

MINISTERIAL COUNCIL ON DRUG STRATEGY

NATIONAL DRUG STRATEGY

Aboriginal and Torres Strait Islander Peoples
Complementary Action Plan 2003–2009

BACKGROUND PAPER



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Action Plan 2003–2009**

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MAY 2006

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In March 2006, the MCDS approved the extension of the *National Aboriginal and Torres Strait Islander Peoples Complementary Action Plan* from 2003-2006 to 2003-2009 to bring it into line with the National Drug Strategy - Australia's Integrated Framework 2004-2009."

The action plans, background paper and glossary were prepared by the National Drug Strategy Reference Group for Aboriginal and Torres Strait Islander Peoples with the help and support of Siggins Miller Consultants. The Intergovernmental Committee on Drugs, the Australian National Council on Drugs, Aboriginal and Torres Strait Islander people in every State and Territory, the National Aboriginal Community Controlled Health Organisation, and a broad range of other key stakeholders contributed to the drafting of the documents.

The (MCDS) is the peak policy and decision-making body in relation to licit and illicit drugs in Australia. It brings together Commonwealth, State and Territory Ministers responsible for health and law enforcement to collectively determine national policies and programs to reduce drug-related harm. The MCDS ensures that the Australian approach to harmful drug use is nationally coordinated and integrated. Its collaborative approach is designed to achieve national consistency in policy principles, program development and service delivery.

May 2006

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
ADAC	Aboriginal Drug and Alcohol Council (SA)
AHW	Aboriginal health worker
AIDS	acquired immunodeficiency syndrome
AIHW	Australian Institute of Health and Welfare
ANCD	Australian National Council on Drugs
APCA	Aboriginal Protective Custody Apprehensions
CAAAPU	Central Australian Aboriginal Alcohol Programs Unit
CAAC	Central Australian Aboriginal congress
CAAP	Council for Aboriginal Alcohol Program
CAAPS	Council for Aboriginal Alcohol Program Services
HALT	Healthy Aboriginal Life Team
HIV	human immunodeficiency virus
IV	intravenous
MCDS	Ministerial Council on Drug Strategy
NACCHO	National Aboriginal Community Controlled Health Organisation
NASAS	Noongar Alcohol and Substance Abuse Service
NDS	National Drug Strategy
NGO	non-government organisation
NRT	nicotine replacement therapy
NSP	needle and syringe programs
OATSIH	Office of Aboriginal and Torres Strait Islander Health
VAHS	Victorian Aboriginal Health Service

DEVELOPING A COMPLEMENTARY ACTION PLAN

The Aboriginal and Torres Strait Islander Peoples Complementary Action Plan seeks to address the particular challenges faced by Aboriginal and Torres Strait Islander peoples in Australia in the use of licit and illicit drugs. It complements all the other national action plans under the *National Drug Strategy Framework 1998-99 to 2002-03*. An updated version of this framework is now available - *The National Drug Strategy - Australia's Integrated Framework 2004-2009* (National Drug Strategy Framework).

The National Drug Strategy is a cooperative venture between the Commonwealth, State and Territory governments, and the non-government sector. Its aim is to minimise the harmful effects of drugs and drug use in Australian society. In recent years, the National Drug Strategy has developed a series of national plans to deal with licit and illicit drug use in Australia.

The National Drug Strategy Framework was developed under the direction of the Ministerial Council on Drug Strategy. Membership of the Council includes Commonwealth, State and Territory Ministers responsible for health and law enforcement. Its collective aim is to decide on national policies and programs to reduce the harm caused by drugs to individuals, families and communities in Australia. The National Drug Strategy Framework is an all-encompassing document on drug strategies in Australia, and highlights the contribution of drug use to illness and disease, accident and injury, violence and crime, family and social disruption, and workplace problems.

Under the National Drug Strategy Framework, a series of action plans addresses the harm caused by tobacco, alcohol and illicit drugs in Australia. Individual plans have been developed to deal with tobacco, alcohol, school-based drug education and illicit drugs. Each plan identifies key areas, strategies and actions for reducing harm arising from the use of licit and illicit drugs.

The principle of harm minimisation has formed the basis of Australia's drug strategy since 1985. 'Harm minimisation' refers to policies and programs designed to reduce drug-related harm. The aim of this approach is to improve health, social, and economic outcomes for both the community and the individual. It encompasses a wide range of strategies, including:

- supply-reduction strategies designed to disrupt the production and supply of illicit drugs;
- demand-reduction strategies designed to prevent the uptake of harmful drug use, including abstinence-oriented strategies to reduce drug use;
- strategies to provide effective treatment, follow-up and rehabilitation services to people affected by use of alcohol, tobacco and other drugs; and
- a range of targeted harm-reduction strategies designed to reduce drug-related harm for individuals and communities (MCDS 1998).

In spite of the volume of work in this area, and the large number of existing plans and programs in various parts of Australia, until now no national strategy has addressed Aboriginal and Torres Strait Islander peoples' problems with use of alcohol, tobacco and other drugs.



Aboriginal and Torres Strait Islander peoples' health in Australia

Despite some barriers to accurate measurement of Aboriginal and Torres Strait Islander peoples' health in Australia, available evidence indicates that Aboriginal and Torres Strait Islander peoples continue to suffer a greater burden of ill health than the rest of the population.

- Life expectancy at birth remains substantially lower among Aboriginal and Torres Strait Islander peoples than the general population and death rates are higher than in the general population for almost all causes of death and for every age group.
- In 1998/99, Aboriginal and Torres Strait Islander peoples were more likely than other people to be hospitalised for most diseases and conditions.
- National survey data from 1994 and 1995 shows that Aboriginal and Torres Strait Islander people were more likely than non-Indigenous people to smoke, consume alcohol at hazardous levels, be exposed to violence, and to be categorised as obese.

All of these are significant health risk factors (ABS & AIHW 2001).

Historical context

Inquiries into the health of Aboriginal and Torres Strait Islander people have consistently commented on the detrimental effects of dispossession and alienation on health and wellbeing. The resulting grief, trauma and loss must be recognised as a contributing factor to the lower health and socioeconomic status that Aboriginal and Torres Strait Islander peoples continue to experience today.

The use of alcohol, tobacco and other drugs is both the cause and effect of much suffering in Aboriginal and Torres Strait Islander communities. Alienation, unemployment and despair arising from dispossession and dislocation all contribute to the use of these substances to attempt to relieve symptoms or temporarily escape. The use of alcohol, tobacco and other drugs does serious harm to physical health, but possibly even more harm to the social health of individuals and the fabric of communities. Acts of alcohol-related violence, over-representation of Aboriginal and Torres Strait Islander peoples in the criminal justice system and other forms of societal breakdown are manifestations of the pain, anger and grief experienced by Aboriginal people arising from the process of colonisation. This disturbing burden contributes to the unacceptable levels of harm currently caused by alcohol and other drug use by Aboriginal and Torres Strait Islander peoples.

Patterns of drug use among Aboriginal and Torres Strait Islander peoples have been shaped by history. Until about forty years ago, Aboriginal and Torres Strait Islander peoples were not allowed to consume alcohol. If people wanted to drink, they would buy large quantities of alcohol and drink it quickly to avoid being caught and incarcerated. Such drinking often occurred in groups in the open air, on riverbanks and in parks. This was the genesis of patterns of drinking at harmful and hazardous levels. This pattern of drinking within the group afforded the people a sense of identity and belonging often denied as part of the colonisation process. Consuming alcohol in groups allowed people to be with family, receive news of other family members, to speak their language, sing songs, tell stories and pursue other activities. Consequently the sharing of alcohol, which is a part of wider cultural practice, had both positive and negative effects on the wellbeing of the Aboriginal and Torres Strait Islander people involved. The pattern of drinking large amounts in a short period of time has been handed down from one generation to the next.

Historical factors have also contributed to disproportionately high rates of smoking among Aboriginal and Torres Strait Islander peoples compared with those of the general population. Until the late 1960s, tobacco was used to control Aboriginal people living on missions, settlements and pastoral properties. Tobacco was issued to Aboriginal and Torres Strait Islander peoples as part of official government rations and as payment for labour in many rural industries.

Changing these patterns will require concerted effort over a long period of time. In many Aboriginal and Torres Strait Islander communities, programs to deal with the use of alcohol, tobacco and other drugs have come and gone with little impact on health and wellbeing, thereby increasing a sense of hopelessness and despair. In contrast, changes to liquor licensing arrangements and controls over supply have produced demonstrable results reducing alcohol-related harms in several regions when implemented with the full support of the community. It is important to continue to develop and disseminate evidence about successful strategies and work towards implementing those strategies strategically, rather than relying on ad hoc attempts to address patterns of drug use that have been shaped by history.

Substance use and criminal justice issues

Alcohol, tobacco and other drugs increase involvement in the justice systems. This link has been documented in a range of reports, inquiries and research papers. The Royal Commission into Aboriginal Deaths in Custody found:

One of the factors which too often interacts with the limited economic opportunities of Aboriginal people and the experience of welfare dependency ... is the use of alcohol and other drugs. Indeed, the topic of alcohol use, in particular permeates this report, as the harmful use of alcoholic beverages is one of the most important factors in Aboriginal people being placed in custody and dying there.

Johnston 1991

Aboriginal and Torres Strait Islander prison populations are increasing faster than non-Aboriginal and Torres Strait Islander prison populations. The proportion of prisoners who were Aboriginal and Torres Strait Islander people rose from 14% in 1991 to 20% in 2001. The rate of imprisonment of Aboriginal and Torres Strait Islander people is approximately 14 times that of the non-Indigenous population (ABS 2002). A recent report found that alcohol was third among six major factors underlying the high rates of Aboriginal and Torres Strait Islander arrest (Hamilton-Hunter 2002). In recent years illicit drug use, particularly heroin, is also playing a significant role in Aboriginal people's involvement in the criminal justice system (Select Committee on the Increase in Prisoner Population 2000).

The Office of the Status of Women has reported a relationship between domestic violence and drug and alcohol use in Aboriginal communities, with between 70 and 90 per cent of assaults being committed while under the influence of alcohol or drugs (Office of the Status of Women 2001). Alcohol has also been found to play a major role in homicide. Just over four out of five Aboriginal and Torres Strait Islander homicides involved either the victim or the offender, or both, drinking at the time of the incident (Mouzos 1999). Clearly the connection between drug and alcohol use and offending behaviour in Aboriginal communities requires a blending of crime prevention and drug and alcohol strategies.

The complementary action plan

In recognition of the special challenges faced by Aboriginal and Torres Strait Islander peoples, the complementary action plan focuses on identifying strategies for reducing harm arising from the use of all substances, including licit and illicit drugs, inhalants, and kava among Aboriginal and Torres Strait Islander peoples. It provides examples of actions and identifies key action areas that are relevant to specific geographic areas. It proposes performance measures to measure the outcomes of the complementary action plan over its life.

Like the other National Drug Strategy action plans, the complementary action plan is not intended to be prescriptive or to define detailed implementation strategies. Rather, it sets a national direction for reducing harm associated with use of alcohol, tobacco and other drugs among Aboriginal and Torres Strait Islander peoples. It provides an opportunity for communities, non-government organisations, Aboriginal and Torres Strait Islander community-controlled organisations and all levels of government to pursue strategies that are specifically relevant to Aboriginal and Torres Strait Islander peoples and appropriate to their circumstances, needs and aspirations.

This background paper is intended to be read in conjunction with the action plan. It outlines the epidemiological data and expert opinion that has informed the strategies and actions, provides detailed references to sources current to mid-2002, and expands the brief introductory discussions contained in the plan. In developing this background paper, we have examined:

- relevant national, state, and regional plans about Aboriginal and Torres Strait Islander peoples' health and substance use to identify common principles and strategies for addressing the use of alcohol, tobacco and other drugs in these populations;
- relevant policy and strategy documents about the indigenous populations of Canada and New Zealand to identify commonalities with Australia, and to ascertain if there are any approaches in these settings that are worthy of consideration in the Australian context; and
- literature reporting evidence from trials, studies, evaluations, effective strategies and interventions in minimising harm from use of alcohol, tobacco and other drugs among Aboriginal and Torres Strait Islander peoples.

The National Drug Strategy Framework says a comprehensive harm minimisation approach must take account of three interacting components—the individuals and communities involved; their social, cultural, physical and economic environment; and the drug itself (MCDS 1998).

Throughout the background paper and the complementary action plan we have tried to draw out relevant differences between urban, rural and regional centres, and remote and isolated communities.

- The range of services available in remote and isolated locations, including health services, falls short of those available in less isolated localities.
- Rural and remote communities are often poorer, with more unemployed people, higher suicide rates and higher domestic violence rates than urban areas (Sheil 1997).
- The health of people living in rural and remote communities is generally poorer than that of their city counterparts (Mathers 1994).

Aboriginal people are more likely than other Australians to live in rural and remote communities (NACCHO 1997, DHAC 2000), and experience lower levels of access to health services than the general population (ABS & AIHW 2001). *Healthy Horizons*, the current health framework for rural, regional and remote Australians, notes that looking after

your own health can be difficult in rural, regional and remote communities where local values tolerate smoking, higher levels of alcohol consumption and associated risk-taking behaviour. Seeking help about some health concerns can be difficult when confidentiality can be compromised because the services are highly visible or only available from people who have become family friends (NRHPF 1999).

Patterns of substance use also differ according to location and availability (e.g. the use of petrol as an inhalant is more likely to be found in remote areas than in urban communities; the way alcohol is consumed varies according to its availability) (DHAC 2000). In developing interventions, it is essential to take into account differing patterns of consumption and barriers to accessing services.

Nevertheless, the National Aboriginal Community Controlled Health Organisation (NACCHO) points out that morbidity and mortality rates experienced by Aboriginal people living in urban areas are far closer to those for Aboriginal people living in rural or remote areas than they are for non-Aboriginal people in any part of Australia. Even though there are more doctors, pharmacies, hospitals and other health care services in urban areas, it is a mistake to suppose that urban Aboriginal people escape the barriers to access that the lack of services in remote areas imposes on them. Mainstream services in urban areas are not necessarily accessible or appropriate for Aboriginal and Torres Strait Islander people. Financial, cultural and other barriers to Aboriginal and Torres Strait Islander access to mainstream services exist in all areas (NACCHO 2001).

An overriding principle in the development of this complementary action plan is acknowledgement of the social, cultural and economic factors affecting the health and wellbeing of Aboriginal and Torres Strait Islander peoples. In recent years a large body of research has emerged that shows how social and economic relations within society, the psychosocial impact of these relations, and experiences during sensitive periods in human development influence population health (Hertzman 1999). In its submission to the House of Representatives' *Inquiry into Indigenous Health*, the Royal Australian and New Zealand College of Psychiatrists said:

Alienation, despair, depression, anxiety and psychosis all contribute to the use of substances in an attempt to escape or temporarily relieve symptoms. A social milieu of unemployment and mainstream hostility makes the abuse of substances in a community worse and there is a powerful feedback loop through which the abuse of substances creates more misery for the abuser and for family and friends.

Royal Australian and New Zealand College of Psychiatrists 2000

Disadvantage and poor health in childhood have been linked particularly to mental health problems, use of alcohol, tobacco and other drugs, and development of chronic health problems in later life. Such problems need to be addressed by interventions that act early and have an impact on the interactions between individuals, as well as on the individuals themselves.

The complementary action plan recognises the importance of addressing social, cultural and economic factors in developing responses to Aboriginal and Torres Strait Islander peoples' use of alcohol, tobacco and other drugs.



THE EXTENT AND NATURE OF THE USE OF ALCOHOL, TOBACCO AND OTHER DRUGS AMONG ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

This chapter gives an overview of the social and individual effects of the use of alcohol, tobacco, illicit and other drugs, kava and inhalants among Australia's Aboriginal and Torres Strait Islander peoples.

Alcohol

National data collections have consistently shown that, although the proportion of Aboriginal and Torres Strait Islander people who drink alcohol is lower than among non-Indigenous people, Indigenous people who do consume alcohol are more likely to do so at hazardous levels (AIHW 1995a, b; MCDS 1998; ABS & AIHW 1999).

Preliminary data from the National Drug Strategy 1998 Household Survey indicated that, among people aged 14 years and over throughout Australia:

- 74 % of Aboriginal and Torres Strait Islander people consumed alcohol compared with 77 % of all Australians;
- among people who drank alcohol, 56 % of Aboriginal and Torres Strait Islander people males and 73 % of Aboriginal and Torres Strait Islander people females usually did so at harmful rates, compared with 36 % among all Australians—hazardous or harmful rates of alcohol consumption were defined as more than four standard drinks a day for males, and more than two standard drinks a day for females;
- among urban populations, the proportion of Aboriginal and Torres Strait Islander people who drink alcohol (62 %) is smaller than in the general population (72 %);
- among urban people who drink, 68 % of Aboriginal people consume alcohol at harmful levels, compared to 11 % of drinkers in the general population (AIHW 1999).

At all ages, Aboriginal and Torres Strait Islander men are more likely than women to drink alcohol and have more hazardous drinking patterns than women (AIHW 1995, ABS & AIHW 2001). The heaviest drinking occurs among Aboriginal people aged 25–34 years, whereas in the general population hazardous drinking is most common in people aged 14–24 years (AIHW 1995). Over 20 % of Aboriginal and Torres Strait Islander male drinkers have been found to be in the high risk category for alcohol consumption, compared with 8 % of non-Aboriginal and Torres Strait Islander males. Aboriginal and Torres Strait Islander females were less likely than Aboriginal and Torres Strait Islander males to be categorised as high risk drinkers, but they were still more likely than non-Aboriginal and Torres Strait Islander women drinkers to be consuming alcohol at hazardous levels (AIHW 1995).

Social impact

Alcohol is related to a number of conditions such as alcohol dependence syndrome, alcoholic liver disease, high blood pressure, stroke and some cancers. It is also often a contributing factor to a range of social issues at both the individual and community level.

At an individual level, alcohol is a common contributing factor to injuries from traffic accidents, assault and self-harm including suicide (Unwin, Thomson & Gracey 1994; DHAC 1999b). A substantial proportion of alcohol-related presentations to primary care facilities are from violence in conjunction with intoxication or withdrawal (DHAC 1999c).

At the community level, alcohol is a contributor to problems including family breakdown, domestic violence, financial and legal problems, child abuse and neglect, and psychological distress among relations, friends and associates of the drinker (Davis 1998, DHAC 1999c, Memmott et al. 2001). Family violence is highly prevalent in some Aboriginal and Torres Strait Islander communities. It is disproportionately directed towards women and often associated with alcohol consumption (Aboriginal and Torres Strait Islander Women's Taskforce on Violence 2000). Although not all communities are affected by violence to the same degree, Aboriginal and Torres Strait Islander women in all communities have identified violence as one of their greatest concerns. Alcohol consumption has been associated with violence for many of these women (Bolger 1991).

Other statistics highlight the toll that alcohol consumption imposes on Aboriginal and Torres Strait Islander communities.

- In Western Australia, data indicates that Aboriginal males are over nine times more likely to be hospitalised for alcohol-related conditions than the non-Indigenous Australian population; Aboriginal females are almost 13 times more likely (Bhatia & Anderson 1995).
- In 1990/91 the homicide rate for Aboriginals was nine times the rate for the general population (Strang 1992). Both Aboriginal offenders and victims were more likely than the general population to have been affected by alcohol (DHAC 2000).
- In 1991 Stathis et al. reported that Aboriginal and Torres Strait Islander inmates were significantly more likely than non-Aboriginal and Torres Strait Islander inmates to report using alcohol before offending, and to state that alcohol was a factor in their imprisonment (Stathis, Eyland & Bertram 1991).
- The 1994 National Drug Strategy survey reported that 49% of urban Aboriginal and Torres Strait Islander respondents had had something stolen or damaged by someone affected by alcohol. In addition, 35% of respondents reported that they had been verbally abused or threatened by someone affected by alcohol.
- Approximately 95% of the urban Aboriginal and Torres Strait Islander population regard use of alcohol as a serious problem, with 55% citing it as the drug of most concern.
- Among urban Aboriginal and Torres Strait Islander people, 65% regard either alcohol abuse or alcohol-related violence as the most serious issue facing Aboriginal and Torres Strait Islander communities (AIHW 1995).

Potential years of life lost

The Central Australia Aboriginal Congress (CAAC) has noted that alcohol is most significant in terms of potential years of life lost before age 65 among Aboriginal people. Many Aboriginal people view this as 'the central tragedy of contemporary life: that young-to-middle aged adults are dying when they have potentially so many years ahead of them' (CAAC 1998). Arnold-Reed et al. (1998) calculated that eliminating alcohol consumption would add 5.9 more years of life expectancy to Aboriginal males and 3.4 more years to Aboriginal females.

Tobacco

Cigarette smoking is associated with increased morbidity and mortality from a range of conditions including various types of cancer, coronary heart disease, stroke, chronic respiratory tract diseases, pregnancy-related conditions and low birth weight (English et al. 1995, Sayers & Powers 1997). Additionally, passive smoking is associated with higher rates of lung cancer and heart disease in adults and asthma and respiratory tract illness in children (NH&MRC 1997). Passive smoking is also associated with higher rates of sudden infant death syndrome (Scragg et al. 1993, Mitchell et al. 1997).

- National surveys have consistently revealed a prevalence of smoking in Aboriginal and Torres Strait Islander peoples that is around twice as high as that for non-Aboriginal and Torres Strait Islander people.
- Prevalence of current smoking is in the order of 50–55% in the Aboriginal and Torres Strait Islander population compared with 20–30% in the non-Aboriginal and Torres Strait Islander population (AIHW 1999, Miller & Draper 2001, AIHW 1995).
- In 1995, more Aboriginal and Torres Strait Islander males (56%) were current smokers than Aboriginal and Torres Strait Islander females (46%) (ABS 1995).
- It has been estimated that tobacco-related disease is responsible for between 1.5 and 8 times more deaths in the Aboriginal and Torres Strait Islander community than in the non-Aboriginal and Torres Strait Islander community (DHAC 1999b).

Briggs highlights some of the historical and social factors associated with tobacco use in Aboriginal and Torres Strait Islander populations:

Up until the late 1960s cigarettes, and more commonly loose tobacco, were used to coerce Aboriginal people living on missions and settlements. Elders from my community have spoken to me about tobacco being used to reward people for staying on missions and doing what they are told. If they left they would lose their tobacco ration. As a result, the Aboriginal community have a love/hate relationship with tobacco: the social enjoyment opposing the health and financial burdens associated with smoking.

Briggs 1996

Similarly, Brady writes:

Tobacco is highly addictive, but there are also social explanations for its entrenched use among Aboriginal people. It is a substance firmly grounded in an economic and cultural life that has long antecedents. ... Perhaps the most damning aspect of this account of Indigenous tobacco use in Australia is the extent to which Europeans are implicated in it. ... The unpalatable truth is that an addiction was intentionally manipulated by Europeans for a number of ends. It would as well for those engaged in health promotion to have an appreciation of this context ... because such knowledge may help professionals to free themselves from implicit assumptions about tobacco use.

Brady 2002

Petrol and other inhalants

Petrol sniffing can lead to serious health consequences for individuals, including death, long-term brain damage and long-term disability. It can cause problems for families and communities through social alienation of sniffers, social disruption, vandalism and violence, inter-family conflict, and reduced morale (d'Abbs & MacLean 2000). Brady and Torzillo note that the social disruption caused by sniffing is often more severe when adults are involved rather than children (Brady & Torzillo 1994). d'Abbs and MacLean observe that petrol sniffing appears to offer young people 'some kind of identity, albeit a negative one, amidst the massive change experienced by Aboriginal communities' (d'Abbs & MacLean 2000).

Petrol sniffing, a form of volatile substance use, is particularly prevalent in particular ethnic and low socioeconomic groups of young people within Australia and overseas (d'Abbs & Maclean 2000). It is difficult to estimate the prevalence of petrol sniffing in Australia owing to fluctuations in the practice and variations among communities, but prevalence has increased since the 1970s, with more users sniffing over longer periods. By the 1990s the practice was occurring across large parts of remote Australia (Brady & Torzillo 1994) d'Abbs and MacLean report that since 1994 a reduction in sniffing has occurred in some areas where it had been prevalent for a long time, although some communities still experience

high levels. Reports of volatile substance use in some urban communities have increased (d'Abbs & Maclean 2000). Substances used in urban locations tend to take the form of glue and aerosol paint, since they are more readily accessible than in remote locations where such substances are hard to procure (d'Abbs & Maclean 2000; Sandover, Houghton, & O'Donoghue 1997; Brady & Torzillo 1994; Drugs and Crime Prevention Committee 2002).

Most Aboriginal and Torres Strait Islander petrol sniffers are males in their teenage years, though the age of users ranges from 8 to 30 years. All the people who try petrol sniffing do not become regular or chronic sniffers, but the practice is regarded as a very serious problem because it mainly affects the young and it carries a high potential for permanent physical damage (CAAC 1998).

Illicit drugs

The National Drug Strategy Household Survey 1994 found a higher prevalence of lifetime and past-year illicit drug use among urban Aboriginal compared with the general population. The lifetime prevalence for urban Aboriginal people was 50% compared with 38% for the general population, and the proportion of urban Aboriginals who had used illicit drugs in the past 12 months was 24% compared with 15% in the general population (MCDS 2001).

Data from the 1998 National Drug Strategy Household Survey indicates that the lifetime prevalence for illicit drug use had increased in both populations (59% for Aboriginal and Torres Strait Islander people and 46% for non-Aboriginal and Torres Strait Islander people). Illicit drug use in the past 12 months was estimated to be 23% in both Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander Australians. It should be noted, however, that prevalence estimates from the 1998 National Drug Strategy Household Survey for Aboriginal and Torres Strait Islander people should be treated with caution due to low numbers of Aboriginal and Torres Strait Islander people included in the survey (Miller & Draper 2001). Meyerhoff notes the lack of research about illicit drug use by Aboriginal and Torres Strait Islander Australians and suggests that the issue has been largely neglected (Meyerhoff 2000).

Injecting drug use

Available evidence suggests that the prevalence of injecting drug use among Aboriginal and Torres Strait Islander people is higher than among non-Aboriginal and Torres Strait Islander people in Australia. The 1994 National Drug Strategy Urban Aboriginal and Torres Strait Islander Peoples Supplement found that 3% of Aboriginal and Torres Strait Islander respondents had injected illegal drugs in their lifetime compared with 2% of the general population. In addition, 2% of respondents indicated that they currently injected compared with 0.5% of the general population (Correll, MacDonald & Dore 2000).

Data from annual surveys of injecting drug users attending selected Needle and Syringe Programs (NSP) conducted between 1995 and 1998 indicate higher proportions of Aboriginal and Torres Strait Islander participation in these programs (5.4%) than would be expected given their proportions in the general population (2.1%). If Aboriginal and Torres Strait Islander people who inject drugs are less likely to attend needle and syringe programs, or were less likely to participate in the NSP surveys, then the rate of injecting drug use among Aboriginal and Torres Strait Islander people could be even higher relative to non-Indigenous people (Correll et al. 2000). Similarly it is possible that data from the National Drug Strategy Household Survey could underestimate both Indigenous and non-Aboriginal and Torres Strait Islander injecting drug use either through under-reporting or poor coverage of groups such as people who are homeless and who may be more likely to inject drugs.

The NSP surveys between 1995 and 1998 also found that significantly more Aboriginal and Torres Strait Islander participants reported sharing injecting equipment in the previous month than non-Aboriginal and Torres Strait Islander participants, and were more likely to report injecting more than one drug. These practices are of particular concern in relation to the risk of transmitting Hepatitis C, HIV/AIDS and other blood-borne diseases. A small qualitative study by Shoobridge found that less than half of the Aboriginal injecting drug users in her sample used new injecting equipment. Shoobridge and Larsen suggest that sharing of injecting equipment reflects cultural practices in which close friends and relatives commonly share possessions. These practices need to be considered in the design of harm-reduction strategies (Correll et al. 2000).

A recent study found that injecting drug use among Aboriginal people in Western Australia had probably increased by 50% or more since 1994. It was estimated that between 3–4% of Aboriginal people aged 15 years and over who lived in towns or cities in Western Australia had injected drugs. Disturbingly, 43% of those interviewed said they normally shared needles, syringes and other equipment when they injected. The study recommends, among other things, greater access to clean injecting equipment and better education and training for users, service providers and the community (Curtin University 2002).

A study of injecting drug use in the Melbourne Aboriginal community conducted by the Victorian Aboriginal Health Service Cooperative found that almost every family in the community had been affected by injecting drug use. The study also highlighted the fact that many peoples' drug use began in jail, where drugs were easy to obtain, and most were sharing needles because clean equipment was not available (Lehmann & Frances 1998). The level of over-representation of Indigenous people in Australian prisons may account, in part, for higher prevalence of injecting drug use in Indigenous communities (Correll et al. 2000).

Tranquillisers and analgesics

The National Drug Strategy Household Survey 1994 found that rates of non-medical use of tranquillisers and analgesics were marginally higher among Aboriginal people than in the general population; and that use of cocaine, LSD and ecstasy were marginally lower (AIHW 1995). The 1998 survey found that 9% of Aboriginal people had used analgesics, tranquillisers or sedatives for non-medical purposes in the year before the survey. Females were 94% more likely to have done so than males (AIHW 1999, MCDS 1998).

Cannabis

The National Drug Strategy 1998 Household Survey reported that 28% of Aboriginal people used cannabis—the illicit drug most used in Australia—in the year before the survey. Males were almost twice as likely to have done so than females (AIHW 1999).

Prescription drugs

Consultations with rural Aboriginal communities by the Aboriginal Drug and Alcohol Council identified concern over the misuse of prescription drugs. A number of communities expressed concern at the easy access people have to prescription drugs such as serapax, codeine and panadeine forte and the number of doctors who prescribe them freely (ADAC 1997). The combination of prescribed medications with other substance use (e.g. over the counter medicines, illicit drugs or alcohol) can compound the physiological, psychological and social problems of people with a mental illness (AIHW 1995, Siggins Miller Consultants, Centre for Primary Health Care, and Queensland Alcohol and Drug Research and Education Centre 2003).

Kava

Kava—a drug extracted from the roots of the plant *Piper methysticum* long used by Pacific Islanders—was first introduced into Eastern Arnhem Land in 1981. Use of kava has generally been limited to the Arnhem Land region of the Northern Territory (MCDS 1998). Some communities encouraged the use of kava as a substitute for alcohol because it was thought that, unlike alcohol, people drinking kava were not prone to acts of aggression (Territory Health Services 1999, DHAC 1999b).

d'Abbs reported that the amount of kava being drunk increased between the 1980s and 1992 (d'Abbs 1993).

Heavy kava use can lead to general ill health including shortness of breath, dry scaly skin, liver damage, malnutrition and changes to red and white blood cells and platelets (Alexander 1985). Long-term consumption of large amounts of kava can lead to toxic effects such as ataxia and ascending paralysis without loss of consciousness (Cawte 1986).

As with use of other substances, Aboriginal communities have expressed concern about the social effects of drinking kava. They include neglecting family and community duties, and spending large amounts of income on kava leaving little for food and other essential items. The *Kava Management Act 1998* (NT) in the Northern Territory prohibits the selling of kava without a licence. Communities may apply to the Liquor Commission for a licence to sell and use kava if there is demonstrated support in the community (territory Health Services 1999).



2 REVIEW OF SELECTED LITERATURE ABOUT THE USE ALCOHOL, TOBACCO AND OTHER DRUGS AMONG ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

Introduction

This chapter considers the evidence on effective interventions in the use of alcohol, tobacco and other drugs and psycho-active substances among Aboriginal and Torres Strait Islander peoples. Our review of the literature found few formal evaluations of Aboriginal and Torres Strait Islander specific substance use interventions of any kind. Nevertheless, a number of introductory comments can be made.

The available evidence suggests that reduced use of alcohol, tobacco and other drugs and related harms are associated most strongly with socioeconomic initiatives and supply reduction measures. Health education programs have been far less effective and much of the research suggests that residential rehabilitation centres have produced relatively few gains considering the investment required (Saggers & Gray 2001).

Brady considers that community involvement and support are crucial to the success or otherwise of any drug or alcohol intervention (Brady 1991). She also regards as critical people's perceptions of their own health, and the motivation of the community to improve health care.

The value of community support and involvement figures prominently in the findings on specific substances as well. In their review of petrol sniffing interventions, for example, d'Abbs and MacLean find that the most successful projects first enjoy widespread support from both the community and families, and secondly involve the active participation of their members (d'Abbs & MacLean 2000). This suggests the importance of work that focuses on developing cohesion within communities, and strengthens motivation and capacity for action. This includes establishing mechanisms for exchanging information between and within communities so that people are aware of what has been successful in the past. Accordingly, d'Abbs and MacLean conclude that use of a range of concurrent, multi-modal strategies targeting the drug, the users, and the social setting where use occurred are the third key factor. They say the limited success of many projects can be attributed at least in part to a failure to consider more than one of these three factors.

The National Drug Research Institute's review of Aboriginal and Torres Strait Islander people drug and alcohol projects for the Australian National Council on Drugs concludes that, despite the limited number of formal evaluations, it is possible to draw a number of key elements from the literature on existing evaluations and experiences described in key informant interviews (Gray et al. 2002). Elements that contribute to better practice in effective projects include:

- clearly defined management structures and procedures;
- trained staff and effective staff development programs;
- multi-strategy, collaborative approaches;
- adequate funding; and
- clearly defined and realistic objectives aimed at the provision of appropriate services which address community needs.

Control of supply

Supply control measures targeting alcohol and petrol have proved significant for Aboriginal and Torres Strait Islander communities, particularly in remote circumscribed settings (DHAC 1999b).

Alcohol

Saggers and Gray argue that a focus on alcohol supply is useful because it directs attention beyond Aboriginal demand for alcohol and towards a wider examination of the ways in which demand is generated and supply promoted (Saggers & Gray 1997). In doing so, it also spreads the responsibility for alcohol-related harm in a more equitable manner throughout the whole community. Limits on the availability of alcohol are something practical that communities can achieve in the short term, while developing and implementing longer-term strategies to address demand for alcohol at individual and community levels. Flick argues that 'changes in the alcohol and drug status of Aboriginal people will only occur when the drug trade is directly challenged, particularly alcohol and tobacco' (Flick 1998). Communities, she argues, must also examine the ways in which they have become commercially implicated, through a dependence on alcohol sales for council revenue for example.

Brady also identifies a range of problems that bans on public drinking in towns can have on surrounding Aboriginal communities, and in the homes of town residents (Brady 1998). These have included drinkers forcing themselves into people's homes or other disruptive behaviour that puts older people and children at risk, damage to people's houses, a lack of police support to deal with this disruption, the lack of a follow-up plan, broader strategies or additional actions to complement dry area decisions, increased exploitation by suppliers of alcohol selling people cheap alcohol in wholesale fashion on the sly, and an ongoing shift of responsibility away from officials such as the town council and Liquor Commission and on to Aboriginal residents, often elderly, without the necessary resources to deal with alcohol-related problems and without easy access to misuse services.

In addition, d'Abbs has noted that the success of dry area restrictions for some more remote communities have led to increasing pressure by nearby towns and others to introduce wet canteens as a 'solution' to the problem of road accidents and disruptions caused by public drunkenness in towns (d'Abbs 1998).

Community bans on the consumption or possession of alcohol, aided by the introduction of legislation in some jurisdictions enabling the declaration of 'dry' areas, have had some success in helping to minimise alcohol-related harms including violence, low workforce productivity, injury, illness and death. They work best in remoter areas where communities are more circumscribed (Davis 1998).

Northern Territory

An evaluation of this strategy in the Northern Territory, where communities can apply for restricted areas status under the *Liquor Act 1980*, found that the introduction of prohibition was associated with reductions in alcohol-related harms in several, though not all, of the communities studied (d'Abbs 1990). The review concluded that this kind of measure does not alone guarantee community control over alcohol. To do so, communities need to develop a coherent strategy for addressing alcohol problems, and there must be community support for restrictions and agreed on roles for the day-to-day control of consumption.

South Australia

A more recent study by the Aboriginal Drug and Alcohol Council (SA) examined the impact of dry areas in South Australia (ADAC 2001). In the case of remote Aboriginal communities, where community action has brought about bans on alcohol, the study found that this measure has been effective in the control of alcohol use. A number of negative consequences were also identified, including for example an increase in the rate of car accidents and fatalities as a result of people driving long distances to access alcohol. In the case of regional towns and urban centres, where local governments had introduced

bans applying to specific areas, the results were quite different. Although businesses and local people reported a reduction in alcohol-related disruption, the evidence suggests that problems were often re-located to another place beyond the restricted area or out of the general public's eye.

Regional and remote Australia

d'Abbs and Togni's review of recent community-based liquor licensing initiatives in regional and remote Australia (Halls Creek, Tennant Creek, Derby and Curtin Springs) found that supply restrictions, mostly targeting takeaway sales and the sale of cask wine, had a modest but definite impact on levels of alcohol consumption and a significant impact on indicators of alcohol-related harm, especially violence, both interpersonal and property (d'Abbs & Togni 2001). They also found generally widespread community support, often qualified by a strong conviction of the need for other measures in addition to supply restrictions. They identified a number of issues around the introduction of such liquor licensing restrictions including:

- the importance of being clear about claims of representation—*who is speaking for the community?*
- the selection of particular kinds of restrictions, including those that limit opening hours, takeaway trading conditions, particular beverages and particular outlets;
- the selection of appropriate additional measures such as counselling or education;
- the choice of selective restrictions that apply solely to Aboriginal people versus universal restrictions which apply to whole towns; and
- the role of liquor licensing authorities in imposing or facilitating restrictions.

All but one town or community implemented these initiatives as part of a broader range of strategies to deal with alcohol-related problems (e.g. Derby's strategy included a soup kitchen, a drink area project to create safe designated drinking areas to address harm related to public drunkenness, a safe house for partners and children, and a health promotion project) (d'Abbs & Togni 1998).

Western Australia

Consultations with members of regional Aboriginal organisations in Western Australia found that liquor licensing legislation, while an important strategy, cannot address the underlying causes of excessive consumption and demand (Gray et al. 1995). In an environment that promotes the misuse of alcohol, licensing restrictions by themselves cannot curb the excessive drinking by some Aboriginal people and the related harm. Local community involvement in licensing decisions, and the need to make sure licensing acts facilitate this involvement, was seen as the key factor in minimising alcohol-related harm by ensuring those best placed to define alcohol-related problems can develop the strategies to deal with them.

Other strategies designed to limit the supply of alcohol on remote communities included women's patrols (e.g. women's patrols at Yuendumu and Mutitjulu stop and search vehicles in order to combat the sly grog trade into their communities) (CAAC 1995). With the support and cooperation of the local police, this strategy has proven successful in many areas.

Tobacco

The control and regulation of the supply of tobacco are addressed in Key Strategy Area 3 of the *National Tobacco Strategy 1999 to 2002-04* (MCDS 1999). They are largely mainstream measures, rather than measures specific to the Aboriginal and Torres Strait Islander community. Examples of tobacco control strategies discussed in NACCHO's report of the National Aboriginal and Torres Strait Islander Tobacco Control Project include supply reduction strategies to limit the availability of tobacco, such as laws that ban sale of tobacco to people under 18 years of age. It recommends actions in community stores, and research into the impact of monetary expenditure on tobacco when developing tobacco policy on pricing and taxation (Lindorff 2002).

Petrol and other inhalants

The introduction of Avgas, a highly refined aviation fuel, as an alternative to petrol has been an effective short-term means of combating petrol sniffing in some remote Aboriginal communities, when combined with interventions targeting the sniffers and the broader contexts for their use (d'Abbs & MacLean 2000). As with measures targeting the supply of alcohol, it needs to be implemented as part of a broader range of longer-term interventions that can address the underlying causes of sniffing. The Petrol Link-up Project (discussed further in the below section on early intervention strategies) recommended a three-pronged approach aimed at:

- reducing of availability of petrol through the substitution of Avgas;
- rehabilitation for sniffers through the use of outstations; and
- positive alternatives through youth programs (Shaw, Armstrong & San Roque 1995).

A follow up study 20 months after the introduction of Avgas to Maningrida in the Northern Territory, along with a targeted employment and skills training program, concluded that although Avgas is a key element in the elimination of petrol sniffing, its general lack of success as a single intervention in other communities indicates the importance of widespread community resolve, and well coordinated employment and skills training strategies (Burns, Currie & Clough 1995). Lacking genuine community support, other initiatives tried over the last 25 years in Maningrida such as the introduction of chemical deterrents, health education campaigns and the public shaming of offenders, have invariably failed.

A study of the impact of substituting Avgas for petrol on Anangu Pitjantjatjara Land communities found that although there was already a marked decline in petrol sniffing from 1984 and 1995, the introduction of Avgas was associated with a steep decline in petrol sniffing and arrests for petrol sniffing dropped dramatically (Roper & Shaw 1996). Since that study, the rate of petrol sniffing has increased, but remains lower than levels before the introduction of Avgas (Roper 1998, Nganampa Health Council 1997). Communities easily accessible by main roads have benefited far less from this measure than more isolated communities (Roper 1998). Some communities have reverted to the sale of petrol because young people still found ways of accessing outside sources (Mosey 1997).

Under community by-laws, the supply or possession of petrol for the purposes of inhalation is illegal on the Pitjantjatjara Lands in South Australia and Ngaanyatjarra Lands in Western Australia. The impact of this measure is in dispute. Under the Northern Territory's *Misuse of Drugs Act 1993* (NT) it is also illegal knowingly to supply a volatile substance, although this legislation has never been enforced. d'Abbs and MacLean conclude that legal sanctions against the possession or supply of volatile substances for the purposes of inhalation, as well as other supply control measures such as locking up petrol supplies or the introduction of chemical deterrents, have not proven to be generally effective (d'Abbs & MacLean 2000).

The greater range and availability of volatile substances in urban areas makes it far more difficult to target supply in the same way as remote communities (d'Abbs & MacLean 2000). A project in the Midland area of Western Australia helped a hardware store concerned that young people were stealing or attempting to buy volatile substances for the purpose of inhalation (Helfgott & Rose 1994). Strategies such as the use of dummy display cans, staff education, signs and liaison with relevant services were successful in a substantial reduction in the problem. The authors note however, that this kind of targeted strategy does not stop people from trying to access volatile substances elsewhere.

Illicit drugs

Like tobacco, the supply of illicit drugs is largely a mainstream matter, but literature identifies a number of issues relevant to supply control issues for Aboriginal and Torres Strait Islander communities.

A study of injecting drug use in the Melbourne Aboriginal community found that most people injecting were also doing some kind of dealing—usually splitting a ‘deal’ or selling on—to fund their habit (Edwards, Frances & Lehmann 1998). The authors argue that in a poor community money that comes from dealing drugs may be an important part of family income; making it difficult for family members who are not involved to speak out against drugs. Young people also told them that older people in the community were supplying them drugs, and this had weakened respect for Elders, particularly when they also know that Elders themselves were using alcohol and cannabis.

Prescription drugs

The Aboriginal Drug and Alcohol Council’s consultations with rural communities identified significant community concern over the misuse of prescription drugs and the easy access people have to prescription drugs such as serapax, codeine and panadeine forte, and the numbers of doctors who prescribe these drugs freely (ADAC 1997).

Kava

Research into the harmful effects of heavy long-term consumption of kava on physical health in Aboriginal communities has concluded that regulation rather than a complete ban would be the most appropriate course to take (Mathews et al. 1988). Bans by traditional owners and/or the local councils on the sale or supply of kava in some Arnhem Land communities have proved unsuccessful without the support of effective government controls on the regional trade in kava (d’Abbs & Burns 1997).

In addition to identifying its negative impact on the physical health and social wellbeing, an investigation into kava use in Arnhem Land by members of Aboriginal communities in the Kimberley found grave community concerns over the financial cost of kava to communities (e.g. a community’s bill for one month in 1987 was nearly \$20 000) (Drury et al. 1987). Supply networks with white entrepreneurs controlled the source and middle levels were causing the loss of vast sums of money from communities that could ill afford it.

The main response by governments to kava-related problems has been the introduction of legislative controls over its supply (d’Abbs & Burns 1997).

- In response to reports of adverse health consequences, the Western Australian Government has prohibited its sale and supply since 1988 under the *Poisons Act 1964* (WA) (Prescott 1990).
- At the national level, the supply of kava is regulated through the *National Code of Kava Management* (Cwlth).
- Under the Northern Territory’s *Kava Management Act 1998* (NT) the selling of kava without a licence is illegal. Communities may apply to the Liquor Commission for a licence to sell and use kava if there is community support for its sale (Territory Health Services 1997). Kava management plans developed by communities include details of limits on purchases and hours of sale (Government of the Northern Territory 2001).

No evidence appears to be available about whether these regulatory actions have succeeded in limiting the consumption of kava, health-related harms, or the economic damage caused by the black market trade. A review of an earlier attempt at regulating supply in the Northern Territory found that community councils were ill-prepared and ill-suited to administering a system of controlled supply of kava, that with few exceptions the Government neither helped councils or other retailers to meet their requirements nor monitored their activities to ensure compliance, and that entrepreneurs had capitalised on the opportunities created by the poorly policed system to use it to their own advantage (d’Abbs & Burns 1997). Following the introduction of controls there was a fall in sales for about 6 months but that this was short-lived, and sales steadily climbed to their previous high levels soon after.

Demand management

Australian National Council on Drugs (ANCD) research on the structural determinants of youth drug use outlines a range of broad and inter-related economic, social and physical factors at the macro-environmental level that influences developmental health within a community, and the incidence of psychosocial disorders and health risk behaviours such as drug use (Spooner, Hall & Lynskey 2001). The evidence is overwhelming that socioeconomic gaps and disadvantage contribute to a range of detrimental outcomes, including drug use.

Aboriginal and Torres Strait Islander peoples—especially those living in rural or remote areas—carry a disproportionate burden of disadvantage in health, employment, education, incarceration levels and public health infrastructure. There is therefore an urgent need for targeted and tailored substance use prevention programs that address underlying disadvantage, of which drug use is both a symptom and a contributory factor.

Research suggests that multi-modal strategies, capable of addressing multiple risk and protective factors in a comprehensive, consistent and coordinated manner, are most likely to prevent drug use. Research also indicates the limitations of drug education, media campaigns and law enforcement approaches to drug prevention. One-off interventions are particularly ineffective. Drug use should not be seen in isolation, or as an individual behaviour, but as one of a range of problems shaped by economic, social and physical environmental factors affecting human development.

Historically, however, Aboriginal health promotion initiatives (e.g. in the public health system) have generally been restricted to ineffective and unsustainable single-strategy initiatives such as posters, pamphlets, and one-off events (NSW Health Department, and the Aboriginal Health & Medical Research Council of NSW 2001). Initiatives have tended to be marginal to most mainstream health promotion activity, and receive little attention in development or evaluation.

Alcohol

Despite the popularity of prevention projects, there is little evidence to suggest the effectiveness or otherwise of models designed to prevent or reduce alcohol misuse. Gray et al. have identified a number of evaluations of health promotion projects and all suggested the limited impact of these projects, even over the short term (Gray et al. 2000). However, they caution that the methodologies used do not allow for generalisations. They also note the importance of remembering the limited efficacy of these kinds of interventions with other populations, particularly when conducted in isolation (Edwards et al. 1994).

Gray et al. conclude their review of alcohol interventions with a caution against allowing the focus on effective alcohol intervention programs to obscure the broader context of alcohol consumption and misuse (Gray et al. 2000). They stress that the fundamental political and economic inequalities arising from dispossession and colonialism must be addressed in the interests of the greater public good and social justice.

CAAPU cites research by the World Health Organization on alcohol policy which concluded that in relation to school-based education, public education, warning labels and advertising restrictions,

... there is no present research evidence which can support their deployment as lead policy choices or justify expenditure of major resources on school-based education or mass media public education campaigns, unless these are placed in the broader context of community action.

Edwards et al. 1994

Work by CAAPU on the development of effective and appropriate health promotion suggests that the most effective health promotion messages are those that come from the community itself (Maher & Tilton 1994).

Victoria

The Victorian Koori Alcohol and Drug Prevention Project initiated in 1985 delivered health promotion services including education classes, sporting and recreational activities and the support of homeless people. The evaluation found that although well received by the community, the project was hampered by a lack of support structures for the Aboriginal alcohol and drug workers (Alati 1993). In addition, the review found that staff were placed under considerable pressure to undertake a wider range of services than was funded for such as counselling, because of Aboriginal people's reluctance to use mainstream services.

Queensland

The Queensland Department of Education's school-based alcohol education package *When you think about it* developed in cooperation with an Aboriginal community in 1993 proved difficult to evaluate quantitatively due to high absentee rates and small sample size completing pre- and post-intervention surveys (Sheehan et al. 1995). On the basis of qualitative data, the researchers concluded that, while the student response to locally developed material was positive, the effect on attitudes, already strongly anti-alcohol, was limited. The need for teacher training to better implement these kinds of projects was identified.

The findings of a review of another drug education program developed on Palm Island, based around social learning principles, were a little more promising (Barber, Walsh & Bradshaw 1989). Pre- and post-intervention surveys of participants and a control group indicated that students responded positively to both the content and method of delivery, and that they were more aware of the influence of peer pressure to drink. In addition, the reviewers cautiously claimed that the program might have helped reduce the numbers of children taking up drinking.

Northern Territory

An evaluation of the Australian Government funded 1993 campaign targeting adolescent alcohol use in the Northern Territory, which included a bush tour by Yothu Yindi and an associated television commercial, concluded that although people's perceptions of the impact of the tour's message were mixed, it was generally effective in reaching its target audience and in highlighting anti-alcohol use agendas (Milne, Josif & Lynn 1993). The findings also suggested that exposure to the television commercial varied according to local viewing habits and although responses to it were generally positive, interpretations of the message varied. The fact that Aboriginal health workers and teachers did express a need for supporting material and information was deemed significant. A subsequent report on the campaign for The Central Australia Aboriginal Congress (CAAC) concluded that it was significantly compromised by its 'top-down' approach and a lack of consultation in some regions, which lead to a lack of cultural appropriateness for those communities (Maher & Tilton 1994).

Recommendations of the review of alcohol services provided by Jungarni-Jutiya Alcohol Action Council Aboriginal Corporation in Halls Creek included the introduction of a number of broad strategies in order to better meet the needs of community members for prevention and community development strategies. These included (Sputore, Gray & Sampi 2000):

- a wider range of social and recreational activities should be developed to alleviate boredom and as an alternative to alcohol and drug use;
- a more comprehensive drug and alcohol education program should be developed, which includes education on safe drinking practices, and education and media campaigns on cannabis, tobacco, petrol sniffing and multi-drug use; and
- efforts should be made to work with other agencies to promote employment opportunities involving further investigation of the feasibility of an Aboriginal tourism venture or other business enterprise.

Western Australia

In addition to specific recommendations designed to further improve service provision, the recent review of drug and alcohol services in Port Hedland and Roebourne recommended a series of broader, preventive, socioeconomic and cultural initiatives (Saggers & Gray 2001). The review recommended that:

- relevant Aboriginal and non-Aboriginal health, education, training and employment agencies should initiate formal collaboration between the proposed regional health planning forum and regional development forum, in order to promote long-term employment and business opportunities for Aboriginal people;
- relevant Aboriginal people and non-Aboriginal agencies should initiate leadership training and mentoring of Aboriginal people for committee work on Aboriginal health and other agencies;
- funds should be sought for Aboriginal health services and local youth agencies to provide cultural initiatives such as bush trips and community-based activities in town and outlying communities, focusing on healthy lifestyles and including young people; and
- the Aboriginal and Torres Strait Islander Commission and Department of Aboriginal Affairs should investigate support for Aboriginal customary law in the Pilbara as a means of tackling substance use and related harms.

Urban and regional areas

Literature contains little on interventions targeting the demand for alcohol by Aboriginal and Torres Strait Islander people living in urban and regional centres of the country.

Moore has suggested that an over-emphasis on research with rural and remote Aboriginal communities reflects outdated conceptual models, and this in turn has hindered the development of appropriate and effective prevention programs for urban people (Moore 1992).

Blignault's study of alcohol use and rates of abstinence among urban Aboriginal people in Western Australia identified higher rates of both abstinence and cessation than the general population, and sizeable numbers of people whose weekly consumption was well within recommended limits (Blignault 1995). The implications of these findings for the development of effective prevention strategies and other kinds of interventions were examined. The study found that issues of employment and housing were clearly important (e.g. Community Development Employment Projects are effective in many communities because they are flexible and include individuals that would otherwise be unemployable). Blignault also highlighted the importance of recreational activities and opportunities to socialise without alcohol and engage in meaningful activities. In addition, awareness of alcohol-related problems, especially in relation to family members, figured prominently in decisions not to drink, suggesting the value of public awareness and education programs emphasising alcohol-related harm within the family.

All initiatives in the alcohol area should be community based, informed by an understanding of Aboriginal culture, and coupled with wider plans for community development, and have empowerment and self-determination as central features.

Blignault 1995

Tobacco

Recommendations to Health Australia from the 1995 Tobacco Control Summit Working Group include a range of prevention strategies for addressing Aboriginal and Torres Strait Islander peoples' use of tobacco. The working group argued that, given the generally poor cessation rates in the whole community, priority should be given to implementing smoking prevention strategies and training, with cessation services to Aboriginal health workers (AHWs) and communities as a secondary consideration (Andrews et al. 1996). Research activities must also focus on supporting the prevention of smoking uptake by young Aboriginal people. The priority target group for pilot tobacco control projects, involving local, community-based research and interventions, needs to be people aged 10 to 20 years or younger with the aim of preventing the uptake of smoking in the next ten years. Training programs should be provided for Aboriginal health workers with a focus on public health and prevention. Rather than focusing on AHWs own cessation, the focus should be on encouraging workers to engage in tobacco control, whether they smoke or not. It was likely that involvement in tobacco control research, advocacy, networks, resource development and interventions could facilitate smoking cessation among AHWs. Finally, the working group also recommended State/Territory or regional level trials of a Quit line for Aboriginal and Torres Strait Islander people, suggesting that a national line may be less appropriate because of the wide range of social and linguistic differences in the Aboriginal and Torres Strait Islander population.

NACCHO's national Aboriginal and Torres Strait Islander tobacco control project, *Time for Action*, recommends that health workers need extra support and specialised programs to help them quit tobacco, owing to the stressful nature of their work (Lindorff 2002).

A number of evaluated projects are reported. The following examples were limited by methodological difficulties that make it difficult to suggest the impact of their interventions.

Western Australia

The Smoking and Health Program of the Health Department of Western Australian implemented an Aboriginal smoking project in 1994 (Walley & Sullivan 1994). A range of strategies and resources were developed and implemented in collaboration with Aboriginal health workers and agencies. These included:

- an Aboriginal Quit newsletter for Aboriginal health professionals;
- Aboriginal Quit media advertisements targeting Aboriginal adult smokers featuring Aboriginal actors and employing humour to convey the Quit message;
- youth strategies including a competition to promote non-smoking messages, the use of young positive Aboriginal role models to help educate youth in schools and the community, posters with role models from different regions distributed to health workers and agencies as well as mainstream agencies, schools and community organisations;
- Aboriginal sports star swap cards—an Australian first, in strong demand from Aboriginal health and youth sporting agencies; and
- an Aboriginal non-smoking training manual—*The Gnummari Wa Western Australian Non-smoking Manual* developed by Aboriginal health workers, Health Department, the Marr Mooditj Health Worker Training College and the Perth Aboriginal Medical Services. Regular workshops with Aboriginal health workers were held throughout the State to explain and encourage use of the manual.

Evaluation of the Gnummari Wa workshops found that participants found them to be informative and relevant and encouraging in their own quit attempts. An evaluation of the radio advertisements proved difficult due to poor response rates to surveys. However, the general response and the publicity generated were encouraging. The advertisements were subsequently re-used in 1995, 1996 and 1997. An Aboriginal media production company was commissioned to produce further radio advertisements and a television commercial that were used in 1997 Quit campaign. Anecdotal feedback from Aboriginal health workers

suggests the usefulness of the newsletter in raising awareness. The authors also note that the project suggests the value in conducting face-to-face approaches in the evaluation of strategies involving Aboriginal health workers.

Northern Territory

The Maningrida 'Be Smoke Free' project was designed to help describe the current knowledge, attitudes and practices regarding tobacco use in school-aged children and to develop and evaluate a culturally sensitive intervention that could be used by other remote communities in the Top End of the Northern Territory (Johnston et al. 1998). The three week intervention was conducted in one of three participating communities and included a locally produced CD-Rom, classroom teaching of the Northern Territory's tobacco curriculum, declaration of smoke-free education and health centres, prizes for *Be Smoke Free* songs and posters created by students, a *Be Smoke Free* concert featuring local rock bands, visits from well-known Northern Territory sporting personalities, and community educational displays.

Teachers administered pre- and post-intervention questionnaires covering current practices, knowledge of and attitudes to smoking. The surveys identified that in spite of having reasonable levels of knowledge on adverse health effects, smoking is perceived as an acceptable and expected aspect of adulthood. They also identified a high uptake of smoking. The reasons for starting to smoke were based around 'liking it' or peer-based. Reasons for not starting to smoke were either health-based or that the participants regarded themselves as too young. Variable attendance meant that little more could be gained from survey results in terms of the effectiveness of the intervention itself. In general though, the authors report that the project met with 'considerable enthusiasm and community wide support'. The CD-Rom proved to be the most popular activity and well received in its subsequent use in smoking education projects elsewhere.

Petrol and other inhalants

The Central Australian Aboriginal Congress (CAAC) argues that petrol sniffing in children and adolescents needs to be understood within the framework of alcohol-related community and family crisis, and the subsequent inability of kin to meet the fundamental social, psychological and cultural needs of their children or deal with problems such as petrol sniffing (CAAC 1998). As such, significant improvements in other areas of substance use are considered unlikely until the wider problems of alcohol use start to be properly addressed. They concede however, that this does not in itself lessen the need for specific programs for young petrol sniffers. Elsewhere, CAAC notes the development of programs in some areas to deal with glue sniffing based primarily on providing alternative activities (CAAC 1995). They suggest that the provision of these programs by Aboriginal peoples themselves is likely to be a critical factor in their success.

In their review of interventions in petrol sniffing in Aboriginal communities, d'Abbs and MacLean conclude that the most effective long-term strategies are likely to be ones capable of improving the health and wellbeing of young people, their families and communities (d'Abbs & MacLean 2000). Rather than developing long-term prevention measures, they found that community, agency and government responses to petrol sniffing have often been reactive and inconsistent, in response to a sudden increase in prevalence and media attention, and that they lack ongoing support or effectiveness (citing Garrow 1997, Mosey 1997). They caution that although an important part of any intervention strategy, prevention projects should not be judged against unrealistic criteria. They should not be expected to meet the needs of chronic sniffers nor can they always prevent some young people from taking up sniffing. The review also found that the participation of Aboriginal Elders and other community members proved critical to the success of many programs.

Illicit drugs

Urban communities

Meyerhoff's review of injecting drug use in Aboriginal and Torres Strait Islander urban communities identified the following themes concerning the causes of use of alcohol, tobacco and other drugs amongst young Aboriginal and Torres Strait Islander people (Meyerhoff 2000):

- experimentation, which appears to be one of the major risk factors for injecting drug among young Aboriginal and Torres Strait Islander Australians;
- boredom and/or a lack of relevant and affordable recreational facilities or activities, particularly in remote, rural and regional areas;
- peer group issues; and
- a lack of positive role models within Aboriginal and Torres Strait Islander communities.

Petrol and other inhalants

Conclusions by d'Abbs and MacLean (2000)

Many difficulties face young people growing up on Aboriginal communities. Channelling of adult attention to these issues by communities, agencies and funding bodies may impact on 'risk' behaviours including petrol sniffing. Many people have argued that youth worker positions should be funded in Aboriginal communities to provide support and increase the range of activities available to young people.

Recreational programs have a useful role to play if they:

- are sensitive to the needs of the community;
- provide a range of programs;
- are genuinely engaging and exciting and provide opportunity for risk-taking; and
- include activities for girls and young women.

Activities should be available after hours, on the weekends and during school holidays. Although sniffers should be encouraged to take part, programs should be targeted at all young people in the community.

Appropriate school, employment and training opportunities have the potential to divert young people from petrol sniffing.

Education about petrol sniffing is most usefully targeted at the community, or select groups within the community such as parents or professional staff. Most young people already know that sniffing is dangerous and scare tactics are generally counterproductive. Educational activities should seek to promote caring capacities in the community rather than spread alarm and despondency. When education is aimed at sniffers it should focus on effects of sniffing which are likely to be of concern to young people.

Moving to outstations has enabled some families to escape problems such as petrol sniffing experienced in some large communities (d'Abbs & MacLean 2000).

In the course of consultations with the Melbourne Koori community, the Victorian Aboriginal Health Service's Injecting Drug Use Project identified a number of recommended demand management strategies (Edwards et al. 1998). They included an emphasis by all involved that cultural wellbeing was the key to dealing with all threats to Aboriginal and Torres Strait Islander health. Some evidence suggested that a movement by young people away from Aboriginal and Torres Strait Islander cultural values was a factor in their excessive use of illicit substances. The project identified the lead role that community organisations could play in providing programs for young people to strengthen culture, in educating the community about drugs and in providing healthy alternatives to drug use. It also identified community education strategies, including traditional Aboriginal values and culture, particularly around parenting, family responsibilities and spirituality. In addition to community education, there also needs to be broader community-based preventive action targeting employment, legal issues, housing, and sports and recreational activities such as arts, music and dance. Potential barriers to effective education include a lack of information that is easy to understand and that relates well to Aboriginal peoples' lives. The project also identified the need for conflict resolution and community development strategies for communities where long-standing conflicts between families and clans make it difficult to develop cohesive, comprehensive prevention programs.

Rural communities

ADAC's consultations with rural communities identified the need for community awareness campaigns about the use of alcohol, tobacco and other drugs (ADAC 1997). There was a need to focus on the harmful effects of alcohol, tobacco and other drugs, misuse of prescription drugs and youth-targeted messages on the negative impacts of tobacco smoking. Recommended strategies included the use of 'shock' tactics, television and other electronic media as part of an ongoing campaign targeting the whole community and radio to target health promotion messages at youth, and the implementation of regular health promotion days in collaboration with community health services.

All communities expressed concern about the use of alcohol, tobacco and other drugs and its impact on the wellbeing of young people. They identified the need to develop 'life' or 'survival' skills programs with cultural activities to teach morals, handling peer pressure, parenting skills, birth control, cooking, cleaning, budgeting, looking after their health and preparing them for life in the larger towns and cities. Youth education strategies could include training peer educators to act as role models and educate youth about the risk of use of alcohol, tobacco and other drugs; and establishing a youth forum for young people to express their views.

Some communities identified lack of employment opportunities, boredom and lack of recreational activities in rural communities as contributing factors in use of alcohol, tobacco and other drugs by young people. Employment and training, such as land management and mechanics courses through TAFE, would be appropriate. Recommended recreation included an after-school youth centre, a youth festival organised and run by young people, weekend activities that focused on having fun, and organised sport. Family education about use of alcohol, tobacco and other drugs was a priority, and education on physical and mental wellbeing (e.g. nutrition, addiction/dependence and drug induced psychosis, financial impoverishment, child abuse, violence and crime, neglect of children's education, and relationship breakdowns). Many also stressed the need to establish healing centres to address the underlying problems causing the use of alcohol, tobacco and other drugs. One identified the need for a counselling service that could provide grief and loss counselling, crisis intervention, and coping and life skills (ADAC 1997).

Kava

No evidence is available on the effective prevention of kava misuse among Aboriginal and Torres Strait Islander peoples. In a 1988 study of the physical effects of heavy consumption of kava, the researchers suggest that the social reasons for the harmful levels of kava use in Arnhem Land are presumed to be as complex as the reasons for alcohol use and petrol sniffing in other communities (Mathews et al. 1988).

Harm reduction

Alcohol

For many years Aboriginal and Torres Strait Islander communities have pursued a range of strategies designed to reduce the harm associated with alcohol use (Brady 1996). They include sobering-up shelters, night patrols and injury prevention projects.

Sobering-up shelters

Encouraged by the findings of the Royal Commission into Aboriginal Deaths in Custody and the decriminalisation of public drunkenness in many jurisdictions, shelters have now been established in a variety of remote, rural and urban settings throughout Australia. They provide a safe alternative environment for temporary supervision and care of intoxicated people at risk of harming themselves or others (Brady 2002, Gray et al. 2000).

Sobering-up shelters can provide an effective means of diverting people from police detention for public drunkenness, and of reducing levels of alcohol-related harm for both individuals and their communities (DHAC 1999b). A study of community attitudes towards the decriminalisation of public drunkenness and establishment of sobering-up shelters in three Western Australian towns found they were generally well accepted by both clients and the police (Daly & Gvozdenovic 1994).

- Data from the Wiluna Sobering-up Shelter in Western Australia indicated a 33 % reduction in alcohol-related injuries recorded at the local primary health care service, a 90 % decline in arrests relating to damage of property and a 67 % decline in arrests for assault during the time of its operation (DHAC 1997).
- In the fifteen-month period from its opening in September 1992, the sobering-up centre in Halls Creek, Western Australia admitted 3745 people, which accounted for 78 % of all people detained for public drunkenness (Midford, Daly & Holmes 1994).
- A recent review of drug and alcohol services in the Pilbara region found that the Roebourne Sobering-up Shelter had an increase of annual admissions from 474 in 1993 to 2043 in 2000, and there was a corresponding decrease in police detentions from 1130 in 1992 to 19 in 2000. Staff at the centre also give clients vitamin supplements, and bottled water and fruit when they leave the shelter. Annual admissions at the Hedland Sobering-up Centre grew from 429 in 1992 to 1902 in 2000, with a corresponding decline in annual police detentions from 851 in 1996 to 114 in 2000 (Saggers & Gray 2001).

Brady and Martin note that each shelter admission represents the aversion of a potentially harmful drinking episode and saving of possibly significant costs of an emergency medical treatment or law enforcement incident (Brady & Martin 1999). Shelters can also provide an important point of contact for alcohol workers.

A study of the establishment of the sobering-up centre in Halls Creek found that its success provided a catalyst for further action by the community (Midford, Daly & Holmes 1994). The study suggests that the community development principles used in its establishment ensured greater community involvement, understanding and ownership of the initiative. A critical factor in the centre's success and subsequent initiatives was that evaluation criteria were built into the process early. Data showing that the centre was meeting its goals gave it local credibility and helped mobilise support in other communities. The Halls Creek community successfully lobbied for liquor restrictions, and have since established a night patrol and alcohol education and counselling centre (Sputore et al. 2000). Ngarinnga Ngurra Aboriginal Corporation also runs a women's safe house, that also provides a family centre and arts centre and undertakes outreach work with the community (Brady 1998).

Night patrols

Night patrols are regarded as an effective means of reducing alcohol-related crime, violence and death (Mosey 1994).

- Tennant Creek's Julalikari Council Night Patrol is an internationally recognised and multi-award winning program initiated and managed by a group of women Elders in response to the harmful levels of drinking and drinking-related illness, accidents and violence, including domestic violence and child abuse, in their community (Ellis 1996). A group of volunteers intervene in disputes, take women to shelters and help men to sober up if required. The patrol involves extensive liaison with other services in the community such as the hospital, police and medical service. A formal agreement on practices and procedures exists between Julalikari Council Aboriginal Corporation and the Northern Territory Police outlining protocols to reduce the numbers of people detained by police for minor offences (e.g. the patrol has the right to decide whether a person should be taken to the community's sobering-up shelter and try to resolve disputes before police are called for backup).

Patrols have also been established in urban areas.

- McKelvie and Cameron describe the work of the Noongar Alcohol and Substance Abuse Service (NASAS) in Perth, which undertakes day and night patrols in inner-city streets and parks as part of a comprehensive range of services. The outreach team mediates between Aboriginal people, the police, private security and community people. It also provides informal counselling and advice, and welfare support and has established a meal program that prepares and distributes lunches to Aboriginal people living in inner-city parks. The outreach team runs a youth-specific program in collaboration with the police to provide culturally appropriate support to young people who are intoxicated or in police custody. It also transports young people home or to a safe environment. NASAS's outreach team follow up with case management of clients accessed through their patrols (McKelvie & Cameron 2000).
- An evaluation of the Ngunowar-Aewah Aboriginal Corporation's night patrol in Wyndham found the number of people arrested by police has not changed significantly since it started, but the police suggest this could be explained by the fact that they spent less time spent dealing with intoxicated people and thus had more time for other police activities. Community members and clients believed the patrol was effective in preventing alcohol-related injury, reducing the numbers in detention and getting people off the streets. The same evaluation reported a decline in police detentions in Kununurra from 1336 in 1995 to 188 in 1997 and attributed it to the combined efforts of Waringarri Aboriginal Corporation's night patrol, sobering-up shelter and the local police (Sputore et al. 1998).

The review of the Commonwealth's Aboriginal and Torres Strait Islander Substance Misuse Program suggests a number of factors as being instrumental in providing successful diversionary interventions, such as night patrols and sobering-up shelters (DHAC 1999b), including:

- the importance of their being part of a comprehensive set of strategies to deal with public drunkenness, as also identified by the Royal Commission into Aboriginal Deaths in Custody;
- involvement of other agencies such as women's shelters and refuges, hospitals and treatment agencies;
- development of formal and informal procedures with police for the delivery of intoxicated people to shelters or other organisations as an alternative to incarceration; and
- workers with the necessary skills to deal with intoxicated people.

Evaluations of drug and alcohol service provision in Roebourne, Port Hedland, Kununurra, and Halls Creek identified the importance of good coordination of service provision between sobering-up shelters, patrols and other agencies (Saggers & Gray 2001, Sputore et al. 1998, Sputore et al. 2000).

Injury prevention projects

Another way to targeting alcohol-related harm is through injury prevention projects (see box). The incidence of alcohol-related injuries and car accidents are cause for particular concern, particularly in their prevalence among adolescents and young adults, and the subsequent traumatic impact on families (Spark, Donovan & Howat 1991).

Spark et al. (1991) stress the importance of community control and involvement in all stages of developing and implementing such projects, particularly in remote settings. Greater community participation and ownership helps ensure the relevance and appropriateness of a message and the continuing motivation and commitment of community members to initiate and maintain behavioural changes to improve their own health. They state that many educational or environmental interventions fail to strengthen the capacity of communities to solve their own problems and gain greater control over the determinants of their own health. The Ottawa Charter for Health Promotion suggests that enabling this capacity should be the purpose of all health promotion initiatives. In summary, they suggest that an appropriate model for Aboriginal health interventions is one:

- where Aboriginal and Torres Strait Islander cultural influences on attitudes to health and health issues are acknowledged;
- where educational and environmental strategies are employed in an eclectic manner that is appropriate to the particular cultural and social situation; and
- that operates at the community level and involves community members in all stages of the process.

Kimberley Aboriginal Health Promotion Project

(an example of an injury prevention project)

The aim of the Kimberley Aboriginal Health Promotion Project was to evaluate the effectiveness of health promotion strategies in Aboriginal communities (Spark, Donovan & Howat 1991). The process of developing an injury prevention project was guided by previous work in the Northern Territory and involved an emphasis on facilitating feelings of empowerment within a community and raising awareness of the need to address health issues. Workshops, conducted by Aboriginal facilitators, were held in two remote Kimberley communities in order to identify health issue priorities for the communities involved and locally relevant health promotion messages in the form of illustrated stories or situations.

Women from one dry community raised the issue of young men driving to the nearest town to drink, with the risk of car accidents through drink driving, and the problems they often cause in the community when they return. The resulting storyboard based on this issue depicted one young man electing not to drink but to look after the others on a drinking trip—this young man drives the car, organises purchase of food, makes sure no alcohol re-enters the community and later breaks up a fight that starts among his mates. The storyboard was subject to further consultation and approval by other community members.

The advertisement was filmed by a local Aboriginal production company and acted by members of a local rock band. Subsequent surveys in two communities in which the advertisement was aired found that about 40 % of people recognised the advertisement and there was a positive congruence between the communication objectives and the perceived message about responsible drinking for the sake of the community and the problem of drink driving.

Wet canteens

Considerable controversy surrounds the notion of establishing community-managed licensed social clubs or 'wet canteens' in Aboriginal and Torres Strait Islander communities as a way of reducing alcohol-related harm (CAAC 1995). Recognising that some people will choose to continue drinking rather than give it up, it has been suggested that clubs may provide a controlled, safer environment where people can learn social, moderate drinking habits and alcohol-related trouble can be contained. The dangerous practice of drinking in camps, riverbeds or parks may also be discouraged. With access to a source of alcohol in communities, people may be less likely to have alcohol-related car accidents driving to and from town to drink. Community-controlled social clubs are also regarded by some as an expression of self-determination and an issue of equality (d'Abbs 1998).

However, the Central Australian Aboriginal Congress argues that it is inappropriate and irresponsible to promote controlled drinking practices as a harm-reduction strategy for many Aboriginal drinkers, given their social, political, cultural and economic situation. Many individuals already have severe and chronic alcohol-related medical problems and 'live in a world that revolves around drinking and drinking to enormous excess' (CAAC 1998).

Evidence from throughout Australia, and from Cape York and the Northern Territory in particular, suggests that rather than mediating alcohol-related harms, the introduction of licensed clubs on remote communities is associated with development of a heavy drinking culture with significant negative impacts on people's health and community wellbeing in the short and long term (Brady & Martin 1999, Martin 1998, d'Abbs 1998, Fitzgerald et al. 2001). The lack of infrastructure capable of providing necessary medical, social and emergency support, including a lack of effective policing in remote communities, further compounds the problem.

The argument that canteens promote responsible, controlled levels of drinking is contradicted by a study of consumption levels on seven of the eight Northern Territory communities with licensed clubs in 1994/95 which found high levels of consumption in all but one community; with a mean consumption level approximately 50% above the level designated 'harmful' by National Health and Medical Research Council guidelines (d'Abbs 1998). This figure equates to an average rate of consumption for female drinkers 183% higher than the Northern Territory average, which is itself 32% higher than the national average. The rate of consumption for men was some 76% higher than figures for the Northern Territory, which is already 42% higher than the national average. The rate of consumption per capita in Cape York where wet canteens are common is the highest in the world (Pearson 2000, Fitzgerald et al. 2001).

Research with Cape York communities found that the numbers of non-drinkers or moderate drinkers actually declines with the normalisation of heavy chronic consumption and a social life based around the canteen (Martin 1998). Evidence from Queensland also suggests that the establishment of a canteen does little to inhibit the illicit or 'sly grog' trade in alcohol (Martin 1998). Community councils become dependent on the profits from wet canteens for their power-base in the community and/or funding for community projects, and this can interfere with decision making when excessive alcohol consumption becomes a problem (Brady 1998). Other alcohol-related harms associated with the introduction of wet canteens includes an increased incidence of injuries caused by fights, accidents and self-harm; more serious injuries and homicides; less expenditure on healthy food; neglect of children's needs; and more domestic violence (Brady 1998).

Ideally, canteens operate within strict guidelines designed to help reduce alcohol-related harms, as promoted by the Northern Territory's Living with Alcohol Program for communities that choose to establish canteens. These may include (Hunter & Clarence 1996):

- selling only light beer or light beer at lower prices;
- selling good quality food and avoiding salty foods that make people thirsty;
- strict rules forbidding credit as a condition of the liquor licence;
- introducing a code of practice for staff and licensees; and
- introducing a code of conduct that enables the club, community or council to ban offenders from the canteen.

However, experience in the Cape, for example, suggests that although many clubs begin with strict rules, these rules often relax over time with pressure from committed drinkers and/or the lure of greater profits (Brady 1998). In response to the Cape York Justice Study, in September 2002 the Queensland Parliament passed new laws to change the management of alcohol and its impact on communities. The *Community Services Legislation Amendment Act 2002 (QLD)* gives community justice groups formal powers to declare dry places within their community, and advise on operation of canteens and limits on alcohol that can be brought into the community. It requires community liquor licence boards to manage canteens in a way that prevents harm arising from alcohol use and associated violence (Parliament of Queensland 2002).

d'Abbs suggests a number of other important social, economic and political factors that makes the safe management of canteens difficult (d'Abbs 1998).

- People in control of clubs have virtual monopolistic control over a highly valued resource.
- They are subject to weak accountability requirements—much weaker than those imposed on most companies.
- The administrative infrastructure in the communities concerned is normally poorly developed, overworked and lacking in adequately trained staff.
- The populations to which the clubs are theoretically accountable have low levels of literacy and numeracy, and contain few people able to maintain a critical scrutiny of transactions and decisions involving club management.
- Populations also tend to be polarised into two camps—one that places a high priority on drinking rights; the other that regards alcohol as a destructive force that destroys social and cultural community life.

Research on alcohol use in the Kakadu–West Arnhem region made a series of recommendations designed to counteract the concentration of economic and political power of those in control of the clubs, and make them more accountable to the diversity of community interests, opinions and needs (d'Abbs & Jones 1996). These included making it mandatory that 50% of a club's elected committee positions be held by adult Aboriginal women residents, that committees include at least one nominee from any drug and alcohol service or committee in the region, and that further restrictions on the availability of takeaway alcohol be considered.

The call by residents of regional towns and centres such as Alice Springs for the establishment of canteens in outlying Aboriginal communities in order to reduce the numbers of heavy drinkers and associated problems with public drunkenness in town is questionable for many reasons (Brady & Martin 1999). Aside from placing a greater burden of ill health and social disruption on communities far less equipped to handle such problems, the evidence suggests that the presence of canteens does little to reduce alcohol-related problems in nearby towns.

A study of rates of Aboriginal Protective Custody Apprehensions (APCA) in Darwin, for example, found that the communities with highest rates all had canteens, and the community with the lowest APCA rate had no club and the strongest dry area restrictions (d'Abbs 1990). This finding also makes it less likely that canteens reduce the likelihood of drink-driving accidents, as some have suggested. As the Central Australian Aboriginal Congress notes, support for canteens also assumes incorrectly that Aboriginal people living in camps and outlying communities visit towns solely for the purpose of drinking (CAAC 1998).

Other strategies

Other harm-reduction strategies identified include provision of women's refuges, safe houses and legal advice centres, establishment of safe drinking camps with basic facilities such as fresh water, toilets and telephone, meal programs, and violence management counselling for men (Brady 1998).

Brady's *The Grog Book*, for example, highlights the work of Tangentyere Council, in Alice Springs, which implemented the Social Behaviour Project in response to reports by their night patrol on the levels of alcohol-related social problems in the town and surrounding camps (Brady 1998). Important incidents are referred on by the night patrol to particular departments in the council for further action and have included coordinating help in resolving family disputes, organising financial support and temporary housing. The Council's bank agency also provides advances on part of people's welfare cheques in the form of food vouchers that can be used at the council-owned supermarket to help reduce the harmful amount spent on alcohol. It provides elderly people in particular a way out of being hassled by others for money. However, the provision of food vouchers has also been criticised by some because it encourages dependency and can be seen as a return to paternalism.

Tobacco

Tobacco harm-reduction strategies that involve a reduction in exposure to environmental tobacco smoke, particularly for children, and education about passive smoking are important and are supported by the evidence. The *Time for Action* report says educational interventions on exposure to environmental smoke in the home are very appropriate for Aboriginal and Torres Strait Islander people as a harm-reduction measure, given the high prevalence of smoking in the home (Lindorff 2002). There is little other evidence to support recommendations on harm-reduction interventions for tobacco (Fiore et al. 2000, Roche & Ober 2001).

Petrol and other inhalants

The introduction and use of unleaded petrol is associated with significant reductions in morbidity and mortality from petrol sniffing (d'Abbs & MacLean 2000). However, the long-term effects of inhaling unleaded petrol are unknown, although the evidence does suggest that the hydrocarbons present in both leaded and unleaded petrol are also neurotoxic.

More research is also needed on the effects of inhaling the other substances introduced to unleaded petrol in place of lead. The health and social problems associated with the high from sniffing petrol, and the associated risk of coma or death, are not alleviated (Goodheart & Dunne 1994).

Other recommended harm-reduction measures include (Brady 1985, d'Abbs & MacLean 2000):

- discouraging people from sniffing in small enclosed spaces such as cupboards where a lack of oxygen and greater concentration of petrol fumes can increase the risk of losing consciousness;
- not surprising or chasing sniffers, as this may lead to sudden death;

- avoiding sniffing from a rag or bag; and
- taking care not to ignite petrol.

Although evidence is lacking about the relative safety of different volatile substances, spraying gases such as lighter fluids directly into the mouth is known to be particularly dangerous and should also be discouraged (d'Abbs & MacLean 2000). Given the overall danger of the practice and the weak nature of the available evidence, the British Advisory Council on the Misuse of Drugs has rejected the proposal that young people should be advised on the relative safety of different substances as a harm-reduction measure (Advisory Council on the Misuse of Drugs UK 1995).

Research with incarcerated Aboriginal volatile substance users found they used some minor harm-reduction strategies, including their choice of inhalant, rejecting petrol where possible for other substances such as glue that are perceived to be less dangerous. Young people in urban and regional areas prefer more readily accessible toluene and glues over petrol, in contrast with those in remote communities where other volatile substances are hard to obtain. The same study also found that people alternate between sniffing through the nose and mouth as a means of minimising harm and prefer to sniff in public places or in company so that help can be more easily accessed if necessary (Sandover, Houghton & O'Donoghue 1997).

Illicit drugs

The literature on illicit drug use interventions in Aboriginal and Torres Strait Islander communities is extremely limited. Most focus on injecting drug or cannabis use, and no evaluations of projects are available. Most are urban in focus.

Nunkuwarrin Yunti in South Australia established the first community-controlled needle and syringe exchange program in 1992. Since then at least another six have been established (Gray et al. 2002). Most are in urban settings. Other community health services also distribute needles without identifying this as a distinct project. While some Aboriginal medical services offer needle and syringe and methadone programs, others feel that to do so would be to condone illicit drug use (DHAC 1999b).

Community attitudes to needle and syringe programs can be mixed. Melbourne-based research found that many community members are uncomfortable with harm reduction as an approach to substance use, especially in relation to needle and syringe exchange programs. People fear that providing clean injecting equipment gives children the wrong messages about drug use. However, the research also suggests that community attitudes are changing, and that some Elders, for example, have changed their minds about needle and syringe exchange services in recent years. They note that the experience of both Aboriginal and Torres Strait Islander and mainstream community-based health services indicate that access to needle and syringe exchange programs reduces the rate of HIV infection among intravenous drug users and leads more people to dispose of needles and syringes safely (Edwards et al. 1998).

The report also highlights the importance of educating injecting drug users about safer injecting practices and ways of cleaning equipment and developing drug-related crime-reduction measures (e.g. provision of methadone treatment) especially considering the over-representation of Aboriginal and Torres Strait Islander people in the criminal justice system. It stresses the value of thinking about harm reduction as a strategy aimed at protecting the health of the community, families and the user from harmful ways of injecting drugs.

The Melbourne injecting drug use project also found that although most participants understood the risk of being infected with blood-borne viruses through unsafe injecting, desperation for a hit often overrode safety considerations. The authors stress the important issues of injecting drug use in jails and youth detention centres, and say that more research is needed into drug use in jails and its impact on Aboriginal and Torres Strait Islander people. Many informants said they had shared needles and equipment in jail where it is extremely difficult to access clean equipment. Some also said that they were introduced to the habit while in jail, to deal with the stress and the boredom. HIV and hepatitis C transmission among Aboriginal and Torres Strait Islander prisoners is a major community concern (ANCA 1996).

A key recommendation from this project was that Victorian Aboriginal Health Service (VAHS) should establish a needle and syringe program (Edwards et al. 1998). Community members reported difficulty in accessing clean needles because of the cost of buying them from pharmacies. Feelings of shame or suspicion and general distrust can also be barriers for Aboriginal people in accessing the needle and syringe programs provided by mainstream services. Reluctance to use local needle and syringe programs has also been identified in other studies (Shoobridge 1997, Larson 1996).

Meyerhoff's review of the literature on injecting drug use by urban Aboriginal and Torres Strait Islander people found that, along with fears around confidentiality, shame can constitute a major factor in injecting drug users not accessing either mainstream or local community health services (Meyerhoff 2000). The stigma associated with illicit drug use for users and their families also makes safe use education difficult. Other cultural barriers to education include community perceptions that illicit drug use is not happening and that education about safe using is culturally inappropriate and condones drug use. Educational interventions targeting unsafe modes of use must consider cultural factors such as languages used, the nature of a community, and the significance of men's and women's business (ANCA 1996).

A recent study of injecting drug use among Aboriginal people in Western Australia found that 43% of those interviewed normally shared needles, syringes and other injecting equipment (Curtin University 2001). The study says there is an urgent need for harm-reduction measures to avoid a significant rise in infections from blood borne viruses such as hepatitis C. Lack of services that can provide culturally appropriate, technically competent, and non-judgemental advice to Aboriginal users is significant. The authors recommend improving access to clean injecting equipment, and providing better education and training on injecting drug use for users, providers and the community.

Work by the Aboriginal Drug and Alcohol Council of South Australia on the educational needs of rural Aboriginal communities about injecting drug use and blood-borne viruses found strong community support for needle and syringe exchange programs in many rural centres (ADAC 1997). The need for health promotion strategies targeting the use of alcohol, tobacco and other drugs, sexual health and blood-borne viruses, especially among young people, was also identified. Peer education was suggested as a valuable strategy, along with the use of television and electronic media. The use of radio for targeting youth was identified as a current strategy in use (e.g. by Coober Pedy through the school radio station which advertises a kid's help line after school hours).

Kava

The 1997 inquiry into the issue of kava regulation in the Northern Territory noted the inadequacy of educational resources about responsible kava use in kava-using communities and called for the development of resources for health workers and drinkers in particular as a matter of urgency (d'Abbs & Burns 1997).

Drury et al. note that some attempt was made to teach communities Fijian ceremonial rules guiding safer kava consumption, but they have been adhered to only marginally (Drury et al. 1987). These guidelines include:

- eating before or after drinking;
- washing hands before mixing;
- keeping people with sores or who are sick from mixing;
- cleanliness of the mixing bowl;
- use of clean water to mix kava;
- washing the cup used to drink kava after each use;
- drinking of water after kava to flush the kidneys and the body system; and
- burying the remains of kava once the active ingredient is extracted.

The very high doses being consumed and the addition of other substances such as aspirin or alcohol are also outside ceremonial guidelines. The weight of evidence does suggest that kava can be consumed in socially regulated ways that minimise harmful consequences (d'Abbs & Burns 1997).

The kava management plans required under amendments made in 2000 to the Northern Territory's *Kava Management Act 1998* (NT) include actions necessary to support the responsible use of kava by communities.

- Warruwi Community's Kava Management Plan stipulates that community education on health and economic matters and the effects of irresponsible use of kava will be implemented, that community leaders will lead by example in the responsible use of kava, that community pay cheques cashed at the shop must have one third the value taken out in foodstuffs to ensure food is supplied to families, and the health clinic, shop and school will provide statistics on health matters, food purchasing trends and attendance respectively. In addition, the Kava Management Committee has the power to take a variety of actions if irresponsible use occurs, including directing the retailer to suspend sales to the community and the provision of counselling by the appropriate family to persons who misuse kava (Warruwi Community Inc. 2001).



Early intervention

Brady identifies the need to broaden the range of interventions targeting the use of alcohol by Aboriginal and Torres Strait Islander people beyond a narrow focus on very early prevention and very late treatment (Brady 1995). The 1999 review of the Commonwealth's *Aboriginal and Torres Strait Islander Substance Misuse Program*, for example, found few examples of early intervention initiatives in primary health care services for Aboriginal and Torres Strait Islander communities. It noted early recommendations by the Royal Commission into Aboriginal Deaths in Custody on the importance of establishing early intervention programs in community and other health services, and training health care staff in screening and intervention techniques (DHAC 1999b).

Similarly, research conducted by the Menzies School of Health Research on alcohol use and interventions in the Kakadu–West Arnhem Region recommended the establishment of a screening and early intervention program in order to address the significant gap in secondary prevention/early intervention measures in the region (d'Abbs & Jones 1996). Given the disproportionate degree to which Aboriginal and Torres Strait Islander people suffer from early onset diabetes and other chronic diseases, and the potentially adverse effects of excessive alcohol use and smoking on their health, a range of early intervention measures need to be actively pursued (DHAC 1999b).

Early intervention programs in primary health care settings

Evidence on the effectiveness of brief intervention measures in the primary health care context is largely drawn from mainstream studies. Review of the Substance Misuse Program notes the work of several researchers who have identified the positive—though difficult to quantify—impact, of early and brief interventions by primary health care professionals on alcohol and other drug use, especially illicit drugs and tobacco (DHAC 1999b).

Couzos and Murray also suggest that positive outcomes can be achieved through the use of either screening tools or individualised questioning or counselling on alcohol, smoking, inhalants and other drugs (Couzos & Murray 1999). Primary health care services are also in a good position to actively disseminate education material on the use of alcohol, tobacco and other drugs, and related health risks (DHAC 1999b). The principles of this kind of early intervention can apply across all kinds of substance use. The Central Australian Aboriginal Congress recommends the use of brief opportunistic intervention programs by primary health care workers targeting the use of tobacco and illicit drugs, in addition to alcohol (CAAC 1998).

While techniques such as brief interventions and motivational interviews have been long recognised as good practice in the management of alcohol and other substance use, they have been slow to develop in health services, especially those working with Aboriginal and Torres Strait Islander clients (DHAC 1999b). The reasons are a matter of debate.

- In the case of alcohol, Brady suggests for example that constant exposure may lead staff to become tolerant of drinking levels that are higher than would be acceptable elsewhere (Brady 1995). Staff may also fear harassing patients and giving cultural affront.
- Davis suggests that ethnocentric views and stereotypes have discouraged their adoption for Aboriginal and Torres Strait Islander clients (Davis 1998).

If the intervention leads to a referral for specialist help, this may be difficult in remote or rural settings where a tertiary service may be some distance away and clients reluctant to travel. Consultations undertaken during the review of the Substance Misuse Program also found that links between primary health care services, either mainstream or Aboriginal Medical Service (AMS), and specialist drug and alcohol services are often ineffective. The review stressed the need for the development of protocols for referral on a regional/local basis (DHAC 1999b).

Alcohol

Brady cites the USA Institute of Medicine's 1990 report, *Broadening the Base of Treatment for Alcohol Problems*, which emphasises the heterogeneous nature of alcohol-related problems and the range of possible available treatment methods (Brady 1995). The report stresses the importance of primary health care programs sharing the responsibility with specialist treatment programs in reducing the burden of alcohol-related problems (e.g. through early interventions by doctors) (Institute of Medicine 1990). Brady says that clinical experience suggests that brief, verbal interventions by doctors can successfully influence an Aboriginal or Torres Strait Islander person's decision to give up the grog, even quite late in their drinking career. She suggests that the doctor-patient relationship may be effective because of its private and personalised nature, and the fact that the doctor is not usually kin, is generally respected and considered knowledgeable, and can provide a legitimate excuse for changing one's social behaviour. Brady has since developed a flip chart resource to guide doctors in undertaking brief interventions with Aboriginal and Torres Strait Islander clients.

In light of Brady's qualitative evidence, which suggests that considerable numbers of Aboriginal and Torres Strait Islander peoples resolve alcohol-related problems without specialist intervention, the Commonwealth's *National Recommendations for the Clinical Management of Alcohol-Related Problems in Indigenous Primary Care Settings* also recommends the use of screening and brief intervention for harmful alcohol use by non-dependant drinkers as an effective means of delivering planned, sustainable and targeted health promotion (DHAC 2000b). The importance of community action to support these activities is also emphasised.

Brady et al. found that, of 29 agencies providing alcohol misuse services primarily to Aboriginal people surveyed in the course of an international study on the use of brief interventions, 15 reported that they offered a program with an abstinence orientation, while the other 14 reported that they offered a variety of approaches including brief interventions (Brady, Dawe & Richmond 1998). Only five of the 18 community-controlled agencies offered a range of secondary interventions beyond an abstinence-orientated treatment focus. Although appropriate for dependent drinkers 'at the severe end of the problem drinker continuum', they argue that this focus is unsuitable for the many people who are drinking at hazardous levels but still amenable to earlier intervention. They conceded that residential treatment facilities based on rigid abstinence goals may reflect the needs of their client base, but suggest that other factors, including policy, funding and a lack of training, have isolated community programs from public health and harm minimisation approaches within mainstream policy.

Brady et al. argue that Aboriginal medical services and other community health services, both government and community operated, could have a far greater role in disseminating simple advice and offering brief motivational interviews to clients opportunistically. The outreach work already undertaken by residential treatment facilities and sobering-up shelters provides an ideal setting for a variety of early intervention techniques, as a complement to the primary focus of their work.

The survey found that many respondents from community-controlled organisations showed interest in further training, including on controlled drinking, despite doubts whether early intervention or harm minimisation techniques would work with Aboriginal and Torres Strait Islander clients. Brady et al. concluded that measures designed to motivate clients to think about their drinking before it becomes destructive to their health and wellbeing should not be associated with or sidelined by continuing debates around abstinence versus controlled drinking.

Tobacco

Evidence in the mainstream suggests that, although underused, brief interventions by general practitioners (for example) have much potential for helping people to quit smoking (DHAC 1999b).

A study of young people in the Melbourne Koori community between 1996 and 1999 using focus groups, surveys and community consultation, identified a range of reasons young Koori people start, don't start, continue or quit smoking (Victorian Aboriginal Health Service 1999). They concluded that:

- encouragement to give up smoking should focus on health and fitness concerns and the cost of smokes—it is also worth appealing to young people's sense of responsibility for others, such as their friends, or their unborn baby;
- encouragement to give up smoking should be linked with other more general health and fitness messages rather than just saying *don't smoke* which people will rebel against anyway;
- young people need continued support from people familiar to them to help them to stop smoking rather than from a stranger on the end of a Quit line; and
- adults and Elders in the community who have successfully stopped smoking are very useful role models for young people who want to give up.

The *Time for Action* report states that parents, older relatives and community Elders are seen as important role models for tobacco use. It confuses children to receive messages about the harm tobacco causes and then see so many older people smoking. Adults should be aware of their influence on children and strongly discourage children from taking up tobacco themselves. Ex-smokers can play an important role in educating the young people of the community about tobacco (Lindorff 2002).

Petrol and other inhalants

It is considered critical to intervene early when people are still only sniffing petrol sporadically (Shaw 1999): people are much less likely to stop sniffing after long periods of intense use. d'Abbs and MacLean identify a range of early or secondary intervention measures designed to halt sniffing before chronic use leads to serious illness and permanent disability. As with other kinds of intervention, there is lack of research that examines other forms of inhalant abuse or has an urban focus.

Resources and funding

Appropriate levels of resourcing and the need for community support, including from courts and welfare agencies (d'Abbs & MacLean 2000), is also identified as critical to the success of outstations.

- Shaw et al. (1995) suggests that a lack of secure funding or disputes over access to resources such as vehicles can often lead to the failure of an outstation program. They also suggest that funding needs to suit the sporadic, small-scale and 'lean' nature of the programs and not jeopardise them by making too many resources available.
- Mosey identified community concerns over a lack of educational opportunities on outstations (Mosey 1997). She found that outstations have also failed when located too close to a main road or community and people were able to leave and petrol was still accessible (Mosey 1997). Support from Elders is also considered critical (d'Abbs & MacLean 2000).

Outstation workers need first aid training and access to adequate telecommunication facilities in case of emergency. A coronial inquiry in Alice Springs into the death of a petrol sniffer who sustained a severe injury at an outstation recommended formal procedures for medical and psychological assessment of sniffers by trained medical personnel (Donald 1998). These findings also suggest that outstations are not suitable for chronic sniffers, serious offenders or very ill or brain damaged people (d'Abbs & MacLean 2000).

Counselling and education

d'Abbs and MacLean also identify the use of individual and family counselling-based approaches as potentially effective early interventions in petrol sniffing. The work of the Healthy Aboriginal Life Team (HALT) in the 1980s and early 1990s is the most well-researched example of this kind of strategy. HALT developed a family counselling and education program based on community development principles. The intervention was designed to help recover the weakened capacity of traditional social and kinship structures—weakened by colonialism, assimilation policies and the more recent dependence on the welfare state—to control and nurture their children and resolve community problems (HALT 1991). The team also used traditional paintings and other media to help formulate information and health messages within an Aboriginal framework in order to generate better understanding and motivate community responsibility in terms of community definitions of the problem. The team also trained chosen community members employed to continue work after they had withdrawn, including the establishment of night patrols (d'Abbs & MacLean 2000).

- Early evaluations of HALT's work with Yuendumu and Kintore communities during the mid-1980s in Central Australia found sniffing had ceased (Smith & McCulloch 1986). Their work with the community of Kiwirrkurra near Kintore also contributed to a reduction in the numbers of sniffers, although a core of chronic sniffers remained (Bryce, Rowse & Scrimgeour 1992).
- Later work on Pitjantjatjara Lands was far less successful, in terms of reducing actual numbers of sniffers. Bryce et al.'s evaluation suggests that HALT's failure was due to a lack of prior relationships with community members along with competition from two other models favoured by community members.

Based on this and other work on HALT, d'Abbs and MacLean (2000) conclude the experiences of the project suggest that:

... in the hands of a skilled counsellor, orthodox counselling and community development techniques can be effective, if used with sensitivity and respect for Aboriginal perceptions and values.

d'Abbs & MacLean 2000

Its lack of success in communities other than the one where it was developed suggests that the model may be less applicable for other groups and communities. Community development work, especially in relation to the difficulties communities often face in reaching agreement on appropriate responses to sniffing and implementing these decisions, is also considered important.

Petrol Link-up was another project conducted for the purpose of helping communities develop the capacity to better respond to petrol sniffing. Although originally intended as a research project, the researchers decided to emphasise the provision of information gathered from existing research and projects to Central Australian communities (Shaw et al. 1995). Conducted from July 1994 to March 1995, the project gathered and collated existing information as a resource for workers and communities, distributed a series of newsletters documenting the project's activities and what other communities were doing to combat sniffing, conducted workshops when invited by particular communities to share information about intervention strategies, and provided administrative support and liaison work to help communities obtain funding. The project was also involved in developing a number of resources still in use in Central Australia (including *The Brain Story*, which depicts through art the damaging effects of sniffing on the brain). The project recommended a three-pronged approach that included the introduction of Avgas, the use of outstations and the provision of positive alternatives such as employment opportunities and recreation activities.

- d'Abbs and MacLean note continued calls from both researchers, outstation managers and other community leaders for an information and support service like that provided by Petrol Link-up.
- The key recommendation of Mosey's recent report on petrol sniffing was the establishment of an inhalant use team to provide information and other support to communities (Mosey 1997).

Night patrols

d'Abbs and MacLean note a lack of evidence on the effectiveness of night patrols and warden schemes as secondary response to sniffing, but conclude that they can play a limited but useful role, especially when they are part of a broader strategy. Communities describe them as critical to dealing with substance use issues. Night patrols can help reduce the numbers of sniffers and related vandalism in the short term, and also give the community a valuable sense that something can be done (d'Abbs & MacLean 2000).

Statutory measures

d'Abbs and MacLean found that, other than providing a break for both sniffers and their communities, the use of statutory measures do not appear to help in early intervention. They also note that some communities have requested the right to develop by-laws in order to enforce treatment orders and this will need careful evaluation if implemented. The evidence also suggests that community-based sanctions such as shaming, banishing or ostracising are ineffective, except in the very short term and/or when sniffing is a new phenomenon and most sniffers are experimenters, when a visitor to the community introduces sniffing, or where there is a functional outstation to send them to (d'Abbs & MacLean 2000).

Outstations

Communities that have outstations often use them as a means of diverting young people from the practice of sniffing, and sometimes as a form of rehabilitation for chronic sniffers. They are often a community's preferred strategy and first choice for dealing with the problem. However, early research on their use did not support the practice (e.g. the 1985 Senate Committee inquiry into volatile substance fumes argued that sending people to outstations does not solve the problem, but only transfers it to a different location less equipped to cope with it, and sniffers who do stop will usually resume sniffing when returned to their community). However, more recent work suggests that outstations can play an important role in combating sniffing, provided changes also occur at the community level (d'Abbs & MacLean 2000).

- The Petrol Link-up Project found that the use of outstations gives both sniffers and their home community a break, provides alternative useful activities for the sniffers, reasserts adult authority over young people, demonstrates the community's concern and care to young people, and functions as a symbolic statement that sniffing is unacceptable to the community (Shaw et al. 1995). They are also regarded as culturally appropriate, by fitting the model of banishment for troublemakers. The threat of being sent away acts as a deterrent for those left in the community and often robs them of the 'sniffing boss'.

The use of outstations has resulted in reductions in the numbers of people petrol sniffing in a number of different communities (e.g. Stojanovski reports that since the Mount Theo Petrol Sniffer Program began in 1994, the number of sniffers in Yuendumu had been reduced from 44 to zero (Stojanovski 1999); success of the program is attributable to a number of factors, including community confidence from past success in dealing with sniffing, initiation and ongoing control of the program by families of sniffers, appropriate support from non- Aboriginal and Torres Strait Islander people, whole community backing and attainment of quick results).

Illicit drugs

Evidence in mainstream settings supports the use of brief interventions and screening tools targeting the use of illicit drugs (DHAC 1999b). The Commonwealth notes the current lack of well-developed and evaluated tools for screening and classifying consumption levels of illicit drugs. The Central Australian Aboriginal Congress recommends the use of brief opportunistic interventions by primary health care workers for illicit drug use (CAAC 1998).

Kava

There is no evidence in the literature of early intervention projects targeting the specific use of kava.

Treatment

Even although historically treatment programs are the most common (and costly) form of intervention in Aboriginal and Torres Strait Islander use of alcohol, tobacco and other drugs, there is limited research on their effectiveness (Gray et al. 2000).

The Commonwealth review of the Substance Abuse Program points out that less than half of OATSIH-funded substance use services are residential-based treatment services and, despite a gradual shift in recent years to funding more primary health care services to do prevention and community education programs, that they are supported by more than half total program funding (DHAC 1999b). The National Drug Research Institute's *Database on Aboriginal and Torres Strait Islander Alcohol and Other Drug Projects* identified 79 treatment services for Aboriginal clients, offering a range of counselling options that were either community or residential based. The majority were oriented to an Alcoholics Anonymous or abstinence approach (Gray et al. 2000).

The Commonwealth review identifies problems in providing residential rehabilitation services for the range of substances. These include the perceived extent of need in the community and the lack of resources to meet that need (DHAC 1999b). Interpretations of 'cultural appropriateness' vary between different services—from employing a board of directors or management who are predominantly Aboriginal or Torres Strait Islander, to incorporating cultural activities into the program, and focusing on racial inequality and loss of culture. These findings suggest the importance of 'transparent processes within a community-based service to facilitate community liaison and participation' in order to ensure cultural appropriateness is determined at the community level.

The limited range of treatment options is also of concern. As a treatment goal, abstinence can act as a deterrent to potential clients in need of help, particularly young people. The historical focus on alcohol has also meant that some services find it difficult to address other substance use problems adequately.

The review notes that in spite of its widespread use, there has been little evaluation of the appropriateness of the Alcoholics Anonymous model for Aboriginal and Torres Strait Islander clients or its long-term benefits. It acknowledges the potential value of Alcohol Anonymous self-help groups to support of those clients who wish to achieve continued abstinence.

A number of services emphasise family and community as 'co-dependents' as an essential part of treatment, recognising the group-based manner in which Aboriginal people drink and become dependent. The review notes the under-representation of women in residential services in particular, although further research is needed into the reasons.

The review concludes that it may be necessary to move from a residential rehabilitation model towards education, health promotion activities, counselling and support services, with a greater emphasis on early identification, and a range of treatment and non-treatment interventions. However, it also underlines the urgent need to improve the capital infrastructure of residential facilities.

The provision of support and training for staff to undertake the important work of linking clients with other services after treatment, such as housing, employment and training, and accommodation services is also stressed. The current lack of resources necessary to provide an appropriate range of aftercare services is a strong theme in consultations with providers, and this lack has a direct impact on treatment outcomes and the potential for relapse. The preponderance of interstate clients in many services makes this even more difficult.

In addition to more effective after care service, the review stresses the importance of case management, development of care plans with clear treatment goals in collaboration with clients, and community-driven development of quality management tools.

In relation to non-residential counselling and support services, the review's findings include:

- counselling and support services should be accessible at the community, family and individual level, and flexible and responsive to needs;
- the diversity of treatment options should reflect the diversity of Aboriginal and Torres Strait Islander peoples (citing Reser 1994); and
- in acute situations models such as debriefing may be helpful and specialised counselling may be needed to deal with longstanding, past or profound, continuing and multiple traumatic experiences.

This last may be needed for whole communities after particular events in order to lessen the likelihood of ongoing negative consequences for the community.

The review also identified a number of important issues in the use of mainstream specialist services. In some regions, the limited number of withdrawal and rehabilitation services or service staff with the necessary expertise in specific forms of drug use can force people who need detox to leave the support of family and community. This suggests the need for more community-based facilities.

The appropriateness of many mainstream services for Aboriginal and Torres Strait Islander clients is also an issue. In addition to employing Aboriginal and Torres Strait Islander health workers in these settings, a comprehensive approach to making mainstream services more responsive to communities' needs should include stronger links between Aboriginal and Torres Strait Islander primary health care service and mainstream specialist services, and the mutual transfer and exchange of health information, education and training. This would both provide better support for individual clients and increase awareness of the needs of Aboriginal and Torres Strait Islander clients in specialist services.

The review also found that, although support and self-help groups by specialist services are an important part of comprehensive approaches to substance use treatment, they do not appear to have been widely adopted for Aboriginal and Torres Strait Islander clients.

Alcohol

The very limited evidence available on outcomes from residential treatment programs is not promising. A review of alcohol treatment rehabilitation services provided by 14 Aboriginal organisations found that few clients achieved the treatment goal of continuing abstinence (O'Connor and Associates 1988). In addition, it found that the outcomes for all programs were limited (to varying degrees) by a lack of staff expertise and administrative problems. However, inclusion of residential facilities or 'dry camps' in some programs was associated with improved health status by giving clients a break from drinking.

A review of programs delivered by the Council for Aboriginal Alcohol Program Services (CAAPS) concluded that the narrow range of available treatment options limited their impact (d'Abbs 1990b). One family-oriented program achieved some degree of positive impact on clients' drinking behaviour, but outcomes of other programs were equivocal.

This review also identified the importance of regular and adequate funding from governments, the need to improve record keeping systems, and the value of community-based field workers as an essential complement to residential programs.

CAAPS uses the model of 'co-dependency' counselling with an emphasis on family involvement in the treatment of their clients. They argue that communities prefer residential facilities, located in urban and regional centres such as Darwin (Nasir 1998). They suggest that treatment programs based on communities are limited in part by the nature of cultural relationships, in contrast with town-based provision where centres are 'safe and accessible without humbug'. The lack of support for clients and their families when they return to their home communities is also identified as a problem requiring constant liaison with councils in home communities.

The Central Australian Aboriginal Alcohol Programs Unit's (CAAAPU) residential program was also evaluated (Miller & Rowse 1995). A review of client registration and discharge forms, interviews with staff and residents, and follow-up with 25 former clients yielded little indication of its effect. The evaluation found no agreed criteria for success and that inadequate funds meant that necessary follow-up data could not be obtained.

CAAAPU's culturally specific and community-controlled approach to treatment was heavily influenced by the work of the Aboriginal and Torres Strait Islander-run treatment centres in Canada. CAAAPU's emphasis on 'culture as treatment' combined adapted forms of the Alcoholics Anonymous model with an emphasis on traditional culture and the strength of participants' cultural identity as a way to improve self-esteem and spiritual wellbeing (McKelvie & Cameron 2000).

Brady has suggested that the apparent lack of success of many residential treatment programs may be owing to a range of factors (Brady 1991). The limited range of treatment options is problematic. A lack of training in treatment or clinical rehabilitation for many staff, who are often ex-alcoholics themselves, has also contributed, and is compounded by a lack of professional support and advice from Commonwealth and State or Territory governments. The history of State-Commonwealth bickering over who should fund services for Aboriginal people has also hampered efforts.

- Many programs remain wedded to a single treatment regime and are insulated from change (Brady 2002).
- Over-reliance on a single disease-based residential model of treating alcohol problems does not recognise the variations in consumption levels and styles of drinking, and the different kinds of life experiences and situations that clients bring to treatment (Brady 1995).

Brady suggests that fruitful avenues for Aboriginal and Torres Strait Islander treatment programs to pursue include better training for board members, exchanges with other non-Aboriginal and Torres Strait Islander therapeutic communities, collaboration in quality improvement reviews, closer partnerships with local state drug and alcohol services and non-government organisation networks, and participation in in-service training programs (Brady 2002).

The relationship between alcohol treatment options and alcohol-related violence is also an issue of concern. Atkinson argues that different treatments are needed in the presence of alcohol-related violence (Atkinson 1991). Where there is violence, emphasis needs to be on giving the victims support and empowerment to enable them to change the circumstances of the abuse, through shelters, resource centres and support services, and that treatment should be a sentencing option if charges are laid.

Tobacco

Despite the disproportionately high rates of tobacco use among Aboriginal and Torres Strait Islander peoples, and its long-term impact on mortality, there is a dearth of research into effective treatment interventions (e.g. subsidised nicotine replacement therapy).

The evidence for effectiveness of nicotine replacement therapy (NRT) in the general population is very strong. The use of NRT increases quit rates approximately 1.5 to 2 fold regardless of setting (Silagy & Stead 2001). Bupropion (Zyban), while not appropriate for all smokers, is an effective non-nicotine medication available only on prescription that approximately doubles the odds of a successful quit attempt and can be combined with NRT (Fiore et al 2000).

Petrol and other inhalants

d'Abbs and MacLean note there is little evidence either in Australia or overseas to guide effective treatment programs for any kind of solvent misuse (d'Abbs & MacLean 2000). They cite a review of the international literature on inhalant misuse programs targeting the general community that found limited data available on treatment suggesting outcomes that were disappointing (Dinwiddie 1994).

American research concludes that solvent users 'defy conventional treatment and prevention efforts' (Beauvais & Trimble 1997).

Brady describes the work of a number of apparently highly successful residential treatment facilities for indigenous youth in Canada which combine traditional and Western healing techniques in a multi-disciplinary approach involving counselling, education and native healing, and a holistic understanding of young solvent users' physical, social and spiritual wellbeing (Brady 1995, McCormick 2000).

d'Abbs and MacLean's review of the literature on petrol sniffing interventions identifies three main approaches to treating petrol sniffing in Australia:

- town-based residential rehabilitation;
- use of outstations or other remote settings as rehabilitation camps; and
- treatment in hospital.

Most if not all the issues relevant to the use of outstations are already covered in the section on early intervention, and therefore this section will focus on town-based services and hospital treatment.

Town-based services

Many programs developed in response to alcohol use now accept clients with other drug problems, including inhalant abuse.

- Evaluation of CAAPS treatment program found that between 1985 and 1990 just under a quarter of its 475 clients were admitted for problems related to petrol sniffing. There was no evidence whether this program had been effective or not (d'Abbs 1990). A lack of funding meant that CAAPS was forced to stop admitting petrol sniffers between 1994 and 1996 (Donald 1998).
- CAAAPU has also accepted petrol sniffers into its residential treatment program with reportedly 'short-term positive results' (CAAC 1997).

Considerable debate has taken place over the last few years about the need to establish a residential rehabilitation facility in Alice Springs and the appropriate objectives for such a facility. The limited evidence available leads d'Abbs and MacLean to conclude that despite

a residential facility's obvious value in the short term as a break for communities, families and sniffers, it may be more effective to allocate resources to programs based on recreation, community development and individual and family counselling. They also note that:

- further study of North American models may provide better guidance on the effectiveness of rehabilitation services;
- without residential facilities, urban and regional centres such as Alice Springs and other communities without outstations have nowhere to send young people for respite from inhalant abuse;
- safe places to sober up are still necessary; and
- long-term care for those who have become too severely disabled to be cared for in their community will also continue to be essential.

Hospital treatment

The main hospital treatment used for sniffers has been chelation therapy for lead poisoning. However, d'Abbs and MacLean found considerable controversy and conflicting evidence on the effectiveness of this form of treatment and the possibility of reversing the more severe neurological consequences of chronic sniffing. The gradual phasing out of leaded petrol in Australia means that its already uncertain role in the treatment of chronic petrol sniffers will be further limited in the future. Currie et al. stress the importance of airway protection for acutely affected petrol sniffers, and recommends early evacuation to a high dependency ward and *aggressive hospital management* (Currie et al. 1994).

Intensive physiotherapy is a long-term need for those sustaining damage from chronic sniffing. It addresses muscle wasting, loss of coordination and symptoms of neuropathy (d'Abbs & MacLean 2000). This aspect of rehabilitation appears to have been neglected both by services and in research and has become a major concern in Canada (Brady 2000). d'Abbs and MacLean also note that much of the acute and long-term care of sniffers is provided by community clinics.

Illicit drugs

There is a lack of evidence about the efficacy or otherwise of current treatment approaches to illicit drug use among Aboriginal and Torres Strait Islander people. The Commonwealth review of the Substance Misuse Program found that many OATSIIH-funded residential rehabilitation services, developed in response to alcohol use, encountered difficulties when dealing with other kinds of substance use (DHAC 1999b). Treatment approaches to illicit drug use tend to be similar to those used for alcohol use. Some services indicated that they lacked the necessary expertise to treat the symptoms of polydrug use. These findings suggest services responding to changing patterns of drug use need support, including in their development of specific programs and special staff training. The review found a reluctance by many residential rehabilitation services to consider admitting clients who are on a methadone maintenance program—it was regarded as merely the substitution of an illegal drug for a legal one and thus unsuitable (DHAC 1999b). Alati also relates that some services have found themselves responsible for administering methadone to a client accepted to their treatment program without any relevant training (Alati 1996). The review did not find any specialist methadone programs for Aboriginal and Torres Strait Islanders.



Consultations with community members by the Victorian Aboriginal Health Service on injecting drug use in Melbourne found widespread concern over the lack of suitable detoxification and rehabilitation services (Lehmann & Frances 1998). They also identified:

- the need for mainstream services to be more accessible and culturally appropriate;
- services for very young users, either Aboriginal or mainstream, were lacking;
- Aboriginal and Torres Strait Islander services were under-resourced, over-stretched and lacking in the necessary skills and experience to cope with drug-related problems; and
- Aboriginal health workers needed specific training on drugs.

The project recommended the extension of existing services or establishment of new ones to:

- enhance access to counselling support for families;
- give more treatment choices for community members who want to stop using;
- develop more culturally appropriate drug rehabilitation programs;
- give better access to residential drug rehabilitation programs and community detoxification services;
- support programs for community members who had stopped using; and
- give better access to grief and loss counselling to deal with stolen generation issues.

In particular, it stressed the importance of assuring that services are confidential, of helping families affected by drugs, and of the overlap between drugs and mental health problems.

Kava

Although a number of programs include kava as one of their target drugs, including CAAP's residential rehabilitation program, there is no evidence on treatment outcomes.



3 NATIONAL, COMMONWEALTH, STATE AND TERRITORY PLANS AND STRATEGIES, AND HOW THEY RELATE TO ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

The National Drug Strategy Framework

This action plan is intended to complement all the other national action plans under the National Drug Strategy Framework. The objectives of the National Drug Strategy Framework are to:

- increase community understanding of drug-related harm;
- strengthen existing partnerships and build new partnerships to reduce drug-related harm;
- develop and strengthen links with other related strategies;
- reduce the supply and use of illicit drugs in the community;
- prevent the uptake of harmful drug use;
- reduce drug-related harm for individuals, families and communities;
- reduce the level of risk behaviour associated with drug use;
- reduce the risks the community of criminal drug offences and other drug-related crime, violence and anti-social behaviour;
- reduce the personal and social disruption, loss of quality of life, loss of productivity and other economic costs associated with the harmful use of drugs;
- increase access to a greater range of high quality prevention and treatment services;
- promote evidence-based practice through research and professional education and training; and
- develop mechanisms for the cooperative development, transfer and use of research among interested parties (MCDS 1998).

How the framework relates to Aboriginal and Torres Strait Islander peoples

They write these great reports: the Royal Commission into Aboriginal Deaths in Custody, Social Justice Reports, and the Bringing them Home report on the stolen generations, the National Aboriginal and Torres Strait Islander Health Strategy. What do they do with them? Jack up their bed, put them on the cupboards so that it looks ok! These things have to be implemented and until they do it's no good talking to us Aboriginals about another plan because they haven't actually implemented all these things along the way, and we're talking about 'It's time for our conscience to get another prick again - we better go and do another report' - and that's the sad part about it.

The late Puggy Hunter, 1999

There are many reports, plans and strategies in the field of Aboriginal and Torres Strait Islander health and the use of alcohol, tobacco and other drugs. The reference group has examined:

- three health and nine drug and alcohol plans from New Zealand and Canada, four of which are specific to indigenous peoples;
- 16 Aboriginal and Torres Strait Islander health plans or strategies in Australia; and
- 12 drug and alcohol plans or strategies (not specific to Aboriginal and Torres Strait Islander peoples).

It also reviewed 16 related reports and policy papers from around Australia, and all the currently available regional health plans developed under the Aboriginal and Torres Strait Islander framework agreements.

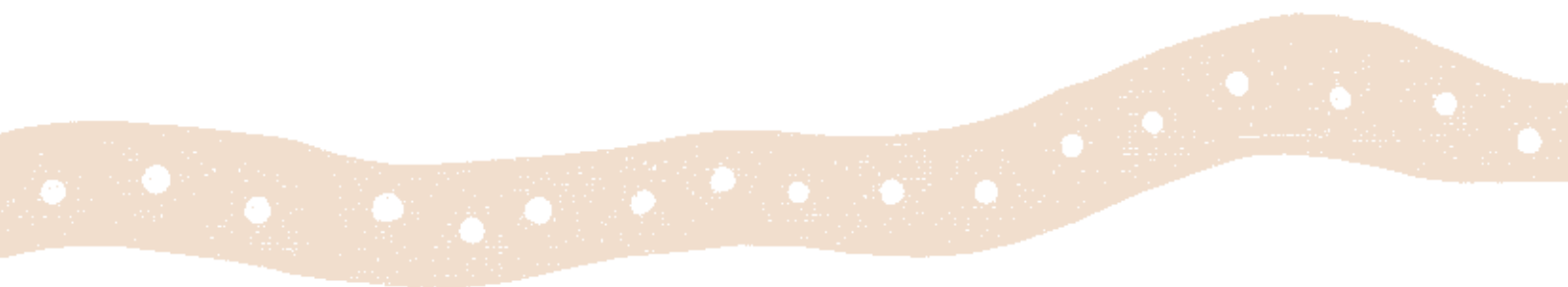
To avoid merely adding yet another document to the pile, and to make this strategy truly complement those effective approaches already in place, we have distilled common principles, key result areas, and types of strategies in the current international, national, State/Territory and regional documents. This analysis adds value to the existing body of material by building on it, rather than developing a plan that does not draw systematically on work done previously.

Common principles

Six common principles for addressing substance use for Aboriginal and Torres Strait Islander peoples within the existing materials have been identified.

1. The use of alcohol, tobacco and other drugs must be addressed as part of a comprehensive, holistic approach to health that includes physical, spiritual, cultural, emotional and social wellbeing, community development and capacity building.
2. Local planning is required to develop responses to needs and priorities set by local Aboriginal and Torres Strait Islander communities.
3. Culturally valid strategies that are effective for Aboriginal and Torres Strait Islander peoples must be developed, implemented and evaluated.
4. Aboriginal and Torres Strait Islander peoples must be centrally involved in planning, development and implementation of strategies to address the use of alcohol, tobacco and other drugs in their communities.
5. Aboriginal and Torres Strait Islander communities should have control over their health, drug and alcohol and related services.
6. Resources to address the use of alcohol, tobacco and other drugs must be available at the level needed to reduce disproportionate levels of drug-related harm among Aboriginal and Torres Strait Islander peoples.

The following sections outline the basis for including each of the key principles and key result areas in the complementary action plan. Examples of strategies from the many international, national, State/Territory and regional plans and strategy documents have been included in each section to illustrate how the relevant principle or key result area could be embodied within a national strategy for Aboriginal and Torres Strait Islander use of alcohol, tobacco and other drugs.



Principle 1: A holistic approach to health

The *National Aboriginal Health Strategy* states that health is:

... not just the physical wellbeing of the individual, but the social, emotional and cultural wellbeing of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life.

National Aboriginal Health Working Party 1989

Both the *New Zealand Health Strategy* and *Canada's Drug Strategy* highlight the importance of reducing inequalities in health status and basing prevention, treatment and rehabilitation strategies on a broad understanding of health determined by underlying social and economic issues such as marginalisation, and disparate social, educational, employment and economic status (NZ MoH 2000, Health Canada 1998). *Gathering Strength: Canada's Aboriginal Action Plan (1997)* outlines a range of strategies and specific actions to enhance aboriginal people's wellbeing in a holistic sense. It is organised around the need to rebuild aboriginal nationhood, to support effective and accountable aboriginal governments, to develop government to government relations between Canada and aboriginal nations, and to take practical steps to improve the living conditions of aboriginal people (Canadian Government 1997).

As early as 1991, the Royal Commission into Aboriginal Deaths in Custody recommended that organisations developing policies and programs:

... recognise the inadequacy of single factor explanations (such as the disease model of problematic alcohol use) of the causes of alcohol dependence and use among individuals and take into account the fact that multiple explanations are necessary to explain the causes of alcohol use and related problems at the community level.

Johnston 1991

The Inquiry into Indigenous Health proposed that, given the complex social and cultural influences on the use of substances:

... it is unlikely that any one activity will resolve the problems in the short, or event the medium term. Substance abuse needs to be seen as both a major problem requiring continuing and improved services and targeted programs, as well as part of the broader health disadvantage of Indigenous Australians which will require action and support from all sectors.

House of Representative Standing Committee of Family and Community Affairs 2000

These concepts have been embodied in the National Drug Strategic Framework, which says that:

... culturally responsive strategies aimed at dealing with the complex social, economic and health impacts that harmful drug and substance use has in Indigenous communities will be an important element of the National Drug action plans.

MCDS 1998

Similarly, the 2002 *Tobacco: Time for Action* report says the Aboriginal concept of health, and the holistic approach that flows from it, sees clients as part of a family and a community as well as an individual, and the whole person—body, mind and spirit—is considered in treating health issues (Lindorff 2002).

Recent State/Territory-level policy and strategy documents also espouse the principle that a holistic view of health should underlie health service delivery for Aboriginal and Torres Strait Islander peoples (Northern Territory Government 1996, NSW Health 1999). The *Northern Territory Aboriginal Health Policy 1996* (NT) notes that to focus only on diseases

or their associated risk factors will have at best only a marginal effect on health status. The policy identifies the direct and underlying causative factors that contribute to excess mortality and morbidity among Aboriginal and Torres Strait Islander people. They include lifestyle, environmental health, housing, water and sewerage, health services, political and cultural identity, demography and geography, education, employment, and economic factors. The policy stresses the importance of addressing this range of issues in order to set the foundation for improving Aboriginal health in the long term (NT Government 1996).

An issues paper from the Western Australia Community Drug Summit Office highlights the need to address underlying causes of substance use such as housing, employment and mental wellbeing, and services both inside and outside the alcohol and other drugs field need to respond to these issues (WA Community Drug Summit Office 2001). In Queensland, Apunipima's 'River of Life' Strategy to improve the health of Cape York people recognises that the primary determinants of disease are mainly economic and social, and that its remedies must also be economic and social. The 'River of Life' Strategy seeks to address the determinants of health that affect peoples' lives—not only access to health services, but creative solutions to address poverty, welfare, marginalisation, access to education, inadequate housing, sewerage, water and nutrition (Apunipima Cape York Health Council 2000).

Examples of strategies—international

New Zealand Health Strategy

- Development of the Reducing Inequalities in Health Framework and work with other sectors to identify wider determinants of health inequalities.
- Support for research on Maori health inequalities and effective interventions.
- Development, implementation and evaluation of plans for reducing Maori health inequalities by district health boards (NZ MoH 2000).

Alcohol and Drug Toolkit (NZ)

- Involving family, and others as essential to improved outcomes in the provision of specialist alcohol and drug treatment and maintenance services (NZ MoH 2000).

Gathering Strength: Canada's Aboriginal Action Plan

- Renewing the partnership between aboriginal and non-aboriginal Canadians through recognition of historic and modern treaty relationships, participation of aboriginal people in the design and delivery of programs affecting their lives and communities, and the establishment of programs to preserve, protect and teach aboriginal languages.
- Strengthening aboriginal governance through strategies such as recognition of the inherent, constitutional right of self-government and the gradual devolution of programming responsibility and resources to aboriginal organisations, the establishment of a governance resource centre, recognition of aboriginal governments, provision of professional development strategies in land, environment and resource management, and improving treaty land claim processes.
- Developing a new fiscal relationship by providing improved multi-year funding arrangements, enhanced accountability of 'first nations' as recognised government bodies to community members and the Government of Canada, development of aboriginal governments' capacity to generate their own revenue through economic development and internal sources, and strengthening the capacity of 'first nations' governments to collect data by statistical training (Canadian Government 1997).

Examples of strategies—State/Territory

Northern Territory Aboriginal Health Policy

- Despite the changes that Aboriginal peoples have experienced in the last two hundred years many people maintain strong cultural links. Aboriginal cultural beliefs and practices need to be acknowledged in the design and delivery of health care.
- Education is important in helping to remove barriers to access services. This is particularly so in the Northern Territory where most Aboriginal people live in rural/remote areas where English is often a second language.
- Aboriginal employment, education and training in a cross-section of health occupations, including management, is integral to increasing Aboriginal participation in the health care system. Employment in both urban and rural centres is needed to increase Aboriginal input and representation across different communities and regions (NT Government 1996).

Ensuring Progress in Aboriginal Health: A Policy for the NSW Health System

- Improved health of Aboriginal people taking account of the need to restore social, economic and cultural wellbeing through:
 - improved health outcomes for Aboriginal people (including an emphasis on substance use and emotional/social wellbeing issues); and
 - improved environments and infrastructure that support the health and wellbeing of Aboriginal people and communities (NSW Department of Health 1999).

Examples of strategies—regional

Strategic Plan for Aboriginal and Torres Strait Islander Health in the Mid-West Region of Western Australia

- Close links need to be established between the alcohol, tobacco and other drugs components of the plan with mental health, self-harm and suicide, and injury and prevention elements of the plan (Mid West Regional Planning Team Western Australia 1999).

Principle 2: Local planning that responds to local needs and priorities

This principle is prominent in existing strategies, plans and reports. The process of regional planning under the Aboriginal and Torres Strait Islander health framework agreements provides a structure for ensuring that local priorities are identified and prioritised for action.

The Review of the Substance Misuse Program says it is well documented that services developed in a region in collaboration with other Aboriginal and Torres Strait Islander and mainstream services can facilitate the most appropriate local mix of services. Furthermore, development of joint regional plans can facilitate links at the local/regional level by identifying the services that are available and bringing players together to discuss needs and develop local networks (DHAC 1999b).

The Australian Aboriginal and Torres Strait Islander Health Council and the Australian Health Ministers' Conference agreed that the regional planning process would aim to:

- allow for full and formal Aboriginal and Torres Strait Islander participation in decision making and determination of priorities;
- generate and present data to facilitate analysis and decision making and where possible, improve the quality of the data available;
- identify priorities on the basis of transparent measures of relative needs, in regions or communities within regions where some action could be taken to improve health status and/or access to health services;

- involve all players in identifying problems and devising cooperative, coordinated solutions to health issues, including the mainstream sector and those responsible for environmental health; and
- inform funding decisions with respect to new and existing health services for Aboriginal and Torres Strait Islander peoples (Department of Human Services Victoria 2001).

New Zealand's *National Drug Policy* also recognises the need for a variety of local approaches rather than a single national approach (NZ Government 1998).

Examples of strategies—national

National School Drug Education Strategy

One objective of this strategy is:

- observation of community cultural protocols and in conjunction with students, parents and the broader school community, identification of areas of particular need and provision of strategies for regions and/or targeted groups (one of the strategy's objectives).

Indicative activities at the State/Territory level to support this objective include:

- the development of drug education strategies and materials that are specific to locations and populations (e.g. Aboriginal and Torres Strait Islander students) (DETYA 1999).

National Tobacco Strategy

- Involvement of relevant communities in developing information and education strategies that are sensitive to the values, beliefs and culture of the groups involved (MCDS 1999).

National Alcohol Strategy

- Support Aboriginal and Torres Strait Islander communities that rely on profits from liquor sales to identify alternative ways of raising revenue (MCDS 2001).

Examples of strategies—State/Territory

Queensland Framework for Action in Aboriginal and Torres Strait Islander Health

- Support the development and implementation of an appropriate model of locally available, community-based prevention, harm minimisation, medical and home-based detoxification and rehabilitation programs (Queensland Aboriginal and Torres Strait Islander Health Partnership 1999).

NT Aboriginal Health Policy 1996

- Develop and implement community based alcohol intervention and rehabilitation services in remote Aboriginal communities (NT Government 1996).
- Continued development of local drug action groups in remote Aboriginal communities to provide a focus and funding for local prevention activities.

Together Against Drugs: WA Strategy Against Drug Abuse Action Plan 1999 – 2001

- Support for limiting the availability of alcohol in specific areas if sought by the local community (WA Government 1999).

Principle 3: Culturally valid strategies that are effective for Aboriginal and Torres Strait Islander peoples

The Commonwealth's *Review of the Substance Misuse Program* says that the impact of the National Drug Strategy (1993–1997) on the Aboriginal and Torres Strait Islander population appears to have been minimal. While a wide range of mainstream interventions have been developed and tested, the Aboriginal and Torres Strait Islander populations appear to have benefited little from the knowledge gained. Higher levels of harmful alcohol consumption among Aboriginal and Torres Strait Islander peoples than in the general population remain. Mainstream media campaigns had little effect on consumption patterns (DHAC 1999b).

A key principle of the *National Drug Policy for New Zealand 1998-2003* is the importance of ensuring that the needs of Maoris are addressed by enabling the development of specific strategies acceptable to them. The policy recognises the limited effect that strategies designed for the general population have had in reducing harm in the Maori community, and emphasises the importance of targeted approaches developed by and for Maori so that acceptable and effective approaches can be developed for advocating behaviour and lifestyle change (NZ Government 1998). New Zealand's *National Alcohol Strategy 2000 – 2003* is guided by:

- appropriateness—including the development of strategies consistent with Maori norms and values;
- effectiveness—including the use of strategies likely to result in a tangible reduction in alcohol-related harm to Maori; and
- efficiency—including the possibility that this may involve culturally-specific interpretations of costs and benefits for Maori.

The same concepts are embodied in the NSW Drug Treatment Plan. It includes the principle that culturally appropriate and sensitive services need to be assured, particularly for people from culturally diverse backgrounds and Aboriginal and Torres Strait Islanders, who may have particular needs relating to their language, cultural beliefs and practices (NSW Health 2000).

The NT Aboriginal Health Policy also states that culturally appropriate and effective health services are essential for Aboriginal people as a significant client group with specific needs (NT Government 1996).

While Aboriginal people share some common cultural heritage, they are not a homogenous group. It is important to be aware of the diversity of Aboriginal people and respect different communication styles and cultural nuances that may be likely to influence interventions (Dale & Marsh 2000). The Ministerial Council on Drugs noted in its background paper to the National Alcohol Strategy that there is a need for meaningful and culturally appropriate evaluation of education interventions in Aboriginal and Torres Strait Islander communities. In particular, evaluation should examine the long-term impact of programs on consumption patterns and alcohol-related harm (MCDS 2001).

A large range of strategies that acknowledge the need for culturally valid strategies that are effective for Aboriginal and Torres Strait Islander peoples have been identified.

General strategies—international

First Nations Tobacco Control Strategy 1998/99 (Canada)

- Funding and support for a national meeting of young aboriginal people to discuss a tobacco control strategy aimed at youth organised by an Assembly First Nations.
- Development of a series of broadcasts on the non-traditional use of tobacco for the Aboriginal Peoples Television Network, including three that target youth.
- Development of a broader media campaign that includes public service announcements featuring the National Chief and Aboriginal youth.
- Addition of a smoking cessation component in the Aboriginal Youth Network website (Community Health Programs Directorate 2000).

Honouring our Health: An Aboriginal Tobacco Strategy for British Columbia (Canada)

- Blending best practices with best traditions in prevention and cessation programs through:
 - adapting current resources to suit cultural and community needs;
 - including Elders and cultural advisors in the development and delivery of services;
 - continuing current community and school-based prevention and protection activities such as campaigns for smoke-free homes and community events; and
 - offering programs based on culturally appropriate models and which blend both traditional approaches and mainstream interventions to smokers and those that chew tobacco.
- Linking with a larger vision of cultural re-vitalisation through:
 - development of a strategic presence by way of involvement in local, regional and national Aboriginal events; and
 - the integration of cultural activities into tobacco reduction activities Government of British Columbia 2001).

Toward a Tobacco-Free Aotearoa: A Five-Year Plan for HFA Funding of Tobacco Control for Maori 1999 – 2003 (NZ)

Activities include:

- smoke-free sponsorship of Maori-specific activities;
- promotion of tobacco issues through the Maori media;
- support for Maori-specific programs designed to improve school performance in order to prevent and reduce teenage smoking;
- support for activities targeting the general population related to activities such as tobacco advertising restrictions, sales to minors, vending machines;
- evaluation of impact of previous taxation increases on low-income and Maori groups;
- pilot programs providing subsidised nicotine replacement therapy and counselling to Maori women provided by Maori in rural and urban settings;
- inclusion of Maori-orientated resources and a Maori language and referral option in the national 0800 smoking cessation telephone helpline;
- development of a Maori-specific component in smoking cessation mass media campaigns;
- possible pilot of a smoking cessation contest in area with high Maori population;
- inclusion of warnings written in Maori on cigarette packets;
- evaluation of current health education resources (smoking cessation) for appropriateness to Maori;
- evaluation of Maori-specific programs by those with appropriate experience with Maori issues as part of a national tobacco evaluation strategy; and
- collection of data on Maori smoking as part of a national tobacco surveillance strategy (NZ Health Funding Authority 1999).

National Alcohol Strategy (NZ)

- Supporting the further development and delivery of health promotion programs designed by Maori for Maori.
- Supporting the development of appropriate advertising and other marketing strategies for Maori to promote both moderation in the use of alcohol and the non-use option.
- Ensuring that all initiatives for age-related alcohol health promotion, especially those targeting youth and older people, also address the needs of Maoris (Alcohol Advisory Council of New Zealand and the Ministry of Health 2001).

Alcohol and Drug Toolkit (NZ)

- Improved service provision for Maoris with severe alcohol and drug-related problems/disorders through increasing cultural content and cultural competence of clinicians in mainstream services and the greater and improved provision of Maori services (NZ Ministry of Health 2001).

General strategies—national

National Action Plan for Promotion, Prevention and Early Intervention for Mental Health

- Support Aboriginal and Torres Strait Islander communities to develop and evaluate culturally appropriate interventions within mainstream and specialised services to identify early signs and symptoms, improve access, and effectively treat mental health problems and mental disorders (DHAC 2000).

National Alcohol Strategy: A Plan for Action 2001 to 2003/04

- Assist Aboriginal and Torres Strait Islander peoples to maintain and develop a wide range of preventive educational, support and treatment programs (MCDS 2001).

National Tobacco Strategy 1999 to 2002/04

- Work with targeted population groups to ascertain the social, cultural and economic factors that influence uptake and continued use of tobacco.
- Action research by Aboriginal and Torres Strait Islander communities to develop best practice in smoking cessation programs (MCDS 1999).

National Hepatitis C Strategy 1999-2000 to 2003-04

- One of the guiding principles for reducing hepatitis C transmission in the community is that health promotion activities for specific communities are best developed and delivered by those communities through peer-based initiatives in partnership with governments, health professionals and researchers (DHAC 2000).

Review of the Commonwealth's Substance Misuse Program

- Use of specific Aboriginal and Torres Strait Islander media to target young people, such as Deadly Sounds (weekly national music program) and Deadly Vibe (national monthly music, arts and sporting magazine). Evaluation of a pilot of the Deadly Sounds series found its content and style appropriate and acceptable to the target audience. The ability of groups to recall messages about not taking alcohol and drugs indicate that this program was also effective in delivering health promotion messages.
- The use of videos as vehicles for distributing health messages has also been found to be effective, including in remote regions (DHAC 1999b).

General strategies—State/Territory

NSW Aboriginal Health Strategic Plan

- Research effective alcohol treatment options or alcohol problems in Aboriginal communities to inform the development of a New South Wales *Aboriginal Substance Misuse Strategy*.

- Develop a clearinghouse (or establish links to an existing one) for best practice Aboriginal substance misuse initiatives in order to support future initiatives throughout NSW (NSW Health 1999).

Ensuring Progress in Aboriginal Health: A Policy for the NSW Health System

Improved access to culturally sensitive and culturally appropriate services through:

- working partnerships at all levels between government and the community-controlled sector in policy, strategic planning and broad resource allocation, identifying needs and determining priorities, and planning and delivery of services;
- improved access to culturally and socially sensitive mainstream health services through activities such as cultural awareness training;
- implement core standards of practice for culturally appropriate primary, secondary and tertiary health service provision; and
- improved access to Aboriginal and Torres Strait Islander community-controlled health services through the development and implementation of strategies to improve coordination in Commonwealth and State resource allocation (NSW Health 1999).

The NSW Drug Treatment Plan 2000 to 2005

- Strategies to increase access for Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse backgrounds may include the establishment of treatment capacity in specialist facilities such as Aboriginal Health Services. In addition, the employment of staff (where appropriate) or the engagement of advisers from various cultural backgrounds to facilitate access for under-represented groups should be a priority. There should be strategies to improve the access of these services to specialist drug and alcohol knowledge and advice (NSW Health 2000).

Together Against Drugs: WA Strategy Against Drug Abuse 1999-2001

- Continued support by the School Drug Education Project for the development and implementation of culturally appropriate professional and community development programs, and curriculum materials, for remote communities (WA Government 1999).

Evidence Based Practice Indicators for Alcohol and Other Drug Interventions:

Summary

- Counsellors should be aware of the importance of family (immediate and extended) to Aboriginal and Torres Strait Islander people, and include them in all interventions (with the permission of the client).
- Where possible, and with permission from the client, agencies should ascertain the services of an Aboriginal and Torres Strait Islander cultural consultant. Preferably this should be someone acceptable to the client who is from the same language group or from the same area. This may include family members, friends or professional services. This is to ensure that interventions are culturally appropriate (Dale & Marsh 2000).

InterAction : Drug Strategy 1999 – 2003 (WA)

- While specialist alcohol and other drug services and general health services are also used by Aboriginal people, these need to be more culturally sensitive (WA Health Department 1999).

Towards a Smoke-Free Future: Queensland Tobacco Action Plan 2000/01 to 2003/04

- Pilot and implement a culturally effective tobacco awareness program for Aboriginal and Torres Strait Islander communities. The program is to be developed by Queensland Health in partnership with Aboriginal and Torres Strait Islander community organisations. Following a trial, the program is to be implemented across the State using a phased approach (Queensland Health 2000).

Queensland Aboriginal and Torres Strait Islander Health Policy 1995-2000

Culturally appropriate service provision to:

- ensure that the public health system responds to the health needs of Aboriginal and Torres Strait Islander people in a culturally appropriate way, through the development and application of specific policies, programs and protocols;
- increase the awareness of Queensland Health staff about Aboriginal and Torres Strait Islander cultures and communities, and the implications of these for the planning and delivery of health services;
- raise the awareness of Aboriginal and Torres Strait Islander people about their health rights, and the roles and functions of the Health Rights Commission and other available avenues for addressing complaints; and
- recognise the role of traditional healing and its importance to Aboriginal and Torres Strait Islander communities where it is culturally accepted and requested (Qld Government 1994).

Towards an Aboriginal Services Plan, Department of Human Services – 2001 (Victoria)

- Development of the range of prevention and promotion information materials and work with the Aboriginal and Torres Strait Islander community to determine the most appropriate ways of communicating messages on harm reduction. Strategies will include peer education and working with key leaders to encourage communication about drug use and drug-related harms across various Aboriginal and Torres Strait Islander communities in Victoria, particularly in rural Victoria (Victorian Department of Human Services 2001).

NSW Drug Summit 1999 – government plan of action

Drug education in schools and the community:

- *Healing Time*, a culturally specific drug education resource for Aboriginal students in junior secondary years, has been piloted and extended to 22 schools in NSW in 2001, 18 of which are in rural areas. Its effectiveness reflects its strong support from Aboriginal community members (Government of NSW 1999).



Principle 4: Central involvement of Aboriginal and Torres Strait Islander peoples in planning, developing and implementing strategies to address the use of alcohol, tobacco and other drugs

The Royal Commission into Aboriginal Deaths in Custody recommended that Aboriginal and Torres Strait Islander people be involved at every level in the development, implementation and interpretation of research into the patterns, causes and consequences of Aboriginal and Torres Strait Islander alcohol use and in the application of the results of that research (Johnston 1991).

The Aboriginal and Torres Strait Islander Health Council and the Australian Health Ministers' Conference agreed that one of the aims of the regional planning process was to allow for full and formal Aboriginal and Torres Strait Islander participation in decision making and determination of priorities (Victorian DHS 2001). The importance of participation by Aboriginal and Torres Strait Islander people in decision making, planning, development and implementation is also stressed in State/Territory and regional-level strategies in Australia.

Apunipima's 'River of Life' Strategy notes that community-based planning provides the opportunity for community members to understand and acknowledge their own health problems and plan solutions (NT Government 1996, Apunipima 2001, NT Aboriginal Health Forum 2001).

The Northern Territory Health Forum also highlights the importance of this principle. It identifies actions intended to improve Aboriginal and Torres Strait Islander involvement in health-related decision making as one of three broad areas that can contribute to improving health outcomes. Involvement of Aboriginal and Torres Strait Islander people in planning, development, and implementation of programs is also a basic principle underlying drug policies and strategies in New Zealand and Canada (NZ Government 1998, Alcohol Advisory Council of NZ 2001).

Examples of strategies—international

New Zealand National Alcohol Strategy 2000

- Ensuring that Maori communities are involved fully in developing policies on alcohol, including control/regulation, education, treatment and research (Alcohol Advisory Council of NZ 2001).

Examples of strategies—national

Royal Commission into Aboriginal Deaths in Custody

- Recommendation 84: That issues related to public drinking should be the subject of negotiation between police, local government bodies and representative Aboriginal organisations, including Aboriginal Legal Services, with a view to producing a generally acceptable plan.
- Recommendation 278: That legislation and resources be available in all jurisdictions to enable communities, which wish to do so to control effectively the availability of alcoholic beverages. The controls could cover such matters as whether liquor will be available at all, and if so, the types of beverages, quantities sold to individuals and hours of trading.

Examples of strategies—State/Territory

Queensland Aboriginal and Torres Strait Islander Health Policy 1995-2000

- To ensure participation by Aboriginal and Torres Strait Islander people in regional and central decision making processes within Queensland Health.
- To develop mechanisms for community involvement in the selection of health staff serving predominantly Aboriginal and Torres Strait Islander communities, or where the position is identified as working with Aboriginal and Torres Strait Islander people.
- To increase the level of Aboriginal and Torres Strait Islander input into planning and development of mainstream health services, in particular hospital and specialist services (Qld Government 1994).

The Koori Services Improvement Strategy 1998 (Victoria)

- Involving the Aboriginal and Torres Strait Islander community in developing, delivering and evaluating policies, programs and services.
- Improving planning and coordination of human services for the Aboriginal and Torres Strait Islander community between communities, service providers and funding agencies and at all levels of government (Victorian Department of Human Services 1998).

NT Aboriginal Health Policy 1996

- In collaboration with Aboriginal people, develop and implement a tobacco strategy to reduce the level of tobacco smoking and its impact on health among Aboriginal people, in urban and rural communities in the Northern Territory (NT Government 1996).

Principle 5: Aboriginal and Torres Strait Islander communities should have control over their health, drug and alcohol, and related services

Community control in matters of health, particularly in the delivery of primary health care, is an international principle that provides the foundation for the delivery of appropriate and acceptable health care (NACCHO 1999).

In 1989, the Canadian Government approved resources to support the transfer of Indian and Inuit Health Services to First Nation and Inuit control. Health Canada has supported First Nations and Inuit people in attaining autonomy and control of their health programs in accordance with time frames developed with First Nations and Inuit people. Long-term evaluation findings indicate that through this process community members gained increased awareness of health issues and health care had become more of a priority in communities where the transfer had been completed. Community health services were found to be integrated with other programs and services such as social services, mental health, home care and education (Health Canada 1999).

The background paper to Australia's *National Mental Health Strategy, Promotion, Prevention and Early Intervention for Mental Health*, recognises that people within the community itself are a vital resource to the process of establishing and implementing mental health intervention programs in Aboriginal and Torres Strait Islander communities. Aboriginal and Torres Strait Islander communities tend to include family and community participation in dealing with problems. Aboriginal community-controlled health services are central for the provision of culturally appropriate holistic services that integrate culture, and social, emotional and physical health for individuals as well as the whole community (DHAC 2000).

The *National Aboriginal Health Strategy* asserts that in order to achieve the necessary improvement in Aboriginal health, Aboriginal people believe they must again be able to control their destiny and to accept responsibility for their own decision making. Community control promotes responsibility and understanding, and allows communities to be active participants in identifying health problems and possible solutions and contributing to needs-based planning (National Aboriginal Health Strategy Working Party 1989). The *National Aboriginal Health Strategy* (1989) highlighted the following benefits of community control in health:

- services that are acceptable to the community they serve;
- services that cater for the social and cultural needs of those they serve;
- promotion of community responsibility and a commitment to improve the health status of the people they serve;
- covert and overt racism from non-Aboriginal and Torres Strait Islander staff working in Aboriginal and Torres Strait Islander health is prevented;
- unethical behaviour and presumptions about lifeways and illnesses that may lead to inaccurate diagnosis is prevented;
- training, education and employment for Aboriginal and Torres Strait Islander people is offered;
- staff are culturally acceptable;
- training and culturally appropriate information for the non-Aboriginal and Torres Strait Islander community is provided; and
- a resource for culturally appropriate research is provided (National Aboriginal Health Strategy Working Party 1989).

Community control of health services also underpins a number of State and Territory Aboriginal and Torres Strait Islander health strategies and plans (NT Government 1996, Qld Government 1994, ACT Government 2000). The *Queensland Aboriginal and Torres Strait Islander Health Policy 1995-2000* outlines the benefits offered by community control of primary health care services as follows:

- to empower Aboriginal and Torres Strait Islander people to determine their own primary health care priorities;
- to empower Aboriginal and Torres Strait Islander people to develop and manage their own health services; and
- to extend the existing network of community-controlled primary health care services to provide access to primary health care for the Aboriginal and Torres Strait Islander population throughout the state.

Principle 6: Resources to address the use of alcohol, tobacco and other drugs must be available at the level needed to reduce disproportionate levels of drug-related harm among Aboriginal and Torres Strait Islander peoples

A key principle of the Australian health system is equity and ensuring access for the most disadvantaged. Because of their greater health disadvantage, Aboriginal and Torres Strait Islander populations require an increased allocation of health resources (DHAC 1999a, Deeble J et al. 1998).

The Commonwealth Grants Commission recently concluded that, despite increased Commonwealth expenditure over the past decade, a further significant increase would be necessary to bring direct Commonwealth expenditure on Aboriginal and Torres Strait Islander people to the Australian average. The commission said that the poorer health status of Aboriginal and Torres Strait Islander people, and their greater reliance on the public health system, would justify at least a doubling of the average per capita government expenditure on non-Aboriginal and Torres Strait Islander people. No State/Territory, region or location had more resources than were required to address Aboriginal and Torres Strait Islander health needs. The commission also found that resources for Aboriginal and Torres Strait Islander health were greater in urban than in rural and remote areas—a pattern that does not match Aboriginal and Torres Strait Islander needs (Commonwealth Grants Commission 2001).

The *Northern Territory Aboriginal Health Policy* includes equity as one of its principles, and describes it as the sharing of resources to ensure an appropriate level of health service is provided for Aboriginal people at the rate needed to improve health outcomes (NT Government 1996). Similarly, the *ACT Aboriginal and Torres Strait Islander Regional Health Plan* has appropriate and relevant distribution of resources as one of its key principles.

The same principle appears in New Zealand's *National Alcohol Strategy 2000-2003*. Their principle of equity also gives priority to reducing the disproportionate levels of alcohol-related harm experienced by Maori.

Examples of strategies—national

National Tobacco Strategy 1999 to 2002-04: A Framework for Action.

- Undertake research to identify the barriers (cultural, social, linguistic, economic, geographic) that may prevent access by targeted population groups to smoking cessation programs.
- Commission research to assess the impact of price increases on tobacco products and its relation to the health and wellbeing of identified low income groups (including Aboriginal and Torres Strait Islander people; people with a mental health illness and some ethnic communities.
- Develop strategies to improve equity of access for targeted population groups (MCDS 1999).

Examples of strategies—State/Territory

Queensland Aboriginal and Torres Strait Islander Health Policy 1995-2000

Needs-based criteria for service provision and resource allocation to:

- extend the network of health care services for Aboriginal and Torres Strait Islander people throughout the State;
- develop service delivery models and best practice standards for the provision of health care for Aboriginal and Torres Strait Islander people;
- ensure the implementation of effective health services for the main health issues affecting Aboriginal and Torres Strait Islander people;
- ensure that expenditure by regional health authorities on Aboriginal and Torres Strait Islander health services is in proportion to the burden of illness and demand for services (Qld Government 1994).

Community Drug Summit Report 13 – 17 August 2001 Volume I (WA)

Under the heading 'Lack of resources to serve Aboriginal needs' the report recommended that government should urgently and significantly increase the level of funding and establish a comprehensive resource base to support Aboriginal community drug action including:

- an expanded knowledge base with specific support for action-based research that addresses Aboriginal communities questions and priorities;
- a significantly improved range of culturally secure treatment, rehabilitation and detox facilities and services either delivered by communities or in partnership with them; and
- a greatly expanded culturally and technically competent and compassionate workforce able to deliver services in the community and other settings.

Aboriginal people may choose to use mainstream services and they must not be afforded a less favourable outcome because they hold a different cultural outlook efforts (WA Community Drug Summit Office 2001b).

Key result areas

Gains need to be made in each of six key result areas if the significant levels of harm currently caused by use of alcohol, tobacco and other drugs in Aboriginal and Torres Strait Islander communities are to be minimised.

1. Enhanced capacity of Aboriginal and Torres Strait Islander individuals, families and communities to address current and future substance use issues and promote their own health and wellbeing.
2. Whole-of-government effort in collaboration with non-government organisations to implement and evaluate comprehensive approaches to reduce drug-related harm among Aboriginal and Torres Strait Islander peoples.
3. Substantially improved access for Aboriginal and Torres Strait Islander peoples to the appropriate range of health and wellbeing services that play a role in addressing use of alcohol, tobacco and other drugs.
4. A range of holistic approaches from prevention through to treatment and continuing care.
5. Workforce initiatives to enhance the capacity of Aboriginal and Torres Strait Islander community-controlled and mainstream organisations to provide quality services.
6. Increased research, monitoring, evaluation and dissemination.

Key result area 1: Enhanced capacity of Aboriginal and Torres Strait Islander individuals, families and communities to address current and future issues in the use of alcohol, tobacco and other drugs and promote their own health and wellbeing

A growing body of research demonstrates that ‘social capital’ within a community is profoundly important to people’s overall sense of emotional and social wellbeing. Effective community participation in decision making requires knowledge, skills, resources and a willingness to work together to find acceptable solutions to community issues (DHAC 2000). Creating healthy communities requires both strengthening of health services and building the capacity of the community to enhance their control over health and other services.

- In addressing the prevention of alcohol-related harm in young people, the *National Alcohol Strategy* highlights research that indicates that community and social capital have been identified as a factor of crucial significance in Aboriginal and Torres Strait Islander adolescents’ consumption of alcohol. The most important community factor appeared to be strong leadership and cohesion within the community (MCDS 2001).
- Community capacity building also features prominently in strategies in New Zealand and Canada (NZ Ministry of Health 2000, Government of British Columbia 2001).

Key result area 2: Whole-of-government effort and commitment, in collaboration with community-controlled services and other non-government organisations, to implement, evaluate and continuously improve comprehensive approaches to reduce alcohol, tobacco and other drug-related harm

The Royal Commission into Aboriginal Deaths in Custody recommended that the Australian Government, in conjunction with the State and Territory governments, and non-government agencies, act to coordinate more effectively the policies, resources and programs in the area of petrol sniffing.

The House of Representative’s *Inquiry into Indigenous Health* similarly proposed the need for a national framework for drug and alcohol programs, which clearly identifies the roles and responsibilities of each sector and provides mechanisms for improved coordination and monitoring between sectors.

The Alcohol and other Drugs Council of Australia’s *Drug Policy 2000* asserts that the complex links between use of alcohol, tobacco and other drugs, mental health and primary health care within the Aboriginal and Torres Strait Islander population make effective coordination of services even more crucial than amongst other populations.

The NSW policy *Ensuring Progress in Aboriginal Health: A Policy for the NSW Health System* describes partnership as essential to providing Aboriginal and Torres Strait Islander people with equitable access to culturally sensitive health services and to address the issues underlying the disadvantage of Aboriginal and Torres Strait Islander people and communities (NSW Health 1999a).

The Australian Government Department of Health and Ageing’s *Review of the Substance Misuse Program* highlighted that lack of clarity in roles, particularly between Commonwealth and State/Territory governments in Aboriginal and Torres Strait Islander health, has had a major negative impact on the delivery of health services. The Aboriginal and Torres Strait Islander health framework agreements provide mechanisms for joint planning and coordination across sectors in Aboriginal and Torres Strait Islander health issues.

The anticipated benefits of working together have been identified in a range of policy and strategic documents. They include:

- addressing cross-border issues such as data and continuity of care and clarifying and enhancing the role of private sector providers (ACT Government 1996);

- establishing agreed priority needs, maximising use of resources and reducing duplication (NT Government 1996);
- local networks of services on the ground and cooperative arrangements are a key factor in best practice models (DHAC 1999b);
- identifying problems and devising cooperative, coordinated solutions to health issues (DHS 2001a);
- identifying and coordinating resources for regional or locally based community education/health promotion initiatives (DHAC 1999b);
- enhancing stakeholder and community participation in developing and implementing strategies to deal with regional and local issues;
- providing greater stakeholder and community awareness of the causes, incidence and impacts of illicit drugs, and of the Government's strategies to address these problems;
- providing more customised responses by governments and others to meet the varying circumstances of different communities;
- creating more effective links with and mobilisation of resources from other funding programs and initiatives;
- encouraging better alignment of the priorities and efforts government at local, regional, State and national levels (NSW Premier's Department 2000); and
- ensuring coordinated and integrated planning and to avoid the separation of alcohol-related initiatives from other social and health-related initiatives (NZ MoH 2000).

Key result area 3: Substantially improved access for Aboriginal and Torres Strait Islander peoples to the appropriate range of health and wellbeing services that play a role in addressing alcohol, tobacco and other drug issues

Many Aboriginal and Torres Strait Islander people are reluctant to leave family and their country for treatment. Many areas have only a few residential detoxification and rehabilitation programs and many people with problems remain untreated. Lack of choice for individuals seeking treatment has been identified as a common concern, particularly where no Aboriginal and Torres Strait Islander organisations provide services (WA Community Drug Summit Office 2001a).

Evidence suggests, however, that many people with alcohol-related problems resolve their problems without specialist treatment (Brady 1993). Primary health care services are often the first contact people have with a professional about their problems with the use of alcohol, tobacco and other drugs, and responses by these services to alcohol and other drug problems are crucial. Evidence is accumulating that screening and brief intervention in primary health care settings for hazardous and harmful alcohol use can be very effective (DHAC 1999b).

Access to primary health care services for Aboriginal and Torres Strait Islander people continues to be affected by discrimination, stigma and disadvantage. In relation to blood-borne viruses such as hepatitis C, which are known to be associated with injecting drug use, discrimination and stigma can come from within their own communities and can further inhibit access to health care and other services offered by that community (DHAC 2000a). Strategies such as providing skills, training and access to resources for staff working in the primary health care sector are required to increase their capacity to provide accessible and effective drug and alcohol services to Aboriginal and Torres Strait Islander peoples at the same level as those provided for the broader community. Given the high numbers of Aboriginal and Torres Strait Islander people in detention, there is a need to make harm minimisation strategies and drug treatment options available to prisoners (WA Community Drug Summit Office 2001a).

Putting the principle into practice (examples)

Lockhart River (QLD) Substance Abuse Project

The Lockhart River Substance Abuse Project targets substance abuse and self-harm in the community, particularly involving young people. The project arose out of concern about increasing involvement of young people in petrol sniffing. The initiative involves representatives from the Community Council, the Community Justice Group, the women's group, Elders, local police, the health clinic and the school. Funding and other support was provided by the Department of Families and the Department of Aboriginal and Torres Strait Islander Policy.

The project employed a number of strategies to address substance abuse. To address the supply of substances to children the community improved security in areas such as locking up petrol at various sites throughout the community. There was also a coordinated campaign on the part of local police to pick up intoxicated children.

The major focus of the project was to provide positive alternatives to substance abuse and operated from a philosophy of rewarding good behaviour rather than punishing bad behaviour. The centrepiece of this strategy was the creation of the Kid's Club in February 1998. This facility was a place for young people to go to play video games, watch videos, and get involved in dancing and other activities. The Club was open from 3pm to 9pm weeknights and at various times on weekends. Children were only admitted to the Kid's Club if they had been to school and were marked on the school roll that day.

The project has organised other positive activities for the young people of Lockhart River including beach barbecues, family activities and trips away to places such as Cairns or the Kowanyama Football Carnival. The project also links to activities of the local sport and recreation officer (Qld Government 2001).

NSW Northern Rivers integrated care program for drug dependent rural women

A new integrated care program for drug-dependent rural women (including women in Aboriginal communities) was trialled in the Northern Rivers Area Health Service. It referred and linked clients to services such as health, education, legal advice and housing, and importantly, involved the full range of government, non-government, and community services. The program also involved GPs. The aim of the program was to improve support for these women in areas such as child care, transport, development of living skills, parenting skills, skills likely to lead to employment and access to other services (Government of NSW 1999).



The Northern Territory *Aboriginal Health Policy* and the Western Australian *Aboriginal Health Strategic Framework* include improving access to health services, both primary health care and special care services. Similarly, the *Top End Aboriginal and Torres Strait Islander Health Plan* includes actions intended to improve equality of access by Aboriginal and Torres Strait Islander people to health care services among three broad areas for improving Aboriginal and Torres Strait Islander health outcomes (NT Aboriginal Health Forum 2001).

Key result area 4: A range of holistic approaches, from prevention through to treatment and continuing care, that is locally available and accessible

The Commonwealth's *Review of the Aboriginal and Torres Strait Islander Substance Misuse Program* noted that recognition of the complex social, economic, psychological and physiological contexts within which alcohol and drug use occurs has led to progressively broadened intervention approaches ranging from health promotion to aftercare services (DHAC 1999b). A number of recent reports and strategy documents note a current imbalance in the range of drug and alcohol interventions available to Aboriginal and Torres Strait Islander peoples.

The Commonwealth's *Review of the Aboriginal and Torres Strait Islander Substance Misuse Program* acknowledged that the current funding within the program was heavily skewed towards tertiary interventions (DHAC 1999b). A Community Drug Summit issues paper from Western Australia commented on a lack of prevention activities, particularly for young people (WA Community Drug Summit Office 2001a). The *National Alcohol Strategy* also indicated that while evidence of the effectiveness of early and brief interventions is accumulating, this type of intervention is relatively infrequent in the general population and even more rare with Aboriginal and Torres Strait Islander clients (MCDS 2001).

Ideally the range of interventions (see box) available include health promotion, prevention, early intervention, treatment, continuing care and relapse prevention (DHAC 2000c).

Some interventions apply to the whole population (e.g. health promotion) while others target groups at particular risk of developing substance use problems or disorders. Canada's *New Directions for Tobacco Control* recognises the need to balance interventions directed at the whole community with those that respond to groups and individuals with particular risks and needs (Steering Committee of the National Strategy to Reduce Tobacco Use in Canada 1999). The need to provide primary prevention and early intervention strategies for individual, families and communities for whom there is greater risk of hazardous and harmful drug use is one of four key themes in the *South Australian Drug Strategic Framework* (SA Government 2001).

Interventions

Health promotion: Action taken to maximise health and wellbeing among populations and individuals

Prevention: Interventions designed to prevent the development of problems and disorders

Early intervention: Interventions target people who have early signs and symptoms of problems or disorders and aims to reduce the impact of the problem or disorder and the damage it may cause to people's lives

Treatment: Aims to provide the most effective treatment to achieve recovery as far as possible

Continuing care: Aims to provide clinical treatment, rehabilitation and support services to prevent relapse of the recurrence of symptoms and to maintain optimal functioning to promote recovery

Relapse prevention: Interventions in response to early signs of recurring problems with the use of alcohol, tobacco and other drugs for people who have already experienced such problems (DHAC 2000).

Key result area 5: Workforce initiatives to enhance the capacity of Aboriginal and Torres Strait Islander community-controlled and mainstream organisations to provide quality services

The importance of enhancing the capacity of workers involved in providing health services to Aboriginal and Torres Strait Islander populations is highlighted in numerous Aboriginal and Torres Strait Islander health and drug and alcohol strategies and plans. Increasing the Aboriginal and Torres Strait Islander health workforce is part of capacity building which is necessary for creating healthy communities.

The New Zealand health strategy considers fostering and supporting Maori health workforce development to be an important strategy in reducing inequalities in health status.

Canada's drug strategy asserts that provision of substance abuse, community development and program evaluation training to aboriginal health service providers will assist their response to the unique constellation of issues facing their communities (Health Canada 1998).

Training of staff in mainstream health services is central to providing services that are culturally appropriate. Aboriginal and Torres Strait Islander drug users who choose not to seek help from community-controlled organisations are often constrained by lack of Aboriginal and Torres Strait Islander staff in mainstream agencies. In places where community-controlled services are not available, mainstream agencies need to be adequately resourced to ensure that they have culturally appropriate services. More training opportunities and better professional support for staff in Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander services are needed to increase the range of available services (WA Community Drug Summit Office 2001a, ADCA 2000).

Key result area 6: Sustainable partnerships among Aboriginal and Torres Strait Islander communities, government and non-government agencies, in developing and managing research, monitoring, evaluation and dissemination of information

In 1999, the House of Representatives Standing Committee on Family and Community Affairs report on the Inquiry into Indigenous health, *Health is Life*, said that there seemed to be little monitoring or evaluation of the effectiveness of programs and activities. It suggested the need for some common standards across services and programs, as well as appropriate mechanisms to monitor ongoing operations and assess their effectiveness (HR Standing Committee on Family and Community Affairs 2000).

The *National Recommendations for the Clinical Management of Alcohol-Related Problems in Indigenous Primary Care Settings* has stated that it was still not possible to recommend interventions that were supported by evidence from systematic reviews of randomised controlled clinical trials in alcohol-related problems in Aboriginal and Torres Strait Islander primary care settings. At best, they found evidence from controlled trials for some recommended interventions in non-Aboriginal and Torres Strait Islander primary care or hospital populations. Uncertainty about their applicability in Aboriginal and Torres Strait Islander populations remains (DHAC 2000b).

On a related issue, the Commonwealth's *Review of the Substance Misuse Program* commented on the lack of established mechanisms for disseminating best practice advice or information about innovative approaches to substance abuse program staff (DHAC 1999b).

In 1991, the Royal Commission into Aboriginal Deaths in Custody made the following recommendations in relation to improving data, monitoring and research in relation to Aboriginal and Torres Strait Islander alcohol and other drug use:

- Recommendation 65: That if Aboriginal people identify it as a priority (and ATSIC is well placed to make such a judgement) the ministerial Council on Drug Strategy, as the body which manages the NCADA, act to develop and implement, in conjunction

with Aboriginal people and organisations, an ongoing program of data collection and research to fill the many gaps which exist in knowledge about Aboriginal alcohol and other drug use and the consequences of such use. Particular areas of need are:

- a) Information about alcohol consumption among urban Aboriginal groups;
 - b) Information about alcohol consumption among Aboriginal youth;
 - c) Longitudinal data in all areas;
 - d) An emphasis on good quality data utilising standard methodology and definitions; and
 - e) Evaluation research that assists in developing improved Aboriginal prevention, intervention and treatment initiatives in the alcohol and other drugs field.
- Recommendation 67: That the National Drug Abuse Data System of the NCADA institute a regular research program to establish baseline data and monitor changes over time in relation to the health, social and economic consequences of alcohol use among Aboriginal people.
 - Recommendation 67: That responsible authorities accurately identify Aboriginal people in administrative data sets such as those covering mortality, morbidity and other social indicators, where such action will provide basic information which will assist Aboriginal organisations to achieve their research and service development goal.
 - Recommendation 69: That with the aim of assisting Aboriginal organisations to develop effective programs aimed at minimising the harm arising from alcohol and other drug use, priority be given by research funding bodies to research investigating the causal relationships between alcohol and other drugs, including their availability, and consequences on community wellbeing and criminal activity.
 - Recommendation 71: That research funding bodies consider commissioning or otherwise sponsoring research investigating Aboriginal conceptualisation's of the nature and causes of alcohol dependence and use and the prevention, intervention and treatment approaches which stem from these (Johnston 1991).

In 2001, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* report stated that Aboriginal and Torres Strait Islander population data that is available is generally of lower quality than statistics for the Australian population as a whole. The report documents the range of efforts currently underway to address the need for complete and consistent Aboriginal and Torres Strait Islander identification in data collections within Australia (ABS & AIHW 2001).

The *NSW Aboriginal Health Strategic Plan* highlighted effective monitoring of progress against agreed performance indicators and improved collection of health information among a number of supportive strategies in the plan (NSW Health 1999b).

Improving health information management featured consistently in the plans of all regions under the *Western Australian Aboriginal Health Strategic Framework* (WA Joint Planning Forum 2002). The *ACT Aboriginal and Torres Strait Islander Regional Health Plan* also includes improving data collection and evaluation among the key principles of its plan. The importance of collecting health information and training Aboriginal and Torres Strait Islander people and communities to design and undertake evaluation and research initiatives is acknowledged in the health strategies of New Zealand and Canada (NZ Ministry of Health 2000, Canadian Center on Substance Abuse and the Canadian Public Health Association 1997).

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