Summary of alcohol misuse among Indigenous peoples

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Contents

Introduction .............................................................................................................................................. 2
Historical evidence of Indigenous use of alcohol.................................................................................. 2
The role of the state in regulation and control of substances ................................................................. 3
History of state and community-based interventions ............................................................................. 4
Patterns of alcohol use ............................................................................................................................... 4
Alcohol misuse related mortality and hospitalisation ............................................................................. 5
Prevention and control of substance misuse ............................................................................................. 6
  Supply reduction ...................................................................................................................................... 6
  Demand reduction .................................................................................................................................. 7
  Harm reduction ...................................................................................................................................... 8
Evaluation ................................................................................................................................................ 8
Conclusion ............................................................................................................................................... 9
References .............................................................................................................................................. 9

Introduction

Alcohol misuse is a major public health problem for Indigenous Australians. The extent of this problem is often misunderstood or misrepresented by non-Indigenous Australians. In a national survey of Indigenous Australians aged 13 years and above, 59 per cent identified alcohol as 'one of the main health problems' faced by their communities and 30 per cent identified 'drugs' as a problem [1]. In this section, we wish to examine the historical record of, and background to, alcohol use by Indigenous Australians, the extent of alcohol use and misuse and related harms among contemporary Indigenous Australians, and the steps that are being taken to address the problem.

Historical evidence of Indigenous use of alcohol

It has been claimed that alcohol was an introduced substance with no part in traditional Indigenous life and that the problems associated with excessive consumption of alcohol by Indigenous Australians are a consequence of this [2],[3],[4]. Brady [5] has cited various references which refute this argument, and which include observations of groups taking advantage of the natural fermentation process. However, the absence of suitable containers, and the natural control imposed by climatic variation, ensured that large-scale production and distribution of alcoholic beverages did not occur [6].
In order to explain the impact of alcohol on the Indigenous society since European colonisation, it is necessary to understand both the pervasive role of alcohol in the new colony, and the disastrous impact of the European invasion on Indigenous ways of life. In 1788, the 'First Fleet' brought both wine and rum. The latter soon became an object of currency in the colony of New South Wales and within five years, there were lurid accounts of alcohol's impact on colonial society [7]. In the Swan River Colony, too, within a year of the European settlement in 1829, struggling colonists had the choice of three hotels and six ale-houses. By 1836 the capital, Perth, had one licensed premise for every 75 people! [8]. These figures help to illustrate the very central place of alcohol in the life of the early colonies.

Alcohol not only permeated European transactions, increasingly it came to define many European-Indigenous relations, as alcohol was given to Indigenous people for work, sex, or simply to encourage fighting for the colonists' amusement [9]. Alcohol-induced prostitution had a harmful effect on child rearing and accelerated the birth rate of mixed descent children, many of whom faced rejection by their European fathers [10]. In his report on the condition of Indigenous people in Western Australia, Roth [11] reported drunkenness, prostitution and widespread venereal disease from La Grange near Broome in the north to Albany in the south.

The role of the state in regulation and control of substances

All industrialised states have attempted to control the production and distribution of psychoactive substances, particularly alcohol. A delicate balancing act has been required between encouraging highly profitable industries (with commensurate revenue to state coffers) and attempting to reduce substance-related health and social harms, and hence, costs to governments. In liberal democracies, state-level attempts to regulate alcohol and other substance consumption are at odds with liberal philosophy which claims that mature, sane adults should be responsible for their own behaviours - including drug taking [12].

While there have been objections to controlling alcohol use among the general population, no such qualms have been raised about the regulation of alcohol to Indigenous people. It has been pointed out that laws prohibiting the supply or sale of alcohol to Indigenous people, introduced between 1838 and 1908 in all Australian states and territories, were the first legal refutation of the equality of Aborigines and Europeans before the law, as set down in British colonial policy. Through time, the laws and subsequent amendments became even more restrictive, and were applied to Indigenous people of 'full descent', 'mixed descent' and to people from the Pacific Islands [6].

As elsewhere in the world, while prohibition limited the supply of alcohol to Indigenous people, dedicated Indigenous drinkers and entrepreneurial Europeans guaranteed that those people with money to buy alcohol would be able to procure it from someone willing to sell it. The social and other costs were considerable, however. Research by Beckett [13], in 1957 in far west New South Wales, revealed a
savage regime of alcohol surveillance, in which police patrolled Indigenous settlements up to six times daily.

The subsequent repeal of legislation prohibiting the supply and sale of alcohol to Indigenous people facilitated widespread increases in drinking and alcohol-related harm. A missionary working in a desert region in South Australia noted the disproportionate amounts of money spent on alcohol off the reserve, with a resultant decline in living standards, increase in family conflicts and destruction of traditional culture and influence [10].

**History of state and community-based interventions**

Since publication of the report *Alcohol problems of Aboriginals* by the House of Representatives Standing Committee on Aboriginal Affairs [14], successive Australian government reports on Indigenous health and related matters have increasingly acknowledged the role of alcohol, and to a lesser extent, other substances, in poor Indigenous health [14]. There has also been widespread recognition of the contribution of historical and structural factors to patterns of misuse. Government and other research reports identify the need for both prevention and treatment programs, indicating that demand for, and supply of, alcohol and other substances, requires attention. Most important has been the acknowledgement that Indigenous family and community initiatives and involvement are crucial to the success of any program [15].

While parallel development of mainstream and community-based health programs for Indigenous people had their origins in the 1970s, programs which specifically targeted alcohol and other substance abuse have grown rapidly in the past two decades. Those initiated by Indigenous people have included supply reduction strategies such as the prohibition or regulation of alcohol; demand reduction programs incorporating health promotion, recreational and cultural initiatives; harm minimisation strategies such as night patrols and sobering up shelters; and a wide range of treatment programs.

**Patterns of alcohol use**

In 1994, the National Drug Strategy (NDS) conducted a national survey among 2993 Indigenous people in urban areas - population clusters of 1000 people, in which about 67 per cent of Indigenous people reside [16]. In the survey report the results were compared to those of the general population in the 1993 NDS Household Survey. No national survey has been undertaken since, and these data still provide the best baseline estimates of the prevalence of substance use among Indigenous people.

The proportion of current drinkers among Indigenous people in the 1994 NDS Survey [16] was less than among non-Indigenous people. The proportions of each group that had never consumed alcohol (15% and 13%) or who drank less than once per week (29% and 27%) were about the same. However, a smaller percentage of Indigenous
people reported drinking at least once a week (33% vs 45%) and more reported that that they used to but no longer drink (22% Vs 9%).

As well as there being a lesser percentage of current drinkers in the Indigenous population, the 1994 NDS Survey [16] found that generally they drank less often - 49 per cent reported consuming alcohol more regularly than once a week compared to 61 per cent of non-Indigenous people. However, on those occasions on which they did drink, 70 per cent of males claimed to drink more than six standard drinks (61g of alcohol) and 67 per cent of females claimed to drink more than four standard drinks (41g of alcohol). This compared to 24 per cent of males and 11 per cent of females in the non-Indigenous population. Importantly, the 1994 NDS Survey found that those who were more socioeconomically disadvantaged were more likely to engage in high risk drinking (and to smoke cigarettes) than other members of the Indigenous population [17].

Studies of alcohol consumption among Indigenous people have also been conducted at local, regional, or territory levels. The results of these show considerable variation. Some of this is likely to be a methodological artefact, but as with smoking, the studies suggest geographic variation that is hidden in the aggregate 1994 Survey results. This is also suggested by a study of regional variation in per capita alcohol consumption in the NT [18].

These studies have shown that the proportion of males who consume alcohol is at least 30 per cent greater than that among females. However, a large survey of NSW secondary students [19] and study of young people in Albany, WA [20] both found that there were no significant differences in the percentages of males and females who reported consuming alcohol. These results suggest that in the future we might see an increase in the proportion of Indigenous women drinkers.

**Alcohol misuse related mortality and hospitalisation**

A number of reports implicate alcohol as a cause of excessive Indigenous mortality. For methodological reasons, few of these studies are directly comparable. Furthermore, many of them are simply associational. That is: they identify causes of death shown to be alcohol-related in other populations; compare either numbers of deaths or mortality rates between Indigenous and non-Indigenous people; report on higher than expected deaths among Indigenous people; and, attribute the observed difference to alcohol. While this can be justified with regard to conditions caused solely by alcohol, caution is needed in attributing the extent of alcohol-related causation in regard to other conditions [21].

While it is not without limitations, the aetiologic fraction method overcomes some of the methodological limitations referred to above. Using this method, Unwin et al. estimated that, in WA, for 1983-85, 1986-88 and 1989-91 the age-standardised rates (ASRs) per 100,000 for all alcohol-caused deaths among Indigenous males were 159, 186, and 152 - with Indigenous to non-Indigenous rate ratios (RRs) of 5.3, 5.8 and 5.2
to one. For Indigenous females the rates were estimated to be 30, 32 and 29 and the rate ratios 5.8, 4.6 and 3.7 to one [22]. In 1989-91 the leading causes of alcohol related deaths and the ASRs per 100,000 among Indigenous males were: alcoholic liver cirrhosis - 42; alcohol dependence syndrome - 30; and road injuries - 19. Among Indigenous women they were: alcohol dependence - 17, cirrhosis - 16, and assault - 7 [22]. In 1983-1991, it was estimated that alcohol caused 9.6 per cent of Indigenous deaths in WA [22].

Various local studies describe: the impact of alcohol on clinic or hospital admissions within Indigenous communities, the excess of health problems among drinkers within Indigenous communities, or the association of problems such as recurrent seizures with levels of alcohol consumption. Proportions of consultations or hospital admissions for alcohol-related problems are about twice as high among Indigenous than among non-Indigenous patients [23] and rates of alcohol-related hospital admissions are higher [24].

**Prevention and control of substance misuse**

As in other areas of Indigenous health, arrangements to address substance misuse are complex. They include Commonwealth and State/Territory substance use policies, which are partly coordinated through the Ministerial Council on Drug Strategy and the National Drug Strategy [25]. These arrangements also include numerous pieces of Commonwealth and State/Territory legislation that control the availability of alcohol and other drugs - some of which, to varying degrees provide communities in general, or Indigenous communities in particular, with a voice in these issues. The Commonwealth Government does not have a direct role in the provision of services but it plays a key role in the funding of State/Territory and Indigenous community-controlled intervention services. In fact, in the 1999-2000 financial year, the Commonwealth provided 58 percent of funds for projects specifically targeting Indigenous people with substance misuse problems [26].

In principle, mainstream substance misuse services are available to Indigenous Australians. In practice, these are often unaffordable, inaccessible, inappropriate and unacceptable. There have been attempts by mainstream service providers to address these problems. However in response to these problems, the level of substance misuse within their communities, and as an expression of self-determination, Indigenous Australians themselves have developed a broad range of intervention initiatives.

A useful framework for reviewing substance misuse interventions is provided by the tripartite approach of Australia's National Drug Strategy - supply reduction, demand reduction and harm reduction [25].

**Supply reduction**

Indigenous communities have taken two main approaches to reducing the supply of alcohol - declaration of 'dry' areas and using of liquor licensing legislation to extend
controls on availability. Some groups have also lobbied for changes in licensing legislation. Legal procedures enabling Indigenous communities to declare themselves 'dry' vary between jurisdictions. These and their effects in the NT, WA, and SA have been reviewed, and were found that they can be effective, but that communities need support to enforce them and policies underlying them must promote Indigenous control [27].

Indigenous groups in the NT and WA have utilised liquor licensing legislation to extend the range of restrictions on the availability of alcohol. Restrictions commonly include limitations of hours of sale and banning the sale of wine in casks of greater than 2 litres (effectively a price control measure). Generally, these supply reduction strategies have been found to be effective in reducing consumption and key indicators of harm. They have been most effective when they have been initiated by Indigenous people, conducted as part of broader strategies to address alcohol-related harm, and have had wide community support [28].

**Demand reduction**

Demand reduction strategies have focused on treatment and health education, and - to a lesser extent - providing alternatives to substance misuse use. In addition, both explicitly and implicitly, various community development projects have the prevention of substance misuse as a goal.

**Treatment**

Effective treatment reduces demand for alcohol or other substances at the individual level. The 1994 NDS Survey found that most people who had sought treatment had done so in primary health or medical care settings: either from Indigenous community-controlled health services or general practitioners [16]. On the basis of reports by Indigenous people about the role of advice from medical practitioners in their decisions to give up drinking alcohol, and their effectiveness in other populations, Brady - among others - has been an advocate of the use of brief interventions for Indigenous people [29]. There have been no evaluations of their efficacy among Indigenous Australians. However, given their effectiveness elsewhere, and as they do no harm, they should probably be used by health care providers as the opportunity presents.

Apart from general primary care interventions, focused treatment projects are the most common form of intervention in Indigenous communities. In 1999-2000, there were 107 such projects, conducted in both residential and non-residential settings [26]. The majority of these targeted alcohol alone or alcohol and some combination of other substances. Although most treatment projects are based on the '12 steps' model - or an adaptation of it - in recent years services have begun to explore a wider range of approaches; including life-skills counselling and vocational training.
Prevention

Most prevention projects provide health promotion services. A list of current health promotion projects is available on the Indigenous Australian Alcohol and Other Drugs Database (http://www.db.ndri.curtin.edu.au). A small number of, largely qualitative, evaluations of alcohol prevention projects has been undertaken. The projects have included: provision of health education classes, sporting and recreational activities, support for homeless people, a bush tour by the band Yothu Yindi and an associated television commercial, alcohol education and related programs for young people, and community education and activities. As with treatment projects, while most were well received by the communities in which they were conducted, the outcomes of these interventions were equivocal. These evaluations also identified a number of process issues that both enhanced and constrained project effectiveness.

Harm reduction

Harm reduction strategies are designed to reduce the impact of drug use on individuals and communities without necessarily reducing consumption. The most common of these are night patrols which provide transport to safe locations for intoxicated persons. Most aim to reduce alcohol-related conflicts and harm.

Sobering-up shelters provide a temporary haven for, and supervision of, intoxicated people at risk of causing harm to themselves or others, and divert intoxicated people from police custody. In 1999-2000 there were 23 such shelters. Evaluation of a shelter in Kununurra found that it was well accepted and led to a significant reduction in police detentions of intoxicated people.

Evaluation

The answer to the perennial question about which interventions work is not a simple one. First, there have been few formal evaluations of interventions - a fact highlighted in various reviews. Second, there are disputes about the criteria by which success is to be judged, and the evaluation methods that should be used.

Despite these problems, evaluations that have been undertaken have reached a number of similar conclusions about what makes an intervention effective. First and foremost among these is the support of, and control by, local communities. Given the diversity within the Indigenous population, interventions must be tailored to the needs of particular communities. As many of those people who misuse psychoactive substances are poly-drug users, interventions are more likely to be successful when they target substance misuse generally rather than the misuse of particular drugs. There tends to be a synergistic effect between interventions, and particular interventions are more likely to be effective when they are implemented in conjunction with others. Importantly, interventions need to be adequately resourced.
and supported. This entails not only funding for project activities, but provision of appropriate staff training and support.

Conclusion

Indigenous and non-Indigenous people alike acknowledge the destructive health and social consequences of substance misuse. The reasons for such misuse, and what governments and communities can and should do about it, however, are contested. Understanding both demand for and supply of alcohol and other substances to Indigenous Australians requires some historical context, and recognition of the link between disadvantage, poor health and excessive substance use. Indigenous health policy over the past three decades, while acknowledging this association, has been developed separately from other portfolios, such as land, employment, education and housing. Thus gains made in some areas of health are unable to be maintained because of poor living conditions. Increasingly, too, there is a tendency to blame Indigenous communities for their own ill health and risky substance use. With respect to substance misuse, evidence from throughout Australia indicates that successful prevention and control measures are dependent upon Indigenous control of the design and delivery of services; the comprehensiveness of prevention and treatment strategies; and adequate resourcing of staff and facilities.

References

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