelines for early intervention in Aboriginal primary healthcare settings, see *Lee et al's Handbook for Aboriginal alcohol and drug work* (Lee et al, 2012, pp. 76-88). The book is available as a free pdf download from Australian Indigenous HealthInfoNet Alcohol and other Drugs Knowledge Centre .

Motivational interviewing

Another approach widely used in early interventions for risky alcohol use is motivational interviewing, a form of counselling that supports behaviour change by helping clients explore and resolve both the benefits and the costs of substance use [45]. Motivational interviewing works by identifying and enhancing the clients' own motivations to change their behaviour. It has been used to develop a range of publicly available resources for both primary care and specialist health practitioners [46]. These include a brief assessment form for AOD interventions [47] and the AIMhi Stay Strong app [48], which offers a structured wellbeing intervention for use by therapists in delivering an evidence-based culturally appropriate support to Aboriginal clients. The resources are available through the Menzies School of Health Research website (www.menzies.edu.au).

Implementing early interventions in Aboriginal settings: challenges

Despite the strong evidence for the benefits of using early and brief interventions there are challenges to implementing these approaches in both Aboriginal and other primary healthcare settings [43, 49, 50].

These challenges include:

- competing demands on health practitioners' time
- lack of confidence to incorporate early and brief interventions
- lack of financial incentive.

In Aboriginal primary healthcare additional challenges are :

- extended direct questioning as required by the AUDIT screening tool has been found to be culturally inappropriate in some settings [51, 52]
- a lack of referral options if harmful alcohol use is identified [53]
- a perception by health workers that routine screening and brief intervention would undermine rapport with the client [53].

Efforts to embed early and brief intervention into routine primary healthcare continue, with work being done on identifying and overcoming the challenges of incorporating these tools into healthcare settings.

Key messages

The evidence-base for effectiveness of primary prevention programs to address alcohol-related harms is sparse. Despite this, there are common components that can be identified in successful community prevention programs, including community leadership, strategic partnerships, clearly defined objectives, collation of data, and identified pathways to achieving objectives .

Secondary prevention or early intervention such as screening and brief intervention in primary healthcare and hospital settings are effective tools for helping to prevent harmful alcohol use. However, evidence also indicates that in both Aboriginal primary health and other clinical settings, the use of screening and brief intervention faces several barriers.

Treatment and rehabilitation

Treatment and rehabilitation programs (also called tertiary prevention) aim to facilitate recovery from harmful alcohol use and/or dependence, and to prevent relapse. Traditionally, most treatment and rehabilitation programs for Aboriginal peoples have involved residential treatment using the Twelve Step approach and mutual support principles of AA.

Twelve step-based residential treatment

The first residential alcohol treatment program established for and by Aboriginal peoples in Australia was Benelong's Haven, a facility set up in Sydney in 1974 by Gumbaynggirr woman, Val Bryant [54].

The Haven's approach was underpinned by the belief that alcohol dependence was a product of an inability to control one's drinking resulting from a disease, rather than moral weakness. The spirituality and group orientation of the Twelve Step model and AA were adapted and interwoven into the Haven recovery program to include Aboriginal priorities for culture, spirituality and self-determination [54].

Benelong's Haven became an example for other Aboriginal residential treatment programs to follow, such as Moree Aboriginal Sobriety House (MASH) in New South Wales (NSW), the Foundation of Rehabilitation for Aborigines with Alcohol-Related Difficulties (FORWAARD) in Darwin, and Namatjira Haven in Lismore, NSW [55].

Another example of one of the earliest residential programs was Milliya Rumurra, established in Broome, in the Kimberley region of Western Australia (WA). Milliya Rumurra, meaning *First day* or *Brand new day,* offered a structured three-month residential holistic program that accommodated families and provided AA, medical talks, nutrition talks, financial budgeting, arts and crafts and women's groups [56]. In later years, Milliya Rumurra shifted away from relying on the disease concept of alcohol dependence to a harm-minimisation approach that incorporated controlled, moderate drinking as a treatment option alongside abstinence [57].

Alcoholism as a family disease

All the residential treatment programs mentioned above shared a common focus on the individual drinker as the subject of treatment and rehabilitation. A view emerged during the 1970s–80s among those working to address alcohol use that a wider focus than the individual was needed.

Harold Hunt, an alcohol counsellor with the Health Commission of NSW and chairman of the National Aboriginal Campaign against Alcohol and Drug Abuse at that time, put forward a model that sought to address alcohol use at an individual, family and community level [58]. He described alcoholism as a family disease that needed to be acknowledged by a policy framework that included the conditions that led to harmful alcohol use [59]. However, like many Aboriginal people concerned with issues around alcohol, Hunt saw AA as being particularly suited to addressing harmful alcohol use among Aboriginal families as it was seen to be based on collective spirituality.

Broadening the model to other addictive substances, organisations such as the Alcohol Awareness Sobriety Centre (the Sobriety Centre) based in Darwin offered treatment based on a family disease model of substance use [60, 61]. In 1987, the Sobriety Centre, now renamed Alcohol Awareness and Family Recovery (AAFR), opened a residential treatment program for families at Wulk Witby, 200 km southwest of Darwin and close to the Aboriginal community of Daly River (today known as Nauiyu). The program had a four-week intensive course, with separate courses for drinkers (categorised as dependents) and the partners of drinkers (categorised as codependent) [60].[2]

Criticism of the disease concept and Twelve Step programs

The concept of harmful alcohol use as being a disease of 'alcoholism' has been questioned for some time. Some risky drinkers become physiologically dependent and have difficulty regulating their alcohol consumption. However not all those who drink alcohol at harmful levels suffer from acute withdrawal symptoms when they stop [62, 63].

The disease concept of alcoholism and the associated Twelve Step programs, which assume that abstinence is the only strategy for recovery, have been criticised for a lack of treatment options [37, 64]. A review of Aboriginal AOD programs by Brady in 2001 noted the narrow range of treatment options offered by Aboriginal residential treatment programs, the majority of which were based on the Twelve Step disease model of treatment [55]. Brady identified this and a number of other issues in residential AOD treatment and made specific recommendations summarised below.

2 A codependent according to this perspective is meeting their own psychological needs by facilitating the self-destructive behaviour of the dependent person, for example, by shielding them from the full consequences of their actions.

Elements of a successful Indigenous residential treatment program

Governance:

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

Training and networking:

- skills training for counsellors to increase their confidence and efficacy
- ongoing, in-service training, staff exchanges and placements with larger organisations
- staff mentored by outside professionals
- close involvement with a local doctor to provide assessment before, during and after admission, supervision of detoxification, pharmacotherapy, assistance with care plans and advice to clients
- formal and informal partnerships with local public health professionals and state AOD services
- membership of and participation in relevant regional AOD non-government organisation (NGO) networks and Therapeutic Community (TC) associations.

Program content:

- a safe drug/alcohol free environment
- an environment that considers people's cultural, familial and social circumstances
- time and place for clients to withdraw from a high-risk lifestyle or situation
- peer support and encouragement to withdraw from use
- education regarding strategies for maintaining moderate drinking, or a lifestyle free of drugs and alcohol, to match client's needs
- encouragement of open reflection and discussion of personal issues related to use
- healthy lifestyle, structured activity and balanced diet during residence
- assistance with community life and daily living skills
- opportunities for vocational, recreational and cultural activities
- planning for discharge, provision for aftercare and follow up.

Source: Brady (2002) [55].

Culture, healing and harmful alcohol use

Another approach to treating harmful AOD use among Aboriginal peoples focuses on the need for culturally grounded healing programs to address the significant and unresolved intergenerational trauma resulting from colonisation and dispossession. Many of these programs combine Aboriginal cultural traditions with conventional Western therapies.

One of the earliest examples in Australia of a treatment program based on Aboriginal healing practices and Western therapies was a residential treatment facility established by the Central Australian Aboriginal Alcohol Program Unit (CAAAPU) in Alice Springs in 1992 [65]. CAAAPU developed an initial treatment program that drew on Aboriginal cultural traditions, Canadian healing practices and AA. Integrating all of these into a single, culturally acceptable treatment program, however, proved difficult.

Gregory Phillips, a Waanyi and Jaru researcher who studied substance use in Cape York, Queensland (Qld) argued that Western models of sickness and health were incapable of addressing unresolved, intergenerational trauma on their own because they do not recognise the spiritual domain [66]. He proposed a program of healing based on a foundation of re-invigorated Aboriginal healing practices, AA and the treatment program developed by the Nechi Institute in Canada. He also argued for redefining community norms about acceptable and unacceptable behaviour; providing AOD training to local people in local language, establishing a treatment centre/healing place, and educating non-Aboriginal health professionals about the nature of addictive behaviours in the community [66].

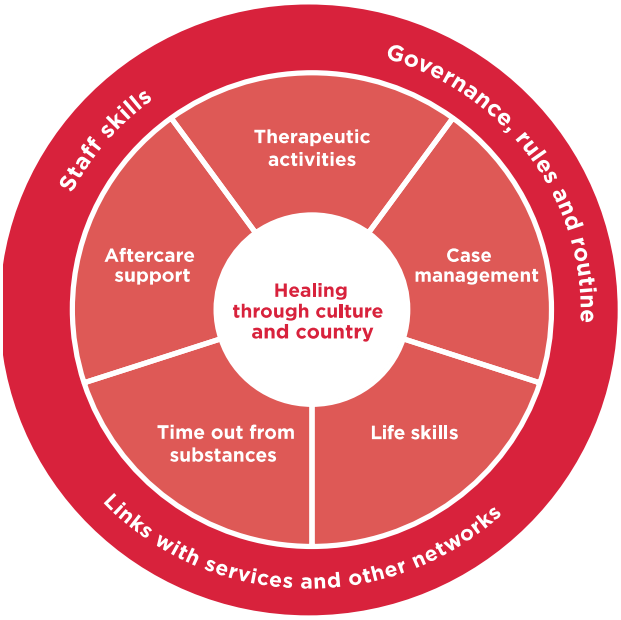
One example of a cultural healing program that has continued to develop over three decades has been the We-Al Li healing program developed by Judy Atkinson and her colleagues in Qld [67]. The We-Al Li program draws on the Aboriginal concept of Dadirri or inner, deep listening and quiet still awareness [68]. As with other Aboriginal community programs it has implemented a 'train the trainer' model which aims to educate and heal while enabling participants to develop their own professional skills. This type of program aims to enhance self and community learning through the healing power of story, cultural and personal narratives, art and ceremonial [69].

Combining healing and therapeutic interventions

An approach to integrating cultural healing with evidence-based therapeutic practices is the Healing Model of Care developed by the Aboriginal Drug and Alcohol Residential Rehabilitation Network (ADARRN), the peak body for Aboriginal residential rehabilitation facilities in NSW, in partnership with researchers at the National Drug and Alcohol Research Centre (NDARC), University of NSW [70].

Staff and clients from six Aboriginal alcohol and other drug residential treatment centres worked with researchers, using a method known as Community-Based Participatory Research (CBPR)[71] to develop the model [72]. It defined core organisational and treatment components for residential treatment services and follow-up care (Fig 1).

Figure 1. Treatment and organisational components of a Healing Model of Care



Source: Shakeshaft et al. (2018) [72]

The steps involved in implementing, monitoring and assessing each of these treatment and organisational components are set out in two program logic models. The program logic for the treatment model is reproduced in the appendices (Appendix 1). The authors argue that these can be applied beyond the six treatment services they were designed for. They also argue that the Healing Model of Care identifies the core elements of a successful program which can then be varied according to local needs .

Non-residential treatment

Treatment approaches to harmful AOD use for Aboriginal people have often focused on residential options. However, there is also a demand for non-residential treatment.

A review of five non-residential programs that included screening and brief intervention, case management, pharmacotherapy and psychological and social support, found that these programs are beneficial provided they are controlled by Aboriginal people, culturally compatible, and have sufficient resources to recruit and retain staff [73].

An evaluation of a community based AOD treatment service in NSW using a modified Community Reinforcement Approach (CRA) found a significant decline in self-reported AOD use, a decline in psychological distress, and increased empowerment [74, 75].

In response to requests by local Aboriginal people the CRA program was modified to include:

- therapists that were local people and trusted by the community
- sensitive discussions around alcohol-related harms
- detailed, rather than brief interventions
- less technical language used
- options for group or individual treatment
- treatment sessions to talk about alcohol issues and the acquisition of skills to address these challenges
- provision of follow up support [74].

More recently, a systematic review of non-residential community based AOD programs for Aboriginal and Torres Strait Islander people found that outreach programs were generally well-supported, partly because they promoted access to treatment and connections with kin and community networks [76].

One review found that Aboriginal peoples are less likely to have access to pharmacotherapies than other Australians and that home-based detoxification programs may be a potentially effective and acceptable program if managed within a culturally informed framework [77].

Supporting the Aboriginal alcohol and other drug workforce

The role of the Aboriginal AOD worker is rewarding, but also demanding and stressful [78].

Several specific conditions have been identified that contribute to workplace stress including:

- heavy work loads
- juggling multiple demands
- lack of role definition
- poor remuneration
- lack of job security.

In addition, grief and loss in the individual AOD worker's lives and their families may also contribute to this stress load [78].

Workforce development strategies to address these issues have been recommended such as:

- ensuring clinical supervision and mentoring is available
- allowing greater flexibility in the way workers choose to engage with clients
- increased remuneration
- increased recognition of Aboriginal ways of working.

In recent years there has been a greater level of training and qualification available among Aboriginal AOD workers, although short term funding of services at times undermines the aim of retaining a stable, qualified workforce [79, 80].

Evaluating treatment programs

The evidence-base for evaluating programs aimed at helping Aboriginal people recover from harmful AOD use remains modest. Many studies offer little more than program descriptions and lack reliable methods of evaluation.

Mutual support groups, such as AA groups in treatment programs for Aboriginal clients have had widespread use, however, there is little evidence of their effectiveness in an Australian context [81].

A recent review of the experiences of Aboriginal clients of AOD services in Australia found three key themes were important [82]:

- availability of cultural activities and cultural reconnection in programs
- the value of holistic and strength based approaches that enhance confidence and sense of pride in clients
- having access to experienced Aboriginal staff who demonstrate empathy and capacity to understand clients' needs.

Evaluations of treatment programs face a number of significant challenges [83]. Aboriginal clients of AOD services often have complex needs that include physical health, mental health and other issues in addition to harmful AOD use. Programs to address these complexities include multiple components and the extended process of healing is not easily measured by mainstream research methods [84].

Key messages

The dominant approach to providing AOD treatment and rehabilitation services for Aboriginal peoples over the last 50 years has been residential treatment based on the Twelve Steps and mutual support principles of AA. In more recent years, treatment programs grounded in various forms of cultural healing have been introduced. These programs are designed to heal the unresolved, inter-generational trauma that is widely understood as underlying harmful AOD use among Aboriginal peoples. In many instances, these programs combine Aboriginal and Western therapeutic models.

There is an ongoing need for resourcing, training and supporting the Aboriginal AOD treatment workforce. While the level of training among AOD workers has increased in recent years, treatment facilities continue to struggle to provide adequate remuneration, working conditions and workplace support.

A second need is the continuing quest for ways of assessing effectiveness of treatment in a manner that combines methodological rigour with cultural sensitivity.

Community-based restrictions on alcohol availability

Local restrictions on alcohol availability, whether through reduced trading hours or restrictions on purchases, target community populations rather than individual drinkers. Evidence suggests that such restrictions can be both effective at reducing alcohol-related harms and strongly supported when they are a result of genuine community input. Where they are imposed with little regard to community input, they are often perceived by those affected as discriminatory and disempowering.

Restrictions usually include one or more of the following:

- price-based restrictions
- restrictions on outlet trading conditions
- restrictions on sales of particular beverages
- place-based restrictions
- restrictions on sales to people from designated communities.

Restrictions can be:

- voluntary: informal agreements made at a local level, usually between liquor outlets and community organisations
- negotiated-mandated: arrangements negotiated by stakeholders at a local level and given legal recognition (e.g. as special conditions attached to a liquor licence)
- imposed: restrictions imposed by governments or other authorities.

Foundations of restriction-based approaches

The strategy of preventing and managing alcohol harms by restricting supply, as well as reducing demand through early intervention and treatment, is based on a public health approach to alcohol policy that emerged in the 1970s.

In the NT, a new liquor act was introduced in 1979, which enabled communities to define their own restrictions or bans on importing and consuming alcohol [85]. By 2010, 112 communities in the NT had become restricted areas [86]. Similar legislation was introduced in WA in 1979 and South Australia (SA) in 1987 enabling Aboriginal communities to choose to restrict alcohol access [87, 88]. While reviews of the restricted areas in the NT found they were associated with reductions in alcohol-related harms and had widespread community support, the laws did not place any restrictions on alcohol suppliers, who could continue to compete for Aboriginal customers [89-92].

Restricting alcohol availability in Yalata, SA

One of the earliest examples of a community's efforts to limit access to alcohol was in Yalata, a small community located on the far west coast of SA, documented by Brady et al [93]:

- 1965: A beer canteen was established in Yalata to foster a culture of moderate drinking after the repeal of laws prohibiting Aboriginal people from drinking.
- 1975: A roadhouse at Nundroo, 47 km from Yalata, was granted a liquor licence and began selling two litre flagons of fortified wine. Over the following years, levels of alcohol-related violence in the community increased and 30% of all deaths were alcohol-related.
- 1984: The community gained freehold title to its land following the introduction of land rights in SA.
- 1990: Yalata Council applied successfully to have Yalata declared 'dry' under the Aboriginal Lands Trust Act. At the same time, attempts to negotiate voluntary agreements with the licensee at Nundroo were unsuccessful.
- March 1991: Five Yalata community members were killed in an alcohol-related car crash. The community was traumatised by the accident and the Yalata Council wrote to the Licensing Commissioner, asking him to visit and discuss the uncontrolled access to alcohol.
- December 1991: After extensive advocacy efforts by local health services, the Women's Centre and community members, there was a hearing before the Licensing Court. The Judge decided that no full-strength alcohol was to be sold for off-premises consumption to residents of, or travellers to or from, the Yalata community and the Maralinga Lands by the licensees of Nundroo, Nullarbor and Penong.

A ten-year follow-up study showed improvements in the quality of life for the residents of Yalata, and a significant decline in deaths from all causes. This was mainly due to a large decline in alcohol-related motor vehicle accident deaths [94].

Other examples of community campaigns for local restrictions are documented in the book, *Learning from 50 years of Aboriginal alcohol programs: beating the grog in Australia* [1].

Restricting alcohol sales in towns: 'Thirsty Thursday' in Tennant Creek

One initiative that became a model for other towns was the trial of restrictions dubbed 'Thirsty Thursday' in Tennant Creek, NT. Tennant Creek ('Jurnkurakurr' in Warumungu) is a town located 500km north of Alice Springs on Warumungu land. At the time of Thirsty Thursday, 37% of its population were Aboriginal. In the mid-1980s, a population decline due to the closure of local businesses led to 14 liquor outlets competing for a smaller customer base [95]. As a result, two local Aboriginal organisations became concerned about how alcohol use was contributing to poverty, marginalisation, violence and poor health experienced by many Aboriginal peoples in town.

In 1995, the Northern Territory Liquor Commission (NTLC) at the request of Julalikari Council, began a trial of restrictions on certain liquor outlets in Tennant Creek [96]. The selected outlets could not sell take-away liquor or liquor from 'front bars' on Thursdays (the day most welfare payments were received at the time). On other days, sales were limited to between 12pm and 9pm. An independent evaluation found in the first 13-week phase of stronger restrictions there were large decreases in: alcohol-related emergency department presentations, admissions to the local women's refuge, reported offences committed, and the amount of pure alcohol purchased [97].

A survey conducted as part of the evaluation also found that a majority of community members supported the restrictions (58%), and half of all respondents were in favour of maintaining them. Following the trial and another hearing, the NTLC announced that the restrictions from the first 13-week trial would be remain indefinitely [97].

In the years that followed, the Tennant Creek restrictions were independently evaluated on two more occasions, with each study demonstrating continued effectiveness and community support [98-100]. Politically, however, restrictions such as these are inevitably contentious, and in 2005 the NTLC revoked the Tennant Creek restrictions, replacing them with a Liquor Supply Plan that retained bans on sales of four litre wine casks, limited purchases of two litre casks and prohibited take-away sales before midday [101].

Other communities, other restrictions

In 2007, the National Drug Research Institute (NDRI), published a comprehensive review of evidence relating to restrictions on sale and supply of alcohol [102]. NDRI identified five success factors which, they argued, shaped the outcomes of restrictions.

These were:

- the need for effective enforcement
- attention to beverage substitution and drinker displacement to other localities
- attention to the specific and changing needs of the target population
- community control, support for and awareness of restrictions
- evidence-based measures, situational suitability and evidence of outcomes.

More recent examples of restrictions on supply

Halls Creek, WA

In 2009, the WA Director of Liquor Licensing introduced restrictions on sales of alcohol from the hotel and liquor store in the town of Halls Creek (located in the Kimberley region of WA). Both premises could only sell low-strength beer to take-away, and the hotel could not sell liquor to patrons before midday. An evaluation of the restrictions found that alcohol-related assaults decreased greatly after the restrictions were implemented, as did alcohol-related presentations to the Halls Creek emergency department and admissions to the Halls Creek Sobering-up Centre [103].

Norseman, WA

Restrictions in the remote town of Norseman, WA were an example of a voluntary agreement between a liquor outlet and Aboriginal residents. In 2008, at the request of Aboriginal community members, the only licensed outlet in town agreed to place limits of daily take-away purchases of certain drinks and to limit the hours take-away liquor was available [104, 105]. The restrictions, with some modifications, were retained. Evaluators found that positive outcomes from the restrictions had helped to improve community relations and were largely supported. They did, however, caution that an increase in drinking at home may have added to difficulties experienced by children in getting enough food and sleep to function at school [104].

Alcohol Management Plans in Queensland

In 2002, the Qld Government introduced Alcohol Management Plans (AMPs) in response to the Cape York Justice Report [106, 107] which found high levels of alcohol-related harm in many Cape York communities [108].

The AMPs were supposed to include three components:

- new restrictions on alcohol availability
- measures to reduce demand for alcohol, including treatment and rehabilitation programs
- new governance arrangements under which licences would be taken away from community councils and vested in separate Community Canteen Management Boards.

While AMPs were intended to have a high degree of community control, in practice they were widely viewed as being forced on the community rather than being outcomes of community wishes or control [109]. The AMPs were also not fully implemented; in particular, most of the promised demand reduction facilities and programs never eventuated [110]. Although the restrictions were found to have contributed to reductions in violence and injury associated with alcohol, attempts to circumvent the restrictions also resulted in many Aboriginal peoples being saddled with fines, criminal records and convictions [111].

Evaluating outcomes

One of the success factors identified in the 2007 NDRI review of restrictions on supply was the use of evaluation to demonstrate outcomes [102]. The list below provides details of indicators which have been used to objectively evaluate restrictions in the past. These indicators should be considered in the first instance but may be supported by additional measures tailored to the specific communities involved.

Indicators of alcohol consumption and related harms in evaluation include [102]:

- volume of pure alcohol consumption by beverage type
- numbers/rates of police reported offences e.g. violent assault, disturbances, drunk and disorderly, drink-driving, road crashes, drink-driver road crashes
- numbers/rates of alcohol-attributable deaths
- numbers/rates of alcohol-attributable hospitalisations
- numbers/rates of emergency department presentations
- representative community survey(s)
- key stakeholder interviews.

Key messages

Tailored restrictions on the local availability of alcohol can reduce alcohol consumption and alcohol-related harms.

Restrictions on alcohol use that have a high degree of involvement from the community are more likely to be sustained. Evidence suggests that alcohol restrictions are more robust when they are supported by legal measures. Restrictions on trading hours and conditions of trade are particularly effective. Over time, the impact of restrictions can lessen, so these measures need to be monitored and adapted to changing circumstances if necessary. While some people may find loopholes to avoid alcohol restrictions, at a community-level tailored restrictions produce positive outcomes.

Alcohol restrictions are just one element of addressing alcohol-related harm. It is important that the underlying causes of harmful alcohol use are also addressed and programs to reduce demand are resourced.

Historically restrictions on Aboriginal access to alcohol were discriminatory in that they did not normally apply to non-Aboriginal people. Advocates of community-based restrictions should be aware of this historical legacy.

Case study of community-led alcohol restrictions: the Fitzroy Valley

In his 2010 Social Justice Report, the then Aboriginal and Torres Strait Islander Social Justice Commissioner, Mick Gooda, described the events behind what he called a transformation from 'community crisis to community control' in the Fitzroy Valley in the Kimberley, WA [112]. The Commissioner's account of the first component of this transformation - the introduction in 2007 of community-led restrictions on sales of take-away alcohol is reproduced in Appendix 2. The second component, the creation of a community-led strategy to reduce high levels of Fetal Alcohol Spectrum Disorder (FASD) in the community, is described in the section, *Meeting the challenge of Fetal Alcohol Spectrum Disorder* in this summary.

Community-controlled liquor outlets and permit systems

Two strategies for managing alcohol use in some Aboriginal communities are - community-owned liquor outlets, usually in the form of licensed clubs, and liquor permit systems that authorise approved individuals to import and consume liquor in otherwise 'dry' communities.

The main objectives of community-owned outlets are to retain the revenue derived from drinking in the community, foster a culture of moderation and deter illicit importation of liquor (i.e. 'grog running'). Historically, most community-owned outlets have achieved the first but not the second or third of these objectives; often, they have become centres for heavy drinking and associated harms. Some community-owned outlets, however, have succeeded in fostering moderate drinking, and this section outlines ways of doing so.

The use of individual liquor permit systems today is confined to some remote communities in the NT, Australia, and some Inuit communities in Nunavut, Canada. Evidence of their impact is sparse but suggests that liquor permit systems can contribute to community management of alcohol provided three conditions are met: committees responsible for administering permit systems are adequately supported and resourced; effective controls are in place to deal with illegal supply of alcohol, and the rules and procedures that make up the permit system are understood and supported in the community.

Community-controlled liquor outlets: reviewing the evidence

Community-controlled liquor outlets are intended to offer drinkers an alternative to buying alcohol at inflated prices from 'grog runners' or going into nearby towns to buy alcohol, where they are often forced by laws and policing practices to drink in unregulated, sometimes dangerous settings.

After the ending of legal prohibition on drinking for Aboriginal people in the 1960s and 1970s, some Aboriginal communities and organisations established community-owned liquor outlets or, in a few cases, purchased existing liquor outlets [113]. Some outlets have endured, others have closed, either by community decision or due to changes in government policy.

A beer canteen in South Australia

One of the first documented examples of an attempt to control the amount of alcohol in the community through setting up a licensed premises was the beer canteen that operated in Yalata on the west coast of SA, between 1969 and 1982 [13, 93]. The outlet was set up by the Lutheran Mission that administered the community at the time in the hope that it would stop people importing port wine purchased in nearby outlets. However, importation of port wine continued, and drinkers consumed both port and beer purchased at the local canteen in small groups, away from the canteen. Cans of beer, carefully rationed by the canteen, became currency in gambling games of 'two up'. An analysis of data on alcohol-related injuries between 1972 and 1982 showed that alcohol-related deaths accounted for 30% of all deaths occurring in the community [13].

In 1982 the canteen closed in response to the wishes of the community.

Brady and Palmer, who observed these developments, concluded that the mission misunderstood the nature of drinking and social control in this Aboriginal community. The missionaries had assumed that the ready availability of beer would lessen demand for port, and that the community and its council had the desire and power to intervene in uncontrolled drinking. In reality, community members were dependent on non-Aboriginal authorities for almost all their daily needs, while having few resources of their own to negotiate with. Drinking provided a temporary escape into intoxication where they experienced power and control, while gambling provided an alternative to the bland social exchange of purchasing beer. In addition, members of the Aboriginal Council, despite expressing concern over the issue of drinking, did not believe they had the right to control other people's drinking [13].

Liquor outlets in Queensland communities

In 1984, after 100 years of restrictions on Aboriginal access to alcohol in Qld, Aboriginal councils on former reserves were granted the authority to operate licensed canteens under the Community Services (Aborigines) Act [114]. The Qld Government promoted community canteens as a source of local revenue, to the point where several Cape York communities became dependent on the income stream to fund local services [107].

In the Cape York community of Aurukun, a committee of male councillors voted to establish a beer canteen despite previous opposition from community members [115]. Initially the amount of alcohol sold to each person was restricted and monitored. Gradually however under pressure from the councillors and the incentive to maximise profits, these limits were relaxed. The result was a greater proportion of income being spent on alcohol at the expense of purchases such as basic food and other essential items from the community store. Also, the amount spent on illicit alcohol continued, despite the availability of alcohol from the canteen. Arrest rates and criminal offences escalated dramatically after the canteen was opened [115].

In another example, the opening of a licensed canteen on Mornington Island led to a rising tide of violence including suicides from 1976 to the 1990s [116].

During 2001, in response to mounting evidence of increased levels of injury and violence associated with alcohol in some Cape York communities [117], the Qld Government commissioned a report to investigate the causes of violence, injury, ill-health and crime in north Qld [106, 118]. The report identified illegal grog running and the financial dependence of community councils on revenue from canteens as central to the nature and consequences of alcohol harm. The Qld Government subsequently introduced legislation prohibiting local councils from holding liquor licences. In the absence of alternative arrangements for administering canteens, most communities have since become legally 'dry'[109].

One community where a community owned liquor outlet appears to have contributed to managing alcohol and reducing associated harms is Pormpuraaw. Supported by government licensing restrictions, the Pormpurraaw United Brothers Sports Club hosts special events, provides meals and operates restricted trading and other conditions which limit alcohol use. A study conducted between 2014 and 2016 found indicators of alcohol-related harm had declined [107]. However, according to the study, the club was not a solution to grog running and governments had not followed through with commitments to provide funding for facilities to reduce demand for alcohol, in particular an alcohol rehabilitation facility.

Liquor outlets in Northern Territory communities

Under the 1979 NT Liquor Act, Aboriginal communities gained the power to impose their own conditions on access to alcohol. Most communities chose to ban alcohol altogether. A small number, however, established licensed clubs [119].

Clubs sometimes attract controversy. For example, the Murrinh Patha Social Club in Wadeye was established in response to concerns about residents travelling to nearby towns to drink and placing financial strains on their families. It was promoted as a way of encouraging a culture of drinking in moderation, and initially operated as intended, with restricted trading hours and limits on the amount of beer being sold [113]. However it became a centre for heavy drinking and associated violence, especially against women and children. The Club Manager requested help from the NT Liquor Commission on several occasions , which reportedly did not respond [120]. Finally, in 1988 a group of non-drinkers led by Elder Freddie Cumaiyi, smashed their way into the club, seized and poured out the beer and demolished the fittings [113]. While levels of harm declined after this action, the amount of alcohol being purchased outside of the community increased, resulting in an increase in car accidents. For a short time, another attempt was made to operate a council owned social club. However, with the collapse of the council, the club was closed.

Another example was the Twereretye Club in Alice Springs, which in 1993 was granted a licence to sell beer for drinking on the premises [113]. The club faced competition from commercial outlets which sold cheap take-away liquor as well as opposition from some Aboriginal groups in the community who believed abstinence was the only strategy for dealing with harmful alcohol use. It did not receive the hoped-for level of patronage from Aboriginal drinkers to keep it financially viable and closed in 2005 [113].

Licensed clubs and urban drinking

One of the most persistent arguments advanced in favour of licensed clubs in communities in the NT, mainly by non-Aboriginal people who do not live in them, is that they will reduce the number of Aboriginal people coming to town and drinking. For example, in 2020 the then Chief Minister Michael Gunner, after drawing attention to the availability of alcohol in Darwin, asked rhetorically ‘Why can’t Aboriginal people make that same choice on their country about whether they have or haven’t got community clubs?’ [121]. In fact, communities already had this choice under existing legislation (and continue to do so), and most had chosen not to establish licensed clubs.

The limited evidence available suggests that contrary to the assumption underlying these calls, community clubs do not deter people from drinking in towns. A 1982 review by the NT Liquor Commission found that licensed outlets made little difference to the numbers of drinkers visiting [122]. In a subsequent review, d’Abbs compared the number of apprehensions for public drunkenness per 100 adult population originating from communities with and without licensed clubs between April and June 1986. In Darwin, three out of the four communities with the highest rates of apprehensions had licensed clubs [90].

Licensed clubs and drinking patterns

Historically, licensed clubs in NT Aboriginal communities have been associated with widespread, regular, frequent drinking; a very different pattern from the intermittent binge drinking associated with visits to towns.

In 1988, a detailed study of alcohol use by Aboriginal people in the NT found that drinkers in communities with clubs reported a higher frequency of drinking than in other settings [123]. In communities with clubs, the proportion of males drinking was higher (84% vs 65%) than in other communities, while the proportion of females was similar to the overall level (19%). In contrast, drinkers in dry communities or where drinking was regulated by permit systems were more likely to consume their liquor in less frequent drinking sessions.

An examination of drinking patterns in seven licensed clubs in the NT in 1994 showed clubs in communities were associated with high, frequent consumption of alcohol for both men and women. Overall, annual per capita consumption of pure alcohol was estimated to be around 42% above the national level for males, and similar levels were found among female drinkers [119].

Licensed clubs and the 2007 Intervention

The 2007 Intervention (the NT National Emergency Response or NTER) significantly changed the conditions under which licensed clubs operated. Under the NTER possession and consumption of liquor was prohibited on all Aboriginal land except for licensed clubs which were permitted to trade under newly imposed restrictions .

A 2015 study of eight outlets located in the Top End found that trading restrictions imposed by NTER had brought significant reduction in sales of alcohol and in alcohol-related harms compared with pre-NTER levels [124]. However, it was noted that reported declines in sales of alcohol from the clubs did not necessarily indicate declines in consumption overall, as a high proportion (45%) of those surveyed, nominated other outlets from which they bought alcohol, such as roadhouses and nearby towns.

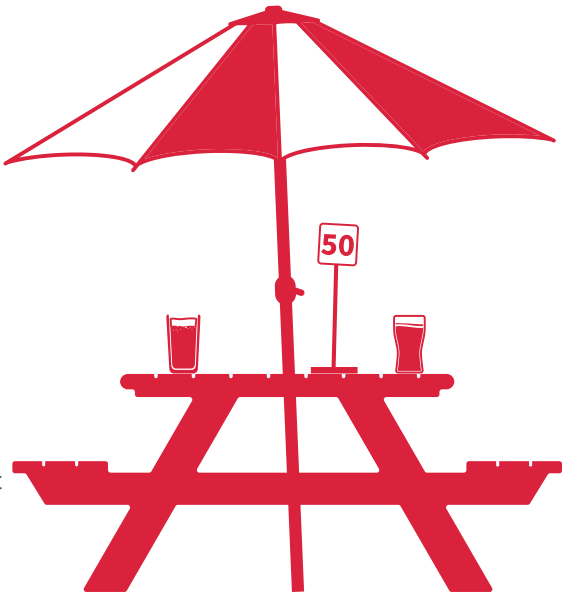
Factors affecting impact of licensed clubs

Clubs operate under a complex environment of legislation, governance requirements and expectations from the community. The 2015 study mentioned above identified five elements that shaped the impact of clubs in communities, namely:

- governance
- physical amenities
- practices around how alcohol is served
- club rules
- the role of the club in the community.

Governance of licensed clubs in Aboriginal communities poses several challenges, and in the past several communities have closed their clubs in the face of these challenges. Key issues include:

- the kinds of liquor licence under which clubs trade
- the quality and role of club committees and their relationship with club managers
- the quality and role of club managers.



Most clubs in the 2015 study operated in pleasant physical settings and all offered some form of entertainment, such as live or piped music and pool tables. All of them used measures to discourage intoxication, such as breathalysing people on entry and limiting the amount that could be purchased on any one day. All of the clubs had rules of conduct, enforced by security staff, security cameras, and bans for misbehaviour.

On the basis of its findings, the 2015 study prepared a checklist to guide communities establishing new clubs:

- plans for such a licensed facility should include a range of hot meals as well as entertainment and activity – not just consumption of alcohol
- the facility should have a kitchen and dining area, as well as a bar area, and should be spacious and able to accommodate small groups of people who may want to drink separately
- alcohol should be stored in a highly secure manner
- the club should be incorporated through a legal vehicle that sets a high standard of governance
- the club committee should have access to professional advice in recruiting and supervising a manager and be fully aware of its responsibilities
- governance training should be provided to club committee members and regularly updated
- as part of capacity building of the club committee, members should become well informed about alcohol-related matters affecting their community
- club management should commit to a transparent process for the return and use of profits to their community
- the club committee should fund an evaluation after the first two years.

Liquor permit systems

A second strategy for managing alcohol use at a community level is the use of liquor permits. These are issued to approved individuals to allow them to purchase, import and/or consume alcohol subject to conditions attached to the permit . In the early 20th century, liquor permits were widely used in Canada, the US and Scandinavia [125]. Today, their use is restricted to some remote Inuit communities in the territory of Nunavut, Canada, and some Australian Aboriginal communities in the NT [126].

Liquor permits in the NT are issued by the Director of Liquor Licensing, who must consult with community members, police, and a local permit committee before reaching a decision to approve or refuse an application [127].

A review in 2015 found that two types of permit systems had evolved. In the first, permits were issued mainly to non-Aboriginal employees in the community, allowing them to import alcohol and drink in their own homes, in what for everyone else was a dry community [126, 128]. Community members had little or no input into decision-making and the system in some communities fostered resentment towards what was seen as discrimination.

The second type of permit system emerged as a core component of alcohol management systems in communities in Arnhem Land, the Tiwi Islands, Groote Eylandt and the Gove Peninsula.

For example, in Groote Eylandt, anyone - Aboriginal or non-Aboriginal, wishing to buy take-away liquor requires a permit, linked to a permit system activated by linked computer nodes at each liquor outlet. Recommendations to issue, revoke or modify permits are made by a permit committee with representatives from police, health services, the community councils, the local mining company, licensed clubs and a consumer representative [129]. An independent evaluation found that in 2005-06, the year following the introduction of the system, recorded assaults and aggravated assaults fell by 73% and 67% respectively, and the system enjoyed strong community support [129]. However, the evaluation also reported that the permit system placed heavy administrative demands on the permit committee, which did not receive adequate support from the NT Liquor Commission or other agencies.

Evidence of the impact of liquor permits is sparse but suggests that permits can enhance community management of alcohol provided three conditions are met:

- permit committees are adequately resourced – liquor permit systems generate a heavy administrative load for both communities and government agencies
- effective controls are in place to respond to illegal supply of alcohol
- rules and procedures that constitute the permit system have legitimacy in the eyes of the community.

Key messages

Community-controlled liquor outlets and liquor permit systems are two strategies for managing alcohol at a community level by providing alternatives for drinkers who might otherwise leave the community and drink in towns and/or purchase liquor at inflated prices from ‘grog runners’.

Historically, many community-controlled outlets have become sites of heavy drinking while having little impact on grog running or the movement of drinkers away from the community. Community-controlled clubs also place a heavy governance burden on communities. However, where these are addressed, and where the physical environment and serving practices promote moderation and sociability, and where rules of conduct, including banning for misbehaviour, are enforced, licensed clubs can become centres for moderate, sociable drinking and relaxation.

Liquor permit systems are not widely used in communities today, and evidence for their effectiveness is sparse. However, they can enhance community control over alcohol use and associated harms provided that:

- permit committees are provided with adequate administrative support
- illicit supply of liquor is policed
- the permit system is regarded as being legitimate by the community.

Meeting the challenge of Fetal Alcohol Spectrum Disorder (FASD)

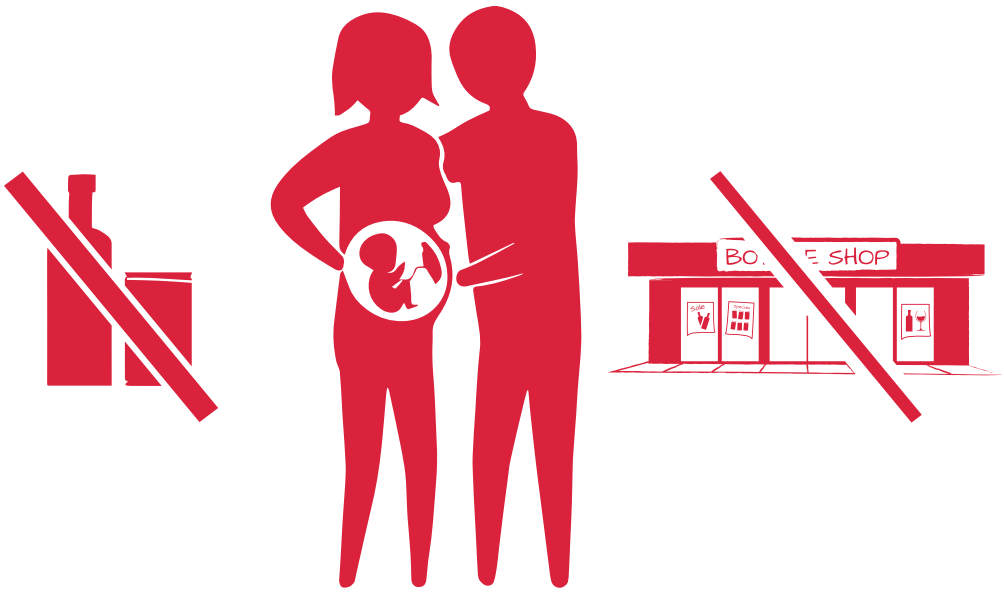
Fetal Alcohol Spectrum Disorder (FASD) is a major source of neurodevelopmental impairment among both Aboriginal and non-Aboriginal Australians. Its effects are experienced not only by families directly affected, but also in health, education, child protection, youth and criminal justice systems. Fetal Alcohol Spectrum Disorder (FASD) can occur in all parts of Australian society where alcohol is consumed during pregnancy. Nationally, the prevalence of FASD is poorly documented and services for prevention, diagnosis and treatment are inadequately resourced. In the case of remote Aboriginal communities, the challenges inherent in diagnosing and supporting FASD are compounded by the costs of delivering specialist services to remote settings. In recent decades, several Aboriginal communities have taken the initiative and developed community-led programs for assessing the prevalence of FASD, creating culturally appropriate education and support services, and developing capacity to diagnose FASD in primary healthcare settings. These initiatives are discussed in this section.

What is FASD?

Fetal Alcohol Spectrum Disorder (FASD) is a diagnostic term used to describe the range of neurodevelopmental and physical impairments that can result from prenatal alchol exposure [130]. Alcohol crosses the placenta and can cause damage to the developing embryo or fetus [131]. No level of alcohol use during pregnancy is considered safe and the current NHMRC guidelines state that pregnant and breastfeeding women should not drink alcohol [132].

The most widely known characteristics of FASD are impairments that affect learning, language, memory, controlling emotions and planning [130]. A smaller proportion of children have characteristic facial features that are associated with FASD. Exposure to alcohol during pregnancy can also impact all the developing organs and systems of the body. The effects of FASD are irreversible and in some cases people will need life-long support [133].

The prevalence of FASD in Australia is unknown. To date, no national studies have been conducted in Australia using the most accurate method for identifying FASD - the active case ascertainment method [134]. The only case ascertainment study conducted to date was initiated in 2009 by two Aboriginal organisations – Marninwarntikura Women's Resource Centre and Nindilingarri Cultural Health services in the Fitzroy Valley region of WA. The lack of broader population data makes it difficult to identify resource needs and, because much of the FASD research has focused on Aboriginal communities, fosters a mistaken impression that FASD is solely an Aboriginal problem[135].



International research has estimated the prevalence of FASD to be between 2-5% of young school children in the United States and Western European countries, with higher rates in disadvantaged populations [136].

In the absence of accurate prevalence data, the true impact of FASD in the community is difficult to determine. In addition to the neurodevelopmental impairments associated with FASD, people with FASD have an increased risk of physical diseases as well as difficulties with completing schooling, employment, AOD use and involvement with the criminal justice system [137].

Recent initiatives in Aboriginal communities have addressed the prevention of FASD, diagnosis and/or provision of support for individuals or families with FASD.

Preventing FASD in Aboriginal communities

Since many of the consequences of FASD are irreversible, prevention is a priority for any strategy to address FASD.

Three principles are important:

- prevention requires more than providing educational resources and urging pregnant women not to drink alcohol
- preventing FASD in Aboriginal communities must be situated in a broader strategy for reducing alcohol-related harms [133, 138].
- strategies for preventing FASD must be led by communities or community groups and adequately supported by government and other agencies.

One example of a community-based attempt to prevent FASD was Apunipma Cape York Health Council's Fetal Alcohol Syndrome Project between 2002 and 2006 **[138]**.

Using a health literacy model the project aimed to:

- raise awareness of the links between alcohol, pregnancy and FASD in the community
- reduce harmful drinking
- increase awareness of, and capacity to, address FASD among service providers
- increase awareness of and resources for preventing FASD at regional and higher policy-making levels.

The project established local FASD action groups and held educational workshops with trained facilitators.

Another example was the Ord Valley Aboriginal Health Service (OVAHS) FASD prevention program, set up in 2008 to establish the drinking patterns among antenatal clients and identify the needs of these women and their families. Over the first 12 months of the program's operation, 78 pregnant women were assessed, 74 of them more than once. Of these, 85% reported consuming alcohol at some point during their pregnancy. However, more than half of the women assessed (56%) reported abstaining from alcohol following their first FASD education session, and another 14% reported reducing their drinking.

One issue that emerged during the program was the need for young women to have more information about contraception. In consultation with OVAHS staff and local Aboriginal young women, a brief intervention resource and interactive workshop was developed to promote awareness of contraception and safe sexual practices. An additional issue identified was the importance of engaging men. It was recognised that fathers were important in influencing drinking behaviour. Subsequently men were included in education and the design of programs and resources, with an emphasis on fathering from conception [139].

A third example of a prevention program is the Making FASD History program implemented by the Telethon Kids Institute in partnership with community organisations in NT and NSW. The program aimed to build the capacity of local health services to lead FASD prevention activities. The Newcastle project also generated a *FASD youth justice model of care handbook* and other resources as well as resources for dealing with FASD in the classroom [140].

Online FASD prevention resources

An extensive range of resources to assist in preventing FASD can be found at:

FASD Hub Australia

Fasdhub.org.au

Alcohol and other Drugs Knowledge Centre FASD

aodknowledgecentre.ecu.edu.au/learn/health-impacts/fasd/

Diagnosing FASD in Aboriginal communities

A FASD diagnosis is an essential first step to providing the appropriate support for children with FASD and their families, but diagnosing FASD is a complex process requiring multi-disciplinary assessment and specialist skills. In rural and remote areas, FASD diagnostic services are often not available or inaccessible [133].

One way of improving access to diagnosis is to increase the capacity of primary healthcare to provide FASD assessments [141]. Examples of programs that have addressed issues of access are:

- Yapatjarrathati Project [142] – a partnership between Griffith University, Gidgee Healing in Qld and others to provide culturally sensitive assessment, develop resources to support training remote health practitioners and implement evaluating outcomes.[3]
- Child and Youth Assessment and Treatment Service (CYATS) – a program in Alice Springs run through the Central Australian Aboriginal Congress (CAAC) that provides early detection of conditions such as FASD, Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) [143].

3 For more details, see https://www.griffith.edu.au/research/impact/yapatjarrathati-projects

Supporting Individuals and families with FASD in Aboriginal communities

FASD can require lifelong support. It has been observed that the National Disability Insurance Scheme (NDIS) does not necessarily provide adequate support for people with FASD [133]. Aboriginal and Torres Strait Islander families face additional burdens because of a lack of culturally appropriate services.

Two programs that address some of these challenges are:

- Jandu Yani U – a parent support program adapted from the Triple P (Positive Parenting Program) to help meet the complex needs associated with raising children affected by FASD [144, 145] in communities in the Fitzroy Valley, WA. The program was offered to all parents and positive outcomes were found for parent coaches, family members and children.
- School-based support: *Fetal Alcohol Spectrum Disorder (FASD) and complex trauma: a resource for educators* - a book for educators of children and young people affected by FASD, prepared by Marninwarntikura Women's Resource Centre [146].

Developing a community-based FASD strategy: a case study [4]

In October 2008, just over a year after alcohol restrictions were brought into the Fitzroy Valley (see Appendix 2 – *Case study of community-led alcohol restrictions: The Fitzroy Valley*), members of the communities gathered to discuss FASD and other alcohol-related issues, including Early Life Trauma (ELT) [147]. The meeting was led by Aboriginal organisations Marninwarntikura Women's Resource Centre and Nindilingarri Cultural Health Services (Nindilingarri). In the following month, a coalition of government agencies, business and community organisations formed a 'Circle of Friends' to support implementation of a FASD/ELT strategy that became known as the Marulu Project.

The Marulu Project had a number of areas of focus:

- Prevention – including consulting with communities to raise awareness of the Project, education across the communities and working with women who are pregnant to prevent alcohol use.
- Diagnosis – including the development of screening and diagnostic processes.
- Support – including mapping the support services in the valley and developing a network of carers.
- High level dialogue – including strategic use of media, contributing to scientific discussions on FASD, and raising the profile of FASD through strategic partnerships.
- Building local capacity – including participation in relevant workshops and conferences and capturing the process of the project.
- Focusing resources – identify and leverage existing resources, approach government and other funders to secure targeted funding for the strategy, and engage local community resources in FASD prevention, support and diagnosis [147].

4 This case study is based on an account by the then Aboriginal and Torres Strait Islander Social Justice Commissioner, Mick Gooda, in the 2010 Social Justice Report [112].

The journey of developing the Marulu Project is shown below:

The Marulu Project[5]

Source: Aboriginal and Torres Strait Islander Social Justice Commissioner 2010 Social Justice report [112]

In 2009, the Marulu Project leadership group approached the George Institute to conduct a prevalence study of FASD. The rationale was that by understanding how many children were affected by FASD, the community could attract the funding needed to prevent FASD and support children affected by FASD. This became known as the Lililwan Project. This community-led project and the continuing engagement through public forums like the Fitzroy Futures Forum ensured that the residents were kept up to date and fully informed of the prevalence study. The process was underpinned by meaningful, respectful collaboration. The project was designed to incorporate necessary elements of Aboriginal culture and knowledge, as well as meeting the requirements of Western research ethics standards.

A set of principles and preconditions for each phase of the project included [147]:

Principles

- First do no harm.
- Commit to a process of two-way learning.
- All activity must deliver short and longer term benefits for the communities.
- Informed participation and consent must be ensured through the sharing of information and knowledge.
- All activities must preserve the dignity of participating individuals and communities.

Preconditions

- Clear and broad consent from:
  - the communities broadly
  - local service providers
- Local control – The Project Leadership Team must be and perceived to be by the communities as being in control of the study.
- An appropriate and adequate workforce.

5 The Marulu Project team: M Carter, J Oscar, E Elliott, J Latimer, J Fitzpatrick, M Ferreira, M Kefford

Among children completing stage two of the prevalence study, a diagnosis of FASD was made in 19% of cases [148]. This is comparable to findings from other marginalised populations in South Africa and elsewhere, but far higher than prevalence estimates from other Australian studies that have relied on passive surveillance methods. The project highlights the need for national prevalence data for the whole population [135].

The Marulu Strategy is ongoing; it remains the most comprehensive, community-led intervention anywhere in Australia for preventing and managing FASD and providing support to families with FASD-affected children.

Key messages

FASD remains a major source of neurodevelopmental impairment. However, there is a lack of reliable national prevalence data for FASD.

In recent decades, several Aboriginal communities and organisations have taken the initiative to develop community programs for preventing, diagnosing and supporting those with FASD.

A number of principles have been identified that provide a guideline for community engagement to address FASD. If these principles are followed there is a promise of positive health outcomes.

These are:

- incorporate community-led partnerships that bring together community groups, service providers and researchers
- embed approaches to address FASD into broader strategies for reducing alcohol-related harm, such as controlling alcohol availability
- address social and cultural determinants of health as well as FASD itself
- provide resources for prevention, diagnosis and support
- provide adequate, consistent and culturally appropriate support – in funding, professional services and enabling legislation from governments.

Services for prevention, diagnosis and treatment of FASD are inadequately resourced and remote Aboriginal communities face additional challenges to accessing specialist services.

Alcohol and community policing

Community patrols (also known as night patrols and street patrols) are community-based initiatives for promoting safety and preventing and resolving disputes by drawing on cultural authority rather than mainstream police powers. Warden schemes and social behaviour projects have similar objectives.

Community patrols originated in the 1970s in several communities – most though not all of them remote. Initially they were unfunded, volunteer-staffed initiatives that sought to mobilise local, culturally-grounded ways of preventing and resolving disputes, and the authority of respected Elders. Community patrols received increased attention following the report of the Royal Commission into Aboriginal Deaths in Custody (RCADIC) in 1991, which recommended the use of community patrols to complement mainstream policing practices [149].

The first community patrol to gain national prominence following the RCADIC report was the Julalikari Community Patrol, founded in the mid-1980s in Tennant Creek, NT. The Patrol began with a group of volunteers from the Julalikari Council using their own vehicles and resources to patrol the streets and town camps at night. The Julalikari Council wanted to do something about managing alcohol use, reducing violence and improving relations with the police. They aimed to offer more satisfactory ways of resolving disputes than the approaches used by mainstream police [150, 151].

However, a common misunderstanding from the wider community was that the purpose of the patrol was simply to remove intoxicated people from the street [151]. In 1991, a formal protocol was negotiated by Julalikari and NT Police which served as a working guide for the role and established mutual responsibilities between both parties [152].

Following the release of the RCADIC report, the number of patrols operating in remote, regional and urban settings grew, as did the flow of government resources to them [153]. In 1991 the first women's night patrol was established in the central Australian community of Yeundumu, in response to five deaths related to alcohol. By 1994 thirteen remote communities in Central Australia had started their own night patrols, many of them run by women [154].

While many patrols focused on community safety, others focused more on youth outreach [155]. At the same time, many patrols became subjected to conflicting role-expectations, with local authorities and other bodies viewing them as extensions of mainstream policing funded to keep intoxicated people off the streets, rather than exercises in deploying Aboriginal authority to prevent and defuse conflicts. A process for establishing a remote night patrol has been described by Anne Mosey who was employed as Coordinator of the Yuendumu Women's Centre [156]. She outlined a community-led process that goes through several stages before becoming established. She also identified conditions likely to ensure a successful night patrol.

These included:

- having a community with over 100 people
- having enough people to sustain the activities (10-20 people)
- ensuring several senior men or women are involved
- making sure there are representatives from each family grouping.

Longer term night patrols need the involvement and continued support from their council, the police and local organisations [156].

Patrolling cities: The Nyoongar Patrol Outreach Service

The Nyoongar Patrol Outreach Service in Perth, WA is one example of a long running urban community patrol that has had to manage differing expectations for the services they offer. It was set up in 1998 as a service managed by volunteers in the inner city suburb of Northbridge. Today it has extended its services to suburban areas of Vincent, Fremantle and Midland and offers a range of support including conflict mediation, referral and advocacy for young Aboriginal people and homeless Aboriginal people.

From the beginning, the Nyoongar Patrol saw its role as primarily an outreach service, working with other agencies to address issues faced by young and homeless Aboriginal people in the area [157]. Stakeholders such as the Northbridge Retailers Association and others expected the patrol to solve anti-social behaviour in the Northbridge area by removing young Aboriginal people from the street. Despite a review which endorsed the service [153] funding was withdrawn in 2005. In that same year the Nyoongar Patrol renamed the service as an outreach service and clarified its function. Since then, it has attracted funding from multiple sources. The service was independently evaluated in 2012[157]. The evaluation identified achievements in several areas, including dispute mediation, engaging at street level with vulnerable Aboriginal people and developing relationships with the business community and other agencies. It also listed five ongoing challenges.

These were:

- unrealistic expectations of the role and capacity of the service, including among some Aboriginal people who expect the patrol to provide a taxi service
- inadequate shelter facilities for homeless people
- the absence of an adequate youth policy framework in Perth
- inadequate information sharing with other agencies
- excessive access to alcohol in the area [157].

Patrols and policing in NSW

A study of community patrols and the way they functioned in NSW found that community ownership was regarded as an essential ingredient for the successful operation of community patrols [158].

Four main activities were common to everyday operations which focused on the wellbeing of young people:

- transporting young people from public places to an alternative safe place
- building mentoring relationships
- looking out for young people in trouble, engaging with them about their issues and referring them to support services
- sharing information with other services to support young people .

Impact of community patrols

The evaluation of the Nyoongar Patrol is one of the few independent evaluations that have been conducted of Aboriginal patrols. Little quantitative evidence is available regarding the impact of patrols on arrest rates, harmful alcohol use, domestic violence or other indicators. Some evaluations reported a reduction in alcohol-related harms **[159]**, while others found no significant effect **[160]**. In a review of evidence, Blagg and Anthony conclude that, where patrols operate within a strong community governance framework, they have been shown to reduce admissions to police lock-ups, youth crime, alcohol-related crime and protective custody apprehensions. They are also widely supported within communities as community safety initiatives [161].

The Intervention in 2007

The 2007 Northern Territory National Emergency Response (NTER), better known as 'The Intervention', radically changed the landscape in which community patrols operated, especially in the NT. Patrols were redefined as vehicles for a government-defined community safety policy. Funding was increased and placed under the authority of the Commonwealth Attorney-General's Department. In the NT, where only 23 of 73 Aboriginal communities directly affected by the NTER had operating patrols at the time, the Government decreed that all communities should have one, within a 10-month period [162].

A review found that while the short time frame and demand of the task may have required a centralised service delivery model, there was little consultation with communities and as a result community ownership of the programs declined [162]. Prior to the NTER, patrols had relied on the active engagement of community Elders, Traditional Owners and key family members. Subsequently, patrols were transformed into what one observer described as 'a non-Aboriginal service model' that removed the basis of the patrols' legitimacy and effectiveness [163].

Warden schemes and social behaviour projects

Warden schemes have had similar roles to night patrols and have sometimes worked in partnership with night patrols, or as an alternative to night patrols [159].

One example of a warden scheme was the Tangentyere warden scheme in Alice Springs which concentrated on working in a compassionate manner with itinerant visitors and campers [57, 159].

Another innovative program designed to strengthen Aboriginal social control over drinkers was the Mwerre Anetyeke Mparntwele (Sitting Down Good) Project, also known as the Social Behaviour Project [164]. The program was developed by Tangentyere Council in the early 1990s and aimed to reduce binge drinking and the conflict and violence associated with it by fostering more appropriate social norms and strengthening Aboriginal law and authority.

As part of the program, a Four Corners Council of initiated male Elders and a Women's Elders Council was established. A set of behaviour rules was produced by the council for visitors and others as to how they should behave when in town. The rules were more recently renewed as *Going to town* rules [165].

Similar approaches to formulating cultural protocols were developed by Traditional Owners in other community groups [166]. The Larrakia Nation Aboriginal Corporation (LNAC) developed a set of cultural protocols as part of a comprehensive strategy for the Community Harmony Project [166, 167] which aimed to help people return to communities, encourage remote communities to establish licensed clubs and expand accommodation options in Darwin.

Key messages

Community patrols, warden schemes and social behaviour projects are ways for Aboriginal communities and organisations to reclaim control over safety and order in their communities. They are intended as culturally appropriate ways of preventing and resolving disputes rather than an extension of state policing.

Many community patrols began as unfunded community initiatives. Over time they have often been subject to conflicting expectations about their role from authorities and the community. Although community patrols are now better funded, community control over how they operate has been undermined.

Community ownership is an important and fundamental principle for the successful operation of community patrols and other schemes. In practice, fostering community ownership is fragile, complex and in need of constant defence. The challenge for governments is to respect and support communities and community organisations working to control alcohol use while at the same time avoiding the errors of either placing excessive expectation on the capacity of community organisations, or exercising excessive control as a price for providing support.

Conclusion: outcomes and issues

The preceding sections summarise findings addressing programs involving; primary prevention; secondary prevention or early intervention; treatment and rehabilitation; local restrictions on supply of liquor; community-controlled liquor outlets; liquor permit schemes; programs for preventing and diagnosing FASD and providing support to affected families, and community patrols and warden schemes. In most of these domains, there is little evidence with which to assess programs outcomes; much of the limited data produced relates to implementation process rather than outcomes. However, it is possible using the evidence available to identify key factors that enable or impede successful implementation. These are summarised in Table 1 below.

In addition to factors listed in Table 1, three other factors underpin successful implementation in all program domains: the importance of a high level of community control of programs; the importance of interpersonal relationships among key players, both within Aboriginal and non-Aboriginal domains and, especially, across these domains, and the need, in evaluating programs, to incorporate Aboriginal criteria and ways of knowing as well as indicators grounded in Western scientific frameworks.

For a full description of programs and initiatives described in this summary, please see the book: *Learning from 50 years of Aboriginal alcohol programs: beating the grog in Australia*.

Table 1: Summary of factors enabling and impeding programs

Program type	Factors conducive to implementation and effective outcomes	Factors that impede implementation and/or positive outcomes
Primary prevention (preventing or delaying uptake of harmful alcohol use)	• community leadership • strategic partnerships between community • organisations and both internal and external agencies • limited, clearly-defined and widely supported objectives • data documenting both baseline and post-intervention • indicators of problem being addressed • a pathway to achieving selected objectives • regular rather than one-off initiatives • a multi-component approach • cultural and recreational components promoting a sense of connectedness.	• few interventions have been evaluated and, of those that have been evaluated, few have demonstrated positive outcomes.
Secondary prevention/ early intervention (preventing onset or continuation of harmful drinking among people already engaging in or at risk of harmful use)	• strong evidence-base for effectiveness of screening and brief intervention in primary healthcare settings among mainstream populations • training and support for service providers • defined referral pathways.	• competing demands on health practitioners' time • reluctance by health providers to question patients about their drinking • a perceived (and often real) lack of referral options for patients requiring follow-up treatment.
Treatment and rehabilitation	• good governance (including clear distinction between roles and responsibilities of boards and managers) • adequate resources • trained staff with linkages to mentoring and professional development opportunities • participatory evaluation models based on partnerships between evaluators and service providers, rather than imposed evaluation models.	• inadequate and insecure funding • narrow range of treatment options offered by residential programs • difficulties in meeting governance requirements • sparsity of evidence of effectiveness • many clients have multiple needs requiring a broad range of treatments • inappropriate referrals to treatment sometimes generated by criminal justice system.
Community-based restrictions on availability	• restrictions tailored to local needs • local community leadership • attention to complementary measures to reduce demand, such as early intervention and treatment • flexibility in responding to changing needs • evaluation to demonstrate outcomes and level of community support.	• opposition from liquor and hospitality industries • reluctance by politicians to impose restriction • effectiveness fades over time • restrictions sometimes lead to unintended consequences such as 'grog-running' or drug substitution.

Program type	Factors conducive to implementation and effective outcomes	Factors that impede implementation and/or positive outcomes
Community-controlled licensed outlets	• community support • imposition and enforcement of strict trading conditions by licensing authority • timely support from government agencies especially police and licensing authorities • strong governance and management • appropriate physical amenities • responsible serving practices • clear eligibility rules (e.g. for suspending patrons for specified offences).	• tension between objectives of fostering moderation and maintaining commercial viability • established drinking cultures favouring heavy consumption • challenges in governance and management; and failure of government agencies to support and strengthen local governance capacity.
Liquor permit systems	• adequate administrative support for local permit committees • geographic isolation • effective controls over illegal purchasing and supplying of liquor ('grog-running') • legitimacy in eyes of community.	• administrative burden on local permit committees • availability of alternative sources of liquor (or other drugs) • community opposition or disinterest

Programs addressing Fetal Alcohol Spectrum Disorder (FASD)	• community-led partnerships bringing together community groups, service providers and researchers
	• approaches for addressing FASD that:
	  • are embedded in broader strategies for reducing alcohol-related harm, including effective controls on alcohol availability
	  • address social and cultural determinants of health as well as FASD itself
	  • cover prevention, diagnosis and support.
	• adequate, consistent and culturally appropriate support, both in funding, professional services and enabling legislation from governments.
		• lack of awareness or understanding of nature, determinants and consequences of FASD both in wider society and among many health professionals
		• difficulties in providing diagnostic and support services, particularly in remote communities
		• inadequate resources for prevention and diagnosis, and for supporting families impacted by FASD.

Alcohol and community policing in Aboriginal communities	• community ownership • adequate resources • clearly defined roles • mutually acceptable expectations with police • mutually acceptable expectations with other community stakeholders • authority of Elders or other senior persons • training and staff development.	• inadequate resources • conflicting expectations with/ from funding bodies, police, other community stakeholders • pressure to function as a 'drunks taxi' rather than resolving disputes • excessive government control.

Source: d'Abbs & Hewlett (2023) [1]

Appendix 1. Standardised program logic model of core treatment components and flexible program activities

a. Client areas of need	b. Treatment program		c. Mechanisms of change	d. Process measures	e. Outcomes
	Core treatment components	**Program activities**			
Primary client areas of need • risky drug and alcohol use • poor quality of life • poor cultural connection. **Secondary client areas of need** • co-occurring mental illness • criminal justice involvement • chronic physical health needs • tobacco use • unemployed/limited education.	Healing through culture and Country	being on Country/spirituality developing kinships making artefacts, fishing, bush medicine.	reconnecting clients to culture and Country via activities and strong relationships.	No. of clients engaged in regular cultural activities	**Primary outcomes** • reduced substance misuse (AUDIT/DUDIT/IRIS & clean urines) • improved quality of life (WHO-QoL) • increased connection to culture (GEM). **Secondary outcomes** • reduced psychological distress (K 10) • reduced risk of BBV (BBV-TRAQ-Needle syringe contamination) • reduction in recidivism (pre/post criminal justice data) • improved physical health (pre/post Indigenous health check outcomes) • reduction in smoking (Fagerstrom) • improvement in employment and education (three months follow-up data).
	Case management	referrals to local health services and visiting specialists regular client assessments case reviews.	clients engaged in the program via positive therapeutic alliance between staff and clients. referrals to AMS to external health and social services. client's social, psychological and physical needs managed concurrently.	No. of clients staying in the program for three or more months No. of Indigenous health checks/other referrals No. of client's needs addressed	
	Therapeutic activities	one-on-one counselling using evidence-based approach (e.g. motivational interviewing, community reinforcement approach, cognitive behavioural therapy) psychoeducational groups informal counselling (yarning)	improving client quality of life increased understanding of substance misuse (e.g. triggers) and personal strategies (e.g. motivations, goals, timeout) for reducing it education and empowering clients to make positive changes in their life.	No. of clients engaged in support groups No. of external counselling sessions provided No. of clients implementing personalised strategies	
	Life skills	develop daily routine positive role modelling redevelop personal responsibility work readiness activities literacy/communication skills	reconnecting clients to culture and Country relearning daily routine and structure to maintain a healthy lifestyle after discharge learning and developing work ready and communication skills.	No. of work ready activities completed No. of vocational-related courses completed No. of clients achieving personalised life skills goals No. of clients following daily structure and routine	
	Time out from substances	improve physical well-being (e.g. sleep routine/nutrition) improve mental/spiritual well-being smoking cessation.	identify and engage in positive alternative activities to substance use to learn how to take time out from substances.	No. of clients engaging in time out activities No. of clients quitting or reducing smoking	
	Follow-up support after discharge	referrals to services post discharge (e.g. ACCHOs) follow-up support follow-up assessment and brief counselling.	continue to access treatment and care required to maintain improved health and well-being post discharge ongoing tailored support for clients post discharge in the continuum of their treatment.	No. of clients participating in follow-up care (e.g. phone calls, assessments, referrals) No. of clients maintaining contact with PHC services and other relevant services they were referred to upon discharge.	

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

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

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

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

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

Source: Shakeshaft et al. (2018) [72]

Appendix 2

Case study of community-led alcohol restrictions: The Fitzroy Valley

This edited extract is reproduced with permission from the Aboriginal and Torres Strait Islander 2010 Social Justice Report [112].

In 2007, a number of Fitzroy Valley community leaders decided it was time to address increasing violence and dysfunction in their communities. Alcohol abuse was rife across the Valley and rather than healing the pain of colonisation and disempowerment, it was causing violence, depression and anguish amongst residents. By 2007, there had been 13 suicides in the Valley over a 12-month period.

The actions of these leaders were careful and modest, aimed at bringing the Fitzroy Valley residents with them on a journey to understand two things, that the alcohol situation was dire, and that the problems of the Valley could be reversed.

The recent history of the Fitzroy Valley reads as a 'how-to manual' for the development and implementation of a bottom-up project for social change. It is the story of a movement that engages with, rather than further marginalises, the local communities. These events demonstrate approaches to community crisis that encourage and build the positive, willing participation of the affected people.

The principles emerging from the Fitzroy experience can inform the development and delivery of government services across the diversity of Aboriginal and Torres Strait Islander communities throughout Australia. If governments apply these principles, they can shift from a service delivery paradigm to become enablers and facilitators of community-based agents of change.

The Fitzroy Valley

> *For thousands of years there were many different language groups living on this land and we are still here today. The Bunuba and Gooniyandi people are the people of the rivers and the ranges. The Walmajarri and the Wangkatjungka people are the people of the great desert. Today these different language groups all live together in harmony in the Fitzroy Valley. That's what makes this place so special. We have strong culture here and we welcome you to our place and our dreams.*[6][168].

The Fitzroy Valley is in the Kimberley region of Western Australia (WA). The town of Fitzroy Crossing is situated near the centre of the Fitzroy Valley. It is the regional hub of the Valley. Fitzroy Crossing is on the traditional lands of the Bunuba people. There are 44 smaller communities spread around the Valley in a diameter of approximately 200 kms. Of these smaller communities, a number are sub-regional hub communities, while others are smaller satellite communities or outstations.

The area is extremely remote. The nearest major centres are Derby (258 km), Halls Creek (263 km) and Broome (480 km). Of the approximately 4,000 people who live in Fitzroy Valley, 1,600 live in Fitzroy Crossing. The majority of the population across the Valley is Aboriginal [147].

6 J Oscar, community member and CEO of Marninwarntikura, in Yajilarra (Marninwarntikura Women's Resource Centre 2009).

The Fitzroy Valley is serviced by a range of different providers, government departments and agencies, as well as non-governmental organisations. Government services include education, police, health and child protection. Local non-governmental organisations provide a range of cultural and social welfare services. For example, the Marninwarntikura Women's Resource Centre (MWRC) provides domestic violence services, and the Kimberley Aboriginal Law and Culture Centre (KALACC) is the peak body for developing, promoting and maintaining law and culture across the Valley.

Community crisis

> *We worry all the time for this land and our people. Especially when we see and live in the shadows of the painful effects of dispossession, oppression, racism and neglect. And when we see how alcohol is being used to mask this pain in our community and how it creates more pain*[7] [168].

In 2007, the communities of the Fitzroy Valley were in crisis. The Fitzroy Crossing Hospital staff described the abuse of alcohol in the communities as 'chronic, chaotic and violent'- it was common for them to treat between 30 and 40 people a night for alcohol-related injuries [169].

Too many people were dying. Community member, Joe Ross, suggested that 'the community had become immune to attending funerals'.[8] The Fitzroy Valley had 55 funerals in one year, of which 13 were suicides. If this rate of suicide was applied to a population the size of Perth, it would equate to 500 suicides per month [170].These astounding figures prompted local community leaders to call for an inquest by the State Coroner of WA, Alistair Hope. In 2008, the Coroner handed down his findings on 22 self-harm deaths in the Kimberley region. A 'striking feature' of the Coroner's findings was the 'very high correlation between death by self-harm and alcohol and cannabis use' [171].

> *We had a community that was just being decimated by alcohol abuse. Children weren't feeling safe about going home. Old people running to a safe place. Old people crying, wanting to move out of their homes because, you know, they were just being harassed by family members who was coming home drunk* [168].

The Coronial Inquest into 22 deaths in the Kimberley also found that the Aboriginal people in the Kimberley region had a real desire for change and that they wanted to play an active role in designing and developing programs to improve their living conditions [171].

The abuse of alcohol in the Valley has historical roots that can be linked to the processes of colonisation and the accompanying social policies that alienated and marginalised the Aboriginal people of the region.

7 J Oscar, in Yajilarra (Marninwarntikura Women's Resource Centre 2009).

8 J Ross, community member, meeting with the Aboriginal and Torres Strait Islander Social Justice Commissioner, Fitzroy Crossing, 31 July 2010.

History , trauma and alcohol abuse

After the period of frontier violence in the late nineteenth and early twentieth century, Aboriginal people worked on stations for little or no wages. For decades, Aboriginal people were the backbone of the industry. Without the Aboriginal women and men who sheared the sheep, mustered the cattle, built the fences and windmills and cooked the food, the pastoral industry would not have been able to operate.

Then in the late 1960s and early 1970s when the equal wage decision for Aboriginal stock workers was implemented in the Kimberley, our people were discarded. We were treated with contempt and expelled on mass from the stations.

Aboriginal people throughout the valley resettled in congested, squalid conditions. In the early 1970s, the population of Fitzroy Crossing rose from 100 to over 2,000 people within two years. It became a tent-camp of refugees fleeing a humanitarian disaster.

Like many such people alienated from their lands, alcohol abuse started, and it got worse and worse over the years. At first, only the older men and middle-aged men drank, then some of the young men and then more and more women and then teenagers, some of them quite young.

The grog has affected every single person in the valley at one level or another. Aboriginal people in the valley have identified grog as the most important health priority that must be confronted.

Source: Oscar 2010 [172]

Fitzroy Valley residents had been cognisant of the damage that alcohol was causing for some time, and they had taken steps to address the problem. For example, in 2004, 300 residents from the Valley met to discuss the issues of alcohol and drug abuse. The attendees of the meeting agreed that there was a need to focus on counselling and treatment.[9] However, very few resources were available, and little was done to address what was an overwhelming problem.

In 2007, in the face of this ongoing and escalating crisis, the senior women in the Fitzroy Valley decided to discuss the alcohol issue and look for solutions at their Annual Women's Bush Meeting. The Women's Bush Meeting is auspiced by Marninwarntikura; it is a forum for the women from the four language groups across the Valley. At the 2007 Bush Meeting, discussions about alcohol were led by June Oscar and Emily Carter from Marninwarntikura. The women in attendance agreed it was time to make a stand and take steps to tackle the problem of alcohol in the Fitzroy Valley [147]. While the women did not represent the whole of the Valley, there was a significant section of the community in attendance. Their agreement to take action on alcohol was a starting point, and it gave Marninwarntikura a mandate to launch a campaign to restrict the sale of alcohol from the take-away outlet in the Fitzroy Valley. The community-generated nature of this campaign has been fundamental to its ongoing success. The communities themselves were ready for change.

9 E Carter, community member and Chair of Marninwarntikura, meeting with the Aboriginal and Torres Strait Islander Social Justice Commissioner, Fitzroy Crossing, 2 August 2010.

Following this bush camp, on 19 July 2007, Marninwarntikura wrote to the Director of Liquor Licensing (WA) seeking an initial 12-month moratorium on the sale of take-away liquor across the Fitzroy Valley [173].The only take-away outlet in the Valley is located in Fitzroy Crossing. As a consequence, much of the focus of the campaign for alcohol restrictions was on Fitzroy Crossing, although its effects would apply across the Valley region.

Marninwarntikura argued that alcohol restrictions were necessary for the following reasons:

- the high number of alcohol and drug-related suicides in the Fitzroy Valley
- the communities were in a constant state of despair and grief
- there was extensive family violence and the women's refuge was unable to cope with the demand from women seeking refuge from violence at home
- childhood drinking was becoming normalised behaviour
- local outpatient presentations from alcohol abuse were unacceptably high
- local hospital statistics suggested 85% of trauma patients were alcohol affected and 56% of all patients admitted were under the influence of alcohol
- criminal justice statistics showed a disproportionally high number of alcohol-related incidents
- local employers were finding it difficult to retain staff as a result of alcohol consumption
- a reduction in school attendance
- child protection issues including a significant number of children under the age of five exhibiting symptoms associated with Fetal Alcohol Syndrome [173].

Marninwarntikura called on the Director of Liquor Licensing to restrict access to take-away alcohol purchased in Fitzroy Crossing in order to provide some respite for the communities and to allow time to address the 'deplorable social situation' in the Fitzroy Valley [173].

During this process, Marninwarntikura liaised with the cultural leadership of the communities through KALACC, one of the three Kimberley-wide Aboriginal organisations which promotes law and culture for the different language groups in the region. KALACC gave its support to the restrictions campaign. The CEO of Marninwarntikura noted the importance of this support from the cultural leadership:

> *It was really important to let Elders know what was happening. We liaised with cultural leaders and Elders through KALACC. KALACC helped facilitate approval from Elders for the alcohol restrictions.*[10]

The support of the Elders and cultural leadership cannot be underestimated. It was a factor that influenced the discretion of the Director of Liquor Licensing to issue the alcohol restrictions [173]. The support from Elders gave the campaign the necessary legitimacy to withstand some strongly held views by sectors of the communities which were against the restrictions.

10 J Oscar, interview with the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, 24 May 2010.

Support for the restrictions was not isolated to the women and the cultural leadership of the Valley. Many of the men from the Valley were strong advocates for the restrictions campaign. The women indicated that 'we couldn't have done it without the men'.[11] However, this campaign was not about gender difference, it was about these communities striving for a better future.

> *… and this must be understood—what we have achieved so far (in the Fitzroy Valley) could never have been done by government acting alone. The leadership had to come from the community. We had to OWN our problems and create pathways for recovery [174].*

A strategic partnership was formed with the WA Police, who also supported the campaign. This strategic alliance bolstered the campaign but did not detract from its community-controlled nature.

Despite obtaining significant community-level support for the campaign, there remained strong voices in the communities who opposed the proposed restrictions. However, those supporting the restrictions stood firm knowing that they would buy the Valley some necessary respite from the trauma and chaos of excessive alcohol misuse. The strength of these leaders was decisive, and the campaign came at a significant personal cost for some key leaders.

Alcohol restrictions in the Valley

It was September 2007 when the WA Director of Liquor Licensing decided that the sale of take-away liquor was a major contributor to high levels of alcohol-related harm at Fitzroy Crossing. The Director deemed the harm sufficient to justify the imposition of a six-month trial during which the sale of take-away liquor from the outlet in Fitzroy Crossing would be restricted. The trial commenced on 2 October 2007.

> *The sale of packaged liquor, exceeding a concentration of ethanol in liquor of 2.7 per cent at 20 °C, is prohibited to any person, other than a lodger (as defined in Section 3 of the Act) [173].*

The trial conditions stipulated that only low-strength beer could be purchased from the take-away outlet in Fitzroy Crossing. Full-strength beer, wine and spirits could not be purchased for take-away. These heavier drinks could still be purchased from the two licensed premises in the Valley (both located in Fitzroy Crossing), but they could only be consumed on the premises during opening hours.

Approximately eight months after the restrictions came into force, a review was conducted to assess their impact and to determine their future. The review meeting included the Director of Liquor Licensing and was attended by various members of the Aboriginal communities in the Valley. June Oscar, the CEO of Marninwarntikura, stated that the meeting was the 'most important 30 min of our lives'.[12] It gave community members the opportunity to present their cases to the Director of Liquor Licensing.

11 J Oscar, meeting with the Aboriginal and Torres Strait Islander Social Justice Commissioner, Broome, 3 August 2010.

12 Quoted in Director of Liquor Licensing Western Australia (2007).

Their views were summarised as follows:

- the women were more empowered, confident and able to speak up and be involved in community-level discussions
- sly grogging was a real problem
- Fitzroy Valley was much quieter and safer
- other Aboriginal communities were looking to the positive example in the Fitzroy Valley
- the restrictions have seen government agencies and non-government organisations become more involved in the communities
- there was a strong desire not to return to the pre-restriction chaos
- substantial and lasting change is needed
- children need to be the priority and the next generation of children need to grow up without the problems of alcohol
- families are stronger and sober, old people are being cared for, young people are thinking about owning homes and children are learning skills
- communities with people affected by FASD need assistance
- if we return to the past, all hope will be stripped away' [173].

After the review meeting in May 2008, the Director of Liquor Licensing extended the restrictions on take-away alcohol indefinitely [173]. Following the implementation of the restrictions, four of the communities in the Fitzroy Valley -Wangkatjungka, Noonkanbah, Yakanarra and Bayulu-also adopted alcohol restrictions that prevented the possession and consumption of alcohol in these communities.

Issues of consent

> *We dealt with dissenting voices by trying to keep all people in the Valley informed. We used media to help keep people informed and to combat misinformation. I agreed to attend all meetings with dissenting voices in the community but only if the meetings were respectful and outcomes could be generated from meetings.*[13]

Issues of consent in the Fitzroy Valley were resolved over time. It was a process rather than a single transactional event. The Fitzroy women wanted to create a 'space for reflection' among their community members. They knew that excessive alcohol needed to be taken out of the picture in order for reflection to occur. This would give people the time and opportunity to think about the crisis that had befallen the Valley. It was not possible for the residents to make informed decisions while they were in crisis.

> *Alcohol restrictions are just a small toe hold into the enormous challenges we face. It is not the answer to our problems. It was never intended to be. Its purpose was always to give us breathing space from the trauma and chaos of death, violence and fear; breathing space to think and plan strategically* [175].

Rather than focusing on obtaining majority support for the restrictions in the first instance, the women acted upon the mandate given to them at the Bush Meeting. Following this, the women consulted with KALACC Elders, health providers and community leaders and others to obtain support from a significant portion of the residents of the Valley.

13 J Oscar, interview with the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, 24 May 2010.

Twelve months after the alcohol restrictions commenced, an independent review showed increased community-level support for the restrictions [176]. The increased support shows that a 'space for reflection' and a different lived experience can change community attitudes. This could be described as building community capacity.

The process for implementing alcohol restrictions in the Fitzroy Valley demonstrates some stark contrasts to the implementation of alcohol restrictions and other measures under the NTER [177]. In many ways, the intended outcomes were to be the same - a reduction in social problems as a result of a reduction in access to alcohol. What is strikingly different between the two approaches is the paths that were taken to achieve the same ends. In the Fitzroy Valley, the decisions were made by the communities at a time chosen by the community leaders.

In the NT, a policy developed in Canberra was imposed by the Australian Government. The most stridently voiced criticisms of the NTER were about the lack of opportunity for the affected people to participate in any decision-making about the policies affecting them:

The single most valuable resource that the NTER has lacked from its inception is the positive, willing participation of the people it was intended to help. The most essential element in moving forward is for government to re-engage with the Aboriginal people of the Northern Territory [178].

Restrictions evaluated

The Drug and Alcohol Office of WA commissioned the University of Notre Dame to independently evaluate the impacts of the alcohol restrictions. This review of the impact of the first 12 months of the restrictions was publicly released in July 2009.

The report, *Fitzroy Valley alcohol restriction report: an evaluation of the effects of a restriction on take-away alcohol relating to measurable health and social outcomes, community perceptions and behaviours after a 12 month period*, provided evidence that the alcohol restrictions were a circuit breaker and had given the residents of the Fitzroy Valley breathing space. It identified an increase in support for the alcohol restrictions from the Fitzroy Valley residents. The report indicated that almost all survey respondents accepted the need for some type of alcohol restrictions and that no one wanted a return to the social conditions prior to their introduction [176].

The University of Notre Dame evaluation found that the alcohol restrictions were having health and social benefits including:

- reduced severity of domestic violence
- a 23% increase in reporting domestic violence and a 20% increase in reporting alcohol-related domestic violence (police and other service providers attributed this to a range of factors including lower tolerance of domestic violence and increased sobriety)
- reduced severity of wounding from general public violence
- a 36% reduction in alcohol-related emergency department presentations; during the busiest period (October–March) this increased to a 42% reduction
- reduced street drinking
- a quieter and cleaner town
- families were more aware of their health and were being proactive in regard to their children's health
- reduced humbug—that is, harassing another individual for money, cigarettes, etc.—and anti-social behaviour
- reduced stress for service providers leading to increased effectiveness of these services
- generally better care of children and increased recreational activities
- a 91% reduction in the amount of pure alcohol purchased through the take-away outlet
- a reduction in the amount of alcohol being consumed by Fitzroy Valley residents [176].

The evaluation also indicated that domestic violence and other anti-social behaviour had not been totally eradicated. However, since the restrictions had come into force, there was a lower tolerance for domestic violence.

A number of negative impacts have resulted from the restrictions including:

- increased travel to Derby and Broome to obtain alcohol
- increased prevalence of people leaving children in the care of grandparents to drink at the licensed premises in Fitzroy Crossing and to travel to other towns to obtain alcohol
- increased pressure on heavily dependent drinkers and their families who are paying substantially more for alcohol
- reducing, but still ongoing divisions within the town about the restrictions
- a general sense that there has not been the expected follow through of targeted government services to deal with the problems of alcohol dependence
- an impact on some local businesses who have seen a downturn in business based on people choosing to shop in other towns (partly) related to obtaining full-strength alcohol [176].

Overall, the Notre Dame study concluded that the benefits generated by the alcohol restrictions outweighed the detriments. It reported that the communities are beginning to stabilise from their chaotic pre-restriction state. This perception has contributed to the increasing support for the restrictions from Fitzroy Valley residents.

However, the alcohol restrictions are not a silver bullet for addressing the social crises in the Fitzroy Valley. Despite the significant reduction in alcohol consumption and alcohol-related violence, the Fitzroy Valley faces an immense task to rebuild the social fabric of the communities.

> *The grog restrictions were never intended to be a panacea for the enormous social disadvantages we face. What we have to imagine is a long term and permanent healing of the gaping wounds that arise from alcohol abuse and violence. This will require collaboration and cooperation [172].*

The restrictions in the Fitzroy Valley are a circuit breaker; they have provided the communities with the necessary reprieve from the pre-restriction chaos to allow time to consider their futures. The Notre Dame Study noted that the gains from the restrictions alone would not be sufficient for the communities to address the ingrained issues associated with alcohol abuse, and ongoing support must build upon these gains:

> *Significant gaps in support services that are needed to enable the social reconstruction of the Fitzroy Valley continue to hinder the community. There continues to be a state of under-investment in the people of the Fitzroy Valley. This gap requires the resourcing of community based organisations operating at the coal face of community development, cultural health, mental health (counselling), education, community safety (policing) and training, to build on the window of opportunity that the restriction has created [176].*

Abbreviations

AA	Alcoholics Anonymous
AAFR	Alcohol Awareness and Family Recovery
ACCHS	Aboriginal Community Controlled Health Services
ADARRN	Aboriginal Drug and Alcohol Residential Rehabilitation Network
AMP	Alcohol Management Plan
AOD	Alcohol and other Drugs
AUDIT	Alcohol Use Disorders Identification Test
CAAAPU	Central Australian Aboriginal Alcohol Program Unit
CAAC	Central Australian Aboriginal Congress
CBPR	Community-Based Participatory Research
CRA	Community Reinforcement Approach
CSR	Curtin Springs Roadhouse
CYATS	Child and Youth Assessment and Treatment Service
ELT	Early Life Trauma
FASD	Fetal Alcohol Spectrum Disorder
FORWAARD	Foundation of Rehabilitation for Aborigines with Alcohol-Related Difficulties
HREOC	Human Rights and Equal Opportunity Commission
ICD	International Classification of Disease
KALACC	Kimberley Aboriginal Law and Cultural Centre
LWAP	Living with Alcohol Program
MASH	Moree Aboriginal Sobriety House
MWRC	Marninwarntikura Women's Resource Centre
NDIS	National Disability Insurance Scheme
NDRI	National Drug Research Institute
NGO	Non-Government Organisations
NHMRC	National Health Medical Research Council
NPY	Ngaanyatjarra Pitjantjatjara Yankunytjatjara
NTER	Northern Territory National Emergency Response
NTLC	Northern Territory Liquor Commission
OVAHS	Ord Valley Aboriginal Health Service
RCADIC	Royal Commission into Aboriginal Deaths in Custody
TC	Therapeutic Community

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