

PZ



House of Representatives Standing Committee on Indigenous Affairs

Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities

Submission by

The Alcohol & Drug Service, St Vincent's Hospital, Sydney

Introduction

St Vincent's Hospital (SVH) Alcohol & Drug Service (ADS) welcomes the opportunity to submit for consideration, comments on the Terms of Reference for the inquiry into *harmful alcohol use in Aboriginal and Torres Strait Islander communities*. The ADS submits these comments to the Committee undertaking the inquiry, the House of Representatives Standing Committee on Indigenous Affairs. SVH ADS thanks the Committee for this opportunity and is available to give evidence at any hearing in regards to this matter if required.

The submission has been organised according to the key focus areas addressed in the inquiry, namely:

- Patterns of supply of, and demand for alcohol in different Aboriginal and Torres Strait Islander communities, age groups and genders
- The social and economic determinants of harmful alcohol use across Aboriginal and Torres Strait Islander communities
- Trends and prevalence of alcohol related harm, including alcohol-fuelled violence and impacts on newborns e.g. Foetal Alcohol Syndrome and Foetal Alcohol Spectrum Disorders
- The implications of Foetal Alcohol Syndrome and Foetal Alcohol Spectrum Disorders being declared disabilities
- Best practice treatments and support for minimising alcohol misuse and alcohol-related harm
- Best practice strategies to minimise alcohol misuse and alcohol-related harm
- Best practice identification to include international and domestic comparisons.

Patterns of supply of, and demand for alcohol in different Aboriginal and Torres Strait Islander communities, age groups and genders

Evidence on the nature and prevalence of alcohol use among Aboriginal and Torres Strait Islander people is available from three key data sources: the National Drug Strategy Household Survey (NDSHS); the National Aboriginal and Torres Strait Islander Social Survey (NATSISS); and, the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) [1, 2].

While the data is limited and has been shown to underestimate actual consumption, it is evident from the findings available that compared to the general population, Aboriginal and Torres Strait Islander people experience higher rates of [1, 3, 4]:

- abstinence
- risky and high-risk drinking among those who do drink
- alcohol related harm
- harm per unit of alcohol consumed

As above, Aboriginal and Torres Strait Islander people are more likely to abstain from alcohol than non-Aboriginal and Torres Strait Islander people. According to 2010 NDSHS data, 24.5 per cent of Aboriginal and Torres Strait Islander people were abstainers compared to 19 per cent of the non-Aboriginal and Torres Strait Islander people while the 2004-5 NATSIHS survey data showed 1.9 times as many Aboriginal and Torres Strait Islander people abstained as non-Aboriginal and Torres Strait Islander people. Of those who did report consuming alcohol however, there were a greater proportion of Aboriginal and Torres Strait Islander people who drank at levels that were risky or high-risk. For example, from 2004-5 NATSIHS data, rates of heavy episodic consumption ('binge drinking') among Aboriginal and Torres Strait Islander people were twice that of non-Aboriginal and Torres Strait Islander people. [2, 3, 5-10]

Aboriginal and Torres Strait Islander people also experience greater levels of harm per unit of alcohol consumed. This is linked to the poorer health and socioeconomic status of Aboriginal and Torres Strait Islander people and is evident from research conducted by Rehm and colleagues (2009) who found that poor and marginalised populations have an even greater disease burden per unit of alcohol consumption than do high-income populations. [4]

Overall, it has been estimated, from the data available, that the prevalence of harmful alcohol use among Aboriginal and Torres Strait Islander people is about twice as great than that in the non-Aboriginal and Torres Strait Islander population. [1, 3] A number of risk factors are also evident as demonstrated by 2008 NATSISS data [7-9, 11]:

- Aboriginal and Torres Strait Islander adults in remote areas were more likely to engage in short term risky/high risk levels of drinking at least once a week in the last 12 months (23% compared to 18%)
- Aboriginal and Torres Strait Islander males were more likely than females to drink at chronic/high risk levels (20% compared to 14%) and engage in short term risky/high risk levels of drinking (46% compared to 28%)
- Aboriginal and Torres Strait Islander adults aged 35-44 years had the highest rates of chronic risky/high risk drinking while those aged 55 years and over had the lowest

The social and economic determinants of harmful alcohol use across Aboriginal and Torres Strait Islander communities

Higher levels of harmful alcohol and other substance use among Aboriginal and Torres Strait Islander people is the product of, and contributes to the health and social gap between Aboriginal and Torres Strait Islander people and the general population. Additionally the impact of colonialism and dispossession and the subsequent trauma and stress from these events has left many Aboriginal and Torres Strait Islander people impoverished, discriminated against, displaced from their families and in poor mental and physical health with limited access to essential treatment and support. The strength and resilience of Aboriginal and Torres Strait Islander people must be recognised and may provide the foundation upon which to build efforts to reduce harmful alcohol and other substance use across Aboriginal and Torres Strait Islander communities. [1, 3, 9]

A study conducted by the World Health Organisation (WHO) has found a clear link between socioeconomic deprivation and risk of dependence on alcohol and other drugs [3]. Aboriginal and Torres Strait Islander people face considerable disadvantage in all social indicators including education, income and employment, and access to capital resources such as housing [1, 3, 9, 12, 13]. While socioeconomic outcomes for Aboriginal and Torres Strait Islander people are improving, they continue to remain below that of the general population. For example, from the 2011 national Census [2, 14, 15]:

- One-quarter (25%) of Aboriginal and Torres Strait Islander people aged 15 years and over reported Year 12 or equivalent as the highest year of school completed, compared to around half (52%) of non- Aboriginal and Torres Strait Islander people.
- The mean equivalised gross household income for Aboriginal and Torres Strait Islander people was around \$475 per week or three-fifths (59%) of that of non- Aboriginal and Torres Strait Islander people (around \$800).
- Aboriginal and Torres Strait Islander people were around three times more likely than non-Indigenous people to be unemployed (17% and 5% respectively).

Research has indicated that higher levels of income, employment and participation in education are protective factors against harmful alcohol and other substance use [3]. This is consistent with findings demonstrating a link between lower levels of alcohol use and higher levels of income among Aboriginal and Torres Strait Islander people [1]. In order to effectively address harmful alcohol use among Aboriginal and Torres Strait Islander people, it is necessary to address the underlying social and economic determinants while also targeting alcohol use itself [3]. Building on the strength and resilience of Aboriginal and Torres Strait Islander people will be fundamental to this.

Trends and prevalence of alcohol related harm, including alcohol-fuelled violence and impacts on newborns e.g. Foetal Alcohol Syndrome and Foetal Alcohol Spectrum Disorders

Harmful alcohol use increases the risk of illness, disability and death. In the case of pregnant women, risky and high-risk alcohol consumption can affect the health of newborns. While Aboriginal and Torres Strait Islander women drink at rates that are lower than non-Aboriginal and Torres Strait Islander women, those who do drink are more likely to do so at levels that increase risk of harm. This is likely to lead to higher rates of Foetal Alcohol Syndrome (FAS) and Foetal Alcohol Spectrum Disorders (FASD) in Aboriginal and Torres Strait Islander communities. [7, 8]

Harmful alcohol use can also impact families and communities, contributing to issues in the workplace, child abuse and neglect, financial problems, family and relationship breakdown, interpersonal violence and crime [1, 7, 9, 16]. Aboriginal and Torres Strait Islander people experience alcohol-related harm at a rate that is disproportionate to the general population [1].

Morbidity and mortality

The higher prevalence of risky and high-risk alcohol use among Aboriginal and Torres Strait Islander people is reflected in the higher rates of alcohol-related hospital admissions and deaths among this population [1, 3, 7].

Over the period July 2008 - June 2010, in NSW, QLD, WA, SA, there were 7,763 hospitalisations of Aboriginal and Torres Strait Islander people that had a principal diagnosis related to alcohol use. This represented 2% of all hospitalisations of Aboriginal and Torres Strait Islander people (excluding dialysis). During this time, Aboriginal and Torres Strait Islander males were hospitalised for diagnoses related to alcohol use at 5 times the rate of non- Aboriginal and Torres Strait Islander males, and Aboriginal and Torres Strait Islander females at 4 times the rate of non- Aboriginal and Torres Strait Islander females. Aboriginal and Torres Strait Islander males and females were also 4 times as likely to be hospitalised for mental and behavioural disorders due to alcohol and other substances. Additionally, Aboriginal and Torres Strait Islander clients are over-represented in the SVH ADS: is close to 10% compared with 1.8% of the total population of New South Wales (NSW). [1, 7]

Intentional harm causing injury or death to self also occurs at greater rates among Aboriginal and Torres Strait Islander people. It has been estimated that 40% of male and 30% of female suicides among Aboriginal and Torres Strait Islander people were attributed to alcohol. Between 2000 and 2004, there were 159 male and 27 female alcohol-attributable deaths from suicide among Aboriginal and Torres Strait Islander people compared to 123 and 27 deaths, respectively, for non- Aboriginal and Torres Strait Islander people. [1, 17, 18]

Rates of premature death, as a consequence of harmful alcohol use, are also higher among the Aboriginal and Torres Strait Islander population, with approximately 7% of Aboriginal and Torres Strait Islander deaths resulting from harmful alcohol use. Over the period 2006-2010, in NSW, QLD, WA, SA and the NT combined, Aboriginal and Torres Strait Islander males died from alcohol-related causes at 5 times the rate of non- Aboriginal and Torres Strait Islander males. Aboriginal and Torres Strait Islander females died from causes related to alcohol use at 8 times the rate of non- Aboriginal and Torres Strait Islander females. Most deaths (261 out of 382 deaths) were due to alcoholic liver disease. [1, 7, 10, 19, 20]

Fetal alcohol syndrome (FAS) and fetal alcohol spectrum disorder (FASD)

FASD is significantly under reported in Australia due to a lack of screening, a lack of a nationally accepted diagnostic tool and a lack of sufficient data. Research conducted in Western Australia estimated the prevalence of FAS in Australia at a rate of 0.02 per 1000 for non- Aboriginal and Torres Strait Islander children and 2.76 per 1000 for Aboriginal and Torres Strait Islander children. Other Australian studies have found similar estimates with one study from the Northern Territory estimating the prevalence of FAS in the Top End of the Northern Territory to be 0.68 per 1000 live births, with the comparable prevalence for Aboriginal and Torres Strait Islander children calculated to be 1.87. [21-24]

Alcohol related violence and crime

Aboriginal and Torres Strait Islander people are vastly over-represented in the criminal justice system. More than 1 in 4 inmates are of Aboriginal and Torres Strait Islander. Aboriginal and Torres Strait Islander people are also 15 times more likely to be imprisoned than non-Aboriginal and Torres Strait Islander people. Between 2000 and 2012 the imprisonment rate of Aboriginal and Torres Strait Islander people increased by 64%. This increase was 13 greater than the increase of non- Aboriginal and Torres Strait Islander imprisonments for the same period (5%). [2, 7, 15, 25, 26]

The link between risky and high risk alcohol use and the over-representation of Aboriginal and Torres Strait Islander people in the criminal justice system has been well established. We know from the *health of Australia's prisoners 2012* report that there is a higher incidence of risky and high risk drinking among Aboriginal and Torres Strait Islander prison entrants compared to non-Indigenous entrants (59% and 39%, respectively). The relationship of this to rates of imprisonment is evident from the 2008 NATSISS. According to the data risky and high risk drinkers were more likely than low risk drinkers to have been arrested in the last five years (29% compared with 15%), to have been formally charged by police (55% compared with 36%) and to have been incarcerated at some point in their lifetime (18% compared with 7%). They were also more likely to have been a victim of violence in the last 12 months (35% compared with 25%). [2, 15, 26, 27]

The relationship between alcohol and violence is also more pronounced among Aboriginal and Torres Strait Islander people. According to a study from the Australian Institute of Criminology, alcohol is one, if not the, primary risk factor for violence among Aboriginal and Torres Strait Islander people. This is reflected in statistics on interpersonal violence from the Office of the Status of Women which found a correlation between domestic violence, and alcohol and other substance use in Aboriginal and Torres Strait Islander communities, with 70% to 90% of assaults being committed under the influence of alcohol and/or other drugs. [7, 27-31]

Without further research into the prevalence of FAS and FASD it is not possible to estimate the role of FAS/FASD in contributing to the over-representation of Aboriginal and Torres Strait Islanders within the criminal justice system and the higher prevalence of violence in Aboriginal and Torres Strait Islander communities.

The implications of Foetal Alcohol Syndrome and Foetal Alcohol Spectrum Disorders being declared disabilities

FAS and FASD can have a profound lifelong impact, initiating or perpetuating a cycle of intergenerational disadvantage and poor health if not detected and treated [21]. A number of studies have demonstrated the link between FASD and behavioural and other problems including a study from the United States study involving life history interviews of 415 individuals with FASD using 450 questions [23]. The study found that:

- 94% of people diagnosed with FASD experienced mental health problems – which was the most prevalent secondary disability
- 43% of people of school age experienced disrupted school experience (suspension, expulsion or drop out)
- 42% of people and 60% aged 12 and over had been in trouble with the law (involvement with authorities, charged or convicted of crime)
- 60% had been confined (inpatient treatment for mental health, alcohol/drug problems, or incarceration for crime)
- 45% aged 12 and over were reported to have exhibited Inappropriate Sexual Behaviour
- 30% of people over the age of 12 experienced Alcohol and Drug Problems
- Problems with Employment were indicated in 80% of adults with FASD
- Problems Parenting: Of the 100 females of childbearing age, 30 had given birth; 40% drank during pregnancy, more than half no longer had the child in their care - of their children, 30% have been diagnosed with, or were suspected of having, FASD

SVH ADS supports the declaration of FAS and FASD as disabilities. FASD is the leading cause of non-genetic, intellectual disability in Australia and elsewhere in the Western World [22]. People with FASD often require the same high level of care and have the same significant cognitive impairments as those with other conditions that qualify for disability support [22, 32]. Declaring FAS and FASD as disabilities will enable those with FAS and FASD and their families/carers to access disability and welfare supports, including Commonwealth Rehabilitation Services, Medicare and Centrelink and potentially the National Disability Insurance Scheme (NDIS) [21, 32]. It will also allow judicial courts to take FAS and FASD into consideration when assessing culpability and sentencing, allowing courts to divert appropriate individuals into treatment and appropriate support rather than prison [32].

FAS and FASD are not a problem unique to Aboriginal and Torres Strait Islander communities or to the Aboriginal and Torres Strait Islander community generally [21]. Aboriginal and Torres Strait Islander women drink at rates that are lower than non-Aboriginal and Torres Strait Islander women [8]. Those who do drink however are more likely to do so at levels associated with harm [8]. Higher rates of FAS/FASD among Aboriginal and Torres Strait Islander children compared to non-Indigenous children are therefore likely due to the higher incidence of risky and high risk drinking among Aboriginal and Torres Strait Islander women and are reflective of other socioeconomic factors impacting the Aboriginal and Torres Strait Islander community.

Best practice treatments and support for minimising alcohol misuse and alcohol-related harm

Treatment and support for alcohol and other substance use problems include a broad range of interventions such as screening and assessment, brief interventions, detoxification, counselling (including cognitive behavioural therapy and motivational interviewing) and group programs (such as 12-step programs (e.g. AA, SMART Recovery etc.), as well as pharmacotherapy (such as methadone and buprenorphine). Treatment can be provided in both residential and non-residential settings and can focus on individuals as well as their families. Broadly speaking, treatment for alcohol and other substance use problems has been shown to be effective. [3, 7]

Due to the heterogeneity of the Indigenous population and the paucity of formal evaluations of Aboriginal and Torres Strait Islander- specific interventions, it is not possible to identify discrete treatment interventions which exemplify 'best practice'. According to Gray and colleagues (2001) 'best practice' lies in the principles and processes that are applied in the development and implementation of intervention programs. Among these are community management and control, developing interventions that meet the needs of clients, adequate financial resourcing, and appropriate training and support for staff. These are explained in further detail below. [1, 3, 33-36]

Community control and management

Aboriginal and Torres Strait Islander people must be key players in the design and implementation of interventions to address harmful alcohol use, with capacity building within Aboriginal and Torres Strait Islander community-controlled organisations a central focus. Despite evidence demonstrating that community control and ownership of treatment service provision can contribute to better health outcomes for Aboriginal and Torres Strait Islander people, there has been a trend of governments funding non- Aboriginal and Torres Strait Islander Non Government Organisations to provide Aboriginal and Torres Strait Islander -specific alcohol and drug interventions. [1, 3, 16, 33, 37-43]

Meeting community needs

Interventions must first be accessible. Determinants of accessibility include geography (availability/affordability of transport and quality of roads), the cultural competency of services, affordability (e.g. of services, pharmaceuticals, and other associated costs such as travel), and availability of services and health professionals (Performance framework). Based on the evidence available it is apparent that Aboriginal and Torres Strait Islander people require greater access to a broader range of treatment interventions and services than is currently available. Access to subsidised medication (e.g. disulfiram) is a particular area of need. [1, 3, 44]

Interventions must also be tailored to reflect local diversity, catering for complex presentations, and include collaboration with mainstream services where appropriate due to community-controlled organisations not always being available or preferred by Aboriginal and Torres Strait Islander people themselves. Assertive follow-up and outreach is effective for reaching clients that do not readily access mainstream services. [1, 3, 7, 11, 41, 45]

Adequate resourcing

Inadequate funding places constraints upon service delivery and impacts on a service's ability to offer comprehensive services and hire trained and qualified staff. Historically, there has been considerable under resourcing of, and discrepancies in, the level of funding for Aboriginal and Torres Strait Islander alcohol and drug projects. [1, 3, 33, 37, 42, 45]

Project continuity

A number of projects, regarded by Aboriginal and Torres Strait Islander communities as successful, have been discontinued due to a lack of recurrent funding. To ensure project sustainability, projects must ensure evaluation and monitoring is built into the project design. Measuring project outputs against specified performance indicators ensures projects meet the needs of the target population and provides evidence for continued funding. Historically there has been a reliance on anecdotal evidence. [3, 33, 37]

Integrated project development

Projects developed in isolation will have limited impact. Projects need to be developed as part of a broader intervention strategy. A combination of harm minimisation strategies has been shown to be effective. Development of intersectoral linkages and provision of 'after care' programs following withdrawal and rehabilitation have been identified as areas of need. [1, 3, 33, 37, 45]

Effective management structures

Structures must take into consideration: cultural issues such as social and family responsibilities; the importance of sharing resources; and, language, literacy levels and forms of communication used by clients, staff and community members. Establishing strong management and administration systems leads to better financial accountability, a more stable work environment and improved project outcomes and is dependent on the development of well-trained and qualified staff. [3, 33, 41, 42]

Adequate staff training and development

Capacity building needs to occur through workforce development including training and education and through expanding the Aboriginal and Torres Strait Islander workforce. Aboriginal and Torres Strait Islander people are significantly under-represented in the health workforce. This impacts the accessibility of services and the capacity of services to effectively address the needs of Aboriginal and Torres Strait Islander clients. [1, 3, 7, 33, 42, 43, 45]

The ADS operates the NSW Aboriginal Quitline. The service includes Aboriginal Quitline Advisors who have undertaken site visits in regional and rural areas to provide training and support to Aboriginal and other health workers. This has improved engagement with communities and has subsequently seen a substantial increase in Aboriginal Quitline calls.

Based on the evidence available, it is apparent that Aboriginal and Torres Strait Islander people require greater access to a broader range of treatment interventions and services than is currently available [1, 3, 44]. For this to occur there needs to be significant funding and workforce development investment with capacity building as a key focus [1].

Best practice strategies to minimise alcohol misuse and alcohol-related harm

Alcohol misuse and subsequent harm are the result of complex and multiple factors. Addressing it requires a comprehensive and evidenced based approach, including strategies to [3]:

- Prevent or minimise the uptake of harmful use
- Provide safe and effective care for those who are intoxicated
- Provide treatment for those who are dependent
- Support those whose harmful use has left them disabled or cognitively impaired
- Support those whose lives are affected by others' harmful use
- Address the underlying social determinants

For any strategy to be meaningful and effective it must have an impact. Impact is measured by monitoring implementation and performance against best practice standards and benchmarks.

The National Drug Strategy, Alcohol Treatment Guidelines, and the National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003 – 2009 (CAP) provide an evidence-based framework for addressing alcohol misuse and related harm among Aboriginal and Torres Strait Islander people [1, 3, 43]. The framework for addressing social and health determinants is shared by the 'Closing the Gap' framework agreed upon in 2008 and the more recent National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023 [41]. These frameworks provide the structure for responding to harmful levels of alcohol use among Aboriginal and Torres Strait Islander people and require continued and in some cases (i.e. CAP), renewed commitment [1, 37, 43].

Additionally, in order to be effective in Aboriginal and Torres Strait Islander communities, strategies and interventions must also:

- Be evidenced based. Research suggests that interventions are more likely to be effective when they are comprehensive and include a combination of harm minimisation strategies including [1, 3, 11, 43]:
 - Supply reduction strategies (such as price controls and volumetric taxation, and restrictions on outlet density, trading hours, and marketing)
 - Demand reduction strategies (such as hypothecation, early intervention programs, brief interventions for high risk alcohol use, and improved utilisation and uptake of treatment for alcohol use disorders and alcohol-related harm)
 - Harm reduction strategies (such as the availability of sobering-up shelters)
- Be community owned ensuring active participation and ownership of Aboriginal and Torres Strait Islander people during all project phases including conception, design, execution, monitoring and evaluation. [1, 3, 37, 41, 43]
- Be accountable with structures in place for the monitoring and review of implementation against indicators of success, with processes to share knowledge on what works. [3, 41]
- Build the capacity and sustainability of community-controlled organisations. [1, 3, 37]

- Be client-centred and flexible responding to the individual needs of the community (i.e. women, young people, those experiencing mental illness). [1, 11]
- Increase the accessibility and capacity of mainstream organisations to work with Aboriginal and Torres Strait Islander clients. This includes enhancing the Aboriginal and Torres Strait Islander workforce and increasing the cultural competence of non- Aboriginal and Torres Strait Islander workers and organisations. [1, 7, 45]
- Include the development of a national FAS and FASD prevention strategy. The strategy must take a whole-of-community approach and focus on early detection and specialised response.
- Include a strategy for reducing violence related harm associated with alcohol.
- Include broader levels structural interventions targeting social determinants of health (e.g. through development of complementary employment and education programs). [1, 43]
- Mobilise for behaviour change for high risk drinking among communities and reduce stigma around alcohol use disorders. While social marketing and health education campaigns have been shown to have limited impact, they do have a role to play when they inform part of a broader intervention strategy. [3]

Best practice identification to include international and domestic comparisons

There is a paucity of evaluations on the effectiveness of alcohol treatment interventions and strategies for Indigenous populations including Australia's Aboriginal and Torres Strait Islander people [1, 46]. This is highlighted by Gray and Siggers (2005) who undertook a review of the evidence base for responding to substance misuse in Indigenous minority populations in Australia, New Zealand, Canada and the United States of America [46]. The authors found that:

- The evidence base for effectively addressing harmful alcohol and other substance use is limited
- Of the interventions for which descriptive publications are available, few were formally evaluated
- What evaluations have been undertaken are variant in quality

Evaluating interventions and strategies for minimising alcohol misuse and alcohol-related harm in Aboriginal and Torres Strait Islander communities is no easy task. This is evident from a review conducted by Gray and colleagues (2000) on evaluated alcohol misuse interventions among Aboriginal Australians [47]:

Among the complex issues to be considered are the broader political context in which evaluation takes place, including issues of self-determination and financial and social accountability, the costs of evaluation, the abilities of both community organizations and government agencies to conduct adequate evaluations and the use of culturally appropriate methods. To these, we must also add the absence of comprehensive longitudinal data for monitoring change, and the methodological difficulty of linking particular interventions with changes in consumption or harm indicators when those indicators are also influenced by a host of other factors. Given these issues, it is perhaps not surprising that so few programmes have been evaluated.

Despite the limitations identified above, several conclusions can be drawn from the literature available [1, 3, 41, 47]:

- There is no simple solution to the problem of excessive alcohol consumption among Aboriginal and Torres Strait Islander people
- The gains from any particular intervention are likely to be limited, unless they form part of a broader intervention strategy
- Interventions can be effective providing they are developed in response to local needs and circumstances
- To be effective interventions must have the support of and be controlled by the local community
- Effectiveness of programmes can be compromised by administrative deficiencies and inadequate resourcing
- There is a need to employ a broader range of treatment models and complementary intervention strategies than is currently available
- There is a pressing need for more rigorous evaluation studies in cooperation with Aboriginal and Torres Strait Islander community controlled organisations. Building skill to enable Aboriginal and Torres Strait Islander people to actively participate in and conduct research is essential.

Key points

In summary of the evidence provided SVH ADS wishes to reinforce the following points:

- The strength and resilience of Aboriginal and Torres Strait Islander people must be recognised and may provide the foundation upon which to build efforts to reduce harmful alcohol and other substance use across Aboriginal and Torres Strait Islander communities.
- While rates of abstinence are higher among Aboriginal and Torres Strait Islander people, those who do drink are more like to drink at risky and high risk levels and experience greater alcohol related harm and harm per unit of alcohol consumed as a result.
- Responding to the higher prevalence of harmful alcohol use and alcohol-related harm in Aboriginal and Torres Strait Islander communities requires a comprehensive, culturally competent and evidence based approach.
- SVH ADS supports strategies aimed at reducing the overall availability of and demand for alcohol. Strategies that have been shown to be effective and which SVH ADS supports include:
 - limiting liquor outlet density and restricting trading hours
 - restricting alcohol related marketing (including sponsorship)
 - volumetric taxation and hypothecation
- Increasing service utilisation and uptake of treatment is essential to reducing alcohol-related harm. Despite the higher prevalence of harmful alcohol use and alcohol-related harms among Aboriginal and Torres Strait Islander communities, Aboriginal and Torres Strait Islander people do not have sufficient access to evidence based treatment and support. Access to subsidised medication is a glaring area of need. Disulfiram has been shown to be effective and should be subsidised through the Pharmaceutical Benefits Scheme.
- Despite the lack of formal evaluative research on Aboriginal and Torres Strait Islander-specific strategies and interventions, a number of best practice elements are evident. Among these are community control and ownership, flexibility in meeting community and complex client needs, and adequate resourcing and capacity building.
- A lack of resourcing and administrative deficiencies has affected the sustainability of Aboriginal and Torres Strait Islander-specific projects. Capacity building needs to occur to ensure the continued and ongoing success of these projects. This includes building skill to enable Aboriginal and Torres Strait Islander people to actively participate in and conduct project administration and research. It also includes enhancing the Aboriginal and Torres Strait Islander workforce and improving the cultural competence of non-Aboriginal and Torres Strait Islander workers and organisations.
- FAS/FASD is a community-wide problem and requires a whole-of-community approach. Declaring FAS and FASD as disabilities is one step in ensuring persons with FAS/FASD get the adequate care and support individual sufferers and their families/carers need. Prevention, screening and early detection, and access to appropriate intervention are key to responding to FAS/FASD and to minimising the complex behaviour, neurodevelopment and intergenerational impacts of FAS/FASD.
- Finally, any developed strategy or intervention will not be effective unless it forms part of broader intervention strategy. Addressing underlying social determinants to health and addressing the link between violence and alcohol must complement any effort to reduce harmful alcohol use and alcohol-related harm in Aboriginal and Torres Strait Islander communities.

References

1. Wilson, M., et al., *The harmful use of alcohol amongst Indigenous Australians*. Vol. 4. 2010: Centre for Indigenous Australian Education and Research Edith Cowan University.
2. Australian Institute of Health and Welfare, *The health and welfare of Australia's Aboriginal and Torres Strait Islander people, an overview 2011*, 2000: Canberra.
3. Gray, D. and E. Wilkes, *Reducing alcohol and other drug related harm*, 2010, Closing the Gap Clearinghouse: Canberra. p. 1-10.
4. Rehm, J., et al., *Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders*. The Lancet, 2009. **373**(9682): p. 2223-2233.
5. Australian Institute of Health and Welfare, *2010 National Drug Strategy Household Survey report*, in *Drug statistics series no. 25. Cat. no. PHE 145*. 2011: Canberra.
6. Trenwin, D., *National Aboriginal and Torres Strait Islander Health Survey 2004-05*, 2006, Australian Bureau of Statistics: Canberra.
7. Australian Health Ministers' Advisory Council, *Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report*, 2012: Canberra.
8. Australian Institute of Health and Welfare, *Substance use among Aboriginal and Torres Strait Islander people*, 2011: Canberra.
9. MacRae A, et al., *Overview of Australian Indigenous health status, 2012, 2013*, Australian Indigenous HealthInfoNet: Perth, Western Australia.
10. HealthInfoNet, A.I., *Summary of Australian Indigenous health, 2012, 2013*: Perth.
11. Breen, C., et al., *Identifying individual- and population-level characteristics that influence rates of risky alcohol consumption in regional communities*. Australian and New Zealand Journal of Public Health, 2014. **38**(1): p. 60-65.
12. Dick, D., *Social determinants and the health of Indigenous peoples in Australia – a human rights based approach*, in *International Symposium on the Social Determinants of Indigenous Health 2007*: Adelaide.
13. Osborne, K., F. Baum, and L. Brown, *What works? A review of actions addressing the social and economic determinants of Indigenous health. Issues paper no. 7. Produced for the Closing the Gap Clearinghouse.*, 2013, Australian Institute of Health and Welfare: Melbourne.
14. Australian Bureau of Statistics. *2076.0 - Census of Population and Housing: Characteristics of Aboriginal and Torres Strait Islander Australians, 2011 Census 2011*; Available from: <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2076.0main+features302011>.
15. Australian Bureau of Statistics. *4704.0 - The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, Oct 2010 2012*; Available from: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/lookup/4704.0Chapter100Oct+2010#Education>.
16. National Indigenous Drug and Alcohol Committee, *Locally designed and operated Indigenous community models and practices that address indigenous alcohol and other drugs misuse*, 2009.
17. Steering Committee for the Review of Government Service Provision, *Overcoming Indigenous Disadvantage: key indicators 2009*, 2009, Productivity Commission, Australia: Canberra.
18. Pascal, R., T. Chikritzhs, and D. Gray, *Estimating alcohol-attributable mortality among Indigenous Australians: Towards Indigenous-specific alcohol aetiological fractions*. Drug and alcohol review, 2009. **28**(2): p. 196-200.
19. Australian Institute of Health and Welfare, *2007 national drug strategy household survey: first results*, 2008: Canberra.
20. Chikritzhs, T., et al., *Trends in alcohol-attributable deaths among Indigenous Australians, 1998–2004*. Perth: National Drug Research Institute, 2007.
21. National Indigenous Drug and Alcohol Committee, *Addressing fetal alcohol spectrum disorder in Australia*, J. Stokes, Editor 2012, Australian National Council on Drugs: Canberra.

22. Committee, E.a.H.S., *Foetal Alcohol Spectrum Disorder: the invisible disability.* , September 2012, Parliament of Western Australia: Perth.
23. Rusell Family Fetal Alcohol Disorders Association. *How can FASD be Identified?* . Available from: <http://rffada.org/what-is-fasd/how-can-fasd-be-identified>.
24. Mutch, R., et al., *Fetal Alcohol Spectrum Disorder: Knowledge, attitudes and practice within the Western Australian justice system. Final Report*, April 2013, Telethon Institute for Child Health Research, Centre for Child Health Research, The University of Western Australia: Perth, Australia.
25. Closing the Gap Clearinghouse, *Diverting Indigenous offenders from the criminal justice system*, 2013, Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies: Canberra.
26. Australian Institute of Health and Welfare, *The health of Australia's prisoners 2012*, 2013, Australian Institute of Health and Welfare: Canberra.
27. Wundersitz, J., *Indigenous perpetrators of violence: Prevalence and risk factors for offending*, 2010, Australian Institute of Criminology: Canberra.
28. Allard, T., *Understanding and preventing Indigenous offending*, December 2010, Department of Justice and Attorney General: Indigenous Justice Clearinghouse.
29. Weatherburn, D., L. Snowball, and B. Hunter, *Predictors of Indigenous arrest: An exploratory study*. Australian & New Zealand Journal of Criminology, 2008. **41**(2): p. 307-322.
30. Putt, J., J. Payne, and L. Milner, *Indigenous male offending and substance abuse*. Drugs, 2005. **1**(9): p. 3.
31. Steering Committee for the Review of Government Service Provision, *Overcoming Indigenous Disadvantage: Key Indicators 2007*, 2007, Steering Committee for the Review of Government Service Provision: Canberra.
32. House of Representatives Standing Committee on Social Policy and Legal Affairs, *FASD: The Hidden Harm. Inquiry into the prevention diagnosis and management of Fetal Alcohol Spectrum Disorders*, November 2012, The Parliament of the Commonwealth of Australia: Canberra.
33. Gray, D. and B. Sputore, *Interventions for Indigenous Australians: The broader context*, in *Best Practice Interventions in Corrections for Indigenous People Conference* 2001, Australian Institute Of Criminology: Sydney.
34. Lynch, J., *Social epidemiology: some observations about the past, present and future*. Australasian Epidemiologist, 2000. **7**(3): p. 7.
35. Gray, D., et al., *Review of the Aboriginal and Torres Strait Islander community-controlled alcohol and other drugs sector in Queensland*, 2009: Brisbane.
36. Steering Committee for the Review of Government Service Provision, *Report on government services 2010: Indigenous compendium*, 2010: Canberra.
37. National Indigenous Drug and Alcohol Committee, *Funding of Alcohol and Other Drug Interventions and Services for Aboriginal and Torres Strait Islander People*, August 2013, National Indigenous Drug and Alcohol Committee: Canberra.
38. Gray, D., et al., *Indigenous-specific alcohol and other drug interventions: continuities, changes and areas of greatest need*, 2010: Canberra.
39. Loxley, W., et al., *The prevention of substance use, risk and harm in Australia: a review of the evidence*, 2004: Canberra.
40. Haber, P.S., et al., *Guidelines for the treatment of alcohol problems*, 2009: Canberra.
41. Department of Health and Ageing, A., *National Aboriginal and Torres Strait Islander Health Plan 2013 - 2023*, 2013: Canberra.
42. Strempel, P., et al., *Indigenous drug and alcohol projects: elements of best practice*, 2003: Canberra.
43. National Indigenous Drug and Alcohol Committee, *Addressing harmful alcohol use amongst Indigenous Austrlians*, 2009.
44. Conigrave, K.M. and K.S. Lee, *Smoking or alcohol dependence among Indigenous Australians: treatment may be needed, not just education*. Heart Lung Circ, 2012. **21**(10): p. 626-31.
45. Australia, P.H.A., *Aboriginal and Torres Strait Islander Peoples' Substance Use Policy*, 2008.

46. Gray, D. and S. Siggers, *6.7 The Evidence Base for Responding to Substance Misuse in Indigenous Minority Populations*. Preventing harmful substance use: the evidence base for policy and practice, 2005: p. 381.
47. Gray, D., et al., *What works? A review of evaluated alcohol misuse interventions among Aboriginal Australians*. Addiction, 2000. **95**(1): p. 11-22.