Submission to the Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander Communities

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SUBMISSION TO THE INQUIRY INTO THE HARMFUL USE OF ALCOHOL IN ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES

Executive Summary

The following submission is written for the Parliamentary Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities. The context of the author's experience in relation to harmful alcohol use and Aboriginal communities is providing drug and alcohol treatment to rural NSW including in Aboriginal specific programs and in consultation with Aboriginal people and communities in that state.
The submission directly addresses five of the seven terms of reference. These are listed below with the key points from each section.

1. **Patterns of supply of, and demand for alcohol in different Aboriginal and Torres Strait Islander communities, age groups and genders; and**
2. **The social and economic determinants of harmful alcohol use across Aboriginal and Torres Strait Islander communities**

Some NSW towns or regions with a large proportion of Aboriginal people have skewed results in alcohol related incidents compared to other places. The reasons for this are not well explained or understood. Community reports suggest that five percent of the population cause ninety per cent of the problems.

- *Analyses of alcohol related incidents by locality and income not only Aboriginality are needed.*
- *Policing practices and legal responses to alcohol problems are different in communities with large Aboriginal populations compared to other places.*
- *The role of Aboriginal party houses in high risk alcohol consumption in rural areas is an unexplored phenomenon*

3. **Best practice strategies to minimise alcohol misuse and alcohol-related harm**

- *Supply restriction has the most evidence for reducing alcohol related harms across the population.*
- *The variation in approaches and management of alcohol restrictions suggests a much greater role for national restrictions on price and availability of alcohol for all communities not just Aboriginal and Torres Strait Islander Communities.*

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

Effective treatment methods have been well established and Lyndon Community has developed delivery strategies that are well utilised by Aboriginal people in the regions serviced. These methods are described in the research conducted by Lyndon Community. However;

- *Treatment types and their effectiveness are not well understood outside the sector. Popular preference is for residential rehabilitation but this is not always an available option or the best option.*
- *Demand for alcohol treatment services outstrips supply in rural NSW. Supply cannot be increased because of associated costs*
- *Effective treatment methods have been well established but are not routinely delivered to Aboriginal people in an accessible way.*
- *Naltrexone is an effective alcohol treatment for Aboriginal people that is being promoted by Lyndon Community*
- *Drug and alcohol treatment practice approaches need to be included in undergraduate professional qualifications such as social work, psychology, occupational therapy and community services to increase the workforce.*

5. The implications of Foetal Alcohol Syndrome

The Lyndon Community has researched the prevalence of cognitive impairment in the rural drug and alcohol treatment population.

- *Aboriginal adults with Foetal Alcohol Spectrum Disorder are a significant proportion of the alcohol treatment population. Effective services for this group are unavailable.*
- *Specialised treatment programs for Aboriginal adults with FASD need to be developed and evaluated.*

CONTENTS

Introduction

This submission uses international and national research literature to support the key points made throughout the document. Before addressing the terms of reference the context of the authors experience in relation to harmful alcohol use and Aboriginal communities is described. Most of the examples of alcohol harms and practice strategies used come from NSW. The term Aboriginal is used throughout the document to refer to Australian Indigenous people rather than Aboriginal and Torres Strait Islander. Aboriginal people were the first inhabitants of the area now known as New South Wales (NSW). Aboriginal is considered the most appropriate term to use in relation to NSW communities (NSW Health, 2004).

Submission Context

The Lyndon Community (LC) is a non-government organisation providing treatment and support to individuals and their families with a drug and/or alcohol problem. LC is one of the largest NGO providers of drug and alcohol (D&A) treatment in NSW. Based in Orange, LC provides residential and non-residential programs in western NSW and Bega on the NSW south coast. LC works closely with Aboriginal people and communities in planning and providing accessible and acceptable treatment approaches for alcohol misuse. Two LC programs are specifically for Aboriginal people – Wandarma Aboriginal Drug and Alcohol Service in Bega, NSW and the Murdi Paaki Drug and Alcohol Network.

Wandarma covers the region from the Victorian Border up the lower south coast of NSW as far as Wallaga Lake (about 115 kms), including Aboriginal people and their families living in the communities of Eden, Pambula, Merimbula, Bega, Bemboka, Bermagui and Wallaga Lake.

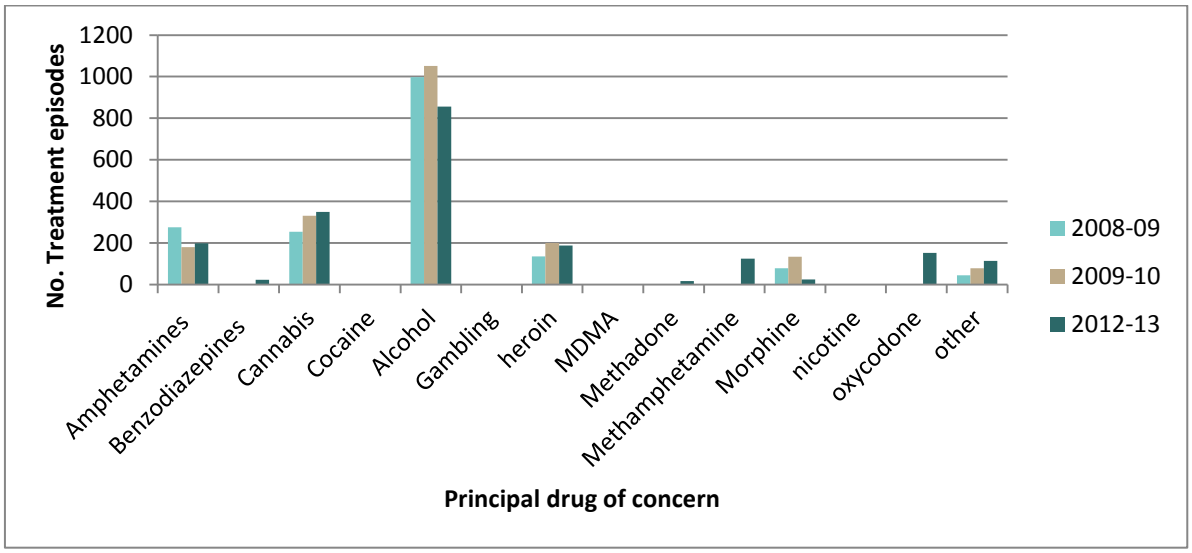
The Murdi Paaki Region is located in western NSW and covers almost one third of the State along the Murray Darling Basin from the Queensland to the Victorian border. More than 8,700 Aboriginal people live in the region, both in major towns such as Broken Hill, and in more than 16 rural and remote Aboriginal Communities in NSW. Five primary partners comprise the Murdi Paaki Drug and Alcohol Network: The Lyndon Community, Coonamble Aboriginal Health Service, Maari Ma Health Aboriginal Corporation, Bourke Aboriginal Health Service, and Walgett Aboriginal Medical Service.

Lyndon Community is a not-for-profit organisation which has supported people in need of treatment for substance misuse for over 30 years. Accredited through the Australasian Council of Healthcare Standards, LC services include withdrawal treatment, rehabilitation, treatment groups, education programs, women's groups, mental health and drug use groups, family support and children's programs, and counselling. LC helps train psychology, social work and medical students from the Universities of Sydney and Newcastle, Charles Sturt University and the UNSW, has a fulltime staff Addiction Physician, and a fulltime rural GP Registrar training post.

Lyndon Community is a leader in drug and alcohol treatment research. Our research aims to develop health service models, implementation strategies and evaluation programs; monitor clinical services and client outcomes; and identify trends in service delivery demand and supply. Current National Health and Medical Research Council and Australian Research Council supported studies are evaluating the effectiveness of an intervention program for Aboriginal people with alcohol problems.

In 2012-2013 LC provided 1,600 individual treatment episodes and delivered education and support to more than 2,000 people via group therapy, training and health promotion events. In 2012-13, 44% of all individual treatment episodes were for Aboriginal people. This is a significant increase from 2006-07 when 28% of clients were Indigenous. The increase is due to making services acceptable and accessible to Aboriginal people. Sixty per cent of treatment episodes are for alcohol problems (see fig.1) and seventy per cent of clients are men.

Figure 1: Principal drug of concern in LC treatment episodes



Response to the Terms of Reference

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

And;

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

Aboriginal and Torres Strait Islander Australians are concerned about drug and alcohol-related harm within their communities. Substance use in combination with poverty, poor housing, and limited educational attainment is identified as a key reason for the 17-year gap in life expectancy between Aboriginal and Torres Strait Islander and non-Indigenous Australians (Gray et al., 2007). Aboriginal and Torres Strait Islander drug use, primarily alcohol, is described as the cause of serious health problems, imprisonment for D&A related offences, and endemic family violence (Australian Bureau of Statistics and Australian Institute of Health and Welfare [AIHW], 2008; Brady, 2007; Weatherburn, 2008).

There is a complex relationship between socio-economic status and criminal justice involvement for alcohol related incidents and Aboriginal people. Aboriginal people are amongst the poorest people in Australia earning half the income of other Australians (AIHW 2007) and could be expected to drink less than those with higher incomes. Those on higher incomes drink more and more often than those on low incomes (AIHW 2010; Holder, 1998). However, consumption increases as the area level disadvantage increases (AIHW 2010). This poses a contradiction for Aboriginal communities in rural and remote Australia.

Population level analyses can mask the interactions between behaviours, health, income and criminal justice involvement (Gravelle 1998). Gravelle (1998) suggests it is an ecological fallacy to infer relations at the individual level (of a town or region for example) from associations between variables at the population level. Even though fewer Aboriginal people drink at risky levels greater attention is paid to Aboriginal people's drinking behaviours than to the population of people who are poor or the population of Australia in general. For example, we know that those Aboriginal people that do drink tend to drink at levels considered risky for both short-term and long-term harm in comparison to non-Aboriginal people (AIHW, 2007). Similar analyses based on income levels and location rather than population level is harder to find.

Towns in the Murdi Paaki region record the highest rates of alcohol related domestic violence and assaults in NSW. The incident rate is seven times higher than in NSW as a whole and 95% of alcohol related offences are committed by Indigenous people (NSW BOCSAR 2013). The statistics run counter to what is found in other parts of the country. The reasons for this are not well understood.

It may be that alcohol related incidents in towns such as Bourke and Brewarrina are higher because the proportions of the communities that is poor but drinking at high risk levels with consequent domestic violence, assaults and alcohol related injuries is higher than elsewhere and so they have more visible problems that attract the attention of police. In towns with large Aboriginal populations, Aboriginal people will be overrepresented in the low income group. There is likely to be a tipping point – as soon as the proportion of the community that is both poor and Aboriginal gets over x%, then the *small proportion* of those who drink heavily and get into trouble starts to disproportionately increase the total number of alcohol related events in that community attributed to Aboriginal people because they make up a higher proportion of the community. Analyses by income levels and population size are needed to better understand alcohol related incidents.

The remote Aboriginal communities of NSW with high crime rates are also likely to be the communities that have the greater proportion of police per head of population and it is a legal response that increases crime statistics and imprisonment. Aboriginal people are frequently imprisoned for alcohol related offences, re-imprisoned on multiple occasions and subject to frequent short sentences for non-payment of fines, public order offences, driving offences and so on (ABS 2010c, Baldry & Cunneen, 2014). Non-Indigenous people are less likely to experience repeated short incarcerations or be monitored in this manner (Baldry and Cunneen 2014). Police in the remote communities record alcohol as a factor in crime routinely and accurately. Similar levels of policing and recording of alcohol related events in other places may well see an increase in alcohol related incidents.

Bourke, Brewarrina, Walgett and Wilcannia are clearly identified both in crime statistics and local discourse as problem locations for Aboriginal, alcohol related problems. Yet Menindee, Coonamble and Cobar, also within the Murdi Paaki region, do not tell the same story even though the Aboriginal population in these towns is significant and has a similar demographic profile (poverty, age and so on) as in the other locations. Local context is significant in policing and other legal responses to alcohol problems.

Some drinking practices may influence alcohol consumption and related problems. Practices such as sharing of alcohol across groups on 'payday' and availability of alcohol via party houses are described by Aboriginal people and drug and alcohol workers in Aboriginal communities in the Murdi Paaki and on the south coast of NSW. Party houses are residential locations where large numbers of people gather to party for several days, consuming alcohol and often other drugs. Supply reduction strategies, where they exist, do not always include methods for reducing private consumption of alcohol e.g. via bottle shop purchases. Private consumption of alcohol to excess in large groups poses risks in relation to domestic violence, child protection and policing. Party houses in particular increase the availability and high risk consumption of alcohol over extended periods of time yet are unexamined as an influence in alcohol related harm and community safety.

Key Points

Some NSW towns or regions with a large proportion of Aboriginal people have skewed results in alcohol related incidents compared to other places. The reasons for this are not well explained or understood. Community reports suggest that five percent of the population cause ninety per cent of the problems.

- ***Analyses of alcohol related incidents by locality and income not only Aboriginality are needed.***
- ***Policing practices and legal responses to alcohol problems are different in communities with large Aboriginal populations compared to other places.***
- ***The role of Aboriginal party houses in high risk alcohol consumption in rural areas is an unexplored phenomenon***

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

Addressing problematic use covers a range of strategies. Berendts (2004) suggested the most effective measures to reduce problematic alcohol use at the population level are supply restrictions (e.g., reduction of alcohol outlets and opening times) combined with structural responses such as increased employment opportunities. There is a higher per capita consumption of alcohol in rural locations (Coomber, Miller, Livingston & Xantidis 2014), and higher density of liquor outlets in rural relative to urban locations (Williams 2000). Rural communities desire to address problematic alcohol use is hampered by lack of information about local conditions influencing alcohol related problems.

Supply restrictions are not applied routinely nor are they similar across towns or regions. For example, in Orange NSW strategies to reduce alcohol related violence have included early closing on high risk days such as Christmas Eve, Anzac Day, and after the local horse races; and restricting the alcohol content of drinks served at race venues to mid-strength beer and low alcohol wine. Lock outs were enforced at the late night venues where patrons could not enter the premises after 1am. This effectively means that people had to choose somewhere to stay before lock out or go home. The number of drinks bought at any one time was limited as were high alcohol drinks such as shots and doubles. These restrictions in force in Orange since 2011 are similar to those recently established in some Sydney entertainment precincts in 2014. In Bega on the NSW far south coast there is no liquor accord and no restrictions on alcohol supply.

The restrictions in Orange targeted all people drinking in licensed venues (Allan, Zeb & Bowtells, 2012). In Bourke, NSW the restrictions purposefully targeted drinking practices of Aboriginal people. A five-year Bourke Alcohol Action Plan developed by the Bourke Alcohol Working Group and licensees included the introduction of alcohol sale restrictions introduced February 16, 2009.

- No fortified wine in containers greater than 750mL;
- No beer in 750mL glass bottles (longnecks);
- No wine in casks greater than two litres
- Only drinks with an alcohol content of 3.5% or lower, packaged in non-glass containers, can be sold between 10am and 2pm. Residents living more than 50km from the licensed venue are exempt from this restriction
- A voluntary undertaking by the six licensees in Bourke at the time that all purchasers must place purchased alcohol into a motor vehicle (as opposed to walking around the streets drinking it).

The NSW Police report on crime statistics in Bourke presented to the Bourke Alcohol Working Group in 2010 comparing the 18 months pre and post the introduction of the alcohol restrictions reported the following:

- Bourke had experienced a 32% drop in intoxicated persons; 22% drop in assaults; 25% drop in domestic-related assaults; 18% drop in sexual assaults; and 34% drop in malicious damage.
- Several of the reductions also showed time shifts that were over and above those that might be expected due to the 10am to 2pm restriction on takeaway alcohol sales.

However, anecdotal reports in 2013 suggest the impact of the restrictions have decreased and there is pressure from licensees and some community members to weaken them. Currently work has been commissioned by the Far West Medicare Local to evaluate local alcohol action. The National Drug and Alcohol Research Centre and an expert evaluation panel including researchers from the Lyndon Community are conducting this work.

Most alcohol supply restriction is the responsibility of local liquor accords including police and local government. The variation in supply restrictions between Orange, Bourke and Bega is a good example of why responsibility for alcohol supply should not be localised. Recent NSW state government action has reduced access to take-away alcohol via limits on bottle shop trading hours. However, state-wide action is unusual. Local groups are not well-informed or well-resourced about how to reduce alcohol supply (Allan, Zeb & Bowtells 2012). The alcohol industry is a major impediment to reducing the supply of alcohol.

Key points

- ***Supply restriction has the most evidence for reducing alcohol related harms across the population.***
- ***The variation in approaches and management of alcohol restrictions suggests a much greater role for national restrictions on price and availability of alcohol for all communities not just Aboriginal and Torres Strait Islander Communities.***

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

Treatment options

For those experiencing the personal impacts of problematic alcohol use, there is a strong imperative to do something to understand and address damage done to relationships, health, and future opportunities. The impacts are across families and communities as well as individuals who drink too much alcohol. Effective treatment is well described in the research literature. Motivational interviewing, screening and brief interventions, cognitive behavioural therapy and residential rehabilitation have all been found effective for reducing alcohol consumption in individuals (e.g. Orford, 2005; Morgenstern & Longabaugh 2000). Their application will vary considerably across the country and it is likely many Aboriginal people seeking treatment for alcohol problems will not have access to evidence-based treatments. This is because more than half the Aboriginal population lives in rural and remote areas and limited or no treatment options exist in those places.

Community consultations about drug and alcohol services frequently identify a need or preference for residential rehabilitation services. Community members perceive this as the most effective treatment and like the idea that their family member or friend will be in a safe abstinent environment for an extended period. In small communities residential treatment gives everyone a break from the alcohol affected person who causes trouble and worry. The criminal justice system also emphasises residential rehabilitation as a preferred

treatment option including making treatment in this setting conditional for release from jail or on sentencing. However, residential treatment is not always the most suitable option. Understanding of treatment types and effectiveness is not widespread.

As a drug and alcohol treatment agency, the Lyndon Community operates on a continuum of care basis consistent with The National Alcohol Treatment Guidelines on treatment matching (DoHA 2003);

- The intensity of interventions should vary, with clients with more moderate to severe problems receiving more intensive treatments. Community based options should be tried first.
- Decisions about treatment setting should be based on the client's treatment goals, preferences, severity of dependence, the presence of comorbid disorders, cognitive and social functioning, relapse history, and social circumstances.

Medical treatments for alcohol problems are available. Lyndon Community aims to increase the availability and use of naltrexone by Aboriginal people living in rural NSW. Naltrexone is primarily used for the treatment of alcohol dependence. Access to primary care treatment for alcohol dependence is limited by General Practitioner's reluctance to address alcohol consumption during consultations (Department of Health and Ageing, 2011). Naltrexone has been found effective in reducing frequency and severity of relapse to drinking, (Latt, Jurd, Houseman & Wutzke, 2002), and has been demonstrated as useful when delivered in the primary care setting without additional counselling or therapy (National Institutes of Health 2006). Naltrexone reduces cravings by blocking the pleasant effects of alcohol while the person taking it continues to drink, which has the effect of reducing consumption over time (Sinclair, 2001). Prescribing naltrexone for heavy drinkers who wish to control their drinking but not abstain has been proven effective (Ray, Krull & Leggio, 2010). Increasing awareness, availability and use of naltrexone is a harm minimisation strategy for alcohol misuse.

The rural Aboriginal community's awareness of available treatment options for problematic alcohol consumption is limited. Access to naltrexone in particular is likely to be further limited because GPs are unlikely to discuss and prescribe the treatment. We have a current project offering a culturally appropriate community awareness campaign on the benefits and effects of Naltrexone using posters and comic books developed by Aboriginal community members; and an education campaign for health workers including GPs. Comics and cartoons have been found to be very effective health promotion tools (Duncan & Smith, 2009; Guillemin, 2004).

Treatment access

In rural areas the issue for Aboriginal people is not what works but how to access what works. Our study of Aboriginal people in NSW treatment programs found that those who located treatment turned up and completed treatment at a higher rate than non-indigenous people (Allan & Kemp 2011). Lyndon Community has found ways of making alcohol treatment accessible and available for Aboriginal people by having soft entry or low threshold entry points to contact with treatment staff (Allan & Campbell, 2011).

The way this works is described in two videos – the links are here;

- Lyndon Outreach Soft Entry Approach: http://vimeo.com/40861846
- Murdi Paaki Drug and Alcohol Network: https://vimeo.com/84113863

Our current NHMRC study into a treatment method – Community Reinforcement Approach - is showing promising early results at 3 month follow-ups with reductions in alcohol consumption and improvements in personal well-being. It has been found to be acceptable to Aboriginal people (Calabria et al 2012). This program is a good example of effective treatment for Aboriginal people but Lyndon Community is the only provider of this program in Australia.

Residential or community treatment options are limited in rural NSW. The map in Fig.2 depicts the locations of the known NGO treatment centres in rural NSW (excluding Sydney's metropolitan area), providing residential D&A services. Assessed against the demand for the D&A services and the client referral locations depicted in Fig.3, there is a shortfall in the supply of accessible residential withdrawal and rehabilitation services in rural NSW, particularly servicing the central and far west of the state i.e. the areas with the most Aboriginal people.

Figure 2 – NGO residential D&A programs (excluding Sydney)

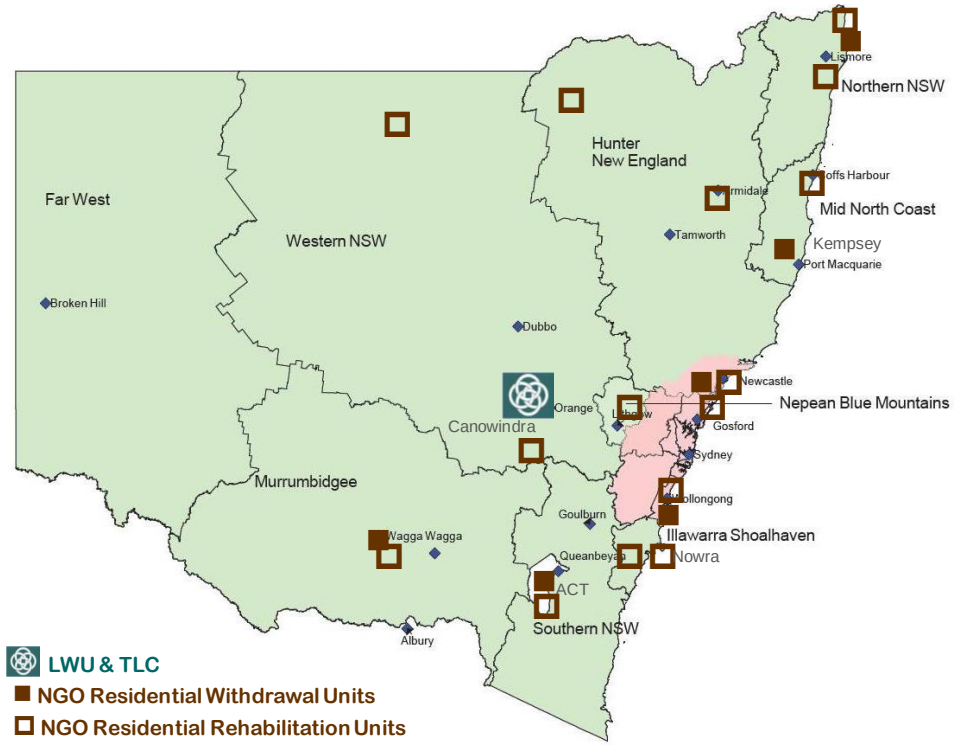
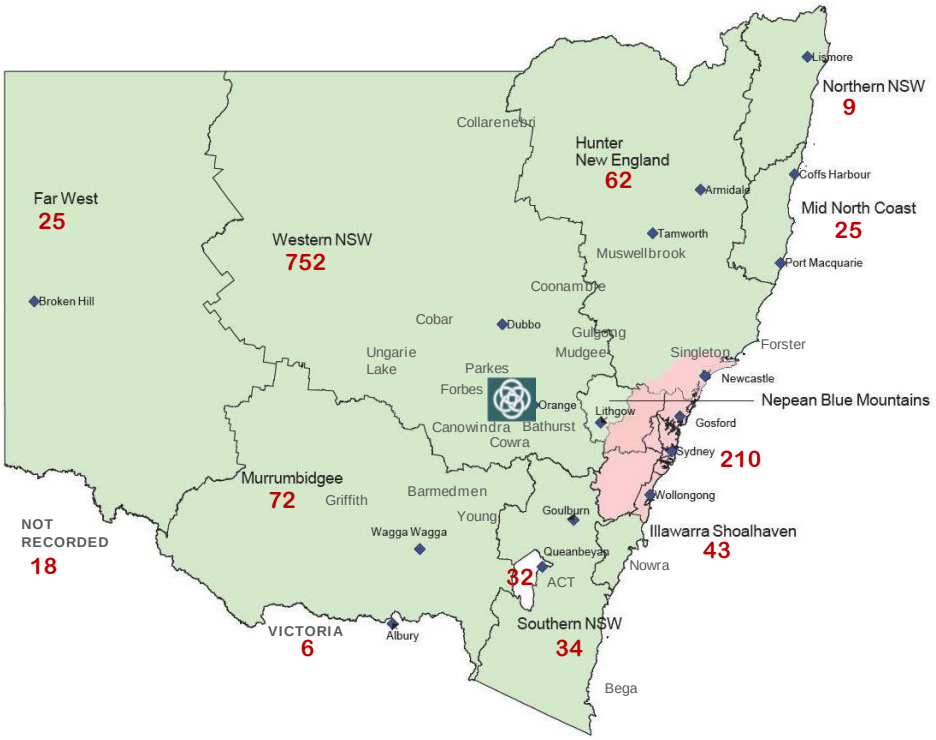


Figure 3 – LC client location of usual residence 2010 (by LHD) map



The current workforce is not well suited to providing effective treatment for Aboriginal people with alcohol problems. Substance misuse has been identified as the predominant problem for people who are homeless, experiencing domestic violence or engaged with the criminal justice or child protection systems (e.g. Slesnick, Glasson, Katafiasz et al 2012; Baldry, Dowse, Clarence & Snoyman 2010). Aboriginal people are grossly overrepresented in these groups which are all key arenas of work for health and community service workers. However, few Australian university courses provide drug and alcohol subjects. For example, strategies for working with substance users has been identified as a key training need of social workers post-graduation (Hall et al 2000). A search of Australian Social Work using the words drug, alcohol and substance as search terms and 2003-2013 as the time period found 67 papers where substance misuse was noted in the abstract as a confounding factor of work with families (e.g. Macnamara, 2009), mental illness (e.g. Gibbs, 2010) or child protection and out of home care (e.g. Tilbury, Buys & Creed 2009; Sheehan, 2010). However, practice strategies were not reported. Education and training on ways of working with and addressing alcohol misuse is a significant gap in professional and practice development in the community service sector.

Key Points

- ***Treatment types and their effectiveness are not well understood outside the sector. Popular preference is for residential rehabilitation but this is not always the best option.***

- ***Demand for alcohol treatment services outstrips supply in rural NSW. Supply cannot be increased because of associated costs***

- ***Effective treatment methods have been well established but are not always delivered because of limited availability and lack of appropriately skilled treatment providers***

- ***Naltrexone is an effective alcohol treatment for Aboriginal people that is being promoted by Lyndon Community***

- ***Drug and alcohol treatment practice approaches need to be included in undergraduate professional qualifications such as social work, psychology, occupational therapy and community services to increase the workforce.***

The Implications of Foetal Alcohol Syndrome

Children born with Foetal Alcohol Spectrum Disorder (FASD) continue to experience problems in adulthood. Adults with FASD have a life span prevalence of 50% for confinement (in detention, jail, prison or psychiatric or alcohol/drug inpatient treatment) and 35% for alcohol and drug problems (Caley, Kramer, Robinson, 2005). This type of cognitive impairment is one factor known to affect people's ability to participate in substance misuse treatment because of the range of cognitive, behavioural and emotional problems such impairment can cause. Some of the behaviours described as common features of cognitive impairment such as impaired self-monitoring and self-regulation and lack of initiative are frequently seen in treatment modalities. Adults with FASD are likely to experience difficulty engaging with and participating in substance misuse treatment that is predominantly based on cognitive and behavioural change activities.
During 2012 Lyndon Community conducted a staff survey of skills and knowledge (n=45) in working with adults with FASD; and screening of all consenting clients (n=50) with the Addenbrooks Cognitive Examination – Revised (ACE-R) for a 3 month period to identify the prevalence of cognitive impairment.

The staff survey identified limited skills and knowledge about working with FASD in the treatment setting yet the screens identified a high prevalence of cognitive impairment in clients. The analysis of completed ACE-R screens found that 56% of participants were likely to have a cognitive impairment. Logistic regression found that cognitive impairment was strongly related to Indigenous status and not related to age or gender. For example, 82% of Indigenous clients had a score indicating possible impairment, compared to 28% for non-Indigenous (Allan & Kemp 2011).

This finding has significant implications for the delivery of psycho-social alcohol treatment as around half of the treatment population may experience difficulty understanding, remembering and applying information about alcohol misuse to their own situation. Further, it is likely that this same group of people will experience barriers to participating in the daily routines of residential treatment and complying with directions from staff (Hensold et al 2006; Mantell 2010).

There is limited information available about specific alcohol treatment methods and approaches likely to be effective for Aboriginal adults with FASD. Rather, more general suggestions are made about needing to adapt and lengthen treatment to improve outcomes for people with cognitive impairments (e.g. Degenhardt & Hall 2000, Sacks et al 2009). Screening to identify cognitive problems seems to be the logical response and Sacks et al (2009) suggest that routine screening of all patients is indicated to identify those who would benefit from modified treatment programs. However, unless the screening makes a difference to the treatment provided it is of limited benefit to patients and would be costly in terms of agency time and resources.

Aboriginal people with FASD and alcohol problems are a significant proportion of the alcohol treatment population (Allan, Kemp & Golden 2012). However, treatment programs, and residential facilities in particular, cannot provide suitable care for this group. Until pregnancy and childhood strategies reduce the number of Aboriginal people with FASD specialised programs are needed. Such programs will be more costly than standard alcohol treatment programs because the programs will need to be longer and require staff with specialist skills.

Key Points

- ***Aboriginal adults with Foetal Alcohol Spectrum Disorder are a significant proportion of the alcohol treatment population. Effective services for them are unavailable.***

- ***Specialised treatment programs for Aboriginal adults with FASD need to be developed and evaluated.***

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