



23 April 2014

Clerk Assistant (Committees)  
House of Representatives  
PO Box 6021  
Parliament House  
CANBERRA ACT 2600

Dear Sir/Madam,

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

*This submission for this inquiry has been prepared by National Faculty of Aboriginal and Torres Strait Islander Health of the Royal Australian College of General Practitioners.*

The RACGP is the specialty medical college for general practice in Australia, responsible for defining the nature of the discipline, setting the standards and curriculum for education and training, maintaining the standards for quality clinical practice and supporting general practitioners in their pursuit of excellence in patient care and community service.

The college recognises that improving the health of Aboriginal and Torres Strait Islander people is one of Australia's highest health priorities. General practice and Aboriginal health services are vital to improving the health and wellbeing of Aboriginal and Torres Strait Islander people and their communities throughout Australia.

The RACGP is committed to raising GP awareness of Aboriginal and Torres Strait Islander health needs and their cultural context, and to advocating for culturally appropriate health delivery systems, which improve health outcomes.

The college also strongly supports the vital role of Aboriginal and Torres Strait Islander health workers and people in partnership with general practice to deliver comprehensive health care.

The faculty Chairperson is Associate Professor Brad Murphy, an Aboriginal man from the Kamilaroi people of northwest New South Wales.

**Introduction**

The RACGP welcomes the opportunity to submit to the Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities.

We note with interest that the Inquiry is confining itself to alcohol use in Aboriginal and Torres Strait Islander communities. There have been troubling examples of alcohol-related violence in the streets of our cities, and also in homes, which has received much attention in the mainstream press, and generated significant concern in all sections of the Australian community. The misuse of alcohol is a concern to all communities in Australia. Some Aboriginal and Torres Strait Islander communities do have problems, where alcohol misuse is both a cause and an effect, and has a unique set of historical



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causes. This occurs in a broader Australian context, however, and not acknowledging this would be to miss a significant opportunity to improve the health of many Australians.

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

The most up to date information on the use of alcohol in Aboriginal and Torres Strait Islander communities comes from the ABS Australian Aboriginal and Torres Strait Islander Health Survey:

First Results, Australia, 2012-13 (available from:

<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/3D7CEBB5503A110ECA257C2F00145AB4?opendocument>)

This shows that 72% of Aboriginal and Torres Strait Islander people aged over 15 had consumed alcohol in the previous 12 months, 13% had last consumed alcohol more than 12 months ago, and 14% had never consumed alcohol. (1% did not know).

Not all of this is harmful use of alcohol. Harmful use is classified into two forms – ***lifetime risk***, or drinking more than 2 standard drinks per day on average; and ***single occasion risk***, or drinking more than 4 standard drinks on a single occasion.

***Lifetime risk***

In 2012-13 18% (1 in 6) Aboriginal and Torres Strait Islander people had consumed alcohol at an average of more than 2 standard drinks per day. Men (26%) were more likely than women (10%) to have a harmful lifetime risk of alcohol drinking. There was no difference in rates between remote and non-remote areas. These rates were identical to the lifetime risk alcohol consumption of non-Indigenous Australians (except for women over 55, where they were less likely to drink at risky levels.)

***Single occasion risk***

In 2012-13, 54% of Aboriginal and Torres Strait Islander people had consumed over 4 standard drinks on a single occasion. Men (64%) were more likely than women (44%) to have consumed at these levels. These rates were slightly higher than the rates for non-Indigenous Australians, being 1.1 times as high. The difference in rates for women were statistically significant, but not for men (meaning that the single occasion risk for alcohol consumption may be the same for Indigenous and non-Indigenous men.)

These figures are national averages, and will hide local variation in different Aboriginal and Torres Strait Islander communities. They also do not describe the severity of the problem in individuals. However, they do show that alcohol misuse is not primarily a problem of Aboriginal and Torres Strait Islander people, but is one that affects everyone in Australia.

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

The context of alcohol use in Aboriginal communities is complex. Current patterns of harmful alcohol use are features of historical and current socioeconomic factors, which is true for all Australians.



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Alcohol has been a part of Australian culture since colonisation. Though Aboriginal and Torres Strait Islander people did have access to alcohol before colonisation, this was when availability and volume of alcohol increased significantly. This availability has been closely tied up with colonial policy, with alcohol restrictions being based on race and decided upon by non-indigenous people. Much discussion about alcohol policy and Aboriginal and Torres Strait Islander people now can be interpreted in this historical context, and is not isolated from this.

Alcohol continues to be an accepted part of Australian culture, being particularly closely associated with sport, and this association being actively promoted through advertising and sponsorship deals.

Any successful policy in this area will result in reduced sales of alcohol and so has been, and will continue to be, opposed by the manufacturers and retailers of alcoholic drinks. The measure of determination to successfully reduce the harm from alcohol misuse can be measured by State, Territory and Federal governments' willingness to resist the well-funded lobbying that will occur<sup>i</sup>.

Alcohol misuse is both a cause and an effect of other problems. Aboriginal and Torres Strait Islander people experience more stressful life events on average than non-Indigenous Australians. These include racism, and deaths of close family. There is often co-morbidity with physical and mental health problems, as well as multiple social problems, and alcohol, though it can contribute to this, is also sometimes used as self-medication for this.

Proposals to reduce harmful consumption of alcohol must understand this context – that alcohol consumption itself is often not the problem, but is a symptom of other underlying problems. Without understanding and working to tackle this, levels of risky alcohol consumption will not fall. The strategies that will succeed in reducing these will come from active involvement of local Aboriginal and Torres Strait Islander communities.<sup>ii</sup>

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

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

There has been a recent focus in public health and policy on Foetal Alcohol Spectrum Disorders (FASD), especially in Aboriginal and Torres Strait Islander communities. One recent paper<sup>iii</sup> estimates that avoiding alcohol misuse in pregnancy could reduce intellectual disability rates in Aboriginal children by 15.6%.

We note that the declaration of FASD as a disability was one of the recommendations that came out the House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry in Foetal Alcohol Spectrum Disorders. (Recommendations 18 and 19 available from [http://www.aph.gov.au/parliamentary\\_business/committees/house\\_of\\_representatives\\_committees?url=spla/fasd/report/chapter5.htm#anc11](http://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=spla/fasd/report/chapter5.htm#anc11))

We also note that this recommendation is supported by the peak bodies advocating for families affected by FASD.



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Relevant to this discussion is the Productivity Commission report from 2011 Disability care and support<sup>iv</sup> showing that Aboriginal and Torres Strait Islander people have twice the rate of disability as non-Indigenous Australians. They also note the significant effect of socioeconomic disadvantage on accessing services for disability, and say

*“...market based service delivery system underpinning the proposed National Disability Insurance Scheme may not deliver adequate care and support to Indigenous people with a disability. While Indigenous Australians will have access to individualised funding on the same basis as non-Indigenous Australians, it may also be necessary to block fund some service providers in order to overcome the additional barriers that Indigenous Australians face. A number of strategies can be used to improve accessibility of services for Indigenous people, including embedding services within local communities, employing Indigenous staff and developing the cultural competency of non-Indigenous staff.”*

Undoubtedly, classifying FASD as a disability will require the provision of appropriate services in this context.

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

A recent report<sup>v</sup> demonstrates that about two-thirds of the episodes of clinical care of people with alcohol misuse occurs in general practice, including referral to Better Access to Mental Health Services or Better Outcomes in Mental Health.

The RACGP and NACCHO National Guide to a Preventive Health Assessment in Aboriginal and Torres Strait Islander Peoples (available from <http://www.racgp.org.au/your-practice/guidelines/national-guide/lifestyle/alcohol/>) set out the current best practice guidelines for identifying alcohol problems. The recommendations are to ask everyone about the amount and frequency of their alcohol intake, and to consider the use of the AUDIT, AUDIT-C or IRIS screening tools.

The RACGP SNAP guidelines<sup>vi</sup> set out the recommended interventions in general practice for the management of alcohol misuse in individuals, and as mentioned below, is recommended by the National Preventive Health Taskforce and the National Drug Strategy.

These guidelines are nationally recognised and evidence-based, and if the inquiry were to make other clinical recommendations this could become confusing for practitioners working on the ground.

It is also important to note that to ensure these recommendations have a beneficial impact in communities, then accessible services for onward referral are required.

It is entirely appropriate that the identification and management of alcohol misuse should be based in primary care. Alcohol misuse often co-exists with other physical and mental health problems, as well as causing them, and so the comprehensive approach of primary care is required to manage this, in the context of a long-term therapeutic relationship is essential.

There is some evidence to suggest that GPs are not currently routinely screening for alcohol problems, or performing brief interventions.<sup>vii</sup> The reasons for this are complex, and include broader Australian cultural norms about alcohol. It is likely that a range of strategies will be needed to improve



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this. This will include educational initiatives and quality improvement programs for health professionals, as well as public health campaigns for the general public. Improved recognition and management of alcohol problems in general practice has the capacity to improve the health of all Australians

For these benefits to be seen in Aboriginal and Torres Strait Islander communities, appropriate clinical care requires correct identification of service users as Aboriginal and/or Torres Strait Islander or non-Indigenous, and services should have culturally appropriate systems in place for achieving this, in accordance with RACGP and AIHW guidelines.

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

Both the National Preventive Health Taskforce<sup>viii</sup> and the National Drug Strategy<sup>ix</sup> highlight the following as being effective with quantifiable benefits:

- higher alcohol taxation, including differential tax rates on forms of alcohol which are particularly subject to abuse;
- partial or complete bans on the advertising and promotion of alcohol;
- measures to reduce drink driving—more intensive enforcement of random breath testing and lowering the legal blood alcohol concentration (BAC) level; and
- brief interventions by primary care physicians to reduce hazardous alcohol consumption.

Co-morbidities are common in those people who are drinking at harmful levels. This includes physical and mental illnesses and other substance abuse problems, as well as complex social situations<sup>x</sup>. The danger for thinking about the services required is that it just concentrates on the alcohol aspect. Tackling this effectively will require a holistic approach in primary care. Ideally, this means supporting community controlled primary health care to do this, as it is the most effective setting for treatment to take place<sup>xi</sup>.

Broader community strategies such as alcohol pricing and strategies that restrict alcohol sales are also likely to be required. There has been some debate about the higher alcohol pricing being less effective in Aboriginal communities, but this is unlikely to be the case<sup>xii</sup>. It will be important to involve local communities in these decisions to avoid unintended consequences specific to individual communities, such as use of other drugs or solvents.

The social circumstances which drive people to misuse alcohol will also need to be tackled, and again, this will only be effective if communities themselves lead. It is highly unlikely that there will be a “one size fits all” approach that will be effective across multiple communities. There is some evidence, for example, that a so-called “soft entry” approach improved access, though it may not fit with conventional program guidelines or funding<sup>xiii</sup>. (A soft entry approach allows drug and alcohol treatment services to be much more flexible and fluid than in conventional services, and is led by the community and based around developing relationships with the service providers.)



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### ***Best practice identification to include international and domestic comparisons***

It cannot be assumed that individual treatment approaches transfer easily across to Aboriginal and Torres Strait Islander settings.<sup>xiv</sup> Evidence from other settings can inform the treatment of individuals who misuse alcohol. However the complex historical, cultural and socioeconomic context means that it is essential that individual local communities should lead in the planning, delivery and evaluation of strategies<sup>xv</sup>.

More evidence is required to be fully confident in the strategies that will work in particular circumstances, though the principles are highlighted by the AIHW.<sup>xvi</sup> Evaluation should be funded and built in to all programs.

### ***Summary***

Thank you for the opportunity to contribute to this Senate inquiry. As the terms of reference are broad and the submission period short, this document sets out the current situation as we see it, and directions for action. It is based on multiple sources of evidence, including previous government reports, which we hope will inform the work of this Senate inquiry, too. We are happy to provide further information or clarification as required and can be contacted on 03 8699 0499.

Yours sincerely,

Associate Professor Brad Murphy

Chair, RACGP National Faculty of Aboriginal and Torres Strait Islander Health



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