BROADENING THE BASE OF INTERVENTIONS FOR ABORIGINAL PEOPLE WITH ALCOHOL PROBLEMS

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Summary

An underlying theme for this discussion is that the range of interventions into Aboriginal alcohol misuse and abuse needs to be broadened. At present, as I shall show, there is a narrow focus on very early prevention, and very late treatment for Aboriginal people, or expressed another way, there is primary and tertiary prevention, but little secondary prevention. In a wide-ranging and thoughtful review of all aspects of the 'treatment' of alcohol problems in the United States, published in 1990, a committee of the Institute of Medicine offered their vision of a multi-faceted effort in alcohol misuse which included both community-wide and specialised approaches (Institute of Medicine 1990). The emphasis of their review is reflected in its title: broadening the base of treatment for alcohol problems. 'The role of community agencies in treatment', the report states, 'would include the identification of individuals with alcohol problems, the provision of brief interventions to a portion of those identified, and the referral of others to specialised treatment' (IOM 1990:6). The role of the specialised agencies is to focus on matching clients to appropriate treatment interventions. It is my view that we need to apply these principles to the treatment of alcohol problems among Aboriginal and Torres Strait Islander people in Australia, so that a much wider range of approaches becomes available to them. Included in this possible wider range of approaches is brief interventions (which take a variety of forms), and this paper is offered as a contribution to the growing body of work in the area of brief interventions and on the role of health professionals as appropriate people to broach the issue of alcohol intake with their patients.

Background

There is in Australia a growing impetus to translate research findings of the value of brief interventions in alcohol misuse into practice. Although this has taken some time, health professionals, primarily general practitioners, are being trained in the straightforward techniques of alcohol screening, offering simple advice, or engaging in brief motivational interviewing with their patients. However (with a few exceptions) these interventions are not being disseminated to, or used by, professionals working in the field of Aboriginal health. In part this is associated with the physical and locational disadvantages experienced by health service providers to some Aboriginal populations, the burden of serious health problems being treated, and the geographical isolation of some health professionals from their colleagues, but it is also because of a sense that these approaches are inappropriate or unworkable in the Aboriginal field. In this paper, I examine factors which suggest that brief interventions could indeed be more difficult, but propose that there are several features inherent in the brief intervention approach which do, in fact, make them a culturally appropriate and feasible approach for use with Aboriginal clients.

Early interventions in general practice

Despite accumulating evidence (Wallace et al 1988; Bien et al 1993; Babor and Grant 1992) that early and brief interventions are extremely effective in reducing alcohol consumption among certain types of drinkers - and that there is considerable interest in Australia in such programs - this form of 'secondary prevention' (IOM 1990; Bradley 1994) is still relatively infrequent, and there are few service units offering them in the general population (IOM 1990:556). These approaches are even more rare with Aboriginal clients and are little known among Aboriginal health professionals or in community-controlled primary health care services. The reasons for the slow development in the use brief interventions for the general population lie partly in the lag

between research findings, policy and practice, and partly because of the resistance of general practitioners, who are known to find alcohol consumption a difficult issue to raise during consultations (Skinner 1987). Nevertheless, there is a burgeoning research literature, and numbers of GPs and other health professionals are gradually being trained to screen patients in the general population for heavy alcohol use, and to deliver brief interventions. As Gossop and Grant note in a WHO publication, these initiatives constitute both 'early prevention' and 'early treatment' which together comprise 'early intervention'. Successful prevention, of course, 'decreases the demands on treatment services to a level where scarce resources can be concentrated on the most important tasks' (Gossop and Grant 1990:42).

While it is not possible to estimate how many general practitioners in Australia have been trained in, or are using, brief interventions, examples of current moves to disseminate brief interventions include the 'Drinking Detective' program based at Sydney's St Vincents Hospital which is currently training general practitioners in the southeastern division of general practice; and Manly Hospital and Community Health Services are teaching early intervention to GPs in that area, with an emphasis on motivational interviewing. In Victoria, GPs are attending workshops on motivational interviewing and on managing substance misuse (37 per cent of all GPs in the North East Victoria Division attended 8 workshops) (Connexions 1995:24). Some of these doctors will have Aboriginal patients within their practices. GPs undertaking these training sessions accumulate continuing medical education (CME) points towards their vocational registration with the RACGP. Training grants for GPs can be sought through the Divisions and Project Grants Program of the General Practice Branch in the Department of Human Services and Health. In 1993-4 for example, four projects in New South Wales have received grants totalling $250,000 in order to train practitioners in various forms of brief intervention, controlled drinking, and early intervention (data from General Practice Branch). In Queensland, brief intervention techniques are being disseminated to hospital staff in a project emanating from the Peninsula and Torres Strait Region Health Authority in Cairns.

While the same barriers (lag between research and practice, and GP motivation) also go some way to explaining why brief interventions have not been implemented so far for Aboriginal people, there are *additional barriers* to the dissemination and use of these techniques among Aboriginal clients. Some of these difficulties relate to wider issues of policy and the complexities of funding and administration for Aboriginal health service providers, and I discuss some of those shortly. Other barriers centre around Aboriginal social and economic disadvantage, and social constructions of drinking and personal autonomy among Aboriginal people. One of the reasons for the need to address these barriers is that there is support from two influential reports on Aboriginal health or related issues; both have recommended that early (or perhaps more accurately, earlier) interventions should be occurring in Aboriginal alcohol use. The National Aboriginal Health Strategy suggested that the staff of Aboriginal health services and other associated organisations should be provided with *adequate and appropriate education to equip them to deal with people with problems of addiction* (NAHSWP 1989:203). A recommendation of the Royal Commission into Aboriginal Deaths in Custody was more specific:

> the possibility of establishing early intervention programs in Aboriginal health services and in hospitals and community health centres with a high proportion of Aboriginal patients be investigated. This would include the training needs of staff in intervention techniques (recommendation 283).

Patterns of alcohol use in some Aboriginal populations

First, an outline of the population and of alcohol use. Aboriginal and Torres Strait Islanders are a hetereogenous group of people, 265,000 at the 1991 census, 1.6 per cent of the total population. Forty per cent are aged less than fifteen. The recent ABS survey of Aboriginal and Torres Strait Islander people (which was of 10 per cent of the population) suggests that 62 per cent of those surveyed were 'drinkers' (they had consumed alcohol in the previous 12 months) and 50 per cent had drunk alcohol within the last month. Seventy six per cent of people surveyed perceived alcohol to be a substance abuse problem one way or another in their locality. Similar numbers of alcohol users were found in a recent random sample of 456 Aboriginal people living in NSW towns (categorised as 'other urban' by ABS) - 57 per cent of these 'urban' people reported they were currently drinkers (Perkins et al 1994)

We know that while there are proportionately more Aboriginal than non-Aboriginal people who are abstainers, we also know that - overall - those Aboriginal people who do use alcohol tend to use it harmfully (Hunter, Hall and Spargo 1991). We know that people consume large amounts of alcohol at a time, and that patterns of heavy consumption vary, from daily, to weekend, to more irregular bingeing consumption. This is not just in rural or remote regions. The NSW towns survey found that the majority of drinkers who had consumed within the last week were binge drinkers (Perkins et al 1994); an Adelaide survey of Aboriginal health service clients reported 53 per cent of males and 17 per cent of females had 'heavy daily use' or 'binge drinking' (Lake 1988); and two Sydney surveys report that between 29 and 44 per cent of drinkers drank more than seven drinks per session (Tharawal Aboriginal Corporation 1994; Aboriginal Medical Service 1991). Most importantly for the purposes of this discussion, we know that there is a widespread conceptualisation among Aboriginal people that they are either drinkers (usually heavy drinkers) or non-drinkers (abstainers) - and we know that, broadly speaking, this conceptualisation is true. Nevertheless, low alcohol beer is used in some areas by people who are not heavy drinkers, and there are a number of 'moderate', 'controlled', or 'responsible' drinkers. For example the NSW towns survey found that about 20 per cent of Aboriginal men and 10 per cent of Aboriginal women were categorised as 'responsible drinkers' (Perkins et.al. 1994).

Alcohol is implicated in at least ten per cent of Aboriginal deaths nation-wide, but analysis of smaller population groups reveals much higher mortality. For example, in Alice Springs town camps, 46 per cent of deaths were alcohol-related; in Katherine, between 30 and 44 per cent of deaths were alcohol-related (Weeramanthri et al 1994).

Existing approaches to prevention and intervention

Earlier, I suggested that what seems to characterise existing approaches to Aboriginal alcohol misuse is a lack of secondary prevention activities: there is primary prevention and tertiary 'treatment', with very little in between. Below, I outline the evidence for this.

Primary prevention efforts have focussed on education and health promotion through the use of posters and radio/tv ads, serials on Aboriginal radio, songwriting workshops and performances such as anti-alcohol rock band tours. It is probably true to say - as with all such types of media effort - that these interventions contribute to changing the 'climate' of opinion rather than changing behaviour. Applied research into these approaches has also provided more information

about Aboriginal viewing and listening preferences, so that we now know that television and video have widely penetrated Aboriginal populations even in remote regions, that there are high levels of viewing, and that preferences include serials such as TV soap operas. Knowing these preferences is important, as BRACS (Broadcasting for Remote Aboriginal Communities Scheme) makes it possible for locally made health promotion items to appear on TV, inserted at the convenience of particular communities. We know now that local content is crucial in specially made health promotion clips. On the other hand, some health education productions made for the wider Australian community have been received very well by Aboriginal audiences. Examples of this include the drug offensive video 'This Time, Next Time' on the subject of alcohol related brain damage; and 'Suzi's Story' about a white middle-class woman with AIDS. Both these films told a story-line and showed the dynamics of family life (Brady 1994).

Prevention campaigns have also focussed on limiting access to the supply of alcohol. This has obviously been easier in remote and discrete communities in the bush than in towns or metropolitan centres. Controlling supply has taken several forms: declaring certain locations 'dry', amending licensing regulations (to restrict sales to certain categories of people, to ration the number and type of beverages purchased, to prevent take-away sales, and to prevent the granting and reissuing of licenses). In other cases, informal agreements between local Aboriginal groups and licensees have restricted hours of sale and amounts of liquor. Under certain circumstances, restricting access can markedly decrease alcohol-related injuries and so acts as a useful harm minimisation technique. These approaches have been validated recently with the publication of a report by the Race Discrimination Commissioner (Commonwealth of Australia 1995). Other interventions now in place in small towns and communities include the use of night patrols, in which groups of mature-age people, usually older women, patrol the streets and intercept illegal drinking, defuse fights, and call the police when things get too troublesome (Mosey 1994). In towns such as Alice Springs, patrol members tell the individuals they pick up that they are drunk, that their behaviour is not acceptable and that they will be taken to the sobering up shelter. Sobering up shelters have been also been an important part of the response to heavy drinking; they are alternatives to the police cells for people apprehended while intoxicated and, in the light of Aboriginal deaths in police custody, function as a harm minimisation strategy.

There are also dry camps in the bush, alcohol-free events such as discos, and in some parts of the country, a growing number of public actions by Aboriginal people about the damage caused by alcohol abuse - marches, demonstrations and speeches outside liquor outlets. In 1988 several dozen non-drinkers physically destroyed the beer canteen at a top end community, an action led by Aboriginal health workers. In July 1990, 300 Western Desert women marched to Curtin Springs, a licensed roadhouse on the fringes of Pitjantjatjara land and made speeches outside the pub. In April 1993 there was a march through Alice Springs which was widely publicised. Women play a significant role in public demonstrations of this sort, legitimating their outspokenness by emphasising their roles as mothers and grandmothers and their concern about the future generations. By stressing these socially-acceptable aims, they have been able to express what would once have been unacceptably critical opinions. Overall, these developments signify a change in Aboriginal community opinion not just towards the purveyors of alcohol, but in attitudes towards drinkers too. While some of this change of opinion has manifested as a growing acceptance of sobering up shelters, outreach work and social controls such as night patrols (which are all relatively modest interventions), some Aboriginal groups (particularly womens groups) in

Central Australia are taking an increasingly hard prohibitionist line. In many ways these developments constitute a new Aboriginal temperence movement, for public demonstrations, beer canteen smashing, and attempts to shut down licensed outlets are all suggestive of a belief that the 'ills unleashed by opening Pandora's Box can be vanquished by closing the lid' (cited by Rowse 1993:395). A surprising number of Aboriginal people take the view that Aborigines should not be allowed to drink; that they 'can't' drink, and that it is not their 'culture' to drink. Such views are not conducive to notions of moderation, techniques for cutting down, and policies of harm reduction. These publicly-expressed views and demonstrable actions form a significant part of the present climate of opinion about alcohol, in which Aboriginal views and the public health perspective sometimes clash. These, then, are some of the preventive actions that have evolved over the last ten years.

At the other end of the scale, tertiary prevention or 'treatment' is usually understood by Aboriginal people to mean 'rehabilitation' or 'residential treatment'. Because there are a limited number of beds available, these centres are utilised by individuals referred at a late stage in their drinking career. There are two important points to make about treatment programs for Aboriginal and Torres Strait Islander people. First, there is evidence that Aboriginal people have a *limited array* of treatment styles available to them. The Quality Assurance Project committee observed that their services needed to provide 'a greater quality and diversity of treatment options...it appears that one model of treatment tends to dominate the current services' (Mattick & Jarvis 1993:222). This model is the residential, abstinence-oriented treatment centre. Secondly, Aboriginal and Torres Strait Islander people are *more likely* to be receiving these residential forms of treatment than are non-Aboriginal Australians, (57.1 per cent of Aboriginal and Torres Strait Islander substance users compared with 47.6 per cent of Australian-born non Aboriginal substance users) (Chen, Mattick and Baillie 1993:17). These findings are in sharp contrast to the orientation urged by the Institute of Medicine's report - that is to *broaden* the base of treatment.

Aboriginal residential centres across the country have never been thoroughly reviewed. Internal Department of Aboriginal Affairs (DAA) surveys have looked selectively at programs (Wilson 1986); O'Connor undertook a review of 14 treatment/rehabilitation services in Western Australia (O'Connor 1988) for the WA Alcohol and Drug Authority; d'Abbs (1990) reviewed CAAPS program in the Northern Territory; and Miller and Rowse (1995) evaluated a program in Alice Springs which incorporated residential treatment, a day program and a training course known as CAAAPU (Central Australian Aboriginal Alcohol Programs Unit; see also d'Abbs et al 1994). In February 1995 the Aboriginal and Torres Strait Islander Commission (ATSIC) called for tenders to assess substance abuse programs they funded, but this process was aborted once it became clear that funding and administration of Aboriginal health, including substance abuse, was to be transferred to the Department of Human Services and Health as of July 1995.

Broadly speaking, it is possible to say that there are few 'true' rehabilitation or treatment centres for Aboriginal people, as many programs are in fact dry camps or dry 'respite villages' without organised counselling services, some with no program at all (O'Connor 1988). Those that do exist rely for the most part on models such as AA or Minnesota/Hazelden, and employ minimally- or un-trained ex drinkers as alcohol workers and 'counsellers'. The most recently established residential centre, CAAAPU in Alice Springs, rather than attempting to embrace innovative approaches or to offer program matching to its clients, has been based instead on models used by native people in Canada, which are primarily 12 steps in orientation. The Northern Territory

government - which has a progressive alcohol policy unit advocating harm minimisation, low alcohol beer, and imposes a levy on alcoholic beverages to be used for prevention programs - had agreed to fund CAAAPU despite disagreeing with its abstention-oriented philosophy. This centre opened in 1991 but has recently closed due to financial mismanagement and the subsequent withdrawal of government funding. A day program is still operating from the premises. The main contribution of such residential centres lies in their valuable 'time out' functions, providing (ideally) a structured program of daily activities, and regular food and rehabilitation for seriously dependent drinkers. The need for and benefits of residential and/or in-patient treatment for particular types of drinker have been documented by Jurd (1994), Ali and Cormack (1994) and others. They also provide a number of latent functions, such as employment for Aboriginal people, and helping ex drinkers who work there to remain sober (cf Levy and Kunitz 1981)

In short, a broad-brush analysis of attempts to deal with Aboriginal alcohol abuse suggests that there are innovative approaches to prevention taking place - the use of the media, rock songs, cartoons, controls over supply and so on, as well as direct interventions such as night patrols, 'saloon smashing' and sobering up shelters. At the other end of the scale is the residential treatment centre catering for chronic, dependent drinkers. But what lies in between? What evidence is there of secondary prevention (or early intervention) in which health professionals or other service providers provide information, advice or physical examinations oriented to alcohol use? This will be considered shortly.

Barriers to innovation in approaches to Aboriginal alcohol abuse

It is important to provide some background to explain why there has been this uneven development in approaches to Aboriginal drinking problems. It appears that a variety of factors have meshed to inhibit the dissemination and use of new approaches and to allow the fossilisation of old ones. Aboriginal service providers have minimal access to the increasingly widely-known variety of options for early interventions, and there seem to be no alternative, accessible formulae for residential programs other than the 12 step model. There is a lack of established mechanisms whereby best practice advice or innovative approaches can be disseminated to Aboriginal health services, substance abuse program staff, or rehabilitation centres, and no single agency or professional body which is in a position to provide resources, advice or updated research data to those working in Aboriginal health services. The body which comes closest to this ideal is the Central Australian Rural Practitioners' Association (CARPA), which has a newsletter and regular conferences, but which draws on a membership limited by geography, relies on the devotion of its members and a shoestring budget. NACCHO (National Aboriginal Community Controlled Health Organisation) is a political organisation with no permanent secretariat and is not intended as a disseminator of advice.

Above all, the lack of policy guidance on Aboriginal health and substance abuse is related to the complex political space that Aboriginal affairs occupies within the Australian federation. While the federal government has constitutional power over Aboriginal affairs, in reality the states deliver programs and there has never been strong health policy or best practice advice coming from Canberra. Aboriginal people access health services either through 'mainstream' providers such as general practitioners who bulk bill, outpatients departments at hospitals, or through Aboriginal Medical Services (AMS). The AMS are usually (though not always) directly funded from Canberra, bypassing the states. Federal funding earmarked for Aboriginal health has always

only been 'top up' funding and health itself has long held an uncertain place within the Commonwealth. Over the last ten years departmental responsibility has gone full circle: up to 1984 Aboriginal health was in the hands of the Department of Health, then it transferred to the DAA, then to ATSIC and as of July this year, Aboriginal health funding reverted to the Commonwealth Department of Human Services and Health.

ATSIC was the main source of special funding for Aboriginal substance abuse programs and it has always been a small budget - in 1992-3 ATSIC spent $13 million on substance abuse, - about $51 per capita. By way of comparison, this is exactly half what the Canadian government spent per capita in the same year on its status Indian and Inuit population (Brady in press). More significantly though, ATSIC is oriented to fund community-based programs, in other words, 'non government organisations', which, by their very definition, are programs run (or managed) by lay people. In addition, decision making over the allocation of ATSIC funds has been devolved to Regional Councils (representative of the communities in their zone) rather than by program managers in capital cities or head office. In this way, decisions over the direction of funding are made by untrained people, many of whom have their own firm views about addiction and treatment (cf Levy and Kunitz 1981). In some cases, these Councils are made up of ex drinkers who are firmly committed to abstinence and AA models (having come through them personally) and so funding applications for programs having a public health approach, including harm minimisation or moderate drinking as their aims, are not always well-received.

Thus a separation has developed, with State and Territory agencies advocating programs such as 'Living with Alcohol' in the Northern Territory, harm minimisation etc on the one hand, and the Aboriginal community-based agencies run by lay people, advocating abstinence and long term treatment on the other. Many of the residential treatment programs referred to earlier continue to be funded because of historical precedents and hastily channelled funding, which became available (in an election year) after the report of the House of Representatives Standing Committee on Aboriginal Affairs report into Aboriginal Alcohol Use in 1977. Without rational policy or strategic planning, the funds were directed to residential rehabilitation programs which employed untrained staff who suffered from lack of professional advice and support (Wilson 1986). Many of them have been funded ever since, despite equivocal findings on outcomes, and despite the objections from many Aborigines to being sent away from their communities to these programs in order to get off the grog. These objections are epitomised by the comment from a Hall's Creek man who told his local medical officer, 'if you want to give up the grog, you do it in front of your mates' (Douglas 1993:176).

The present role of doctors with Aboriginal patients

It seems relatively safe to make two points about the role of medical officers and advice-giving to Aboriginal drinkers. First, advice from a doctor to give up alcohol has been an influence in the decisions of at least some Aboriginal people to do so *once they were seriously ill* (Brady 1993). This is not early intervention! Second, at present it is very rare for anyone to give personalised *early* advice to Aboriginal patients that excess drinking may be harmful to their health.

There is no doubt that doctors (and some other health professionals such as nurses) are already intervening with Aboriginal patients who are suffering from serious health problems associated with their drinking. Interviewing Aboriginal people who had given up drinking altogether without

formal treatment I found that concern about ill health and the warnings of doctors were key influences. Many of these people were impelled to stop drinking out of sheer necessity, or risk death. People did not, inevitably, take notice of these warnings on the first occasion. But comments included: 'the doctor gave me a hard talk'; 'The doctor said to me straight "its your, not my, life"'; 'doctor told me this is your last chance. If you don't stop, you'll be finished'. People showed faith in doctors, and many could remember the names of doctors who had spoken to them or treated them years before. Most, however, were suffering very serious alcohol related complications by this stage - people in their late 30s and 40s who had been drinking heavily for 10-15 years. They had experienced chronic liver damage, pancreatitis, cardiomyopathy, major vehicle accidents, trauma, loss of limbs, bashings and fights, the loss of numerous close relatives, repeated imprisonment, loss of drivers licenses, of work, the desertion of spouses. Some of these people asserted that no-one had told them before that alcohol was damaging to their health (Brady 1993).

Interviews with medical officers working either in an AMS or as State/Territory District Medical Officers regularly visiting rural populations, provided some limited data about the circumstances under which they advised their Aboriginal patients to stop drinking. Some of these conditions were temporary or were associated with finite courses of medication - for example the use of some antibiotics is compromised by alcohol use; individuals on medication as a result of post rheumatic fever heart problems; and TB medication. Other temporary conditions doctors nominated which would prompt them to offer advice about alcohol use were fitting, and pregnancy. Other more serious presenting complaints which prompted these doctors to give advice included heart attacks, and to qualify for assessment for heart surgery; pancreatitis, enlarged heart, enlarged liver, overweight or hypertensive individuals, diabetes, and individuals with multiple episodes of trauma or multiple infections.

So what are the chances of getting to these people much earlier? And is there any substantial recognition that early interventions are necessary or possible with Aboriginal drinkers?

There is a handful of health professionals around the country who are beginning to raise the issue of alcohol screening and early interventions for Aboriginal clients. The medical officer based at the Hall's Creek Hospital in Western Australia has written a treatment strategy for Aborigines in which he suggests programs to 'enhance the capacity of health and welfare staff to undertake early interventions' (Douglas 1993:211). Dr Kayte Evans at the early intervention unit at Royal Darwin Hospital has been attempting early counselling with Aboriginal patients at Bagot (in Darwin), and with patients admitted to hospital (pers. comm.10/11/93). A project based in Cairns with the Peninsula and Torres Strait Regional Health Authority has surveyed Aboriginal health workers in ten Queensland communities with a view to introducing brief interventions and there appears to be sufficient interest to try it. Medical officers based at an AMS in east Arnhem Land have reported decreased alcohol consumption at two year follow-up after personalised health advice was given to over three hundred Aboriginal people living in the region (Pers.comm.Dr John Fraser 14/6/95).

In Victoria, a cooperative effort between the Koori Health Unit and the Addiction Research Institute has produced a touch-screen computerised and adapted version of the AUDIT questionnaire using Koori voices, images, and Archie Roach songs. So far, this console has been installed in the foyer of a Koori health service in rural Victoria. Individuals attending the health

service can administer the test themselves, while the computer calculates their score and produces a print-out giving each person their results (Pers.comm.Greg Powell 13/6/95). There is no information available yet as to the influence this self-testing might be having on referrals for further intervention.

In Alice Springs, various agencies are using approaches which fall loosely under the rubric of early interventions. Staff of the sobering up shelter visit Aboriginal prisoners in gaol. They are informed two weeks before someone is to be released, and talk with them about their alcohol use, suggest referral, offer to see them again. The sobering up shelter is a voluntary overnight accommodation which people are free to leave, and staff initially did not speak with inmates about their drinking. However, many inmates of the shelter are regulars, and realising that this provides a rare opportunity for contact with (mostly Aboriginal) drinkers, staff now talk to inmates, advising them to eat before they drink, and to try and set money aside (Pers.comm. Dr Carol Watson 3/9/94). Police and Aboriginal night patrol wardens who pick up intoxicated people simply tell people that they are drunk, that they are to be taken to the shelter, and that they should talk to a counsellor in the morning. This approach has been collaboratively developed between the police, the night patrol and the sobering up shelter staff.

The potential for an enhanced role for doctors

In order to consider elaborating on the existing role of medical officers in advice-giving with Aboriginal patients, it is useful to examine first of all some of the logistical issues - do Aboriginal people have easy access to doctors? what sort of services do they use?

Aboriginal people access primary health care services and see doctors in a variety of ways: through attendance at Aboriginal Medical Services and community health centres, through general practitioners, visiting Royal Flying Doctor Services or District Medical Officers, and through out-patient departments at hospitals. According to a recent ABS survey, 18.8 per cent of Aborigines surveyed in 1994 had consulted a doctor in the previous two weeks (ABS 1995:16). By comparison, 20 per cent of those surveyed in the general Australian population in 1989-90 had consulted a doctor in the previous two weeks (ABS 1992:25). These figures are comparable, but considering the much poorer health status of Aboriginal and Torres Strait Islander people, doctor visits should ideally be higher. However, the use of outpatients/emergency was much higher in the Aboriginal population - about eight percent had used outpatients or emergency facilities in the previous two weeks, compared with only two and a half percent of the general Australian population. In short, comparing the two populations, members of the wider population are eight times more likely to consult a doctor than they would an outpatients service; whereas Aboriginal people are three times more likely to use outpatients rather than going to a doctor. From these figures we can conclude that use of doctors by Aborigines is roughly comparable with their use by the general population, but that hospital outpatient services are also a key source of contact between Aborigines and medical staff. In terms of general hospital admissions, we know that Aboriginal and Torres Strait Islander people are admitted to hospital between 1.6 and 3.2 times more frequently than other Australians (Minister for Aboriginal Affairs 1991), which reinforces the potential importance of hospital-based interventions.

There are approximately sixty Aboriginal community-controlled health services which offer clinical primary health care across the country, located in all major cities as well as in some rural

and remote areas. It is not known what proportion of the Aboriginal population actually use them although it would not be impossible to assess this. Metropolitan Adelaide's Aboriginal Medical Service has a client load of between 7000 and 8000; Nganampa Health in the remote Pitjantjatjara lands in South Australia services a population of 2,400. Sydney's Redfern clinic sees up to 100 Aboriginal patients on a busy day. Large services employ up to five or six medical staff in one location; others, such as Nganampa Health, employ three doctors who cover six community clinics and numerous homeland centres. Small services use local doctors of their choice or RFDS medical staff who might fly in once a fortnight. Altogether, these services potentially have access to a significant proportion of the Aboriginal population.

Doctors who work on salary for Aboriginal Medical Services seem to spend longer with their patients than do doctors in private general practice, with staff in two metropolitan services estimating that their consultations last between twenty and forty minutes. However, this is because patients usually present with a complex of health problems rather than with a single complaint, as well as being associated with the more relaxed context within which consultations take place in these services (Sibthorpe 1988). Spending enough time with a patient is an important feature in Aboriginal perceptions of what constitutes a good service (Aboriginal Health Organisation 1989). Staff in AMS often know patients and their families well; they therefore have a better idea of the difficulties of changing drinking habits, and are more knowledgeable about Aboriginal drinking styles. AMS also employ Aboriginal health workers who will be familiar with the drinking histories of at least some patients attending the health centre, and so have a better chance of identifying suitable patients for interventions. On the other hand, knowing a patient well can make it more difficult for a doctor to broach the subject of alcohol use whereas new patients will have a full history taken including their alcohol consumption.

A doctor working in an Aboriginal medical service or with primarily Aboriginal patients is more likely to be familiar with alcohol related disorders and is probably more familiar with the physical stigmata associated with heavy use, or the beginnings of heavy use. This can have both positive and negative connotations. Familiarity with Aboriginal alcohol consumption levels can lead to a degree of acceptance and tolerance which might not exist among private practitioners. Medical staff dealing regularly with Aboriginal clients can become cynical, and be even less confident than those working in private practice that their advice could be influential. Clinicians may subtly communicate this so that expecting a poor prognosis can become a self-fulfilling prophesy of failure, as Donovan (1988) points out. Doctors are now under more pressure to screen patients and engage in prevention for a variety of ailments, and this is particularly so in services catering to Aboriginal needs - this is yet another disincentive for those who feel they have quite enough to do without adding alcohol interventions to the list.

In the general population, one of the current approaches to the dissemination of brief interventions among health professionals, is to utilise peer education - that is, general practitioners training other general practitioners, nurses training nurses. This peer education approach would probably be particularly appropriate with doctors in the Aboriginal health field. Training by someone with inside knowledge of the advantages and difficulties of work in the Aboriginal field is more likely to convince doctors that the interventions are worth trying, and that such approaches are not unaware of the particularities of Aboriginal circumstances. Medical staff will need evidence to convince them that their interventions can be beneficial.

We do not know how many Aboriginal people utilise general practitioners in private practice and impressions of useage vary. For example, an Adelaide study of Nungas' use of health services was pessimistic about their use of 'mainstream' GPs, and included observations from a GP in an area with a large Aboriginal population that very few had sought out medical attention from his practice (Aboriginal Health Organisation n.d:87).On the other hand, a survey of Aboriginal people in Cambelltown, Sydney in 1994 found that 86 per cent said they would go to a private GP when in need of medical advice, and in response to a question about satisfaction with medical services in their area, 83 per cent said they were satisfied with the services provided by private GPs (Tharawal Aboriginal Corporation 1994:254). A study from Townsville showed that some doctors in private general practice are popular with Aboriginal patients, who use them in preference to attending an AMS, particularly if they bulk bill (Speare and Kelly 1991). Other features of general practice that influence Aboriginal clients include the degree of rapport with staff, the physical appearance of premises (not too upmarket) and practices that do not insist on appointments (Speare and Kelly 1991:55-56).

There are very few data on Aboriginal attitudes to medical practitioners and western medical knowledge, but drinking histories collected from Aboriginal people provided indications that considerable trust is placed in doctors (see also Myers 1985:280). There is also a sense that people *expect* doctors to give them advice. For example a middle aged man, a diabetic, from Belyuen in the Northern Territory said:

> It's every medical officer's job, you know, especially when you're overweight and you are a diabetic, that sort of thing they come up and tell you 'you're not supposed to be drinking' or, 'give up smoking, its no good for your pressure' (Len Singh in Brady 1995)

and another interviewee said,

> ...doctor told me I only got one life, because you can't say no to doctor when he's told you, you want to believe doctor because he's a man doctor when he tell you, he see you, everthing inside your body. He tell you straight 'Give it up, don't you go back to grog'. (Mrs GD in Brady 1995).

A key difference between a doctor providing health information and advice associated with heavy use of alcohol, and a generalised alcohol awareness program is that the information given by a doctor is *personalised.* The damage is being done to that individual person, his own liver is being damaged. While there have been some valiant efforts made at health education for Aboriginal populations, progress has been very slow, and the abstract, intangible nature of the damage that may be caused by overuse of alcohol is hard for people to comprehend. In addition, indigenous beliefs in some regions (and not just in remote Australia) mean that people attribute sudden illness or death to supernatural causes, and will deny the role of alcohol (Reid and Mununggurr 1977). On the other hand, people with low levels of education, for whom English is a second language do know about what is commonly referred to as 'pressure', diabetes, and livers. People who live in the bush are hunters, with intimate knowledge of the body organs of large animals - they know what a healthy liver looks like. In fact, laboratory specimens of diseased livers are used to effect by alcohol counsellors in the Northern Territory - as one Aboriginal health worker explained to me, 'a lot of people, they like to see something in front of their natural eye - because they cannot understand. When we try to educate our people, pretty hard for them to believe sometimes' (Jack

Little in Brady 1995).

In this context, I believe the use of tests such as GGT to be *extremely important* for Aboriginal clients. Results are a tangible, personalised piece of information. The use of personalised health advice, of which test results are a part, dovetails with one of the most important 'cultural' factors - the need for the patient to have *legitimation* of his or her decision to change drinking habits in the eyes of others - this will be discussed shortly.

Apart from the issue of expectations that Aboriginal people have of their doctors, it is also important to bear in mind that the climate of opinion *is* beginning to change and Aboriginal people (in some regions at least) are becoming more accepting that alcohol abuse constitutes problematic behavour and are less willing to tolerate it. While drinking is still the norm, it is not quite so deviant to be sober.

Cultural factors

It is now accepted wisdom that services offered to Aboriginal clients should be 'culturally appropriate' - although there are few clear ideas about what this actually means. (Westermeyer 1981; Sibthorpe 1988; RCIADIC 1991:288). One of the many problems of such notions is the assumption of cultural homogeneity, and another is the presumption of fixed normative systems. I argue below that there are certain features of brief interventions which are appropriate for use with Aboriginal people in that they are respectful, sensitive and flexible - whether they are in keeping with local cultural and social processes is for Aboriginal people themselves to decide.

So far, it has been the residential treatment programs which have portrayed themselves as being culturally appropriate and they increasingly use icons of Aboriginality, concepts such as 'caring and sharing' and even spirituality, in order to fulfil this promise. However, there are contradictory elements inherent in the techniques used in some residential programs that would seem, in fact, to be *inappropriate*. I have written about this in more detail (Brady in press). One of these is the confrontational and public confessional nature of many of the group sessions, and at CAAAPU, the use of mixed sessions of this sort with both men and women present. These techniques have certainly provoked resistance among at least some clients (Miller and Rowse 1995).

Notions of personal autonomy

Brief interventions carried out in the privacy of an encounter between a doctor (or other health professional) and patient would seem to be far more appropriate with people for whom confrontations are at odds with the 'character of the culture'. In Australia, while there might be ritualised angry harangues about drinking *in general* in tradition-oriented communities, it is not accepted behaviour directly to confront individuals with their drinking activities. William Miller made similar comments with respect to Navaho drinkers in the southwest of the United States, observing that many Navaho students and colleagues had endorsed in principle the idea that the one-to-one, non-invasive approach of motivational interviewing ought to be highly compatible (Pers. comm. William Miller 30/3/95). Another positive feature of the private doctor-patient encounter (as opposed to the group encounter) is that it mimicks the way in which traditional healers operate in parts of Australia. Traditional doctor-patient interactions were and are conducted on a one-to-one basis, with an individual seeking out the services of a practitioner, and the diagnosis and treatment taking place on a relatively private level (Brady in press). If others

are present, they would normally be close kin.

Perhaps the most difficult issue to come to terms with in Aboriginal social life - and one which is relevant to this discussion - is the high degree of personal autonomy and the extent to which this coexists with intensive relatedness to others. Many anthropologists have written about this apparent paradox (Myers 1986; Martin 1993; d'Abbs et al 1994:76-78). Suffice it to say here that these concepts - autonomy and relatedness - lie at the heart of Aboriginal social life across many regions of the country.

Autonomy is frequently evoked by people in the context of their drinking and people with whom I have worked in rural and remote Australia subscribe to an anti-authoritarian ethic, stressing that drinking is an individual's 'own business'. Drinkers proclaim their ownership of their bodies and vigorously resist the interference of kin and consociates - they resist being 'bossed'. Notions of autonomy can therefore serve as facilitators of dysfunctional drinking because a commitment to non-intervention (that is, recognising the autonomy of another) means that social controls do not operate to prevent drinking. However, the same principle of autonomy can work in reverse: it can also imply that an individual has the liberty to make a decision to curb his or her own drinking and that no-one can interfere with that (Rowse 1993:397).

Significantly, most of those I interviewed who had stopped drinking without treatment, asserted that they had 'done it' on their own, of their own free will; people were emphatic on this point. This was *despite* the fact that they had received health warnings and several admitted that a doctor had been instrumental in making them consider their drinking. The decision, then, is understood by the individual to have arisen from within them, to be their own choice - what Prochaska and Di Clemente call 'self-liberation' (1986). Associated with this is the ubiquitous belief that no one can persuade anyone else to stop drinking. The following quote is but one illustration of this:

> We've got to go our own way you know, own way. If you want to stop drinking, you've got to worry about yourself. See, I can't tell other people to stop drinking, they've got to find out for themselves. After an accident or - that's their lookout. We can't stop people from drinking. That's their life. When we tell people 'you want to stop drinking' they say 'no, that's our life. You can't tell us what to do. That's our problem. That's what they say. Yeah, a lot of blokes say that (story no 37 Mr. Q. in Brady 1995)

another man said:

> Can't force people, can't force people to stop drinking. They gotta find out themself. When they get sick or something like that. So I had to do it for myself. They gotta do it for theirself. They got one life. We all got one life. But I can't force them. If they want to drink, they drink. If they want to stop, they can stop (story no.34 Mr P. in Brady 1995)

These observations (and many more like them) refer particularly to the persuasive efforts of peers, or others not perceived to have any overarching moral or social right to make a comment on the personal conduct of an individual. A doctor though, does have an overarching moral or social right to express concern about a patient's health and the damage that drinking may be causing. In addition, as I suggested earlier, it is likely that doctors are elevated in status and beyond the patient's social milieu. A doctor is an outsider, and it is precisely this 'otherness' that endows him

or her with the authorization to engage with Aboriginal patients in a way that close consociates cannot. Aboriginal health workers on the other hand, may be too closely associated with that group of peers and consociates which is *not* expected to comment on peoples' behaviour. Professional 'distance' is made difficult by social knowledge, as Sibthorpe pointed out in a study of an AMS in rural New South Wales. She observed,

> It was certainly clear that many Durri clients were more comfortable in professional interactions with white staff than with Aboriginal staff and in many instances Aboriginal staff seemed intensely uncomfortable performing some of the tasks which their job demanded (Sibthorpe 1988:303; see also Myers 1986:269).

This situation became apparent in the case of sensitive medical complaints, and also in the case of a drug and alcohol counsellor, who resigned in the face of considerable resistance and apathy. The failure of this counsellor to survive in an area with many dependent drinkers in need of support,

> was attributed by white staff at Durri to the fact that he was 'not local'...Aborigines whom I asked about his resignation stated however, that it was partly because he *was* local that people would not discuss their problems with him. They implied that this was the cause of a good deal of animosity towards him (Sibthorpe 1988:302).

It remains to be seen whether advice from or dialogue with a health worker who is a member of the 'community' would be acceptable.

With these ethnographic insights in mind, it is undoubtedly crucial that a brief intervention of whatever kind not be didactic or authoritarian in its delivery, neither should it be open to interpretations of interference with an individual's personal freedom. Obviously, this is the case for *any* patient not just an Aboriginal patient, and Rollnick and colleagues have written about 'psychologic reactance', the resistance and withdrawal which occurs in the case of attempts at overt persuasion of someone who is not ready to change (Rollnick, Heather and Bell 1992:27). In one Aboriginal community I was told of a doctor who spoke to people 'rough way' about their drinking and how drinkers responded by 'fighting' (ie resisting) him (Brady 1993:404). An Aboriginal pastor told me: 'If I say "hey! don't drink, it's killing you!" it bounces back - next day I see that bloke drunk. I have to leave them to decide'. These are but small examples of a very generalised objection to being bossed around.

The fact that interventions utilising motivational interviewing or versions of it (Rollnick and Bell 1991), are oriented to working with the patient's own words and *their* analysis of their drinking, and in the end, their decision, are all significant factors which concur with Aboriginal understandings. The goal is, as Rollnick and colleagues point out (1992), to work with the principle of individual autonomy by encouraging the client to explore his ambivalence, and move at a more measured pace. By so doing in the Aboriginal context, the autonomy of the individual is emphasised (highly 'culturally' appropriate) and the 'self determination' of the decision is stressed (highly politically correct). I would argue then, that these elements do 'dovetail with the social and cultural expectations of Aboriginal people' as recommended by the Royal Commission into Aboriginal Deaths in Custody (RCIADIC 1991:288).

An important feature of this 'self determination' is the discussion of options, and providing a *choice* of abstaining or of cutting down on intake. Within the variety of brief intervention/motivational interviewing approaches there is no ideological adherence to either one or the other. This is a feature which will appeal to some Aboriginal people but not to those who believe strongly that there is, in fact, no choice: total sobriety is the only solution to Aboriginal drinking problems. One of the advantages of a choice of cutting down is that abstention can be used as a fall-back position if moderating intake proves to be too difficult. On the other hand, if moderation is not supported, then abstention is a perfectly legitimate option.

The need for a legitimating excuse

Earlier I pointed out that autonomy co-exists with relatedness in social life. Relatedness is not just relevant because people are densely surrounded by others to whom they are related; it is relevant because being related requires demonstration. People who do not demonstrate their feelings of relatedness through acts of generosity are believed (by western desert people for example) to be 'like rocks', barely human, according to Myers (1986). Acts which signify relatedness include reciprocal demonstrations of concern, giving and receiving, and making demands and claims on others. Aboriginal drinking is essentially a social affair. The credits and debts of exchange and what has been termed 'demand sharing' (Peterson 1993) lie at the core of the drinking event in Aboriginal settings. People have reported that reactions to declining a drink include accusations such as 'what are you, trying to be different?', 'acting like a white man', 'you don't love us any more', 'if you don't fill it up, you're no mate of mine'. In order for an individual to extricate him or herself from such a socially pressured context, more than mere willpower is required. People must engage in a series of elaborate social reassurances with their peers or their kin in which they must communicate their refusal of alcohol, without placing their relatedness, their relationship to the offerer of alcohol, in jeapardy. This is no easy task. 'I'm still your friend but I'm not going to touch that drink'; 'I'll drink a coca cola for you' are examples of the verbal persuasions used. The proferring of an external legitimation, a face-saving device is, for many Aboriginal people, one way out of this dilemma and a doctor can provide this.

What doctors say has a crucial role in the *public* legitimation of a change in drinking status. We know that doctors - for the most part - are treated with respect, and that people do - sometimes - take their advice. People who give up drinking explain that when their drinking mates continue to put pressure on them to drink, they use a repertoire of explanations. For example, Christianity provides a legitimating excuse for not drinking, as Myers observed with Pintupi people in Central Australia:

> The effectiveness of Christianity in the context of Pintupi culture is that it provides an *authority outside the individual subject* on which he or she can base a refusal to participate in drinking. "I can't drink; I'm a Christian" has become an acceptable form of refusal. Former alcoholics articulate their abstinence as adherence to *an authority outside themselves* (Myers 1986:269, my emphasis).

A doctor too can take on the role of the authorising Other, becoming an authority outside the individual subject. Utilising a doctor's advice can be a means whereby people may legitimately excuse themselves from drinking. One could ask again whether or not advice from an Aboriginal health worker would carry the same degree of public suasion. A further example of the utility of such external devices is the provision of medical bracelets to particularly vulnerable Aboriginal

people (for example those taking Antabuse, or suffering from alcohol-related brain damage) both to signify and to defend their non-drinking status (Pers.comm. Ernest Hunter, 10/8/95). A medical bracelet is 'proof' that an individual is set apart, and has been authorised to be so by a doctor.

The drinking culture

We know that there is a widespread conceptualisation among Aboriginal people that they are either drinkers (usually heavy drinkers) or non-drinkers (abstainers), and we know from a variety of survey results that broadly speaking, this conceptualisation is true. It is clear that the high alcohol intake of most Aboriginal drinkers, and the fact that many are dependent users means that these people will not be amenable to change until they experience major trauma or life-threatening illness. Despite this, there are 'moderate', 'controlled', or 'responsible' drinkers in the Aboriginal population but who nevertheless run the risk of gradually developing into heavier use.

The evidence for this pattern of use is derived from several studies. In 1988 Peter Lake, a doctor with the AMS in Adelaide, surveyed 102 consecutive patients of the service and found that 'while a good proportion of the patients in this study had advanced alcohol problems, others were good candidates for early intervention' (Lake 1988:21). In Hall's Creek, WA, Douglas observed that there is 'little infrastructure to assist problem drinkers who are willing to relinquish alcohol but are unable to do so' and no formal mechanisms whereby problem drinkers could be identified early in their habit (Douglas 1993:192). The survey of NSW towns categorised about 20 per cent of Aboriginal men and 10 per cent of Aboriginal women as 'responsible drinkers' (Perkins et .al. 1994). Finally, a study comparing Aboriginal with non-Aboriginal patients in a withdrawal unit at the Rozelle Hospital in Sydney found that the median daily ethanol intake for the Aboriginal patients had been 520g compared with 395g in the non Aboriginal sample (Chegwidden and Flaherty 1977). Collecting some very interesting information in the form of drinking histories, Chegwidden and Flaherty found that the Aboriginal members of their sample began drinking to excess more quickly than did the non-Aborigines but that there was an average of between three and four years of moderate drinking before excessive drinking began. 'Moderate drinking was followed by an average period of excessive intake of alcohol for 15.3 years before admission to the unit' (Chegwidden and Flaherty 1977:700).

It could be argued that all clients (irrespective of their race) suspected of harmful alcohol use should be informed that such use will ultimately damage their health. However, these sparse data indicate that there *are* candidates within Aboriginal populations who fit the criteria of 'low dependence drinkers' for whom brief interventions are thought to be appropriate. It is perhaps necessary at this point to reiterate research findings that most brief intervention studies exclude severely dependent drinkers needing psychiatric referral and those lacking social supports (Chick 1993); that the advocation of brief interventions is not a call to abandon intensive treatment approaches (Mattick and Jarvis 1994); and that alcohol dependence is a serious disorder associated with a high mortality rate (Jurd 1994).

Socio-economic issues

Perhaps the most obvious drawback to the use of brief interventions with Aboriginal drinkers is that of socio-economic circumstances. Many, perhaps the majority, of Aboriginal heavy drinkers live in what O'Connor has described as 'awful circumstances'. O'Connor believes that the type of advice and counselling that takes place during brief and other such interventions is irrelevant

in the Aboriginal context, and constitutes

> *moral persuasion*, using *language* and *logic* and *appeal to Western values* - losing your job, your comfortable home, your respectable family, your good name...Whether the jargon is *rehabilitation*, *recuperation* or *counselling*, when these white middle-class based enterprises are over, the client must again return to deprived and awful circumstances (O'Connor 1988:187 original emphasis).

Indeed, it is important to remember that the Aboriginal unemployment rate in 1991 was three times the national average, that average income is two-thirds of the national average, and that large numbers of Aboriginal people live in what the rest of Australia would categorise as shanty towns of corrugated iron and tarpaulins. Imprisonment rates as documented by the RCIADIC are extraordinarily high; Chegwidden and Flaherty observed in 1977 that only one out of 55 Aboriginal in-patients had *not* been arrested for drunkenness and that most had been arrested more than 10 times. Added to this is the appalling health status with life expectation at birth being between 18 and 19 years shorter than for non-Aborigines. The Rozelle study also found that the treatment process was complicated by the severe deafness of several Aboriginal patients, undoubtedly resulting from repeated and untreated *otitis media*.

O'Connor is correct when he observes that the 'middle class' logic of losing your home and your job depend on having a home and a job to lose. Brief interventions, however, are not intended to replace the residential facilities (drying out, rehabilitation camps, respite houses, treatment centres) which provide supportive stuctures, activities, meals. They are not aimed at persuading severely dependent drinkers to stop. Their success probably would depend on the existence of other social and familial supports, on catching certain groups of drinkers who are beginning to experience difficulties and who are looking for an excuse, who need to have some strategies in reserve.

Another hurdle to the efficacy of brief interventions is minimal levels of education, even among Aborigines in urban areas. The 1977 study of Aboriginal men at Rozelle Hospital found that 56 per cent had either no formal schooling or a primary education only (Chegwidden and Flaherty 1977:700); and in 1994, a survey of users of Tharawal AMS in Cambelltown found that 40 per cent of adults had not completed education beyond primary school (Tharawal Aboriginal Corporation1994). This means that the use of reading material and self-monitoring tools such as diaries would not always be appropriate - techniques which are used in general population programs such as Alcoholscreen. It must be said however, that low levels of education and literacy, and in some regions the use of English as a second language, also beg the question of client comprehension in intensive and residential programs. There are often heavy doses of 'alcohol education' and abstract theorising taking place in these longer-term facilities, and comprehension problems have been documented (Miller and Rowse 1995; O'Connor 1988). Brief interventions have an advantage in that they need not engage in verbiage.

Ideological issues

Many (but by no means all) Aboriginal professionals and para-professionals in the alcohol service delivery field are ideologically committed to the goal of abstention, to the notion of alcoholism as a disease, and to the sole use of Aboriginal ex-drinkers as counsellors. They have publicly

stated their antipathy to (variously) the public health model, controlled drinking, social drinking and harm reduction approaches (for example Sumner 1995:17). There are, in fact, compelling reasons which explain the power of the model of abstention as the only way out of heavy drinking for Aboriginal people. It is simply easier for people to portray themselves as non-drinkers (a status which will in the end become accepted by drinking partners) than to try to sustain the equivalent status of a 'light' drinker.

It is crucial that the spirit and potential importance of the role of brief intervention not become entangled within this argument. Brief interventions are not necessarily associated either with abstention *or* with 'controlled' drinking - they are, quite simply, based on the notion the health professional, particularly a doctor, has an important part to play in motivating an individual to consider his or her drinking and the impact it is having on their physical or social wellbeing *before* this impact (and consumption) becomes catastrophic. A doctor leaves the decision up to the individual about whether that person could lower their intake, or cut it out altogether. Brief interventions should not be interpreted as a threat to those people who adhere to the abstention model as the only appropriate goal for Aborigines.

Conclusion

Any health intervention, to be successful, must garner the willing and active participation of the client - and herein lies the nub of the problem of prevention and treatment. In the case of Aboriginal people, all the evidence suggests that Aboriginal people have many more reasons than other Australians to be wary of health professionals and contacts with health services. Because of this there are greater barriers to active participation and 'compliance' (an unpleasant word). Low socio-economic and educational levels, time, transport and access, as well as priorities other than health are also barriers to participation in health improvement. It is for these reasons that what is known as community control of service provision is so important. The details of the extent and nature of 'community control' vary across the country but the outcome ideally should be that the context and ambience of the service, the rapport with professional staff and the sense of belonging and ownership of a community health centre all combine to facilitate a willingness to join with the process of health improvement. As Ian Anderson observes, it would be wrong to assume that self determination is a principle only appropriate to overt political activity:

> The implication of any health intervention is that the recipient will consent to change aspects of his or her behaviour, and possibly values. This is an ethically difficult position for service providers, particularly given the history of coerced social change and Aboriginal communities. However, not only is it ethically wrong to impose change on people, it is actually impossible in any comprehensive sense, unless you want to regulate every aspect of their lives. This is one reason why self-determination is a necessary principle of Aboriginal programmes. It is only realized where programmes are structured in such a way as to allow Aboriginal people to engage with the possibilities, have the necessary resources to make changes, and be convinced that the changes will enhance their lives (Anderson 1994:35-36).

If developments such as brief interventions are found to be appropriate, and if they are to become an accepted part of the range of early interventions available to Aboriginal as they are to non-Aboriginal people, then the factors that Anderson mentions should ideally be present. Self

determination is relevant both at the level of the individual 'self' decision-making process as well as the larger context within which these exchanges might take place. Notwithstanding the potential role of community-controlled AMS in the provision of earlier interventions into alcohol misuse, there are many other moments of contact between health professionals and Aboriginal clients which present opportunities for opening up dialogue on the issue of alcohol (GPs, RFDS, District Medical Officers, hospital outpatients, prisons).

There are also many impediments, some of which I have documented in a preliminary - and theoretical - way. The applicability of new treatment fashions needs to be evaluated critically, and as Robin Room has cautioned, professional enthusiasm can from time to time, lead to the application of models in inappropriate circumstances (Room 1985). In the spirit of broadening the base for approaches to alcohol misuse though, Aboriginal people have a right to test out and implement some of the approaches now gradually being made available on a wider scale. Such interventions should ideally be seen to be part of a range of possibilities and options for Aboriginal clients, options which can be offered in a respectful relationship between the best advice of a health professional, and a patient.

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Appendix 1

ADVANTAGES OF BRIEF INTERVENTIONS BY DOCTORS WITH ABORIGINAL CLIENTS

- NON CONFRONTATIONAL
- PRIVATELY-GIVEN ADVICE
- STRONG BELIEF IN INDIVIDUAL DECISION-MAKING ABOUT DRINKING
- CHOICE BETWEEN ABSTENTION AND CUTTING DOWN
- DOCTOR PROVIDES LEGITIMATION TO CHANGE HABITS
- A FEW YEARS OF MODERATE USE PRIOR TO HEAVY USE
- HIGH USEAGE OF DOCTORS (19% IN PREVIOUS 2 WEEKS) (ABS)
- PERSONALISED HEALTH ADVICE
- VALUE OF TESTS SUCH AS GGT - LEGITIMATION
- KNOWLEDGE OF BODY ORGANS (LIVER etc)

Appendix 2

DIFFICULTIES OF INTRODUCING BRIEF INTERVENTIONS WITH ABORIGINAL CLIENTS

- **POOR DISSEMINATION OF NEW APPROACHES TO DRINKING**
- **LACK OF POLICY OR BEST PRACTICE ADVICE TO AMSs**
- **PROGRAM FUNDING DIFFICULTIES (NON PROFESSIONALS)**
- **DICHOTOMY BETWEEN 'DRINKERS' AND 'ABSTAINERS'**
- **ANTI-MODERATION VIEWS**
- **ADHERENCE TO DISEASE MODEL**
- **HEAVY INTAKE BY THOSE WHO DO DRINK**
- **LOW EDUCATION AND LITERACY LEVELS (re. diary etc.)**

**

leftovers:
The Australian-based centre for the WHO randomised controlled trial of brief interventions included 30 Aboriginal respondents and Professor John Saunders reported that there was no difference in their response. (Pers. comm. 14/3/94)***

Finally, broadening the base of alcohol interventions for Aboriginal people is in keeping with a so-called 'holistic' view of health to which indigenous people are said to subscribe. Reviving Engel's 1977 creation of the 'biopsychosocial' view of health, Donovan (1988) writes of a biopsychosocial model in addictive behaviours:

an important feature of the biopsychosocial model is a move away from a reductionist view of illness. It is insufficient to say that a person is either well or ill...[these views] have been replaced by a broader, holistic view (Donovan 1988:13).

Details of adaptations:

These would include eliciting a **drinking history** and the need for awareness of different drinking patterns. Its important for doctors to know something of the drinking styles of Aboriginal people in the area s/he works in. For example, in screening about alcohol use a patient might state he consumed several bottles of fortified wine with several others in a matter of hours and the doctor might conclude the person was a regular binger. But the patient may be living in a dry area, or responding in a one-session binge to a bereavement or other personal crisis. Also it may be 'normal' for an Aboriginal drinker to consume amounts considered extraordinary by outsiders. In short, the service provider should be concerned with the frequency of such drinking episodes and how long this has been going on as well as with the actual amount consumed on one occasion (see Topper 1981:82 on the Navaho). Another example of the relativity of problem-definition would be if someone reported not having had a drink in the month before the consultation - this does not necessarily measure improved drinking behaviour, 'remission', or the absence of drinking problems. Aboriginal people have a variety of drinking styles including months on and months off.

The pros and cons of drinking will provide different definition of what constitutes a **'problem'**. The occasional injuries or fights would not signify a 'problem' associated with drinking for many Aboriginal men - problem definition would probably include frequent arrests, loss of licenses, loss of jobs, hospitalisation and so on. (Topper 1981).

Talking about **standard drinks** could be a problem in some areas and some experimentation would need to be done about how best to explain this.

Tips on cutting down could include 'culturally relevant' items such as:
- take only a little money with you to the pub
- use the doctor as an excuse
- change from drinking 'wine' (ie port) to beer, then light beer
- avoid your heavy drinking mates