Government of South Australia
Southern Adelaide Health Service

Evaluation Report of the:

Australian Alcohol Guidelines For Indigenous Communities & Don't Gamble With Your Health - health promotion playing cards

(Produced by the Aboriginal Drug & Alcohol Council SA)

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EXECUTIVE SUMMARY

In March 2003, the Aboriginal Drug & Alcohol Council SA (ADAC) received funding from the Commonwealth Government to adapt the *Australian Alcohol Guidelines*, so that they could be presented in a way that was culturally appropriate and useful for indigenous people. It was intended that the guidelines would be published on the Office for Aboriginal and Torres Strait Islander Health's (OATSIH) web site.

With additional funding from the Alcohol Education & Research Foundation (AERF) ADAC printed the guidelines in booklet form, and developed a complimentary flipchart. They also produced an alcohol screen (AUDIT), and a number of associated materials to accompany the guidelines. The concept of the 'health promotion playing cards' emerged out of ADAC's consultations around the adaptation of the guidelines. They were produced from funding provided by the Department of Health and Ageing.

Drug & Alcohol Services SA (DASSA) was contracted by ADAC in June 2005 to undertake an evaluation of the *AAG for Indigenous Communities* and *Don't Gamble With Your Health* – health promotion playing cards. It was agreed that the main focus of the evaluation would be indigenous community responses to the guidelines including; awareness, use, intention to use, and the perceived value and usefulness of the guidelines. The evaluation also sought to collate views about how these resources could be improved, if reprinted and/or available as a PDF via the Internet.

The evaluation primarily drew upon interviews with a sample of 50 Aboriginal Community Controlled Health Organisations on ADAC's mailing list. Interviews were also undertaken with organisations and individuals with a particular interest in the guidelines, expertise in the area of indigenous alcohol use, and experience in the development of health promotion materials/graphic design. Responses to the cards were also sought as part of these interviews, and gained from 70 returned feedback sheets which were distributed with the cards.

In conducting the interviewees considerable effort was made to locate staff who were either familiar with the ADAC resources, or had relevant areas of responsibility. In light of ADAC's time constraints for finishing the evaluation, it was only possible to complete interviews with 32 organisations i.e. 64% of the sample. A total of 47 staff were interviewed - 89% of whom identified themselves as being an indigenous person.

Just under half the organisations contacted (i.e. 46%) had at least one staff member who was either 'highly aware' or had 'some awareness' of the *AAG for Indigenous Communities.* Whereas, in just over half the organisations contacted (i.e. 54%) staff appeared to have 'limited awareness' or 'no awareness' of the guidelines. Among those who reported 'no awareness' about half expressed a keen interest in obtaining copies of the guidelines – which was passed on to ADAC during the course of the evaluation.

Five of the 7 staff who were 'highly aware' of the ADAC resources, were currently using the guidelines, and flipchart. Among the 8 who had 'some awareness', 3

reported some use of the flipchart, and another 3 indicated that they intended to use the guidelines and/or flipchart in the future. Three interviewees were currently using the alcohol screen (AUDIT). Interestingly, they did not report any of the limitations of this screening tool for indigenous health workers that have been described by others in the literature. There was little reported awareness and no reported use of the associated resources (i.e. handout on standard drinks, 'quick guide' and 'survey to find out if alcohol is damaging your health').

A very diverse range views were put about the perceived usefulness of printed health promotion resources in general, and the *AAG for Indigenous Communities* in particular. Some offered a critique of 'paper based' approaches to health promotion, especially in contexts where there was limited literacy, and English was not the first language. Some spoke about non-clinical approaches to health promotion, while others talked about 'getting along side people' and giving similar messages, but without using specific resources. One interviewee offered a critique of the philosophy of harm minimisation which informs the *Australian Alcohol Guidelines*, while another spoke about the potential for incorporating the guidelines and alcohol screen (AUDIT) into routine clinical practice.

In light of the Commonwealth Government's identification of the 'untapped potential' for screening and brief intervention initiatives in indigenous primary health settings ADAC's adaptation and distribution of the guidelines and alcohol screen (AUDIT) can be seen as a step toward providing indigenous health workers with the 'tools' to undertake these types of interventions. At this point in time these 'tools' have resonated with a fairly small percentage of the sample of health workers spoken with - around 20-25%, if those who intended to use the resources are also included.

Some organisations expressed a sense of being too overwhelmed by other matters to attend to the guidelines. Some indicated that they did not have relevant staff to attend to substance abuse issues and/or health promotion. Some reported that they did not undertake health promotion work, while several indicated that they 'outsourced' substance abuse and/or health promotion to specialist agencies.

Nonetheless, the overall findings about the level of awareness, and use, of the *AAG for Indigenous* Communities may speak of the limitations of producing and distributing health promotion resources in the absence of a broader promotional campaign and specific training for health workers. At the time of undertaking the evaluation ADAC were involved in a national 'train-the-trainer' program, which included the guidelines, flipchart and alcohol screen. It remains to be seen whether a broader base of indigenous health workers use these resources following this, and other forms of training.

A number of suggestions were made about how the guidelines could be improved if they were reprinted and/or available via the Internet. There was a general consensus that the text was good, notwithstanding the need for health workers to further adapt/modify it in communities where there was low literacy and English was not spoken as a first language.

Interviewees affirmed that it was important to have lots of graphics, but opinion was divided as to whether this had been done as well as it might. About half the

interviewees thought that the graphics were good, simple, clear, and got the message across. Some thought that the images should be more realistic (i.e. less cartoon like). Others raised concerns about: the association between the text and images; the suitability of the main image (as well as the fact that its difficult to discriminate when reproduced at small scale); the complexity of the table of standard drinks; and the general look of the guidelines and flipchart, which some considered to be 'too cluttered'.

A number of practical suggestions were given for improving the lay out including: giving prominence to the title *AAG for Indigenous Communities* rather than the descriptor 'alcohol & your health'; providing a contents page and layout tabs/markers for the start of each guideline; and simplifying the table of standard drinks.

Of the 11 who commented on the format of the guidelines, 6 suggested that it would be useful to have posters to 'reinforce the message'. Four talked about the possibility of the guidelines being available in PowerPoint/DVD format, which appears to be particularly applicable in school contexts. Several suggested that it would be useful to have the guidelines available individually, to hand out to clients.

Up to two thirds of organisations included in the sample, had at least one staff member who was aware of the cards. There also appeared to be a higher level of awareness of the cards within organisations, as compared with the guidelines.

Most interviewees, and respondents of the feedback sheets, spoke very highly of the concept of 'health promotion playing cards' - although, a few thought they were valued as a useful commodity, with limited potential as a health promotion resource. They also reported that they had been well received among those they had distributed them to. In addition to their general use as playing cards, a significant number of respondents and interviewees reported that they had used them in some structured way, as a 'discussion starter' in various program contexts, and/or for maths/learning games in the classroom.

Several pointed out that the distribution of the cards could shade over into issues of gambling, but this appeared to be of only minor concern in some communities. Some thought that the images and messages were too explicit, negative, or harsh, but for the most part these were deemed to be appropriate, relevant, and realistically confronting the realities of life for many young indigenous people. In some contexts, most notably prisons/detention centres, they appear to have engendered a sense of pride.

When asked about possible improvements to the cards, many thought that they were fine as they were, whereas as others raised a broad range of suggestions. The two most significant were: improving their design and layout - which was seen by some to detract from their function as playing cards; and incorporating a broader range of health messages - including more positive 'do' messages.

INTRODUCTION

Background

The Commonwealth Government approached the Aboriginal Drug & Alcohol Council SA (ADAC) in early 2003, about their interest in adapting the *Australian Alcohol Guidelines*[1], so that they could be presented in a way that was culturally appropriate and useful for indigenous people.

Then, in March 2003, ADAC received funding of $40,000 from the Department of Health and Aging, Office for Aboriginal and Torres Strait Islander Health (OATSIH), to revise and adapt the *Australian Alcohol Guidelines* for publication on the OATSIH web site.

Following the receipt of these funds, ADAC approached the Alcohol Education & Research Foundation (AERF) for adjunct funding, to print these guidelines in booklet form, and develop a complimentary flipchart.

In May 2003 ADAC employed a project officer for a period of 6 months to adapt the text of the *Australian Alcohol Guidelines* and work with a local artist, employed by ADAC as part of their Indigenous Substance Misuse Health Promotion Unit. The Indigenous Substance Misuse Health Promotion Unit then undertook the layout and design of the guidelines.

Development of the *AAG for Indigenous Communities*

Early into the project there was an opportunity to present the first three guidelines to an informal session of health workers at the Fourth National Aboriginal and Torres Strait Islander Health Workers Conference (June 2003). Feedback from this session stressed the importance of including information about the situations and places in which people drink, and incorporating more visual material, including the possibility of a poster as part of the overall package.

ADAC also sought feedback from a number of key experts in the field of indigenous alcohol use. Some expressed concern about the 'perceived alcohol industry basis of the *Australian Alcohol Guidelines*', and caution about inadvertently being seen to promote drinking or reflecting a sense that alcohol was 'good'. This led to giving the guideline about abstinence more prominence, strengthening messages about the potential harms, damage and risks of alcohol, and revising the guideline in relation to pregnancy to recommend abstinence, rather than the more discretionary tenor of the NH&MRC endorsed guidelines.

The first draft of the guidelines was then sent to members of the National Expert Advisory Committee on Alcohol, and the Project Reference Group for the Development of Resources to Enhance the Education and Training of Aboriginal and

[1] Australian Alcohol Guidelines: Health Risks and Benefits. Endorsed in 2001 by the National Health and Medical Research Council. Commonwealth of Australia.

Torres Strait Islander Workers in the Illicit Drug Field. Some members of this reference group continued to be involved in the development of the guidelines.

Throughout this time on-going feedback was sought from indigenous people in a variety of health related agencies, and ADAC staff. In particular, Makin' Trax staff were integrally involved in many consultations, and took the draft guidelines to various communities in South Australia and the Northern Territory. Young people in several TAFE colleges were also consulted about the best way to present information on standard drinks.

In response to this feedback it was recommended[2] that the guidelines:

- be designed for indigenous health workers, who were seen to be 'best placed to use and interpret information for other people'. As such, they were written in the 'first person' so that health and substance abuse workers could read the information directly to clients,

- re-order the *Australian Alcohol Guidelines* in a way that reflects their relevance and priority for indigenous communities i.e. "the most important issues for Aboriginal people are at the beginning",

- put greater emphasis on: the situations that put people at risk; mental health and social issues made worse by alcohol; and the problems associated with drinking while using medication,

- include other relevant issues such as: smoking and alcohol; breastfeeding; and drink spiking,

- expand the table of standard drinks to include more drinks and containers familiar to indigenous people eg. wine casks, cartons, mugs etc,

- include a glossary to explain key terms, and

- provide a comprehensive list of support services.

A comparison of the order and content of the NH&MRC endorsed and the ADAC guidelines is provided in the appendix 2.

In addition to the booklet form of the guidelines, ADAC produced a flipchart, alcohol screen (AUDIT), and a range of associated materials as follows:

- *Alcohol and Your Health: Australian Alcohol Guidelines for Indigenous communities* – 36 page booklet

- *Alcohol and your Health: Australian Alcohol Guidelines for Indigenous communities* – 76 page flipchart

[2] Aboriginal Drug and Alcohol Council (SA) Inc. Annual Report (2002-2003) pp.26-27

- *Alcohol and your Health: Alcohol Screen (AUDIT)* – folded A3 sheet (4 A4 pages). Adapted from the Dept. of Veterans Affairs Alcohol Screen

- *Alcohol and your Health: for Indigenous communities, Australian Alcohol Guidelines, What is a 'standard drink' – 2* A4 sheets (4 pages)

- *Alcohol and your Health:* Survey to find out if alcohol is damaging your health – A4 sheet (2 pages)

- Untitled quick A4 guide to the Australian Alcohol Guidelines – A4 sheet (2 pages)

One thousand copies the flipchart, and 5,000 copies of each of the other resources were produced.

Development of *Don't Gamble With Your Health* – health promotion playing cards

The idea for the health promotion playing cards emerged out of ADAC's consultations for the development of the guidelines. They were developed by the Indigenous Substance Misuse Health Promotion Unit, from funding provided by the Commonwealth Department of Health & Ageing. One hundred thirty thousand packs of the cards were produced, sub-packed for distribution in boxes of a dozen.

The cards were launched by South Australian MP and Parliamentary Secretary for Health, Christopher Pyne, and ADAC's Director, Scott Wilson on 23rd June 2005, as part of Drug Action Week (see appendix 3 for media coverage of this event).

They were distributed to a broad range of indigenous organisations and communities, and mainstream organisations working with Aboriginal clientele by the Commonwealth Department of Health and Aging, via National Mailing and Marketing. However, they were not sent to all remote communities and organisations in the Northern Territory, because of concerns about card games and gambling. ADAC retained 6,000 packs of cards for distribution to organisations in South Australia.

EVALUATION FRAMEWORK

Scope of the evaluation

Drug & Alcohol Services South Australia (DASSA) was approached, and then contracted by ADAC in June 2005, to undertake an evaluation of the *Australian Alcohol Guidelines for Indigenous Communities* and *Don't Gamble with Your Health* (health promotion playing cards), which they had recently published and were currently distributing (the cards were distributed by the Department of Health & Aging).

It was agreed between ADAC and DASSA, that the main focus of the evaluation would be indigenous community responses to the *Australian Alcohol Guidelines for Indigenous Communities* (hereafter, *AAG for Indigenous Communities* or 'the guidelines') and *Don't Gamble With Your* Health (hereafter, 'the cards').

The *AAG for Indigenous Communities* were produced in a booklet and flipchart form along with an alcohol screen (AUDIT) and various associated materials as identified above. Given the greater significance and production effort of the guidelines it was agreed to concentrate on these, with responses to the cards, sought as part of the interviews with a sample of organisations from the ADAC mailing list.

In particular the evaluation was to consider:

- awareness of the booklet and flipchart form of the guidelines, alcohol screen, associated materials, and the cards
- use of, or intention to use the guidelines, alcohol screen, associated materials, and the cards
- the perceived value and usefulness of the guidelines, alcohol screen, associated materials, and the cards
- the adaptation of the NH&MRC guidelines (i.e. the form and content of the ADAC guidelines)

Further, it was intended that the evaluation capture as broad a range of responses and feedback as possible, and collate and test any views about how the *AAG for Indigenous Communities* and associated materials could be improved, if reprinted, and/or available as a PDF via the internet.

Methodology

As agreed to between DASSA and ADAC, data collection included:

- interviews with key personal involved with the development of the guidelines and associated materials

- content analysis of the guidelines (i.e. comparison between the NHMRC & ADAC guidelines)

- documentation and analysis of verbal and written and feedback provided to ADAC

- semi-structured telephone interviews with a sample of 50 Aboriginal Community Controlled Health Organisations selected from the ADAC mailing list (the format for these interviews is provided in appendix 1)

A number of additional interviews were also undertaken with:

- other organisations and individuals on ADAC's mailing list with a particular interest in the guidelines and/or expertise in the area of indigenous alcohol use, and

- individuals with particular expertise in the development of health promotion materials/graphic design.

Conduct of the telephone interviews

Given that the ADAC designed the guidelines for indigenous health workers (who were seen to be best placed to use and interpret the information for others), the sample for the telephone interviews was limited to Aboriginal Community Controlled Health Organisations (ACCHO's) on the grounds that these organisations employ various indigenous health workers and clinical staff, thereby increasing the likelihood of speaking directly with the group for whom the guidelines were specifically developed.

A sample of 50 organisations was selected from ADAC's mailing list. This represents approximately 40% of all NACCHO members (leaving aside associated members), and about 12% of ADAC's overall mail-out. The number of organisations selected from each state/territory was roughly proportional to the overall distribution of ACCHO's across the states and territories (see table 1 below). Within each state/territory, organisations were selected to reflect a diversity of geographical regions and degree of accessibility and remoteness.

Further, NACCHO and the various representative bodies in each state and the Northern Territory were contacted, advised of the conduct of the evaluation and invited to provide feedback about the guidelines. All declined for various reasons including: key staff on leave and not available to comment; down on staff; not a priority to attend to giving feedback; minimal role in distributing the guidelines and therefore not in a position to comment. Most referred the author back to their member organisations.

Several other organisations on ADAC's mailing list were also contacted because of their particular interest in the guidelines and/or the 'expert views' that they could offer. More general conversations and interviews were conducted with these key informants.

Telephone interviews were undertaken from late September 2005 to early January 2006. They commenced approximately 5 months after the distribution of the guidelines, and 2 months after the distribution of the flipchart. Considerable time was spent, and numerous calls were made, 'navigating' through each organisation trying to locate staff who were familiar with the guidelines and/or for whom the guidelines would be relevant given the scope of their work.

In canvassing an initial group of 6 organisations, it appeared that awareness of the guidelines was fairly low and/or staff were only aware of some items (eg. the flipchart, but not the booklet, alcohol screen, and associated materials etc.). There was also some confusion with the recently distributed *The Grog Book*[3] ('the green one'). To overcome these difficulties a photograph of all the ADAC resources was e-mailed to a relevant person in each organisation, who was then potentially able to locate the resources, and make inquiries among other staff (see appendix 5).

Given the length of time it took to locate and engage appropriate staff in each organisation, and ADAC's time constraints for finishing this report, it was only possible to complete interviews with 32 organisations (i.e. 64% of the sample). A list of these organisations is provided in appendix 6. Of the 18 for whom interviews were not completed, viable contact could not to be established with 5 organisations within the available time frame (i.e. contact in general and/or locating appropriate staff members to interview). In the remaining 13 organisations, contact could not be re-established (having already had preliminary discussions), for the purpose of undertaking interviews despite several attempts to do so, within the available time frame.

Table 1: Number of ACCHO's from each state and territory included in the sample

State/territory	Included in sample	Completed interviews
NSW	12	6
ACT	1	1
Victoria[4]	8	3
Tasmania	1	1
South Australia	6	4
Western Australia	8	6
Northern Territory	7	7
Queensland	7	4
Total	50	32

A total of 47 staff (leaving aside incidental contact) were spoken with in the 32 organisations for whom the interviews were completed. One focus group was held with 5 staff of an Adelaide based health organisation. All other interviews were

[3] Brady M. (2005), *The Grog Book: Strengthening indigenous community action on alcohol, Revised Edition*. Canberra: Australian Government, Department of Health and Aging.

[4] The low number of Victorian ACCHO's for whom interviews were completed, is largely due to this being the last state for which interviews were conducted, and the lead times required to successfully locate appropriate personnel to interview.

undertaken by telephone. The interviews were conducted in an informal manner and took between 15-30 minutes. They often took place after several preliminary conversations with each interviewee and/or others in their organisation.

The range of personnel interviewed/spoken with included: 14 drug & alcohol workers (2 were also team leaders); 9 health workers; 5 directors/managers of clinical/health services; 4 clinical/community nurses; 4 health promotion/education officers; 4 managers/CEO's; 3 mental health/social emotional wellbeing workers; 2 project coordinators; 1 youth support worker, and 1 elder. During the course of the interviews, 42 (i.e. 89%) identified themselves as being an indigenous person.

One of the purposes of the evaluation was to gain as broad a range of feedback about the guidelines and the cards as possible, and report this with a sense of proportion about any views that were put. The author has every confidence that this has been achieved. However, it would be misplaced to suggest that the percentages given below are anything but broadly indicative. Here it is also noted that all quotations are paraphrased from the interviews, rather than exactly verbatim, although every attempt has been made to reproduce them as accurately as possible.

FINDINGS

Distribution of the *AAG for Indigenous Communities*

ADAC undertook the mail-out of the guidelines, alcohol screen, and associated materials from mid-February 2005 - May 2005. Ten copies of each resource were sent to 270 OATSIH funded organisations and approximately 135 other organisations included on ADAC's mailing list. One copy of the flipchart was also distributed to each of these organisations, from June – July 2005 [5].

This initial distribution was followed by a 'snowballing' process whereby some of these organisations requested further copies, and a further 266 organisations who found out about the guidelines through other means, contacted ADAC to request copies.

Several organisations on the ADAC mailing list also played a clearinghouse role. In particular; the National Aboriginal Community Controlled Health Organisation (NACCHO) requested 135 copies, and the Aboriginal Medical Research Council of NSW requested 100 copies, to distribute to their respective members. The Aboriginal Medical Service Alliance for the Northern Territory also facilitated ADAC's distribution of the guidelines to its members.

A range of other organisations including the Drug and Alcohol Office in Western Australia, and the Queensland Drug and Alcohol Research Centre have also undertaken some secondary distribution of the guidelines. Key informants from these organisations indicated they would be using the guidelines in training programs, and distributing among indigenous substance misuse workers. The organisers of various special events and conferences also ordered multiple copies of the guidelines.

Here it is noted that ADAC's mailing list is somewhat less than fully comprehensive for the purpose of a truly national distribution. It is understandably more heavily weighted toward organisations in South Australia and those states/territories with which ADAC has a closer association (ie. Northern Territory, Western Australia & Queensland). It includes most of the Aboriginal Community Controlled Health Organisations in SA, ACT, Western Australia and the Northern Territory, but only about 60% of those in Queensland and 50% those in Victoria and NSW. Overall approximately 65% of all NACCHO members are included on ADAC's mailing list (these figures vary somewhat when associate members are also taken into consideration). See appendix 4 for an overview of ADAC's mailing list.

[5] There appears to have been some delay between the completion of the draft guidelines and their publication and distribution. At the time of writing, they had not been officially launched, but they had featured as part of a National Indigenous Train-the-Trainer workshop, sponsored by the Drug & Alcohol Office of Western Australia, Queensland Aboriginal Islander Forum, and ADAC.

Awareness of *AAG for Indigenous Communities*

Reporting on awareness of the *AAG for Indigenous Communities*, among the sample of ACCHO's is no straightforward matter. Not the least because, inquiring about awareness, generates awareness. Finding appropriate staff to interview in each organisation drew attention to the ADAC resources, and the interviews generated additional attention to, and interest in, the guidelines.

Further, classifying levels of awareness was at times a highly interpretative exercise. Identifying those who were 'highly aware', and those who had 'no awareness' was more straightforward than classifying those who had 'some awareness' and those who had 'limited awareness'. In ascertaining 'level of awareness' a number of factors were taken into consideration including: immediate recognition; familiarity with either the booklet, flipchart, alcohol screen, or associated materials; ability to locate copies of any of the resources in the organisation; the number and range of staff aware of the resources; and use/intention to use. Classifying levels of awareness was a case of 'line of best fit' through all these considerations.

Table 2: Level of awareness of the *AAG for Indigenous Communities*

Level of awareness	**Number**	**Percentage**
Highly aware	7	22%
Some awareness	8	25%
Limited awareness	7	22%
No awareness	10	31%
Total	32	100%

As indicated in Table 2 above, at least one staff member in 7 organisations (i.e. 22%) was 'highly aware' of the *AAG for Indigenous Communities*. Of these, 5 were aware of the booklet, flipchart, alcohol screen, and associated materials. One was aware of the booklet, flipchart and associated materials but not the alcohol screen. The other was only aware of the booklet and flipchart. Five of these interviewees were currently using the guidelines. One indicated their intention to use them, while the other indicated that they would not use them.

At least one staff member in a further 8 organisations (i.e. 25%) had 'some awareness' of the *AAG for Indigenous Communities*. This group included 3 organisations in which someone in a management role was aware, but not overly familiar with the resources and had passed them on to staff who in turn had some awareness and/or were able to at least locate either the booklet or the flipchart. Also included in this group were 4 organisations in which staff were able to locate the resources following the receipt of the e-mail image, and report some recognition of the guidelines among their colleagues. This group included 1 organisation in which a staff member appeared to have a reasonable level of awareness of the guidelines and intention to use them for training purposes in the future, but little practical

familiarity with them - they indicated that they would provide feedback after they had the opportunity to look at them.

In 7 organisations (i.e. 22%) there appeared to be 'limited awareness' of the *AAG for Indigenous Communities*. This group included 3 organisations in which a staff member reported being 'aware' or 'vaguely aware' of receiving the guidelines or 'recalled seeing a copy somewhere', but indicated they were not familiar with them, and/or were not able to locate them. In 2 organisations staff reported that they would 'try to locate them in the future', in one case, once they had a drug & alcohol worker on board. In the remaining 2 organisations, staff reported limited recognition, and/or limited recognition from others following the circulation of the e-mail image of the ADAC resources.

In 10 organisations (i.e. 31%) it was not possible to locate any staff who had any awareness of the *AAG for Indigenous Communities*. These organisations are taken as having 'no awareness' of the guidelines, bearing in mind in the words of two interviewees: "the materials may have been received, unpacked and someone may have taken them"; and "they could be on a shelf somewhere."

This group included staff from 4 organisations who expressed a keen interest in obtaining copies of the guidelines (these requests were passed on to ADAC during the course of the evaluation). Staff from 3 organisations commented on the issue of high staff turnover and the continuity of awareness of these types of resources. In 2 organisations staff spoke about being overwhelmed with other priorities. Further, 2 organisations indicated that health promotion was a 'specialist area' done by outside agencies. (In one of these cases it was possible to speak with staff from the 'outside' agency who undertook this work - a state based drug & alcohol service who employed indigenous substance abuse workers, both of whom were familiar with, and using the *AAG for Indigenous Communities*. A point which reflects the limitations of the sample).

Among the 13 organisations for whom interviews were not completed, but some initial contact made, tentatively it can be reported that there appeared to be a 'high level' of awareness in 1, 'some awareness' in 3, 'limited awareness' in 2, and 'no awareness' in 5. Some preliminary indication about the level of awareness was unknown for 2 organisations. It is reasonable to conjecture that once the image of the ADAC resources was forwarded by e-mail, these 13 organisations would probably reflect a similar pattern of awareness as outlined for the 32 organisations summarised in table 2 above.

Two general observations about awareness of the guidelines are also worth making. Firstly, interviewees appeared to be more aware of the flipchart, followed by the booklet, followed by the alcohol screen, with there being little reported awareness of the associated materials (i.e. 'quick guide', 'what is a standard drink', and 'survey to find out if alcohol is damaging your health').

Secondly, in locating appropriate personnel to interview (and in several cases in the interview itself) there appeared to be some confusion between the guidelines and *The Grog Book* (for which there was a very high level of awareness). The revised edition of this publication had been more recently launched and distributed, and

some interviewees, through lack of awareness of the ADAC resources, may have thought that the author was ringing up to talk about 'that alcohol book'.

On that note, *The Grog Book*, has a well-established history and covers a lot of broad ground about managing alcohol in indigenous communities. The *AAG for Indigenous Communities* has a much more circumscribed focus. It would appear to be in ADAC's interests to engender a clear understanding among indigenous health workers that the guidelines are an adaptation of the NH&MRC endorsed *Australian Alcohol Guidelines* - and therefore do not attempt to be a definitive reference about alcohol and health, nor cover the full range of broader concerns about alcohol for indigenous people.

Conclusion

By way of summary, it could be said that just under half of the organisations contacted (i.e. 46%) had a least one staff member who was either 'highly aware' or had 'some awareness' of the *AAG for Indigenous Communities*. Whereas, in just over half of the organisations contacted (i.e. 54%), staff appeared to have 'limited' or 'no awareness' of the guidelines. In some of these cases, the process of seeking appropriate staff to interview may not have successfully located staff who knew about the resources. That said, in many instances this conclusion was drawn after an e-mail image the ADAC resources was circulated around the organisation by staff and/or section managers, who themselves reported that no one was aware, or that there was limited recognition and awareness.

Arguably this is a disappointing finding for ADAC, given that 10 copies of the guidelines, alcohol screen and associated materials had been sent to each of the organisations contacted, followed by a copy of the flip chart, in the preceding six months. Clearly some organisations expressed a sense of being too overwhelmed by other matters. Some had other priorities. Some 'outsourced' substance abuse and/or health promotion matters to other specialist organisations. Further, ADAC could take some encouragement from the interest in the guidelines that the evaluation process appeared to generate. Around half of the interviewees who reported that they were not aware, were keen to obtain copies of the guidelines and other resources.

These observations, along with the argument that the sampling process may have confronted the vagaries of who might have 'opened the mail and known about the guidelines', may speak of the limitations of forwarding resources by mail, in the absence of a higher profile launch, promotional campaign, and training for indigenous health workers.

Given the relative ease with which an e-mail image of the resources was forwarded to most organisations, and then passed around these organisations as part of the process of seeking interviews, it may be that a simple single, or multi-media introduction to the resources, forwarded electronically to each organisation could have facilitated a better awareness of the guidelines, flipchart and alcohol screen, in the absence of a more thorough-going campaign.

Use of the *AAG for Indigenous Communities*

Interviewees were asked whether they had used any of the ADAC resources, whether they knew anyone else in the organisation who had used them, and how likely they would be to use the guidelines, flipchart and alcohol screen - in order to gauge the level of use, intention to use and perceived usefulness of the resources.

Use and intention to use, is obviously related to awareness. Someone can hardly use the guidelines if they're not aware of them. However, it's also the case that someone may not *attend to* the guidelines, if they have a prior reason for discounting the usefulness of these types of resources - which was the case for some interviewees.

In order to examine these matters, this section begins by considering the current and intended use of the guidelines among those who were either 'highly aware' or had 'some awareness'. This provides a good window into the potential of this resource. Use of the associated materials and the alcohol screen are also considered, followed by a discussion about the broader context of health promotion work in indigenous primary health care settings.

Current and intended use of the guidelines & flipchart

Of the 7 interviewees who appeared to be 'highly aware' of the guidelines, 5 were currently using them and indicated that they would continue to and/or extend their use. One was not currently using the guidelines, but planned to do so, while the other indicated that they were not likely to use the guidelines.

Of the 5 who indicated they were using the guidelines, their use included:

- Public education (flipchart), individual client assessment (alcohol screen), and training an indigenous substance abuse worker (booklet), who has in turn conducted community education (flipchart). This drug & alcohol/domestic violence worker also indicated their intention to modify the alcohol screen and use it in conjunction with other materials in order to talk about a 'continuum of drinking' and screen clients in conjunction with the substance abuse worker.

- Education programs for clients in prisons, and young people (flipchart), health promotion events (booklet & flipchart), professional reference material (booklet). This Education & Health Promotions worker reported that Youth Outreach Workers, the Family Support Team and the Clinical Team may also have used the flipchart with clients. They indicated that they would continue to use the flipchart in their prison work, because it is a significant context of men 'not drinking', and potentially absorbing messages about the risks and harm of alcohol.

- Working with groups of young people in schools and on camps (booklet & flipchart), presentations with indigenous health workers (booklet & flipchart), men's camps (booklet & alcohol screen), and work with individual clients referred by the police, magistrate, and medical centre staff (booklet & alcohol screen).

This drug & alcohol counsellor was currently showing the resources to medical/clinical staff & distributing to other health centres. They enthusiastically anticipated finding further application for the resources.

- Youth life skills workshops (flipchart – "it's the bible for youth workshops"), and health promotion work in relation to alcohol, standard drinks and diabetes. This drug & alcohol worker stressed the importance of their ongoing work targeting young people who are 'coming into the age group where they will be exposed to alcohol' and their use of flipchart in undertaking this work. They also indicated their intention to use the alcohol screen one to one with clients.

- Individual client assessment (alcohol screen) and as a professional reference for developing further community education resources (booklet). This drug & alcohol worker indicated that they were considering incorporating some parts of the flipchart into a men's health group/program. They also suggested that it was 'still early days' and too soon to provide comprehensive feedback.

The interviewee, who was 'highly aware' but not currently using the guidelines, was a mental health co-ordinator who indicated their intention to use the flipchart in anger management workshops, and with groups in an alcohol rehabilitation centre. They also reflected on the potential of the guidelines for training staff.

Among the 8 interviewees who had 'some awareness' of the *AAG for Indigenous Communities*, 3 reported using the flipchart. Of these, one interviewee indicated that a doctor had gone through the guideline about pregnancy with young women. Another had used the flipchart to go through the guidelines with a client, while the third had used it to explain standard drinks to students as part of Drug Action Week in schools, and taken then to Crocfest. Beyond these interviewees, use of the guidelines with was limited to discussion with other staff; and general display of the flipchart in office, reception and clinical settings. Three interviewees reported their intention to use the guidelines. One spoke about incorporating the flipchart into a men's group, and schools programs. Another indicated that they would include the guidelines in general health promotion events, and use it as a reference for developing their own resources. While the third, indicated that they would be using the guidelines as a teaching resource for indigenous health workers.

Obviously there was no current use among those who indicated they had no awareness of the guidelines, but 4 of these 10 interviewees expressed a keen interest in obtaining copies of the ADAC resources. Their use remains to be seen.

Use of the associated resources

In addition to the guidelines, ADAC also produced and distributed a 'standard drink' handout, a 'quick guide' to the guidelines and 'survey to find out if alcohol is damaging your health', as listed on page 8. There was little reported awareness and no reported use of these materials. These resources appear to have been sidelined. Even though there is a straightforward intention behind their production, it is not immediately self evident in their layout. Someone unfamiliar with these resources may have difficulty organising these 4 pages (which are not numbered or clearly

labelled on both sides of the page) into 3 resources. Further, the 'quick guide' presents some, but not all guidelines, in a numbered fashion, neither corresponding to the NH&MRC or the ADAC ordering of them - which is also potentially confusing.

Use of the Alcohol Screen (AUDIT)

The ADAC alcohol screen (AUDIT) is adapted from the Department of Veteran's Affairs AUDIT screen: *The Right Mix: Your Health and Alcohol*. The AUDIT (Alcohol Use Disorders Identification Test) is an internationally validated 10 question screening tool which is designed to identify alcohol dependence, hazardous and harmful levels of alcohol consumption, and binge drinking.

Given the case that has been made for 'secondary prevention' of alcohol misuse among Indigenous people[6], and the reported limitations of the AUDIT screen for indigenous health workers in a significant and high profile clinical trial[7], it seemed prudent to explore these matters with those interviewees who were using this screening tool.

The reported limitations of the AUDIT screen in this clinical trial at a metropolitan Aboriginal health service were twofold. Firstly, that clients were "embarrassed or resentful about being approached by Aboriginal health workers about their drinking." Secondly, that indigenous health workers felt "uncomfortable approaching the patients about their drinking (especially those who were older, known to them socially, or members of their extended families) and were uncomfortable administering the AUDIT, which was seen as too long and too intrusive."[8]

Among the 32 organisations for whom interviews were completed, staff in 3 organisations (all were drug & alcohol workers) reported that they were using the ADAC alcohol screen. One of these workers was not an indigenous person, the other two were. Both the indigenous drug & alcohol workers indicated that they were screening clients, and found no problems with either the instrument or the process.

The first worker thought that the alcohol screen was "straightforward, simple, and communicated a better understanding to clients". When asked about their comfort, and their clients comfort in undertaking the screening process they indicated that clients were concerned with confidentiality, but that it had never been a problem. They went on to say that "if anything they are more comfortable coming to me because I am known, and they know me."

The second worker reported that he went through the screening process slowly with clients in 2 sessions. He indicated that many of the men were working in the mines and earning good money, and that they were aware that they needed to moderate

[6] See for example Brady, M. *op.cit*. 1995. Also, Review of the Commonwealth's Aboriginal and Torres Strait Islander Substance Misuse Program *op. cit*. 2000

[7] Sibthorpe B, Bailie R, Brady M, Ball S, Sumner-Dodd P, Hall W. The demise of a planned randomised controlled trial in an urban Aboriginal medical service. *Medical Journal of Australia*, 2002; 176:273-6

[8] *ibid.*, p. 275

their alcohol consumption to retain their jobs because their blood alcohol concentration was tested at the mine. He went on to say:

> "They learn that I'm not trying to stop them. It's very simple and I get a very positive response. I'm very comfortable doing the screening and challenging clients to come down a level. The thermometer (i.e. standard drinks 'risk chart') is very sensible – they love it."

This worker went on to explain that he had a long-term history in the community and had built up trust over many years. He indicated that he was now also working with, and screening, some women and elders.

Another interviewee who was not currently using the alcohol screen, but was contemplating doing so, was also asked about the reported limitations of the aforementioned clinical trial. In response he said:

> "I would not have a problem using the AUDIT screen. Yes, you do work with your aunties and uncles - and some members of the community won't access the co-op because of relationships with staff. But, you build up trust, confidentiality and privacy. The elders will come and see me now."

Several other interviewees reported that they were considering using the alcohol screen. One of these indicated that it might be possible to incorporate some of it into annual health screens (notwithstanding that theirs was a dry community). Interestingly one health worker in a metropolitan organisation suggested that the alcohol screen could be produced as a 'self directed' pamphlet (2-fold A4 format) that could be placed in health/medical service waiting rooms.

Only one interviewee who was familiar the alcohol screen, indicated that they were not likely use it. She spoke about the 'huge problems' of privacy as well as hypocrisy (i.e. trying to identify an appropriate person who didn't drink to undertake the screening). With a chuckle she confided that an overweight nurse can't really talk about diet to others with much credibility.

The broader context of health promotion work

Use, and intended use of the guidelines, relates to questions about the perceived value of these types of health promotion resources, which shade over into broader questions about health promotion work in ACCHO's. This was the topic on which most interviewees had most to say - more so, than specific feedback about the guidelines. For many, discussion about the text, graphics and layout etc. seemed less relevant than general comment about the 'business of health promotion'. A very diverse range of views were put about the perceived usefulness of the guidelines and health promotion resources in general. It is to these views that this report now turns.

As previously discussed 2 interviewees advised that their organisation 'did not do any health promotion work', but rather referred this out to specialist agencies under various agreements. Another indicated that their organisation "did not attempt

primary health promotion, because the success of this approach depends on other things going on the community and available staffing."

In another 9 organisations staff spoke about immediate circumstances overwhelming the possibility of undertaking health promotion work. Two reported that their organisation was "too occupied grappling with funding and staff cutbacks" and/or a "difficult financial situation" in order to attend to health promotion matters in general, and the *AAG for Indigenous Communities* in particular. While in 7 of these organisations staff spoke about not having specialist drug & alcohol staff, and/or staff shortages, and/or staff to utilise the resources, and/or dealing with a high turnover of staff, and/or the skill level of staff. Some interviewees also spoke about there being "too much else going on", "being flat out keeping the clinic open", "attending to the immediate crisis of medical problems", and "having other priorities at the moment" (eg. petrol sniffing).

It could be said that about one third of the organisations in the sample appeared to be dealing with a range of situational factors, which mitigated against doing health promotion work, and/or limited their awareness and use of the guidelines at this point in time. But ultimately, these situational factors change over time. An organisation that did not have a drug & alcohol worker at the time of interview, might at some point in the future, secure funding and a suitably qualified person, embrace some health promotion work, and utilise the guidelines etc.

Arguably of greater interest to ADAC and others, are the range of views put about the usefulness of 'paper based' resources, and 'clinical approaches' to health promotion. In considering these views it is important to be mindful that they are general views, and not directed to ADAC specifically.

A critique of 'paper based' health promotion resources was strongly put by a program coordinator who was 'highly aware' of the ADAC resources but who indicated that they were unlikely to use them.

> "The paper-based stuff is miles off, a waste of time. From a marketing point of view it would be like getting less than a 1% response from a letter drop in the mailbox. The tribal context is very vocal and based on who is credible to give information. The translation of middle class resources is misplaced….there is poor literacy and the resources appeal to middle class logic and the consequences of drinking. But it is not a logical thing. You don't drink two casks of warm Moselle for a logical reason. You have to go back further. What is the underlying reason? There is an all pervasive anxiety, loss of identify and place in the world. The orientation of this organisation is sub-clinical: primary health promotion is employment and culture - those sorts of things."

Far less forcefully a Clinical Services Manager observed that:

> "It has potential as a teaching resource, but it may need to be modified….there's lots we can't use because it's in English. We're working with clients with limited literacy and numeracy – resources have to be almost completely pictorial."

Another Manager also noted that:

> "Our mob is not that literate, but I understand that you have to do it for the whole of Australia. It should be kept very simple for Central Australia. For Indigenous people English is not their first language."

These last two interviewees (only one of whom was aware of the flipchart) understood that the guidelines were written for indigenous health workers to explain to others, but suggested that a further process of 'translation' may be necessary in some communities. They also spoke about developing and adapting the ADAC resources to local demands and events.

The themes of 'translation', 'credibility of information givers', and 'appropriate ways of working' were echoed by other interviewees. One clinic manager noted that:

> "The drug & alcohol worker has flip chart displayed in their office, but tends to work more informally. He takes people aside – it's an indirect approach. The doctor also sits down with the kids, men, and women in non-clinical settings - women go to the centre and men go to the beach or the bush. It's done in an informal way using translators. You can't get points across with the written word, and these sorts of materials, it's of limited value. So we are not likely to use the guidelines. We cover similar ground but don't use formal resources."

Another interviewee, a drug & alcohol worker said:

> "It's difficult to bail up clients and say have a look at this. You can't really do in your face education. Your need people who have turned their life around who can influence younger people – you know, mentors."

Others also spoke about getting along side people, giving similar messages about standard drinks and harm minimisation, but not using specific resources.

Several drug & alcohol workers also observed that they were "mainly working with clients who were well beyond health promotion." One went on to raise a question about who the resources are aimed at:

> "You've got those who drink and those who don't. Who are we pitching at? I don't know where you would start to reduce drinking among the drinkers."

One interviewee offered a critique of the philosophy of harm minimisation, which informs the Australian Alcohol Guidelines, and ADAC's adaptation of them as follows:

> "We don't agree with the principle of 'the safe use approach'. Abstinence is in our constitution and we operate a dry community. We still agree with harm minimisation, but toward abstinence, not safe use. The message that there is a safe use is a problem: grog is not safe; yarndi is not safe; speed is not safe. They have the potential to kill our community. We're giving a message that does not need to be given. That approach may work for some sections of society, but not us. It's a middle class approach – they put a Nunga picture on it. We would like to see something that promotes abstinence – that points out our kids have severe defects from substance abuse. We need to spell out the consequences of alcohol for our children and grandchildren. If someone ever wanted to produce resources like that, we would be interested and would like to contribute."

In contrast to this critique of the of the philosophy of harm minimisation, a key informant from another organisation on ADAC's mailing list noted:

> "It's the community controlled health organisations who see majority of indigenous clients, especially in regional and remote areas - there is enormous potential to incorporate the guidelines, screening tools and brief interventions into routine clinical practice. In many instances visits to the clinic may be the only time that our people seek any medical help. You would expect ATODS[9] staff to be very familiar with drug & alcohol assessments, but nurses, health workers, doctors and other clinical people, need the guidelines for their work – the AUDIT is good for clinical staff, it's not intrusive."

She went on to put the case that there is "a lot of mileage in the brief intervention approach for young people, when they may be at critical stages in life". She also proudly spoke about the expanding cohort of young indigenous people, living a more 'middle class lifestyle' (and becoming role models), who require the same range of treatment options and social supports as the mainstream population. Her comments reflect something of the momentum that has been building for the last 10 years or so around broadening the range of interventions for indigenous people beyond abstinence and 12-step approaches[10].

Conclusion

The Commonwealth Governments most recent review of the Aboriginal and Torres Strait Islander Substance Misuse Program highlights the 'untapped potential' for screening and brief intervention initiatives in Indigenous primary health care settings."[11]

Within this broader context, ADAC's adaptation and distribution of the *AAG for Indigenous Communities* and the alcohol screen (AUDIT) can be seen as a step toward providing indigenous health workers with the 'tools' to undertake these types of interventions. Clearly these 'tools' have resonated with those interviewees whose use of the resources is detailed above. However, these workers constitute only a relatively small percentage of the total sample of 47 ACCHO staff interviewed/spoken with.[12]

It appears that a number of situational factors have limited the awareness and use of the *AAG for Indigenous Communities.* These include staffing constraints (including the skill level and turnover of staff), having other priorities, and referring health promotion and/or substance abuse matters to 'specialist organisations'.

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[9] Alcohol, Tobacco and Other Drug Services - Queensland

[10] See for example: Brady M. *Broadening the base of Interventions for Aboriginal people with alcohol problems*. Technical report no. 29. Sydney: National Drug and Alcohol Research Centre, 1995. Also, Brady M, Sibthorpe B, Bailie R, Ball S, Sumnerdodd P. The feasibility and acceptability of introducing brief intervention for alcohol misuse in an urban Aboriginal medical service, *Drug and Alcohol Review,* 2002; 21: 375-380.

[11] *Review of the Commonwealth's Aboriginal and Torres Strait Islander Substance Misuse Program: Final Report* (2000), Commonwealth Department of Health and Aged Care, Canberra, pp. 8-9.

[12] In percentage terms, the number of interviewees currently using the guidelines and Alcohol Screen, is around 17% of the sample. If those who indicated their intention to use the materials were included, it would be around 25%.

The use of the guidelines and alcohol screen also appears to have been limited by the lack of a broader promotional campaign surrounding them. In the words of one interviewee:

> "ADAC need to do a brief orientation. A lot of resources just get sent out and sit on the shelf – you need to build some momentum, which is especially important when you don't have a trainer."

Indeed, others also spoke of 'resources sitting on the shelf', and/or 'staff not being trained to use them'. However, as one informant from another organisation on ADAC's mailing list noted, "ADAC did well to get the resources out without any budget for education or any induction process."

A consideration of the Commonwealth Governments aims in providing the funding to ADAC to adapt the *Australian Alcohol Guidelines* is beyond the scope of this evaluation. Here it is simply noted that ADAC weren't funded and given a brief to develop a longer-term campaign to promote the *AAG for Indigenous Communities* or the alcohol screen. As it is generally understood in the health promotion field, the production of these types of resources on their own is of limited value if they are not supplemented with a range of awareness campaigns and specific training for health care workers.[13]

At the time of undertaking this evaluation ADAC were involved in a national train-the-trainer program, which included the guidelines, flipchart and alcohol screen. It remains to be seen whether these resources are used by a broader base of indigenous health and substance misuse workers, in the fullness of time, following their incorporation into this and various other in-service and formal training curriculum.

How could the *AAG for Indigenous Communities* be improved?

The ADAC has lamented that it can be difficult to get feedback about the content and form of their resources, and this has been somewhat reflected it the present evaluation.

It was mainly those who were 'highly aware' or had 'some awareness' of the guidelines who provided feedback, although not all did, and some were very limited in their comments (eg. 'fine', 'good' etc.). Some who had 'limited awareness' also provided feedback based on their initial perusal of the guidelines, which was often sparked by the request for an interview. Just fewer than half the sample (i.e. 15 interviewees) offered specific feedback about the form and content of the guidelines.

Nonetheless, it has been possible to glean some ideas about how the guidelines could be improved, if they were ever reproduced, or published on the OATSIH website as originally intended. In order to do this, interviewees were asked a series

[13] The limited use of the alcohol screen might be a case in point. If indigenous health workers don't think that it is part of their role to undertake this type of screening, and/or if they don't have the competence to do it, and/or if they are not feeling confident about screening clients, then this 'tool' is not likely to be used.

of questions about the text, graphics, layout, and format. They were also asked if they knew about, and what they thought about any other resources that explained 'standard drinks' or the effects of alcohol. Further, the opinions of several other informants with expertise in the production of health promotion resources/graphic design were also sought. The views of these informants along with the feedback from interviewees about how the guidelines could be improved are presented here under the sub-headings of; text, graphics, layout, and format.

Text

No interviewees were sufficiently familiar with the NH&MRC endorsed guidelines to provide comment about how the text had been adapted from the source material. However, there was a general consensus that the text was 'good'. Typical responses include:

> "Yeh, its easy to learn from regardless of your level of education. Its written in simple English."
>
> "I go by how clients respond. I work with Koori men, and they have responded well."
>
> "I have not really got any feedback - its simple, the community can relate to it."
>
> "It's good language - not boring information. It's at a level that people can understand. The plain text lays it out in as simple as terms as possible. I've got no problems with it – it's outlined in layman's terms."
>
> "For us it is good. Its easy to understand, but it might have to be modified for some communities."

The issue of the modifying the guidelines was echoed by 3 other interviewees who offered thoughts about the level of the language, the need for further translation, and/or selective use of the text. Comments included:

> "The text is good, but sometimes you have to translate to the level of the client. Generally speaking the English is too high in some resources – it's our work to go down to our people. Our people don't read or write - they need simplicity."
>
> "There is a lot of text - you need to take lots out and speak direct to clients."

One interviewee highlighted the distinction between using the guidelines for training indigenous health workers, and working directly with clients as follows:

> "From a trainers perspective they are very good, but I would dismantle and use different words for clients. If you are working with a group, they will tell you what they and you need to know."

One interviewee suggested that the guidelines could cover other situations such as: "others taking advantage of you when you're drunk" (for both men & women); and "stuff about schoolies week, safe-environments, and pedestrian safety". Another

thought that the guidelines could deal more with the social context of drinking and 'getting out of drinking' (i.e. expand the section on 'ways of saying that's enough').

Interestingly one interviewee who intended to use the guidelines for training courses and workshops was initially concerned that "they may not have been in the right order" (i.e. not properly reflecting the NH&MRC guidelines). However, they appeared to be comfortable with the adaptation, and understood the logic behind re-ordering the guidelines and modifying the content.

Outside the interviews with the sample of ACCHO's, one informant from another organisation on ADAC's mailing list suggested that there might be 2 errors in the text. Firstly, the guidelines should refer to 'alcohol related brain injury' rather than 'alcohol related brain damage', on the grounds that this was the correct clinical terminology. Secondly, they should more clearly explain that dementia is not caused by alcohol, but rather, can be seriously exacerbated by alcohol.

Graphics

Interviewees generally affirmed that it was important and good to have lots of graphics, illustrations and pictures in the context of communities with low literacy levels and/or where English was not the main language. But opinion was divided on whether this had been done as well as it might.

About half of those who offered comment presented a favourable view of the graphics. Typical comments include:

> "They are good, simple and clear – a mix of positive and negative messages."
>
> "Yes, they get the message across – it doesn't beat around the bush. Like the picture of alcohol and the car crash and the picture of the healthy diet."
>
> "The pictures are good. The kids will tell you if they aren't. These are fine. If anyone was going to rip it to shreds, it would be the kids…but the main image may be a problem for some communities up north."

Others offered a less favourable view. Two commented on the relationship between text and images as follows:

> "It took a while to work out some of the associations between the text and the images."
>
> "It's really good to have lots of illustrations given low levels of literacy, but they are very repetitive and sometimes it's hard to tell what they mean. The same image is sometimes repeated several times over a number of pages. They might be linked to the text, but sometimes it's hard to tell. Sometimes the image of the bodies and the car accident has the glass with the cross through it, sometimes it doesn't."

Two interviewees thought that the images should be made more realistic. One warned against the perception of providing "dumbed down information", while the other noted that:

> "Our mob get offended by stick and south park style cartoon figures. There is already too much shame going on without ridiculous looking images…..and the ADAC stuff is just too cluttered."

On this last point, another interviewee spoke in more general terms about ADAC's 'in-house style', which they described as being "too complicated and difficult to follow".

One of the previous comments also raises a question about the suitability of the main image (the outline figure of a 'male' and 'female' with small 'green bars' to symbolise the number of drinks) for communities in the top end. As it was explained to the author, this image could be seen as a stylised form of a traditional 'spirit figure', which would not be appropriate as health promotion image. Neither of the 2 interviewees who raised this matter were from communities to the north of Australia. And it should be said that the author was not in a position to canvass this matter with appropriate people in these communities. It is simply noted here for ADAC's further consideration. Further, several interviewees reported that these symbols are difficult to discriminate once they are reproduced on a small scale (as they are in the booklet), especially for those with poor eyesight.

Layout

Only a few interviewees offered specific comment about the layout of the guidelines - although some noted in passing that they thought that it was 'good' or 'friendly'. Several thought that the flipchart was 'too big' and/or 'too long'. Several offered comment and suggestions about the table of standard drinks (as detailed below). One suggested that ordering information should be provided on the back noting; "it's not clear how you get more – you need a phone number, fax and website address".

Other informants with expertise in the production of health promotion resources/graphic design offered a number of suggestion about how the lay-out could be improved, including:

- Giving prominence to the title *Australian Alcohol Guidelines for Indigenous Communities* rather than the descriptor 'Alcohol and Your Health'. This matter became very self evident in the course of this evaluation when the author was frequently having to explain over the telephone that the evaluation was "about the Australian Alcohol Guidelines for Indigenous Communities, but that this was not the main tittle on the front of the book, which said - alcohol and your health."

- Providing a contents page, markers/margin/lay-out tabs and starting each guideline on a new page. This would greatly improve navigation through the document. As it stands, if you want to go to a particular guideline, you have to thumb through the entire document until you find it. It was also suggested that it

might be possible to provide a clearer hierarchy of typeface and standard formatting for each guideline.

- Simplifying the table of standard drinks. A number of interviewees provided feedback about this table, and/or commented on comparable resources for communicating messages about standard drinks. There was a strong view that this table would be better if it had more realistic images. The graphics depicting 'bottles' 'cartons' and 'casks' contain additional text and/or are text based, which was seen to complicate rather than simplify the presentation of this information. Also, some suggested that it in trying to be comprehensive about *types of alcohol*, ADAC might have overlooked including different *types of containers* (eg. jars & mugs).

Format

Eleven interviewees commented about the format of the guidelines. Six of these suggested that it would be useful to have posters. Two noted:

> "posters are best as you often have a high turnover of staff who are not aware of these sorts of books."

> "posters are good - even park people will have a day off and come into the clinic where they might see a poster."

Several of those that said it would be useful to have posters also mentioned other formats such as stickers and calendars as a way of "reinforcing the message."[14]

Four interviewees talked about the possibility of the guidelines being available in PowerPoint/DVD formats. One referred to this as a "more upmarket approach" that could be presented to indigenous health workers. Another said:

> "Hey, could you put it on disk. I mostly go to communities with a lap top. After a big hunt, I go through topics and films to get some messages across."

The other two interviewees spoke about using a PowerPoint/DVD format in their school based work with young people.

Lastly, two interviewees suggested that it would be useful if the guidelines were available individually (so they could be handed out to clients), while another asked the author whether they were available in this format.

[14] This begs the question as to what message or image might be reinforced in a poster format. If ADAC developed a poster to convey the '4 standard drinks for men & 2 standard drinks for women message', or a poster outlining standard drinks they could possibly be in the unenviable position of being seen to promote alcohol consumption. On the other hand, it may cause friction if they claimed the imprimatur of the *Australian Alcohol Guidelines* but reflected messages that over emphasised the risks, harm and damage of alcohol, at the expense of messages about safe levels of alcohol consumption. As it stands there was some negotiation required to frame the alcohol and pregnancy guideline in stronger terms than it's NH&MRC counterpart.

Don't Gamble With Your Health - health promotion playing cards

Awareness of the cards

In undertaking the interviews with the sample of ACCHO's in relation to the guidelines, interviewees were asked about their awareness of the *Don't Gamble With Your Health*, health promotion playing cards. They were also asked about who they had distributed them to, what the response had been like, and their general thoughts about them. Additionally, at the time of writing this report, ADAC had received 70 feedback sheets, which were distributed with the cards. They are also considered here. People and organisations who provided this feedback are referred to as 'respondents' to differentiate them from the 'interviewees', included in the sample of ACCHO's.

Of the 32 completed interviews, at least one staff member (usually more) was aware of the cards in 20 organisations (62%). The level of awareness appeared tenuous in two of these organisations, where staff reported that they 'knew of another worker who had come back from a meeting with some', or 'had seen some'. Both these organisations were in the NT, and along with 2 others in the NT/Central Australia region (who were aware of the guidelines but not the cards), may not have received the cards - in which case they could not reasonably be expected to be aware of them.

If you took this into consideration, it appears as if 66% of organisations who received the cards, had at least one staff member who appeared to be aware of them. Without further information about the precise distribution of the cards, it's difficult to quantify the level of awareness beyond this figure, which should be treated as indicative only. There also appeared to be a higher level of awareness of the cards *within* organisations (as compared with the guidelines) This may reflect their novelty value, as well as the relative ease of circulation and distribution among staff, clients and community members.

The concept of 'health promotion playing cards'

Of the completed interviews, staff in 17 organisations (i.e. just over half) provided feedback about the cards. For the most part, interviewees spoke very highly of the concept of health promotion messages on playing cards. Typical comments include:

> "Very good idea – I've never seen anything like it before."
>
> "Pretty colourful – a tremendous idea, which gets the massage out there."
>
> "Great - a good way of subtly getting the message across – they get people talking."
>
> "Excellent, a really good idea. The messages are good. I would use them on camps - not for gambling, but for the messages."
>
> "Good idea, good images and no hard reading."

> "They are a better idea. All the cards have been handed out – they're readily distributable and consumable. They're better than the flipchart as a way of getting the messages out."

With regard to being readily 'distributable and consumable', another interviewee suggested that:

> "They have limited value as a health promotion resource - they are valued as a useful and usable commodity."

Another interviewee hinted at this idea, indicating that in the context of their community a pack of cards would be worth about five dollars, so "the cards were valued among those who received them."

Among the respondents of the feedback sheets there was an equally enthusiastic view about the concept of the cards - bearing in mind the low response rate and that the sample may be predisposed toward those with a favourable view.

Distribution and use

From both the interviews with the sample of ACCHO's, and feedback sheets returned to ADAC it is possible to identify that the cards have been distributed to:

- young people – in general, in schools and classroom programs, in detention, and in organised health programs and support services,
- the elderly – in general, and organised programs,
- indigenous health and substance abuse workers who have in turn distributed them to clients,
- health/medical centre clients and hospital patients in 'help yourself' and targeted ways (e.g. within the context of particular programs),
- prisons – inmates in general, and specifically participants in education and substance abuse programs,
- health promotion events and workshops,
- annual events such as NAIDOC and Drug Action week, and
- various events, seminars and conferences.

In addition to their general use as playing cards, a significant number of respondents and interviewees reported that they had used them in some structured way for: learning/maths games and health promotion in the school context; and as a discussion starter in various other program contexts. A good example is youth support worker who noted:

> "For some inmates it's their first exposure - they may not have ever heard about or thought about, say foetal alcohol syndrome. We go through the messages and talk about it the men's health program. They are a good discussion starter – we've kept three decks for ourselves, to work with."

Several non-indigenous respondents thought that the cards were a "good way to get attention without being overbearing or breaching subjects that are taboo (sic)." This view was echoed by another who noted "it has assisted us break down barriers – using specific cards to help describe what is going on." Yet another respondent affirmed the medium of cards as an everyday object so that people don't feel preached at."

Two respondents indicated that they had not distributed the cards because of the view that some of the images reinforce harsh and negative stereotypes, and in another instance, concern that they might encourage gambling. One respondent indicated that their organisation had not distributed the cards because of the perception that one of the graphics depicts "a white foetus in an indigenous woman".

Several interviewees also pointed out that the distribution of the cards could shade over into issues of gambling. Interestingly one indigenous health nurse in the Northern Territory described her way around this dilemma as follows:

> "It's mainly women who gamble. I have a clinic with young mums and grandmothers. I get the mums to play cards and talk about the messages. They ask: what does this mean? And we talk about it."

She went on to talk about being careful about not promoting, or been seen to promote gambling.

Relevance of the messages

Some non-indigenous respondents were concerned that the images reinforced negative stereotypes. However, most indigenous respondents and interviewees did not share this view. Of those that did, one indicated that some members of the community "did not like the kids seeing what was going on". While 2 others thought that some of the messages were "too explicit, and would bring shame in talking to others."

For the most part, however, the images and messages were deemed to be appropriate, relevant, and not too harsh or negative. They were seen to realistically confront the realities of life for many young indigenous people. Further, the overwhelming view from interviewees and respondents was that the cards had been very well received.

> "They had a huge response - every one grabbed them. They are culturally appropriate. The youth grabbed them, and the elderly grabbed them. They both really liked them."

> "The general feedback (i.e. from other staff) is that they are excellent."

> "There's been a very positive response. There are limited indigenous specific resources and many small places and remote communities don't have the ability to produce resources. We would be in a difficult situation without ADAC and the local mainstream drug & alcohol agency."
>
> "The cards have been very popular with young people and health workers. They are not too heavy - kids are exposed to more on TV. They are not real life images, and the community can decide about distributing them."

It would also appear that in some contexts the cards have engendered a sense of pride. Despite the 'negative' images, something about the cards being specific to indigenous people was a source of esteem. This is well illustrated by several respondents in both adult and juvenile custodial contexts who observed that inmates were either keeping their cards in their cells, or requesting that they go into their property, so they would not be stolen, and therefore available for when they were released.

Possible improvements to the cards

When asked about possible improvements to the cards, many said that they were fine as they are. Others raised a broad range of issues and suggestions too numerous to fully document here. The two most significant suggestions were:

- The possibility of incorporating a broader range of health messages (eg. sexual health, DV & alcohol, effects of alcohol & HEP C on liver, illicit use of prescribed drugs etc), and including more positive and 'do' messages (eg. good diet, exercise etc.).

- Improving the design and layout of the cards. Three interviewees and numerous respondents who completed the feedback sheets drew attention to the way they could be improved as playing cards. This revolved around:

    - improving the suit and number identification so they stood out more from the text/pictures ('to make them better for playing cards'),

    - having simpler images ('less busy', 'decrease the art work' etc.) with a clearer message, layout, and possibly plainer back. Several interviewees suggested that they were so visually busy they were difficult to use as playing cards and that they had observed people get the cards back-to-front when shuffling and dealing, and

    - including counting cards (i.e. the 5's & 6's) for playing euchre - which ADAC are already aware of.

One interviewee spoke about the look of the picture cards (i.e. king, queen & jack) not appearing recognisably 'indigenous' because people have not traditionally worn headdress, but 'suspending' this understanding and accepting the images. They also spoke about the possibility of using more of a contemporary style of headband as another alternative.

On the theme of design and layout it would appear that the cards have been designed separately from the *AAG for Indigenous Communities* with no visual resemblance between the images and graphics used in each. The cards carry messages about a broader range of topics than just 'alcohol and health'. Nonetheless, they include messages about standard drinks for men and women on the '2' and '4' of each suit, as well as 2 cards about foetal alcohol syndrome, one card about drinking and driving, one about being in a safe place, and one about going easy and not losing control. With the exception of the modified image of a pregnant woman, none of these graphics bears any resemblance to those used in the guidelines. Whatever the reasons for this are, some opportunity may have been lost to repeat potentially iconic images.

The words 'potentially iconic' are used because some questions hang over the graphics and images used in the guidelines, as discussed above. Here the question is simply whether it would be desirable to have several highly recognisable images that could be used in a variety of formats, over time, to reinforce messages about alcohol and health.

As to formats, the feedback sheet asked respondents "What other ways could the images and messages in the playing cards be used to raise awareness of substance misuse among your clients/community?" The popular suggestions were posters (around 35% of respondents), followed by calendars (around 17% of respondents), and then a host of miscellaneous paraphernalia from stickers to stubbie-holders, and placemats to PowerPoint, none of which were nominated by more that about 3% of respondents. Arguably these responses are somewhat problematic given that posters and calendars were suggested as prompts to the question. Nonetheless, on the basis of the interviews with the sample of ACCHO's there is little reason to doubt the perceived utility of these formats, along with the increasing popularity of the DVD/PowerPoint format - especially for school based work.

As raised in connection to the guidelines, this still begs the question as to what messages and images might be selected for posters, calendars or any of these other formats. One interviewee suggested that individual cards could be produced as a poster, along with a poster depicting all the cards. From the cards and the guidelines another obvious candidate is: "the four standard drinks for men and two standard drinks for women" message. This would mirror the promulgation of this message within the wider community. However, as some interviewees have argued in connection to the guidelines, these may not be the most relevant and appropriate 'messages' for indigenous communities. Instead they put a case for drawing attention to the potential risks, harms and damage that can be caused by alcohol.

Conclusion

Up to two thirds of the organisations included in the sample of ACCHO's had at least one staff member who was aware of the cards. There also appeared to be a higher level of awareness of the cards within each organisation, as compared with the guidelines. The cards appear to have been very well received as a strong concept for promoting messages about health in a highly accessible form, because of the prevalence of card playing as a past time among many indigenous people -

although, a few thought they were valued as a useful commodity, with limited potential as a health promotion resource. Several interviewees and respondents pointed out that the distribution of the cards could shade over into issues of gambling, but this appeared to be of only minor concern in some communities.

In addition to their general use as playing cards, a significant number of respondents and interviewees reported that they had used them in some structured way, as a 'discussion starter' in various program contexts, and/or for maths/learning games in the classroom.

Even though some thought that the images and messages were too explicit, negative, or harsh, most deemed them to be appropriate, relevant, and realistically confronting the realities of life for many young indigenous people. They also reported that they have been well received among clients and in the community in general.

While many thought that the cards were fine as they are, others made useful suggestions about improving the design and layout to enhance their function as playing cards. It was also suggested that the cards could carry a broader range of health messages and a better balance between positive 'do' messages and negative 'don't' messages.

APPENDICIES

1. Format for telephone interviews
2. Comparison of the order and content of the NH&MRC endorsed and ADAC Australian Alcohol Guidelines
3. Media coverage of the launch of the playing cards
4. Overview of ADAC's mailing list by state/territory
5. Image of ADAC resources e-mailed to organisation when seeking interviews
6. List of organisations for whom interviews were completed

APPENDIX 1: Format for telephone interviews

Evaluation of the Australian Alcohol Guidelines for Indigenous Communities & Don't Gamble With Your Health (health promotion playing cards)

Record of contact for seeking telephone interviews

Organisation:

State:

Phone number:

Date of first contact:

Person/s spoken with:

Person/s referred to:

Record of contact:

Telephone interview

Date:

Name of person:

Position:

Context of organisation

How would you describe the location of your service by accessibility and remoteness? (Is it CBD, regional, remote, or very remote?)

What region does the service cover? (Include a brief description of any outreach services)

Is there a designated substance misuse worker?

Awareness of the ADAC resources

Are you aware of:

- the Australian Alcohol Guidelines for Indigenous communities? Y/N
- the flipchart form of the guidelines? Y/N
- the Alcohol Screen (AUDIT)? Y/N
- the associated A4 size materials -
  - what is a 'standard drink' handout? Y/N
  - 'quick guide' to the Australian Alcohol Guidelines? Y/N
  - 'survey' to find out if alcohol is damaging your health? Y/N
- the health promotion playing cards Y/N

Use of the ADAC resources

Have you used any of these resources? (If yes, how have you used them? Detail the use of all resources, noting the context in which they have been used eg. with individuals or groups, health promotion, counselling, reference etc.)

Do you know whether anyone else in your organisation has used any of these resources?

How likely do you think you are to use the:

Guidelines?

Flipchart?

Alcohol Screen?

On a scale of 1-10 how would you rate the overall usefulness of the guidelines & flipchart to your work? (1 being not very useful, 10 being very useful).

Are you aware of any other resources relevant to indigenous people that promote the NH&MRC guidelines and/or standard drinks? How do you think they compare?

Ideas about how the guidelines or flip chart could be improved?

I would like to ask you a series of questions about the text, illustrations, layout & format. We will go through them one by one.

Firstly, what do you think about the text? (Could it be improved in any way?).
(eg. language, literacy levels, terminology, emphasis etc.)

What is your view of the graphics? (Could they be improved in any way?).
(eg. style, placement, appropriateness, illustrate the points etc.)

What do you think about the layout, or 'user friendliness' of the guidelines and flip chart? (Could this be improved in any way?).
(eg. is the information easy to find and follow?)

What do you think about the format/s (i.e. booklet and flipchart)? Can you think of any other relevant and/or useful formats?

Is there anything else that you would like to tell me about the guidelines and/or flipchart?

Health promotion playing cards

What do you think about the health promotion playing cards?
(Eg. *the concept, messages, images etc.*)

Who have you distributed them to?

What has the response been like?

APPENDIX 2: Comparison of the order and content of the ADAC & NH&MRC Australian Alcohol Guidelines

Comparison of the order and content of the ADAC & NH&MRC Australian Alcohol Guidelines			
No.	**NH&MRC**	**ADAC**	**Commentary on ADAC guideline**
1	To minimise risks in the short and longer term, and gain any longer-term benefits	If you do drink – how you can minimise the risks to your health	The ADAC guideline has a stronger emphasis on the potential harms, damage and risks of alcohol consumption, and does not allude to the notion of 'longer-term benefits'. It includes a section on: 'what can happen when you drink too much'; a more detailed discussion about the contexts of drinking, (eg. drinking together as a group, drinking in public places), 'ways of saying that's enough', and ideas about taking care of yourself when your out drinking.
2	When undertaking activities that involve risk or a degree of skill	Abstinence, or choosing not to drink alcohol	This guideline has been re-ordered to affirm a message about abstinence, choosing not to drink, and respecting others choices not to drink.
3	When responsible for private and public drinking environments	If you are pregnant or thinking about having a baby	The ADAC guideline emphasises abstinence in pregnancy as opposed to the more discretionary tone of the NH&MRC guideline. More prominence is given to it through the re-ordering, and it draws attention to Foetal Alcohol Syndrome.
4	People with a health or social problem that is related to alcohol, or made worse by alcohol (including alcohol dependence)	If you're already sick because of alcohol	The ADAC guideline spells out in a more detail the potential health and social problems of alcohol consumption. It more strongly advocates 'giving drinking a rest' and abstinence. It places less emphasis on the possibility of controlled drinking.
5	People with a relative who has, or has had, a problem with alcohol	If you take medication or other drugs	This guideline incorporates a section on poly drug use.
6	People with a mental health problem (including anxiety or depression) and/or sleep disturbance	If you have a mental health problem	This guideline is framed in a way to more directly address people's experience of sadness, grief and trauma, as opposed to more abstract labels for mental illness.
7	People taking medications or other drugs	If you are 18 years old	The ADAC guideline emphasises the illegality of underage drinking and omits discussion about the supervision of young people learning responsible drinking.
8	Older people	If you are 18 to 25 years	This guideline includes an expended section on 'avoiding harm from drinking', which incorporates matters in relation to drink spiking.
9	Young adults (aged about 18-25 years)	If you are an older person	This guideline includes information about life expectancy and a section on keeping your body healthy.
10	Young people (up to about 18 years)	I your family has a history of problems with alcohol	This guideline puts more emphasis on 'not drinking any alcohol at all'.
11	Women who are pregnant or might soon become pregnant	If you are driving a vehicle or using heavy machinery	This guidelines includes a section on driving, which emphasises the added risk of unmade or badly maintained road surfaces
12	People who choose not to drink	If you are providing alcohol to others	The ADAC guideline is generally expanded and includes: information about products that should never be drunk (eg. methylated spirits & kava); a section on alcohol management plans; and safer drinking in the Islands (the discussion about boating, might be more appropriately placed in the guideline about activities involving risk i.e. ADAC guideline 11)

APPENDIX 3: Media coverage of the launch of the playing cards

SOCIAL ACTIVITY: South Australian MP Christopher Pyne and members of the Canberra Aboriginal community test the new cards.

Go get the message: It's in the cards

By BRONWYN HURRELL
in Canberra

MESSAGES discouraging alcohol and drug abuse, petrol sniffing, smoking and gambling are to be delivered to Aboriginal communities on playing cards funded by the Federal Government.

The Adelaide distributors of the cards deny they are promoting card-game gambling, saying the idea was generated in indigenous communities and will send positive messages.

The cards include conventional warnings such as "your smoking harms others" – as well as "culturally appropriate" slogans such as "Sister-girl says wear a condom" and "Jack says your community needs you straight", and graphics designed by Aboriginal people.

Developed by the Aboriginal Drug and Alcohol Council of South Australia, 130,000 packs of cards printed by Spicers will be distributed nationally.

Card games are banned in some indigenous communities in the Northern Territory because of previous gambling-related issues.

But the "Don't Gamble with your Health" cards are already a hit with communities, with one group in Whyalla requesting 2000 packs.

They will also be introduced at Yatala Prison.

Commenting on the project which cost almost $500,000, ADAC executive director Scott Wilson said: "Some people might think we are promoting gambling." But Mr Wilson said cards were generally played socially rather than in gambling situations and poker machines, featured in the warnings, were the real problem in terms of gambling.

South Australian MP and Parliamentary Secretary for Health Christopher Pyne – himself an avid bridge and poker player – launched the cards in Canberra yesterday as part of Drug Action Week.

Mr Pyne said the cards were "confronting" and designed to "bombard" people with positive messages. "This project is particularly important given the disproportionate harms suffered by Aboriginal and Torres Strait Islander communities attributable to the use of alcohol and other drugs," he said.

FULL HOUSE: Some of the cards which seek to discourage substance abuse.

APPENDIX 4: Image of the ADAC resources e-mailed to organisations when seeking telephone interviews


ALCOHOL AND YOUR HEALTH
ALCOHOL AND YOUR HEALTH
Australian Alcohol Guidelines

APPENDIX 5: Overview of ADAC's mailing list by state/territory

Overview of ADAC's mailing list as of July 2005

State	Number of organisations in ADAC's initial mail out	Number of organisations in ADAC's additional mail out	NACCHO Member Organisations in each state/territory[15]	NACCHO members included in all ADAC mail outs	NACCHO members included in sample
NSW	51	18	40	20	12
ACT	15	2	1	1	1
Victoria	21	3	25	13	8
Tasmania	2		1	0	1
South Australia	100	65	9	8	6
Western Australia	34	3	20	17	8
Northern Territory	48	9	13	13	7
Queensland	35	10	16	10	7
Totals	**306**	**110[16]**	**125[17]**	**82**	**50**

[15] Not all ACCHO's are members of NACCHO, and some are associate rather than full members. Nonetheless the numbers of NACCHO members were used as a guide as to the distribution of ACCHO's across the states and territories.

[16] At the time of writing a further 156 organisations have contacted ADAC to request copies of the guidelines.

[17] NACCHO were contacted and asked if they could provide details as to the number of ACCHO's in each state/territory, and the number of member organisations in each state, but for whatever reasons, did not provide this information. For the most part this information has been gleaned from theirs, and state affiliate web sites (some of which were modified during the course of the evaluation). The author estimates that number of NACCHO members is around 128-135, but had no straightforward way of confirming this. The modest discrepancy between this estimate and the number of members in each state/territory was of no consequence in determining the sample. The intention was to broadly use the distribution of ACCHO's as a guide for determining the proportion of the sample to be selected from each state/territory, and identify the extent to which the ADAC mailing list included all ACCHO's in each state/territory.

APPENDIX 6: List of organisations for whom interviews were completed

Organisations for whom telephone interviews were completed

Organisation	State
Aboriginal and Islander Alcohol Relief Services Ltd.	QLD
Ampilawatja Health Centre Aboriginal Corporation	NT
Armidale and District Services Inc.	NSW
Awabakal Newcastle Aboriginal & Torres Cooperative Ltd.	NSW
Biripi Aboriginal Corporation Medical Centre	NSW
Bunnurong Health Service - Dandenong and District Aboriginal Co-op. Ltd.	VIC
Central Gippsland Aboriginal Health and Housing Cooperative	VIC
Condobolin Aboriginal Health Service Inc.	NSW
Dubbo Aboriginal Medical Service	NSW
Goolburri Health Advancement Aboriginal Corporation	QLD
Goolum Goolum Aboriginal Cooperative	VIC
Illawarra Aboriginal Medical Service Aboriginal Corporation	NSW
Kakadu Health Service	NT
Kalparrin Incorporated	SA
Katherine West Health Board Aboriginal Corporation	NT
Kimberly Aboriginal Medical Services Council Inc.	WA
Kununurra Waringarri Aboriginal Corporation	WA
Mawamkarra Health Service Aboriginal Corporation	WA
Miwatj Health Aboriginal Corporation	NT
Mutitjulu Community Health Service Aboriginal Corporation	NT
Nganampa Health Council Incorporated	NT
Ngangganawili Aboriginal Medical Service Corporation	WA
Noongar Alcohol and Substance Abuse Service Inc. (NASAS)	WA
North Coast Aboriginal Corporation for Community Health	QLD
Nunkuwarrin Yunti	SA
Oak Valley Maralinga Inc. Health and Aged Care Services	SA
Tasmanian Aboriginal Centre Inc.	TAS
Tullawon Health Service Inc.	SA
Winnunga Nirnmityjah Aboriginal Health Service (ACT) Inc.	ACT
Wirraka Maya Health Services Aboriginal Corporation	WA
Wurli-Wurlijang Aboriginal Corporation Health Service	NT
Yulu-Burri-Ba Aboriginal Corporation for Community Health	QLD