Australian National University

THE DEVELOPMENT AND IMPLEMENTATION OF ALCOHOL POLICY: ANTHROPOLOGICAL INSIGHTS ON TRANSLATION FROM THE GLOBAL (THE WORLD HEALTH ORGANIZATION) TO THE LOCAL (INDIGENOUS AUSTRALIA)

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Acting Director, CAEPR
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Australian National University, August 2022

Artist's statement

The Southern Cross is known by many First Nations people as Mirrabooka, Ginan or Birubi – a body of stars that encompasses celestial stories deriving from creation-forming ancient knowledges that transcend time and space. These aided our Ancestors with navigation and as seasonal indicators, and symbolise an important relationship between people, land, sea and sky. A symbol that is as vitally significant today, that we still uniquely and collectively identify with in memory, story, art and song. This artwork is the embodiment of my style and my connection to manay (stars), interpreting the night sky using cool and dark tones. The inner space between the stars is to draw the viewer in and symbolise the powerful force within and between these bodies of stars. Our old people not only gazed upon the stars, but most importantly they looked at what lies within and surrounding those dark places in the above.

Krystal Hurst, Worimi Nation, Creative Director, Gillawarra Arts

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Krystal Hurst, *Reclaiming the Southern Cross*, 2019. Acrylic on paper.

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The development and implementation of alcohol policy: Anthropological insights on translation from the global (the World Health Organization) to the local (Indigenous Australia)

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Abstract

In this paper I explore the challenges of implementing policy advice when moving from the global (in the form of the World Health Organization [WHO]) to the local (Australian Indigenous communities). Much of the thinking about alcohol problems and policy has necessarily been framed broadly at a national or international level – the level at which WHO operates. It examines change in societal policies, compares experiences across societies, and tracks advances in knowledge of what works in different contexts. It facilitates collaborative international projects on the prevention of alcohol harms, making these findings available as guides to policy action. Such collaborations have produced multiple-authored publications that have become definitive texts in the field of alcohol policy.

WHO also sponsors cross-national trials of different screening and treatment interventions. But in the local context even public interest policy must carry the people along with it. In Australia it must take account of both the wider population and the Indigenous sector, where public policy should ideally dovetail with local social and cultural circumstances at the community level. Here there are regional differences, and special vulnerabilities. Understandings of the local and the particularities of the socio-cultural context are the province of anthropology, and I argue that anthropology – often neglected – has much to offer through considering how to make alcohol policies relevant and workable.

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Acronyms

AA	Alcoholics Anonymous
ACCHS	Aboriginal Community-Controlled Health Services
AFL	Australian Football League
AIATSIS	Australian Institute of Aboriginal & Torres Strait Islander Studies
APPG	Alcohol Policy and the Public Good
ANU	Australian National University
APA	Alcohol Protected Areas
ARDS	Aboriginal Resource and Development Services
ARF	Addiction Research Foundation
ASSIST	ASSIST program (Alcohol Smoking and Substance Involvement Screening Test
AUDIT	Alcohol Use Disorders Identification Test
CAEPR	Centre for Aboriginal Economic Policy Research
CAR	Cross-cultural Applicability Research (Project)
CARPA	Central Australian Rural Practitioners Association
FARE	Foundation on Alcohol Research and Education
FASD	Foetal Alcohol Spectrum Disorder
FSANZ	Food Standards Australia and New Zealand
GDP	Gross Domestic Product
GP	General Practitioner
GRA	General Restricted Areas
HOSW	Healing Our Spirit Worldwide

IARD	International Alliance for Responsible Drinking
ICAP	International Center for Alcohol Policies
ILO	International Labour Organization
IRIS	Indigenous Risk Impact Screen
KALAAC	Kimberley Aboriginal Law and Culture Centre
KAMSC	Kimberley Aboriginal Medical Services Council
MA	Master of Arts (post-graduate award)
MUP	Minimum Unit Pricing
NDARC	National Drug and Alcohol Research Centre (UNSW)
NGO	non-government organisation
NDS	National Drug Strategy (Australia)
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NPY	Ngaanyatjarra Pitjantjatjara Yankunytjatjara
NPYWC	Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council
NT	Northern Territory
PAAC	People's Alcohol Action Coalition
PAHO	Pan American Health Organization
PSA	Program on Substance Abuse (WHO)
RCT	randomised clinical trial
SBI	Screening and Brief Interventions
SFNT Act	*Stronger Futures in the Northern Territory Act 2012*
SOP	special occasion permit (Canada)
UN	United Nations
WHO	World Health Organization

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Executive Summary

This paper gives an overview of the alcohol policy recommendations made in recent years by the World Health Organization (WHO) and provides a brief history of the research collaborations that made them possible. One theme of the paper is the challenge of implementing policy advice that has been formulated in an international context but that will have relevance and applicability at sub-national and smaller, local levels of government. The paper describes attempts by WHO to reach indigenous and minority populations and include their perspectives into its policy making through an Indigenous Peoples and Substance Use Project, via its publications on alcohol policies in developing societies, and by its support for the international indigenous addictions network known as Healing Our Spirit Worldwide.

Alcohol policies need to take account of both the wider population and special groups within it such as Indigenous Australians, where there are regional and cultural differences and special vulnerabilities. Anthropology has much to contribute to understanding the socio-cultural contexts of these local and community-based settings, and I argue in this paper that anthropological research and its insights can and should have a greater role in making policies work at the grassroots. The paper examines the WHO alcohol policy 'best buys' (such as pricing, promotion, and controls over availability), and other policies that can make a difference (such as focusing on alcohol's harm to others, and primary care interventions). I show how these policies can be made relevant and of practical value in Indigenous settings by making better use of an anthropological perspective.

Key insights

- As well as being endorsed as a WHO policy 'best buy', formal controls over the physical availability of alcohol continue to be well supported by the residents of many remote and rural Indigenous living areas. These formal controls can be implemented by local governments, by-laws, Aboriginal housing bodies or town councils, or by state/territory liquor regulations. One of the reasons they are supported is that restrictions that are 'external', and have been formally instituted, help to protect local individuals or groups from blame when they attempt to act for the community good.

- Recent research supported by WHO has focused on alcohol's 'harm to others' – a welcome re-direction of attention to a broader range of alcohol-related harms than those affecting just the individual drinker. An anthropological perspective on this issue reveals that concern about the effects of alcohol on *others* (children, grandchildren, family members) has long been a catalyst for Indigenous community action. It has provided the underlying rationale for community-supported bans on packaged alcohol and campaigns against liquor outlets. The fact that this concept dovetails with Indigenous concerns means that it could be leveraged to mobilise even more sustained community activism and become the focus of health promotion and safer drinking campaigns.

- Screening and brief alcohol interventions in primary health care settings can help Indigenous people to reconsider their alcohol use. GPs and other health care providers should continue to be encouraged to use these interventions, not only because there is clinical research supporting their use, but because anthropological research reveals another benefit. The advice from a doctor or other respected professional can be used by a patient trying to control their drinking as a shield against the social pressure to drink – a face-saving excuse.

- New thinking is needed to minimise the risk to women and children in remote communities where existing alcohol restrictions are lifted suddenly, either by accident or design. Recent developments in the Northern Territory (due to the end of the Stronger Futures Act), reveal a flawed policy process, in

which unprepared communities have been precipitously exposed to open alcohol status. There needs to be proper consultation, outreach, and better support from liquor licensing authorities, discussion of options, best practice guidelines issued for new or existing social clubs, and discussion of alternatives to licensed clubs in remote communities, such as the trial roll-out of short-term special occasion licences.

- WHO research evidence supports quasi-government alcohol monopolies, especially monopolies over off-premises sales, as a valuable public health strategy. With disinterested management, they eradicate the profit-driven pressured selling of alcohol by commercial operators; limit the number of outlets; provide stable controls over opening hours; and their profits provide funds to ameliorate alcohol-related harms. With an alcohol-attributable death rate 3.5 times the national rate, the Northern Territory constitutes a special case for such a policy intervention.

- Reliable, evidence-based alcohol research in the public interest is more needed than ever. This is because transnational alcohol corporations with vested interests, fund their own think-tanks and quasi-independent research organisations, and through them seek to bias research findings, undermine public health policies and influence government policy-making processes.

- Because of shortfalls in government funding to Indigenous community, youth and other grassroots organisations, the alcohol industry is moving in to fill this funding gap via grants, partnerships, and sponsorships paid for by wine, beer and spirits companies. Entering into such arrangements risks compromising community-based non-profit organisations, placing overt or covert pressure on them, for example if they lodge objections in liquor licensing matters.

- Good alcohol policy needs to incorporate a perceptive and equitable allocation of funds that protects non-government organisations (NGOs), community-based and frontline services from financial shortfalls that might make industry funding attractive to them.

- Despite a long history of opposing and obstructing the implementation of health warning labels on alcohol containers, the alcohol industry is now appropriating Indigenous designs, imagery, naming and messaging on its labelling as a marketing strategy that appeals to socially conscious customers. This trend demands Indigenous policy attention and debate about whether these marketing strategies constitute respect for ‘culture’ or appropriation of it.

- Industry-funded bodies have co-opted Indigenous figureheads, spokespeople and sports stars for their ‘healthy lifestyle’ and moderation campaigns. The penetration of industry interests in health promotion and policy settings, and into the Indigenous domain itself, are emerging issues that should be of concern to government and Indigenous policy-makers.

Introduction

For many years the World Health Organization (WHO) has concluded that alcohol misuse is a global public health issue of serious proportions. It causes around 3 million deaths each year, and the overall burden of disease and injuries attributable to alcohol remains unacceptably high. In 2010 WHO member states agreed on a Global Strategy to reduce the harmful use of alcohol and 10 years later, concerned by slow progress, the WHO Executive Board called for accelerated action in the form of an action plan to implement the Global Strategy.[1] The first consultation draft of this action plan appeared in late 2021 and after further drafts and consultations, the World Health Assembly, meeting in Geneva on 27 May 2022, adopted the Global Alcohol Action Plan (Foundation on Alcohol Research and Education (FARE), 2021).[2]

By initiating and supporting international expert collaborations to distil the best research evidence for action in specific areas of health, WHO has provided authoritative guidance on the best strategies to address alcohol related harms. These blueprints are designed to assist nation states around the world to make policies, at the national level and at sub-national levels such as provinces, states, regions, or municipalities. The fact that WHO has had a presence in the drug and alcohol field since the first World Health Assembly in 1948:

> *in itself has carried a message to government offices, city councils, and village assemblies around the world…that responding to these problems is a vital part of health and social planning whatever a country's stage of socio-economic development (Editorial, 1991, p. 1387).*[3]

Although the European regional office of WHO has been particularly active when it comes to alcohol issues, the Geneva head office has responsibility globally for public health, including mental health and substance abuse. This includes a special responsibility for these issues in developing societies. Over the last few decades WHO has paid some attention to the alcohol-related harms and circumstances of minority and indigenous populations.

Internationally, indigenous populations have special United Nations (UN) status that allows pressure to be exerted by the 'court of world opinion' to improve their wellbeing – including managing alcohol-related harms. While globally, indigenous groups experience greater negative impacts from alcohol, in those countries that give them special domestic status and a degree of autonomy enabling local controls, they may have more opportunities than the wider population to implement local policies – through by-laws on tribal lands and restrictions over alcohol supply. For this reason, it is important that indigenous peoples have access to good policy evidence and advice to inform local practice. Despite these opportunities, many recommended alcohol control policies are not within the power of a local community to implement, and governments often thwart truly local initiatives by imposing unnecessary administrative oversight or by blocking local decisions that are not to their liking. There is no international health-oriented treaty imposing binding obligations on signatory nations for alcohol, as there is for tobacco, opium, and other drugs.

The responsibilities of WHO lie in serving its member states and the world as a whole. But in order to focus on the patterns of alcohol use and the policies and interventions relevant to the 'Indigenous sector', there is inevitably a need for a much more local, community-based focus. What policies and interventions supported by international evidence can make a difference at the community level and be embraced by the community? Most Indigenous Australians live in urban or peri-urban environments, where policies need to address the wider population as well as the Indigenous population component. In other regions in an Indigenous context, or on Aboriginal-owned land, it makes more sense to examine alcohol problems and solutions from the ground up, at

[1] This WHO Executive Board statement is known as Decision EB146(14).
[2] https://www.who.int/teams/mental-health-and-substance-use/alcohol-drugs-and-addictive-behaviours/alcohol/our-activities/towards-an-action-plan-on-alcohol
[3] Since this optimistic moment, the management of, and commitment to, alcohol issues has varied considerably (cf. Room, 2021, pp. 426–427).

the local level. In this context the contribution of anthropology has much to recommend it, since anthropological work and thinking has focused on the negotiations, dilemmas and realities of everyday life for Indigenous people. An anthropological perspective throws light on the significance of some of the WHO-recommended approaches to minimising alcohol-related harms that are discussed later in this paper.

Much of the thinking about alcohol problems and policy has necessarily been framed broadly, at a national or international level. This is the level at which WHO operates: examining change in societal policies, comparing experiences across societies, and tracking advances in knowledge of what works in different contexts. WHO does these things by facilitating expert, collaborative international projects to scrutinise scientific studies on the prevention of alcohol harms and making these findings available as guides to policy action. It also sponsors cross-national trials of different screening and treatment interventions. One of the questions examined in this paper is whether and how do such research findings and recommendations for best practice policies reach the community-based health services and local action groups – that is, the organisations and people that can make a difference? What have been the challenges – both ideological and financial – faced by WHO as it attempts to move alcohol policy from the global to the local (that is, to indigenous community settings), and to secure the participation of indigenous and minority groups? How are these policies brought to life and made culturally relevant in different settings? In the process of tracing the intended or actual influence of WHO recommendations in this paper, I have drawn on my own associations with WHO[4] and my research experience as an anthropologist having witnessed, analysed and documented the struggles of Australian Indigenous communities to prevent and manage alcohol related harm. I have also drawn on a lecture series I have presented to the Masters (MA) Indigenous Policy course convened by CAEPR, which I called 'Alcohol Policy and the Community Good'. I wanted to make WHO's research findings and recommendations available to students of Indigenous policy and to policy makers, and to explore how and whether WHO findings and recommendations reach community-based health services and the local action groups that can make a difference.

First, I outline briefly the major published alcohol policy compilations from the 'Alcohol Policy and the Public Good' (APPG) collaborative group at WHO, and explain why it is so important to have expert evidence such as this framed in the public interest, for the community good. One major rationale for this framing is to counter the influence of competing advice emanating from policy think-tanks funded by the liquor industry, and to be alert to the industry's increasing political influence and its reach into community organisations.

In the next part of the paper I examine cases studies in which WHO has endeavoured to assemble and share policy advice relevant to the international and domestic indigenous sectors: 1) a project on Indigenous Peoples and Substance Abuse that closely involved Australian representatives, 2) the Healing our Spirit Worldwide network, and 3) the dissemination of WHO's work on Screening and Brief Interventions (SBI) in Australia.

The third section of the paper looks at policies that could make a difference, including the three WHO recommended policy 'best buys' (pricing, promotions and availability), illustrates these with examples from Indigenous settings, and discusses the potential for some as yet untried policies. I draw attention to a new and emerging concern in the regulation of marketing and promotion: the alcohol industry's co-option of Indigenous cultural and artistic imagery in its marketing.

[4] I was fortunate to receive a WHO Travelling Fellowship in 1991 which allowed me to spend three months in Canada researching First Nations treatment programs for volatile solvent users, and to visit the Addiction Research Foundation in Toronto. Subsequently I participated in WHO consultations on drug and alcohol issues and attended meetings and completed writing assignments for the Alcohol Policy and the Public Good II project (Brady, 2000). In the mid-1990s I acted as a WHO Temporary Advisor to the Indigenous Peoples and Substance Abuse project as described later in this paper (WHO, 1996). All these engagements and placements were hugely informative and introduced me to indigenous and non-indigenous experts from many backgrounds and countries. I particularly acknowledge the support and generously shared expertise of Andrew Ball, Myrna Cunningham, Andrew Chapeskie, Kayleen Katene, Steve Kunitz, Maggie Hodgson, Coralie Ober, Robin Room and Jill Torrie.

Lastly, I propose that an anthropological perspective can provide insights and guidance to make alcohol policies workable from the ground up, and I identify areas where such a perspective has been neglected. To illustrate the unacknowledged value of an anthropologist's-eye-view, I discuss three issues to which WHO has drawn particular attention in the alcohol policy field: the secondary prevention approach known as screening and brief intervention; the importance of alcohol's 'harm to others' as a means of reinforcing the need for alcohol controls; and the necessity to mobilise people at the neighbourhood or community level.

The role of WHO in distilling the evidence

WHO supports, and at times commissions, expert international teams to review the alcohol research evidence, scrutinise the science, and 'distil from it what is really relevant for the policy making process' (Asvall, 1995, p. vi). It regularly asks experts in the international field to sift through and recommend best practice – the 'best buys' – for policy interventions. This process has produced a rich lode of publications.

The 'Alcohol Policy and the Public Good' group

The first of these was the seminal monograph *Alcohol control policies in public health perspective* (Bruun et al., 1975; cf. Anon. 1974) – the outcome of a process initiated by the Finnish Foundation for Alcohol Studies in collaboration with the European office of WHO. It began in 1973, with a small scientific meeting reaching agreement that WHO had an important role to play as a think-tank and as an intermediary between scientific research into alcohol control policies, and governments who implement public policy. This was indeed how it developed. A 1975 monograph, (Bruun, et al., 1975) known as the 'purple book', is famous in alcohol research circles for making the link between per capital consumption of alcohol and adverse consequences, providing a scientific case for *population-level* harm prevention measures such as taxation and supply measures. It drew attention to the fact that alcohol problems were preventable, and that national governments and international agencies had a role in formulating effective and rational alcohol policies. Naturally, these conclusions were very unattractive to the alcohol industry.

In the early 1990s, another expert WHO-affiliated group (of 17 authors) convened under the leadership of Griffith Edwards to review the development of the world literature pertaining to alcohol policy. This produced *Alcohol policy and the public good* (APPG) (Edwards et al., 1995). It was a collaborative effort with WHO, whose Regional Director provided a foreword affirming that the book provided a solid scientific basis on which to build policies globally (Asvall, 1995). APPG was followed by *Alcohol: No ordinary commodity. Research and public policy* (Babor et al., 2003) – once again endorsed by WHO – designed to 'inform and empower policy-makers who have direct responsibility for public health and social welfare' (Babor et al., 2003, viii). A second edition was published under the imprimatur of PAHO, the Pan American Health Organisation, and a third edition of *Alcohol: No ordinary commodity* is due out in 2022.

These authoritative publications have become the definitive texts for alcohol researchers worldwide, and provide considered, evidence-based policy blueprints for nation states. The research reviewed in these publications shows that attempts to understand an individual's drinking behaviour cannot be divorced from their broad historical, social, cultural and economic circumstances, reminding us that alcohol policies should not focus solely on consumption – just as comprehensive health policies should not focus solely on 'disease'. Unfortunately, the ability of the WHO to tackle these broad-based underlying social and cultural determinants is constrained by its budget. And because alcohol as an issue has been 'left' to WHO (rather than being consistently addressed by any other global body), the implication is that any problems related to alcohol are only about *health,* when in fact a wide range of historical, social, cultural and economic factors are involved (Room, 2021, p. 423).

Why do we need evidence-based, public interest alcohol policy?

Alcohol policies can be defined as authoritative decisions on the part of government or other legitimate public interest non-government groups, to minimise or prevent alcohol-related consequences through laws, rules, and regulations (Babor et al., 2003, p. 95; cf. Babor, 2002). The world needs reliable alcohol policy advice, independent of vested interests, private industry or advocacy groups, and designed to promote the public good.

WHO's expert groups have recommended policy 'best buys' at many levels of government, from overarching national policies to community-based strategies. We know from international comparative studies that alcohol policies aimed at the community good are associated with lower levels of consumption and harm (Carragher et al., 2014). In some countries (Finland, Norway, and Sweden, for example), alcohol policies are understood to be part of the welfare state and it is accepted that scientifically- and evidence-based knowledge is necessary for social planning to protect the community's welfare. However, not all countries are applying this knowledge, some have inadequate or outdated alcohol policies unduly influenced by vested interests; a group of WHO-affiliated scholars continues to urge WHO to show leadership and provide a consistent global public health message. These scholars have encouraged WHO to create a global health policy that would comprise 'a set of principles and strategies for local, national and international action aimed at reducing alcohol-related problems' (Jernigan et al., 2000, p. 495). National policy decisions on alcohol matters made by nation-states such as Australia and Canada, affect their Indigenous and First Nations populations along with members of the wider general population. These include policies such as drink-driving countermeasures, the legal drinking age, legal age of purchase, labelling showing standard drinks, and where drinking is allowed. In Australia we also have (since 1991) the compulsory fortification of wheat flour for bread, with thiamine designed to prevent Wernicke-Korsakoff syndrome – with heavy drinkers being particularly at risk. In Australia, the states and territories have their own liquor acts (most based on harm minimisation), which allow them to administer and enforce legislation over sale and supply, trading hours, and the drinking environment including responsible service. State departments are also responsible for promoting the liquor, hospitality and tourism industries in their state or territory.

It is at the regional and neighbourhood level that alcohol policies may have special utility for indigenous people, and in some countries (including Australia) self-determination policies allow for local option laws and community by-laws on lands owned by native peoples, by-laws that can deal with alcohol problems. If data are available, a region dealing with a spate of problems in a defined area can develop regionally targeted and coordinated policies that are informed by best practice. Central Australia, for example, has been identified as a good testing ground for alcohol policy effects, because we know that alcohol-related harms are high in that region (Chikritzhs & Weeramanthri, 2021). However, the lack of Indigenous data on alcohol-related morbidity and mortality *disaggregated by region* is a major problem which makes it difficult to gain a true picture of the seriousness of harms in specific geographic regions.[5] As Nicolas Peterson has pointed out, by fudging the regional differences, cultural differences between the urban, rural, remote and very remote Aboriginal populations (and the way they experience and deal with alcohol) are also elided (Peterson, 2010, p. 252). Another problem is the gulf between policy rhetoric and implementation, despite Australian governments and their agencies being well informed about evidence-based supply, harm and demand reduction, as Chikritzhs and Weeramanthri (2021) point out. D'Abbs wrote in exasperation of the obsession with punitive measures used repeatedly by governments (particularly in the Northern Territory [NT]), most of which had 'not a shred of evidence' to support them (2015, p. 462). This lack of evidence probably extends to many so-called 'cultural' programs as well which are notoriously difficult to evaluate.

[5] The problem of geographically aggregated data also includes Indigenous health statistics such as the Infant Mortality Rate, which is reported as a national figure, when it clearly varies widely by region. It is often through small-scale surveys and firsthand on the ground research that we gain a more realistic picture of the extent of alcohol-related harms and other health indicators in particular communities.

The undue influence of the alcohol industry in Australia

One of the major reasons for having strong leadership in the public interest from an organisation such as the WHO, is the need to counter the undue influence of the alcohol industry, and of neoliberal economic policies, on both domestic and international alcohol policies (Jernigan et al., 2000, p. 496). The alcohol industry is part of what David Courtright has characterised as *limbic capitalism* – a 'means of doing business that relies on and encourages the excessive consumption of products driven by limbic areas of the brain related to motivation, reinforcement and memory' (Courtright, 2019; Myles, 2020, p. 428). This kind of habituation propels consumption even when it has devastating consequences for society and the individual by undermining appetite control.

In 2012 an editorial in a leading addiction journal suggested that there was a 'war of ideas' underway over who will shape national and international policy on alcohol (Jernigan, 2012, p. 85), and there is a growing literature on how liquor industry funding seeks to influence alcohol science and shape policy (cf. Babor 2017; Casswell, 2016; Chikritzhs & Weeramanthri, 2021; Hawkins & McCambridge 2020; McCambridge et al., 2018; Moodie et al., 2013). Rob Moodie and colleagues (2013) have articulated four common strategies employed by these transnational corporations to undermine effective public health policies and programs.[6] They are:

- to bias research findings (by funding quasi-independent research organisations)
- to co-opt policy makers and health professionals (by writing national alcohol policies for unsuspecting governments)
- to lobby politicians and public officials to oppose public regulation (by contributing donations to pro-business politicians), and
- to encourage voters to oppose public health regulations (via social marketing campaigns stressing individual decision-making).

Influence on policy

The alcohol industry has become adept at disseminating its own 'policy guidelines' through think-tanks it funds such as the US-based International Center for Alcohol Policies (ICAP) [1995–2015]. This organisation aims to counter the influence of WHO by organising regional forums and issuing its own policy documents and reviews of the literature (Drummond, 2000; Jernigan, 2012; cf. Grant & Litvak, 1998). ICAP has now amalgamated with another organisation to form an International Alliance for Responsible Drinking (IARD), which is the lobbying group for 12 of the world's largest multinational alcohol corporations and is supposedly dedicated to 'promoting understanding of responsible drinking'. IARD continues the ICAP tradition of producing policy reviews to undermine and question research published by WHO.

In this country, winemakers, distillers, and brewers fund a policy body known as DrinkWise Australia; its directors include representatives from the Australian Hotels Association, the Brewers Association and Retail Drinks Australia. DrinkWise presents itself as advancing the public interest (cf. Patay et al., 2022, p. 6), it promotes moderation and safer drinking, and appears to provide considered advice. However, these messages are in keeping with the usual focus of drinks-industry advice: they emphasise the positive effects of drinking, the need for alcohol education, and they support treatment and interventions focused on those who are heavy or dependent drinkers. The industry prefers to direct attention to these matters rather than promote the population-

[6] Moodie et al., 2013 identify corporations that sell and promote unhealthy commodities such as tobacco, alcohol and ultra-processed food and drink as being the major drivers of non-communicable diseases.

wide measures recommended by WHO and other legitimate policy-making bodies. Industry bodies also work hard to remove from official advice any phrases that might trouble the alcohol industry – such as 'alcohol and other drugs' – because the fact that alcohol is a drug is uncongenial to the industry's image. Given the role of transnational corporations in promoting and selling alcohol (and other unhealthy commodities) and driving global epidemics of non-communicable diseases, it begs the question asked by Moodie and colleagues: what role should these industries have in the prevention and control of these diseases? Why are they involved at all? WHO recommends that the alcohol industry should not participate in the development of government alcohol policies (Riley, 2017, p. 57.)

As documented by Moodie and colleagues, to protect its interests the liquor industry tries to influence the drafting of policies and action plans and to water down, co-design, or otherwise shape government policies. The industry feels compelled to do so because of the unpalatable truth that the most effective policies act to constrain and regulate the free operation of business, directly threatening their profitability (McCambridge et al., 2018). Industry interests often campaign against policy proposals that are known to reduce harm. In Scotland for example, the alcohol industry mounted a series of legal challenges to a proposal to implement Minimum Unit Pricing (MUP) of alcoholic beverages, despite this being a well-researched and WHO-recommended strategy to reduce harm. Industry objections delayed its introduction by six years. In Australia, businesses made wealthy through their sales of alcohol, such as Woolworths and Leedal[7] have refused to cooperate with local efforts to restrict sales of packaged alcohol (Brady, 2017; d'Abbs & Togni, 1998). The alcohol industry managed to delay the finalisation of Australian government advice on drinking guidelines and standard drinks, and continues to manufacture doubt about research on alcohol-related illness and other harms.

Donations to political parties are an additional problem. Representing hoteliers nationally, the Australian Hotels Association together with other hospitality and liquor companies, are among the largest political donors in the country to both sides of politics (d'Abbs, 2015).[8] Recently the international research community has expressed concern over proposals that the alcohol industry should be allowed to 'co-regulate' consumer information with governments. This suggestion has rather surprisingly been endorsed by WHO – apparently countering its own earlier advice – as part of its new Global Alcohol Action Plan for 2022–2030. It would mean that government and industry share regulatory roles, including over alcohol labelling (FARE, 2021; O'Brien et al., 2021). The website of the alcohol-industry-sponsored IARD notes that they look forward to 'regular dialogue' with the WHO and other stakeholders.[9] IARD has offices in Washington, but in Geneva as well. A seat at the table would enable these organisations to promote industry-friendly solutions (Casswell, 2016).

The struggle over warning labels

These developments may appear far removed from Aboriginal or Torres Strait Islander communities, but they are, in fact, highly relevant, especially in the case of health warning labels on alcohol containers. This is because there are relatively high rates of foetal alcohol disorders in the Indigenous community and low levels of community knowledge of Foetal Alcohol Spectrum Disorder (FASD) (Fitzpatrick et al., 2015). The tactics employed by various industry groups over health/pregnancy warning labels on alcohol containers provide an illustration of what happens when these vested interests begin to influence governments.

When Australia first proposed including health and pregnancy warning labels on alcohol in 1988, the brewers and the Australian Hotels Association immediately lobbied against it (Ford, 1988). In 2007 the industry's well-

[7] Leedal is a Western Australian Indigenous corporation that owns licensed premises.
[8] The situation was considered serious enough for there to be a Senate Committee into the political influence of donations (2018/2019) https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Political_Influence_of_Donations/PoliticalDonations/Report_1/section?id=committees%2Freportsen%2F024147%2F25779
[9] www.iard.org

funded public relations machinery was claiming that alcohol warning labels were 'pointless.'[10] There was a change of heart when in 2011 the industry-funded body DrinkWise released warning labels it had designed itself that could be applied voluntarily.[11] The labels were small, gave ambiguous messages, and were inconsistently adopted by drinks companies. In 2018 the Brewers Association changed tack by claiming that warning labels on containers were 'outdated' because consumers could access information on their phones (O'Brien et al., 2021, p. 1620). This filibustering and protracted negotiations continued into early 2020, when the drinks industry challenged a recommendation by the regulatory body Food Standards Australia and New Zealand (FSANZ) to make strong clear pregnancy warning labels in black and red print mandatory. The regulator has a role in food safety and labelling, and in the protection of public health. In a vivid illustration of the strategies designed to undermine effective policy (as listed by Moodie and colleagues mentioned earlier), the industry bombarded FSANZ with objections. Lobbyists (including Diageo, Lion, the Brewers Association, Australian Grape and Wine Inc., and Alcohol Beverages Australia) were able to meet twice with the food minister in an attempt to dilute the proposed warning label.[12] Subsequently the minister apparently agreed with the industry lobbyists and sent the labels back to be redrawn. This prompted a vigorous and ultimately successful campaign among civil society organisations (such as FARE) and community advocates. In July 2020, ministers finally agreed to the mandatory labels using visible imagery and wording (such as 'Alcohol can cause lifelong harm to your baby').

The agreed-upon warning labels are strongly supported by the Aboriginal and Torres Strait Islander social justice commissioner, Bunuba woman June Oscar. Ms Oscar was one of several leaders who had instigated liquor restrictions in the Kimberley in 2007 as part of a campaign to prevent FASD. Other Indigenous health organisations applauded the decision on warning labels. Indeed, it is likely that health warning labels on alcohol containers will have salience for Indigenous consumers. These labels provide an 'official' reminder of harm, and we know that warning labels on tobacco are read and recalled by Indigenous smokers (Nicholson et al., 2015). Hopefully alcohol warning labels will be even more influential.[13] The endorsement of the Indigenous community health sector for these labels is an example of a national policy endeavour 'bringing the people along' with it and reaching grassroots communities.

WHO projects to strengthen action in indigenous and developing societies

The developing societies project

The Geneva office of WHO has responsibility for public health on a global basis. This includes a special responsibility for developing societies and smaller population groupings, not just nation states. In 1996, the WHO Program on Substance Abuse (PSA) decided to do something about the fact that most of the evidence on the impact of alcohol misuse and effective policy was derived from developed countries. The PSA initiated a project (Alcohol Policy in Developing Societies) to collate material from developing societies on the variety of cultural influences on drinking.

The first publication from the project was a 1999 WHO publication of case studies from eight developing countries (Riley & Marshall, 1999) followed by a richly detailed volume *Alcohol in developing societies: A public*

[10] 'Industry body says alcohol warnings pointless.' *ABC News,* 25 June 2007, 7.17pm.
[11] Industry-created warning labels were critiqued by FARE in 2013, see https://drinktank.org.au/2013/07/brewers-claims-about-alcohol-warning-labels/ and see FARE's report on consumer testing www.fare.org.au/wp-content.uploads/FARE-Labelling-Market-Testing-Report.pdf
[12] The minister in question was Richard Colbeck. https://www.smh.com.au/politics/federal/minister-met-with-alcohol-lobby-before-pregnancy-warning-label-sent-back-for-review-20200618-p553w9.html
[13] In November 2021 there was an attempt by the industry to reduce the powers of FSANZ, when Alcohol Beverages Australia proposed that the government should *exclude* public health matters from its brief, and relocate FSANZ from the Health to the agriculture portfolio. https://www.smh.com.au/politics/federal/alcohol-lobby-push-to-weaken-public-health-regulation-20211118-p59a7e.html

health approach (Room et al., 2002), co-published by WHO-Geneva and the Finnish Foundation for Alcohol Studies. The developing societies project revealed that several countries had no national alcohol policies, or had disjointed approaches (Riley & Marshall, 1999, p. 27, p. 69). It also highlighted the impact of colonialism, industrialisation, social transformation, new consumption items, and the maintenance of identity in the face of changing norms. As one of the project publications explained, the colonial past leaves 'strong marks on the alcohol situation in many parts of the developing world today, as well as in the "fourth world"' (Room et al., 2002, p. 27). The Project kept firmly to its brief, focusing primarily on developing societies (rather than the indigenous peoples within them or indigenous 'fourth world' peoples such as First Nations Canadians or Australians). Nevertheless, it included short case studies from Inuit in Alaska, Navajo in New Mexico and the Aboriginal people of Tennant Creek, NT. Contemporary life in these societies (and we might add, in Indigenous contexts in Australia), can be characterised as a *bricolage* that mixes Western consumption patterns and beverages with cultural and traditional practices, providing a welcome disruption to essentialist ideas about culture and tradition. There is much of relevance to Indigenous concerns in these publications, including the legacies of history, the influence of age and gender, drinking customs and the incorporation of alcohol into exchange networks, 'wet' and 'dry' drinking cultures, and the globalisation of alcohol industries and their marketing activities in poor and marginalised communities. A sociological imagination and acknowledgement of the value of ethnography permeated these two WHO-affiliated publications, expanding on the usual orientation of public health and addiction research.

In the 1990s, WHO began to pay more attention to the burden that alcohol-related problems placed on indigenous peoples worldwide. This was because an International Decade of the World's Indigenous People was declared between 1994 and 2003 and WHO had a mandate to develop a global program of action. WHO is the only global agency to take consistent responsibility for alcohol problems internationally, including alcohol problems affecting indigenous peoples; the International Labour Organization (ILO), the World Bank, and the UN Office of Drugs and Crime take only a sporadic interest in alcohol and are often diverted into other drug issues.

WHO and the Indigenous Peoples and Substance Use Project

The decade provided the impetus for member states to develop integrated policies to improve the health of their indigenous populations (PAHO, 1995), and WHO announced it would be increasing cooperation within the UN system and its member states to make this possible. It would assist governments to address indigenous health needs in a culturally effective manner, provide member states with technical support, and consider how it could contribute to the promotion and maintenance of indigenous knowledge (WHO, 1995). As part of the focus on Indigenous populations, WHO's Programme on Substance Abuse (PSA) started a project on indigenous peoples and substance use involving all regions. The indigenous peoples project enabled direct contact between WHO policy makers, Indigenous program managers and other stakeholders concerned with alcohol and other drug use. It brought them together for workshops and meetings, supported Indigenous networks, commissioned country-specific situation analyses, research papers and reviews, and arranged placements. I describe what I know of it here as an example of WHO's attempts at engagement with a disparate and varied set of stakeholders.

The project arose in response to requests from indigenous sources, as well as the findings of a Street Children project (1991–1996) that had found the majority of the vulnerable street children throughout the world to be indigenous youth, sniffing glue and taking other drugs[14], indicating the need for the PSA to address indigenous peoples' substance use (Alderete, 1999). The projects' objectives were to identify and develop culturally appropriate interventions to reduce alcohol and other drug harm, run pilot projects, and establish a network of

[14] Dr Andrew Ball, Director-General's Office WHO, *pers. comm.*, 1 June 2021. In the 1990s Dr Ball (an Australian) was an addiction specialist in the Program on Substance and his energy largely drove its engagement with indigenous peoples.

indigenous people working in prevention and treatment. It aimed to describe the nature and extent of drug use problems among indigenous communities and identify culturally appropriate interventions to reduce its harms. The project asked how local communities could develop effective local responses. Phase I involved commissioning case studies or overviews from up to 15 indigenous communities around the world to get an idea of the range of issues and the interventions taking place, if any. There were papers from Tonga, Morocco and Greenland, the Ogoni people of Nigeria, the Portiguara Indians of Brazil, and a Vietnamese hill tribe among others. Two case studies were commissioned from Australia, one on Aboriginal youth and the other focused on the Torres Strait (cf. Emblad, 1995). Dr Marcia Langton[15] and I attended a meeting focused on resilience strategies organised by the UN Division of Social Policy and Development in February 1995, along with indigenous experts and observers from different countries (Brady, 1995a). Prominent contributors were Maggie Hodgson from the Nechi Institute (Canada), Mike de Gagné (Health Development Canada), Myrna Cunningham (Nicaragua) and representatives from the Sami Parliament (Indigenous groups in the Nordic area). This meeting recommended that the WHO take an active role in responding to substance use problems in indigenous peoples worldwide because it was the most appropriate body to provide technical assistance.

In Phase II of the project, the PSA convened consultative meetings in different countries, involving many of those who had attended the 1995 UN meeting. There was a planning meeting held in Costa Rica in March 1996. The meeting aimed to prepare a framework for the development of practical guidelines for indigenous communities to create their own local action plans, policies, and programs. Country representatives prepared overview papers in advance to document the available services, programs, and the role of communities in their respective countries. At the suggestion of the Maori delegates,[16] the discussions were framed by the five action areas nominated in the WHO Ottawa Charter for Health Promotion. *Strengthening local community action* is one of the Ottawa Charter's five areas for action to improve health that the group found a useful template for discussion and basis for action-planning (AIATSIS, 1996; WHO, 1996).[17]

The meeting generated some international cross-fertilisation of alcohol policies and strategies designed to meet the needs of Indigenous populations. For example, the Maori representatives shared material from their Manaaki Tangata ('caring for people') program, framed to support Maori alcohol workers. It also included a resource kit for safer alcohol use and information on how to develop a Manaaki Tangata hospitality policy for serving alcohol at home, at marae (Maori community centres) and sports clubs (Alcohol Advisory Council, 1994). Since 1974, residents of marae have been able to apply for special short-term licences to serve alcohol for social events, a strategy that has not been tried in Indigenous communities in Australia. The significance of the Manaaki Tangata approach is its acceptance of the need to 'live with alcohol' safely – a harm minimisation approach – rather than promoting abstinence or bans on liquor on marae, which had been dominant strategies in earlier years. The Manaaki Tangata harm minimisation approach is similar to that of the NT Government's Living with Alcohol program (1992–2002); but unlike the case of the NT, Maori-instigated and run. Because Living with Alcohol was a *government*-instigated and run program there was some resistance from community-controlled Aboriginal organisations to its 'safe drinking' messages. Indigenous participants identified the need to develop a reference document on community action strategies as a priority objective. The paper submitted by Australia (AIATSIS, 1996) formed a framework for this and was the basis of *The Grog Book: Strengthening Indigenous community action on alcohol* (Brady, 2005), a guide to grassroots action informed by evidence-based policy.[18]

[15] Dr Langton had just written *Too much Sorry Business*, 1991, for the Royal Commission into Aboriginal Deaths in Custody, and was Chairperson of the Australian Institute of Aboriginal & Torres Strait Islander Studies (AIATSIS) Council (1992–1998).
[16] Margaret Manuka-Sullivan and Kayleen Katene were both from the New Zealand Alcohol Advisory Council.
[17] The five action areas nominated in the Ottawa Charter for Health Promotion are: Building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and reorienting the health services.
[18] The original idea for *The Grog Book* (first published 1998) as a community action manual came from Marcia Langton. WHO provided the opportunity for a first draft. Thousands of copies have been distributed free by the Australian Government since then (www.alcoholresources.gov.au). A South African version of the book was published in 2004.

In 1996 WHO arranged for Indigenous representatives to be seconded to Geneva to work on the project. This was made possible by the financial and logistical support of the national governments of three countries (Canada, Australia, and New Zealand). The late Coralie Ober from Queensland was one of these secondments and she worked out of the WHO/PSA office for several months. With Pacific Island, Aboriginal and Torres Strait heritage, Ober was an experienced health and substance use researcher and advisor. In Geneva she worked alongside Kayleen Katene from New Zealand. They drafted a policy guide for governments, with guiding principles based on community involvement in health and the recognition of indigenous groups as peoples in their own right. The indigenous secondments benefited both the WHO project and the individuals involved who later made major contributions in their home countries. In the years after the WHO placement, in Queensland Ober co-developed and validated an Indigenous-specific screening test (the IRIS: Indigenous Risk Impact Screen), for the early identification of alcohol and other drug problems and mental health risks. It was found to be reliable, simple, and effective (Schlesinger et al., 2007; Islam et al., 2018).[19] Kayleen Katene is now in the New Zealand Ministry of Health.

WHO's global and local funding difficulties

Once the secondments finished, there was no new funding for the later stages of the WHO Indigenous project, so the activity (which had been gaining momentum) came to an end. This was disappointing given how much work went into the earlier phases and how fruitful the project had been; indeed the demise of the Indigenous Peoples and Substance Use project is an illustration of how funding limitations constrain WHO's ability to maintain indigenous participation.

Its demise may have been related to a dwindling of WHO work on alcohol in the late 1990s referred to by Room (2021, p. 427) who attributes this in part to pressure from tobacco and alcohol interests. WHO confronts ongoing budgetary constraints and has difficulty in raising money for alcohol research programs. WHO's funding comes from obligatory contributions from member states (calculated according to their population and Gross Domestic Product [GDP]), and voluntary contributions from states, philanthropic foundations, and the private sector. The bulk of funding, particularly for areas such as alcohol (viewed as contentious and somewhat marginal), comes from voluntary contributions. The early 1990s brought some new funding for alcohol issues, however at present (2022) this funding is at a low level (Room, 2021, p. 423; Editorial, 1991, p. 1387).

It is the wealthy developed countries (Canada, the US, New Zealand, Australia) who can afford to contribute funds to indigenous projects such as the one I have described.[20] This may have the effect of providing greater benefits to indigenous people from those countries rather than, say, indigenous and tribal peoples from poorer countries, such as the Maya of Guatemala or the Akha Hilltribe peoples of Thailand – groups who had contributed overview papers to the WHO project. Certainly not all these indigenous groups from developing countries are always able to send representatives to WHO workshops and brainstorming sessions. At present (2022), because of conflicting priorities and a lack of external funding, there are no WHO projects or activities targeting indigenous populations in the alcohol, drugs and addictive behaviours unit. The unit has had several meetings with representatives of indigenous communities and UN entities but it has been unable to secure sustainable funding support.

In the absence of any specific projects at present on indigenous substance use, the needs of indigenous populations are being included in the drafts of the Global Action Plan on Alcohol.[21] At the sub-national level, the

[19] Coralie Ober was a research fellow at the Queensland Alcohol and Drug Research and Education Centre at the University of Queensland School of Population Health, a deputy co-chair of the National Indigenous Drug and Alcohol Council (abolished by the Liberal government in 2014), and a director of FARE. Sadly, she died in 2015.
[20] The Australian government's Drugs of Dependence branch, together with AIATSIS, contributed funds to allow for Australians to participate in the meetings of the Project. Health Canada funded the Costa Rica planning meeting.
[21] *Pers. comm.*, Dr Vladimir Poznyak, Department of Mental Health and Substance Use, WHO, June 6, 2021.

WHO Collaborating Centres (in Canada and Australia for example), may be in a position to engage with and assess the needs of First Nations and Indigenous peoples by developing linkages with local service providers. WHO has established 800 Collaborating Centres worldwide to support, coordinate and use existing networks to give greater visibility to the health issues that WHO tackles within their countries. It creates an international collaborative network that uses national institutions for international purposes. [22] For example, one WHO Collaborating Centre located at the University of Adelaide,[23] in conjunction with Drug and Alcohol Services South Australia has been trialling the WHO's ASSIST program (Alcohol Smoking and Substance Involvement Screening Test) and arranging for it to be translated into the Western Desert language Pitjantjatjara. It has already been translated into languages such as Arabic, Chinese and Farsi, and tested in Australia, Brazil, India, and Puerto Rico. [24]

Healing our Spirit Worldwide: A grassroots network

Although the paucity of global funding has caused WHO's direct engagements with indigenous projects to falter, WHO has made other attempts to support local indigenous needs.[25] An independent network of indigenous practitioners in the substance abuse field was created in the early 1990s, and with WHO support and sponsorship it has flourished since then as Healing Our Spirit Worldwide (HOSW).

HOSW was the brainchild of First Nations Canadian Maggie Hodgson who was previously the Executive Director of the Nechi Institute in Alberta, a training centre for Native substance abuse workers. She had the idea of creating regular 'gatherings' of indigenous peoples working in addictions and health from around the world, to share ideas and highlight programs and healing in alcohol and substance abuse. In 1990 Hodgson promoted the idea at the International Congress on Alcohol and Addictions (in Berlin) and lobbied WHO for support.

The Canadian government agreed to fund and host the first of the HOSW gatherings in Edmonton, Alberta in 1992, which was co-sponsored by WHO. It was described as a world indigenous conference promoting addiction-free lifestyles; it also included cultural performances. Around 3300 indigenous people from 17 countries attended, including a large contingent from Australia. Donnaleen Campbell, then a trainee editor of the *Aboriginal and Islander Health Worker Journal,* was invited to present. The second HOSW was held in Sydney in November 1994, hosted by the New South Wales Department of Health. A Geneva-based representative from the WHO Program on Substance Abuse attended that gathering and met with Indigenous representatives to invite contributions and directions for the Indigenous peoples' project. In 1998 WHO commissioned a paper on the Health of Indigenous Peoples for discussion during the third HOSW conference in Rotorua, New Zealand; this was also co-sponsored by WHO. The conference provided an opportunity for networking among indigenous people in the health professions (Alderete, 1999). Planning is underway for the ninth HOSW gathering which will be in Vancouver in 2023.

Screening and brief interventions: Delayed dissemination

One of WHO's major contributions to alcohol policy in recent years has been its support for cross-national trials of alcohol treatment approaches that can be delivered as an early intervention to large numbers of people through primary care services. This work is a further example of its global, international role having relevance

[22] https://www.who.int/about/partnerships/collaborating-centres
[23] The Australian Institute of Health and Welfare in Canberra is also designated as a WHO Collaborating Centre.
[24] *Pers. comm.*, Dr Robert Ali, University of Adelaide, July 2021.
[25] Indigenous representatives are of course included in WHO activities through many different WHO offices and teams. For example, to mark the International Year of the World's Indigenous Peoples in 2021, with the theme 'Leaving no one behind: Indigenous peoples and the call for a new social contract', the Gender, Equity and Human Rights Team convened a webinar (during the Covid pandemic, August 9, 2021) on social inclusion approaches for the health of indigenous peoples in rural and remote areas. It was chaired by a member of the Standing Rock Sioux who is also a member of the UN permanent forum on indigenous peoples, and had contributions from indigenous representatives from India, Brazil, Arizona USA among others.

and applicability at the community level. Here I outline the challenges faced in attempts at disseminating a WHO-endorsed treatment approach into Australian Indigenous primary care settings.

In the early 1980s there was a growing awareness that most alcohol-related harm was not experienced by 'alcoholics', and that a much greater number of people in the general population who engaged in harmful consumption were going unrecognised. Because of this, a WHO collaborative study was instituted on the early detection of harmful drinking. The first phase examined simple screening instruments; the second phase worked on the development and evaluation of methods of 'brief intervention' (Saunders, 1987, 1995; WHO Brief Interventions Study Group, 1996). WHO defines brief interventions as practices that aim to identify a real or potential alcohol problem and motivate an individual to do something about it. A brief intervention is a form of secondary prevention which assesses a person's current drinking and gives simple advice on health risks before problems become intractable. The studies led to the development of simple screening instruments (questionnaires) to identify non-dependent drinkers in primary care settings who were at high risk, and the trialling of brief interventions by health workers (WHO Brief Intervention Study Group 1996, pp. 948–955). This became known as 'SBI', screening and brief intervention.

To test this approach in different cultural groups and healthcare settings, a randomised clinical trial with 1600 participants took place in eight countries. Australia's National Drug Strategy (NDS)[26] supported the clinical trial along with WHO, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in the United States, and several other countries. Australian university-based research centres and alcohol clinicians had a close involvement with the WHO studies, and Australia was one of the eight SBI trial sites. The Darwin sample included 30 respondents who were Aboriginal; their responses were similar to those of other subjects[27] The study found that brief interventions reduced daily alcohol consumption by 17% and reduced the number of alcohol-related problems and emergency department admissions.[28] This study also developed and provided international validation for the AUDIT (Alcohol Use Disorders Identification Test), a simple screening test designed to detect risky and harmful drinking patterns, finding that it was a suitable screening tool in both developed and developing countries. WHO concluded that 'strong evidence points to the frequent effectiveness of simple help given in general or primary care settings, and the importance of the primary care response to drinking and drinking problems deserves strong emphasis' (Edwards et al., 1995, p. 210).

Following these findings, the Australian NDS disseminated information for General Practitioner (GPs), encouraging them to provide 10-minute interventions with suitable patients, screen using the AUDIT, and provide advice on 'standard drinks'. Medical schools were funded across the country to educate trainees in drug and alcohol detection, researchers were finessing interviewing techniques and the best ways to support and resource GPs (Saunders & Roche, 1989; Mattick & Jarvis, 1993, p. 149). The question was, would these recommendations from the international and national research findings extend their reach into Indigenous community health settings? And would these alcohol interventions produce similar results with Indigenous subjects?

Although the NDS had initially targeted GPs in 1986 with information about brief interventions, there was no strategy to target Indigenous primary care settings via their community-controlled health services or peak body, and this failure delayed dissemination of the approach to this sector by several years (cf. Kingdon, 1993). Even if they *had* been exposed to the principles of brief interventions, instead of seeing alcohol problems as being part of the daily work of their primary care clinics, most Aboriginal health services at that time saw alcohol

[26] Originally known as the National Campaign against Drug Abuse (1985).
[27] *Pers. comm.*, Professor John B. Saunders, 16 July 1997, who noted that this had never been formally published because of the small numbers but gave me permission to quote him. The Australian patients contributing to the overall sample for the WHO study numbered 273 men and 124 women (WHO Brief Interventions Study Group, 1996).
[28] A Cochrane review in 2018 examined 69 studies of brief interventions and found generally positive results along with five reports that provided very low-quality evidence of adverse effects. Their conclusion was that there was 'moderate quality' evidence that brief interventions reduce alcohol consumption in hazardous and harmful drinkers (Kaner et al., 2018).

problems as being the responsibility of tertiary treatment – the residential rehabilitation programs and sobriety groups who treated 'alcoholics'.[29] And new ideas had not reached the residential rehabilitation programs either. They were still locked into the disease model and abstinence goals using the Minnesota model based on the 12 Steps. In part this was because they were disconnected from the broader-thinking networks of the mainstream therapeutic communities, and because they were funded through the Aboriginal Affairs portfolio rather than the Department of Health. There was a failure by the residential programs to facilitate training in a wider range of techniques for the ex-drinkers who filled the role of counsellors. In the late 1990s, a survey of state/territory and non-government drug and alcohol agencies primarily serving Aboriginal people found that Aboriginal community-controlled agencies offered a *limited range* of treatment options. They were unaware of the new approaches to treatment domestically and internationally (Brady et al., 1998; cf. Shakeshaft et al., 2010).[30]

In my lectures to CAEPR MA students, I suggested that Granovetter's (1973) social networking theory of the 'weakness of strong ties' explained the limited range of treatment options available at the time. The Indigenous alcohol treatment programs had been run by dense networks of people with strong ties to one another through their shared experiences. These people thought similarly about issues and accessed the same sources of information. They had little contact with government services or non-government organisations (NGOs) beyond their circle, and had little communication with federal or state health departments other than acquitting the requirements of their grants. In Granovetter's theory, strong ties such as these are a weakness because they prevent people from accessing information from more distant parts of the social system. On the other hand, the strength in having many 'weak' ties to a wide range of loose networks from further afield in the social system (acquaintances, colleagues and work contexts), is that it allows for the free flow of more and different information, innovation and new ideas.[31]

Policies that could make a difference

In 2010 the health ministers of 193 Member States, including Australia, signed on to the WHO Global Strategy to Reduce the Harmful Use of Alcohol. This represented an international consensus that reducing alcohol harm and its health burden is a public health priority (Jernigan, 2012, p. 81; WHO, 2018). This includes action on WHO's recommended three most effective alcohol policy approaches – their 'best buys' (WHO, 2017):

- alcohol pricing and taxation
- regulation of marketing and promotion, and
- limits on physical availability.

Putting these approaches into action will not always be within the power of the community, but each of them – price, marketing and availability – has particular resonance for the Indigenous domain.

[29] To align brief alcohol interventions with the daily work of an ACCHS, as well as fulfil the demands of 'gold standard' proof of efficacy, a team including myself started a randomised controlled trial (RCT) in an urban Aboriginal health service (1997–98). It was not successful, but not because brief interventions didn't 'work'. The methodology necessary for a RCT acted as a barrier to -lAboriginal participation as we described later (Sibthorpe et al., 2002). Roche & Freeman (2004) discuss mainstream service providers' difficulties with delivering brief interventions.

[30] Several respondents did, however, express interest in learning about different approaches to treatment and non-abstinence goals. These Indigenous drug and alcohol workers had clearly not had the opportunity to learn new skills.

[31] My personal attempts at dissemination included writing a technical report for the National Drug and Alcohol Research Centre in 1995 on how brief interventions could be part of 'broadening the base' of alcohol interventions for Indigenous people (Brady, 1995c). This work was supported by Professor Wayne Hall. I encouraged Central Australian doctors to use brief interventions to give Aboriginal people an 'excuse' to stop drinking (Brady, 1998). In 2003 the Department of Health and Ageing published our brief intervention resource for GPs to use with Indigenous patients (Brady & Hunter, 2003) and Brady, Hunter and others also conducted workshops for rural GPs and frontline workers. I suggested Indigenous treatment centres should network more freely with mainstream therapeutic communities in order to broaden their knowledge base (Brady, 2002).

Alcohol pricing: A WHO 'best buy'

Well-evidenced research collated by the WHO shows that increased alcohol prices and appropriate taxation has a gold star for effectiveness in reducing alcohol consumption and harm. This is because the heaviest drinkers and those most at risk of harm, disproportionately use the cheapest alcohol (Riley, 2017, p. 84). In 2010 Australia's Henry tax review recommended a volumetric tax on all alcoholic beverages – that is, a tax levied on the actual alcohol content of drinks (Skov, 2009).[32] But despite the findings of the Henry review, Australia's support for the WHO Global Strategy (via our National Alcohol Strategy 2019–2028), the advice from WHO, and the previous experience with the NT alcohol levy, Australia has equivocated nationally about reforming the pricing and taxation of alcoholic beverages.

Australia's NT has put advice on pricing into practice on two occasions. In 1992 the NT imposed a small levy on drinks containing more than 3% alcohol by volume as part of its successful 'Living with Alcohol' program (1992–2002), and subsequent studies demonstrated that this 'tax' was the primary effective measure of that program (Chikritzhs et al., 2005). However, a High Court ruling disallowed the levy.

A later review (the Riley Review) of alcohol policies and legislation in the NT, was convinced by several key WHO studies that pricing measures were an effective tool for governments to reduce harm, and it recommended a floor price be implemented by the government as a priority (Riley, 2017). The Riley Review recommended that the Australian Government should show leadership, drive appropriate reform to alcohol taxation, and recommended a single volumetric tax across all alcohol products. The NT Government followed this advice in October 2018, and placed a $1.30 minimum unit price on beverages containing at least 10 grams or alcohol – or one standard drink. The aim was to minimise the harms arising from the use of high-alcohol, low-cost beverages such as cask wine, which contributes inordinately to alcohol problems among vulnerable drinkers and in disadvantaged communities. The minimum price applies to on-trade, off-trade and online sales, but the price is set low enough that it has little effect on on-trade prices.

It is important to note that this policy intervention to raise the price of high alcohol-content drinks – recommended at the highest level of international policy-making – has had strong support from grassroots Indigenous organisations including Congress, the Aboriginal Community-Controlled Health Service (ACCHS) in Alice Springs. Also in Alice Springs, the civil society group People's Alcohol Action Coalition (PAAC) argued tirelessly in favour of minimum unit pricing (MUP). It called out the unethical price-cutting behaviour of liquor outlets and has lobbied supermarkets to stop selling wine for less than $8 per bottle (PAAC, 2011).[33] The Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council (NPYWC) reported on its own alcohol advocacy saying:

> *We are also a member of PAAC…and continue to support the push for an increase in the price of a standard drink, or 'floor price' so that beer is the cheapest drink, and for a takeaway-free day. We also want to see stronger rules for local bars that serve many Aboriginal drinkers (NPYWC Aboriginal Corporation, 2010, p. 17).*

Local NT medical officers such as Steve Skov and John Boffa invoked WHO's research findings as a way of rebutting arguments opposing the MUP e.g. the argument that increased prices penalise most drinkers for the bad behaviour of a few (Krein, 2011). The Aboriginal-controlled and community sector showed itself to be strategically in advance of the government and the general public, who are generally less supportive of price rises than they are of other public health policies on alcohol (Hogan et al., 2006; Smee, 2018; Wilkinson et al.,

[32] In Australia, wine is taxed differently from other alcoholic beverages, and a volumetric tax would sharply raise the price of cask wine, which can be very cheap and is known to be the cause of harm.
[33] It is notable that MUP usually has the support of publicans, who complain with some justification that it is the supermarkets and liquor barns whose cut-price promotions and sales of large containers are responsible for most of the alcohol-related harms, not pubs.

2009). As in the case of health warning labels, the lobbying and networking of concerned service providers, NGOs and civil society was crucial in providing support for the MUP (Patay et al., 2022).[34]

MUP is beginning to show the desired effect: a recent analysis of NT sales data by Taylor and colleagues (2021) shows that per capita consumption of cask wine has halved, without significantly increasing sales of other types of alcohol. A before and after study of intensive care in Central Australia showed alcohol- and trauma-related admissions were reduced following a range of new harm minimisation policies including the MUP (Wright et al., 2021). So far, the Territory is the first and only jurisdiction in Australia to implement a MUP. It follows similar moves in the United Kingdom: Scotland introduced the MUP in 2018 and Wales in 2020.[35] The NT, Scotland and Wales provide examples of one of WHO's most strongly recommended policies being implemented at the sub-national level. Along with the implementation of policies on alcohol warning labels, the MUP will reduce harm among Indigenous consumers as well in the general population.

Regulation of alcohol marketing and promotion: A WHO 'best buy'

Alcohol marketing is a global industry: the largest corporations extend their influence across industrialised nations as well as developing ones. There is also clear evidence of industry penetration of the Indigenous domain and I discuss two examples here. One is the burgeoning number of industry partnerships and sponsorships with Indigenous organisations – a result of government failure to adequately fund community services, grassroots programs and youth activities. This failure allows the alcohol industry to step in and fill the gap in funding. The second example of the industry capitalising on the Indigenous domain, is its deployment of Indigenous imagery and symbolism on and around its products. As Babor and colleagues suggest in their WHO research volumes, the question for policy-makers is whether the promotion and marketing of alcohol should be regulated *in the public interest* or whether it should be left to the industry to self-regulate? (2003, p. 173). How much power do local communities and leaders have in this endeavour?

People at the grassroots have limited scope to influence policy on the marketing and advertising of alcohol. Indigenous communities do have some powers however, such as making decisions over advertising billboards on their land or curbing the promotion of alcohol on TV and radio stations they control, on premises they own, and in licensed social clubs on Indigenous communities. Nevertheless, Indigenous organisations need to be on the alert to industry tactics that target the Indigenous domain, such as co-opting Indigenous spokespeople, sponsorship schemes, education programs, establishing charities, and donations to grassroots organisations: all these things are happening.

In Australia, DrinkWise has moved into the Indigenous health promotion and public awareness field. It has recruited prominent Aboriginal actors, Aaron Pedersen and Deborah Mailman, alcohol activist June Oscar, and the AFL player Aliesha Newman to narrate alcohol educational videos about drinking, peer pressure, and FASD.[36] For decades, these industry-related organisations have deliberately delayed the finalisation of health warning labels on alcohol containers about FASD. The fact that they have now produced FASD awareness advertisements using well-known Aboriginal narrators can only be described as disingenuous. It is important that Indigenous health organisations and spokespeople tempted to become involved in industry-funded health promotion activities, should be fully aware that they are being used to create image-polishing good news stories for bodies that may have vested interests in promoting alcohol use.

[34] However, in some contexts, alcohol is known to be price 'inelastic'. Anthropological fieldworkers have documented that in some regions and under certain circumstances Indigenous drinkers will pay inflated prices for alcohol (Gray, 2012; Martin, 1998; cf. Babor et al., 2003, pp. 107–110).
[35] Significantly (and cleverly), the Welsh act is known as the *Public Health* (Minimum Price for Alcohol) Wales Act, 2018 (emphasis added).
[36] https://drinkwise.org.au/our-work/indigenous-education-resources-and-partnerships/#

Industry partnerships with Indigenous groups

When governments fail to provide sufficient funding for the community sector, industry funders can step in. Governments welcome these arrangements that relieve them from providing extra funding, and the alcohol industry encourages arrangements that provide them with useful bargaining chips, for example when difficulties arise in negotiating development plans or other proposals with government. To counter these activities and avoid funding gaps that allow the industry to pick up the tab, good alcohol policy needs to include the appropriate and adequate distribution of government resources.

The alcohol industry has been ingratiating itself with Indigenous community-based organisations through its supposedly good deeds offering funding, sponsorships and 'partnerships'. These arrangements are presented as evidence of their corporate social responsibility and friendly relationships with community organisations, thus providing what some researchers have called the 'illusion of righteousness' (Yoon & Lam, 2013) for those people Kowal identifies as 'White anti-racists' (Kowal, 2015)

The Endeavour Group[37] (previously part of Woolworths) that owns the largest retail drinks network in Australia, Dan Murphy's and BWS, claims that it has collaborative solutions to Indigenous alcohol-related harms and publicises its philanthropy and Indigenous 'partnerships'. Endeavour Group now contributes funds to the otherwise underfunded Darwin Larrakia Night Patrols – whose tasks include dealing with public intoxication. Such an apparent act of goodwill should be viewed in the light of a relentless five-year long campaign (2015–2021) by Woolworths/Endeavour to establish a Dan Murphy's liquor megastore in Darwin in the vicinity of Larrakia communities. It should also be seen in the context of disagreement among the local Larrakia people about the development. Woolworths' pressure for the development to go ahead near two 'dry' and vulnerable urban Aboriginal communities continued in the face of well-publicised vehement opposition from Indigenous, public health and civil society organisations, and the public. In a surprising development, after the proposal had been rejected by official channels, the NT Government intervened to *facilitate* approval of the megastore by pushing through a sudden policy change. The government empowered the Director of Liquor Licensing to make the decision without needing to consider the community impact and public interest (Chikritzshs & Weeramanthri, 2021, p. 9).[38] Eventually, after a highly critical review of Endeavour Group's consultative processes by Gilbert and Tobin lawyers, the company withdrew the proposal in April 2021. It is remarkable that while the Endeavour Group was continuing to push ahead with this highly contested development in Darwin, it was being welcomed as a new member of the industry-funded International Alliance for Responsible Drinking (mentioned earlier) designed to 'help shape global standards for alcohol sales'.[39]

The Endeavour group has created another Indigenous partnership in Cape York, with Jawun (a small not-for-profit organisation) and arranges for the secondment of business and corporate representatives to work with and 'build capacity and economic independence' in Indigenous communities such as Mossman Gorge. 'This is a good news story' proclaims a headline on the joint Jawun/Endeavour Group website.[40] In New South Wales, the Endeavour Drinks Group supports The Glen, an indigenous men's residential drug and alcohol rehabilitation centre on the Central Coast, as well as a youth program, the Tribal Warrior Aboriginal Corporation in Redfern (Endeavour Drinks Group, 2017).

Appropriating Indigenous imagery and concepts

[37] Endeavour Group 'demerged' with Woolworths in May 2021, presumably so that Woolworths can promote itself as a wholesome business free from associations with gambling and booze.
[38] The unprecedented intervention of the NT Government would undoubtedly have allowed the Dan Murphy's store to proceed, had Woolworths Group not dumped the project in 2021.
[39] https://www.endeavourgroup.com.au/news-and-media/endeavour-group-identified-as-international-leader-in-responsible-supply-of-alcohol
[40] See jawunedg.com.au

The authors of the WHO-affiliated volume that identified alcohol as 'no ordinary commodity', point out that alcohol brands target local markets (through television, radio, print, point of sale strategies and the internet), and develop niche markets by associating brands with lifestyles, sporting events, and consumer identities (Babor et al., 2003, 173). We can now add 'Indigenous identities and symbols' to this list, as a form of alcohol marketing is emerging that engages directly with Indigenous tropes, particularly in the wine industry (which contributes around $45 billion in gross output to the Australian economy) (Gillespie, 2019).

Wine producers are increasingly communicating with local Indigenous groups in order to claim a degree of corporate social responsibility while increasing their sales. For example, in a bid to demonstrate that they recognise their grapes are produced on Indigenous land, some wine growers are printing an 'acknowledgement of country' on their wine labels (Allen, 2021). Emma Kowal (2015, p. 92) has discussed the origins of acknowledgements of country (and Welcomes to Country), as examples of:

> *The work that White anti-racists do to create and maintain their identity and remain intelligibly 'anti-racist' to Indigenous and non-Indigenous observers … [it is] a culture, discourse and identity most prominent in educational, academic and bureaucratic settings, that certain people within those settings invest in.*

In keeping with this trend, there is discussion among wine growers, commentators and indeed some Aboriginal people from the wine-growing regions of settled Australia about the putative associations of *terroir* (a concept that incorporates the physical and metaphysical aspects of soil, climate, landscape and people, into the character of wine) with Aboriginal notions of 'Country'.[41] Wine makers are re-naming their wines, for example using original Aboriginal language names for country. They are even naming wines after Aboriginal people: *Billi Billi Shiraz* is named in honour of an 'Aboriginal king' who lived near the owner's property at Mount Langi in Victoria. You can buy it at Dan Murphy's. Some wineries are hiring Aboriginal artists to produce artworks for their wine labels.[42] Others use Aboriginal-style artwork apparently without evidence of Aboriginal participation in its production. The Italian-Australian company Casella Wine for example uses an Aboriginal-style graphic of a kangaroo on its 'Yellowtail' wines – over 1 billion bottles of this wine have been exported to over 50 countries (McIntyre et al., 2019, p. 61). In the US a craft beer company called Down the Road Beer Co. makes cans of 'Dreamtime New England IPA'. This features New Age-style imagery of an Aboriginal male head with feather and headband. Its 'hazy, New England style' beer, made with Australian hops, will apparently allow the drinker to 'breathe deep the stardust of [your] ancestors'. Such practices allow wine and other alcohol makers to imagine themselves to be culturally aware, concerned and supportive 'White anti-racist' businesses.

This is a little different when the wine growing or wine marketing enterprise has full Indigenous participation and ownership. In these cases, the corporations do (usually) have the cultural authority to select their own imagery and marketing strategies. In Canada, the Nk'mip 'Spirit Ridge' vineyard and winery in British Columbia is owned and worked by Osoyoos First Nations. Their wine labels depict images derived from rock art specific to the local area, and drawings of their ancestors' stone artefacts. They also use local language terms (along with English ones) to name wine types; and their high-quality wine is sold on the premises along with drums, masks and other culturally significant items (Brady, 2017). In Australia an Aboriginal owned and run vineyard in New South Wales, Murrin Bridge Wines, produced wine between 1998 and 2008. It was the first Indigenous vineyard in Australia.[43] This business used labels designed by an Aboriginal designer of their choice – a well-known local artist, Lindsay Kirby. These First Nations wine producers in British Columbia and New South Wales made the most of their Indigenous heritage in their imagery, products, and advertising. Significantly, however, neither

[41] Max Allen: Australian Terroir – Belonging to Country (caulfieldmountain.blogspot.com)
[42] One Victorian winery displays Aboriginal art in its cellar.
[43] In 2005 I spoke to Craig Cromelin, who was instrumental in starting Murrin Bridge Wines. He said he was greatly encouraged by feedback such when a Murri woman called him to say how fantastic it was that an Aboriginal group was making wine. She said that it made her proud to be Aboriginal (Craig Cromelin, *pers. comm.*, August 2005).

Nk'mip nor Murrin Bridge wines made or marketed cheap, high-volume products such as cask wine. Both aimed at the high-quality wine market.

There is a growing fashion for native ingredients and natural fermentation which is spurring experimentation with indigenous species of grape, bush fruits and even green ants being added to spirits, beer, and wine. A few Aboriginal entrepreneurs are experimenting with these products as well, including Larrakia man Daniel Motlop who is associated with Seven Seasons Pty Ltd,[44] and others making non-alcoholic beverages are drawing on these 'indigenous' tropes.[45] Producers are increasingly reaching out to Aboriginal and Torres Strait Islander groups for their endorsement. Around 98% of Australian wine enterprises employ fewer than 20 people, and many are small, family managed vineyards. This perhaps allows winemakers more opportunity for negotiation and discussions with local Indigenous people (Gillespie, 2019).

Some of the ethical complexities of these developments have been raised by wine writer Max Allen (2020). It is hard to put aside the extent of the physical, social and emotional harms caused by alcohol in the history of Australia, and the duplicitous behaviour of alcohol producers, retailers, and their representative organisations, some of which persists today. It is also hard to avoid remembering that all marketing – whether it has Indigenous credentials or not – is aimed at selling more alcohol. Marketing strategies that exploit the public interest in all things Indigenous may not necessarily be problematic, but they still need careful surveillance and consideration by Indigenous stakeholders. Such marketing arguably appropriates Aboriginal culture rather than respecting it. It is still a marketing strategy – and one that is designed to appeal to the radical sympathies of those who might purchase this wine: a segment of the public anxious to acknowledge that they live on unceded Aboriginal land. The question for Indigenous people is whether this is a homage to aspects of their culture, or opportunistic appropriation? It may be that relevant Indigenous groups need to make new policy decisions to help them distinguish between acceptable and unacceptable industry uses of their designs, language, and natural resources.

Regulating physical availability: A WHO 'best buy'

Evidence compiled by WHO's international research teams has provided strong support for the need to regulate availability, a strategy that includes measures such as setting a minimum age at which alcohol can be purchased, restricting hours and days of sale or sales of certain categories of beverage, and restrictions over outlet density. In the Indigenous context, among the alcohol misuse interventions that have been evaluated, targeted restrictions regarding supply have demonstrated successful outcomes. As an intervention they are 'external' and impersonal and from a grassroots perspective, avoid the perception that local leaders are 'bossing' people about or restricting their 'rights' – unacceptable in circumstances where there is a cultural ethic of non-interference in peoples' autonomy. They produce results that are more amenable to quantitative measurement (hospital and refuge admissions, trauma cases, mortality) (Gray et al., 2000; Saggers & Gray, 1998; e.g. Wright et al., 2021) than are health promotion or education campaigns. These are more difficult to evaluate.

Limiting the physical availability of alcohol is a leading example of how an internationally-validated policy disseminated by WHO – one of its recommended 'best buys' – can be mobilised at the community level. While communities are unable to make the liquor laws themselves, in many Australian instances there are examples

[44] https://glamadelaide.com.au/daniel-motlop-launches-seven-seasons-gin-at-digitally-immersive-party/
[45] Non-alcoholic beverages also draw on these notions (such as promoting a healthy lifestyle), including a non-alcoholic craft beer 'infused with native ingredients' launched by a Gamilaroi man Clinton Schultz and reported in December 2017, see https://www.sbs.com.au/nitv/article/2017/12/05 'Plans to shake up Australian drinking culture with Indigenous non-alcoholic craft beer' by E. Archibald-Binge.

of regulations on availability being adopted, adapted, and put into practice by Indigenous groups in remote and rural settings or smaller neighbourhoods.

Indigenous groups have successfully operationalised these mechanisms over the last 30 years using Australia's state/territory liquor laws, despite the first attempt to regulate the physical availability of alcohol ending in failure. In 1971 Yolngu leaders of Yirrkala in northeast Arnhem Land lodged objections to the licensing of a new pub (the Walkabout Tavern) planned for the nearby mining town of Nhulunbuy. After the initial application, objections in response, several more reapplications, new objections and dismissals of those objections, the Walkabout was granted a licence against Yirrkala's wishes.[46] Since that time, liquor regulations have allowed greater opportunity for community input, and local capacity building and better access to legal and land rights organisations have contributed to better outcomes, so that Indigenous objectors have had more success in curtailing or limiting licences. Much depends on the wording of state laws and whether these make allowance for community impact assessments when licensing agencies are considering the renewal or granting of licences. Aboriginal communities and/or their representative councils have in some regions of Western Australia, South Australia and the NT managed to restrict sales of certain drinks, delayed opening times of takeaway outlets, limited the hours and days of opening, and prohibited off-premises sales (see Brady 2000, p. 488–492; Brady et al., 2003; Saggers & Gray, 1998). Interestingly, this embrace of targeted restrictions contrasts with a tendency in the wider population to support deregulation and liberalisation.[47] Extended trading hours in hotels are now very common. Once regulations have been loosened, it is hard to tighten them (Marsden Jacob Associates, 2005).

Formal control over alcohol supply is a strategy that is often strongly supported by Indigenous organisations and communities. This is in part because it is an upstream strategy[48] that can be reinforced by regulation, using the authority of a licensing agency of some kind. The Aboriginal women who were the proponents of a ban on off-premises alcohol sales in Fitzroy Crossing in 2007 suffered harassment and resistance. They needed the authoritative back-up of external state agencies including the Coroner's office and the Director of Liquor Licensing, in addition to local community support (Brady, 2017, p. 231). June Oscar, a major proponent of the campaign, said:

> *To put a stop to this devastating crisis we had to make the law work for us... Our community worked with lawyers, Ministers and senior government officials to ensure that the WA liquor licensing act would be used for our interests…instead of privileging the vested interests of the liquor licensing industry. The chronic oversupply and overconsumption of alcohol was limiting our rights and freedoms (Oscar, 2018).*[49]

Since 1979 in the NT, Aboriginal communities have been able to regulate the physical availability of alcohol,[50] using a variety of 'local option' laws (as they are known in studies of alcohol policy); these allow local residents to decide on their liquor status. Widely seen as a democratic right, the principles inherent in local option laws are laudable: they enable those most affected by the presence and activities of a licensed outlet to have a say

[46] In subsequent years on its own admission the Walkabout did not enjoy the 'best of reputations' and was the subject of numerous complaints. In 1995 it was found guilty of supplying beer to an Aboriginal woman with a BAL of .35%. Its licensee now claims that management has 'embraced' the many changes to licensing laws and supply-side issues (Tourish, 2017, p. 1).
[47] One example has been the winding back of the Sydney lock-out laws, brought in to curb drunken violence in Kings Cross. Between 2014 and 2021 last drinks were at 3am, no movement allowed between venues after 1.30am, and restrictions were placed on certain types of drinks (shots etc.). In March 2021 (after sustained lobbying from industry and the public), 1.30am lock-outs were abolished, last drinks moved to 3.30am, and restrictions on shots were removed.
[48] Upstream strategies in health care deal with macro level factors and broadly-based initiatives; downstream strategies focus on providing equitable access to care (cf. Merck, A. 'The upstream-downstream parable for health equity', Institute for Health Promotion Research, San Antonio). https://salud-america.org

[49] The film about the development of the Fitzroy Crossing alcohol restriction is called *Yajilarra* (Marninwarntijura Women's Resource Centre, n.d.)
[50] The NT Liquor Act of 1978 gave Aboriginal communities and reserves the option of being declared as restricted areas by the Liquor Commission and the power to approve, establish or renew licences.

on an issue that affects their civic amenity (Taylor, 2019). Unfortunately, in mainstream Australia local option votes have fallen out of favour since the early twentieth century, particularly among governments who now believe them to be anachronistic. But in the NT, between 1978 and 2007 they were used by residents to voluntarily declare most Aboriginal lands to be dry areas.[51]

The right of the residents of these communities to make local option decisions was removed in 2007 with the NT Emergency Intervention. This was followed by the *Stronger Futures in the Northern Territory Act 2012* (SFNT Act) which continued the blanket alcohol restrictions over locations designated 'Aboriginal Protected Areas'. The SFNT Act sunsets in July 2022 and the outgoing Commonwealth Minister for Indigenous Australians allowed the legislation to lapse prior to the federal election of May 21, 2022. This has allowed the NT Government to pass legislation lifting alcohol restrictions in previously Alcohol Protected Areas (APA)[52] unless communities apply for an interim APA lasting two years. That is, they must actively seek to reinstate their dry status. Many of these (220 to be exact) are small homeland/outstation communities, and it is not clear how they will be assisted to apply for the interim two-year restriction. Although communities classed as 'General Restricted Areas' (GRA) under the *Liquor Act 2019* (NT) will continue with their existing restrictions, this decision still allows alcohol to flow freely into 344 APAs that were previously dry, placing residents (especially women and children) at extreme risk. These communities were unprepared for the precipitous and unexpected lifting of restrictions, as there was no consultation.[53] They will be distressed and unprepared for such an eventuality. Public health bodies and local NGOs have expressed alarm over this development, which reveals a decidedly flawed policy process by the NT Government.

Regulating physical availability at the community/local level

WHO's recommended 'best buys' in alcohol policy are designed to be driven by national governments, and as I have shown above, they can be flexible enough to be mobilised at the state/territory level, sometimes with input from a local neighbourhood or community. Norman Giesbrecht and colleagues observed that:

> *[W]hile there is international guidance for addressing alcohol-related problems, the local community is often faced with a range of harm from alcohol that is related to easy access to alcohol, extensive marketing, ineffective regulation, inadequate enforcement, or the absence of an organized response (Giesbrecht et al. 2014, p. 203).*

However, communities and local governance regions can develop their own controls that, for example, restrict the advertising and promotion of alcohol or influence the sales and serving practices of local outlets. They can also mobilise local strengths, social values and attitudes in order to minimise harms, as I discuss below.

On-premises monopoly systems

Unlike the systematic approach to alcohol retail monopolies and rationing regimes evident in several northern European countries, in Indigenous Australian settings the experiments with licensed canteens and social clubs have been the result of ad hoc policy development with poorly articulated policy aims.

Licensed clubs were opened in remote Indigenous communities in Queensland, South Australia and the NT from 1969 onwards, often having their beginnings in beer rationing systems or rudimentary canteens. Their number in Indigenous Australian settings has varied over time, influenced by changes in government policy and

[51] The pre-existing community-focused right to decide was removed by the 2007 Northern Territory Emergency Response which imposed additional dry areas without consultation. The relevant legislation is now the SFNT Act.
[52] The number of living areas designated APAs in the NT total 5 major communities; 5 minor communities; 220 outstations; 79 community living areas; and 35 town camps (Aboriginal Living Areas with unrestricted alcohol access post July 17, 2022, Northern Territory Government Department of Chief Minister and Cabinet, May 27, 2022).
[53] Thanks to Michael Dillon and Neil Westbury for their input on this issue.

local sentiment. These clubs are effectively small-scale monopolies that are the sole source of alcohol in otherwise dry and usually remote locations, with other sources of alcohol many kilometres away. In most cases, the clubs also provide the only social centre and gathering place in a remote community, thereby making drinking a central focus of social life – a consequence with both positive and negative implications. In principle, their monopoly status should be employed by the local community to institute local policies such as having a carefully chosen board, by modifying the premises' physical layout, by employing suitable staff, deciding on opening hours, and operating as a mutual society with profits distributed for the benefit of local people. In practice, the overall performance of these boards and the management of the clubs has left much to be desired, as this author has found (Brady, 2014, 2017). We should be insisting that communities have access to better advice to help them make decisions on such club operations, especially if the composition of club boards means that they are dominated by enthusiastic drinkers who might be influenced by club managers with vested interests in expanding alcohol sales.

Proper governance in these matters should result in less nepotism and self-interest and fewer alcohol-related harms. But there has been little, if any, dissemination of best practice direction and guidelines on making house policies for these premises in any state or territory that has them. The only attempt to do so in the NT was a 1996 publication prepared for the government's Living with Alcohol Program: *Ideas for Sports and Social Clubs. Creating safer drinking environments* (Hunter & Clarence, 1996). It had contributions from the Territory's drug and alcohol bureau, Tangentyere Council, and the 12 social clubs in existence at the time. It set out the basic principles of responsible service, governance, signage, codes of conduct etc. The book was distributed to all clubs but there was no follow up, on-site training in its use or ongoing monitoring of clubs (cf. Shaw et al., 2015).

Policy guidance is still needed here, particularly in a changing social context in which new social clubs may be opened in communities that have never had one before.[54] The missing policy elements include establishing the criteria – a set of social prerequisites – that should be met *before* any new club is established. These should include a transparent discussion of the advantages and disadvantages of opening a club at all, establishing whether the community has enough social capital and cohesion to sustain one, and general agreement on what would constitute proper representation on the club board (e.g. a mix of drinkers, non-drinkers, health service, police etc.). Should the club have a sunset clause? Under what circumstances should it be wound up? Best practice for the establishment of a new club (or indeed in reconstituting an existing one) should actively promote responsible drinking, public safety, and a happy community; and should expect that the club reports to the community, including on funds given for community projects, on a regular, transparent basis.

The distribution of profits is potentially a fraught process, as I have shown in case studies of some Indigenous-owned community hotels and licensed clubs in remote locations. In some cases (such as the Murrinh Patha social club at Wadeye, and the Crossing Inn at Fitzroy Crossing) profit-making was placed ahead of the community interest, resulting in considerable alcohol-related harm to the population – including serious sequealea such as FASD in children, homicide and suicide (Brady, 2017, p. 133, p. 242). A community needs to be clear about whether commercial or social goals are going to drive their licensed enterprise and there is a need for guidelines to prevent licensees, managers and board members from personally profiting from alcohol sales. In short, the club treasurer should not have decision-making powers over sales practices! Despite the lack of clear best practice advice being provided to remote communities by state or local governments, community members do have some opportunities to contribute to local control policies, by making house rules and elaborating on behavioural standards and the penalties for breaches.

The experience gained by other, non-Indigenous community-owned licensed premises could be of value, such as the community hotels in the small rural towns of South Australia. As I have outlined previously (Brady, 2017,

[54] The Bagala Aboriginal Corporation in the NT community of Barunga was granted a new licence to open a social club in January 2022 – the first new licence to be granted since 2007.

2021), the original South Australian community hotels were based on a model of liquor control usually associated with the Swedish city-port of Gothenburg in the 19th Century. The Gothenburg system was designed around ownership of licensed premises by semi-private trusts that regulated liquor sales on philanthropic principles, so that the shopkeeper or manager was restricted to taking only 5% profit. Any additional profit was divided between the municipality and local charities. These were spent on civic benefits such as libraries, local orchestras, parks and gardens, welfare needs. Other regulations in the system meant that the public houses improved their lighting and ventilation; provided warm, cooked food at moderate prices; and banned sales of liquor on credit. The most important principle of the Gothenburg system however, was that of 'disinterested management': it employed respectable persons on salary, who derived no profit from sales, thus eliminating the stimulus of personal gain. In South Australia today, such hotels still exist, and their principles remain largely intact, with the board members (elected from the local community) deciding on where the profits will go and with their managers employed on salary.

There are lessons to be learned from these domestic South Australian examples, as well as from the robust findings of international research on similar enterprises if only Australian governments would make use of them. State monopolisation of alcohol sales (or versions of it) has been relatively common internationally as a way of minimising harm and enabling states or municipalities to collect revenue. Examples of such monopolies in international indigenous settings and developing countries are described in the WHO publication mentioned earlier, *Alcohol in developing societies* (Room et al., 2002). The WHO APPG research team (Edwards et al., 1995, p. 132) concluded that:

> *Monopoly systems are flexible instruments which can be operated sensitively in the public health interest. Putting health rather than commercialism first, they can discourage the competitive market forces, which otherwise drive alcohol sales upwards.*

Off-premises monopoly systems

Much international research today relates to *off-sales* (rather than on-sales) monopolies. A notable historical example was that of Britain during World War I, when the national government intervened to take control over off- and on-sales of alcohol. In order to protect the production of munitions and thus support the war effort, the government nationalised the drinks trade in and around Carlisle (a centre for munitions production), took over the breweries, dramatically reduced off-sales and 'grocers' licences', closed half the pubs and placed the rest under the management of a Central Control Board. The state-run pubs in Carlisle and Gretna introduced catering and recreation; there were no more 'liquid lunches' for those working with munitions; and managers were paid a salary rather than their income being tied to alcohol sales (Greenaway, 1998; Nicholls, 2009, p. 147). The 'Carlisle system' lasted until 1973.

More recent examples are to be found in north America and in the Nordic countries (Room, 2004, 2020). In Sweden today, the *Systembolaget* stores are an efficient and popular solution to the ad hoc development of commercial liquor barns such as occurs in Australia. Off-sale monopolies contribute to public health in a number of ways, as Room and Örnberg (2019) point out. They have:

- a limited number of outlets (typically fewer than in a system of private licensed shops)
- fewer hours and days of sale
- public health (not commercial) interests which drive products and pricing
- conditions of sale (fewer promotions, stricter responsible sales rules)

- encouragement of experimentation with different control measures
- disinterested management (with no incentives to 'push' sales), and
- limits on political lobbying (their public status puts constraints on their political activity).

In 2017 Robin Room, a leader in the formulation of best practice in alcohol policy and an advisor to WHO, suggested that the NT was a prime candidate for the government to operate a retail monopoly over off-premises alcohol sales. With an alcohol-attributable death rate 3.5 times the national rate, and consumption 26% higher than any other Australian jurisdiction, Room argued that a government takeover of takeaway sales in the NT could be justified as a special case. Despite good evidence to support the benefits of monopoly systems in general, and the obvious benefits of such a system in the NT, there is no sign as yet that the NT Government (or any other Australian government) will act on this suggestion.

Short-term special occasion licences

Another policy that could make a difference is to encourage the introduction of short-term special occasion licences to provide an alternative to the provision of permanently licensed clubs in remote communities. Special occasion licences allow for alcohol to be served locally at particular events and occasions. This is an alcohol control policy that has not been tried in Indigenous communities in Australia,[55] although special occasion licences are common in First Nations and Maori settings in Canada and New Zealand, in communities that are otherwise 'dry'. In New Zealand, the Maori-created Manaaki Tangata program (mentioned earlier in this paper) indigenised the basic principles of host responsibility and provides guidance on the service of alcohol at community events, in homes, and on marae.

In Canada, on-reserve communities have several options for alcohol management including the ability to apply for a 'special occasion permit' (SOP). These are used to serve alcohol legally at events such as sports, weddings and fund-raisers. Specific facilities in communities (such as sports fields, ice skating rinks and indoor sports venues) are licensed for these specific occasions, and the (Indigenous) permit-holder has responsibility for the safety and sobriety of those in attendance (Gliksman et al., 2007; Shaw et al., 2015). A special occasion permit comes with the requirement for trained and certified servers. Community members can undertake a 'Smart Serve' training course to achieve certification; servers must remain sober and monitor guests, sales have strict timelines, and there are no 'last calls' to avoid a late rush on drinks. Shuttle services are encouraged to avoid drink driving.[56] The special occasion permit acts as a vehicle for members of the community to learn about the liquor laws, about signs of intoxication and how to monitor drinking behaviour.[57]

In Ontario, this community strategy was supported by the (then) Addiction Research Foundation (ARF, a quasi-governmental drug and alcohol research and policy organisation), which provided outreach and training to help the communities understand the rules of bar behaviour and safe service. Communities were asked if they would like to appoint someone to liaise with the ARF, usually a nurse or an education officer. This kind of practical support seems to be a helpful and necessary form of outreach, but it is not provided by the relevant liquor licensing bodies either in Canada or in Australia. These agencies simply monitor compliance with regulations and monitor activities from a distance.[58] As is the case on New Zealand marae, the provision of short-term special occasion licences on Canadian First Nations reserves educates members of those communities, provides them with insight into the effects and consequences of consumption, and gives them responsibility for

[55] The idea was raised in a report to the NT Government in 2015 (Shaw et al., 2015).
[56] This information derives from a visit to the Chippewa community of Kettle Point, on Lake Huron, Ontario; thanks to Candice Wild.
[57] Denise de Pape, Ministry of Health, Victoria BC, *pers. comm.*, October 11, 2013.
[58] Thanks to Marg Rylett and Katherine Graham from the Centre for Addiction and Mental Health (previously the Addiction Research Foundation), in London, Ontario for briefing me on these activities in October 2013.

managing the occasion safely. Perhaps it is time to trial this style of alcohol provision in Indigenous settings in Australia.

Alcohol problems from the ground up: Insights from anthropology

While WHO can provide expert policy guidance and alert us broadly to 'what works' and what does not, there is a need to marshall the existing social and cultural inclinations of a population. There is a need to 'carry the people along'. It is here that anthropological research methods and perspectives have a role. It is ethnographic research – often longer-term and with researchers known to the people concerned – that provides nuanced understandings of the cultural contexts behind peoples' struggles with alcohol. Epidemiological research, short term survey-based research that asks people direct questions, and on-line searches of the literature using 'key words' are unable to achieve such nuanced understandings. Ethnography can highlight both the cultural barriers and the opportunities for change. Even if these studies are not directly about drinking,[59] they can provide insight into the social worlds and lived realities of daily life that bear upon drinking. Nicolas Peterson's important work on 'demand sharing' is a case in point (Peterson, 1993).

As part of its trials of different treatment approaches and brief alcohol interventions, WHO – to its credit – realised that the usual diagnostic criteria and instruments used for identifying alcohol and drug related disorders were strongly 'Western' (and ethnocentric). To address this, it designed CAR, the Cross-cultural Applicability Research Project (1991) as a multi-disciplinary collaborative project to test the applicability of screening and assessment tools across cultures. The CAR study demonstrated the importance of ethnographic and linguistic approaches (Gurege et al., 1997). It highlighted for example the different cultural meanings attached to 'drinking', 'intoxication', the difficulty of counting drinks, and the differing interpretations of what constitutes 'problematic' drinking, 'loss of control', 'tolerance', 'withdrawal' and 'hangover.' Too often, these ethnographic understandings have been missing from the alcohol policy research literature.

Here I provide two cases in which an anthropological approach can deepen understandings of Indigenous relatedness and autonomy: how these can be used to activate action on the ground, and so link an international policy focus with mobilisation at the community level. The first example shows how the rationale for much Indigenous discourse on alcohol intervention is on alcohol's 'harm to others', which happens to be an issue of great concern to WHO. I show how this could be further elaborated as an action strategy. The second example explains how a 'brief alcohol intervention' by a primary care physician – seen from an anthropological viewpoint – can be both culturally-relevant and of practical use in Indigenous settings.

Leveraging alcohol's harm to others

In recent years WHO has directed attention onto alcohol's 'harm to others' as a way of reinforcing the need for alcohol controls. The 2010 WHO Global Strategy to Reduce the Harmful Use of Alcohol states that people exposed to the effects of harmful drinking by others should be protected, and be an integral part of policies addressing alcohol harm (Laslett et al., 2019). This emphasis reflects the agreement among expert groups that policy should not focus solely on the alcohol-dependent individual but should extend to the broader community affected by a wide range of alcohol harms. Endorsing an Australian-led review of the range and magnitude of these harms, a WHO spokesman stated that the harmful use of alcohol can:

[59] I agree with Robin Room's (1984) characterisation of ethnography as being guilty of 'problem deflation' in alcohol studies. However, since his 1984 publication, ethnographies have become more realistic in weighing up what he calls the 'gains' and the 'losses' of drinking. As Marcia Langton (2010) has pointed out, ethnographers such as Peter Sutton, Emma Kowal and Francesca Merlan have challenged the problem-deflating stance taken by some earlier anthropologists.

> *ruin the lives of individuals, devastate families, and damage the fabric of communities. The World Health Organization's global strategy to reduce the harmful use of alcohol underlines that special attention needs to be given to reducing harm to people other than the drinker (Laslett et al., 2010, p. ii).*

The reason this focus is so relevant in the Australian Indigenous context is that concern about alcohol's harm to others has for many years been one of the most powerful catalysts for Indigenous people to speak out and take action on alcohol issues. Because of the deeply embedded social values attached to 'caring' and 'looking after'[60] family in Indigenous ways of understanding the world, the concept of harm to others can be marshalled to act both as the catalyst for community mobilisation and the justification for it (cf. McCoy, 2008).

One very good example of this was when restrictions over takeaway sales were first mooted at Fitzroy Crossing in 2007. Facing a crisis of high numbers of alcohol-related deaths, a surge in suicide, and the increasing prevalence of FASD in children, two local women, June Oscar and Emily Carter, led a campaign to end sales of takeaway alcohol in the town. It provoked a polarising and fractious debate and considerable resistance from those with vested interests in continued alcohol sales. The women strategically sought the backing of influential local and national bodies as allies, such as the elders of the Kimberley Aboriginal Law and Culture Centre[61] and medical specialists and paediatricians in Perth and Sydney. They needed more than this to fortify their case and protect themselves from retribution however, and a key factor to turn opinion around was the undeniably harmful effects of alcohol consumption on children. After months of increasing dispute and a flood of media stories, a front-page article in the *West Australian* publicised locally-compiled evidence that alcohol was affecting one-quarter of Kimberley children under five years of age (Strutt, 2007, p. 1). This devastating statistic turned opinion around and made it impossible for anyone to oppose the restrictions – both politically and socially impossible (Brady, 2017, p. 231).[62] It was concern for the harm to children that encouraged the community leaders to persist with the liquor restriction. By articulating the need for the restriction in these terms, the proponents of the takeaway ban were protected from criticism. Another illustration of how 'harm to others' has been deployed was at the NT community of Wadeye in 1988. There, after a growing incidence of alcohol-fuelled violence, homicides and unrest, dozens of Aboriginal women and men who were health workers or members of the local sobriety group physically attacked (and ultimately closed down) the community's popular licensed social club from which the troublemakers sourced their alcohol. The female health workers explained that they wrecked the premises because of the effects of widespread drinking and violence on the health of the community's children: they were going hungry, faltering in growth. The male elder who led the attack legitimised his intervention by repeatedly and publicly expressing anxiety about the safety of women and children: unchallengeable reasons for taking drastic action (Brady, 2017, p. 132). When in the 1990s Aboriginal women demonstrated against grog in the streets of Alice Springs and Coober Pedy, their speeches did not target the drinkers *per se*, but emphasised their culturally validated responsibilities *for others,* as carers, mothers and grandmothers. They invoked their concerns for the future generations if alcohol was not controlled and the messages written on their banners invoked these anxieties: 'Our sons and daughters all dead from grog'.

Alcohol's 'harm to others' can also be a useful lever at the individual level. Many Indigenous men and women I interviewed who had stopped drinking described the harm their drinking had inflicted on others in the family; in retrospect they saw this harm as a strong motivating factor in their decision to stop. Unfulfilled family responsibilities to partners and children, shame at not being a good father because of drunkenness, causing injury and even the death of others while drink-driving were all cited as reasons to 'give the grog away' by these individuals (Brady, 1995b).

[60] McCoy explores the concepts of nurturance, 'holding', looking after, taking care of others'.
[61] KALACC is a peak body supporting the Law, culture and languages of 30 Aboriginal groups in the Fitzroy Valley region.
[62] Thanks to Dr John Boulton, then senior regional paediatrician in the Kimberley, who drew my attention to the influence of this news story.

Arguing that controls are needed because of alcohol's harm to others provides Indigenous people with a culturally-appropriate and acceptable rationale for group action – action that might need defending, because it might take away peoples' 'right' to drink for example. Realising the extent of harm they have caused to others can also be a motivating factor at an individual level, and simultaneously acts as a way of justifying (to others) a person's abandonment of drinking. Campaigns designed to influence Indigenous community opinion around alcohol availability and to bring about controls over supply, need to pay attention to Indigenous cultural values such as these.

In 2010 an impressive, multi-authored review of the research was published on alcohol's harm to others (Laslett et al., 2010), followed by a WHO publication covering nine societies (Laslett et al., 2019). Each of them documented the scope and patterns of alcohol's harm to others. The nature of the research covered in the review, however, failed to present any discussion of how the idea could be operationalised on the ground by kin-based societies, or why the responsibility to protect others from harm might hold particular cultural relevance for indigenous peoples. These research reviews omitted the insights provided by ethnography and so missed the opportunity to inform other policy makers that invoking alcohol's 'harm to others' can be a lever to mobilise community action.

Brief alcohol interventions: The doctor as a face-saving device

As in the case of the review of alcohol's harm to others, anthropological contributions have been largely missing from the publications on brief interventions by alcohol policy researchers and clinicians. This meant that they largely failed to grasp a key value of the intervention for Indigenous people: that doctors can be (and are) used by them to 'take the blame' for their decision to quit drinking, thus absolving the individual from responsibility.

In 1994 I was studying natural remission (or 'natural recovery') among Aboriginal drinkers – interviewing ex-drinkers at their homes in rural and remote communities in the NT and South Australia to discover the motivating factors causing them to stop drinking. All were keen to share their stories and as it turned out, some of these drinkers had had a form of 'brief intervention'.[63] In some cases, a doctor (or a nurse) had spoken to them persuasively about their drinking; in their terms, they were given the 'hard word'. The interviews revealed a special, *culturally useful* role for health professionals because, as they tried to extricate themselves from the drinking life, these ex-drinkers were often derided – usually by relatives or by their former drinking mates – for their efforts. They faced huge conflicts because the drinking act (and as a corollary, the refusal of alcohol) was freighted with meaning associated with relationships to kin, sociality, and identity. Medical practitioner Max Kamien once observed of Aboriginal people in Bourke that refusing a drink with mates was a breach of etiquette akin to 'refusing an invitation to eat with a Bedouin' (Kamien, 1978, p. 152).

Working with Pintupi people in the Western Desert in the 1980s, the anthropologist Fred Myers (1986) was one of the first to publish the insight that to legitimise a decision to become sober, drinkers asserted their Christianity as an acceptable shield against social pressure (Christians 'can't' drink). I found that as a relative outsider, a doctor (including a medical practitioner of Indigenous descent) is a person with a form of 'diplomatic immunity'.[64] He or she has the authority to raise concerns about alcohol use which can be a difficult issue to broach by those who are socially close to the individual, such as family members and even familiar Aboriginal health workers. As one health worker observed to our research team: 'You need someone *out of the extended family* [to talk about alcohol], someone out of it all.' (Brady et al., 2002; Brady, 1993, 1995b; Sibthorpe et al., 2002). A doctor is an authorising Other, a more distant figure who can diagnose alcohol-related damage and provide objective proof

[63] These interviews have been published in full and are available free from the Department of Health's alcohol resources website (Brady, 1995b).
[64] This phrase was used in a similar social and cultural context by Andrew Stojanovski (2010).

of it.[65] A further even more persuasive reason why doctors have a culturally useful role, is that amid intense social pressure, Aboriginal people need a legitimate excuse to stop drinking – an acceptable explanation to present to their public. A doctor is in a position to offer them that excuse, legitimise their decision in the eyes of others, and so help to navigate the social pressure.

As mentioned earlier, screening and brief interventions (SBI) by doctors and primary care professionals were exhaustively tested and trialled cross-nationally in WHO-sponsored projects and have been found to produce moderately positive outcomes**.** The SBI approach is a way of reaching large numbers of people in a non-stigmatising venue (i.e. a general health practice rather than a specialised drug and alcohol service), and forms a natural part of any health professional's expected role – to express concern and give advice (Hunter et al., 1999; Brady, 1993, 1995b, 1995c, 1998). These 'secondary prevention' approaches had been missing from Indigenous settings.

Notwithstanding these positive indicators for the implementation of SBI in Indigenous settings, and published research explaining why they may have particular salience in these settings, some Australian addiction and alcohol policy researchers took a surprisingly hesitant position. Despite the precautionary principle that it is ethical to take action to prevent harm even in the face of suboptimal evidence (Babor et al., 2003, p. 273), some researchers were concerned about the lack of firm evidence for the effectiveness of brief interventions. They worried about the ethics of Indigenous people being offered interventions apparently supported by lesser levels of evidence (Shakeshaft et al., 2010, S42; Gray et al., 2002).[66] Some critics highlighted the mixed reactions in Indigenous settings to a widely-used screening test – the AUDIT – in its first iteration in which Aboriginal people understood the meaning of the questions differently, or were hostile to being asked these questions.[67] (The test has now been adapted and shortened to three questions.) Other Australian researchers had political objections, saying that brief interventions:

> *may actually be disadvantageous particularly if they are seen by funding agencies as a cheap alternative for the provision of interventions that are more costly but which actually address underlying issues (Gray et al., 2002, p. 5).*

This refers to underlying issues such as colonisation and political and economic factors (Saggers & Gray, 1991, p. 113; Saggers & Gray, 1998, p. 189). Such issues are arguably beyond the range of a primary health clinic where busy health professionals are not in a position to do much about the colonisation of Australia. However, some researchers appear to have revised their earlier concerns, accepting that brief interventions are likely to produce more benefit than harm (Shakeshaft et al., 2010), and have producing detailed and useful publications exploring the best ways of delivering SBI in Indigenous settings (cf. Clifford et al., 2013). Objectors from the political economy perspective later conceded that the use of brief interventions should, in fact, be recommended (Gray et al., 2007, p. 767); primary care manuals for Indigenous services now provide guides to delivering brief interventions. Even so, all these caveats, refinements and hesitations tend to miss an important point. Irrespective of the number or wording of questions in the AUDIT, or whether a brief intervention does or does not address colonisation as an underlying cause of alcohol problems – individual advice about problematic drinking from a respected medical outsider can not only provide the Indigenous patient with the motivation to change, but more importantly provide the necessary shield from criticism (from kin or drinking partners) for

[65] Although my interviewees often reported the doctor's warning or advice had motivated them to stop drinking, they also stressed their autonomy. Health professionals need to balance their words of advice with respect for the strong culturally determined sense of personal autonomy, and resistance to being 'bossed' around.

[66] Such concern about the ethics of providing poorly evidenced approaches to alcohol treatment for Aboriginal clients has not deterred the Australian Government from giving virtually unqualified financial support over decades to Aboriginal residential 'rehab' programs using the Twelve Steps/Alcoholics Anonymous (AA) model, along with many 'cultural' approaches that have certainly never been subjected to the level of evidence provided by RCTs. See Edwards et al., 1995, p. 193 who say that conventional research into AA has failed to produce any meaningful results demonstrating its efficacy.

[67] Our own work elicited some of these reactions (Sibthorpe et al., 2002), and interviews undertaken in Cairns by Jan Parr and Karen Jacobs produced mixed responses to the AUDIT (John B. Saunders, *pers. comm.*, 2 July 1997).

giving up the grog. Thinking about the intervention in this way – an anthropological way – gives us a different way of evaluating its usefulness.

Anthropologists have provided rich descriptions of the social negotiations inherent in daily life. Fieldworkers such as O'Connor (1984), Martin (1993), Peterson (1993; 2015) and Saethre (2013) have described Indigenous networks of dense sociality, the strong commitment to kin, and how in tradition-oriented communities these commitments underpin the pressures of demand sharing and reciprocity and influence exchanges over alcohol. More importantly, many of us have demonstrated how people have created avoidance techniques as ways of getting around these sometimes burdensome obligations (Peterson, 2010, p. 255). Invoking an authorising outsider (Jesus, for example, or the doctor) is one strategy that can help drinkers to externalise, depersonalise and deflect the blame when explaining their resolve to stop drinking.

Anthropological studies examining the social meaning of drinking have been in existence (including in non-Indigenous settings) since at least the 1930s, when Tom Harrison pioneered a grassroots study examining British pub life and the meaning of drinking for Lancashire men (Mass Observation, 2009). There are numerous recent publications by Australian anthropologists on Indigenous perceptions of drinking and the influence on drinking of concepts of personhood, personal autonomy, relatedness, and shared identities.

One would hope that such insights[68] might be relevant to researchers from other disciplines exploring how to ameliorate alcohol-related harms in the Indigenous population. Yet few Australian clinical studies have picked up, elaborated on, or even acknowledged these anthropological insights.[69] Researchers in the addiction field, 'dominated by the theoretical and methodological epistemologies of biological and laboratory sciences' (Olsen et al., 2015, p. 474) seem to have missed the publication of relevant qualitative, anthropological and participant observation accounts. This is unfortunate for the reasons I have outlined: clinicians need an understanding of the cultural significance and meanings attached to the drinking problems of their Indigenous patients (cf. Alati et al., 2000, p. 58).[70] These need to go a little deeper than what Peterson (2010, p. 253) has termed the 'discourse of enchantment' surrounding public and non-specialist discussions of 'culture', which can be a complicated and slippery concept often removed from critical appraisal.

There is a paucity of qualitative studies published in the alcohol and other drugs field today, although some journals have invited more submissions of qualitative research papers (e.g. Olsen et al., 2015). As Gillian Tett observed recently about modern uses of anthropology, the:

> *worm's eye approach does not usually produce neat power points or flashy spreadsheets. But it can sometimes be more revealing than any bird's-eye or Big Data view (Tett, 2021, p. 27).*

Brief alcohol interventions have – somewhat belatedly – now been endorsed for use by ACCHSs, and recommended in primary care manuals designed for Indigenous settings. The Clinical Procedures Manual for remote and rural practice (known as the CARPA Manual)[71] published regularly by a coalition of Aboriginal and other professional health organisations, devotes a whole section to brief interventions (Remote Primary Health Care Manuals, 2017, pp. 138–142). An evidence-based approach to Aboriginal primary health care written for the Kimberley Aboriginal Medical Services Council (KAMSC) advises that early detection and brief intervention may reduce the future risks from excessive alcohol intake, and that people are more likely to give up drinking

[68] These are insights gained after months or years of challenging fieldwork; anthropologists such as Basil Sansom lived in the drinking camps south of Darwin in the late 1970s in order to produce his brilliant, insightful study of drinking (Sansom, 1980).
[69] For example, one recent study by addiction researchers of Indigenous alcohol consumption (Conigrave et al., 2021) examined 'psychological needs' such as autonomy and connectedness, while failing to consult any published anthropological work based on long-term fieldwork that deals specifically with these issues, such as Glaskin, 2012; Martin, 1993; Myers, 1986; McCoy, 2008.
[70] Frontline service providers however, can appreciate the significance of these insights, judging by feedback from workshops run by Ernest Hunter, myself and others (Hunter et al., 2004). The workshops introduced participants to minimal brief interventions and the idea of 'the excuse'. Participants felt as if they had been given permission to apply the principles of brief interventions with their Indigenous patients.
[71] CARPA = Central Australian Rural Practitioners Association.

when encouraged by their family 'with regular help from their doctor and Aboriginal Health Workers' (Couzos & Murray, 1999, p. 164; cf. pp. 37–38).[72] The AUDIT has become a standard screening tool in numerous settings, including Indigenous services. The Australian Government has now mandated that the ACCHS it funds should standardise their alcohol screening by using the shortened version mentioned previously: the 3-question AUDIT-C questionnaire (Islam et al., 2018).[73]

Mobilising the community

WHO has long been aware that alcohol-related problems are experienced most directly at the local level: it is in local neighbourhoods that the negative effects of alcohol are felt most intensely. As *Alcohol policy and the public good* observes, public health policy needs the acceptance and backing of the community (Edwards et al., 1995, p. 210); to be effective, such policy needs to intersect with the issues that most concern local people. As a statement from WHO explained:

> *community actions can increase recognition of alcohol-related harm at the community level, reduce the acceptability of public drunkenness, bolster other policy measures at the community level, enhance partnerships and networks of community agencies and nongovernmental organisations, provide care and support for affected individuals and their families, and mobilise the community against the selling and consumption of illicit and potentially contaminated alcohol' (WHO 2008, p. 3; cited in Davison et al., 2011).*

The 1980s and 1990s saw a high level of grassroots Indigenous activism around alcohol issues in some parts of the country, prompted by disastrous levels of alcohol-related harms that people could no longer tolerate. The original cohort of women and men who engaged in these activities is now elderly and many have died. Their marches, pickets and public speeches (as well as strategies using media, film, art, and comic strips) constituted radical, trail-blazing social actions that broke through a widespread hesitancy in the north and centre of the country about speaking out honestly about alcohol troubles.[74] Aboriginal women involved in these actions often demanded total bans on sales and were supporters of abstinence. Like their American and British temperance antecedents and 'saloon-smashers' of the 19th Century, these 20th Century Aboriginal-led actions focused on the exploitative 'liquor traffic'. Rather than attacking the drinkers themselves, they targeted the pubs and takeaway outlets that profited from the misery created by their promotion and sales of cheap wine (Schrad, 2021).

Some of these grassroots actions were socially contagious, with informal networks channelling communication across widely separated regions. Pitjantjatjara women in South Australia for example, who engaged in a number of campaigns against alcohol sales, were inspired by the female health workers and others who had stormed the social club at Wadeye, far to the north. Learning from each other's experiences, the conveners of these actions incorporated additional tactics such as delivering letters to the liquor licensing authority, involving children in demonstrations, and making placards with strong anti-alcohol messages (see Fig. 1). Participating in these campaigns acts as a consciousness-raising activity in itself, as people learn about creating by-laws, or how to engage with liquor licensing authorities. In Western Desert and Central Australian communities for example, communities have mobilised to collect statistics, give testimony, lobby the bureaucracy, trial different sales regimes, and vote on decisions. These activities gave people a sense of achievement and agency that

[72] Brief interventions continue to be debated and the results of studies analysed. A pessimistic assessment by Holmwood (2021) of their effectiveness in reducing *population* levels of drinking, still could not deny the clinical value of addressing unhealthy alcohol consumption in primary health care. None of these caveats negate the significance of a thoughtful intervention by a health professional who can provide an Indigenous patient with an external, authorising 'excuse' to stop drinking.

[73] A review of progress in implementing the WHO global strategy to reduce the harmful use of alcohol found that since 2010, 52% of countries have reported an increase in the use of SBI. But disappointingly, progress seems to be skewed towards the wealthiest countries (Jernigan, 2017, p. v).

[74] Thanks to Jane Lloyd (previously of the Domestic Violence Unit of the NPYWC), for these comments.

had previously eluded them over alcohol issues. An interesting Canadian study of First Nations and Métis communities found similar benefits (Davison et al., 2011).

Figure 1 Grassroots action against sales of alcohol: Women from the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council march through Coober Pedy, South Australia, 2008

Image courtesy of NPYWC.

In Australia, much grassroots community activism targeting alcohol and alcohol-fuelled trouble has been supported and enabled by Indigenous and non-Indigenous NGOs (such as the NPYWC, land and town councils, health services and legal aid). The NPYWC gave Aboriginal women across a huge region of western and central Australia a voice to speak about alcohol. It helped consolidate their views and provided essential logistical support for their activism, which was largely directed at limiting the physical availability of alcohol. Christian organisations (such as ARDS,[75] the community development wing of the Northern Synod of the Uniting Church), have also supported anti-alcohol activism and grassroots understandings of health promotion. Linguists, often missionary linguists, have been engaged in 'knowledge translation' for years.[76] Many of these organisations have employed anthropologists (some from overseas), linguists, social workers and community developers. These people brought ideas from the wider world about community mobilisation and development strategies. In the 1980s and 1990s, NGOs such as Tangentyere Council in Alice Springs commissioned sympathetic academics and writers to prepare literature reviews and other small research projects. These brought the international alcohol policy and research world (including that of the WHO) to the attention of community-based organisations, contributing to a growing pool of local interest in community-based campaigns

[75] ARDS=Aboriginal Resource and Development Services.
[76] Paolo Freire's liberation theology and community problem-posing research, for example, was much in evidence in the late 1970s.

around alcohol and providing a link to the best practice advice of WHO (Lyon, 1990, 1991; O'Connor, 1988; Simmons, 1988).[77] Aboriginal health and civil rights activists themselves visited the UN and WHO (Cook & Goodall, 2013) and attended international conferences.

In their early years Aboriginal health services also benefited from the experience, commitment and professional networks of their founding medical staff and the public health physicians who followed.[78] Many of these individuals had links with international organisations such as WHO, Save the Children and the People's Health Movement, and had experience in developing and refugee health. Whether present and emerging cohorts of health professionals in these services have similarly robust networks, and keep up to date with the international literature, is not known. Partly as a result of their foundations in the international primary health care movement however, Aboriginal health services continue to tackle the social determinants of health and engage in a much broader range of activities in alcohol prevention, treatment and activism than simply the interactions that take place in their clinics (Freeman et al., 2019, p. 536). The multi-faceted activities around alcohol problems run by Congress health service in Alice Springs for example, include partnering with the PAAC. Together with other civil society groups such as church groups, trade unions and other Aboriginal organisations, PAAC advocates for evidence-based measures to reduce alcohol harm and, as mentioned earlier, it was instrumental in lobbying for a minimum unit price for alcohol in the NT.

Conclusion

In 1950 WHO appointed an anthropologist to its staff: Dr Cora Du Bois. It was the first such appointment to an international health organisation and acknowledged that cultural factors might influence how different peoples experience health and illness (Coreil, 1990). I was disheartened, though, to learn that Du Bois lasted less than two years, because no one in WHO was apparently interested in her work. 'She did not fit the role expected of anthropologists. WHO needed then, as it does today, her kind of critical observations' wrote a WHO insider (Litsios, 2018, p. 732). As far as I am aware there is no official 'WHO anthropologist' position on staff today. But at least some of the research collaborations commissioned and sponsored by WHO have since then explored the localised, embedded, cultural and attitudinal factors that influence how alcohol is perceived, used, controlled, and produced. The two WHO volumes on alcohol issues in developing, minority and indigenous populations mentioned earlier (Riley & Marshall, 1999; Room et al., 2002), contain ethnographic detail about the resilience and the vulnerabilities of societies in dealing with alcohol problems. They enrich and balance the other WHO volumes on alcohol policy and the public good by exemplifying an 'anthropological imagination' that treats alcoholic beverages as items carrying cultural meanings that extend well beyond their physical effects.

One insight gained from writing this paper has been that even today, studies in Indigenous health and alcohol misuse deriving from conventional surveys, epidemiology, psychology, biomedicine and clinical studies undervalue, or are unaware of, the ethnographic literature. They often ignore what anthropology can offer – a problem in situations where there are no community-specific indicators of harm or quantitative data on consumption, sales, harm, or infringements (cf. Smith et al., 2019). As I have documented here, an anthropological perspective could enrich and clarify the relevance of WHO's focus on alcohol's 'harm to others', thus making it into a lever for Indigenous community action. I have also shown that anthropology has provided a unique insight into how Indigenous drinkers mobilise their interactions with health professionals, to give them a face-saving excuse to give up drinking. Seeing the doctor–patient conversation in this way reinforces the huge

[77] In 1991 Pamela Lyon annotated the work of Robin Room on community action and alcohol problems, and directed the attention of Tangentyere Council to an early WHO manual for community health workers dealing with alcohol-related problems. In 1988 anthropologist Rory O'Connor reviewed Aboriginal treatment programs, referring to international and WHO affiliated research.
[78] These included doctors with wide public health and international expertise such as John Boffa, Trevor Cutter, Ernest Hunter, Rob Moodie, David Scrimgeour, Randy Spargo, Peter Tait, Paul Torzillo and Ian Wronski.

potential role of doctors and other frontline workers with drinkers wishing to extricate themselves from the drinking way of life.

I have described how – more than two decades ago – WHO in Geneva launched a program on Indigenous Peoples and Substance Abuse. Unfortunately, after a promising start, WHO allowed the Indigenous Peoples project to lapse because of funding difficulties. The program's indigenous researchers and interns grappled with the challenges of writing a policy guide applicable across very different societies with wide variations in social, economic and political circumstances. Many countries are unwilling to recognise, let alone make specific policy for, their indigenous or minority populations. The program also confronted the fact that not all drug use can be typified as problematic: for some indigenous peoples, drugs form an integral part of traditional healing, ritual or spiritual practices. Kava, alcohol and tobacco for example, all have reciprocal or ritual uses in some settings (Room et al., 2002, p. 87).

Insufficient funding continues to limit WHO's attention to alcohol and other drug problems among indigenous populations. A 2018 review found little change in the resources at WHO for its alcohol work. In a recent article Room (2021, p. 428) asserts that WHO has failed to adequately resource its work on alcohol, with only a 'tiny staff' in Geneva responsible for the issue. Despite good intentions, Room concluded, the WHO response to global alcohol problems has been inadequate, reflecting the failure of member states' governments and the organisation itself to provide the resourcing warranted by the magnitude of alcohol's damage. Since its launch in 2010, WHO's Global Strategy to reduce harmful use of alcohol has had mixed results. It has so far failed to convince low to middle income countries to devote increased resources to national efforts to avert the 'slow-moving disaster' of harmful alcohol use (Jernigan, 2017, p. vi). Some countries report decreasing their alcohol restrictions, while others increase them. While just over half responding countries increased their taxes on alcoholic beverages, not all adjusted them for inflation.

There is no clear progress on restrictions over the marketing of drinks, and many countries still allow the alcohol industry to sponsor sports and social events. As I have shown in this paper, the alcohol industry in Australia is co-opting Indigenous imagery and spokespeople to spruik its credentials, while arguing that this recognises and honours Indigenous culture. By making financial contributions and entering into partnerships, the industry is extending its reach into the Indigenous sphere. Whether this is exploitation or homage is ripe for Indigenous policy discussion, as I have suggested. One of the most disappointing developments recently has been the suggestion deriving from WHO itself that government should allow the alcohol industry to work with it to co-regulate consumer information – that is, alcohol labelling (O'Brien et al., 2021). I have described how this turned out in Australia, when the involvement of the liquor industry in plans for drinking in pregnancy warning labels led to deliberate delays and obstructions to the recommended design.

Indigenous organisations, civil society groups and researchers, indeed all those engaged in ameliorating alcohol harms should be mindful of the 'double game' operated by alcohol industry interests. In Robin Room's words:

> *one in public, involving the firms' own public relations, industry peak organisations and 'social aspects' organisations, particularly oriented to seeking a common dialogue with civil society organisations, professional groups and government agencies; and the second, behind closed doors, with the politically powerful (Room, 2021, p. 431).*

In short, coherent, culturally-informed alcohol policy advice designed to serve the community good is more needed than ever.

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