No Wrong Door?
Managing Indigenous homeless clients in Mt Isa.

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Executive Summary

In early August 2003 the Jimaylya Topsy Harry Centre (JTHC) opened as a transitional accommodation centre with managed alcohol consumption for homeless Indigenous clients in the regional city of Mt Isa, North-west Queensland. Since that time there has been no comprehensive evaluation of the Centre although it has been included in a few reviews along with other agencies.

The JTHC is unusual and perhaps unique in that it not only aims to provide crisis accommodation with the longer term goal to facilitate clients through various stages of housing and eventually to stable urban tenancies, but the Centre also incorporates a managed drinking programme for alcoholic clients. Most other homelessness service facilities in Australia today focus on abstinence and short-term crisis accommodation.

This research paper presents the findings of an exploratory investigation of JTHC conducted by the authors during 2011-2012. Our research aimed to provide a detailed description of the Centre and analyse its operational approach within the context of current knowledge about public place dwelling and the culture of Indigenous drinking in the Mt Isa region, and also within the perspectives of other nationally and internationally relevant research.

**Public place dwelling and alcoholism in Mt Isa**

A key point in the paper is that particular local characteristics of the relationship between homelessness, alcoholism and mobility are significant for understanding relevant Indigenous issues in Mt Isa. Whether visiting for short or extended periods, some Indigenous people coming to Mt Isa often choose to sleep rough, whereas most non-Indigenous homeless people will only do so involuntarily. According to local service providers, the number of public place dwellers and drinkers in Mt Isa has generally increased in the last few years for a number of social, economic and cultural reasons. Depending on the individual and their circumstances, the period of planned public place dwelling may extend and become out of their control. Whether suffering from primary, secondary or spiritual homelessness, Indigenous public place dwellers are vulnerable in a number of ways including high-risk drinking behaviours.

Several services in Mt Isa work daily to provide public place dwellers with accommodation but JTHC is the only place with a managed alcohol program that can offer both short and long-term accommodation for alcoholic clients where they are...
supported by a range of health and social services together with education and training programs so that they may progress towards more moderate drinking, stable tenancies and mainstream housing.

**Indigenous styles of drinking**

The paper demonstrates why it is important to understand aspects of cultural difference when considering the behaviour of Indigenous people in crisis. In rural, remote and urban communities some Aboriginal people engage in heavy drinking in culturally distinctive ways. These styles of drinking are documented and are characterised by the propensity for the majority of Aboriginal drinkers to indulge in binge drinking, the preference for drinking with kin, the propensity for demand-sharing and reciprocal shouting, and the expectation that they will not be held accountable for their actions when they are drunk. Despite a range of government policy initiatives over many decades concerning the consumption of alcohol by Aboriginal people, certain aspects of Indigenous styles of drinking persist and are evident in Mt Isa today.

**The Centre and its clients**

With a culturally distinctive approach, the JTHC offers a range of support services which are tailored to a wide range of needs, particularly education, employment and housing. Interviews with staff together with internal reports from JTHC demonstrate the nature and extent of local client need, staff commitment and other agency support within the challenging fields of Indigenous homelessness and substance abuse in this remote region. The current manager has been at the Centre since its inception. His longevity in the position and extensive knowledge as a member of the local Indigenous community combined with a distinctive ‘tough love’ management style when dealing with the clients, contribute to continuing stable operations.

Client numbers fluctuate for a number of predictable reasons throughout the year, e.g. there is a significant increase in numbers around the time of the annual Mt Isa rodeo season. Typically, however, there are about 30 residents each night; some are short-term stayers, some medium stayers and there are some long-term residents. A significant number of clients recycle through the Centre, the river-bed and other centres in Mt Isa. We identify this as an area for much-needed research and evaluation, especially to obtain longitudinal data on client movements.
Service Delivery Analysis

This paper puts forward a preliminary analysis of the Centre’s services based on three core operating principles: harm minimisation, accommodation leading to housing, and cultural maintenance and building of social capital and resilience.

Harm minimisation is contextualised in the comparison between (a) reduction in the supply of alcohol, and (b) reduction in the client’s demand for alcohol, within the field of alcohol rehabilitation. JTHC is significant because it offers the opportunity for both voluntary personal supply reduction and demand reduction, which are not offered in other centres. The JTHC has had many successes in terms of harm minimisation through provision of emergency accommodation and transitional accommodation as well as significant numbers who access services and training. Further success is impeded particularly by the lack of surplus rental housing in Mt Isa and the long waiting times for available tenancies.

During their stay at the Centre, clients have opportunities and challenges to increase their cultural capital and we found that there may be a range of forces operating that deserve further investigation. It seems at this early stage of research that not only are there cultural factors that can both facilitate or inhibit rehabilitation, but also, the very attractive features of the institution itself may create a safe haven for a proportion of clients with complex behavioural problems, and thereby inadvertently contribute to a reduced motivation for change amongst certain of these long-term clients.

The Road Home revisited

In 2008, the Australian Government’s White Paper on homelessness, *The Road Home* identified several priority groups for attention including Indigenous Australians. This report also recognised that the causes of homelessness are multi-dimensional, including substance abuse. Consequentially, the Australian Government’s three strategies to address homelessness set out in *The Road Home* are designed to impact positively on public place dwellers in need of treatment for alcohol abuse. The new whole-of-government approach that targets the causes of homelessness and alcoholism indicates a policy framework that values and necessarily relies on local and community-supported solutions, such as the combined approach of JTHC.

Currently the JTHC opens the right doors for Indigenous people in accommodation crisis in Mt Isa and with appropriate resourcing the Centre can have a stronger future in this significant area of social need. Our analysis revealed opportunities for improved services that require some additional expenditure and also raised more
complex questions around the need and manner of future evaluation of the Centre. It also demonstrated the value of contextualizing and evaluating a service within the local field of service delivery in order to obtain a more holistic and powerful model for explaining the strengths and gaps in urban service delivery. Finally, our findings contribute to the current strategic Mt Isa Homelessness Plan entitled ‘Sheltering the Isa’ which involves a coordinated whole-of-sector approach under the umbrella policy of The Road Home.
1. Introduction

In the context of continuing high levels of homelessness and alcohol abuse within the Indigenous Australian community,\textsuperscript{ii} the Jimaylya Topsy Harry Centre (JTHC) in Mt Isa offers a case study with an unusual and culturally distinctive approach to the complex issues involved in rehabilitation and housing provision within a changing policy environment. JTHC incorporates a managed drinking environment and a range of support services tailored to a wide range of needs, particularly education, employment and housing. Demonstrating a strong cultural focus, the Centre takes its name and inspiration from the Kalkadoon word ‘jimaylya’ meaning ‘pink waterlily’ and the memory of respected elder Topsy Harry, who was one of the oldest Kalkadoon people who had been living in the region prior to when the Centre began in August 2003 (Qld. Department of Communities n.d.).

After setting out the social policy and local cultural contexts, this paper presents a brief description of the Centre’s aims, treatment programmes and outcomes, especially as they compare and contrast to other centres in Mt Isa.\textsuperscript{iii} Interviews with staff together with internal reports from JTHC demonstrate the nature and extent of local client need, staff commitment and other agency support within the challenging fields of Indigenous homelessness and substance abuse in this remote region.

Our discussion also draws on external reviews of the Centre such as Jimaylya Topsy Harry Centre: model of service delivery (Qld. Department of Communities 2006), Mt Isa Community Partnerships Project (Mount Isa Centre for Rural and Remote Health 2006) and the Vulnerability Survey (Qld. Department of Communities 2012). These studies vary in approach and depth but reflect an interest in service integration, identified in the Australian Government’s White Paper, The Road Home that continues today through the whole-of-government policy approach. Also in the evaluations, there is some recognition of the implied contradiction for a rehabilitation centre that allows continued drinking. On the contrary, most other treatment programmes focus on abstinence and short-term crisis accommodation. The JTHC aims to provide crisis accommodation also but has the longer term goal to facilitate clients through various stages of housing and eventually to stable tenancies. As the title No wrong door?\textsuperscript{iv} suggests, this paper seeks to review the Centre’s approach.

From an analytical perspective, the Centre’s approach is characterised by three operating principles: harm minimisation, accommodation leading to housing, and cultural maintenance that includes building of social capital and resilience. Our
preliminary research demonstrates both the innovative and conventional aspects of JTHC’s community-based approach in dealing with a range of Indigenous clients. We argue that JTHC is clearly a good practice case study in effectively implementing these three operational goals with recognisable and realistic outcomes for particular Indigenous clients. However the Centre’s long-term successes are not so clear mainly due to the lack of any systematic longitudinal evaluation study and the difficulties of tracking clients after they leave.

The study raises a critical question of all the homelessness facilities in Mt Isa and elsewhere in Australia regarding the extent to which a proportion of clients can become physically comfortable as well as socially institutionalised in these facilities, losing all motivations to re-enter normal lifestyles, either in Aboriginal communities or mainstream Australian society through regional cities and rural towns.
2. Policies and programs in Mt Isa

Social policy context

Recent research demonstrates that levels of alcoholism and homelessness in Australia are alarming and that Indigenous Australians have been statistically over-represented in both categories for some decades. It is also well known that continued excessive consumption of alcohol can spiral into homelessness. Conversely, it is also acknowledged that extended periods of public place dwelling which typically involve exposure to harmful situations, can be a significant factor inducing alcoholism (Memmott and Chambers 2012:100-101). Despite their connection, however, few intervention programmes specifically target alcoholism and homelessness together, except where the emphasis is on zero-tolerance of alcohol. From the broadly-based community Alcohol Management Plans (AMP) to the more specific overnight sobering-up centres and ‘detox’ centres, most programmes focus on reduced consumption or complete abstinence from alcohol (and other drugs) and outsource accommodation and other support.

During the period from 1985 to 2009, the Australian Government’s primary response to homelessness has been the Supported Accommodation Assistance Program (SAAP) which became Specialist Homelessness Services in 2009. Although these programmes provided and continue to provide significant accommodation assistance, ‘too many’ were leaving SAAP without being housed and instead were moving into boarding houses or sleeping rough again. Indeed many Indigenous rough sleepers apparently did not gain access to SAAP services at all, or if they did, only the overnight accommodation. It was many years after SAAP commenced that the particular nature and extent of Indigenous homelessness or public place dwelling began to be understood more holistically and acknowledged through newly targeted policies (Memmott, Long and Spring 2003).

In January 2008 Prime Minister Kevin Rudd announced a ‘new approach’ to homelessness (agreed by COAG) that required governments at all levels to intervene. In the language of social inclusion the government’s white paper The Road Home sets out the strategies:

1. *Turning off the tap*: the services will intervene early to prevent homelessness
2. *Improving and expanding services*: services will be more connected and responsive to achieve sustainable housing, improve economic and social participation and end homelessness for their clients

3. *Breaking the cycle*: people who become homeless will move quickly through the crisis system to stable housing with the support they need so that homelessness does not recur (Australian Government 2008:v).

Given the Australian Government’s (2008:viii) recognition that causes of homelessness are multi-dimensional including substance abuse, then the Australian Government’s three strategies to address homelessness set out in *The Road Home* are also designed to impact positively on public place dwellers in need of treatment for alcohol abuse. The new whole-of-government approach that targets the causes of homelessness and alcoholism (and acknowledges the links) indicates a policy framework that values and necessarily relies on local and community-supported solutions, such as the combined approach of JTHC.

In 2005, the Queensland Government introduced a policy strategy ‘Responding to Homelessness’ which brought together the previously separate policy areas on Indigenous public intoxication and homelessness with a focus on five “hotspots”, viz. Townsville, Mt Isa, Cairns, Brisbane and the Gold Coast. The first three locations had a specific focus on Indigenous rough sleepers and public intoxication. Although established prior to 2005, the JTHC was consistent with the Queensland Government’s policy directions relating to public intoxication and homelessness.

Following the recommendations of *The Road Home* in 2008, the Australian Government has supported the integration of services for the homeless; the reasoning being that these complex and multifaceted problems are best solved by targeting the root causes or social determinants of the problems. Consistent with these aims, a range of alcohol reforms were introduced in Queensland to restrict or ban drinking within Aboriginal Shires. Many Queensland Indigenous communities continue to have severe alcohol abuse problems, such as Mornington Island and Doomadgee (Queensland Government 2011) and also regional cities such as Mt Isa, Townsville, Cairns; and indeed others all over Australia remain as sites for Indigenous drinking and for associated social problems including homelessness (discussed below). This is the context in which JTHC operates.

In this paper the term ‘public place dweller’ occurs interchangeably with ‘homeless’ although it is important to acknowledge the range of meanings involved. The conventional categories of primary, secondary and tertiary homelessness (now
accepted by policy makers in Australia) were adapted by Memmott et al. (2012a) to include more nuanced categories and some different terminology, such as public place dwellers, at-risk housed and spiritually homeless, with the aim of targeting the needs of Indigenous homeless people more effectively. Overall, the approach fits within a socio-cultural model where policies and solutions focus on social and cultural aspects compared with alternative approaches. For several years now the debate on homelessness nationally and internationally has moved away from an ‘individualist’ approach (focussed on the individual factors such as alcohol dependence) to greater emphasis on structural and social factors or social inclusion models (Greenhalgh et al. 2004:10).

Public place dwelling and alcoholism in Mt Isa
In Australia generally, major cities and regional centres attract Indigenous people despite the lack of accommodation and this also applies to regional Queensland. The particular social and cultural phenomena of Indigenous mobility can account for the visits to Mt Isa by Aboriginal people from a regional catchment of rural towns and discrete remote communities (see Figure 1). The relationship between mobility and homelessness in the region and also alcoholism has particular local characteristics.
Figure 1 Map of the ‘beats’ or circular mobility of the Northwest Queensland/Northern Territory border region people into Mt Isa, and showing the origins of most of the clients at the Jimaylya Topsy Harry Centre. (Source: Long 2005: 359.)
Some Indigenous people in the Mt Isa region are highly mobile, especially at particular times of the year such as mid-August when the annual rodeo is held. Many also visit Mt Isa regularly for a range of reasons, such as health appointments and court appearances as well as recreation and family visits (Memmott et al. 2006). Regular Indigenous visitation to Mt Isa occurs from the discrete remote communities where alcohol is banned (dry communities under an AMP) in North-western Queensland, such as Doomadgee and Gununa (Mornington Island) and from the Georgina, Sandover, Plenty and Barkly regions, such as Alpurrurulam and Bonya; and also from the small rural towns of those regions including Camooweal, Dajarra, Boulia, Burketown, Normanton, Cloncurry (see Figure 1). A minority of homeless Indigenous people visit from the east coast population centres such as Townsville, Palm Island, Rockhampton, Woorabinda, Ingham, Innisfail and Cairns as well as Darwin in the NT.

According to local service providers, the number of public place dwellers and drinkers in Mt Isa has generally increased in the last few years for a number of possible reasons. For example, there has clearly been a drift of people into Mt Isa from ‘dry’ communities. Staff and management at the JTHC report that people come from remote Queensland communities with Alcohol Management Programmes (AMPs) as well as from eastern-central Northern Territory communities on the Sandover and Plenty Rivers catalysed by the NT Intervention. Not only is this a politically controversial topic, the facts are debatable. In the very recent survey that included Jimaylya (viz. Qld. Department of Communities 2012), very few clients gave the AMP in their community as reason for coming to Mt Isa to drink. This of course may be because they did not wish to admit the reason or that it was one of many influencing factors.

Whether visiting for short or extended periods, Indigenous people coming to Mt Isa often choose to sleep rough although some do so involuntarily (Memmott et al 2003:8). Depending on the person and their individual circumstances, the period of public dwelling may extend and be out of the individual’s control. The visitors may initially stay with relatives but if drinking escalates and violence ensues, the drinkers may be evicted and then end up on the streets. Many do choose to stay with relatives until housing can be obtained. If drinking becomes excessive while staying with relatives, the relatives or the government housing officers may evict the visitor who may end up in the riverbed. Alternatively the drinking can de-stabilise tenancies
rendering them ‘at risk’ which may in turn result in loss of tenancy and rough-sleeping for them and their relatives.

Those sleeping rough tend to congregate in or near central service locations for a variety of reasons including ready access to alcohol.\(^4\) Several locations close-by are popular public dwelling places, mostly in the Leichhardt River bed that runs the length of the town. As argued elsewhere (e.g. Memmott et al 2012a), many Indigenous public place dwellers are not homeless (although they may be at risk). In Mt Isa some choose to sleep rough while away from their home community. The fact that their return to their home communities may be delayed by lack of transport and/or lack of financial support, adds further to the risk.

**Indigenous-centred support programmes**

In both regional and urban centres, treatment programmes targeting Indigenous Australians are sometimes short-lived (or fail to operate) due to funding constraints and/or inadequate human resources and often are not closely evaluated. JTHC is managed by the Queensland Government’s Department of Communities and staffed by an Indigenous manager who is employed by that Department. The Centre is unusual in that it is has been operating for nearly nine years operated by Indigenous (mostly) staff in daily contact with people in crisis who are able to access a managed drinking regime.

There is some evidence that the Indigenous community has supported local Indigenous-centred support programmes operating in other places where the people in crisis usually congregate. One such programme, the Toonooba Day Activity Centre operated in Rockhampton in the early 1990s, was managed by an agency of the Anglican Church (Memmott et al 2002). Although the Centre operated for only a few years, it provided a shelter and gathering place with appropriate services for public place dwelling people from Central Queensland Indigenous communities, such as Woorabinda, and the towns of Dingo and Duaringa. Its distinguishing feature compared to most other support centres was that the ‘riverbank drinkers’ could congregate and drink. In addition, people occasionally slept on the site although generally it was not permitted.

Around the same time, a group of Indigenous drinkers in inner Sydney suburb of Redfern followed a similar approach and proposed a Day Activity Centre on the site (Cope St) of their usual drinking area (Memmott et al. 2005). As requested, the Centre would keep people at risk ‘off the streets’ and close to a range of services
including retail, medical, legal and social. Once again the drinkers were intending to continue their risk-taking alcohol consumption albeit in a supported environment. The group that workshopped the idea agreed that a proposal could follow the Toonooba Centre model but evidently the proposal did not progress any further.

While there were many reasons to support the idea of the Redfern Centre, those involved were well aware that this kind of model is vulnerable to criticism for its support of continuing alcohol abuse (and mirrors debates such as the role of needle exchange in treatment of heroine addiction). Many Aboriginal community health services promote abstinence, however, enforced abstinence has not proven to be the most effective treatment strategy for Indigenous people. Without appropriate support after treatment, relapse is common (Alati et al 2003).

In Mt Isa, river bed dwellers (consisting of both primary and secondary homeless people) have had access to supported accommodation of a kind for at least last two decades. In the 1990s, an old hall with a caretaker provided some assistance for otherwise unaccommodated visitors (Durnan 2001). While Durnan’s (2001) study made many recommendations for improved services to campers in Mt Isa, it did not focus on the treatment of alcoholism apart from advocating restrictions on areas of public drinking. Lack of accommodation was the main priority and it is from this background that the JTHC was established, opening on 3rd August 2003.

From the beginning, the Centre aimed to provide appropriate case-management services to Indigenous (as well as non-Indigenous people) who are homeless and in crisis. By also taking on an unusual approach to alcohol consumption the Centre warrants further investigation that potentially has broader applicability. Having set out the broad social policy context and regional background to Indigenous homelessness services, we now explore the underlying causes and problems associated with homelessness of Indigenous people in the Mt Isa region (and relevant across Indigenous Australia), which also encompass the relationship between their homelessness and alcoholism.

Indigenous culture of drinking
Since white settlement in Australia, the availability of alcohol in a range of settings led to an identifiable style of drinking by Aboriginal people that has also been shaped by a range of state and federal government policies. Many observers have described and commented on Aboriginal drinking behaviours in different parts of Australia including Queensland, e.g. Memmott (1991); Martin (1998); Phillips (2003); and,
Brady (2010). On missions in Queensland (during the period up to the 1970s), alcohol was generally not available so when Aboriginal people travelled to places where they could drink, such as the centres of Cairns and Mt Isa, they would typically drink heavily for an extended period. This kind of ‘binge drinking’ remains prevalent in Aboriginal communities.

After the Queensland State Government took over the administration of the mission settlements in Queensland during the 1960s and 1970s, community canteens were established in all but five of these communities (Doomadgee, Woorabinda and three Torres Strait Island communities). Drinking followed local rules regarding quantity and duration which varied between communities, e.g. in some centres people could drink up to a fixed amount (typically six cans) for five or six days per week during a three hour time period.

Various strategies have been implemented to target risky drinking behaviour but the strength of the culture of drinking should not be underestimated. The establishment of Aboriginal licensed social clubs (nine in Queensland until 2008) was motivated by the idea that Aboriginal control and a positive social environment would bring about moderate drinking (Brady 2004:60-61). Overall the evidence is not positive, e.g. in the NT, the Tyeweretye Club established in Alice Springs in 1993 was closed down in 2005 largely because it became a significant on-premise venue for drinking and was supplementing off-premise drinking rather than replacing it (Brady 2010:449). As Brady argues the Aboriginal operated canteens and clubs in communities across Australia fed into the ‘pervasive culture of heavy drinking’.

In rural, remote and urban communities no matter what rules were in place, some Aboriginal people engaged in heavy drinking in culturally distinctive ways. Indigenous styles of drinking were characterised by the propensity for the majority of Aboriginal people to indulge in binge drinking, the preference for drinking with kin, the propensity for demand sharing (Peterson 1993) and reciprocal shouting, and the expectation that they will not be held accountable for their actions while they are drunk (Memmott 1991).

With recognition of this perspective, Aboriginal academic Marcia Langton also showed a clear understanding of Aboriginal alcohol use in the report of the Aboriginal Issues Unit to the Royal Commission into Aboriginal Deaths in Custody (Langton 1990:302). The report argued that: Aboriginal people detained for excessive drunkenness do not have incentive and motivations to occupy themselves in other ways; alcohol is a powerful addictive chemical substance; and, as a group they have
not developed inhibitions and social rules that Anglo-Saxon society expects. These reasons were identifiable in the drinking behaviour of Aboriginal people in North-west Queensland at the time. Memmott (1991) described a number of components to the Aboriginal style of drinking that he observed in the 1970s and 1980s in North-west Queensland and characterised as ‘hotel bar drinking’, ‘outside drinking’, ‘drinking like a ringer’ and ‘private party drinking’.

For decades Indigenous people from communities such as Gununa (Mornington Island) have visited Mt Isa for social reasons, including heavy drinking (Memmott 1979:440; Dalley 2011:173) even though the community had a canteen from 1976 until the time of alcohol restrictions c.2005. A number of bars but particularly the Snakepit and a night club, the Late Night Spot were the popular places for Aboriginal visitors to drink (in the 1970s and 80s) as well as the river bed near the town bridge – all characterised by excessive drinking by Indigenous drinkers. In recent times, the binge-drinking pattern has persisted in many ways, at least in the riverbed. The drinkers have moved further up and down the river bed but old spots are still used, a practice that is also complicated by other risky behaviours, such as other drug-taking.

In places where there was never a liquor outlet, e.g. Doomadgee and Alpurrurulam, drinkers would travel to town centres to purchase alcohol and then retreat to favourite drinking places on the return road to their community, located just outside the community reserve or DOGIT boundary. This provided some benefits for residents in that drinking occurred elsewhere but sometimes the drinkers would return drunk to the community and cause disruption through fighting and/or create risk of road accidents. Such circumstances are ongoing. Even if alcohol is available in the community some choose to travel to drink ‘outside’ with more freedom and less restrictions.

During the period when Aboriginal men were employed as ‘ringers’ (stockmen on cattle stations) in the pastoral industry, they would work and not drink for several weeks and then be paid and have time off. Often as young single men with time and money for drink, they would gravitate to rural towns and to Mt Isa and spend their money on alcohol. Since those times similar behaviour is associated with government pension pay-days.

Private party drinking is one kind of illegal drinking that occurred in people’s houses in a ‘dry’ community when people drank out of sight of the Aboriginal police and/or white staff – a kind of outside drinking. At the time of writing, the penalties for possession of alcohol in a dry community are a significant deterrent. A significant
recent addition to home party drinking styles is the production of ‘home brew’ at Mt Isa and in communities, e.g. at Gunana (Dalley 2010:169).

In general, Aboriginal drinkers in Mt Isa like other Australians now prefer ‘takeaways’ for a variety of reasons including ‘lower prices, easy availability and bulk buying’ but also for other social and cultural reasons (Brady 2010:447). For Aboriginal drinkers, the group of people that they are drinking with is very important and is based on kin relationships. Takeaways allow more effective choice over drinking companions and also the places to drink. Certain orientations from the town in Mt Isa and in the riverbed are associated with people from particular communities and people know where to go to find them (pers.com Manager, JTHC).

Despite all the changes of policy concerning the consumption of alcohol by Aboriginal people, certain features of the above styles persist. In Mt Isa as in other places these are a significant cause of the problems associated with public-place dwelling and alcoholism. The Jimaylya Topsy Harry Centre aims to provide appropriate case-management services to Indigenous and non-Indigenous people who are homeless and in crisis but the Centre follows an unusual approach to alcohol consumption.

In the next section we briefly discuss the ‘logic’ of the Centre: its location, layout and approach, including its aims, programmes, human and physical resources and short, intermediate and long term outcomes. Thereafter follows an examination of the Centre’s role within the group of Mt Isa’s service institutions for Indigenous people with accommodation and addiction needs. The final section of the paper returns to a critical focus on JTHC and its clients.
3. Jimaylya Topsy Harry Centre

Location, layout and approach

As part of the Department of Communities’ Responding to Homelessness initiative (Qld. Department of Communities n.d.), the Jimaylya Topsy Harry Centre received additional funding in 2008 to “assist Aboriginal and Torres Strait Islander people achieve an improved quality of life by providing appropriate shelter and care, using a case management approach that results in a smooth transition to mainstream housing and to the development of skills that will assist them to maintain housing and/or move into employment” (JTHC 2008). For over eight years the Centre has offered a safe place for people who are homeless or in crisis situations to come and seek assistance under intense case management, to obtain help from support agencies and to find temporary accommodation.

JTHC is located on the southern end of town in Mt Isa on a piece of crown land that had been controlled by the Queensland state department responsible for Aboriginal and Islander affairs. Physically the Centre consists of administration and service buildings and several different accommodation facilities (see Figure 2). Apart from the main office and case-worker’s office, there is a kitchen, laundry, large multi-functional room used as a dining room and television lounge for common use. Accommodation is comprised of: outdoor semi-enclosed sleeping shelters; Yudu or single men’s quarters (single rooms); single women’s quarters (dormitory-style sleeping); a three bedroom facility for couples in crisis; and, six two-bedroom houses used by clients transitioning to rental housing. The site offers some space for possible infrastructure expansion.
The Centre operates with six to eight staff at any one time comprising an administration leader, team leaders and support staff. Over the years the Aboriginal manager in conjunction with relevant departmental contacts has developed the policies and procedures which he regularly updates in consultation with other Aboriginal staff. There are also fortnightly client meetings allowing clients to voice concerns or maybe suggestions concerning any aspect of service delivery. The systems of rules ensures that the Centre can operate according to its mission, enabling the clients to be ready each day to attend courses and to access the assistance available including referral to Centrelink and a range of health (especially sobering-up), legal, housing, educational and other services (including shopping). Clients are rostered for daily cleaning of the Centre’s facilities, a non-negotiable responsibility.

Mt Isa Technical and Further Education (TAFE) offers a programme of courses at the Centre on four mornings of the week. Relevant TAFE sessions are compulsory for those on the housing waiting list and the staff sees this aspect as a significant antidote to client boredom. The courses are designed for Indigenous clients and the programme involves three courses, two of which are oriented to tenancy success: (i) Numeracy (including budgeting) and Literacy, (ii) Living Skills (cooking, hygiene and house maintenance) and (iii) Basic Mechanics (strip down and build motors). Despite these programmes the Manager recognizes a need for more demand-driven
programmes to address boredom amongst those clients who remain unemployed, particularly ‘hands on’ (or manually oriented) creative activities, such as furniture making, sewing, leather-craft and small-motor repair.

While in residence, clients purchase their own food and alcohol and although drinking is allowed, it is subject to strict rules of consumption. Alcohol may be consumed on the premises in a prescribed area at prescribed times under management surveillance. Hours of consumption are restricted at certain times to prevent hangovers for those who must attend TAFE courses. Individual clients have limits (set on their consumption based on regular health checks) which reportedly some clients do not like. Unconsumed alcohol is labelled as the owner’s and stored for later consumption. The Centre’s gates are not locked and drinking rules can be worked-around by going off-site (with some consequences).

Enforcing the rules about alcohol consumption at the Centre is one of the main problems. As the Manager explains:

Hardest thing is our clients – their drinking behaviours – they want to go for a ‘reviver’ [drink] in the mornings. They take off, instead of attending TAFE class; go down to the river for an early drink. They stash grog outside the Centre in the riverbed – bury it in the sand. Staff make a reconnaissance trip to the river, plus they see them stagger back later.

Despite the difficulties, however, the mood is positive. As one staff member resolutely stated: ‘Our number one priority is our clients. No good banning them; we must case manage them and try to change their ways slowly.’

Alcohol restrictions are also a problem for the staff in that the majority of clients have a range of health problems. Each client is checked daily and their drinking limits are adjusted accordingly, e.g. no wine, only beer if the client’s blood pressure is high. The staff report confusion and upset as well as frustration in the face of abuse when implementing changes.

Client profile

The current manager who has been at the Centre since it began, offered his extensive knowledge of the kinds of clients as well as details of their circumstances. Most clients are referred to JTHC by the police or ‘Housing’ (formerly the Department of Communities – Housing and Homelessness and now Department of Housing and Public Works) so they can access accommodation and other services. Some are long-term Mt Isa residents and others come from communities in the region to visit family, attend hospital or the courts, whilst yet others are from places well outside the NW Queensland region, such as east coast or NT ‘top end’ communities. Some
records are available at the Centre on the numbers of client admissions and visitors (as shown in Table 1: monthly client numbers for 2009, 2010 and 2011) but little comprehensive recording of other relevant data has been made.

As Table 1 suggests, the number of clients passing though each month varies greatly and there is no indication of whether the same people are returning or how often they return. Although the Centre population fluctuates for seasonal and social reasons, e.g. summer rains and the Mt Isa rodeo, in general there are approximately 30 clients in residence. Length of stay varies from overnight to months and in some cases, years; some clients recycle perhaps a number of times through the Centre from the riverbed where they may have resumed their public drinking lifestyle for a time. Others do not return and a proportion has progressed to a home of their own: a recent report, ‘Homeless to home sweet home’ featured a couple’s move to mainstream social housing tenancy (Qld DOC 2011).

A snapshot of statistics from 30th May 2012 relating to 50 clients from 30th September 2011 illustrates a trend at JTHC: 27 clients had left Jimaylya and 23 were still resident. Of those who left, 2 went to the NT, 2 to the east coast of Queensland, 1 to the Gulf region and 9 left for unknown destinations. 13 clients moved to alternate accommodation in Mt Isa: 6 to other service centres (3 to KASH, 2 to AP, 1 to

![Graph](image-url)
Nawamba)\textsuperscript{xiv} and 7 moved into social housing. Out of the above 27, only 2 had returned to Jimaylya. The significant number of stayers (just under 50%) particularly requires further investigation and foregrounds questions about the appropriate benchmarks for measuring success in a programme that targets homelessness and alcoholism.

Further evidence-based research may be significant for JTHC’s future since its combined approach to Indigenous homelessness and alcoholism presents an holistic or cultural emphasis that is not universally favoured. While some researchers such as Gray et al. (2010) and Taylor, Thompson and Davis (2010) prioritise cultural factors in the treatment of alcoholism, for example, others including many Indigenous organisations favour a more mainstream approach. From within both perspectives the experts decry the lack of evidence based studies to inform Indigenous rehabilitation programmes. More specifically, calls for locally defined and developed Indigenous treatment strategies have joined the discourse e.g. Phillips (2003).

With reference to homelessness, there is increasing evidence that Indigenous people’s experience varies in significant ways from non-indigenous people’s experiences and needs. As Memmott, Birdsell-Jones and Greenop (2012) argue, Aboriginal people’s long history of continuing cultural traditions have sometimes been misunderstood when, for example, rough sleepers in Mt Isa have been categorised as ‘homeless’. While technically they may be without a home, they may actually have other prior needs that go unaddressed (such as health, transport) when categorised as ‘homeless’. Consequently, special services are required outside a mainstream approach. In this context it is important to view the combined group of services in Mt Isa that target Indigenous people’s needs.

Relationships between homeless centres and support services in Mt Isa

The Jimaylya Topsy Harry Centre (JTHC) is only one of three key centres for homeless Indigenous people in Mt Isa, the others being the Arthur Peterson Special Care Centre (APSCC) known as ‘AP’ and the Kalkadoon Aboriginal Sobriety House (KASH)\textsuperscript{xv}. The strong association between public place dwelling and public drunkenness in Mt Isa is well recognised by these agencies and their supporting services and so their programmes primarily target both these areas. For various historical and policy related reasons, each centre has a different approach and mode of operation. The
following discussion compares and contrasts the centres in brief, relying on the management and staff perspectives on their own centre as well as on their counterparts in service of the homeless. Apart from JTHC, further in-depth exploration of the individual centres is outside the scope of this study.

Similarities between the centres revolve around their goals to assist Indigenous people in crisis, especially those who are homeless and suffering from substance abuse although service emphasis varies. All three centres have some impact in alleviating the effects of living in a public place, especially in the riverbed which is recognised as an unsafe environment.

Although servicing the North-west Queensland region, all centres have had clients from much further afield in the NT and Queensland at times. Given that Indigenous community connections are not influenced by state borders, clients come from home communities in the NT, such as Alpurrurulam, Bonya and other places in the Barkly area. At the time of writing, however KASH has referrals mainly from the lower Gulf communities of Doomadgee, Gununa and Normanton.

JTHC, AP and KASH all liaise with other services including Alcohol, Tobacco and Other Drugs Services (ATODS), Homeless Help Outreach Team (HHOT), Riverbed Action Group Outreach and Support Services (RAGOSS), Mt Isa Community Mental Health Services and Mt Isa Sexual Health Services (where clients have access to professional counsellors, such as social workers, psychologists) and also to income and job agencies, such as Centrelink and Job Services Australia. The Queensland Department of Housing, the Queensland Police Service, Queensland Legal Aid, Queensland Transport and the Queensland Ambulance Service are also effective support agencies.

Differences between the centres exist primarily in their approach to drinking behaviour which reflects the preferences and needs of particular clients who choose to attend and who are referred to each centre but also in the type of accommodation offered. Although both JTHC and KASH offer accommodation, JTHC allows alcohol whereas KASH does not allow drinking on the premises and its clients practise genuine abstinence. On the other hand, AP is not strictly focussed on abstinence although it does not allow alcohol. It is an over-night facility where people leave after breakfast and most clients resume public-place dwelling and drinking for the day and return to AP at night. So in effect, these clients are not actually abstinent. It is also relevant that both JTHC and AP are ‘in town’ and relatively close to bars and liquor
outlets whereas KASH is ‘out of town’ and people are relatively removed from the supply.

Another dimension of difference between the three facilities is client costs. At JTHC clients must pay for their own food and their alcohol; also there is an accommodation charge for the Wuliberri houses where people live in the final phase before moving to outside tenancy in mainstream social housing. By contrast, accommodation and food are free at AP. There are some rules (evening showering is compulsory before the meal and clients are provided with clean pyjamas for the night while staff wash the clients’ clothes) but with next to no expenses at AP, there is ample money retained for daily alcohol. Also at AP there appears to be a stronger and clearer division between clients and staff whereby clients may react against the perceived hierarchy by abusing staff, perhaps resenting a lack of engagement in their own care (pers. comm. recent Staff Manager to P.M.). At JTHC the staff–client relationship is reportedly more congenial; a possible reason is that clients have more independence in their day-to-day living and also hold a stake in the management of the centre in that they manage their own alcohol consumption and participate in regular management feedback and meetings.

The following diagram (see Figure 3) represents the typical movements of clients between services in Mt Isa. While the diagram illustrates the usual pathways of clients to and from JTHC, it does not purport to describe the dynamics that operate (e.g. bottleneck in moving to appropriate housing) and the varying forces that impact on clients. Using an example, it is easy to follow a typical pathway: an Indigenous visitor with limited resources comes to Mt Isa primarily for medical or court reasons and stays with relatives in a rental house in town. He remains for a few nights waiting for a lift back to his home community but meets up with ‘countrymen’; someone shouts a carton or a flagon and he starts drinking and then ends up in the river bed. As a result he joins with others who shelter overnight at AP. With no money for a taxi to get to the airport, he misses the plane home. Afterwards, the person is likely to be invited to re-join the drinking group and another countryman’s ‘shout’! If his drinking behaviour becomes more entrenched then he may be referred to JTHC. Many factors will determine his length of stay, return to the riverbed or progress to housing.
All centres aim for minimum stays in an effort to move people into housing. There is a ‘bottleneck’ however because of lack of housing at each stage. Waiting lists have been operating for decades. Where some clients should be staying for short (2 weeks maximum), some stay for medium periods (c. 3–6months) but many are staying longer. These circumstances do not apply to AP. People seldom go from AP into housing but must go to JTHC first and study the approved TAFE courses.

Problems do not necessarily end when housing is obtained. A major difficulty experienced by Indigenous tenants is in holding onto the tenancy when relatives come to stay which is especially a problem if the visitors are drinkers. Householders cannot deny accommodation to these visitors because of strong traditional values.
around responsibilities to extended family. As different people in the region have said:

They come and go, I can’t say anything [meaning can’t refuse]. Stay for 1 or 2 weeks then go home;

Murri people don’t care about how many people all living under one roof. Let 3 carloads stay – didn’t worry anyone. Nobody got upset. They slept anywhere;

Never got stressed out by visitors. Being an Aboriginal person it’s a normal state of life. Never want to turn family away, one day you might need them ... We’re good hearted people – we like to share (Memmott et al 2012b).

Nevertheless, many of those responsible for a house do not like it when drinking and fighting occur. For the visitors who are rejected from houses as non-complying kinsmen there are few options other than JTHC or a return to public place dwelling and then to JTHC or AP. The Jimaylya Centre recognises that a major problem is how to break this cycle and generate lifestyle practices that are conducive to stable tenancies.

The ‘recycling’ phenomenon is demonstrated by clients (evident in the diagram) who leave JTHC and either go to AP where they can drink more freely during the day and then return in the evening to AP for accommodation, or return to the river bed. Two-thirds of AP clients have recycled through the river bed and back to AP on a daily basis (according to a recent AP manager). At the time of writing, however, rough sleepers were not sleeping in the riverbed overnight. The reason for this may in part relate to the vigilance of the Police Liaison Officers and the HHOT (Outreach Team) that keep watch on public drinking places but may also relate to the entrenched culture of drinking by Aboriginal people in Mt Isa. The drinkers’ motivation to move through the centres and public places is based not only on the opportunities to consume the quantity of alcohol that they wish but also to have control over the time of day that they drink and their choice of drinking companions and drinking style.

The drinkers having developed a daily strategy for drinking and support are certainly not without risk. At AP, clients must leave to drink but they have ‘everything they need to sustain a drinking lifestyle’ including free meals and bed, easy access to ATMs, Centrelink and access to a hotel for takeaway liquor (pers. comm. to PM, Manager AP and JTHC). Unlike at JTHC, they engage in regular (if not daily) binge drinking in the riverbed which can result in them passing out unconscious thus rendering them vulnerable to assault, robbery, exposure to weather, untreated health problems and even homicide.
Unfortunately when a proportion of clients leave JTHC they recommence binge drinking and sooner or later they need support so return. Repeating clients do not want to go to JTHC because they are not free to drink anytime or to excess. Instead they prefer to dry out at AP and then re-enter the fray. This results in a significant category of clients who remain in AP for many years leading this lifestyle. These circular flows are shown in the diagram above.

As staff have stated, clients often have a complex range of problems and the Jimaylya Centre and support agencies do not achieve much beyond limited primary health care. While many mental and social problems remain untouched, there are underlying issues which may contribute to ‘spiritual homelessness’. The River Bed Action Group (RAGOSS) are overwhelmed with primary health needs and typically no mental health services are provided by this service either. At least if these drinkers are willing to go to JTHC, then many more services are available to them.

In summary, the JTHC has many strengths and challenges that relate to the individual client, their family, the system (especially local services) and the overall organisation and management of the Centre. None of these have been systematically documented. A comprehensive evaluation could comment on the programmes at the Centre in terms of outcomes that relate to its aims. Despite the lack of such an evaluation we can still comment on the broad trends that appear to be operating and the apparent gaps in service delivery.

From the preliminary investigations done for this paper we have learnt that individual clients can make certain progress towards rehabilitation and the Centre works well in many ways (Memmott and Nash 2012). For the short, medium and long-term stayers there is quite a range of expectations and need. In the short and medium terms, success should continue to focus on the practical aspects of shelter and reduced risks in terms of drinking behaviour and therefore general safety. For many this could be achieved by facilitated return to their home communities. In the medium term and long-terms, clients take-up of training opportunities will be significant for setting themselves on a path to successful housing, albeit made more difficult if suitable housing is not available.

From the staff point of view, there are many challenges. During the everyday operations of earlier years at JTHC, there have been instances where upset and violence from clients has led to staff resignation and client referral to other agencies. The management has been able to resolve the problems through appropriate and
effective training and other internal mechanisms that promote communication between staff and clients.

JTHC is locally seen as the place for Indigenous people with an alcohol problem to go especially if they prefer to continue drinking. Other centres also refer clients on to JTHC if they are not complying easily with the abstinence rule. In the following section we look more closely at the Centre’s overall approach to understand how the individual client negotiates his/her relationship with other clients and the Centre itself.
4. Three operating principles at JTHC

JTHC’s operational model and philosophy fit within current government policies but the Centre also maintains an Indigenous cultural focus that is significant for the Mt Isa region. Indigenous people comprise 16.6% of the Mt Isa population according to the 2006 Census (or 3,267 people in a total city population of 19,660).

Our research (including the internal government reports on JTHC, the Centre’s records and also interviews with staff) leads to a preliminary analysis of the Centre’s services situated within the literature on Indigenous homelessness and alcoholism. This discussion is limited by the lack of detailed information about programme and performance indicators that a more comprehensive evaluation could provide. Nevertheless, it is clear that the services at JTHC are based on three core principles that will be considered in turn:

1. Harm minimisation,
2. Accommodation leading to housing, and
3. Cultural maintenance and the building of social capital and resilience.

Harm minimisation

Despite the lack of both quantitative and qualitative studies on Indigenous alcoholism and public place dwelling nationally, the literature does contain significant evidence of strategies that work, although to varying extents and in different ways.

In 1985 the National Campaign Against Drug Abuse (NCADA) established harm minimisation as the main approach (Brady 2007:760) to treat substance abuse including alcoholism. Since then harm minimisation has been the most favoured government strategy in the treatment of ATOD abuse. Strategies to eliminate excessive alcohol intake also include reduction of supply and demand. Abstinence (or total reduction of demand) continues to be the method that many Indigenous-run centres support for reasons described below. While there is evidence for positive and negative impacts of both supply reduction and demand reduction strategies, it appears that success may be locally based.

Supply reduction

In 2000 Gray et al. (2000:11) tentatively suggested that ‘supply reduction intervention may be effective’ in the treatment of alcohol abuse by Indigenous Australians. In 2002 the Queensland Government initiated a policy, Meeting Challenges, Meeting Choices (MCMC) which aimed to tackle a range of issues for remote Indigenous
communities including alcohol, substance abuse and rehabilitation (Queensland Government 2002). These reforms included alcohol supply reduction programs which after reports of success were introduced again in 2008. The programs achieved a significant reduction in serious injury and hospital admissions in the 2 years after their introduction in four Cape York communities where excessive alcoholism was related to serious physical injury from assault. Despite some increases in reported serious injury following the initial decrease, an evaluation of the overall programs (from 1996-2010) in terms of rates of serious injury showed that ‘the absolute and the proportional rates of serious injury retrievals fell significantly as government restrictions on legal access to alcohol increased; they are now at their lowest recorded level in 15 years’ (Margolis et al 2012: 503). Other evidence suggests, however, that supply reduction or restricted access may not have been widely successful in terms of reducing addiction in communities where heavy drinking is endemic, as drinkers can go elsewhere or produce their own supplies (as discussed below).

The shift by governments towards prohibition (d’Abbs 2011) is based on legislation which has been passed in different states to create ‘dry’ areas. Alcohol Management Plans (AMP) have been adopted by several central-eastern NT communities, relevant to the study region, viz. Alpurrurulam (Lake Nash), Ampilatwatja (Amaroo) and Owairtilla (Canteen Creek) are ‘dry’ communities. In North-west Queensland, as noted above, the State Government instituted alcohol reforms during July 2008 and has encouraged communities to go ‘dry’. Some communities have ‘alcohol limits’ but the rules vary between jurisdictions including those relevant to Mt Isa. The most notable large discrete settlements that had a dry policy at the time of writing in accordance with State and imposed Alcohol Management Plans were Gununa (Mornington Island) and Doomadgee.

No systematic study has been carried out on the displacement impact of AMPs in North-west Queensland, neither in terms of short term recreational visits to rural towns for drinking sprees nor as longer term migrations. Anecdotal evidence on this phenomenon over recent years has been mounting, albeit equivocal. Whatever the case, Doomadgee and Gununa families figure prominently in Aboriginal drinking circles in Mt Isa.

Although banned in most communities, availability of ‘home brew’ kits in local community stores can be a significant supply problem. The practice of illegal home-brewing of beer at Gununa highlights an underexplored area of alcohol-related health
risks. It is understood that when this kind of substance, i.e. beer is consumed prematurely in the brewing process, the drinkers can sustain long-term kidney damage due to excessive sugar consumption (pers.comm. Phil Venables, Qld Attorney-General’s Dept.)

So supply reduction may not be enough (Hudson 2011), especially when the client has not been offered a treatment plan that addresses the nature and causes of their addiction. According to Gray and Wilkes (2011), both supply and demand reduction need to be addressed and therefore they advocate training, consistent with the philosophy of JTHC.

**Demand reduction**

For Indigenous groups in Australia (and also US, Canada and New Zealand), educational programmes about the effects of risky alcohol behaviours together with life skills programmes including a focus on cultural affirmation have been widespread, although few evaluations have been conducted to establish the effects on demand (Gray and Saggers 2005:387). The brief intervention model where clients are counselled in a targeted way during the initial days of their treatment about the health risks also has had some strong advocates in Australia (Brady et al. 2002). The main type of demand reduction programme in treatment centres, however, is based on the Alcoholics Anonymous (AA) approach known also as ‘Twelve Steps’ with some adaptation. On initial consideration, JTHC programmes may appear to be in opposition to AA, since AA is fundamentally against continued consumption of alcohol within their treatment programmes. Further investigation however suggests that a more complex set of forces is operating in this ‘wet’ centre.

The other centres, AP and KASH, enforce an abstinence rule but generally are unable to follow through with supporting social mechanisms that an AA programme would entail. Most of the staff are aware that their time and resources as well as that of the support services are mostly consumed by primary health care needs. Moreover client recycling would confirm this overall view. KASH’s involvement of client families outside the centre is definitely a positive step in rehabilitation, although often the families are part of the same Indigenous drinking culture in Mt Isa (described above).

JTHC’s approach to supply and demand reduction has a slightly different profile. When viewed in the light of the AA’s successful mechanisms, this Centre potentially has another pathway to improved or at least the maintenance of less risky alcohol
behaviours; although further research and evaluation is necessary before any definite conclusions can be made in this area. Meanwhile, JTHC’s managed transition to housing requires reformed drinking behaviours that are reinforced by educational and other support. Most importantly in the context of the AA study where drinkers take control over their behaviour and choose not to drink, the drinkers also have opportunity for input and choice within the managed drinking regime.

Managed drinking at JTHC has the following features that combine in a unique way to produce supply and demand reduction effects:

- Restricted hours for drinking results in reduced consumption
- Clients ‘in charge of’ their own demand (over-ruled by health condition)
- Alcohol supply limited (in type and quantity);
- Consumption monitored
- Alcohol supply locked away out of drinking hours; and
- Clients engaged in the decision-making about rules for drinking

In this scenario, clients are generally safe, can continue drinking and can access many kinds of support. Set hours and restricted supply for drinking necessarily result in reduced consumption for those habitually heavy drinkers. And although the clients can decide the overall rules and how much they drink each session, their behaviour is constantly monitored. Inappropriate risk behaviour results in immediate termination of drinking and penalties imposed by the Manager. Two members of staff are stationed nearby during the sessions. Despite the surveillance, the system seems to empower the clients who exert peer-group control to prevent deviancy knowing that anti-social behaviour by one may result in penalties for all. It is our contention that the dynamics of the drinking group indicate not only the reason for some clients preferring JTHC but also point to the significance of supportive social networks especially within the Centre.

Outside the Centre, clients may recommence risky drinking behaviour when they reconnect with kin or countrymen who are heavy drinkers. Alternatively they may stay with kin who are light or non-drinkers and thus sustain their more moderate drinking style. Unfortunately in all of these contexts, any support for reduced or managed consumption is not guaranteed. But clients can return to the Centre at any time and their role as socially significant members within the Centre is supported.
Despite indicating some failure of the treatment process, recidivism within the Centre is preferable to a return to public-place dwelling and binge drinking in Mt Isa. River-bed drinkers are likely to become excessively intoxicated, sleep in river-bed settings, be assaulted, raped or robbed and suffer extreme weather conditions (rain, heat, cold) when sleeping, all of which are adverse for their health, both mental and physical.

In the remote regions of Australia supply reduction is aimed at communities as a whole but this is not feasible in a large regional city, such as Mt Isa. So the value and significance of the Jimaylya model lies in voluntary personal supply and demand reduction, i.e. making the choice to change personal consumption habits. It also lies in its capacity to be replicated and adapted in the future to the other rural and remote regional cities in Australia that have been identified as experiencing forms of Indigenous homelessness. (See Figure 4)

**Figure 4** Map of known centres of Indigenous homelessness based on literature analysis and other anecdotal sources. (Source: Memmott, Greenop et al 2012: 10)
Accommodation leading to housing

Unlike most alcohol treatment centres, JTHC is residential. Not only does it offer clients accommodation for short, medium and longer terms but one of the Centre’s main goals is to progress people to permanent housing outside the Centre. Indigenous people generally have favoured residential rehabilitation programmes (Brady 2002:7+) because of the recognised social pressures that operate on drinkers.

At Jimaylya, treatment is phased together with the stages of housing. Once the needs of the client are assessed on entry to the Centre, a programme of services and treatment follows (as described above). Some debate has emerged over the relative priority of housing or treatment for the homeless substance abuser. Both approaches have their advocates.

In a ‘treatment first’ scenario, the client is encouraged or most frequently required to practise abstinence or at least reduce their level of alcohol consumption (Johnson et al 2012:4). The tension in the debate comes from assessment of the costs and benefits of prioritising one over the other. Clearly when a recurring alcoholic client is housed, the person is in danger of losing the house for a variety of reasons. For example, visiting relatives may engage in rowdy drinking sprees possibly with some violence attracting neighbours’ complaints to police and ultimately the government housing office. After several warnings for this kind of behaviour, tenants are often evicted. Loss of a house is a serious set-back in their rehabilitation programme.

Similarly, a state of continuing homelessness for a reforming alcoholic may be a factor inducing low motivation and a poor response to treatment. Surveying various programmes in both the provinces and major cities of Canada, Leach (2010:13) concluded that ‘housing first appears to be the most effective model for breaking the cycle of Aboriginal homelessness’ in that country. With many similar social conditions in Australia, the same may prove to be true here. Already in Australia ‘a number of studies now suggest that homelessness induces drug use’ (Johnson et al. 2011). The extent to which this applies to alcoholism in regional and remote Australia requires further investigation. In Mt Isa, public place dwelling leads to binge drinking due to the culture of drinking. Furthermore, reciprocated ‘shouts’, the ‘captain’ syndrome\textsuperscript{\textsuperscript{xix}} and possibly other risky behaviours\textsuperscript{xx} can result in daily binge drinking (particularly for the residents of the Arthur Peterson Centre). JTHC attempts to reverse this pattern.
Cultural maintenance and building social capital

After talks with the manager and staff at JTHC, it became clear that aspects of the clients’ indigeneity and their life experiences as Indigenous people impact heavily on their circumstances of homelessness and substance abuse, especially alcoholism. While indigenous styles of interaction (including pressure from kinsmen) can maintain and worsen drinking behaviours, they are also potentially a source of social strength for the client and their family. That strong social relationships through extended family connections are highly significant for Indigenous people’s well-being and cultural identity is well-documented for Indigenous people all over Australia, including North-west Queensland, e.g. Trigger (1992); Memmott (1996) and Dalley (2012).

As discussed above, most alcohol treatment programmes in Australia including Indigenous programmes are based on abstinence, and follow the Twelve Steps model (or an adaptation of it) developed by Alcoholics Anonymous, e.g. ‘No one size fits all’ (Australian Government 2007); and this has been the case for decades (Brady 1995). Apart from the obvious benefits of abstinence, there has been relatively little understanding about the critical components of the AA programme or how the AA method works especially long term. At The Center for Addiction Medicine in Boston, researchers have recently made two very significant findings: that the most consistent pathways for recovery are ‘through mobilising adaptive changes in the social networks of the attendees and enhancing socially relevant abstinence self-efficacy’ (Kelly et al. 2012: 297). This suggests that successful participants will have established sustainable groups of friends, relatives and supporters who are non-drinkers and that the participants will feel strong, proud and happy to identify with and belong to these groups, all indicative of real life changes. So although an important goal is to attain total abstinence, strengthened social support is given primacy together with the compassionate spiritual framework of AA.

So what aspects (if any) of AA are present in JTHC? What does this research offer to treatment of Indigenous alcoholics? JTHC drinking style is characterised by small group harmony, drinking in relative moderation, reciprocated shouting, and group control of internal (Centre) behaviour (supplemented by ultimate Centre control if the internal control breaks down). Compliance with Centre ‘rules’ is achieved because of the negative consequences of excessive behaviour (i.e. loss of privileges), weekly practice at reduced drinking intensity for many involved in the TAFE programmes, and regular health checks and imposed limits if a client’s health problem is known.
Even though it is not run on AA lines, managed drinking at JTHC appears to actually incorporate some significant aspects in common with the AA approach. It is possible to view the programmes in terms of potential opportunities and threats to building ‘social capital’ (Putnam 2000) and resilience for various client profiles. An investigation with this focus can identify areas where additional support would be beneficial. It may be significant to consider the extent to which short term/medium/long-term stayers can benefit from and build resilience when they are allowed controlled drinking and also able to access to kin outside. Furthermore the length of stay may significantly impact on programme success influencing the level of skills acquired and thereby readiness for the next phase of housing.

Controlled drinking regimes in Australia have been promoted because of the positive effects including increased levels of social and cultural appropriateness as well as the expectation of reduced consumption or modified drinking behaviour (Brady 2010). With similar positive aims, the managed drinking regime within JTHC (discussed so far) offers a safe and supported environment for clients with the ultimate aim of client independence.

However despite this formula achieving a certain level of success, the presence of some long-term clients at JTHC suggests that the system may be failing for one sub-category of clients because either or both of the two main problems – alcoholism and housing – are not being resolved. As Brady (2002) alerted, rehabilitation centres that are isolated from mainstream therapeutic practice, as those in Mt Isa are, may not be offering effective programs such as counselling and advice on addiction and employment but instead are merely providing care and rest. Closer examination of the various client profiles at JTHC however suggests that there are many factors involved, some not specifically related to drinking or homelessness but instead possibly related to the institutional setting and the psychological profiles of the clients.

There may be structural problems in that the institution itself is inadvertently facilitating a third preferred lifestyle option for some of its clients. As opposed to public place dwelling and rental house dwelling a third option is simply remaining in the JTHC. As indicated by the snapshot on 31st May 2012 of clients from 30th September 2011 (see earlier), the retention rate can be almost 50%. (It should be noted also that the eight months period represented a different proportion of each client’s stay – some had been there considerably longer.) So for some residents it can be said that rather than acting as an agency of change with a goal of passing
through JTHC, the Centre can become a venue of lifestyle stability where those residents are able to enjoy the balance of drinking and safety after several unsuccessful attempts at passing through.

If this is the case, then why is this category of long-term clients failing to normalize within the wider Mt Isa urban environment? Is it indeed because of a lack of supportive social kin who will encourage a drinking culture of moderation or, returning to the categories of Indigenous homelessness outlined earlier, is there a case of spiritual homelessness occurring which remains undiagnosed and untreated?

Appendix 1 presents a table of Client Categories which illustrates the actual and potential strategies for building social capital and resilience. There are short, medium and long-term categories each with defining characteristics in relation to consumption of alcohol and motivation for housing. The table then links the length of stay to both opportunities for building social capital and resilience, and the threats that mitigate against them.

**Long-term clients** have different institutional experience from short and medium term clients. Long termers tend to be heavy drinkers who are not looking for permanent housing (even if they were when they first arrived), so it is comfortable for them to come and go (c.20 clients for 8 years), using the Centre for periodic slowing down or stabilizing (relatively) as they need to. These clients may have an enhanced status or role in the Centre which allows them to influence conditions for their own advantage. When inside they may act as opinion leaders in adapting the rules through the Centre’s clients meetings, including with respect to drinking, and so if this is important to them, then it is in their interests to stay even longer. While remaining as clients they can maintain links with friends and family outside – sometimes returning to abusive or at least risky drinking behaviour which may lead them back to Centre. Although family and friends can visit JTHC, no children are allowed. Consequently clients need to leave to access their full social network. So although long-term drinkers may have built their resilience and social capital inside the Centre it is not clear that it is transferable to the ‘outside’ and to their overall rehabilitation. An ongoing goal for research and Centre evaluation is to determine the nature and extent of outside barriers.

**Short-term or crisis clients** who are drinkers may not like the ‘rules’ (as developed by the longer term clients). However they can go ‘outside’ to drink which may lead to more moderate drinking than before, for example, in town hotels or if they link up with family/friends who are moderate or non-drinkers. Or the result may be a return to the
riverbed which may in turn lead to them recycling through the AP Centre and back to Jimaylyya. It may be that some of the short-term stayers are not benefitting from the services as much as they could and do not stay because they are not as comfortable (as the long-stayers). The short-termers do not have the social capital within the Centre to readily change things.

Interestingly, there are parallel findings for homeless clients in New York. Using a different categorisation of clients from the ‘common-sense view’ based on length of stay, Emirbayer and Williams (2005) applied Bourdieu’s notion of ‘the game’ to illuminate how things worked for the clients of a homeless shelter in New York. The ‘players’ received services depending on how they behaved in terms of the shelter hierarchy and in relation to other clients. Those clients who were most successful in accessing services (e.g. housing) were those who understood the system best. Some progressed through the system by receiving preferential treatment from staff (staff-sanctioned capital) and others were facilitated because staff recognised their influence with other clients (client-sanctioned capital) and their disruptive potential.

At JTHC, the clients with the most social capital in terms of progress towards rehabilitation and/or housing do not correspond to length of stay. Inside the Centre the most dominant clients (those with the most social capital) are heavy drinkers, as reported by staff. To extend the analogy between the New York centre and JTHC would require at least more data from the clients themselves which we acknowledge is missing at this stage of the research. Nevertheless, interesting initial comparisons can be made.

Initially it may seem like a severe indictment of the programme where these individuals achieve neither permanently reformed drinking nor integration into housing and where continued drinking is not necessarily a disadvantage. In fact, passage through the stages of housing is influenced by other factors, such as lack of available housing in Mt Isa due to an acute housing shortage. By taking a more nuanced approach as suggested by the New York study we may explore how the different client groups negotiate their roles and status within the Centre. Despite the structural parallel with the New York case study, cultural considerations are nevertheless salient for understanding how particular clients at JTHC engage with the service delivery system.
5. Discussion on JTHC’s service delivery approach

The argument for managed drinking and the modification of drinking behaviours is offered on the basis of cultural appropriateness and counter to the argument for abstinence. There has been a history of attempts at cultural appropriateness in Indigenous alcohol treatment in North America that influenced Australian practices (Brady 1995) and various aspects of Indigenous knowledge and worldview continue to be incorporated into Indigenous rehabilitation programmes. In a similar way JTHC has incorporated a broad range of educational, health-related and recreational activities with cultural content to strengthen their clients’ self-efficacy as Indigenous people who may feel oppressed and disconnected from life due to the long-term effects of colonising forces. For example, clients are taken onto Country and able to participate in traditionally based subsistence activities, such as fishing.\textsuperscript{XIV}

As the literature suggests, multiple strategies are required (Margolis 2011:506; d’Abbs 2011) including a localised approach. In the study area, there are distinctive Indigenous cultural and behavioural patterns which need to be taken into consideration, such as high regional circular mobility (Memmott et al 2006); maintenance of cultural identity systems manifested through kinship and in residential groupings (socio-spatial behaviours) (Memmott 1983; Memmott et al 2012b); large household formation structures transforming into crowding caused by the common practice of accommodating relatives and countrymen (Memmott et al 2012b); and, socialising in extended family groups that leads to drinking and fighting (Durnan 2001), especially in the case of JTHC clients. The layout and functioning of the Centre intentionally reflects local Indigenous cultural norms and protocols, e.g. common areas for cooking, eating and socialising are focussed on the outdoors particularly through the use of hearth areas and open shelters. Other cultural protocols are evident in the gendered social spaces; and also the ‘smoking’ of deceased clients’ accommodation. The Centre also employs Indigenous staff who have been under the leadership of the same Aboriginal Manager since its establishment.

The success that Jimaylya has had in assisting and rehabilitating Indigenous alcoholics may be attributable to a range of factors contained within their methods – both formalised, as in access to services, as well as the effects of less tangible and more qualitative factors, such as the dignity that comes from cultural affirmation in an
openly Indigenous-centred place, and the ‘tough love’ style of administering the Centre rules by the Manager. Although the Centre does not formally focus on emotional and spiritual well-being, the staff and management share an holistic approach to health that is supported by Indigenous health authorities.

Some Indigenous clients in other alcohol rehabilitation programmes have had success through a certain spiritual awakening that cannot be discounted. For example, the Milliya Rumurra alcohol rehabilitation centre near Broome in Western Australia which began in 1978 primarily for Indigenous clients adapted the AA programme to focus more on their individual and social and educational needs, including a spiritual aspect ‘which some clients appreciate (Ikin 1999:12). In some Queensland communities, Red Dust Healing, an Indigenous-led programme which promotes self-efficacy through spiritual and cultural affirmation as well other methods, is getting ‘good results’ particularly for Indigenous men (pers comm. to DN, Randal Ross 15/4/2012). No equivalent programme has yet been tried at Jimaylya, but there is a suggestion to do so and some support for it.

The success of the transition to rental housing service is measured anecdotally by the fact that ‘only one couple came back’. After admission, the process for homeless clients who may be sleeping rough (or faced with that prospect) is from crisis accommodation, to singles accommodation, to accommodation in a Jimaylya house and then to a public rental house in Mt Isa – the pathway out. The Centre management is realistic about clients’ successes in terms of the pathway i.e. modification of consumption and the end goal of no drinking or controlled drinking. It remains to be objectively established whether the Centre owes its stability and successes primarily to its programmes or more specifically to the long-term commitment and administrative style of the Indigenous founding Manager and his key support staff who continue their roles.

There is a history of policy failure by Australian governments in facilitating good advice and service delivery for alcohol treatment and housing. Referring to alcohol policy, Brady (2007) listed three main barriers to good policy advice: structural barriers with government; ideological and conceptual barriers in Indigenous organisations; and, accommodating Indigenous cultural differences. At the programme level, Indigenous alcohol treatment programmes have often been criticised for insularity, especially for not making optimal use of local services, and for the lack of evaluation or regular and comprehensive review. There may be lots of anecdotal reporting of successes and failures but there is little evidence-based
reporting. This lack is not only detrimental to applications for funding but can be a barrier to greater effectiveness.

To best secure its future and its potential for reproduction elsewhere, the JTHC needs to have a comprehensive evaluation, even though the process has both positive and negative considerations. Cunneen’s (2006:339) comments on Indigenous community approaches to justice are relevant to an assessment of Jimaylya’s approach to alcoholism and homelessness:

... Indigenous community initiatives providing both community capacity building and localised responses ... will never be evaluated to the statistical standards of a government-funded research body. Indeed in many cases their annual operating budgets are significantly less than the cost of a professional evaluation. More importantly, it may be that the strength of community-based programmes is their localised role in social networks and their capacity to operate in the margins of state regulation and control.

Similarly for Indigenous housing policy, Milligan et al (2011) identified bureaucracy as a reason for lack of service but found that individual and systemic racism as well as inadequate resources and investment were the other inhibiting factors. When viewed together, it would seem difficult for any Indigenous organisation to be able to deliver in one, let alone both areas of need. As a ‘bottom up’ organisation focussed on service delivery with a modest operating structure, Jimaylya has bypassed some of the problems and negotiated through the barriers that a larger organisation might face and has been able to deliver a locally focussed set of impressive programmes with the support of numerous local agencies.
6. Summary and conclusion

For several decades, Indigenous housing and homelessness, alcoholism and education have all been subject to complex and changing government policies and programmes which have been rarely drawn together in a single site. This paper presents a preliminary case study of the Jimaylya Topsy Harry Centre in Mt Isa, one such site attempting to integrate the front-line treatment of Indigenous alcoholism and responses to homelessness. In some ways the Centre fits with programmes in mainstream and other Indigenous centres but departs from usual practices in other significant ways, most particularly in the managed consumption of alcohol and an Indigenous-centred approach.

Anecdotally and otherwise, the Centre has clearly had many successes over the last eight years in terms of service delivery to Indigenous people in crisis in Mt Isa. It is the unusual and possibly unique combination of programmes and cultural emphasis that make JTHC stand apart. Given its relatively unique service delivery in this regard, a most important question is whether, and to what extent, Jimaylya is making headway in the treatment and rehabilitation of public place dwellers who are suffering from alcoholism as well as other associated mental health conditions. Although the Centre manages to minimise risk for clients, more attention could be given to improving the longitudinal effectiveness of its programs in terms of rehabilitation since proportions of its clients are recycling through and back again and may become long-term clients.

This study demonstrates that the multi-factorial problems of Indigenous homelessness and substance abuse can benefit from analyses that see local solutions in the broader context of health practice and social policy in other parts of Australia and the world. It also demonstrates the value of contextualising and evaluating a service within the local field of service delivery in order to obtain a more holistic and powerful model for explaining the strengths and gaps in urban service delivery. Further evaluation is needed to decide whether JTHC has a winning formula that is transferable and adaptable to other regional cities in Australia with high levels of Indigenous homelessness and public place dwelling. However, there are sufficient positive findings in the Jimaylya case study to justify proposals for service enhancements in the Centre, such as further manually-oriented TAFE programs (with suitable infrastructure) to stimulate the residents, a carefully designed emotional and well-being programme to identify and treat deep-seated cases of spiritual
homelessness, and a tracking programme for clients into mainstream rental housing to see what extra social supports they may need to maintain a moderate drinking culture and a stable tenancy.
References

Alati, R. et al. (2003). "'It was a nice day ... A beautiful day': an analysis of relapse into substance misuse among Indigenous drinkers." *Drug and Alcohol Review* (22): 135–141.


Accessed 12/9/2011 at


Canberra, Australian Government, Department of Families and Housing, Community Services and Indigenous Affairs.


Queensland, Department of Communities (n.d.) “Jimaylya Topsy Harry Centre Mount Isa” [pamphlet]
Queensland, Department of Communities (2006). Jimaylya Topsy Harry: model of service delivery, Department of Communities (Housing and Homelessness), Queensland Government.


Queensland, Department of Communities (2012). Vulnerability Survey. [unpubl. paper]


## Appendices

### Appendix A

Appendix A presents a Table of Client Categories at JTHC, after Memmott, Birdsell-Jones and Greenop (2011).

<table>
<thead>
<tr>
<th>Client category</th>
<th>Short-term stays</th>
<th>Medium-term stays</th>
<th>Long-term stays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number at October 2011</td>
<td>20</td>
<td>14</td>
<td>10</td>
</tr>
</tbody>
</table>

#### Characteristics

- **Individuals or couples:**
  - From NW Queensland
  - Heavy drinkers
  - Very transient

- **Couples:**
  - From NWQ
  - Short term
  - Heavy drinkers off-site

- **Individuals or couples:**
  - From NWQ
  - Short-term, intermittent
  - Heavy drinkers in wet area

- **Individuals or couples:**
  - Not from NWQ
  - Short-term
  - Looking for work/house
  - Drink off-site in hotels
  - Off-site partners?

- **Couples or trips:**
  - < 1 year
  - Medium = heavy drinkers
  - Dept. of Housing waiting list

- **Individuals - short stays:**
  - Looking for house
  - On-and-off with family
  - Often drink off-site with family

- **Individuals – short-medium stays:**
  - On-and-off drinking
  - Trying to get house/work

#### Opportunities for building social capital/resilience

- Link to other services e.g. ‘brief interventions’ on admission with GPs – evidence that brief interventions give client information and support at the beginning to change;

- Heavy drinkers encouraged to remain on site when they are drinking;

- Peer-group influence and positive modelling in daily chores and drinking behaviours

- Strategies available including family oriented program

#### Threats

- Housing bottleneck
  - Recidivism
  - Social group is kin – outside the centre in Mt Isa – not necessarily ‘dry’
  - Lack of time to complete TAFE courses

- Recycling and so do not progress or gain maximum benefits of programs

- Content within system;
  - Possible negative effect on short-term clients who do not fit in to their rules

- Intermittent or permanent for several years;

- Heavy drinkers

- Not looking for work/house

- Limited due to cultural and non-cultural reasons e.g. lack of connection to home community/family/land/knowledge;

- Often good relations with staff;

- Leaders; insider knowledge of long-termers can be positive influence on service – direction and support
1 Sheltering the Isa: Mount Isa Homelessness Community Action Plan. Available at:
2 "Indigenous" and "Aboriginal" have been used interchangeably in this paper to refer to the First People of Australia.
3 Refer to Memmott and Nash (2011) for a more detailed description of the Centre.
4 No Wrong Door is the Queensland Department of Communities’ program of integrated service provision for clients. Available at: http://www.communitydoor.org.au/nowrongdoor
5 ‘Rates of risky consumption of alcohol and other drugs (AOD) and related harms among Indigenous Australians are generally twice those in the non-Indigenous population’ (Gray & Wilkes, 2010).
6 ‘The rate of homelessness for Aboriginal and Torres Strait Islander people is four times that of non-Indigenous Australians’ (AIHW 2010).
7 AMPs were the outcome of the Indigenous Communities Liquor Licences Bill 2002 (Qld) together with the Community Services Legislation Amendment Bill 2002 (Qld). The latter Bill provided the basis for creation of Community Justice Groups which enabled community members to formulate an AMP designed to minimise the harm caused by alcohol abuse in Indigenous communities. Accessed 12/5/2012 at http://www.austrlii.edu.au/au/legis/qld/bill/csocab2002439/
9 COAG is the Council of Australian Governments that includes not only the Prime Minister but all State Premiers and Chief Ministers.
10 Aboriginal and Torres Strait Islander Communities Amendment Act 2008. It amended the following legislation: Liquor Act 1992 Aboriginal Shire Councils can no longer hold a liquor license; Alcohol may not be transported into or through restricted areas, except on designated highways; Drinking in public places will be banned; and Carriage limits will apply within private residences. Maximum penalties of A$37,500. Aboriginal and Torres Strait Islander Communities Act 1984 Home-brew and equipment will be banned. Police Powers and Responsibilities Act 2000 Police can search without a warrant if they suspect a person or house of harbouring alcohol. Aboriginal and Torres Strait Islander Services. 2009b Fact Sheet 2: Legislative Changes.[online] Available at: http://www.atsip.qld.gov.au/governmant/programs-initiatives/alcohol-reforms/documents/fact-sheet-02-legislative-changes.pdf Accessed 30 May 2012.
11 Alcohol supply restrictions applied to 19 communities with high levels of alcohol-related violence and social harm. The Queensland Government’s policy goals are to: Reduce domestic violence and other violent behaviour; Increase overall health for everyone living in the community; Create safer communities, especially for women and children; and Provide opportunities to rebuild social norms and healthy families. Aboriginal and Torres Strait Islander Services. 2009a. Alcohol reforms. [online] Available at: http://www.atsip.qld.gov.au/governmant/programs-initiatives/alcohol-reforms/default.asp Accessed 30 May 2012.
12 Alcohol consumption patterns vary according to state/legal history and proximity to centres. In the NT alcohol consumption has been greater in camps around larger towns and least among people living in remote communities (Race Discrimination Commissioner in Cuneen (2006:338). By contrast, Queensland’s remote Indigenous communities had canteens with unrestricted drinking until recently.
13 Deed of Grant in Trust (DOGIT) is a form of land tenure granted to the Doomadgee community in 1987 under the Community Services (Aborigines) Act 1984.
14 The Queensland department with major policy responsibilities regarding Indigenous people has undergone numerous name changes.
15 In 2007, staff from the Jimaylya Topsy Harry Centre engaged with the couple who left the river bed community and moved into the centre’s free dormitory-style emergency accommodation. The couple took up a healthy living programme and began learning life skills, including general education. Within 12 months, they were ready to be successfully relocated into mainstream public housing. [Summarised from DOC press release]
16 KASH is the Kalkadoon Aboriginal Sobriety House; AP stands for APSCC (Arthur Peterson Special Care Centre); and, Nawamba House is an accommodation and general support unit (refuge) against domestic and family violence in Mt Isa.
17 KASH closed in early May 2012 due to financial problems (after this paper was drafted) but re-opened several weeks later run by the Salvation Army.
18 Based on semi-structured interviews with the managers of these three centres by P. Memmott during 2011.
19 Pronounced ‘Wurratila’.
20 Other exceptions include Dugalunji Camp of the Myuma Group near Camooweal and Biddungu near Gregory Crossing.
21 A ‘captain’ is the leader of a drinking group by virtue of his (or her) capacity to shout the drinks for that day from their welfare payment (received usually on the same day).
22 Although not investigated for Indigenous homeless people in Mt Isa or explored for this preliminary study, other strategies such as transactional sex or ‘selly-welly’ (Holmes and McRae-Williams 2011) may gather money and alcohol for women involved.
23 This constitutes an ‘ Aboriginal service setting’ as defined elsewhere by Memmott (2010:39-41) drawing upon behaviour setting theory from environmental psychology.
Memmott attended a Client Meeting (21/06/12) at which four of such higher status clients vented their views on a range of day-to-day matters in the Centre. The Centre Manager has emphasized the value of these leaders to the overall running of the Centre. Their knowledge of the Centre rules and procedures at times resulted in their identifying staff who were not fulfilling their duties properly thereby “keeping the staff on their toes” according to the Manager, which he regarded as a positive contribution.

The authors are exploring the theoretical implications of ‘social capital’ for the clients at JTHC to be published elsewhere.

‘Country’ has become the usual term to refer to land for which Indigenous people have specific relationships and responsibilities.