Introduction

Drugs are chemical substances. Drugs that are taken recreationally are known as psychoactive drugs - they act on the brain to alter the way we think, feel or act [1]. Alcohol is the most widely used psychoactive drug in Australia [2]. The 2007 National Drug Strategy Household Survey (NDSHS) found that just over 80% of Australians aged over 14 years, had drunk alcohol in the previous 12 months. The NDSHS also found that around 20% of Australians drank alcohol at risky or high risk levels (with more males than females drinking at risky or high risk levels) [2, 3].

The health and social costs of alcohol use are high. In 2004-5, the total cost of drug use in Australia was around $55 billion, with alcohol use alone accounting for around $15 billion, and alcohol use combined with the use of illicit drugs adding a further $1 billion [4].

In 2003, it was estimated that alcohol was responsible for around 3% of ill-health and early death (the burden of disease) [5]. It has been estimated that the burden of disease associated with alcohol use by Indigenous Australians is almost double that of the general Australian population (around 6%) [6].

Indigenous Australians are aware of the costs of alcohol and have been actively involved in dealing with harmful alcohol use in their communities.

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More detailed information about alcohol in Indigenous people can be found at:

http://www.healthinfonet.ecu.edu.au/alcoholuse_review
What is the problem?

Alcohol use can cause harm to the user and to others. Harms resulting from alcohol use are experienced by people diagnosed with a drinking problem and by people without a diagnosis [7].

SOURCES OF INFORMATION - HOW MUCH IS DRUNK AND WHO IS DRINKING IT?

Alcohol sales figures tell us how much alcohol is drunk in Australia, but they do not tell us how much alcohol individuals and different population groups (such as women or Indigenous Australians) are drinking [8-11]. Surveys are our best way of getting this information.

Since 1985, when the National Drug Strategy was introduced, a 3 yearly National Drug Strategy Household Survey (NDSHS) or similar survey has been conducted [2, 12, 13]. These surveys can tell us how many people in Australia drink alcohol and how much alcohol they drink [2, 8]. These surveys do identify Indigenous Australians but the number of Indigenous people is too small to provide information on differences between regions and localities [8].

In 1994, the NDSHS carried out a special survey of Indigenous Australians residing in urban areas with populations of more than 1000 people [14]. This is the most comprehensive alcohol and other drug-specific survey undertaken among Indigenous Australians.

Information on alcohol use among Indigenous Australians is also available from the National Aboriginal and Torres Strait Islander Social Survey (NATSISS) and the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) [15, 16].

LEVELS OF ALCOHOL USE

The National Health and Medical Research Council (NHMRC) have issued drinking guidelines aimed at reducing alcohol-related harm [3, 17, 18]. Risky use, as identified by the NHMRC, has been used to evaluate survey information to estimate levels of harmful alcohol use in the community.

Table 1 shows the percentage of recent substance use, by Indigenous status, for persons aged over 14 years in 2004 [19, 20]. The percentage of the Indigenous population drinking alcohol in a way that it is harmful to their health is about twice the percentage of the non-Indigenous population.

In most surveys, the percentage of ‘recent’ abstainers (those who have not used alcohol in the past 12 months) is higher among the Indigenous population than the non-Indigenous population [2, 14, 15, 19, 21]. The higher percentage of abstainers in the Indigenous population is due to the higher percentage of people who used to drink but have given up - often because of the harmful effects of alcohol use [21, 22].

Table 1. Current substance use (previous 12 months), percentage of persons aged >14 years, by Aboriginal status, 2004

<table>
<thead>
<tr>
<th>Substance</th>
<th>Aboriginal</th>
<th>Non-Aboriginal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>52.0</td>
<td>22.5</td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abstainer</td>
<td>21.3</td>
<td>16.1</td>
</tr>
<tr>
<td>Short-term high risk</td>
<td>52.0</td>
<td>35.5</td>
</tr>
<tr>
<td>Long-term high risk</td>
<td>22.7</td>
<td>9.7</td>
</tr>
<tr>
<td>Cannabis</td>
<td>23.0</td>
<td>11.3</td>
</tr>
<tr>
<td>Meth/amphetamines</td>
<td>7.0</td>
<td>3.2</td>
</tr>
<tr>
<td>Pain killers/analgesics (non-medical use)</td>
<td>6.0</td>
<td>3.1</td>
</tr>
<tr>
<td>Inhalants (including petrol)</td>
<td>= 1.0</td>
<td>0.4</td>
</tr>
<tr>
<td>Heroin</td>
<td>= 0.5</td>
<td>0.2</td>
</tr>
<tr>
<td>Injected drugs</td>
<td>= 3.0</td>
<td>0.4</td>
</tr>
</tbody>
</table>

Note: *Data for NSW, Vic, Qld, WA, SA and NT combined

PATTERNS OF ALCOHOL-RELATED HARM

Indigenous Australians experience harms associated with alcohol use, including deaths and hospitalisations, much more often than other Australians [2].

The harmful use of alcohol is also a contributing factor in a wide range of social problems including:

- violence
- social disorder
- family breakdown
- child neglect
- loss of income including the loss of income due to the purchase of alcohol and other drugs
- high levels of imprisonment [2, 23]

Alcohol-related deaths (mortality)

Indigenous Australians die earlier than non-Indigenous Australians as a consequence of harmful alcohol use and alcohol-related conditions. Approximately 7% of Indigenous Australian deaths are alcohol-related [2, 24]. The percentage of Indigenous Australians dying from alcohol-related causes is between five and 19 times higher than for non-Indigenous Australians in Qld, SA, WA and the NT [23].
Intentional harm causing injury or death to self also occurs at higher rates among Indigenous Australians. Alcohol plays an important role in this difference and it has been estimated that alcohol is associated with 40% of Indigenous male and 30% of Indigenous female suicides [23, 25]. Between 2000 and 2004, there were similar numbers of Indigenous and non-Indigenous suicides where alcohol was a key factor. When you consider that Indigenous Australians only make up about 3% of the total Australian population there is a clear over representation of Indigenous people in these numbers [25].

**Alcohol-related sickness (morbidity)**

The higher percentage of Indigenous Australians drinking at risky and high-risk levels is also seen in the higher percentage of alcohol-related hospital admissions for this population. In 2005-06, hospital admissions in NSW, Vic, Qld, WA and the NT, showed admissions for alcohol-related injury from traffic accidents among Indigenous Australians were 20% and 30% higher for males and females than those experienced by non-Indigenous Australians [2]. In the case of assault, 50% were alcohol-related and Indigenous Australian men and women were hospitalised around 6 and 33 times more than non-Indigenous Australians [2, 26].

Additionally, Indigenous Australians visit their general practitioner for ‘alcohol abuse’ nearly 3 times more than non-Indigenous Australian patients, further evidence of the burden on health of harmful alcohol use [27].

**Social and emotional wellbeing**

Excessive alcohol use has been involved in a wide range of social and emotional harms. For example, of those people in the general Australian population with an alcohol use problem (4% of females and 9% of males) just under half of the females and just over one third of the males also experienced another mental health problem (comorbidity) [28]. It is likely that more Indigenous Australians with an alcohol use problem would also have another mental health problem [29].

After accounting for the difference in the age structure of the Indigenous population compared with the non-Indigenous population, the evidence shows that in NSW, Vic, Qld, WA, SA and the NT combined, Indigenous Australian men and women were hospitalised for mental health problems related to psychoactive substance use 4.5 and 3.3 times more than non-Indigenous males and females [30]. The burden of ill-health due to alcohol dependence and harmful use is also 4.5 times greater than that experienced by non-Indigenous Australians [6].

Harmful alcohol use has also been associated with social disruption [31], family violence and breakdown [32-34], child abuse and neglect [35-37], income being used to fund alcohol, and very high levels of imprisonment [33, 38-41].

**What are the causes of the problem?**

**SOCIAL DETERMINANTS OF HEALTH AND HARMFUL ALCOHOL USE**

Differences in the health status of individuals exist because of inequalities in society [42]. The ‘lifestyle’ choices of individuals influence their health status (such as activity levels and diet), but it is the broader influences of society that are often outside of an individual’s control that either cause or protect against ill-health [9, 43-45]. These broader influences are known as the social determinants of health and include education, employment, income, and social forces of inclusion and exclusion. These social determinants exist at the family, local, regional, national and international level – and they influence an individual’s health throughout life [46].

Addressing the social determinants of health, that is, promoting those factors known to protect against ill-health and reducing those factors that contribute to ill-health, is the best way to improve the health of individuals [47].

Inquiries since the late 1970s have emphasised a link between the social determinants of health and the poor health status experienced by Indigenous Australians [33, 48, 49]. These inquiries have recommended the creation of strategies that target the poor environmental, social and economic conditions under which most Indigenous Australians live [23, 50]. There has been some improvement in a number of social determinants, but Indigenous Australians continue to be disadvantaged compared with non-Indigenous Australians [23, 50, 51]. Many Australian reports have identified a relationship between alcohol and other drug use with socioeconomic factors such as education, employment and low income [47, 52]. Within the Indigenous Australian population lower levels of alcohol use have been shown to be related to higher levels of income [30, 53].

**WHAT IS THE HISTORICAL BACKGROUND?**

Current patterns of alcohol use among Indigenous Australians - and the factors that decide those patterns – need to be placed in the historical context that they have...
come from to be understood. Indigenous Australians had some exposure to alcohol prior to European contact [54, 55], but the amount and availability of alcohol increased significantly following the arrival of the ‘First Fleet’ [56]. White settlers used alcohol in exchange for sex and labour with Indigenous Australians and the harmful effects of alcohol on the lives of Indigenous Australians soon became obvious [57]. Alcohol became a ‘cure-all’ for Indigenous people’s pain, with many using it to cope [55] with the devastation of being ruled by white settlers, including the loss of country [58], and illness and death resulting from disease and confrontation [59, 60].

Restricting access to alcohol

Laws restricting Indigenous Australians access to alcohol first came into force in the late 19th century, and had been passed in all states and territories by the early 20th century [55]. These laws placed Indigenous Australians under strict watch and excluded them from hotels (which were important centres of social activity) but did little to reduce access to alcohol. Non-Indigenous people profited from the illegal sale of alcohol to Indigenous Australians, and Indigenous Australians developed riskier drinking patterns for fear of being caught [61-63].

Indigenous access to alcohol became a civil rights matter, and from the 1960s states and territories put an end to the laws [64]. Unfortunately, the risky drinking patterns established under the restrictions continued and still have a major impact on the health of Indigenous Australians today [65].

Dispossession and the Stolen Generations

The social determinants underlying the past and current health status of Indigenous Australians include a history of removal from country, racism, social exclusion and a legal framework supporting removal of children from families. While white rule and loss of country are not the cause of all alcohol-related harm among Indigenous Australians, drinking patterns are a response to this history, as found among other indigenous peoples [66].

In 1788, when the British arrived in Australia they declared it to be terra nullius or ‘empty land’ [67]. As settlement spread throughout Australia, widespread displacement of Indigenous peoples from the lands they had occupied for at least 60,000 years occurred. As a result of both introduced disease and violence the numbers of Indigenous Australians fell sharply and it was believed that they were doomed to die out. A policy of ‘protecting’ the remaining population was introduced. Under this policy, many were placed in missions or taken to government settlements where they lost all independence because of laws that controlled where and how they could live [68].

By the 1920s the Indigenous population was increasing and, following World War II, the Commonwealth Government introduced a policy under which Indigenous Australians were to become as one (‘assimilated’) with the white population and its way of life [69]. The policy talked about including Indigenous people in the Australian population, but really it was still believed that Aboriginality would meet a timely end [69, 70]. Part of the policy involved the forced removal of children from their families - now known as the Stolen Generations [71]. The policy of assimilation had a devastating impact on Aboriginal families and ways of life, and the effects of this are still felt today. This includes the high level of mental health problems experienced by Indigenous Australians, and the lack of parenting models resulting in unacceptably high levels of child abuse and neglect [71, 72].

More recent policies

From the early 1970s through to the mid-1990s, government policies moved away from assimilation to self-determination (self-management). The Indigenous rights movement and the self-determination policies saw the rise of national Indigenous representative groups and community-controlled health and substance use services [73, 74]. During the 1990s, the Council for Aboriginal Reconciliation was established and the Aboriginal Reconciliation Act passed (1991).

The Liberal-National Government of 1996-2007, moved away from the principle of self-determination to an emphasis on national unity and a concept of togetherness [75]. The focus was on ‘practical’ measures for addressing disadvantage [76].

In 1997, the Bringing Them Home report detailed the suffering of the Stolen Generations and the terrible impact previous policies had had on the health and well-being of Indigenous Australians [71]. However, in 2007, the NT ‘Intervention’ [77] (the Liberal Government’s response to the Little Children are Sacred report [36] on child abuse in Indigenous communities) was introduced without enough discussion with, and involvement of, Aboriginal people. The NT ‘Intervention’ required sections of the Racial Discrimination Act to be over-ridden in order to make it legal [78-80].
In 2007, the Labor Government came to power and committed itself to ‘Closing the Gap’ between Indigenous and non-Indigenous Australians (essentially the policy of all Australian governments since the 1970s) [81]. In February 2008, the Prime Minister gave a formal apology to Indigenous Australians for the past wrongs committed against them through the policies of former governments [82]. The apology intended to mark a new era of understanding and partnership between Government and Indigenous Australians in which practical goals could be achieved.

What is being done?

INTERVENTIONS AND THEIR EFFECTIVENESS

The current policy for targeting harmful alcohol use in Australia - The National Alcohol Strategy 2006-2009 - aims to ‘prevent and minimise alcohol-related harm to individuals, families and communities by developing safer and healthy drinking cultures in Australia’ [83].

Prevention strategies include primary, secondary and tertiary strategies, and a combination of all three is likely to be the most successful in minimising harm from alcohol use. There is a lot of knowledge about how to prevent harmful alcohol use among the general population [47]. When general programs are changed to ensure that they are culturally appropriate, in discussion with local communities and Indigenous organisations, they are likely to be helpful for Indigenous Australians [45, 84, 85].

Primary prevention strategies also include school and parent education programs, and programs that provide alternative activities to alcohol use – such as sporting, recreational and cultural activities. Indigenous communities in Australia have identified the importance of these types of programs in encouraging positive family relationships, and in developing young people’s self-worth and cultural connectedness - factors shown to protect against substance use [9, 91].

Limiting the supply of alcohol is another primary prevention strategy. International evidence has shown that restrictions of the supply of alcohol and other drugs are effective in reducing use and harms [47]. In addition to the various state and territory restrictions on the sale of alcohol (such as who can sell alcohol and at what times, at what age a person can purchase alcohol, and where it can and cannot be drunk) there are other local strategies that the state and territory liquor licensing authorities introduce – including restrictions on the sale of drinks that are low in cost but high in alcohol content (such as cask wine), restrictions on hours of trading, and bans on drinking alcohol in particular public places [24, 92]. These strategies are not Indigenous-specific but are often applied in areas where there are a high percentage of Indigenous people [9]. In addition, Indigenous people have declared their communities ‘dry’. These strategies have resulted in less alcohol being drunk, young people being older when they first use alcohol and reductions in alcohol-related harms [93, 94].

SECONDARY PREVENTION

Secondary prevention strategies aim to prevent risky or problem drinking, and stop use developing into dependence (addiction) [95]. These strategies are normally provided through Aboriginal community controlled health and substance-use specific services, and through mainstream medical and substance-use specific services.

Brief interventions are an important part of secondary prevention. These strategies include education about alcohol-related harms and recommended drinking guidelines, and support and advice for those trying to reduce or stop use [7]. Australian evidence shows that brief interventions used with non-Indigenous Australians may be more effective than longer treatments for those who are not alcohol dependent [7]. The same may be true for Indigenous Australians if the brief interventions are delivered in a culturally sensitive, respectful, and non-judgemental manner [7, 85]. There is little evidence to show that screening for harmful alcohol use among Indigenous
Australians is useful, but a number of screening tools have been adapted so they can be used in Indigenous settings, including the IRIS and AUDIT-C, and they may help in the earlier detection of alcohol problems within this population [96, 97].

The evidence for the usefulness of education and health promotion strategies is uncertain for non-Indigenous and Indigenous Australians [47]. These approaches are popular - partly because they are low cost - but it is recommended that these strategies are delivered in combination with other strategies [7].

Alcohol-specific harm reduction strategies deal with the immediate harm caused by drunkenness and include night patrols and sobering-up shelters. In some cases a reduction of these harms is considered more important than the actual substance use [45]. A small number of reviews and reports of night patrols in the NT [98, 99] and WA [100] show night patrols can reduce alcohol-specific harm [45, 100].

**Tertiary Prevention**

The main focus of tertiary prevention is treatment for harmful alcohol use. In the general population, treatment can lead to positive outcomes such as reductions in criminal behaviour, reduced drug use and improved physical and psychological health [47, 101]. Research shows that any form of treatment is likely to lead to a reduction in alcohol use and related harm [102].

Indigenous Australians seek treatment for alcohol-related problems at a later stage than non-Indigenous Australians and often have other mental health problems. Planned treatment programs are common [47, 85]. Programs include:

- helping people remove alcohol from their system (withdrawal management)
- mental and physical strategies to help people stop using (cognitive behavioural therapies)
- brief support and advice about alcohol use (brief interventions)
- sobering-up in hospital (inpatient detoxification)
- preparation for life without alcohol (residential rehabilitation)
- help adjusting to life without alcohol (aftercare services) [7]

There is a lack of evidence about treatment strategies for Indigenous Australians [45, 103, 104] because few programs have been formally evaluated [45, 84]. However, guidelines now exist for the treatment of Indigenous people with alcohol-related health issues and more is known about what contributes to effective treatment among Indigenous Australians [85, 99, 103, 105, 106].

**Barriers to Treatment**

Indigenous Australians are not accessing or do not have access to the full range of treatment services. In particular, the availability of early intervention strategies, drug therapies to reduce drinking setbacks and aftercare services are limited. Services (Indigenous and mainstream) are also lacking for clients who have mental health issues in addition to harmful alcohol use (comorbidities), and for women, young people, and families [9, 85].

Many mainstream services are not accessed by Indigenous Australians because they are considered inappropriate or are not available in particular areas [7, 9, 85]. However, some Indigenous Australians prefer the anonymity offered by mainstream services because of the ‘shame’ associated with harmful alcohol use [107]. Mainstream services need to be culturally suitable and accessible for Indigenous Australians [85]. This may include the employment of Indigenous staff in mainstream organisations and/or partnerships with Indigenous organisations [85, 107].

Aboriginal community-controlled organisations offering Indigenous-specific alcohol and other drug interventions are limited by a lack of resources, short-term funding, difficulty attracting qualified and trained staff, and trouble accessing training and workforce development for staff [9]. Community-control alone is not enough if an organisation is under-resourced and inadequately staffed, and these limitations need to be addressed [9].

**What works?**

Indigenous Australians are well aware of the devastating impact alcohol is having on their communities and many strategies to address harmful alcohol use have come from Indigenous Australians. Indigenous Australians should be key players in the design and operation of strategies to address harmful alcohol use; and the effectiveness of Aboriginal community-controlled organisations needs to be a key focus [9, 47, 84]. As community-controlled organisations are not always accessible or preferred by Indigenous Australians, mainstream organisations need help to provide culturally sensitive services. These organisations should work in partnership with Indigenous organisations [85].
There is no single solution to the harms associated with alcohol use and given the lack of evaluations of Indigenous-specific alcohol use interventions [45, 108], decisions about the type of strategies to use may need to continue to come from observed assessments, or evidence from other populations and settings [96]. What the available evidence does show is that for interventions to be effective they should:

• have the support of and be controlled by local communities
• be designed specifically for the needs of a particular community and sub-groups within the community
• be culturally sensitive and appropriate
• have adequate funding and support
• provide aftercare
• meet the needs of difficult cases

Most importantly, a combination of harm minimisation strategies is most effective.

What needs to be done?

Despite what is being done, a lot of harm remains. Past governments have acknowledged the influence of social factors on ill-health and substance use and have committed to Closing the Gap [81]. However, Australia’s Indigenous health policy has not been developed alongside employment, education and housing strategies. As a result, improvements in health have been off-set by the continuing poor living and social conditions experienced by many Indigenous Australians. Recently, the Council of Australian Governments (COAG) identified seven essential ‘building blocks’ that must be in position to address Indigenous disadvantage. These include a focus on:

• healthy homes
• safe communities
• improved health
• early childhood
• schooling
• economic participation, and
• the creation of opportunities for leadership and governance

This represents a clear recognition of the connection between the underlying social determinants and health status.

The National Alcohol Strategy [83], Alcohol Treatment Guidelines [85, 104] and the National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009 (CAP) [106] provide an evidence-based framework for addressing harmful alcohol use among Indigenous Australians. The six key result areas identified in the CAP provide useful benchmarks for assessing current services and planning for future programs [106].

A recent report on organisations conducting Indigenous-specific alcohol and other drug services in Australia [9] found that several of the key result areas are not being met and recommended:

• all levels of government recommit to the principle of community-control
• the creation of services to meet the needs of sub-groups within the Indigenous Australian population
• improved access for Indigenous Australians to a wide range of Indigenous-specific interventions
• better access to workplace development and training, and
• incentives for Indigenous Australians to enter into education which will prepare them for work in the alcohol and other drug sphere [9]

There has been some reduction in the levels of harmful alcohol use among the non-Indigenous Australian population, but harmful alcohol use among Indigenous Australians remains high. A two-pronged strategy is needed to reduce alcohol-related harms among Indigenous Australians.

Firstly, a recommitment to the key result areas outlined in the CAP [9]. The policy framework shared by the National Alcohol Strategy, the National Drug Strategy and the CAP provides an evidence-based guide for Australia’s response to the harmful level of alcohol use among Indigenous Australians and can guide Indigenous and mainstream organisations providing these services. Mainstream organisations need to be familiar with the above frameworks, and the design and delivery of services should be culturally sensitive and occur in consultation and partnership with Indigenous organisations.

Secondly, the role of the social determinants of health in the alcohol-related harms experienced by Indigenous Australians need to be addressed [42]. Wide-ranging strategies are needed that improve protective factors in addition to addressing the harms from substance use [9].
References


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68. Haebich A (1988) For their own good: Aborigines and government in the southwest of Western Australia, 1900-1940. Nedlands, WA: University of Western Australia Press


The Australian Indigenous HealthInfoNet is an innovative Internet resource that contributes to ‘closing the gap’ in health between Indigenous and other Australians by informing practice and policy in Indigenous health.

Two concepts underpin the HealthInfoNet’s work. The first is evidence-informed decision-making, whereby practitioners and policy-makers have access to the best available research and other information. This concept is linked with that of translational research (TR), which involves making research and other information available in a form that has immediate, practical utility. Implementation of these two concepts involves synthesis, exchange and ethical application of knowledge through ongoing interaction with key stakeholders.

The HealthInfoNet’s work in TR at a population-health level, in which it is at the forefront internationally, addresses the knowledge needs of a wide range of potential users, including policy-makers, health service providers, program managers, clinicians, Indigenous health workers, and other health professionals. The HealthInfoNet also provides easy-to-read and summarised material for students and the general community.

The HealthInfoNet encourages and supports information-sharing among practitioners, policy-makers and others working to improve Indigenous health – its free on line yarning places enable people across the country to share information, knowledge and experience. The HealthInfoNet is funded mainly by the Australian Department of Health and Ageing. Its award-winning web resource (www.healthinfonet.ecu.edu.au) is free and available to everyone.