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Preventing harmful drug use in Australia

REVIEW OF THE SERVICES PROVIDED BY JUNGARNI-JUTIYA ALCOHOL ACTION COUNCIL ABORIGINAL CORPORATION

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1.0 INTRODUCTION

Jungarni-Jutiya Alcohol Action Council Aboriginal Corporation (referred to in this report as Jungarni-Jutiya) oversees the operation of the Halls Creek Night Patrol and Alcohol Centre. The Jungarni-Jutiya management committee plans to expand the organisation's services—possibly to include a residential treatment facility. As part of the planning process, Jungarni-Jutiya initiated an assessment of the needs of the Halls Creek community and an evaluation of its existing projects. This report presents the findings of the needs assessment and evaluation, and recommends strategies to improve and expand Jungarni-Jutiya's alcohol intervention services.

On receiving funding from the Office of Aboriginal and Torres Strait Islander Health (OATSIH) to undertake the needs assessment and evaluation, the Chairman of Jungarni-Jutiya formally invited staff from the Indigenous Australian Research Program at the National Drug Research Institute (NDRI) to carry out the project. The Jungarni-Jutiya management committee members had a clear understanding of what they wanted to achieve by undertaking the study, and formulated the following objectives, on which NDRI staff based the project.

- Assess the management capabilities and functioning of Jungarni-Jutiya Alcohol Action Council.
- Assess the extent to which the Alcohol Centre projects and Night Patrol are meeting their stated objectives.
- Identify factors that impede or facilitate the meeting of Jungarni-Jutiya objectives.
- Assess whether or not the Jungarni-Jutiya alcohol projects are meeting community needs.
- Make recommendations that will assist in the improvement of services provided by Jungarni-Jutiya.
- Make recommendations on the future direction of Jungarni-Jutiya, with particular reference to live-in rehabilitation provision and the extent to which it can address the treatment needs of the people living in Halls Creek and surrounding desert communities.

1.1 Halls Creek

Jungarni-Jutiya is based in the East Kimberley town of Halls Creek, which is located approximately 300 km east of Fitzroy Crossing, and 360 km south of Kununurra. Halls Creek is situated in the divide between traditional lands of the Kija and Jaru speaking people's and most Aboriginal people living in and around the town belong to one or other of these groups.[1] Halls Creek was first settled by Europeans in 1885 after gold was found in the area, and the population rapidly swelled to several thousand

people. However, by 1890 the gold rush was over and the town's population quickly diminished. In 1940, the town was relocated to flatter ground approximately 14 kilometres north-west of the original town site. Sections of the old post office and other brick buildings still stand at 'Old Town', which is a popular local tourist site. Also situated at the old town site are a caravan park and homestead which have been for sale for over a year. In 1998–99, Jungarni-Jutiya submitted to funding agencies a proposal to purchase these and convert them into a residential alcohol treatment centre.

According to the Australian Bureau of Statistics, at the 1996 Census, the town of Halls Creek had a population of 1037, and the Halls Creek Shire—which includes Aboriginal communities such as Billiluna, Balgo and Lamboo—had an estimated population of over 2996, 58 per cent of whom were Aboriginal.[2] However, Atkinson and his colleagues have found these figures to be a gross underestimation of the Halls Creek population, and have calculated the Aboriginal population to be as high as 2700.[3]

Halls Creek has a number of health, welfare, legal, educational and recreational services and facilities, and a range of privately owned businesses. They include: the five bed Halls Creek Hospital, Community Health Services, Home and Community Care (HACC) Programs, Yuri Yungi Aboriginal Medical Service, Aboriginal Legal Service, Justice Department, Family and Children's Services, Ngaringga Ngurra Safe House, Ngoonjuwah Aboriginal Resource Centre, three churches, TAFE, Halls Creek District High School, Red Hill Catholic Primary School (located in a town-based Aboriginal community), Kimberley Language Resource Centre, Halls Creek Arts Centre, Puranyangu-Rangka Kerrem Radio Station, Jungarni-Jutiya Alcohol Counselling and Education Centre, Salem Sobering Up Shelter, Halls Creek Night Patrol, Safer WA Committee, Halls Creek Youth Service, recreation hall and public oval, Halls Creek People's Church Frail Aged Hostel, police station, Halls Creek Tourist Information Centre, two roadhouses, two grocery stores, several variety stores, and various trade services.

In the Kimberley Region, of which Halls Creek is a part, over the period 1992–93 to 1996–97, annual consumption of pure alcohol among persons aged ≥15 years was19.0 litres per person.[3] That is, 1.8 times the Western Australian average of 10.7 litres. Based on data from both Western Australia as a whole and the West Kimberley, it has been estimated that the average level of consumption among Aboriginal drinkers is 1.6 times that of non-Aboriginal drinkers;[4] and this level of consumption is reflected in death rates, and a hospital discharge rate for alcohol-related conditions that is almost three times the non-Aboriginal rate. [3]

1.2 Alcohol interventions

To address the high rate of alcohol consumption and related harm, in Halls Creek three alcohol intervention projects have been developed that together offer a range of acute intervention, treatment and prevention services. The first of these services to be established was the Salem Sobering Up Shelter which opened in September 1992 as part of a response to the decriminalisation of drunkenness in Western Australia and the recommendations of the Royal Commission into Aboriginal Deaths In Custody.[5, 6] The Halls Creek Alcohol Action Advisory Council (AAAC)—a committee of representatives from the local shire, health services, police, churches and Aboriginal organisations—was formed to oversee the planning and development of the Sobering Up Shelter which was to be funded by the Western Australian Drug and Alcohol Authority (ADA). The ADA put the operation of the Shelter up for tender and this was won by the Halls Creek People's Church which continues to manage the Shelter.

Soon after its formation, the AAAC organised a community meeting where—it has been reported—there was strong support for the implementation of other alcohol interventions.[7] Following this, the AAAC lobbied for the introduction of additional restrictions on the availability of alcohol and, on the 1st November 1992, the State Director of Liquor Licensing imposed licensing restrictions that:

- prohibited the sale of packaged liquor in the town before midday; and,
- limited the sale of cask wine to the hours between 4:00 pm and 6:00 pm and limited sales to one cask to any one person on any day.[7, 8]

In February 1997, these restrictions were supplemented by an informal 'accord' in which licensees agreed that on Thursdays (the day on which most social security entitlements are paid) no cask or fortified wine would be sold, and no full-strength beer would be available between 12:00 and 5:00 pm.

In 1994, Ngoonjuwah Aboriginal Resource Centre established a Night Patrol—also as part of the response to the recommendations of the Royal Commission into the Aboriginal Deaths in Custody. However, shortly after its establishment, the Night Patrol experienced a number of operational difficulties that were caused by inadequate resources, and which resulted in its temporary closure. Despite its rocky beginnings, the Night Patrol was re-established in 1995. In that year, and in 1996, Ngoonjuwah received funds to purchase a vehicle and to cover administrative costs. These funds were not expended until the third quarter of 1996, and the Patrol effectively began to function in the fourth quarter of 1996.

To complement the Sobering Up Shelter, the licensing restrictions, and the Night Patrol, the AAAC successfully went on to establish the Alcohol Education and Counselling Centre (also known as the Alcohol Centre) in June 1995.[9] As its name suggests, the Centre was established to provide non-residential counselling to substance dependent persons and their families, and to deliver alcohol education and

health promotion programs. Again, as the AAAC was not incorporated at this time, funding for the Alcohol Centre was initially administered by the Ngoonjuwah Aboriginal Resource Centre.

1.2.1 Jungarni-Jutiya Alcohol Action Council Aboriginal Corporation

Despite the achievements of the AAAC, there was some community concern about the limited Aboriginal representation on the committee.[1] It had been reported that, due to limited Aboriginal involvement in the planning and implementation process, some aspects of the AAAC initiatives did not have the full support of the community and were considered by some as culturally inappropriate. To address this problem, a representative from OATSIH suggested that the AAAC become an Aboriginal Corporation.[9] Accordingly—after considerable negotiation between the members of the community, existing committee members, and OATSIH staff—the AAAC was renamed and incorporated as Jungarni-Jutiya Alcohol Action Council Aboriginal Corporation in 1997. Unlike many Aboriginal Corporations, Jungarni-Jutiya actively invites non-Aboriginal representatives from other service agencies to be associate members of its Council. These members 'enjoy all the rights and privileges of membership, but, (the constitution states, do) not in any circumstances have the right to vote'.[10] Shortly after the incorporation of Jungarni-Jutiya, steps were taken to transfer the financial administration of the Alcohol Centre, and the management of the Night Patrol from Ngoonjuwah, to the Jungarni-Jutiya committee.

Halls Creek Night Patrol

The primary objective of the Halls Creek Night Patrol is to identify people in need of immediate assistance and to respond to those needs by:

- providing intoxicated people transport to the Sobering Up Shelter, their homes, or a safe place;
- providing women and children 'at risk' support and safe transport to their homes or a safe place; and,
- identifying incidents of domestic violence and where possible assist police to resolve them.[11]

The Night Patrol is staffed by a Coordinator and four patrollers. It operates from Wednesdays to Saturdays between the hours of 5:30 and 10:00 pm, with finishing times being extended if necessary. The Patrol Coordinator is based at the Alcohol Centre to answer the telephone and two-way radio, while the four patrollers monitor the streets and pick-up intoxicated people in a modified 12-seater bus. The Coordinator remains in regular contact with the patrollers, informing them of any requests for assistance. Patrol staff are provided with uniforms, and are paid at the end of each shift.

Jungarni-Jutiya Alcohol Education and Counselling Centre (the Alcohol Centre)

As stated previously, the Jungarni-Jutiya Alcohol Education and Counselling Centre was first opened in 1995. By early 1996, it was beginning to experience a number of management and staffing difficulties, and in April 1996 the Coordinator resigned. The Centre remained closed from that time until a new Coordinator was appointed in early September 1996 and steps were taken to re-establish its services.[9] The Alcohol Centre currently has a staff of seven: a Coordinator, a male and a female health worker, a trainee secretary, two part-time cleaners, and a part-time women's worker who voluntarily works extra hours when needed. The building has a reception area, three offices, a meeting room, kitchen, laundry, male and female toilets, and an outdoor area is currently under construction.

The objectives of the Alcohol Centre are as follows.

- To reduce the harm in Aboriginal communities caused by alcohol and substance misuse.
- To address the many issues that are evident in Halls Creek and surrounding communities as a result of alcohol and substance abuse.
- To have in place preventative and educational programs that will benefit the community.
- To maintain a Counselling Centre for client treatment and support.
- To provide for our Community a healthy and safe place where the young are able to thrive.
- To continue to look for improvements in methods of dealing with alcohol and substance misuse.[12]

The main services provided at the Alcohol Centre are regular Aboriginal '12 Steps' based treatment meetings, but also include individual counselling, after-school activities for children, and advocacy work. Men's treatment sessions are held on Tuesday and Thursday mornings, and women's sessions are held on Monday and Wednesday mornings. Individual counselling is available to those who are unable to attend the morning meetings or who prefer a more confidential setting. In addition to these services, the Alcohol Centre is also used as a meeting place where people can go to socialise in an alcohol free environment or seek assistance and advice in completing health and welfare forms or accessing other service agencies. School based drug and alcohol education has been offered in the past; however, at the time the evaluation, was conducted, this service was not being provided.

2.0 METHODOLOGY

Essentially, the main aims of this evaluation were to:

- identify community needs;
- evaluate the extent to which Jungarni-Jutiya's alcohol projects were meeting those needs; and,
- recommend strategies to better address those needs, and to address un-met needs.

The evaluation was conducted in four stages (see Figure 1). Stage one involved the planning of the evaluation and the setting of research objectives. There were two parts to stage two: assessing community needs and evaluating existing projects. Stage three involved a comparison between the findings of the needs assessment and those of the project evaluation in order to identify the extent to which the existing services were meeting community needs. Based on this comparison, in the final stage, recommendations were made regarding the enhancement of existing services and for the provision of additional services.

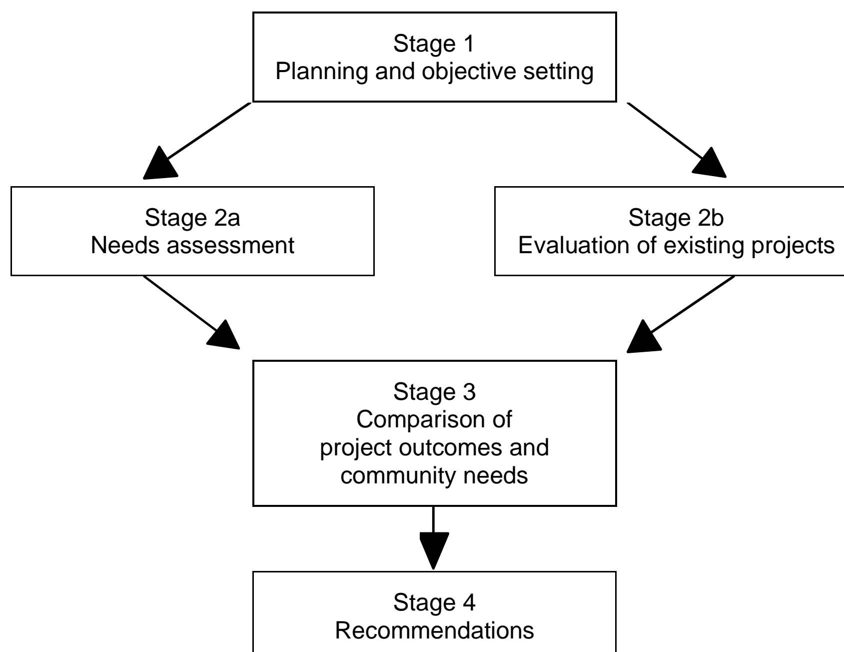

Figure 1: Stages of the evaluation process

2.1 Planning and objective setting

It was initially intended that the 'planning and objective setting' stage would involve the Jungarni-Jutiya committee and the evaluation team in the joint development of the project objectives. However, Jungarni-Jutiya committee members themselves identified the desired outcomes and independently formulated them into objectives prior to the proposed joint meeting. As a consequence, for the evaluation team, the planning stage mainly involved the design of appropriate research and data collection methods—based on the objectives prepared by Jungarni-Jutiya. This process was carried out in conjunction with the Jungarni-Jutiya Chairperson and Coordinator, and resulted in the development of a comprehensive evaluation strategy.

2.2 Needs assessment

To identify the needs of the community, a survey was conducted among clients, community representatives and other service providers. This survey was conducted concurrently with the evaluation interviews and included the same sample group (see below). Respondents were asked a range of questions regarding:

- the types of drugs used and their effects;
- the context in which they are used (i.e. social or cultural setting);
- the person or persons using them;
- how they are used;
- why they are used; and,
- consequence of that use.[13]

Respondents were also asked what additional action, if any, was needed to address these issues. Responses to these questions were summarised, keyworded, and ranked in order of the frequency with which they were mentioned. This was done to identify the main concerns shared by community members regarding alcohol misuse and associated problems, and to identify what they considered to be the main service needs for Halls Creek and surrounding communities. Some of the results of this assessment are presented in a separate section in Chapter 3, and others are presented in the sections dealing with specific projects.

2.3 Evaluation of existing projects

Evaluation of the existing projects involved the development of appropriate performance indicators, and collection and analysis of data relevant to these. The evaluation methodology was based on the principles for the evaluation of Aboriginal health and substance abuse projects identified by Gray and his colleagues.[14]

2.2.1 Performance indicators

Jungarni-Jutiya had already identified and was monitoring a number of performance indicators that measured the output or, more specifically, the productivity of the Night

Patrol and the Alcohol Centre. Unfortunately, however, no indicators that measured the outcomes of the projects had been established. To overcome this problem, the evaluation team first consulted community members, and asked them to identify what they saw as problems related to alcohol misuse in Halls Creek. They then conducted a literature review to identify performance indicators that measured changes in these problems. The set of performance indicators that were finally developed included those already being monitored by Jungarni-Jutiya to measure outputs, and those developed specifically to assess project outcomes. These included the following.

- Alcohol-related morbidity and mortality among Aboriginal people as recorded by Halls Creek Hospital.
- The number of arrests made and the number of intoxicated people detained in the Halls Creek police lock-up.
- The number of people picked up by the Night Patrol.
- The frequency of community disturbances and other alcohol-related harm—as identified by community representatives and the police.
- The impact of the alcohol projects on the work-loads of other service providers.
- The productivity of the staff and the degree to which the alcohol projects are providing services.
- Community knowledge of, and opinions about, the work undertaken by the Night Patrol and Alcohol Centre.
- The number of people who have made positive changes to their drinking behaviour.

2.2.2 Data collection

Data collected for the evaluation included, interview, statistical, observational, and documentary data. Most of these data were collected over three weeks in July and August 1999. However, additional police and hospital data were obtained in the weeks following this period. These data were analysed to evaluate the existing alcohol projects and to identify potential future alcohol interventions.

Interviews

Based on previous experience, it was decided that unstructured interviews would be used to undertake the community survey.[15] The interviews were conducted using a checklist of questions that were formulated following the preliminary community consultation process. During preliminary discussions with relevant stakeholders, a range of issues associated with alcohol and drug misuse, community service needs, and current and future alcohol and drug intervention projects were identified as topics to be investigated. These issues were the foundations on which the community interview checklists were designed.

Sample Groups

One hundred and sixteen people were interviewed in a total of 48 small groups, at the Alcohol Centre, their homes or camps, or the offices of various agencies. The 48

groups represented four larger sample groups: Jungarni-Jutiya staff and clients, community representatives, and other service providers. The Coordinator, women's worker and two health workers at the Alcohol Centre, and the Night Patrol Coordinator and two of the four patrollers voluntarily participated in the evaluation survey. A total of 21 clients who had used one or both of the services offered by the Jungarni-Jutiya alcohol projects participated in the survey. They included clients at the Alcohol Centre during the data collection period and ex-clients who were interviewed in the community.

Community members were not randomly selected. Instead, local cultural etiquette was followed and, initially, 14 key community representatives—identified by the Chairperson and Coordinator of Jungarni-Jutiya—were invited to participate in the survey.[15] This group was made up of the chairpersons, leaders and elders of local Aboriginal communities and/or family groups, and other community members who were known to be actively interested in alcohol and drug intervention issues. Of this group all but two were able to be interviewed. In turn, these key representatives were asked if they would like to invite or recommend any other relevant persons to participate in the survey. This resulted in the recruitment and interviewing of another 33 community members—making a total of 45.

A list of 27 relevant health, welfare and legal service agencies, and private businesses was prepared with the assistance of the Jungarni-Jutiya Chairperson and Coordinator. All but two of these service provider groups were represented in the survey by one or more employees. Six of the service providers who participated in the survey were also identified as key community representatives. To avoid duplication of participant numbers, these representatives have only been identified as service providers.

Table 1: Survey participants

	Jungarni-Jutiya Staff	Jungarni-Jutiya Clients	Community members	Service provider representatives.	Total
Number of respondents	7	21	45	43	116

Statistical Data

Statistical data collected for the evaluation included hospital morbidity and police arrest data, and admission data from the Night Patrol and Alcohol Centre. Despite some limitations due to inconsistent and under-reporting, hospital morbidity data and police arrest data are commonly used as indicators of alcohol-related harm that are sensitive to interventions.[15–18]

Hospital morbidity and mortality data were obtained from the Health Department of Western Australia. These data included:

- the estimated number of alcohol-caused deaths in Halls Creek by Aboriginality, for the period 1992 to 1997 (however, the number of deaths was too small to permit meaningful use of these data); and,
- the estimated number of alcohol-caused hospital admissions (morbidity) to Halls Creek hospital by Aboriginality for the period 1991 to 1998.

Police data were obtained from the Crime Research Centre and Halls Creek Police Station and included:

- quarterly arrests by type of offence for the period 1990 to 1998; and,
- quarterly data on people transferred by police to the Sobering Up Shelter or another place.

In addition to hospital and police data, project data were also collected. The Alcohol Centre Coordinator provided the evaluation team with a range of project admission and administration data. Most of these data recorded project output. They included, the number of counselling and/or education sessions conducted, the number of clients who attended, or in the case of the Night Patrol, the number of people picked up and transferred to a safe place. Unfortunately, very little data was recorded on the outcomes of the services—such as, observed or reported behaviour change among Alcohol Centre clients, or reductions in the incidence of alcohol and other drug related harm. To compensate for the lack of this type of data, the female health worker, and the Alcohol Centre Coordinator worked through a list of all clients who had attended group or individual counselling to identify any short- or long-term behavioural changes that they may have made. Where possible, the reported outcomes achieved by clients were then crosschecked with the clients themselves and/or members of their families.

Observations

Observations were made of the Night Patrol and Alcohol Centre to assess staff productivity and performance, client responses to the services, the management of the projects, and the resources and facilities available to them. Daily informal visits to the Alcohol Centre for 15 minutes to 2 hours were made in the early morning and/or afternoon. Two formal observations were made of the treatment sessions—these included accompanying the client pick-up service in the morning. The female evaluator observed the women's session and a male evaluator observed the men's session.

Two formal observations of the Night Patrol were also undertaken. The first visit to the Night Patrol was brief and focused upon the preparation of the patrollers for their shift and the Coordinator's role as manager and telephone/radio monitor. On the second

visit the evaluators accompanied the patrollers on the bus from the beginning to the end of their shift. In addition, two unscheduled, unobtrusive observations were made of the patrollers on the main street of the town and at the hotel.

Documentary and Project Data

Reports, committee meeting minutes, policies, and project descriptions were all reviewed as part of the preliminary planning stages of the evaluation. As well as establishing an historical perspective of the Alcohol Centre and Night Patrol, they were used to formulate the community survey questions. The documentary data provided an insight into the processes involved in the establishment of the services, their operation and management over the years, and the relationships and networks that staff of these projects have had with the staff of other health and welfare agencies. This information proved useful when analysing and cross-checking other data that were collected.

2.2.3 Data Analysis

The analysis of interview data was mainly descriptive, however, attempts were made to measure the frequency with which specific issues and recommendations were raised. A summary of each interview was prepared, and responses related to the causes of substance misuse, problems caused by such misuse, and strategies recommended to address those problems were keyworded and ranked in order of the frequency with which they were mentioned. Statistical Package for the Social Sciences (SPSS) ARIMA time series analysis and multiple regression procedures were used to test the impact of the introduction of the Sobering Up Shelter and liquor licensing restrictions and the Night Patrol and the Alcohol Centre on police arrest and hospital morbidity data. Observational data was mainly used to cross check survey responses regarding the delivery of the alcohol projects' services. Documentary data was used mainly to establish an historical perspective of the development and function of Jungarni-Jutiya and its services.

2.4 Comparison and the development of recommendations

Two sets of comparisons were made between the needs identified by the community—particularly those relating to what they saw as the causes and consequences of alcohol misuse—and the data from the evaluation of Jungarni-Jutiya's services. In the first of these, comparison was used to identify the extent to which existing services were meeting community needs. In the second, comparison was used to identify un-met community needs. The results of these comparisons were then used to develop a set of recommendations aimed at strengthening existing services and providing a basis for the development of new intervention strategies.

3.0 RESULTS

3.1 Community perceptions of alcohol-related problems

To assess community needs, key respondents were asked what they saw as the reasons people used alcohol and other drugs and what they saw as the consequences of that use. Most respondents interpreted these questions as relating solely to *misuse* and its consequences. In Table 2, responses to the first of these questions are listed in order of frequency. The most common were boredom, grief and personal problems, colonisation and loss of culture, and a lack of education about safe drinking practices. In Table 3, the range of problems identified by respondents as being consequences of alcohol and other drug use are listed. The most frequently reported of these were violence and assaults, child neglect and abuse, injuries and other health problems, poverty, and 'humbugging' of family members by drinkers. The majority of respondents believed that many of these causes and consequent problems were not being addressed, or were being addressed inadequately, and that more should be done to tackle them.

Table 2: Reasons given for why people misuse alcohol and other drugs

Reasons	Groups of respondents
Boredom—Nothing to do and unemployment	30
Way of dealing with problems and grief	21
Colonisation and loss of culture	12
Aboriginal people were not taught how to drink safely, & now children are learning bad drinking habits from adults	10
Excessive drinking is now a way of life and has become a part of Aboriginal contemporary culture and important to the practice of sharing	8
Loss of purpose and leadership among some adults	6
Peer pressure	4
A sense among Aboriginal people their future is limited	3
Location of liquor store	2
Service providers experience difficulties in accessing 'at risk' people who need assistance	1

Table 3: Problems perceived to be caused by alcohol and other drug misuse

Problems	Groups of respondents
Violence and assaults	31
Child neglect and abuse	21
Unsupervised children and teenagers wondering the streets at night	17
Injuries & other health problems (including mental illness & suicide)	17
Family members humbugged by drinkers, causing them emotional & financial stress	16
Poverty	14
Crime	6
Drinking on the main road	6
Lack of respect for elders	5
Affects on tourism and gives the town a bad reputation	5
Health problems caused by tobacco	2
Petrol Sniffing	2

3.2 Impact of interventions on alcohol-related harm

As indicated previously, police arrest rates for offences usually associated with alcohol, and alcohol-related hospital morbidity rates, are commonly used indicators of alcohol-related harm and they may reflect—among other things—the impact of alcohol intervention strategies. In this section of the report, we examine the impact of the various interventions on these indicators.

The Sobering Up Shelter and liquor licensing restrictions were both introduced in the third quarter of 1992, and the Night Patrol and Alcohol Centre each began *effectively* functioning during the fourth quarter of 1996. As a consequence, it is not possible, statistically, to separate out the effects of the Sobering Up Shelter and restrictions or the Patrol and the Centre. Thus for the purposes of analysis the interventions were paired and treated as two variables. The arrest and morbidity rates are graphed in Figure 2 and the timing of the pairs of interventions is indicated by the vertical lines on the graph.

In the quarterly periods from the 1990:1 to 1992:3 the mean arrest rate for alcohol related offences was 52.5 per 1000 persons. In the period between the introduction of the Sobering Up Shelter and the restrictions (1992:3) and the introduction of the Patrol and Centre (1996:2) the rate was 40.8 per 1000 persons; and in the period from then until the end of 1998 (1998:4) was 44.1 per 1000 persons. The mean over the latter two periods was 42.0 per 1000 persons. The quarterly rates were analysed statistically to test whether these variations were due to the introduction of the interventions.

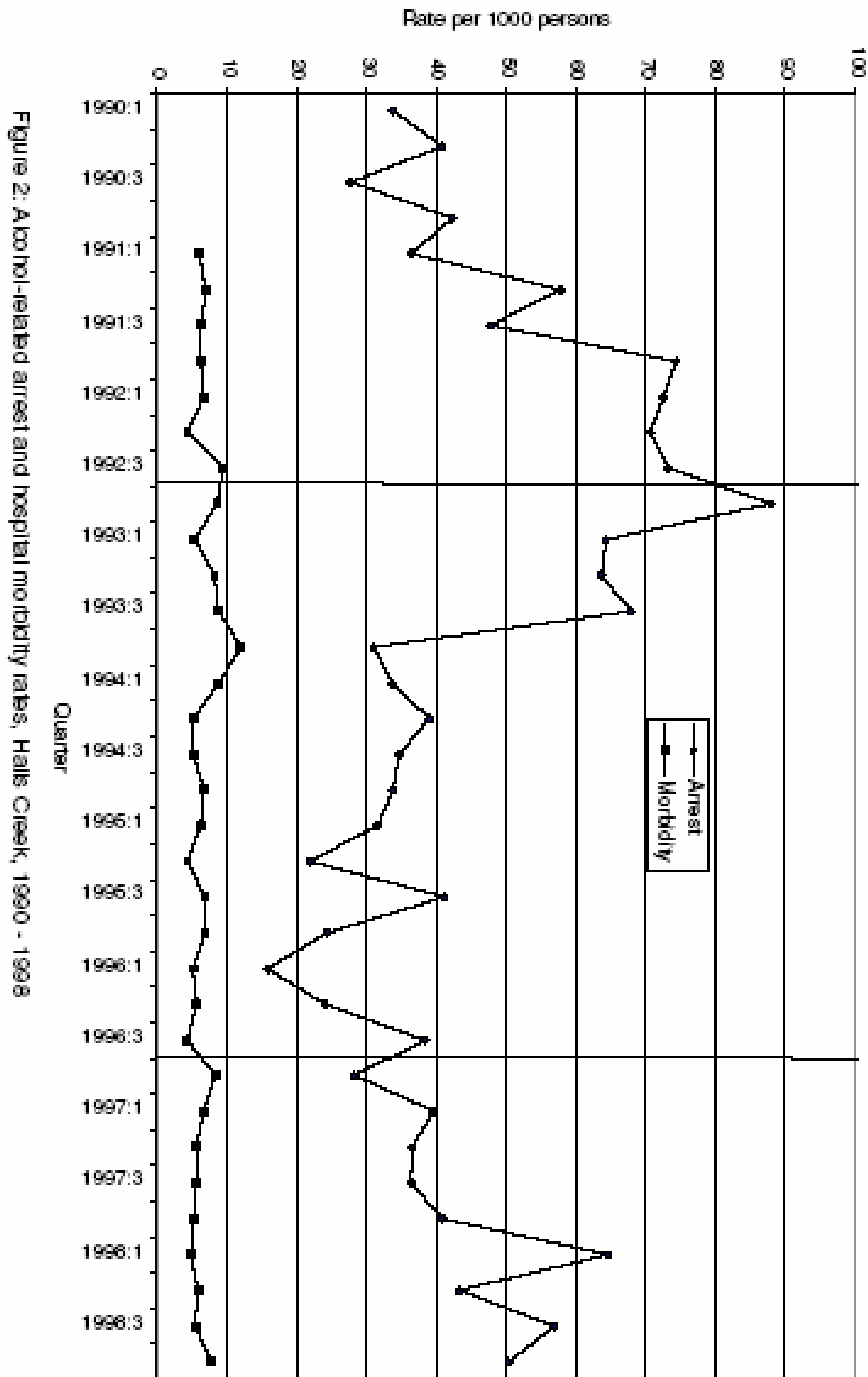

Figure 2: Alcohol-related arrest and hospital morbidity rates, Halls Creek, 1990 - 1998

A Durban-Watson test indicated that there was positive serial autocorrelation between the quarterly rates (D-W=0.69 p=0.05). That is, the rate in one month was partially determined by the rate in the previous month. For this reason, regression analysis was not appropriate and ARIMA time series analysis was the test of choice. The series showed indications of instability of mean over time and required a single application of differencing to reach stationarity. Variance in rate also appeared unstable and was natural log adjusted prior to examination.

Time series analysis showed that, when considered separately, neither introduction of the Sobering Up Shelter and the restrictions (b=6.50 p=0.59) nor the introduction of the Patrol and Alcohol Centre (b=-1.56 p=0.90) had any statistically significant effect on the rate of alcohol-related arrests. Similarly, when controlling for the effects of these pairs of interventions on each other, it was found that they had no statistically significant effect on arrest rates.

This indicates that none of these interventions has had a significant effect on the rate of arrests for alcohol-related offences, and that the variation is largely due to random fluctuations. Discussion with the police suggests that the apparent differences were due to an increased focus on making arrests for alcohol-related offences in the year leading up to the introduction of the Sobering Up Shelter and the restrictions and were not part of an increasing trend in the committal of such offences.

Similar analyses were made of the impact of the various interventions on rates of alcohol-related admissions to the Halls Creek Hospital. In the quarterly periods from the 1990:1 to 1992:3 the mean alcohol-related morbidity rate was 6.6 per 1000 persons. In the period between the introduction of the Sobering Up Shelter and the restrictions (1992:3) and the introduction of the Patrol and Centre (1996:2) the rate was 6.8 per 1000 persons; and in the period from then until the end of 1998 (1998:4) was 6.1 per 1000 persons. The mean over the latter two periods was 6.5 per 1000 persons. As a Durban-Watson test showed that there was no significant autocorrelation within the series, the effect of the interventions was tested using the SPSS multiple regression procedure. As with the analysis of the arrest data, the results of this testing indicated that the introduction of neither the Sobering Up Shelter and the restrictions (b=-0.01 p=0.99) nor the introduction of the Patrol and Alcohol Centre (b=-0.56 p=0.0.41) had any statistically significant effect on the alcohol-related morbidity rate.

It is important to note that both the alcohol-related arrest and morbidity rates are *indicators* of harm. As well as sometimes being directly affected by interventions such as those introduced in Halls Creek, they are also influenced by other factors such as police activity and hospital admission procedures. The results of the testing undertaken shows only that the interventions had no statistically significant effect on

these indicators—not that they had no effect at all. As we show in the sections of the report that follow on other measures—which are just as important[14]—the Patrol and Alcohol Centre can be shown to have had considerable effect.

3.3 Halls Creek Night Patrol evaluation

3.3.1 Identify people in need of immediate assistance and respond to those needs

The main objective of the Halls Creek Night Patrol is to identify people in need of immediate assistance and to respond to those needs by: providing intoxicated people transport to a safe place; providing women and children ‘at risk’ support and safe transport; and, assisting police in resolving incidents of domestic violence.

Table 4: Halls Creek Night Patrol pick-ups and transfers

Month	Taken Home	Taken to Shelter	Taken to Hospital	Taken to Refuge	Taken to Police	Total
1997						
May	185	66	2	1	2	256
June	161	56	3	2	4	226
July	108	91	3	3	1	206
Aug	124	151		5	1	281
Sept	137	68	2	1		208
Oct	126	64	4	2		196
Nov	80	38				118
Dec	82	103	6			191
1998						
Jan	110	36	3			149
Feb	164	51	2	2		219
Mar	267	45		2		314
April	184	31	2		1	218
May	119	34	6	3		162
June	170	24	5	1		200
July	219	68	6	2	1	296
Aug	70	51	1			122
Sept	162	41	2	3		208
Oct	76	19	2			97
Nov						
Dec	334	77	1			412
1999						
Jan	119	28	3			150
Feb	183	25	3	2		213
Mar	188	32	3			223
April	187	36	1			224
May	87	9				96
Total	3642	1244	60	29	10	4985

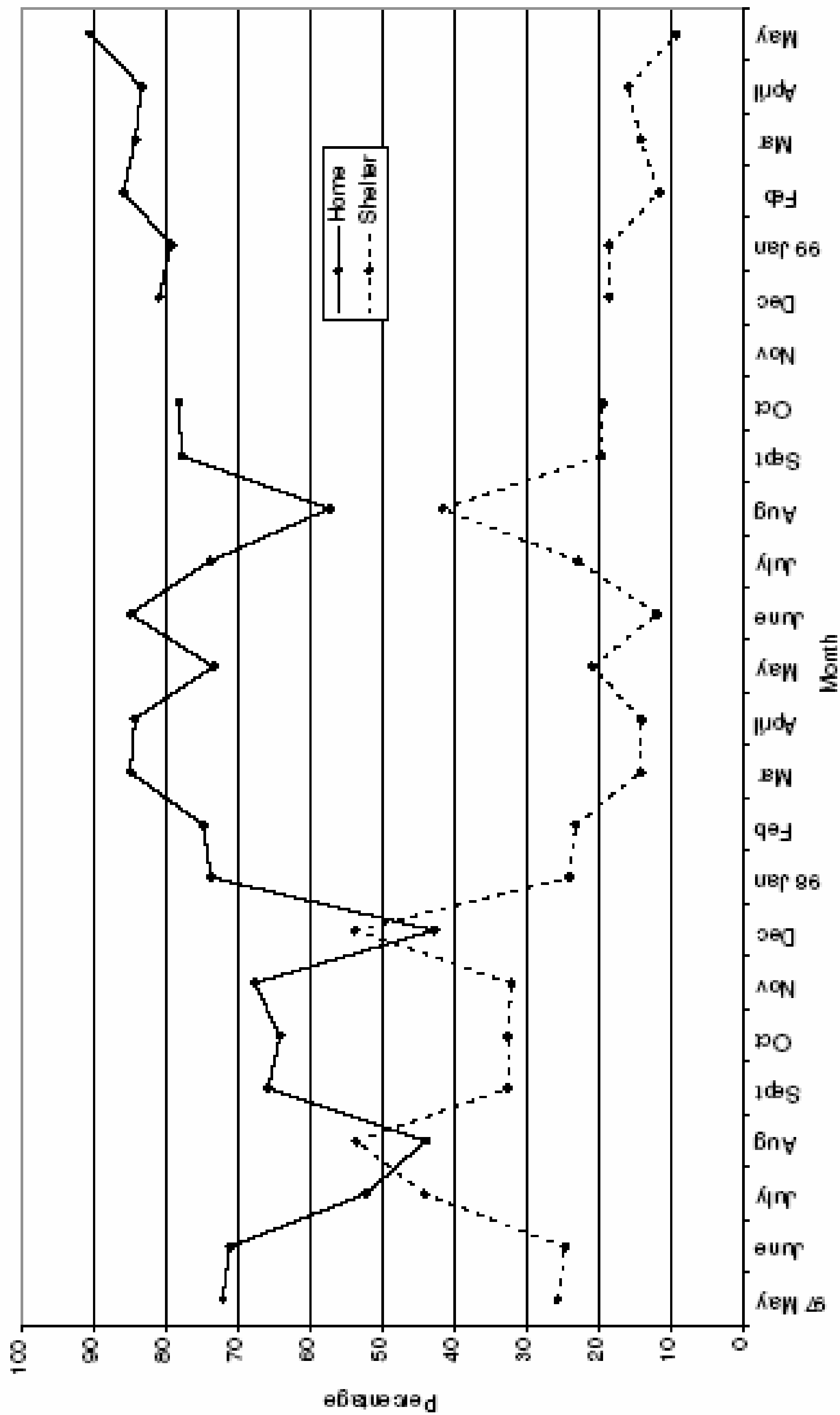

Figure 3: Percentage of Night Patrol pick-ups taken home and to the Sobering-up Shelter, Halls Creek, May 1977 to May 1999

In the period, May 1997 to May 1999, the Patrol assisted clients on a total of 4985 occasions, that is an average of 199 client contacts per month (Table 4). Had figures been available for the month of November 1998, the number would have been even higher. Most of the clients who were provided with assistance on these occasions were taken to their own homes or camps (73 per cent) or the Sobering Up Shelter (25 per cent). On 928 occasions (18.7 per cent), those provided with assistance were juveniles and all were either taken home or placed in the care of a relative.

As Figure 3 shows, there has been a marked change in the percentage of clients that Patrol members have taken to the Sobering Up Shelter. In the period May to December 1997, the mean monthly percentage of clients taken to the Sobering Up Shelter was 35.1 per cent. However, in January 1998 there was a sudden decline in this percentage. In the period from then to May 1999, the mean monthly percentage of clients taken to the Shelter by Night Patrol staff declined by almost half to 18.5 per cent.

Some respondents attributed this decline to strained working relationships between the patrollers and Shelter staff and a consequent reluctance by patrollers to take clients to the Shelter. However, on five occasions an evaluation team member observed patrollers actively promoting the Sobering Up Shelter and making repeated attempts to convince clients to stay there. For example, one client was asked, 'You want to go to the Shelter? ... You should go there'. Despite such efforts, all five clients opted to be taken to their own camps. Various other allegations have been made about the reasons for the decline. However, it was not possible to substantiate any of these.

As indicated previously, alcohol-related violence was a major concern for a large section of the population and respondents from 31 groups reported instances of intoxicated people becoming violent and/or of drunken elders being assaulted by juveniles. However, many of them were of the opinion that the number of such incidents had declined since the establishment of the Patrol. Although it was not possible to determine the degree to which the Patrol contributed to a reduction in alcohol-related violence, it is obvious that the Patrol went to considerable lengths to prevent such incidents. As well as its general transfer of clients, between May 1997 and May 1999, the Patrol attended 13 community and domestic disturbances, transported 29 clients to the Women's Safe House, and transferred 10 aggressive clients to police custody.

Observations by the evaluators suggest that the patrollers have the skills to resolve drunken disputes in an effective and appropriate manner. For example, in an incident witnessed by two of the evaluators, a woman flagged down the Patrol and asked for assistance in removing an intoxicated man from her camp. After picking the woman up, the Patrol team went to the police station to ask for backup, and then took the

woman to her camp. While waiting for the police to arrive, the patrollers managed to calm the man down and he eventually left without incident. He was later picked up by the Patrol and taken to his own home.

It is evident from the available data that the Patrol has achieved its objective of identifying people in need of immediate assistance and in responding to those needs. In addition, the Patrol appears to have made some contribution to reducing domestic disturbances and violent offences against persons. Furthermore, Patrol staff have achieved these outcomes in an effective and professional manner.

3.3.2 Perceptions of the operation of the Patrol

As part of the needs assessment, respondents were asked what they saw as the strengths and weaknesses of the Patrol, and were asked for suggestions as to how the operation of the Patrol could be improved.

Patrol strengths

Representatives from 25 of the 48 interview groups specifically stated that the Patrol was 'doing a good job' and this appeared to reflect the views of the vast majority of respondents in these groups. Furthermore, at least one respondent from each of the 48 interview groups identified one or more strengths of the Patrol. In order of frequency, these were that it:

- had a good working relationship with the police;
- reduced violence and harm caused to and by intoxicated people;
- was managed well;
- was attempting to address the problems associated with young people roaming the streets; and,
- offered its pick-up service fairly.

As indicated above, the majority of respondents was particularly impressed by the working relationship between the Patrol and the Police, and the impact this collaboration was perceived to have had on reducing the number of intoxicated people taken into police custody. This perception was reflected among the patrollers and the Police; although representatives of both suggested that their working relationship could be further improved. For example, a police representative suggested implementation of an exchange system in which—four or five times a year—a police officer was attached to the Patrol. Such an arrangement, he said, would allow both parties to develop a better understanding of each other's roles and aid in the development of better ways of working together. The evaluators concur with this suggestion.

Weaknesses

Despite the overwhelming support for the Patrol, a small number of respondents expressed some concern about the Patrol—concerns that were sometimes at odds with the views expressed by the majority of respondents. Respondents from only two groups believed that the Patrol did not do a good job. However, people from one explained that the main reason for this was the limited funds available for its operation. In fact, limited resources and under-staffing were the most frequently reported problems associated with the Night Patrol. Most respondents suggested that the Patrol needed more funds to extend its hours of operation and to employ more staff to work those hours.

Respondents from four community groups were concerned that the Patrol was inadvertently 'rewarding drunks' and encouraging them to come to town to drink by providing them with 'free transport' home or to the Shelter. These respondents were also frustrated because the Patrol provided no 'real' long-term solutions for the problems associated with alcohol and other drugs. However—as most of these respondents themselves acknowledge—the Night Patrol is an acute intervention, the purpose of which is to prevent immediate harm caused by or to intoxicated people. The Patrol is just one part of a larger alcohol intervention strategy, designed to address both immediate and long-term problems associated with excessive use of alcohol and other drugs.

Respondents from three of the community groups thought that the Patrol could do more to address the problem of young children and teenagers roaming the streets at night. However, these views were contrary to those expressed by most respondents, and previously cited project records indicate that Patrol members have made considerable efforts in this regard. It is difficult for the Patrol team to do much more because, legally, they are unable to pick up underage people against their will.

Respondents from two groups claimed that the Patrol members discriminated against clients who were confined to wheelchairs or who had tendencies to violence. However, the patrollers have actually removed the back seat so that people who were either in wheelchairs or who were unconscious could be lifted into the back of the Patrol bus. This suggests that rather than discriminating against such clients extra effort has been made to accommodate them. At the time observations were made of Patrol activities, no evidence was found to suggest violent or abusive clients were being avoided; and, again, such allegations were contrary to the views expressed by a majority of respondents.

In general the majority of respondents in all groups were pleased with the service delivery and outcomes of the Night Patrol. Nevertheless, a number of

recommendations were made as to how these services could be improved. These are listed below.

- Increase the Patrol's hours of operation.
- Increase funding and resources available to the Patrol.
- The Patrol's contact details should be advertised.
- The Patrol should coordinate with the organisers of local events to assist in removing intoxicated people from the events.
- More effort should be made to pick up old people and kids, and not to pick up those that come to town to gamble.
- A penalty system should be introduced that forces regular clients to attend treatment.
- Employ staff from different family groups.
- The Patrol should carry out foot patrols and patrollers should patrol inside the hotel.

Most recommendations were put forward by a small group of respondents and action on some is not warranted for the following reasons.

- The implementation of a penalty system is not feasible because people cannot be forced into treatment (unless by court order).
- The available evidence suggests that the Patrol is doing all it can to pick up children and there is no evidence that it picks up gamblers if they are not intoxicated.
- Based on observations of the effectiveness of the Patrol's current practices, and given that the Hotel employs security personnel to monitor its patrons, there does not appear to be a need for either foot patrols or for patrollers to enter licensed premises.

However, the evaluation team believes that the suggestions discussed below are worth considering.

Respondents from 18 groups recommended that the Night Patrol's hours and or days of operation should be increased. One person stated that, 'Most start drinking after the bottle shop opens at twelve (pm). By the afternoon a lot of them are choked down'. Another respondent explained that if these drinkers were not taken home before they started sobering up, they would start a second drinking binge in the late afternoon/early evening. Given the Night Patrol's current level of funding, it is not possible to increase the days on which it operates nor to significantly increase its hours of operation. Nevertheless, it would appear feasible to extend its hours of operation by two and a half hours on Fridays—which along with Thursday pension days is one of the two days of the week on which most alcohol consumption takes place—so that it commences operation at 3:00, rather than 5:30 pm. (There is no need to do this on Thursdays because, under the 'accord' hours of trading of licensed

premises are restricted on that day.) It is likely that this would have some impact on both the amount of alcohol consumed and related harm.

Extension of the Patrol's hours of operation will require additional funds to employ the Patrol Coordinator and the four patrollers for an extra two-and-a-half hour per week, and to cover operational costs for this period. It may also be necessary to employ additional patrol staff and, if so, allowance should be made for the purchase of more uniforms, and insurance costs. These funds should be sought from both the Western Australian Aboriginal Affairs Department, which currently funds the Patrol, and from the Halls Creek Shire Council and local businesses which benefit from the service.

Both community and business representatives recommended, that the Patrol's contact details and hours of operation be more widely advertised or distributed to community groups, service providers and businesses. Four respondents explained that if they need the assistance of the Patrol, they telephone the on-duty police officer who then passes the message onto the Patrol Coordinator. These respondents considered this process to be inefficient, and believed it would be more useful if they were able to talk directly to the Patrol Coordinator. The evaluation team members agree that there are advantages to people contacting the Patrol directly and support the recommendation to advertise the Patrol's contact details.

Respondents from four groups believed that much of the trouble and disturbance reported to be associated with 'band nights' and other social events could be better managed with the assistance of the Patrol. They suggested that, the Patrol should coordinate with the organisers of such events, to assist in providing a transport service to patrons. The evaluation team agrees that the Patrol's involvement in social events has the potential to minimise alcohol-related violence and other inappropriate behaviour, and supports this suggestion. However, the organisers of these events themselves have a 'duty of care' to patrons and are, to some degree, responsible for their safety. Involvement of the Patrol in such events should not detract from that responsibility and the evaluators believe that, if it is involved, some form of payment or acknowledgment for its services should be negotiated between the coordinators of the event and the Patrol.

3.4 Alcohol Centre evaluation

3.4.1 Alcohol Centre activities

As indicated previously, the Alcohol Centre has six objectives. Three of these:

- Reduce the harm in Aboriginal communities caused by alcohol and substance misuse;
- Address the many issues that are evident in Halls Creek and surrounding communities as a result of alcohol and substance abuse; and,

- Provide for our community a healthy and safe place where the young are able to thrive;

are broad and holistic in nature and the extent to which they have been achieved is reflected in the achievement of specific objectives related to the provision of treatment and prevention services, which are addressed below.

- ***Maintain a counselling centre for client treatment and support***

The major thrust of the Alcohol Centre's activities is the provision of treatment and support for alcohol dependent people. The treatment program involves separate male and female 'Aboriginal 12 steps' treatment sessions, which are offered twice a week on an on-going basis. The program includes education of clients about the health and social effects of alcohol misuse, with particular emphasis on the impact this misuse has on family members.

To determine whether the treatment program had produced any positive outcomes, a review was carried out of the records of all 49 clients who participated in the treatment program between June 1998 and June 1999 (the only period for which data were available). It was found that, over that period, there was an average of 148 client contacts per month, and that the majority of clients attended treatment and/or individual counselling sessions on a regular basis. Of the 49 clients, 27 (55 per cent) had reduced the risk of harm to themselves or others by making the following positive changes to their drinking behaviour:

- twelve had remained sober for six months or more;
- ten maintained long periods of sobriety and only drank on rare occasions—usually as part of 'sorry business' or other important events; and,
- five continued to drink heavily, however, the frequency with which they did so had considerably reduced (this meant, for example, that they had reduced the number of days per week on which they drank and/or the amount of time spent drinking on any particular occasion).

These treatment outcomes did not only benefit individual clients and their families. Jungarni-Jutiya staff and community members also reported that at least five of these clients had also become valuable members of their communities. For example, one has become an active leader in an outstation community and another has become a health worker at the Alcohol Centre.

It is important to acknowledge the contribution made by outlying 'dry' communities in the rehabilitation of at least some clients. As well as participating in the Centre's treatment program, three of those who maintained sobriety had moved to 'out-of-town' communities to get away from the pressures to drink. This arrangement not only offered them a break—or 'time out'—from the 'grog', but also gave them the opportunity to learn how to function and cope within the community without the use of alcohol.

The outcomes of the Alcohol Centre's treatment program are equal to those reported for various residential treatment programs.[16] However, what is particularly impressive about them is that—unlike many residential programs, which have high rates of relapse when clients return to their communities—these outcomes have been achieved and maintained within a community setting.

Strengths

Given its successes, it is not surprising, that most groups of respondents were pleased with the delivery of services and the outcomes achieved by the Alcohol Centre. Fourteen interview groups identified the education provided to clients as a particular strength of the Centre's treatment program. Respondents from 13 groups also believed that one of the greatest strengths of the Centre's program was its apparent impact on the reduction of alcohol problems in Halls Creek. In particular, they believed it was contributing to positive changes in clients' drinking behaviour. Respondents from eight interview groups also believed the Centre provided a positive environment in which people felt comfortable and that this had led to an increase in client numbers. Among the comments made about the Centre were the following.

- 'I see many drinkers go there, some of them have changed, ... some clients break out again, but they *are* making a difference' (Aboriginal respondent).
- 'Seems to be more people going to the Alcohol Centre. It's seen as a friendly place for people to meet' (Non-Aboriginal respondent).
- 'I've been in Halls Creek for five years and since then I've seen improvement in the service. Only need to look at how many people go there' (Aboriginal respondent).

Weaknesses

A small number of respondents expressed concern over each of a number of aspects of the treatment program. The most important of these related to the need for a grief counselling program, a perception that behavioural change resulting from the program was only short term (4 groups) and to the underlying philosophy of the program (4 groups).

Respondents from 10 groups identified a need for interventions that help drinkers cope with grief and personal problems. Members of four of these community and service provider groups recommended that a professional grief counselling service be based in Halls Creek. The role of grief in precipitating alcohol misuse has been recognised by other Aboriginal organisations such as Tangentyere Council in Alice Springs, and it is recommended that the Alcohol Centre expand its program to include a grief counselling component, and that this be offered widely in the community as both a treatment and preventive measure.

While a number of respondents believed that the Alcohol Centre had led to positive changes to clients' drinking behaviour, some believed that these changes were often

short lived. As one respondent explained 'The Alcohol Centre … got them for a while, but then they're back on the street and starting (drinking) again'. It is important to note, however, that short term change and relapse is common to most drug and alcohol treatment services; and, as mentioned earlier, the longer term outcomes achieved by the Alcohol Centre are equal to those of many residential treatment programs.

The other concern respondents had was with the approach to treatment and rehabilitation. Although modified and adapted for Aboriginal people, these respondents considered the Aboriginal '12 steps treatment' philosophies to be unsuitable for some clients and sometimes to be in conflict with the beliefs of more traditional people. For example, although one client—to whom two of the evaluators spoke at considerable length—believed the '12 steps' helped him to stop drinking, it was clear that he had some difficulty in interpreting the role of God in this process. In addition, one Aboriginal service provider was of the view that the approach disempowered Aboriginal people. Most importantly, the approach does not address the need identified by several groups for people to learn to drink safely.

While, at the local level, the number of respondents expressing these concerns is small, studies elsewhere have identified the limited range of options as a serious impediment to the effectiveness of treatments programs.[19, 20] Accordingly, the evaluators recommend that attempts should be made to make the Aboriginal '12 steps' approach more appropriate for the Halls Creek setting. It is also recommended that in addition to the '12 steps' approach, alternative treatment approaches be trialed, including harm minimisation, controlled drinking and other abstinence-based approaches.

Although not identified by respondents as a weakness of the Alcohol Centre, the evaluators were concerned that the members of nine of the 48 interview groups stated that they did not know anything about the Alcohol Centre, and that another group '… didn't even know there was one'. While this lack of awareness is not of great concern where it involves those who are unlikely to need the service, three of these groups were made up of representatives from agencies whose clients might benefit from the services the Centre provides.

- ***Have in place preventative and educational programs that will benefit the community***

The preventative and educational programs offered by the Alcohol Centre include a radio program and a limited range of alternative activities. In the past, the Centre also conducted a school-based alcohol and drug education program. However, this was not operating at the time of the review. The local Alcohol Radio Program is aired once a week and hosted by the Alcohol Centre Coordinator. The aims of the program are to

raise awareness of the harms associated with alcohol misuse and to encourage people with alcohol problems to seek treatment. Alternative activities are offered in an attempt to prevent alcohol misuse by alleviating boredom and promoting local Aboriginal culture; although—except for some activities provided for children—at present these activities are limited to clients undergoing treatment. The activities for children consist of after-school art classes and video sessions on Friday afternoons. For clients, fortnightly trips to favourite hunting and fishing spots are provided as a reward to those who regularly attend treatment sessions. Unfortunately no data has been kept on the functioning and outcomes of these services and, therefore, it was difficult to measure the extent to which they have benefited the community.

Strengths

Among clients, the most popular service provided by the Alcohol Centre is the bush outings. The popularity of these outings highlights both the need for more alternative activities—identified by community groups—and their important role as incentive to attend treatment sessions. A small group of clients acknowledged that attempts were being made to address the needs of children and that these efforts were, in their own way, contributing to positive outcomes. For example one respondent stated, '(The Alcohol Centre) … is doing a good job; even with the kids who go there.'

Weaknesses

Based on the observations of the limited range of services provided in this area and the small number of positive comments about them, there is clearly a need for expansion and improvement in this program area. Members of 10 community and service provider groups identified lack of knowledge of safe drinking and harm minimisation practices as one of the reasons that people misuse alcohol. As one Aboriginal respondent said, 'Need to teach them how to be social drinkers and mainly focus on kids'. However, at present, very little is being done by the Alcohol Centre to educate people in this regard. Accordingly, the evaluation team recommends that education on safe drinking practices be incorporated into both the Centre's treatment program and education programs. Given sensitivities in this area, however, it is important that parents have input into the development of such a program for young people.

Ten groups of respondents also expressed concerns regarding the use of other substances—in particular cannabis, petrol and tobacco—and the apparent increase in such use. Of particular concern to these groups was the effects these substances had on the physical and mental wellbeing of the users. Respondents from six groups reported incidents in which individuals had experienced what were apparently psychotic episodes as a result of multi-drug use—especially the combined use of alcohol and cannabis. Respondents from all ten groups identified a need to contain and reduce the use of these substances. At the time of the review, little was being

done by Jungarni-Jutiya in this area and the evaluators recommend that the Centre—in conjunction with agencies such as the Kimberley Community Drug Service Team—develop a range of health promotion strategies to address the use of cannabis, tobacco, and petrol sniffing.

Given the emphasis placed by community members on boredom and lack of things to do and the popularity of bush outings for clients, it is clear that there is widespread support for the more broadly based alternative activities. Importantly, expansion of such activities could provide an environment in which social pressures to drink are reduced. Community members and clients suggested a range of activities including family events such as alcohol free music nights, and camps for young people in which alcohol and drug education is a component. Such an expansion of alternative activities has the potential to lead to a reduction both in the number of people who excessively use alcohol and an increase in the number of clients who seek additional treatment. Accordingly, the evaluation team recommends that the Alcohol Centre take an active role in working with other agencies and groups to provide alternative activities to the wider community and that the outcomes of these efforts be monitored for future evaluation.

- **Continue to look for improvements in methods of dealing with alcohol and substance misuse**

This evaluation and needs assessment project is, itself, an excellent example of the extent to which Jungarni-Jutiya has sought to improve its methods of dealing with alcohol and substance misuse. Prior to undertaking this project, Jungarni-Jutiya also prepared a written proposal for the establishment of a residential treatment centre at 'Old Town', which outlined the facilities needed and the cost involved in purchasing and refurbishing them.

As indicated above, in the past, Alcohol Centre staff conducted an education program at the Halls Creek District High School (a combined primary and high school). Unfortunately, this program ceased due to difficulties experienced by the school in allocating set times for the health workers to visit. A school representative explained that it is difficult to plan these types of programs because of high staff turn-over, curriculum-based learning, and the fact that there are already a number of extra-curricula activities being offered by other outside groups. Despite these obstacles representatives from both the High School and the Alcohol Centre were interested in having the alcohol health workers meet with students on a regular basis. One suggestion put forward by a school representative was that the alcohol health workers' role in the school should be more flexible. This person believed that involving the health workers in sports, library classes, and other school-based activities could help them establish a rapport with the students, and enable them to offer impromptu alcohol and drug education and counselling. Based on the fact that both parties are

interested in some form of school-based alcohol and drug program, the evaluation team recommends that the health workers meet with teachers to plan strategies for inclusion of a drug and alcohol component in class room activities. However, the coordinator of the Halls Creek Youth Service indicated that—if it was not possible to conduct such education programs within the school—he was interested in incorporating them into the youth program.

At the time of the evaluation, plans were being made for a health worker to conduct an on-going alcohol and drug program at Red Hill Catholic School. The objectives of the planned program are to educate children about the harms associated with alcohol and other drug use, and to provide a support service for those who may be experiencing problems as a result of their parents' drinking.

3.4.2 Future directions of the Alcohol Centre

An objective of the study was to make recommendations on the future direction of Jungarni-Jutiya, with particular reference to live-in rehabilitation provision and the extent to which it can address the treatment needs of the people living in Halls Creek and surrounding desert communities. To address this objective, and to place treatment needs in the context of the other objectives of the project, respondents were asked to recommend strategies to address the broad range of problems that they had identified. A total of twenty-seven different intervention strategies were identified. In Table 5, these strategies are grouped according to the categories used by the National Drug Research Institute to classify interventions by, or for, Aboriginal people, [21, 22] and the number of respondent groups that recommended each strategy is indicated.

The largest category of intervention strategies recommended by respondents was prevention strategies. In all, one or more of these were mentioned 104 times by the 48 groups of respondents. The most commonly recommended of these strategies were the provision of alternative social and recreational activities, and the provision of work opportunities—either in general or through community-based business enterprises such as a tourism venture. The frequency of these responses reflect the emphasis that the groups of respondents placed on 'boredom and nothing-to-do' as reasons why people misuse alcohol. The category of preventive strategies also included health promotion activities and the maintenance of existing liquor licensing restrictions.

The second largest category of interventions recommended by groups of respondents were treatment strategies—which were suggested 66 times. This category also included the most commonly cited individual strategy—the establishment of a 'drying-out' or treatment centre. With regard to this, however, it is important to note that of the 39 groups who favoured this strategy, only 26 did so spontaneously. Given the importance placed on this option in the objectives of the review that were developed by Jungarni-Jutiya, the 22 groups who did not initially recommend it, were asked

whether or not they thought that this would be of benefit to the community. Of these 22 groups,13 supported the strategy when prompted, and nine did not. Other treatment options raised included the provision of counselling. and skills and training that boosted self-esteem and independence.

Table 5. Alcohol and other drug intervention strategies recommended by respondents

Recommended intervention strategies	No. of groups of respondents	Totals
Acute intervention		
Detoxification service	8	8
Treatment		
Dry-out/ treatment centre	39	
Address underlying problem and offer counselling	10	
Activities & services that boost self esteem & independence	9	
Life-skills training	8	66
Support services		
Promote families and establish family support networks	19	
After care Services	8	
Food Vouchers	3	
Soup Kitchen	2	
Hostel for men	1	33
Prevention		
Supply reduction		
Liquor restrictions	11	
Health promotion		
Health education campaigns	6	
Education on how to drink safely	5	
Cannabis interventions	4	
Alternatives to use		
Offer more recreational and social activities	22	
Services and activities specifically for young people	22	
Cultural initiatives		
Cultural focus/education/awareness	6	
Broad-based socio-economic initiatives		
Promote work opportunities	11	
Business Venture	10	
Work with, and promote community participation	6	
Change lifestyle social structure	1	104
Improved service delivery and coordination		
More active networks between services	14	
Aboriginal service provider meetings	2	16
Other		
Establish drinking area	5	
Youth detention Centre	1	
Gambling interventions	1	
Lobbying	1	8

The provision of support services for alcohol dependent people and their families was the third most common category of intervention strategy suggested. Such proposed services included the promotion of family support networks, and after-care services. The other strategies raised included, improved service delivery and coordination, the provision of a detoxification service, and various miscellaneous options including the establishment of a 'drinking area'.

The strategies recommended reflect the concern in the broader Halls Creek community with the prevention of alcohol and, to a lesser extent, other drug misuse. While there is certainly a concern about the provision of treatment, the concern of the broader community is not simply confined to the care of chronic drinkers. Given the priorities expressed by the community, the evaluators recommend that, in the medium term, Jungarni-Jutiya—in conjunction with other agencies—focus its activities on extending its range of preventive strategies. As well as the views of the broader community, there are other good reasons for such a focus.

Zinberg has shown that, in order to understand and successfully deal with alcohol and other drug use, it is necessary to consider:

- the drug (and its effects);
- the set (the user and his/her mental and emotional state); and,
- the setting (or the environment in which the drug is used).[23]

In a review of drug use and interventions among Aboriginal people Brady observed that, '... of the three, the setting has been most neglected'.[24] This observation holds true for Halls Creek. Jungarni-Jutiya's own objectives themselves reflect the broad, holistic approach to the reduction of alcohol misuse and its consequences advocated by Zinberg. In Halls Creek, issues surrounding 'the drug' and, importantly, its availability are being addressed through liquor licensing restrictions and the informal accord. 'The set'—at least in the case of chronic drinkers—is being addressed by the Alcohol Centre's current treatment program. However, as shown in this review—and from the perspective of many people in the community—'the setting' has been largely neglected.

As a consequence of this neglect, the evaluators recommend that in the future, the Jungarni-Jutiya Alcohol Centre gives greater emphasis to its own objectives of:

- (reducing) the harm in Aboriginal communities caused by alcohol and substance misuse;
- (having) in place preventative and educational programs that will benefit the community;
- (and providing) a healthy and safe place where the young are able to thrive.[12]

As Atkinson and his colleagues have shown, in the Kimberley as a whole funding for alcohol misuse programs is not commensurate with the magnitude of the problem, and that in Halls Creek virtually all of the funding for such programs is committed to the provision of acute intervention and treatment services.[3] It is neither feasible, nor desirable, that funds currently going into these services simply be diverted to the provision of a wider range of preventative and community development services.

Accordingly, it is recommended that OATSIH consider favourably the allocation of additional funds to Jungarni-Jutiya for this purpose. These funds should include allocations for at least one additional staff member—and appropriate training for such a person and existing staff members—to undertake the provision of these services. Clearly, however, provision of the full range of such services is beyond the mandate of OATSIH. It is also recommended, therefore, that Jungarni-Jutiya enter into negotiation with the Aboriginal and Torres Strait Islander Commission and other appropriate State government agencies to plan ways in which services can be better provided.

In recommending that, in the future, Jungarni-Jutiya place greater emphasis on preventative interventions the evaluators are not suggesting that further development of the treatment program not be undertaken. Most of the specific recommendations relating to the enhancement of counselling and training made by the community can be implemented within the framework of the present treatment program; and these can be further enhanced by the development of additional support services for clients and their families.

However—despite the widespread community support for a residential treatment facility that has been documented—the evaluators do not recommend the establishment of such a facility in the near future for two reasons. First, a residential facility—focusing on the needs of a relatively small number of chronic drinkers and their families—would do little to address the broad range of factors underlying alcohol misuse and the problems arising from that misuse that were identified by the community and the important concern that something be done to prevent children from misusing alcohol and other drugs.

Second, the Halls Creek community as a whole is likely to get more benefit from investing available resources in a range of preventive and community development projects than it will from a residential treatment centre. Residential treatment is expensive, and research suggests that the outcomes of residential programs are not significantly greater than those of non-residential programs.[16] Thus, if funds are limited, the priority should be to invest them in the expansion of preventive programs.

It is important to note that the evaluators are not against the provision of residential treatment *per se*. The recommendations made in this report are based on assessments of the best means of addressing the needs identified by the broader Halls Creek community, and the likely level of funding that government agencies are able or willing to commit to alcohol intervention projects. Such assessments lead, *independently*, to the same conclusion reached by Atkinson, Bridge and Gray in the development of an Aboriginal health plan for the Kimberley. That is, '… *until there is a significantly large*

commitment of new funds (emphasis added)' a residential treatment centre in Halls Creek should not be funded.[3]

It is also important to note that there is an important element of disagreement on this point between the evaluators and some of the Jungarni-Jutiya committee members and Coordinator. While *all* agree that there is a need for a significant injection of funds to address alcohol problems in Halls Creek, the Jungarni-Jutiya committee members and Coordinator believe that persons with alcohol problems and their families should be removed from the 'setting' to a proposed residential treatment centre, and given respite care and the skills to deal with alcohol on their eventual return to the community. The evaluators, on the other hand, are of the view—expressed above—that greater benefit will be achieved by investing in programs that change those factors in the 'setting' that lead to the misuse of alcohol and related harm.

3.5 Jungarni-Jutiya management and finances

Jungarni-Jutiya is a well managed organisation. Special effort has been made the Alcohol Centre Coordinator to empower the Aboriginal committee members and provide them with appropriate training in the proper protocols for the management of a non-profit organisation. Each committee member has a personal file that contains documentation of meeting minutes and policies regarding the management of the organisation. A review of the meeting minutes found that proper procedures have been followed and that important decisions have been made democratically and effectively. Although one committee member recommended that other members become more involved in discussions and share their ideas, most were happy with the manner in which the services of Jungarni-Jutiya were managed, and two groups of respondents stated that they had observed marked improvements in the committee's management skills.

The only real gap in that was observed in the management of Jungarni-Jutiya's services related to the keeping of client records at the Alcohol Centre. As indicated in the Methodology section of this report, client records contained insufficient data to enable assessment of client outcomes, and these had to be determined by interview with the health workers. It is recommended, therefore, that an improved system of client record keeping be introduced and the health workers receive instruction in its use.

Table 6: Alcohol Centre Profit & Loss Statement 7/1/98 – 6/30/99

INCOME		
Income Staff Training		4 723.00
Income JJ Recurrent		264 489.00
Open Account		50.00
Other Income		17 231.24
TOTAL INCOME		286 493.24
EXPENDITURE		
Administrative Assistant		6 135.60
Annual Leave Loading		320.00
Bank Charges		780.12
Building Maintenance		6 935.65
Cleaning		403.55
Coordinator		8 999.15
Direct Debit		68 343.75
Education		7 782.28
Electricity and Water		4 786.90
Equipment R&M		339.00
FH Worker		6 972.65
Freight		103.88
Fuel Oil		3570.04
Insurance		3 936.85
Leave Fares		1 350.00
Male Health Worker		1975.75
Motor		
Reg & Ins	443.55	
Service	1121.08	1 564.63
Office Equipment		1 121.15
Other Allowances		1 816.49
P.A.Y.E Tax		24 269.61
Payment		0.00
Printing Stationary		4 192.84
Rates		3 423.60
Receptionist		1 400.00
Review		13 953.00
Staff Training		3 725.70
Superannuation		6 981.00
Telephone		2 772.40
Training		3 725.70
Travel		5 467.61
Vehicle registration		1 332.00
Uncategorised Expenses		8 109.60
TOTAL EXPENSES		203 343.80
TOTAL INCOME OVER EXPENDITURE		$83 149.44

No respondents expressed any concerns over the financial management of Jungarni-Jutiya. Records of meetings show that the Alcohol Coordinator has regularly presented financial reports to the committee. There was some minor variation in the financial reports submitted to OATSIH and those prepared by Jungarni-Jutiya's auditor for the 1998–99 financial year. However, this appears to be related to the availability of records of transactions at the time which they were prepared and to minor changes in the categorisation of items. The profit and loss statements, prepared by the auditor,

for both the Night Patrol and the Alcohol Centre are re-produced in Tables 6 and 7. In the 1998–99 financial year, both programs actually came under budget without any negative consequences for service delivery. The evaluators strongly recommended that these surplus funds remain in the possession of Jungarni-Jutiya and that they be used to assist in the expansion of its range of services.

Table 7: Night Patrol Profit & Loss Statement 7/1/98 – 6/30/99

INCOME	
A.A.D Income	30 000.00
Other Income	9 628.10
TOTAL INCOME	39 628.10
EXPENDITURE	
Administration Support	714.84
Bank Charges	193.20
Cheque Cancelled	0.00
Fuel & Maintenance of Vehicle	424.00
Repairs and Maintenance	2 857.4o
Wages & Top Up	27 343.05
Uncategorised Expenses	0.00
TOTAL EXPENSES	31 532.65
TOTAL INCOME OVER EXPENDITURE	$8 095.45

As well as strategies to improve specific aspects of Jungarni-Jutiya's programs, the evaluation also identified some issues in the areas of inter-agency relationships and staffing in which improvements could be made. A small number of groups of respondents believed that the working relationship between the Alcohol Centre and Sobering Up Shelter should be strengthened in an attempt to increase the number of clients who are referred to and attend treatment. Staff from the Alcohol Centre and the Sobering Up Shelter both explained that, previously, a referral system had been in place. However, over time, this had gradually broken down. Some staff and community members suggested that, in recent years, the relationships between some members of the Alcohol Centre and Sobering Up Shelter had been strained and that this may have led to a break down in the working relationship between the two services. Despite this, a majority of representatives from the both the Shelter and the Alcohol Centre agreed that re-establishing the referral service would benefit clients, and they expressed a willingness to reinstitute the previous arrangement. Accordingly, the evaluators recommend that formal meetings between the Alcohol Centre Coordinator, the Night Patrol Manager and Sobering Up Shelter Manager should be held four times a year. The purpose of these meetings would be to identify and

implement strategies to better coordinate their services, and to monitor the effect of such coordination on their overall service outcomes.

During discussions, both Jungarni-Jutiya staff and community representatives suggested that more could be done to improve the referral and liaison systems between the Alcohol Centre and out-of-town residential treatment centres. One staff member explained that, once a client is referred to a residential treatment program, the Alcohol Centre is rarely informed of the clients progress, or notified of when the client leaves the program. This makes it difficult to provide after-care and relapse prevention services. In order to address these difficulties, the evaluators recommend that the Alcohol Centre Coordinator should meet with the managers of out-of-town residential treatment centres to develop suitable referral and liaison procedures to ensure that clients continue to receive on-going support when they have left such centres.

Both observation and discussion revealed that the two Jungarni-Jutiya health workers have a considerable amount of free time, which could be used to plan and implement other alcohol intervention programs. It was observed that other than preparing for and conducting treatment meetings twice a week, much of the health workers' remaining time was spent waiting for clients seeking drop-in counselling. However, on the rare occasion that this occurred, the clients usually requested that they be counselled by the Alcohol Coordinator. Therefore, the evaluation team recommends that the health workers be assisted to play a more active role in expanding the services of the Alcohol Centre in accordance with the priorities identified in this review.

The Jungarni-Jutiya health workers receive informal on-the-job training and support from the Alcohol Coordinator, and on occasion, from the Women's Worker. They have been taught, and assisted, to use computers, plan and present treatment and education sessions, and to keep client participation records. The staff believe this has helped them considerably and has led to improvements in their ability to carry out their duties. However, they believe that additional course-based training would be of benefit to them, particularly in developing and implementing future alcohol intervention services. Furthermore, they felt that such training should be provided locally, because—as one respondent explained—some staff members have family commitments which make it difficult for them to travel. Staff also suggested that visits to other Aboriginal prevention and treatment projects would be useful in expanding their awareness and knowledge of appropriate and suitable alcohol intervention strategies. The evaluation team members are in support of both recommendations and recommend that OATSIH (the main funding agency) should favourably consider providing resources so that additional training can be provided to all Jungarni-Jutiya staff members who request it and that the cost of visits to other intervention projects or programs can be met. It is likely that the implementation of these strategies will

lead to improvements in the methods used by Jungarni-Jutiya to deal with alcohol and substance misuse.

4.0 SUMMARY AND RECOMMENDATIONS

The staff and committee of Jungarni-Jutiya are to be commended for their efforts to combat the misuse of alcohol and its consequences. The incorporation of Jungarni-Jutiya in 1997 marked a significant turning point in attempts to address problems of alcohol misuse among Aboriginal people in the Halls Creek area. The establishment of Jungarni-Jutiya signalled increased Aboriginal participation in the management and delivery of services, and promoted a sense of ownership efforts to address alcohol misuse among members of the Aboriginal community. The new organisation, grew out of, and has built upon work by, the Halls Creek Alcohol Action Advisory Council. Jungarni-Jutiya took over management of Halls Creek Night Patrol and Alcohol Centre and has implemented various improvements in management and service delivery.

Below, the main findings of the review are summarised and in the following sections specific recommendations are made in regard to Jungarni-Jutiya's services. The Jungarni-Jutiya Alcohol Action Council Aboriginal Corporation appears to be well managed. The management committee has been ably supported by the Alcohol Centre Coordinator. The records of committee meetings indicate that correct procedures have been followed, and decisions made democratically and effectively. The finances of Jungarni-Jutiya have also been well managed and in the 1998–99 financial year both the Night Patrol and Alcohol Centre came in under budget. There is room for improved coordination between Jungarni-Jutiya and the Salem Sobering Up Shelter and other treatment agencies. There is also so scope for more effectively using the time of the health workers employed at the Alcohol Centre.

Statistical data collected by the Halls Creek Night Patrol show that it is clearly meeting its objectives and observation by the evaluators suggests that it is doing so in effective and professional manner. Community groups generally reported that the Patrol was 'doing a good job' and there was a perception that it had a good working relationship with the local police. The Patrol's own statistical data suggests that there is room for improved coordination between it and the Salem Sobering Up Shelter and a significant proportion of community groups were of the view that the Patrol's hours of operations could be usefully extended.

Review of the activities of the Alcohol Centre show that it is conducting an effective community-based treatment service and that its achievements are comparable with those of residential treatment programs elsewhere in Western Australia and the Northern Territory. Within the Halls Creek community there was considerable satisfaction with the treatment program, although some suggested that the range of treatment options could be expanded. However, the range of preventative services

provided by the Centre is limited and in this area the Centre is not meeting its stated objectives.

In the case of both the Night Patrol and the Centre a number of factors impeding or facilitating their objectives were identified and various recommendations made to improve their delivery of services. These are contained in the sections of the report relating specifically to them and, as they are too detailed to summarise here, readers are referred to those sections.

Clearly, within the terms of its objectives, the Night Patrol is meeting the needs of the Halls Creek Community. With regard to the provision of treatment services, the Alcohol Centre is doing so as well—although, a significant proportion of the community expressed a need for the provision of a residential treatment centre. However, the survey conducted among members of the community identified needs for a broad range of prevention and community development strategies that—although among its objectives—are not presently being met by the Alcohol Centre.

As indicated above, specific recommendations that will assist Jungarni-Jutiya to meet its objectives are listed in the following sections of the report. With regard to the future directions of Jungarni-Jutiya, the evaluation team recommends that, in order to meet community needs, the Alcohol Centre direct its attention to the provision of a greater range of preventative and community development services—and that it should be resourced to do so. Despite the support among a significant proportion of the community for a residential treatment centre, the evaluation team recommends that this not be resourced at this time. There are two reasons for this recommendation. First, such a centre will not meet the greater demand within the community for preventative services. Second, the existing community based treatment program is relatively effective, and investing additional resources in a residential facility is unlikely to achieve returns commensurate with the investment or equal to those achievable through the implementation of additional preventative strategies.

4.1 Future Directions

- Consideration should not be given to the establishment of a residential treatment in Halls Creek until a comprehensive preventative program has been planned and implemented.

- The Alcohol Centre's existing community-based treatment and rehabilitation program should be expanded and enhanced.

- Jungarni-Jutiya, in consultation with relevant service and funding agencies, should develop a strategic plan for the expansion of the preventative component of the Alcohol Centre's program.

- The Office of Aboriginal and Torres Strait Islander Health Services and other funding agencies should give favourable consideration to adequately resourcing an expanded preventative program in Halls Creek.

4.2 Halls Creek Night Patrol

- The Patrol should extend its hours of operation on Fridays by two-and-a-half hours—commencing operation at 3:00 rather than 5:00 pm.

- Funds to finance the increase in operating hours should be sought from the Western Australian Aboriginal Affairs Department, the Halls Creek Shire Council, and local businesses.

- The Patrol's contact details and operation hours should be more widely advertised and distributed to community groups, service providers, and local businesses.

- The Patrol should coordinate with organisers of local events to assist in removing intoxicated people from those events. Given that this would assist event organisers to meet their 'duty of care' obligations, negotiations should be undertaken regarding possible payment for such the provision of such services.

- To enhance understanding of each other's roles and to facilitate cooperation, four or five times a year, a police officer should be attached to the Patrol.

4.3 Alcohol Centre

Treatment

- A review of the existing treatment philosophy should be undertaken, and if necessary, modified so that it meets the needs of a broader section of the community.

- In addition to the existing treatment approaches, alternative treatment options should be trialed, including harm minimisation, controlled drinking and abstinence-based approaches.

- Life-skills training should be offered to clients and members of their families to assist them with such matters as budgeting.

- The Alcohol Centre should expand its program to includes a grief counselling component, and that this should be offered widely in the community as both a treatment and preventive measure.

- The existing after-care program should be expanded, to include outreach and other community-based strategies. This should include the establishment of support networks for clients and members of their families. Like grief counselling, such services should also be provided widely as a preventative, as well as a treatment, measure.

Prevention

- A wider range of social and recreational activities should be developed to alleviate boredom and as an alternative to alcohol and other drug misuse.

- A more comprehensive drug and alcohol education program should be developed, which includes:
  - education on safe drinking practices; and,
  - education and media campaigns on cannabis, tobacco, petrol sniffing and multi-drug use.

  The assistance of the Kimberley Community Drug and Alcohol Team should be sought in the development of the program, and attempts should be made to re-establish an education program for young people either in the school or through Halls Creek Youth Service.

- In accordance with community wishes, staff should take a greater role in coordinating inter-agency activities that address alcohol and other drug related problems.

- Efforts should be made to work with other agencies to promote employment opportunities. This should involve further investigation of the feasibility of an Aboriginal tourism venture or other business enterprise.

Management

- Formal meetings between the Alcohol Centre Coordinator, the Night Patrol Manager and Sobering Up Shelter Manager should be held four times a year in order to identify and implement strategies to better coordinate their services, and to monitor the effect of such coordination on their overall service outcomes.

- The Alcohol Centre Coordinator should meet with the managers of out-of-town residential treatment centres to develop suitable referral and liaison procedures to ensure that clients continue to receive on-going support when they have left such centres.

- An improved system of client record keeping should be introduced and the health workers should receive instruction in its use.

- Health workers should play a more active role in enhancing and expanding the services of the Alcohol Centre.

- Staff should be offered on-site, accredited training to complement the on-job-training and support they are currently receiving. This should include training to develop the proposed expanded prevention program. OATSIH should favourably consider providing resources for this purpose.

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