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Substance Misuse and Mental Health among Aboriginal Australians

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OVERVIEW

In this chapter, we briefly examine substance misuse and mental health among Aboriginal Australians¹. We explore a range of issues including current substance use and related harms, social and emotional wellbeing and co-morbidity, and the social determinants of mental health and substance misuse. We examine the range of services that have been developed to address these issues, through the National Drug Strategy's demand, supply and harm reduction framework. We argue that a multi-systemic strategy is required that addresses issues of cultural security, evidence-based practice to enhance treatment outcomes, better service coordination, and attention to the development of the Aboriginal substance misuse and mental health workforce. We reiterate that until the social and structural determinants of good mental health are addressed, the co-morbidity of substance misuse and mental health among Aboriginal Australians will linger.

THE BACKGROUND

For over 200 years, colonisation, racism and domination have left a legacy of marginalisation and mental anguish that is still with us today. Few Aboriginal Australians have been spared that anguish or the self-destructive behaviour that has been particularly associated with the harmful use of alcohol and other psychoactive substances. More and more frequently, alcohol and other substance misuse is being represented as *the* problem of Aboriginal Australia, the source of all or most of its ills, especially poor physical and mental health. Alcohol and other substance use by Aboriginal people is influenced by many factors—including use as an escape mechanism but also as a focus of socialising—and it is apparent that the causes and effects of alcohol and other drug use among Aboriginal Australians need to be better understood. Without such understanding, there is a great risk that policy interventions will be simplistic and ineffective and that the current opportunity for change will be lost.

The search for effective answers to today's problems with alcohol and other substance misuse must start with the facts and not with the slogans and stereotypes that are thrown around so liberally in the media. Each Aboriginal person has a lived experience and as such can and should tell their stories themselves. The experience of assimilating into Western ways or holding onto Aboriginal ways creates anxieties for many Indigenous people that reverberate through the families that make up the Aboriginal Australian world. While Australia now has racial vilification laws, Aboriginal Australians are still made to feel uncomfortable in settings where others are welcomed. Furthermore, in some instances Indigenous Australians are still denied access to public places.

¹ Editors' comment: In this chapter, Aboriginal Australians includes both Aboriginal people and Torres Strait Islander people.

The apology by the Prime Minister of Australia on 13 February 2008, recognising past wrongs against the Stolen Generations of Aboriginal Australians, may provide some relief but it can never be the solution on its own. In reality, there is still a demeaning stereotype of Indigenous Australians that has to be dismantled.

In the non-Aboriginal population, the prevalence of substance use is thoroughly documented (AIHW, 2006) and the *National Mental Health Survey* (Teesson et al., 2000) has documented the high prevalence of co-morbid substance misuse and mental illness in that population. The authors of the latter report concluded that there is growing evidence for some direct causal relationships between substance misuse and poor mental health, in particular cannabis use leading to psychosis in the vulnerable (Teesson et al., 2000, p. 49). They also demonstrated that regardless of whether substance use complicates psychiatric disorder or vice versa, the prognosis is poorer for both conditions together than for either condition alone.

What then is the extent of co-morbid substance misuse and mental health problems among Aboriginal people? Several reports and studies have documented high rates of substance use among Aboriginal people in general and young people in particular (ABS & AIHW 2008; SCRGSP, 2009; Zubrick et al., 2005). While there are no large-scale studies of Aboriginal mental health (such as the *National Mental Health Survey*), evidence from a number of sources indicates that co-morbidity is more common than in non-Aboriginal populations, although as Hunter (2003) observes, identifying disorders of social and emotional wellbeing in Aboriginal and Torres Strait Islander populations is problematic. He also notes that among Aboriginal people mental health disorders and substance use problems continue to be treated separately (Hunter, 2003, p. 129) and that this contributes to poor prognosis.

This chapter will explore these issues in more detail and focus specifically on four important areas of concern. What are the problems? What are the underlying issues? What is being done to address harmful substance use among Aboriginal people? What else needs to be done?

SUBSTANCE MISUSE AND RELATED HARMS

It is important to note that not all substance use is substance misuse (Gray et al., 2008). Here we use the term 'substance misuse' in the public health sense, meaning any use of a psychoactive substance that causes harm to users or to others. This is a broader definition than the psychiatric definitions of 'substance abuse' or 'substance dependence' used in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000; see also Gray et al., 2008).

For methodological reasons it is far easier to ascertain the prevalence of use of various psychoactive substances than it is to document the frequency and levels of such use, and whether or not individuals are using those substances at harmful levels (Chikritzhs & Brady, 2006). Nevertheless, the levels of each are related and estimates of the prevalence of substance use provide an indicator of likely levels of harm. The figures on current prevalence (that is, any use in the previous 12 months) presented in Table 9.1 have been compiled from AIHW publications (2005, 2006) for the year 2004.²

Table 9.1: Current substance use (previous 12 months), percentage of persons aged ≥14 years, by Aboriginal status, 2004

Substance	Aboriginal/ Torres Strait Islander	Non-Aboriginal / Torres Strait Islander
Tobacco	52.0	22.5
Alcohol		
Abstainer	21.3	16.1
Short-term high risk	52.0	35.5
Long-term high risk	22.7	9.7
Cannabis	23.0	11.3
Meth/amphetamines	7.0	3.2
Pain killers/analgesics (non-medical use)	6.0	3.1
Inhalants (including petrol)	≈1.0	0.4.
Heroin	≈0.5	0.2
Injected drugs	≈ 3.0	0.4

Source: AIHW, 2005, 2006.

² Note limited Indigenous sample size for the NDSHS (AIHW, 2005).

- The NDSHS had a sample size of 29,445 Australians aged 12 years and older with a response rate of 46%.
- The NDSHS does not have an enhanced Indigenous sample. Only a small number of Indigenous respondents are included in this survey with 460 Indigenous Australian participants. This sample size is very small and therefore the estimates should be interpreted with caution. The small sample size also limits the reliability of time series analysis.

There have been dramatic reductions in tobacco use among non-Aboriginal Australians over the past two decades, to the point where in 2004 approximately 23% were current smokers. Among Aboriginal people, however, the rate was more than double, at about 52%.

Alcohol is the most widely used substance among Aboriginal people, as it is among non-Aboriginal Australians. Among those aged 14 years or older, more Aboriginal people abstain from alcohol use (about 21% compared to about 16%). However, a reason for this higher rate of current abstinence is that more Aboriginal people are ex-drinkers (rather than lifetime abstainers), many of whom have given up because of the serious health consequences of their drinking (Brady 1995; CDHSH, 1996). Among those who do drink, considerably more Aboriginal people consume alcohol in a manner that poses high risks to their health in both the short (52% versus 35.5%) and long term (22.7% versus 9.7%).

When we consider the use of illicit drugs, or the use of licit drugs in a harmful manner, the prevalence of use among Aboriginal people is about twice that among non-Aboriginal people (cannabis 23.0% versus 11.3%; amphetamine-type stimulants 7% versus 3.2%; non-medical use of painkillers and analgesics 6% versus 3.1%; inhalants, including petrol, about 1% versus 0.4%; and heroin about 0.5% versus 0.2%). Furthermore, about 3%, compared to 0.4% had injected drugs in the previous 12 months.

In Table 9.2, we have estimated changes in the prevalence of use of various substances by comparing the data in Table 9.1 with that for Aboriginal people in 1994 and 1993, and non-Aboriginal people for 1993 (CDHSH, 1996). Apart from increases in the use of amphetamine-type stimulants (10%) and the non-medical use of painkillers and analgesics (7%), in the period 1993–2004, there were significant reductions among non-Aboriginal Australians in the use of tobacco (–22%), alcohol (–14%) and cannabis (–13%). In 1994–2004, however, apart from a small reduction in the proportion of tobacco users, among Aboriginal people, there were increases in the percentage of users of alcohol (15%) and cannabis (5%) and, in particular, amphetamine-type stimulants (204%) and painkillers and analgesics (107%). Similarly, over the same periods, while there was a reduction of 20% in the prevalence of injecting drug use among non-Aboriginal people, there was about a 50% increase among Aboriginal Australians. As highlighted in several studies, poly-drug use is common among Aboriginal Australians (Burns et al., 1995; CDHSH, 1996; Gray et al., 1997; Shoobridge et al., 2000). For many, this is confined to the use of alcohol and tobacco, but for others this is extended to include cannabis and the use of other substances.

Table 9.2: Percentage changes in current prevalence of substance use, 1993/1994 to 2004, by Indigenous status

Substance	Aboriginal/ Torres Strait Islander % change 1994–2004	Non-Aboriginal / Torres Strait Islander % change 1993–2004
Tobacco	-4	-22
Alcohol	15	-14
Cannabis	5	-13
Meth/amphetamines	204	10
Pain killers/analgesics	107	7
Injected drugs	50	-20

Source: CDHSH, 1996; AIHW, 2005, 2006.

Although confined to Western Australia, the results of the *Western Australian Aboriginal Child Health Survey*—the most comprehensive study undertaken of Aboriginal children and young people—indicate levels of substance use among young Aboriginal people. In the survey young people aged 12–17 were asked about their experiences with cigarette smoking, alcohol

and marijuana (cannabis). Of the 17-year-olds in the survey, 58% smoked regularly, over 61% of males and 43% of females were drinking alcohol, and 45% of males and 21% of females were using marijuana at least weekly. These rates are a major concern, particularly the high level of cannabis use.

Alcohol and other drugs are the cause of, or contribute to, a wide range of social problems among Aboriginal Australians. These include violence, social disorder, family breakdown, child neglect, loss of income or diversion of income to purchase alcohol and other substances, and high levels of imprisonment. In addition, these substances have a significantly deleterious impact on the health of Aboriginal Australians (ABS & AIHW, 2008).

Studies over the past two decades have shown that Aboriginal people are much more likely than their non-Aboriginal counterparts to suffer from conditions caused by substance abuse, and tobacco smoking has been identified as the single most preventable cause of death among Aboriginal people (ABS & AIHW, 2008, p. 113; Cunningham, 1994; Measey et al., 1998; Unwin et al., 1994). Alcohol abuse causes about 7% of Aboriginal deaths and Aboriginal people die at much younger ages from these conditions than do non-Aboriginal Australians (ABS & AIHW, 2008, p. 140; Chikritzhs et al., 2007). Alcohol also makes a significant contribution to the hospitalisation of Aboriginal people (ABS & AIHW, 2008, p. 113). There is little published data on Aboriginal deaths and hospitalisation associated with illicit drug use. In Western Australia, however, in 1994–2000, the crude rate of hospital admissions for conditions caused by psycho-stimulants and drug psychoses increased eight times from 2.8 to 22.4 per 10,000 person years among Aboriginal males, and 3.6 times from 4.3 to 15.5 among Aboriginal females. For the period July 2004 to June 2006, there were 4 214 hospitalisations of Indigenous Australians relating to substance use in New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory, around twice the rate of other Australians (AIHW 2008, p. 1030).

SOCIAL AND EMOTIONAL WELLBEING AND CO-MORBIDITY

In the non-Aboriginal population it has been shown that there is a high prevalence of co-morbid substance misuse and mental health problems (Shand et al., 2003; Teesson & Proudfoot, 2003). For example, it has been estimated that among those with an alcohol-dependence disorder 20% have an anxiety disorder and 24% an affective disorder (Shand et al., 2003). The evidence shows that there are causal pathways in both directions between these problems. For example, 'there is a causal pathway from depression to substance use in males, and from daily cannabis use to depression and anxiety in females. There is also evidence that cannabis use precipitates psychosis in persons who are vulnerable because of a personal or family history of psychosis' (Teesson et al., 2005, p. 43). These shared risk factors for mental health and substance misuse have implications for prevention and treatment, with potential co-morbidity issues needing to be addressed as soon as symptoms of one disorder appear (Teesson et al., 2005).

There has been no comprehensive study of co-morbidity in the Aboriginal population, but evidence of the relationship comes from a number of sources. In Table 9.3 the ratios of observed rates of hospitalisation (the rate of actual cases) to expected rates of hospitalisation (those to be expected if the rates were the same as in the non-Aboriginal population) for mental and behavioural disorders are presented (ABS & AIHW, 2008, p. 112). Of particular relevance here is the fact that the table shows that Aboriginal men are over four times, and Aboriginal women over three times, as likely to be hospitalised for 'mental disorders attributable to psychoactive substance misuse' than their non-Aboriginal counterparts.

Table 9.3: Hospitalisations for mental and behavioural disorders, ratio of observed to expected cases among Aboriginal males and females, 2005–06

Disorder	Male			Female		
	Observed	Expected	Ratio	Observed	Expected	Ratio
Mental disorders due to psychoactive substance misuse	2,436	538	4.5	1,331	400	3.3
Schizophrenic, schizotypal and delusional disorders	1,517	558	2.7	1,035	412	2.5
Mood and neurotic disorders	1,111	906	1.2	1,816	1,790	1.0
Disorder of adult personality and behaviour	93	51	1.8	143	168	0.8
Organic mental disorders	81	34	2.4	71	30	2.3
Other mental disorders	266	186	1.4	183	264	0.7
Total	5,504	2,273	2.4	4,579	3,064	1.5

Source: ABS & AIHW 2008.

Aboriginal suicide is covered in detail in Chapter 6, but we highlight it here because of its relationship to substance misuse. In the period 2001–05, the suicide rate among Aboriginal males in Queensland, South Australia, Western Australia and the Northern Territory was almost three times that among non-Aboriginal males, and among Aboriginal females aged less than 44 years was over twice that among non-Aboriginal females (ABS & AIHW, 2008, p. 169). The relationship between substance misuse—specifically alcohol misuse—and suicide is evident in Table 9.4, which shows that suicide was the most common cause of alcohol-related deaths among Aboriginal males and the fourth most common cause among Aboriginal females (Chikritzhs et al., 2007).

Table 9.4: Most common causes of alcohol-attributable death among Aboriginal males and females (based on aggregates 1998–2004)

Condition	n	%	Mean age at death
Males			
1 Suicide	222	19	29
2 Alcoholic liver cirrhosis	210	18	56
3 Road traffic injury	87	7	30
4 Assault injury	70	6	34
5 Haemorrhagic stroke	60	5	27
Total	649	56	35
Females			
1 Alcoholic liver cirrhosis	136	28	51
2 Haemorrhagic stroke	78	16	25
3 Assault injury	48	10	32
4 Suicide	33	7	27
5 Road traffic injury	18	4	36
Total	313	65	34

Source: Chikritzhs et al., 2007.

It is important to note that the hospitalisation and suicide data presented above are only the tip of the iceberg. A study of cannabis use in remote Aboriginal communities in the Northern Territory found that some mental health symptoms increased as cannabis use increased (Clough et al., 2005). Specifically with regard to children, the *Western Australian Aboriginal Child Health Survey* states:

The ages of 12–17 years represent an important period in the social and emotional development of young people. The transition to adulthood brings with it a range of

demands, pressures and temptations. Compared with earlier generations, today's young people are under great pressure, with a more competitive labour market requiring higher education standards and greater skills. Aboriginal young people, like other groups in society who are sometimes marginalised and subject to discrimination, are potentially more vulnerable to harmful health risk behaviours. (Zubrick et al., 2005, p. 207)

This and other research on the frequency of mental health problems (ABS & AIHW, 2008; Swan & Raphael, 1995; Zubrick et al., 2005) and high levels of harmful substance misuse indicate that levels of co-morbidity are likely to be significant (Hunter, 2007; Kelly, 2006; Parker & Ben-Tovim, 2002; Santhanam et al., 2006). In turn, this highlights the need for interventions which address both sets of morbidities, since addressing one without the other is likely to have limited efficacy.

SOCIAL DETERMINANTS OF MENTAL HEALTH AND SUBSTANCE MISUSE

Poor Aboriginal mental health and risky health behaviours are not simply the fault of individuals (Saggers & Gray, 2007; Walter & Saggers, 2007). We have known since medieval times—when high rates of disease were noted among miners—that social conditions are implicated in the health status of communities. The legendary work by John Snow, who mapped cases of cholera in London and traced them to a public water pump, resulted in much greater recognition of the importance of environmental conditions such as water and sanitation to health (Lynch, 2000). In more recent times, it was a study of British civil servants which showed the impact of occupational status on health that was to lead to a renewed interest in the social determinants of health (Townsend & Davidson, 1982). In Australia, Turrell and his colleagues have similarly demonstrated that Australians in low socioeconomic positions suffer more ill health at all stages of life (Turrell & Mathers, 2000).

Social factors which cause or protect against ill health and substance misuse occur at all levels, from the macro-social to the individual, and are at play at all stages of the life course, from before birth to old age (Lynch, 2000; see also Chapter 6). These have important implications for intervention. With respect to substance misuse, for instance, macro-level policies such as increasing the price of alcohol through taxation at the national level, and state and territory laws pertaining to the minimum drinking age are proven strategies for limiting alcohol-related harm.

Like substance misuse, many mental health problems are influenced by social factors outside the control of individuals and their immediate contexts (Hunter, 2007). It is not simply about 'individual problems with individual psyches' (Tatz, 2004, p. 22).

Contemporary social indicators

The history of oppression has contemporary consequences for the structural position and health status of Aboriginal Australians (RCIAIDC, Johnson, 1991; RCIADIC, Dodson, 1991; Saggers & Gray, 1998). Despite improvements in recent years, Aboriginal Australians continue to lag behind the general population on virtually every social indicator. In 2004, only 52% of Year 7 Aboriginal students met national benchmarks for reading literacy, compared to 91% among the non-Aboriginal population. This reflects wide discrepancies in a range of educational indices including numeracy and overall academic performance (ABS, 2006). Aboriginal adults are more than twice as likely as non-Aboriginal adults to be unemployed, and Aboriginal household incomes are only 59% of those of the wider population. Overcrowding and housing in poor states of repair are also much more common among Aboriginal people. These factors are implicated in poorer general health, lower life expectancies, higher substance misuse and higher reported mental health problems (ABS & AIHW, 2008).

Dispossession and the Stolen Generations

For Aboriginal Australians, the social determinants of health include the consequences of invasion and dispossession, and issues such as racism which impact on people's everyday lives. When Europeans invaded Australia in 1788, they declared the land *terra nullius* (occupied by no one) despite the presence of hunter-gatherer societies which had occupied the country for at least 60,000 years. Numbering an estimated 750,000 people, they lived in small semi-nomadic groups in diverse environments ranging from the coast to the arid interior, and maintaining complex social and religious lives (Saggers, 2003).

As European settlement spread north and into the interior of the continent, Aboriginal groups were dispossessed of their country and many were herded into missions or government settlements. Until the middle of the 20th century, Aboriginal people's lives were ruled by discriminatory legislation that intruded into every aspect of their lives—dictating where they could live, attend school and work, who they could marry and even what they could eat and drink. The rations of flour, sugar, meat, tea and tobacco established nutritional habits that helped transform them into one of the unhealthiest populations in the world (Saggers, 2003).

Government policy towards Aboriginal people has fluctuated between attempts to protect them from European violence and the consequences of settlement, to assimilation with the European population, which saw the forced removal of many Aboriginal children from their families. The numbers affected by these racist policies are highly contentious, but the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families (HREOC, 1997) reported that 'Nationally we can conclude with confidence that between one in three and one in ten Indigenous children were forcibly removed from their families and communities in the period from approximately 1910 until 1970' (p. 37). This history of separation is strongly implicated in the poor mental health and substance misuse problems of many Aboriginal Australians (Swan & Raphael, 1995).

From the early 1970s to the mid-1990s, at the national level, there was bipartisan support for policies of Aboriginal self-determination and/or self-management. Although implementation of these policies was under-resourced, the policies provided for the growth of Aboriginal community-controlled services, including health and substance misuse services.

However, under the Howard Liberal-National Party coalition government, there was a backing away from support for self-determination, the Aboriginal and Torres Strait Islander Commission (ATSIC) was abolished and there was a move to 'mainstreaming' of Aboriginal service provision. This came to a head in 2007 with the Australian Government's Northern Territory 'Intervention' (*Northern Territory National Emergency Response Act 2007*), which was one of several measures introduced in response to the *Little Children are Sacred* (Wild & Anderson, 2007) report on child abuse. Many Aboriginal people have supported the need for the input of resources and action. But there was considerable disquiet about the fact that the Act facilitating the Intervention overrode provisions of the Commonwealth Government's *Racial Discrimination Act 1975*. Furthermore, many claim that consultation with, and involvement of, Aboriginal people was inadequate, and that the Intervention is a 'new paternalism' that risks contributing to existing abuse and neglect (Brown & Brown, 2007; CAONT, 2007; Central Land Council, 2008).

WHAT IS BEING DONE?

It is important to note that while funding comes from the Australian and state and territory governments, most alcohol and other drug interventions among Aboriginal Australians have been initiated and conducted by Aboriginal people themselves (Gray et al., 2002). In fact some, such as that conducted by Benelong's Haven (Chenhall, 2007), pre-date policy and funding commitments by governments.

In 1985, the Australian and state and territory governments agreed to a coordinated effort to address alcohol and other drug use. This was initially known as the *National Campaign*

Against Drug Abuse. This umbrella strategy, now known as the *National Drug Strategy* (MCDS, 2004), is based on the principle of harm minimisation:

Harm minimisation does not condone drug use, rather it refers to policies and programs aimed at reducing drug-related harm. It aims to improve health, social and economic outcomes for both the community and the individual, and encompasses a wide range of approaches, including abstinence-oriented strategies. (MCDS, 2004, p. 2)

The *National Drug Strategy* (NDS) is based on three major strategies to minimise drug-related harm: demand, supply and harm reduction. In non-Aboriginal populations, there have been extensive reviews of these strategies and their effectiveness (Babor et al., 2003; Hulse et al., 2002; Loxley et al., 2004; Stockwell et al., 2005).

To complement the NDS, a plan focusing specifically on alcohol and other drug use among Aboriginal Australians has also been developed; the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan* (MCDS, 2003). The 'CAP', as it is commonly known, identifies six key result areas for the focus of intervention. It is not intended to be prescriptive in terms of specific interventions, but provides a framework for intervention from within which particular state and territory jurisdictions can implement strategies they deem appropriate to their own jurisdictions. Like the NDS itself, the CAP is based on demand, supply and harm reduction strategies, and this provides a useful framework for the review of current interventions.

Demand reduction

As the name implies, demand reduction strategies are designed to reduce or prevent substance-related harm by reducing demand for those substances (CDHAC, 1999; MCDS, 2006). They include broad-based prevention projects and both community-based and residential treatment services.

Prevention and early intervention programs to address substance misuse among Aboriginal people are mostly conducted by Aboriginal community-controlled organisations. They include health promotion projects, recreational activities and community development projects. Research conducted for the 1999/2000 financial year on behalf of the Australian National Council on Drugs (Gray et al., 2002) identified a total of 57 such projects nationally. Since that time, there has been a steady expansion of these projects, but as there is no regular auditing of interventions on a national basis, the current number of such projects is not available.

In 1999–2000, there were 107 Aboriginal-specific treatment services. Of these, 32 provided alcohol-focused residential treatment, most with an abstinence-based approach (Gray et al., 2002).

Over the past decade, a number of services have responded increasingly to calls for a more diverse range of treatment options or alternatives to an abstinence-only approach (Brady, 1995). An example of such a response is that of a residential treatment service in Western Australia, Milliya Rumurra, which employs a diverse approach to meet the needs of individual clients (Strepel et al., 2004).

Although the number of evaluations of such interventions is relatively small, there are clear indications of their effectiveness (Gray & Siggers, 2005; Gray et al., 2008).

Supply reduction

Generally, the greater the availability of a particular substance, the higher the levels of use and related harm. Supply reduction strategies are those that aim to reduce availability and thus the levels of harm. Such strategies target both illicit and licit substances. In the case of illicit drugs such as amphetamine-type stimulants these include outright prohibition. In the case of licit substances such as tobacco and alcohol they include taxation and other price control measures, and constraints on who may or may not purchase particular substances and under what circumstances (MCDS, 2006).

In the non-Aboriginal population, a combination of taxation and purchase age restrictions and health promotion campaigns (a demand reduction strategy) has significantly reduced tobacco consumption. In the Aboriginal population, however, both these measures and the few Aboriginal-specific strategies (Ivers, 2001, 2003) have had limited success.

Under various pieces of state and territory legislation, over many years, Aboriginal people have undertaken a range of strategies to reduce the supply of alcohol. In discrete communities, these include declaring their communities 'dry' (prohibiting alcohol) and establishing wet canteens to regulate availability. In towns, supply reduction strategies include working with non-Aboriginal residents and liquor licensing authorities to impose additional restrictions on the availability of alcohol. Of these, the least successful has been the establishment of wet canteens (d'Abbs, 1998) and the most successful has been licensing restrictions (National Drug Research Institute, 2007).

In contrast to community-initiated alcohol supply reduction measures, as part of its Northern Territory Intervention, the Australian Government imposed alcohol restrictions in many remote communities. At the time of writing, however, these restrictions have not been evaluated.

Supply reduction strategies have also been used to considerable effect in the reduction of volatile substance use, particularly petrol sniffing. Evaluations, first of the 'Comgas' Scheme under which non-sniffable aviation fuel (avgas) was substituted for regular petrol and more recently the substitution of non-sniffable Opal fuel for regular petrol, have demonstrated the effectiveness of these strategies (Access Economics, 2006; Shaw et al., 2004).

Law enforcement is an essential component of strategies to reduce the supply of both volatile substances and illicit drugs. 'Best practice' strategies and their impact have been reviewed in studies commissioned by the National Drug Law Enforcement Fund (Delahunty & Putt, 2006; Gray et al., 2006).

Harm reduction

Harm reduction strategies are those designed to decrease immediate harms associated with substance misuse. The most common of these strategies have been developed in response to the acute harm caused by alcohol intoxication.

Night patrols, or mobile assistance patrols, are aimed at removing intoxicated persons from public to safe places to minimise the likelihood of them causing harm to themselves or others. The first such patrol was established by Julalikari Council in Tennant Creek in the mid-1980s. The numbers of these patrols expanded rapidly following recommendations made by the Royal Commission into Aboriginal Deaths in Custody that they be supported (RCIADIC, Johnson, 1991). Although the current number of operating patrols is not known, in 1999–2000 there were 69 (Gray et al., 2002).

Sobering-up shelters provide safe surroundings for intoxicated people. As in the case of night patrols, there was an expansion of sobering-up shelters following the RCIADC and in 1999–2000 there were 22 of them. Most focus on those intoxicated by alcohol but some have also provided beds for those intoxicated on volatile substances. Like night patrols, sobering-up shelters are effective but must be properly resourced and have sustainable Aboriginal involvement.

Needle and syringe programs (NSPs) are designed to reduce the harm associated with injecting drug use, particularly the spread of blood-borne viruses such as hepatitis C and HIV. Although they are sometimes contentious, the evidence in the wider Australian population shows that they have been effective (Dolan et al., 2005).

In Aboriginal communities, NSPs are also an issue of contention. Nevertheless, there are several operating around the country and innovative and successful strategies have been established to also link Aboriginal people who inject drugs into NSPs (van der Sterren et al., 2006; Williams et al., 2006).

Addressing co-morbidity

The issue of co-morbidity is of concern and the Australian Government through the Department of Health and Ageing has a 'National Co-morbidity Initiative' which aims to increase awareness, provide support to service providers and improve access to resources (Butler, 2008). It is also providing capacity-building grants for non-government organisations. As yet, however, although there are interventions that address mental health and substance misuse issues separately, there are very few that specifically address co-morbidity in Aboriginal contexts. An example of a program that does so is that operated by Warlpiri Youth Development Aboriginal Corporation (formerly the Mt Theo-Yuendumu Substance Misuse Aboriginal Corporation). One of the objectives of this Northern Territory-based program is to prevent suicide and petrol sniffing among the young people in the community (Saggers & Stearne, 2007).

In an attempt to address the gap in services for those suffering from co-morbidities, the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) has developed a model for integrating substance misuse, mental health, and primary health care services (AMSANT, 2008). At the time of writing, one of AMSANT's member organisations, Central Australian Aboriginal Congress, is conducting a trial of this model.

Recent initiatives

Unpublished data supplied to the National Drug Research Institute by Australian and state and territory governments shows that over the period from 1999–2000 to 2006–07 there was a significant increase in the number of alcohol and other drug intervention services specifically for Aboriginal people, and a doubling of funding for such projects. In 2006–07 few of the substance misuse services were specifically addressing issues of co-morbidity, and a study of services in Queensland found that the staff of many services felt they did not have the expertise to do so (Gray et al., 2009). Since 2006–07, resourcing of both Aboriginal substance misuse and mental health received a significant boost under agreements reached by COAG. Up to \$98.6 million has been allocated to increase drug and alcohol treatment and rehabilitation services in regional and remote Indigenous communities under two new measures announced by COAG in July 2006 and December 2007.

WHAT NEEDS TO BE DONE?

As we have discussed, alcohol and other drug misuse plays a significant role in the disruption of Aboriginal people's lives. Having also established that this drug misuse often co-occurs with mental health disorders and problems of emotional and social wellbeing, it is important to plan appropriate treatment and rehabilitation services to complement broader interventions. Generally intervention requires a multisystemic approach. But this is not always utilised. While it appears that much is already being done, the epidemiological evidence indicates that in many respects, things are getting worse not better.

Cultural security

Cultural competence is addressed in considerable detail in Chapter 12, but it should be further reiterated that a fundamental principle when working with Aboriginal people is to ensure that engagement is maintained in a culturally secure manner (Houston, 2001). The term 'culturally secure' describes a guiding principle that ensures respect for cultural difference. Cultural security is central in the development of programs, services, policies and strategies. Aboriginal leadership, community consultation and involvement form an essential part of this process. In our efforts to reduce alcohol and other drug-related harm a culturally secure approach is imperative.

The development and delivery of culturally secure alcohol and other drug programs should be based on recognition of the following principles:

- a holistic concept of health and wellbeing grounded in an Aboriginal understanding of the historical factors that have influenced alcohol and other drug-related harm

- culture as a central core component
- reinforcement of Aboriginal family systems of care, support and responsibility
- Aboriginal ownership and control.

There also needs to be recognition of the diversity within and between Aboriginal Australian communities in remote, regional and urban areas.

Practice to enhance treatment outcomes

Social Learning Theory (Bandura, 1977) provides a culturally secure framework for understanding hazardous and harmful alcohol and other drug use. It acknowledges that people learn to use alcohol and other drugs within their social environments. Expansion of support programs that assist Aboriginal families to break the cycle of harm is essential for intergenerational change.

It is critical that services are culturally secure and evidence-based to increase access to services and improve treatment outcomes. Services need to ensure that treatment models adhere to these principles and adapt accordingly to maximise effectiveness.

In the development of any intervention strategies, recognition of the historical, socioeconomic and political factors must be considered. Alcohol and other drug misuse cannot be seen in isolation from other factors because there is always a multiplicity of causes (Edwards, 1982). In a report by RCIADIC, Pat Dodson clearly articulated the principle that alcohol and other drug problems ‘must be approached on a community basis and not with an individual disease ideology in mind ... and ... need[s] to be linked to a broader approach which deals with the structural determinants’ (RCIADIC, Dodson, 1991, vol. 2, p. 738).

Australian governments do have programs in place to address underlying structural factors such as poor housing and educational outcomes and high unemployment, and over past decades some improvements have been made. However, there is a need for significantly increased levels of investment in such programs, for at present levels the gaps between Aboriginal and non-Aboriginal Australians are likely to continue (Altman et al., 2008). Under the Closing the Gap initiative \$4.6 billion is provided to address these gaps. The government will work in partnership with Indigenous Australians, state and territory governments, business, community organisations and all Australians to improve Indigenous outcomes.

The evidence indicates that individuals and families who seek treatment and support for substance misuse problems are more likely to succeed if change can be seen as worthwhile. Saunders and Allsop (1989, 1991) highlight the important role that factors such as improved housing and employment play in sustaining post-change lifestyles. They further state that changing behaviour in an environment of limited support and high temptation is challenging.

Improved linkages across services and local partnerships

Given the often complex problems with which Aboriginal people regularly present, the need for streamlined clinical referral pathways to other specialist services is essential. Models of shared care and case management support a comprehensive and holistic approach to assist Aboriginal people and their families. Swan & Raphael (1995) and Teesson & Proudfoot (2003) clearly identify the need for new programs to provide both improved identification and service delivery in the assessment, treatment and management of people with co-morbid disorders within mental health services, alcohol and other drug services, and by general practitioners and other health care providers; and further program collaboration and inter-agency approach in the shared case management of clients with co-morbid disorders.

An example of a working collaboration is that between Milliya Rumurra Aboriginal Corporation (residential alcohol and other drug treatment service) and Northwest Mental Health Services. A formal agreement outlines each agency’s roles and responsibilities in terms of clinical referral pathways, information exchange, and shared management of clients with co-morbid presentations. This process was negotiated between the two services and is a demonstration of how

working together can enhance treatment outcomes for clients. The development of formal across-agency linkages is an extremely effective way to support clients and enhance service delivery.

Workforce development strategies and partnerships

Workforce development for the Aboriginal alcohol and other drug sector has been an area of neglect for many years and there is a need to provide support and training for the existing workforce. Gray et al. (2004, p. 24) state: 'Several evaluations of substance misuse intervention programs have reported that program staff believe they have insufficient training and skills to adequately address substance misuse problems at either the individual or community level.'

Workforce development is a key result area of the *Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003–2009*. The Complementary Action Plan clearly articulates the need for '[w]orkforce initiatives to enhance the capacity of Aboriginal and Torres Strait Islander community controlled and mainstream organisations to provide quality services' (p. 7).

In keeping with national strategic directions to address the issue of workforce development, the Indigenous National Alcohol and Other Drug Workforce Development Program was funded by the Australian Government in 2005. This unique program, led by the Western Australian Drug and Alcohol Office, has established national partnerships with the Northern Territory, Queensland, ACT, New South Wales and South Australia to deliver the Indigenous National Alcohol and Other Drug Worker Training Program, CHC30802 Certificate III in Community Services Work. Consolidating partnerships across jurisdictions to develop and sustain a competent and skilled workforce will provide the initiative to enhance service delivery and produce better outcomes.

Workforce development measures must include a greater understanding of the co-morbidity of substance misuse and mental health. A skilled workforce is the key to assisting Aboriginal community action and capacity-building processes that can facilitate addressing contemporary needs and sustaining intergenerational change.

CONCLUSION

The poor mental health of many Aboriginal Australians is associated with harmful use of alcohol and other drugs. Aboriginal people's use of alcohol, tobacco and other drugs is much higher than among the general population (within which some significant reductions in use have occurred, as in the case of smoking). The co-morbidity of mental health and harmful substance use among Aboriginal people needs to be contextualised by the legacy of colonisation, racism and marginalisation from dominant social institutions. International and Australian research clearly demonstrates that health in general, mental health and substance misuse are affected by social and structural factors such as housing, education, employment, income, transport and access to supportive social networks. Until Aboriginal people are generally equal in terms of social indicators such as adequate housing, literacy levels, employment and income, the prevalence of harmful substance use and mental health problems among them is unlikely to decline.

Despite the structural impediments, through community-controlled organisations, Aboriginal people are themselves doing much to address Aboriginal substance misuse. The *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan* provides a framework for reducing the demand for psychoactive substances, the supply of them and the harms caused by them. It is clear from these endeavours that Aboriginal people themselves acknowledge the importance of tackling substance misuse if health and wellbeing is to improve.

Despite current efforts, much still needs to be done both for the Aboriginal community-controlled sector and in mainstream service delivery to Aboriginal Australians. Services, wherever they are provided, need to be culturally secure, incorporating holistic concepts of health and wellbeing, with culture at the core, and respecting Aboriginal families and community notions of ownership and control. All services also need to be evidence-based to improve outcomes and to acknowledge the link between better outcomes and the structural determinants of health. Models of shared care and case management are integral to holistic and comprehensive service delivery

and these, in turn, are dependent on a competent and effective workforce that is capable of working collaboratively with communities to address the challenges of Aboriginal mental health.

Reflective exercises

- 1 Looking at the data presented in this chapter, what are the substance abuse rates of alcohol and drugs for the Aboriginal and Torres Strait Islander population compared to the non-Aboriginal and Torres Strait Islander population? Discuss what you think are the contributing factors of these outcomes.
- 2 What forms of approaches are in place to address alcohol and drug abuse?
- 3 One of the key issues in addressing alcohol and drug abuse is workforce development. How can this help?

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