Submission

To the House of Representatives Standing Committee on Family and Community Affairs

Inquiry into

Substance Abuse

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Torres Strait Islander Affairs

Introduction

Like all other groups within our community, Aboriginal and Torres Strait Islander people abuse both licit and illicit drugs. This abuse leads to, at the individual level, ill-health and, at the community level, dysfunction.

Substance abuse has been introduced into Aboriginal and Torres Strait Islander culture since European contact. Traditional Indigenous society was never disrupted by alcohol or other harmful drugs.

Heroin and other hard drugs are now impacting on Aboriginal youth, particularly those in urban areas, and petrol sniffing is widespread in a number of remote communities, yet it is the licit drugs - alcohol and tobacco – which account for most of the ill-health from substance misuse.

Alcohol Misuse

In comparison with Australia's non-Indigenous population, a far larger proportion of Aboriginal and Torres Strait Islander people completely abstain from alcohol. Those who do drink, however, a far more likely to do so to excess or to consume alcohol in a harmful way, often binge drinking.

The National Health Survey of 1995 found that 21% of Indigenous adult males who drank alcohol, or 13% of all adult males, could be classified as "high risk drinkers" using the National Health and Medical Council guidelines for alcohol consumption, drinking 13 or more standard drinks in a single session. Only 5% of the wider adult male population fell into this category.

It is always difficult to quantify the extent of the health consequences from excessive alcohol consumption within the Aboriginal and Torres Strait Islander community, but it has been estimated that Indigenous males are five times more likely to die from an alcohol-related medical condition, and that Indigenous females die at four times the rate of women in the broader population.

Concern in relation to harmful alcohol consumption extends beyond the health impact on individuals. The pattern of drinking in Indigenous communities is different and the harmful consequences therefore impact more on the community as a whole.

In addition to the impact of road trauma and domestic violence which is seen in the wider community from alcohol abuse, Aboriginal and Torres Strait Islander communities suffer from wider physical violence, neglect of children, poor general nutrition and poverty as a consequence of spending a very high proportion of limited budgets on alcohol, and a general break-down of the sense of community.

At its worst, this impact is documented in a study by Douglas J Gladman and others, *Study of Injury in Five Cape York Communities*, (Australian Institute of Health and Welfare, April 1997). Without disputing in any way the extent of deliberate and accidental injury, unintentional self-harm and suicide in these communities documented by Dr Gladman, unnamed for their protection, they are very much "worst cases".

The Royal Commission into Aboriginal Deaths in Custody highlighted the link between alcohol abuse and the high rates of imprisonment amongst Aboriginal people. A number of the Royal Commission Recommendations, such as 63 to 71, 80, 246 to 251 and 282 to 288 related directly to substance misuses programs. Successive Governments have addressed these recommendations.

I would acknowledge, however, that the harmful impact of excessive alcohol consumption continues to be very widespread.

Response to Alcohol Abuse

As alcohol abuse impacts on communities, it is the responsibility of each Aboriginal and Torres Strait Islander community to develop an appropriate response within that community. It is the responsibility of all governments, the Commonwealth (through the Aboriginal and Torres Strait Islander Commission and through agencies such as the Department of Health and Aged Care), State and Territory, to strengthen and assist these communities as they seek to minimise the harm caused by alcohol abuse.

For a large number of communities, this has involved obtaining agreement to ban or restrict the sale of alcohol. Where a community is not completely "dry", restrictions can involve prohibiting the sale of types of alcohol (fortified wine, spirits or full strength beer), or restricting sales generally through a "wet canteen" with limited trading hours.

Restrictions on alcohol sales, however, must have the full support of the community. Any attempt to prohibit the sale of alcohol, a legal product widely-available elsewhere, without the consent of a community would be ineffective as well as discriminatory. Many Aboriginal people believe that the problems of binge drinking became established soon after the removal of restrictions on drinking alcohol (and the granting of many other citizenship rights) after the 1967 Referendum. To many, drinking was identified with full citizenship. The pattern of heavy drinking bouts may also be a legacy of the earlier prohibition on alcohol when the illegal substance could only be "enjoyed" as quickly as possible when it was available.

Successive governments have supported measures to increase empowerment. The most significant of these is the establishment of the Aboriginal and Torres Strait Islander Commission (ATSIC). Increasingly, decision-making within ATSIC is being decentralised, and a community looking to strengthen itself can anticipate some financial support through a grant allocation process in which it has some direct say.

Communities must also have the right to use the existing liquor licensing laws to ensure that, where appropriate, restrictions are placed on the sale of alcohol. These legal challenges can include action to remove the license from an outlet with a record of selling to intoxicated Indigenous people or, as, for example, has happened in Tennant Creek, agreement to restrict sales from all outlets on the Thursday when social welfare payments made – "pension payday".

Communities can expect that ATSIC, through its funding of Aboriginal Legal Services, will provide the necessary financial support for the legal action needed to secure restrictions on alcohol sales. This support is important even when acknowledging that the most significant breakthroughs (such as in Tennant Creek) have occurred through negotiation and consensus rather than through legal proceedings.

Communities can also expect that ATSIC will assist in providing alternatives to the social exchange associated with heavy drinking. Through its Sport and Recreation Program, ATSIC assists many communities through the funding of sporting facilities, Sport and Rec officers, and funding to individual sporting teams to stage and attend carnivals.

In addition to empowering communities, the problems of alcohol misuse must be addressed at the individual level. There is a range of alcohol rehabilitation programs seeking to assist those with particular alcohol problems. Funding for these is provided through the Office for Aboriginal and Torres Strait Islander Health or the National Drug Strategy, both located within the Department of Health and Aged Care. ATSIC still retains an advisory role in relation to policy and priorities in these programs and fully recognises their continuing importance. The current ATSIC Board of Commissioners has reaffirmed the need to focus more directly on its role in Indigenous Health Policy in the future, an initiative which I fully support.

Tobacco

Smoking has been identified as the most significant public health issue for Aboriginal and Torres Strait Islander people. (Dawn Gilchrist, *Aboriginal and Torres Strait Islander Health Worker Journal*, July/August 1998) This is because circulatory and respiratory diseases are the major causes of excess deaths in the Indigenous community, and smoking is the major preventable cause of these excess deaths.

The National Health Survey (which does not provide data on remote communities) indicated that some 56% of adult Indigenous males smoked (the figure for the non-Indigenous community is 27%) and the 46% of Indigenous females also smoked (20% for non-Indigenous females).

It is well known that Aboriginal and Torres Strait Islander people die between 17 to 20 years earlier than other Australians. There is a clear link between these early deaths and the higher rates of smoking. Indigenous people

smoke at twice the rate of other Australians. Within two to five years of quitting, the risk of developing the life-threatening diseases associated with smoking is reduced by half.

Smoking is a problem across all Aboriginal and Torres Strait Islander people, from those in the large cities to remote outstations. Both Aboriginal men and Aboriginal women smoke more than their non-Aboriginal counterparts. Indigenous youths take up smoking at a much earlier age than non-Indigenous smokers, and so are exposed to its public health risks for longer and the health consequences begin earlier.

Response to Tobacco

Public health campaigns which have impacted so successfully on smoking levels in the broader community have had virtually no impact in Indigenous communities. Further, smoking is not seen as a significant health risk by Indigenous people. Even amongst Indigenous health professionals, smoking is seen as a secondary issue to the problems of hard drugs, alcohol and petrol sniffing which are so immediately and obviously decimating communities. The Substance Misuse Strategic Plan by the National Aboriginal Controlled Health Organisation (NACCHO) produced after extensive consultation with individual Aboriginal Medical Services and community members, does not have a large focus on smoking. In this it reflects community priorities and the fact that the adverse impacts of smoking are seen long-term amongst a people all too familiar with early death.

All government agencies, including ATSIC, need to review the effectiveness of their public education campaigns. The simple and effective public health message – that smoking kills – must be put across in the Indigenous community as it has in the wider community.

Building on this public education campaign, there is a need to lessen the broad acceptance of smoking by Indigenous people. Undoubtedly, increasing public disapproval is one fact which has led many non-Aboriginal smokers to quit. It is not tolerated in workplaces and is increasingly being restricted in public places such as shops and restaurants. ATSIC and other agencies involved in public health must work to replicate these restraints within Aboriginal communities. Smoking should be discouraged at ATSIC and other community meetings, no matter how informal the setting. All formal bans on smoking (in vehicles and offices for example) should be strictly enforced.

NACCHO's draft policy supports higher taxation on alcohol to discourage sales. It has no such policy in relation to cigarettes. Although expensive, cigarettes are easily transported and very good distribution networks ensures that they are available everywhere. In remote communities, where a cabbage may cost three times the price of one available in a city supermarket cigarettes are sold at not much more than their city price.

Yet recommending increases in excise is a difficult issue. Smoking is highly addictive. Its principal active component, nicotine, is many times more

addictive than heroin. Those who are addicted will often simply pay whatever price is demanded, cutting back on essentials, even food and clothing. Even in the wider community, it is the poor who smoke more, and it is unjust to place an even higher taxation burden on those least able to pay.

On the other hand, the taxation raised from imposts on cigarettes does not recover the public health costs arising from the burden of disease directly attributable to smoking.

There can be far less controversy about the need to make every modern aid to quitting available in the remotest of communities, as cigarettes themselves are. Gums, patches and other aids to quitting (nicotine replacement therapy), even when available only through pharmacies in urban areas, should be freely available through Aboriginal Medical Services and other health delivery agencies.

Health Workers should be trained in counselling. Many health workers themselves smoke, and there may be a need for specialist counsellors if quit campaigns are to succeed.

Kava

Kava is an extract from the root of the pepper plant. It is not an intoxicant but a sedative, yet its social, if not its physiological, effects can be compared to alcohol. It is a licit substance, and its misuse appears confined to a limited range of Aboriginal communities in the far North of Australia.

Kava was introduced into Aboriginal communities in the early 1980's by community workers with the full consent of the communities themselves and government agencies. It was believed that the consequence of the drug would be preferable to those of alcohol.

Research work by the Menzies School of Health Research has found very high levels of kava consumption in some Arnhem Land communities. Some individuals may consume up to 900 grams of powdered kava per week, with consumption of at least 610 gram per week common in heavy consumers. The Menzies School is undertaking further epidemiological work to determine the neuro-cognitive and physiological effects of the abuse of kava, but links to ischaemic heart disease and serious infections, particularly pneumonia, are suspected.

Kava has not lived up to its promise of limiting the adverse consequences of excessive alcohol consumption. It can often be used as an adjunct to alcohol. One of the most significant adverse impacts of alcohol in Indigenous communities is that it diverts the limited personal expenditure of community members (in communities where there is effectively no paid private sector employment opportunities) away from family essentials such as nutritious food, clothing and children's education. Kava expenditure has exactly the same impact.

Response to Kava

The Indigenous experience with Kava serves to demonstrate that there is rarely an innovative and simple solution to any drug abuse problem.

Authorities in Western Australia have place legislative restrictions on kava through a permit system, but there seems little justification in more fully prohibiting the sale of a substance which remains arguably less harmful than alcohol, which no Australian government would ban.

The public health response should be similar to that of alcohol. Certainly, no official encouragement should be given to the expansion of kava consumption beyond its current limited range of communities. Further research into the adverse health consequences, such as that being undertaken by the Menzies School, is needed and should be adequately funded.

Petrol Sniffing

Solvents of all types – glues, thinners etc - are inhaled by young drug abusers, Indigenous and non-Indigenous, living in all areas of Australia.

In a range of remote communities, however, there is a particular problem in relation to sniffing petrol. This form of substance abuse is particularly damaging because chronic sniffing quickly results in neurological damage and, frequently, death. Dr Maggie Brady (*The Prevention of Drug and Alcohol Abuse Among Aboriginal People: Resilience and Vulnerability*, the Australian Institute of Aboriginal and Torres Strait Islander Studies, Canberra, 1995) acknowledges 63 deaths between 1981 and 1991, but believes that this figure is a undoubted underestimation.

Community elders are particularly concerned when petrol sniffing occurs in their communities because those involved are often so young – as young as ten years of age – and because those involved spend much of their time in a trance-like state, disrupting any chance of normal family life within those communities. Petrol-sniffers can become violent and disruptive within their communities. The neuro-cognitive damage that quickly occurs with petrol sniffing not only limits a young person's ability to gain a formal (Western) education, but also limits their ability to learn the cultural and traditional beliefs from community elders.

Response to Petrol Sniffing

The longer-term solution to youth petrol-sniffing undoubtedly lies in providing alternatives to young people, including a range of sporting and educational opportunities.

Aviation gasoline (AVGAS) does not provide the same intoxicating effects as either leaded or unleaded petrol. Some communities have, by agreement, banned all sales of petrol, running their vehicles on AVGAS. The support of a

grant scheme administered by the Office for Aboriginal and Torres Strait Islander Health enables those communities to effectively remove the petrol excise from the more-expensive AVGAS, making substitution an economically feasible alternative. More harm-minimisation and diversion programs are needed. These programs should focus on strengthening traditional authority within remote communities and on providing alternatives to youth who have few opportunities for recreation or diversion.

This approach demonstrates that, when assisted sensibly by Commonwealth agencies, individual communities can devise their own solutions to problems, and successfully implement them.

In other communities, attempts are made to remove young petrol sniffers from the main community location to isolated sites where there is no access to petrol or other drugs and where traditional tribal discipline can be re-established.

The per capita death rate in those communities with a significant petrol-sniffing problem probably equates to that of non-indigenous young people in those urban areas most effected by heroin. The focus of all Australians is on limiting the harm from hard drugs. We must never overlook the particular problems caused by petrol sniffing in remote communities as we focus on the more visible problem of heroin use in our capital cities.

Marijuana

Available evidence indicates that Indigenous Australians misuse marijuana at a greater rate than in the general population. Marijuana use appears to be highest amongst those under 25, and some community elders have particular concerns at the young age at which some begin to experiment with this illicit drug.

Response to Marijuana Abuse

The pattern of marijuana abuse does not appear to differ greatly from that in the wider community, and the response in the Indigenous community should mirror the wider response.

The focus should be on very young users, with education efforts aimed at preventing children and young teenagers from experimenting with any drugs, licit or illicit. This is considered important, as the use of harder drugs by Indigenous youth in urban areas and larger regional centres is a growing problem and marijuana is often the first drug of experimentation.

About half of all adult Indigenous people over 14 admitted to trying at least one illicit drug – marijuana was the drug most often tried. This compares with an experimentation rate of 38% in the general population.

Amongst older Aboriginal and Torres Strait Islander Australians, the somewhat higher rate of continuing marijuana use may be linked to the higher

rate of smoking (cigarettes and tobacco). These recognised health risks need to be addressed in campaigns to reduce smoking by Indigenous people. Smokers who are also occasional marijuana users will tend to eliminate their marijuana use if they quit smoking.

Heroin and other injected illicit drugs

Published health statistics would indicate that Aboriginal and Torres Strait Islander people use hard drugs, such as heroin, at a slightly higher rate than other Australians.

There is growing anecdotal evidence, fully matched by the concern of Indigenous community leaders, that a flood of cheap and widely available heroin has lead to an expediential growth in heroin use, particularly by young Aboriginal and Torres Strait Islander people in urban and regional centres.

Canberra may be taken as a typical city with a small but distinct Indigenous population. In February 2000, the ACT Office of the Department of Health and Aged Care, with the full co-operation of all ACT Government Agencies, held a workshop in attempt to identify the extent of and respond to injecting drug abuse by Indigenous youth in the Australian Capital Territory.

Based on estimates from, amongst other sources, the usage of the Canberra Needle Exchange, about 5% to 10% of Indigenous youth and young adults aged between 15 to 30 may be injecting drug users. As many drug users turn to crime to support their addiction, informal figures from the ACT justice system provided to the Workshop confirm the extent of the problem. In 1999, 25 offenders entering the ACT Adult Correctional Services to begin a custodial sentence were Indigenous persons either addicted to an illicit drug or with a health problem related to substance abuse. 25 of the 966 persons entering the Probation or Parole system for a non-custodial sentence were Aboriginals or Torres Strait Islanders with similar drug problems. Proportionally, the situation was estimated to be far worse for young offenders. Only 160 young persons were dealt with by the ACT Youth Justice System and required detention or some form of custodial supervision – of these 35 were Indigenous youths with a history of injecting drug use. With Aboriginal people making up less than 2% of the ACT population, Indigenous drug users are more than 100 times over-represented in juvenile detention centres than in the ACT population as a whole.

Aboriginal Medical Services and Aboriginal Legal Services are reporting informally that they are facing difficulties in maintaining their normal services to clients. The demands arising from the consequences of hard drug abuse are overwhelming vital day-to-day routines.

Response to Heroin Abuse

There is no one clear response to the problem of heroin abuse, within Government or in the wider community. The situation is no different within the Indigenous community.

The Commonwealth Government and ATSIC recognise the importance of harm reduction measures. Blood-born infections picked up by injecting drug users as a result of unsafe injecting practices are far more likely to spread quickly and widely within the Aboriginal and Torres Strait Islander population, given their higher rate of some marker diseases (such as Sexually Transmitted Diseases), their poorer health status generally, and the higher rates of poverty and disadvantage.

ATSIC is represented on the Indigenous Australians' Sexual Health Committee, a sub-committee of the Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRAD), and has established a working relationship with ANCAHRAD. There is a need to redouble the education and public health campaigns relating to AIDS, HIV and Hepatitis, especially Hep C. Successful campaigns in the Indigenous community must extend beyond safer sex campaigns and the education of injecting drug users, to include a broader understanding of blood borne diseases, such as understanding the dangers of blood in sport or in some traditional cultural practices.

Neither I nor ATSIC wishes to express a formal view on some of the more controversial harm-reduction measures that have been proposed, such as safe injecting rooms. Where harm-reduction measures are adopted by a State, Territory or local government, however, equity demands that these are easily accessed by Indigenous drug users, or more culturally-appropriate alternatives established to address needs in the Indigenous community.

I support any increase in law enforcement aimed at reducing the large quantities of hard drugs being imported into Australia and distributed within the country. I believe that such a position is fully supported by the great majority of Aboriginal and Torres Strait Islander people and especially ATSIC. Aboriginal people in remote communities and Torres Strait Islanders are ideally placed to assist in efforts to protect Australia's extended coastline or to monitor remote and rarely used airstrips.

I support initiatives to assist individuals seeking to overcome their addiction. Often, the most effective programs to assist Indigenous users are those designed and run by Indigenous Community members themselves. Such programs are financially supported by the Department of Health and Aged Care, either through the Office for Aboriginal and Torres Strait Islander Health or the National Drug Strategy. Funding for these programs needs to reviewed to ensure that the available resources keep pace with the growing need.

Community Development – The Broader Picture

The impact of licit and illicit substance misuse is proportionally greater on Aboriginal and Torres Strait Islander people. The underlying cause of this greater harmful impact is the poverty and neglect in Aboriginal communities.

Successive Commonwealth Governments have been committed to overcoming this disadvantage and to empowering communities so that they can address their social and health problems.

The rate of unemployment for Aboriginal and Torres Strait Islander people is 26%, but without the 33,000 people employed under the Community Development Employment Program (CDEP), this rate of unemployment would be closer to 40%. The Commonwealth remains committed to CDEP, and has increased CDEP funding in the 2000 –2001 Budget. Changes in emphasis in CDEP projects currently being pursued by ATSIC, which aim to give participants greater skills for employment in the wider work-force, are also supported.

ATSIC programs such as the Community Housing and Infrastructure Program are not just capital construction projects. An essential element of each project is on community development through involvement in all aspects of the program including: planning, employment and training, environmental health issues and the ongoing maintenance of the assets. Improved health outcomes are one objective of the CHIP program.

Successive Commonwealth Governments have also attempted to empower Indigenous communities by providing greater educational opportunities for young people, through programs like ABSTUDY. At one level, these special educational assistance programs have been very successful – there is now a far greater number of Aboriginal teachers, doctors and other health professionals, lawyers and other professionals. General levels of educational attainment, however, remain far below that of Australians generally.

The Commonwealth also remains committed to assisting Indigenous enterprises, both through a business loan scheme and through the Aboriginal and Torres Strait Islander Commercial Development Corporation. Greater economic independence holds the promise, in the longer term, of an end to welfare dependence and a lessening of the many social problems that lead young people without faith in the future to abuse drugs.

Indigenous Community Needs

As the whole Australian community focuses more on the problems of substances abuse, it is important that the particular needs of Indigenous Australians are given due attention and that, of the funding available for harm minimisation, there is equitable funding for Indigenous-specific programs.

The Terms of Reference rightly require all members of the Committee to examine the social and economic cost of substance abuse. These social costs relate to family relations and domestic violence and the economic cost relate to those associated with health care, law enforcement and loss of productivity. Substance abuse touches the lives of families involved directly and the rest of us are affected as we pay the economic costs of the health care, road trauma and law enforcement through the taxation system.

In some Indigenous communities, the social cost of substance abuse is so pervasive that every community member is directly and personally impacted. Some communities can never hope to function effectively unless they receive the assistance they require to overcome the problems resulting from alcohol abuse or petrol sniffing. Substance abuse threatens to rob many Aboriginal and Torres Strait Islander people of their birthright to pass on to new generations their timeless cultural values and traditions.

There are very real differences in the scale of the problem in the Aboriginal community and the broader Australian community.
Within the Indigenous community it is also essential to recognise that programs which may work well in urban environments may not work well in remote areas. Additionally, consideration needs to be given to sub-groups such as women and youth.

It is important, therefore, that the allocation of funding always reflect this far higher impact in the Indigenous community. Those agencies who provide services in drug education or rehabilitation must always be aware of the particular needs of Indigenous Australians. This must include the appointment of Aboriginal and Torres Strait Islander people, with the appropriate community and professional background to boards and committees. Where appropriate, separate Indigenous steering committees or advisory boards need to be established. A sound working relationship must be established with ATSIC as the elected representative body for Indigenous Australians, and career paths developed for drug and alcohol health professionals specialising in Indigenous health.

Looking to the Future

Licit and Illicit drugs are abused by Aboriginal and Torres Strait Islander people at a higher rate than by other Australians. This social outcome is consistent with the disadvantaged social and economic position of Indigenous people within Australia.

Since the early 1970's, successive Commonwealth Governments have recognised this disadvantage and put in place a range of social, economic and health programs in an attempt to overcome this disadvantage.

Through taking an holistic approach to addressing the causes of drug abuse, and by empowering Indigenous communities, it is hoped that the harmful consequences of licit and illicit drugs can be minimised.