On 28 March 2024, Dr Maggie Brady provided written responses to interview questions provided by Prof Virginia Berridge.

Virginia Berridge:
How did you become involved in this general area?

Maggie Brady:
It was serendipitous. My first connection with the field of alcohol and other drug research came about in the late 1970s, when I worked as a research assistant in the medical school of Flinders University in Adelaide, South Australia. A sociologically-minded psychiatrist there (Dr Rod Morice) began a research project in a remote Indigenous community examining its high rates of volatile solvent use (petrol sniffing) and the accompanying juvenile court appearances among young people. Joining that project team, my task was to liaise with two senior Aboriginal women who were our local assistants, and generally get to know the community. I also sat in on the court hearings to see how the justice system dealt with them. It was my introduction to the lives of Indigenous Australians living remotely, as well as an introduction to the world of alcohol and other drug studies and social research. As I was also enrolled in a Masters' program in anthropology these research visits became part of my dissertation work. I wrote about how these western desert people (many of whom had been in contact with white Australians for only a matter of fifty-odd years) dealt with the disruptive effects of alcohol and drugs in their community of around 300 people.

Our team looked into the effects of leaded petrol (only phased out in the mid-1980s) and associated cognitive damage on teenagers. We produced an annotated bibliography of the domestic and international literature about volatile solvent use, so I became familiar with the literature. It was a rapid learning curve as I tried to learn something of the Pitjantjatjara language, to understand peoples' perceptions of the antisocial and disengaged behaviours engaged in by their youth, and what they thought of the risky drinking engaged in by adults. Although very concerned about the negative physical and social impacts of these behaviours, people in the community upheld a basic belief in the right of individuals to conduct themselves as they wished, and there was a strong ethic of non-interference in others' lives. Our project was somewhat idealistically based on the 'problem posing research' outlined by Paolo Freire (*Pedagogy of the Oppressed,* 1970), and we tried to provide the community with our research findings (holding meetings and having an interpreter to feed back our data) in the hope of empowering and stimulating local action. Not surprisingly in view of the cultural disincentives to intervene in other peoples' lives, this did not occur, and it

was only many years later that local people created a special supervised bush camp for the teenagers who had been inhaling petrol, and campaigned against takeaway alcohol sales.

The petrol sniffing study led to further research in the same community in the early 1980s, this time looking at alcohol misuse which was a major cause of community unrest and ill health and mortality at the time. This was my introduction to investigating alcohol problems. With the help of the two experienced nurses resident in the community, we set up a questionnaire to log each alcohol-related incident on a basic form. We noted the source of the alcohol, sex, age, the type of injury (or illness), part of the body injured, and severity, and from this simple form we learned a great deal about what was going on. We learned that during intoxicated altercations, men and women each received injuries to different parts of their bodies, strongly suggesting that the disputants still knew what they were doing even when supposedly 'out of control', and that cultural factors came into play. Looking back over the (extremely rudimentary) health records we established which deaths had been alcohol-related over several years. By documenting these data on alcohol-related morbidity and mortality, and feeding it back to the community, we did two things. We highlighted for local people just how many community members were dying from accidents, injuries and illnesses (local people were not aware of the extent of these figures and how much damage alcohol was causing). Secondly, our work later backed up the community's case demanding restrictions on alcohol sales, heard before the State's licensing court. These data were used to convince the court to impose conditions on the liquor licences of three local outlets that had been selling unrestricted quantities of cheap fortified wine (port) in 2 litre glass flagons. The data also formed a baseline study against which to measure the impact of the subsequent restrictions on sales. Injuries dropped!

Soon after this, I moved to live in Darwin, and because of the earlier research into alcohol harms in the Aboriginal community, I was asked by the government's Drug & Alcohol Bureau to examine the impact of drinking on a small Northern Territory town, Tennant Creek. Another steep learning curve, alerting me to the fact that drinking in the Northern Territory was enthusiastic, excessive and certainly not confined to the Indigenous population. Once again, I aimed to mix an ethnographic approach with whatever 'hard' data were available. Among other things, the ethnographic approach revealed that the white Australian drinkers organised themselves into different licensed venues according to their work status in the town (the police had their own club away from the eyes of the public); everybody knew who drank where, and the publicans knew what everybody drank as they walked in the door. Alcohol was served as a matter of

course at every social event including parent-teacher nights and church events. I wrote a monograph entitled *Where the Beer Truck Stopped;* the title refers to the apocryphal story explaining how the town came to be built in that particular spot.

In relation to key things you have accomplished, please explain how these came about. What was going on at the time, how did you get involved; how did your work progress?

I now realise that the context for my work throughout the 1980s and 1990s was strongly influenced – and enabled – by the exciting public health initiatives coincidentally taking place internationally and in Australia at the time. It was a time of innovation. In 1986 the first International Conference on Health Promotion took place that resulted in the Ottawa Charter for Health Promotion with its breakthrough perspective. In Australia in 1985 the first ever national framework was announced: it was an explicit partnership between government and non-government sectors to deal with alcohol and other drugs, the National Campaign Against Drug Abuse (NCADA). This morphed into the National Drug Strategy in later years. NCADA took a public health approach: to minimise harm and to get all jurisdictions (across our federal system) to liaise with one another. This was also the time of the HIV/AIDS epidemic, which meant that in Australia it was, thankfully, a harm minimisation approach that drove the national strategy. HIV/AIDS posed a significant threat to the Aboriginal and Torres Strait Islander community and because of its association with substance abuse, the epidemic forced the national government to commit funds and pay greater attention to ways of bringing the Indigenous community on board, involving community health services and other organisations in strategies to reduce harms and mobilising appropriate forms of communicating health messages (about condom use for example) to the grass roots – the social marketing of health. These developments were facilitated by the progressive Labor government of the day, together with a forward-thinking health minister, Neal Blewett. In this period there were research into drug abuse grants, helpful public servants and better liaison between the states and the national government and I benefited from this, by undertaking a number of short term projects (on approaches to HIV/AIDS education for example). In the 1990s, Australia was one of several countries participating in the WHO international randomised controlled trial of brief alcohol interventions, and there was a welter of international and domestic projects investigating the role of screening and brief interventions (SBI) publications. In terms of influences on my research direction, these WHO-sponsored studies were 'in the air' at the time.

As a result of my serendipitous involvement in the two early studies, I found

myself to be one of only a few social scientists working on drug issues at the time (1980s) with Indigenous people. Government agencies and health services were both baffled and concerned about what to do, but strangely the National Campaign Against Drug Abuse initially omitted petrol sniffing from its focus, ostensibly because it affected Indigenous people, a relatively small proportion of the overall population. Nevertheless, petrol sniffing was widespread in certain parts of remote Australia in the late 1980s, and although leaded petrol was slowly disappearing, sniffers were absorbing damaging hydrocarbons, experiencing brain damage, dying in accidents and creating distress in families. Some were being treated with chelating agents in hospital. I wanted to understand more about the social meaning of sniffing, and the reasons for its uneven geographical distribution among communities. Why did communities in some regions have epidemics of inhalant use while others appeared to have escaped it, even though all had shared histories of cultural disruption and dispossession, commonly said to be the underlying 'causes' of petrol sniffing. With a research grant from the federal government, I spent months at a time in three different regions of the country to try and research these questions. I also went to Canada, the other 'fourth world' country experiencing petrol sniffing among its First Nations population. Supported by a WHO travelling fellowship, I could travel freely across the country where I met key First Nations and other practitioners, visited treatment programs for sniffers, experienced a sweat lodge, and enlarged on my knowledge of the physical and social impact of sniffing in another setting. These were tremendously useful experiences and I now realise the great value of such fellowships in one's early career in enabling the networking and sharing and long-term exchanges of ideas. On my return I published *Heavy Metal. The Social Meaning of Petrol Sniffing in Australia* in 1992 and later published an article comparing different uses of 'culture' in healing programs in Canada and Australia.

I learned a great deal from the experience of working in this way, a kind of mixed methods methodology but with an emphasis on participant-observation, field-based work (that is, living in the community of study alongside local people). As well as collecting quantitative data and interviewing people, I could make note of the unrehearsed casual remarks of everyday life (which can be so revealing), and observe at first hand local, non-confrontational forms of social control in which community members accommodated and managed the unwanted drunken behaviours of their kin and co-residents. I discovered that many of the western desert Indigenous communities I spent time in shared perceptions (expressed through their polysemous language terms) that young sniffers were metaphorically deaf (and therefore unable to understand and 'hear' the remonstrations of their families), and that this way of thinking helped to explain

some communities' unwillingness to intervene. Families and the social system itself were overwhelmed by the burden of this 'new' and unfamiliar drug use and the bizarre behaviours that went with it. I also learned from a casual comment that for some young boys, sniffing petrol was a deliberate ploy to become skinny, previously unrecognised form of male anorexia. Sniffing killed their appetite. I confess that these experiences of, and insights from, field-based research have since made me wary of 'survey findings' reporting on responses to direct questions. Anthropology, it is said, examines the gap between what people say they do and what they actually do (and there usually is such a gap). It's good to bear that in mind.

This work in the 1980s and 1990s taught me that there was an important place for applied research, and that research could in fact be of *service* to the people being studied. I have published my research in academic journals and books read by university and clinical researchers (and hopefully policy-makers), but I have also reported directly to government departments and made resources and written explicitly for frontline service providers and community activists working at the grassroots. Between 1986 and 2000 I was based at an Indigenous research centre, archive and clearing house, the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS), while I was funded by a number of external or government agencies. AIATSIS is not part of a university but a separate statutory body with an Indigenous Council. This was a flexible base for this kind of work, with a less academic focus and a greater service focus, and with some key Indigenous leaders as CEOs or council members, AIATSIS was an ideal base from which to produce these contributions to the Indigenous addiction field. At the time, one research project seemed to lead to another in a natural progression, with the help of research funds, and amid the background mentioned earlier, of new government frameworks and initiatives that valued harm minimisation and the need to partner with grass roots organisations.

The first 'community-based' publication I wrote was in the form of a book of edited interviews I did with Aboriginal and Torres Strait Islander people who had given up previous heavy drinking without treatment – a form natural remission. It seemed to me that these positive accounts of how ordinary Indigenous people had overcome their chronic drinking could be useful to others – if not as actual guidance, then at least inspiration. It was called *Giving Away the Grog* and was published and made available, free, through the federal government's health department. The study came about because while working in different Indigenous communities on other issues I had met and chatted with people who told me they had once been drinkers but had given up (or more colloquially, they had 'given it away'). Grog is an imported term (originally referring to the watered-

down rum on British ships) used ubiquitously by Indigenous and non-Indigenous Australians to refer to alcohol. The issue demanded more detailed attention, so with a research grant I started the fieldwork in a couple of communities in the Northern Territory (NT) where I already had contacts. As I recall, the project received logistical support from the NT's innovative Living with Alcohol program of the 1990s. The work also coincided with that of Mark and Linda Sobell who had spearheaded research into natural remission/self-change/natural recovery – so the topic of recovery without treatment was part of the climate of research at the time.

In this case, as my fieldwork progressed in a kind of 'opportunistic snowball' methodology, I found many willing participants who wanted to tell their story of giving up drinking and who referred me to others they knew. It's probably important to explain that the kind of fieldwork I was doing meant driving long distances to discrete Indigenous settlements of a few hundred residents, often hundreds of kms from towns such as Alice Springs, Katherine or Darwin; liaising with the local health service and community council; and following up contacts and finding the right people to talk to. I think that people were eager participants in this study because it was aimed at collecting success stories, rather than documenting the tragedies that often accompanied intoxication. I wanted to know what had motivated people to stop drinking, what had been the barriers to or facilitators of their decision. Some said no one had ever asked them about their success over drinking before; one woman wept as she remembered how challenging it all was; and others used the copies of their story that I sent back as 'proof' that it could be done. People spoke with great emotion about their struggles. It was illuminating material, providing insights into the barriers faced by Indigenous individuals who had tried to 'give away' the grog on their own, amid tight kin networks and the often unhelpful attitudes of family and friends. The research led me to an appreciation of the way in which a doctor's advice (a 'brief intervention') or sometimes a stark warning had influenced several interviewees to give up drinking. These people then *made use* of the doctor. They excused themselves from having to drink with their old crowd by placing the 'blame' for this decision on what the doctor had told them. In this way people avoided breaching the cultural expectation to always share and join in the drinking circle. Refusal of a drink without an acceptable excuse was a breach of social etiquette. The doctor provided that excuse. This qualitative research led me in 1995 to pursue the potential value of implementing brief alcohol interventions for Indigenous patients as a regular feature of primary health care services. As mentioned earlier, this was a period in which significant research attention was paid to SBIs and they were being trialled in Australia. I was involved in one such study in an Aboriginal health service in which we trained the doctors in brief

motivational interviewing; the Aboriginal health workers were much more reticent about delivering the SBIs. Recent research has produced equivocal findings about the 'success' of brief interventions delivered in primary care to Indigenous clients with risky drinking. However, these studies ignore or are not aware of the hidden (and difficult-to-measure) cultural uses of the- doctor- as- an- excuse. I wonder whether in these recent studies, the clients receiving a standard SBI were not in crisis as were the individuals who had recounted their stories to me: the 'teachable moment' had not arrived. The book *Giving Away the Grog. Aboriginal accounts of drinking and not drinking* is still in print 25 years later.

The other community resource I managed to produce during the 1990s came about partly because of the UN's International Decade of the World's Indigenous People [1994–2003]. This resource was called *The Grog Book. Strengthening Indigenous Community Action on Alcohol,* first published in 1998. I had the chance to make it happen partly through my involvement in a WHO project.

Because WHO had a mandate to develop a global program of action as part of the Decade of the World's Indigenous People, its Programme on Substance Abuse started a project on Indigenous peoples and substance abuse in the mid-1990s [1995–2004]. This was pushed along from within WHO by Dr Andrew Ball, an Australian who worked hard to network with Indigenous addiction workers internationally. The project was designed to identify and develop culturally appropriate interventions to reduce alcohol and other drug harm, run pilot projects and create a network for people working in prevention and treatment. It was a great initiative, as it enabled direct contact between WHO policy makers, Indigenous program managers and other stakeholders, and created a core group of committed Indigenous and non-Indigenous activists, primarily First Nations Canadians, Australians and Maori, and representatives from Argentina and Nicaragua. I was able to attend meetings in New York with Indigenous academic Dr Marcia Langton and contribute to Phase II of this project which involved a planning meeting in Costa Rica. For this meeting I prepared a paper suggesting a framework for community-based action to prevent and manage substance abuse. This paper formed the basic structure for *The Grog Book*, as a practical guide to grassroots action.

It's probably important to note here that the idea for *the Grog Book* also came about through a discussion with Indigenous academic Marcia Langton: we were both aware of the ground-breaking handbook *Where There is No Doctor: a village health care handbook*. Known to anyone involved in developing health at the time, this was an international handbook for people living far away from medical centres, designed for people to take the lead in their own health care

based on the principle that health care is everyone's responsibility. It was the brainchild in the 1970s of the renowned developing health physician David Werner. It seemed to us that Indigenous communities in Australia would make good use of a handbook like this, only this time designed to inspire, guide, and stimulate action on alcohol abuse.

The Grog Book took its subtitle 'Strengthening Community Action on Alcohol' from the Ottawa Charter for Health Promotion – a strategic decision to draw attention to the 5 action areas nominated in the Ottawa Charter of 1986. The book would, I think, now come under the rubric of 'knowledge translation' as it was designed to transform expert findings and policy recommendations into practical interventions so that communities could devise their own local action plans and programs. It was designed to channel expert policy findings (such as those emanating from WHO), and examples of good practice to Indigenous networks and programs, some of which had been quarantined into separate areas of government funding and policy and as a result had become cut off from new developments in the addiction field. Most residential treatment programs for Aboriginal people were, for example, still reliant on 12 Steps programs and hosting AA meetings, rather than exploring other motivational strategies.

It took over a year of field visits and networking and interviews with Indigenous program managers to solicit their contributions, and to collect, sift through and select the best examples of activities going on in different Indigenous contexts in remote, rural and urban areas. The book starts with basics: what alcohol is, what the different strengths are, 'standard drinks', the history and effects of alcohol prohibition for Aboriginal and Islander people, and continues by giving carefully-chosen case studies of prevention, intervention and treatment taking place in Indigenous contexts. These included examples of prevention and local action, men's groups, trials of different alcohol restrictions, women's campaigns against packaged alcohol, and both sides of the debate about having a licensed club in a remote settlement. The book is free, still in print and in demand.

In 2002 a South African public health researcher Kirstie Rendall-Mkosi (who worked with David Sanders at the University of the Western Cape, and Charles Parry of the MRC) saw the book and realised it was relevant for the local drinking problems surrounding workers on wine farms in the Cape, and for those people living in the townships near Cape Town. Between us Kirstie and I created Summer and Winter School courses at UWC for frontline workers (nurses, alcohol workers, social workers) and later we researched, wrote and published a local version of *The Grog Book* with local content, case studies, and stories *Tackling Alcohol Problems. Strengthening community action in South Africa*

[2004].

Apart from this publication, I was very lucky to have commissions to prepare overviews of alcohol and other drugs – their early use by Aboriginal people, pre contact uses of tobacco and the production of mildly alcoholic drinks, policy history as it affects Indigenous populations, psychoactive substance use by young people, the use of local social controls – which have not only broadened my knowledge during the writing process but gave me the opportunity to participate in some WHO and other roundtables, and to have the work published.

What was your part of the world like as it relates to your work in this field?

There are advantages and disadvantages in being based in Australia. It is a long way from Europe and from North America from which the many well-funded universities, research centres and charities have coordinated large scale studies, and around which cohere the best talent in prevention and treatment research. It's hard to escape the feeling that the main action was (and is?) happening in the northern hemisphere, where WHO also has its HQ in Geneva and Copenhagen. Distance and travel funding were always an issue, although I was able to attend some international meetings with the help of WHO and other fellowships, and with the support of various research institutions. However, my involvement was only possible during the period in which there were few, if any, Indigenous academics or researchers with the training and availability to attend these meetings. These days it would be inappropriate for someone such as myself to attend. From the mid 1990s there were increasing, and quite legitimate, challenges to non-Indigenous researchers being seen to be writing about Indigenous people and their social problems, including substance misuse problems.

The Indigenous health field in Australia in which I found myself initially comprised a smallish group of people who all knew one another. Only a handful of anthropologists had published ethnographies of drinking, but few if any of them were undertaking applied research, perhaps due to Robin Room's famous insight that the anthropological method itself has an inherent tendency to 'deflate' social problems. In fact, there was some pushback from academia about anthropologists (such as myself) involving themselves in applied work, community actions or prevention programs.

My WHO travelling fellowship to Canada demonstrated that Australia was lagging behind in several areas. The federal government in Canada had direct influence providing funding streams to First Nations programs, which often seemed to be related to its treaty responsibilities. In some early treaties with First

Nations, the government agreed to provide a medicine chest, which in its modern interpretation grew into the principle that it was the federal government that had a prime responsibility to fund Indigenous health. There were no treaties in Australia, and the responsibility for Indigenous health has always been shared, and disputed, with the states and territories. This presents ongoing problems of coordination and arguments over funding. I learned much about these international comparisons from my colleague the late Stephen Kunitz (who was a US based historian of medicine and epidemiologist) who made many visits to Australia to compare the histories of government dealings with Indigenous peoples (such as treaties and federal responsibility), the history and timing of European settlement, and how these factors have far-reaching effects on Indigenous health and wellbeing.

Although being very 'disease-oriented' in their treatment approaches to alcohol dependence and use, the First Nations Canadians were far advanced in their syntheses of traditional healing techniques with aspects of western therapeutic approaches to treatment. In the 1990s there was increasing exchange of First Nations personnel between Canada and Australia, and the Canadians had a strong influence. After visits to Canada by several Aboriginal treatment workers sweat lodges began to spring up in various locations in Australia! It seemed that Indigenous organisations involved in alcohol work were eager to learn from other First Nations substance misuse programs, rather than from mainstream therapeutic approaches.

What has it been like working in this area? What were the key facilitators and challenges?

This was and is a challenging area. In Australia, and I suspect elsewhere, the Indigenous addiction field was and still is beset by debates about the causes of (and therefore the solutions to) substance misuse and the role of colonisation (which began in Australia in 1788), the subsequent dispossession of many Indigenous groups from their traditional lands, and the dismantling of their way of life. Researchers in the Indigenous field often had competing positions on the etiology of drug and alcohol problems. Most of us agreed that the most basic underlying context for present day social problems was the colonisation and dispossession of Australia's First Nations, however I always leaned towards the need to take action on the proximate causes (too many liquor outlets? Not enough support for local social controls? Limited alternative activities and meaningful engagement?).

When I first entered this field, there were very few qualified Indigenous academics holding research positions in tertiary institutions, meaning that it was

acceptable for me as a non-Indigenous person qualified in anthropology and public health, to plunge into the huge, complex, fraught world of research in Indigenous social problems related to substances. On the other hand, there were some innovative interventions beginning to develop at the community level, in which Indigenous community organisations and individuals were trying out different strategies to reduce harm. Into this mix came the Indigenous community-controlled health, legal and treatment services, which grew in size and reach in the late 1980s and 1990s. With funding, these organisations commissioned researchers of their choice for specific enquiries, allowing a more grass-roots perspective to permeate government decisions.

I was fortunate to begin work in the drug and alcohol field at a time when there was growing concern, both at the grassroots and at the level of government, about the huge toll that alcohol misuse was taking on Indigenous Australians. Indigenous leaders spoke out about the shocking health statistics at the UN and at the WGIP. Dr Marcia Langton was one of a few courageous Indigenous leaders who openly confronted the increasing toll of alcohol and the need for Indigenous communities and governments to take action. Today this area is even more challenging because there is now less tolerance of research being done ‘on’ Indigenous and minority groups by non-Indigenous investigators, and there is a welcome emphasis by First Nations health activists on the need for non-Indigenous ‘allies’ to work alongside and in partnership with community organisations and Indigenous research centres. There has been a reaction against research that is said to provide a ‘deficit discourse’, the idea that statistical comparisons between First Nations people and the broader community inevitably present the former as ‘lacking’ or inadequate, rather than taking a ‘strengths-based’ approach. This critique might also apply to research that documents difficult issues such as social unrest, incarceration rates or drug and alcohol problems. Although it was once a useful political strategy to present such comparisons at UN and other international fora, such approaches are now being contested.

Who has been the greatest influence on you, and in what way?

If I have to make such a choice, I guess I would have to say that Robin Room has had the greatest influence on me. I will always appreciate the fact that he saw the value in my qualitative approach to ‘addiction’ research. Not only has Robin injected his fertile sociological imagination to all that he has done he affirmed that it was ok for me to be (what seemed like at times) a lone anthropologist not attached to any of the major drug and alcohol research centres and feeling very much on the periphery of the real action. He gave me

the opportunity to make a contribution. In one of those pivotal moments in life, in 1988 I had been invited to give a paper in Zagreb at the International Union of Anthropological and Ethnographic Sciences (IUAES) meeting (which is held every five years). It was my first major international conference. There, at a session on alcohol and social controls, I met Robin and other key researchers such as Mac Marshall (an anthropologist who had worked in PNG and the Pacific on tobacco and alcohol), Bea Medicine (the first American Indian to receive a PhD in anthropology.), and the Canadian medical anthropologist Jill Torrie. The experience propelled me into applying for a WHO travelling fellowship to further my experience, which took me across Canada visiting Indigenous treatment programs. Robin welcomed me on a visit to the Addiction Research Foundation in Toronto and introduced me to the Sobells – later this contributed to my interest in natural recovery. Robin gave me the impetus to write up and publish what I had been finding in the field, and over the years he has tasked me to write papers that pulled together research in the Indigenous substance abuse area that not only extended the range of my reading but provided me with publications in social science journals such as *Contemporary Drug Problems.* He generously invited me to make a written contribution to the WHO (Europe) *Alcohol Policy and the Public Good II* project, which once more succeeded in broadening my networks; I met key players and expanded my awareness of what was current thinking on alcohol issues.

It was Robin's wide-ranging interest that first alerted me to the 'Gothenburg system' in its Australian manifestation. He had noticed that a rural pub in southern Australia was said to be modelled on the Swedish system, owned and run by a board of local citizens, with profits distributed locally and designed to decrease drunkenness. It had a monopoly on sales in an otherwise 'dry' region. I made a mental note of it. Many years later I realised that similar thinking had inspired some Aboriginal communities to purchase their own licensed hotels, and I embarked on a study (published as a book in 2017) of these Aboriginal community-owned pubs and licensed clubs in rural and remote regions. Since then, I have found a new area of research to pursue: the social history of these community pubs in mainstream Australia. On a road trip across southern Australia, I visited that rural pub that Robin had noticed (said to be the first Gothenburg-style hotel in the British empire), and discovered that it had paved the way for half a dozen other small towns in that State to also buy their licensed hotels; most of them still exist. I published an article on that research as well.

More recently I have become interested in the history of temperance ideas and how they have been mobilised in the Indigenous context. Having witnessed the uprisings against liquor outlets among Aboriginal women during my fieldwork, I

realised there were parallels between their activism and the mainstream temperance movement of the early 20th century. Although the Aboriginal women in the 1980s and 1990s were not directly influenced by women's temperance organisations such as the WCTU, there were surprising similarities in their thinking and strategizing. Once again, Robin's own publications, provocations and insights into the history of alcohol policy, on temperance and community activism, and on the history and possible future role of monopolies, have in turn all stimulated and reinforced my interest in these issues. I can't thank him enough for all of it.

Where do you see field going and where would you like it to go?

I would like to see the like-minded 'community' of international alcohol researchers become tougher on the liquor industry. Industry representatives should not be sitting on government panels working on policies or action plans alongside legitimate alcohol policy and research players. The alcohol industry does not invite independent alcohol researchers into its round table planning sessions on marketing or policy!

In terms of my own area of interest and expertise I believe that we need to be much more vigilant about the activities of the liquor industry and its relationship with the Indigenous sector. In Australia the industry has penetrated the Indigenous domain through its use of sponsorships, donations, promotions, the recruiting of Indigenous figureheads, adding an Indigenous person here and there to its advisory bodies, and by using Indigenous imagery on its products. It is now fashionable, as well as being politically desirable, to have Indigenous or 'tribal' imagery on your wine label, and to acknowledge that your botanical spirits or organic wines have been grown and made on the land of the [Indigenous name] people; some products have been given Aboriginal names. While these acknowledgements by non-Indigenous alcohol producers might appear to be honouring Indigenous cultures, they can also be seen to be a form of appropriation, for purely marketing purposes – designed to appeal to a certain type of customer. Is this 'value-adding'? It is certainly great public relations for the industry, at a time when all things Indigenous are receiving attentive respect. It is up to the next generation of researchers, both Indigenous and not, to be alert to the implications of these activities, and develop new strategies to manage them.

I believe that engaging with the ethnographic method in which longer-term research is undertaken, is the best way to produce nuanced understandings of the contexts behind peoples' struggles with alcohol and other drugs. Epidemiological research, clinical studies, short term survey research that asks

direct questions (I might leave out on-line searches of ‘key words’), all have their place – but they will never pick up on the social meanings of drinking, the cultural barriers to change or action, or conversely the ways in which an understanding of cultural meanings and social organisation can offer avenues for change. For example, WHO has paid attention to alcohol’s ‘harm to others’ in the family and community (not just harm to the alcohol-dependent individual) as a way of reinforcing alcohol controls. As it happens an ethnographic approach reveals that *harm to others* has been the catalyst for action in many regions of Indigenous Australia. This is because it taps into culturally embedded values that reinforce caring for and looking after children and family. For example, local evidence of the extent of FASD affecting dozens of children in one region was enough finally to trigger decisive community action to restrict sales of alcohol, and providing enough of a rationale for such action to defend the proponents of the restrictions from criticism and harassment. A concept such as this, that carries cultural weight and meaning, can be leveraged to support action; you can’t learn about this from a survey. I hope that WHO and the governments and think-tanks engaged in alcohol policy debates and strategies for action will continue to commission and value contributions from the social sciences (particular from sociological and anthropological studies), because these enrich and balance the randomised controlled trials, biomedical studies and cross-cultural surveys that inform their work.