

# Preventing substance misuse among indigenous peoples: a comparative review

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## INTRODUCTION

The aim of this presentation is to report on key findings of a comparative review of “The evidence base for responding to substance misuse in indigenous minority populations”<sup>\*</sup> which was undertaken by myself and Professor Sherry Saggars.<sup>1</sup> A paper on this review is included in a book which has just been published by John Wiley & Sons, entitled *Preventing Harmful Substance Use: The Evidence Base for Policy and Practice*.<sup>2</sup> In this presentation, I am not going to go into the details of specific intervention strategies. Rather, I am going to look at the broad lessons for Australian policy and practice that can be learnt from the review.

In doing so, however, I will not confine myself to discussing only the results of the review. I will also make reference to three other studies by our research group which support and further illuminate the findings of the comparative review. These studies include two which were initiated by the Australian National Council on Drugs – the ANCD – and supported by the Australian Government Department of Health and Ageing. They were a project that mapped the distribution of substance misuse intervention projects for Indigenous Australians and the allocation of resources to them;<sup>3</sup> and another which identified elements of best practice in the delivery of Indigenous intervention projects.<sup>4</sup> The third of these additional studies was conducted for the Department of Health and Ageing and looked at *Substance Misuse, Primary Health Care and Indigenous Australians*.<sup>5</sup> Before looking at what these inter-related studies tell us, I first want to make a few brief points about the level of substance misuse and related harms among Indigenous Australians.

## INDIGENOUS AUSTRALIAN SUBSTANCE USE

The most comprehensive attempt to document the extent of substance misuse among Indigenous Australians was conducted in 1994 for what is now the Australian Government Department of Health and Ageing.<sup>6</sup> This was a survey of Indigenous households conducted as a supplement to the triennial household surveys of drug use conducted for the Australian Government. There has been no adequate, comprehensive survey undertaken since that time. However, the triennial household drug surveys and some regional and local studies do provide indications of change since 1994 – indications that are not cause for comfort.<sup>5,7</sup>

Although there has been a small decrease in tobacco consumption, the prevalence of smoking among Indigenous people remains about twice that in the non-Indigenous population – and tobacco-caused deaths are the greatest preventable cause of death among Indigenous Australians. At the time of the 1994 survey, it was estimated that although Indigenous people drank less frequently than non-Indigenous people, when they did drink they were *at least* twice as likely to do so at harmful levels. At that time fewer Indigenous females than males reported

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<sup>\*</sup> In this paper, I spell the word ‘indigenous’ with a small ‘i’ as a common noun to denote Indigenous peoples in general, and with a capital ‘I’ as a proper noun to denote specific Indigenous peoples as in ‘Indigenous Australians’.

drinking, but more recent studies suggest that among young Indigenous females the proportion of drinkers is increasing.<sup>5,7</sup>

While licit drugs still account for a much greater proportion of mortality and morbidity than do illicit drugs, there is evidence of significant increases in cannabis use and the use of other illicit drugs among Indigenous Australians – including rates of injecting drug use that are significantly higher than in the non-Indigenous population.<sup>5,7</sup> Furthermore, while in total population terms it is not of the same magnitude as other substance use, there is evidence that petrol sniffing is now endemic over a wider area than it was 15 years ago.<sup>8</sup>

Although there is some variation, these patterns of substance misuse are similar to those among diverse indigenous minority populations in New Zealand, Canada and the United States. A fact that indicates that other than biological and cultural factors play a significant determining role.<sup>9</sup>

## RESPONDING TO INDIGENOUS SUBSTANCE MISUSE

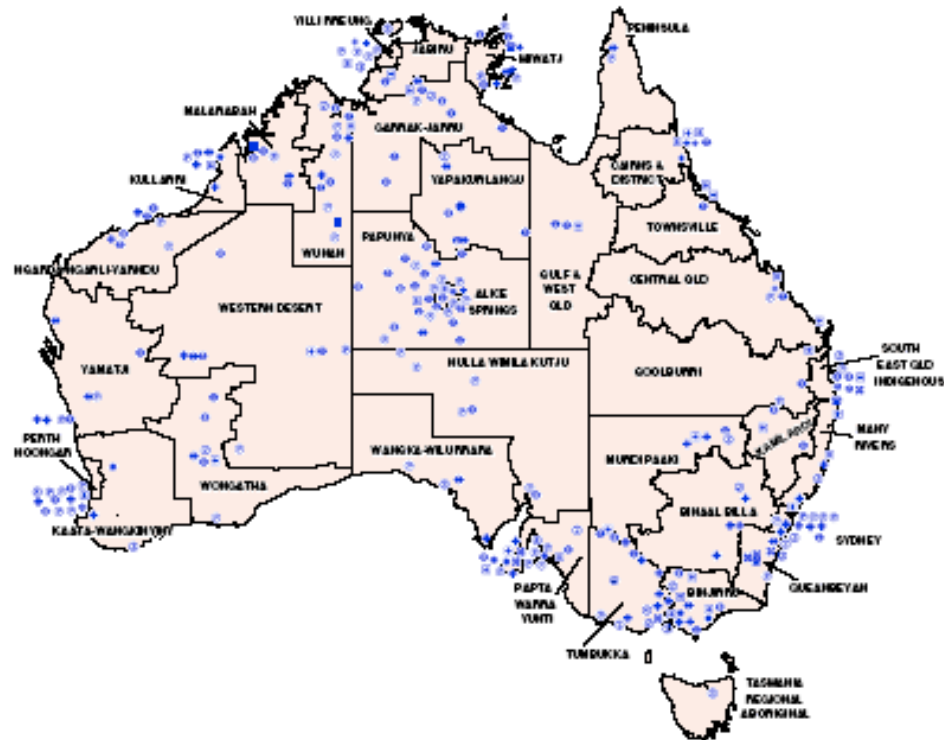
In our comparative review we had two objectives:

- first to identify the range of measures taken to prevent substance misuse and related harms among indigenous minority populations in Australia, New Zealand, Canada and the United States; and
- second to identify their effectiveness.

Essentially – what is being done to address a common problem and what works?

With regard to the first objective, Australia is the only one of the four countries in which a comprehensive attempt has been made to document the range of substance misuse interventions for indigenous peoples. This is our mapping study to which I referred earlier.<sup>3</sup> In it we identified 277 intervention projects that directly targeted substance misuse and we mapped their distribution by intervention type, service population, and allocation of financial resources by Aboriginal and Torres Strait Islander Council regions. Although the study is now two years old and deals with the 1999–2000 financial year, it is important because it is the only study of its kind – albeit one that needs updating.

Although no attempt has been made to formally document the range of interventions in the other three countries, there is an almost overwhelming number of papers describing particular interventions targeting indigenous peoples in the ‘grey’ literature, government publications and academic journals. The types of intervention strategies that have been applied vary between countries, state and provincial levels within them, and in response to the type of substance and its legal status. However, despite the plethora of descriptive reports, relatively few interventions have been formally evaluated in any of the four countries. There are several papers that review various aspect of these evaluations and these are cited in our review.



## KEY FINDINGS

To some extent, all of our findings from the comparative review reflect an imbalance in the provision and targeting of services. In reviewing these imbalances, I will concentrate on the Australian situation – although to a greater or lesser degree they are evident in the other countries we considered.

### Focus on individuals, family and community

The first of these imbalances is at the level at which interventions are targeted. It is generally agreed that substance misuse by individuals – like many public health problems – is to a considerable degree socially determined – and not solely a function of individual psychological and biological make-up. Furthermore, it is generally agreed that in order to address substance misuse in populations, it is necessary to intervene at all levels of the hierarchy of determinants.<sup>2,8,10</sup>

Considered from this perspective, one of the most striking aspects of our international review was that most interventions are targeted at the individual, family or community levels of the hierarchy. In all four countries, treatment of individuals or families is a predominant form of intervention. Much of this is based on the 12-steps model – sometimes adapted to local cultural situations. Although in recent years, this has been broadened to include other treatment modalities and elements such as life-skills training. Other interventions at the individual, family and community levels include health education campaigns and various recreational activities. We identified few interventions at the macro-social level that specifically target substance misuse among indigenous peoples – although some broad-based

interventions at this level implicitly see reduction in substance misuse and other health problems as a secondary consequence.

## Few evaluations – but indications of success

As I indicated previously, there is a large number of papers describing interventions targeting individual, family and community levels (what Lynch refers to as proximal and distal determinants<sup>10</sup>). However, There is a paucity of studies that formally evaluate such interventions. Nevertheless – from each of the four countries on which we focused – there are indications of success. I will not go into these in detail, but will mention a few illustrative examples. In terms of supply reduction this includes dry community declarations in Australia and the United States, liquor licensing restrictions in Australia, and the substitution of aviation fuel for regular petrol in Australia. Successful demand reduction strategies include life skills and social support programs in the United States, recreational activities in Canada, and strengthening social cohesion in New Zealand. Harm reduction has received greater emphasis in Australia than elsewhere and there is evidence for the effectiveness of both night patrols and sobering-up shelters.

It is important not to interpret the apparent increase in Indigenous substance misuse and the relatively small number of evaluation studies as meaning that such interventions are not working. Rather, it is simply an indication that more work needs to be done in this area. There are indications from other sources – including community and expert acclaim, and awards for service delivery – that many projects are having positive effects. Although, it is also clear that many intervention projects are less than optimally effective because important supports and resources are not in place or are inadequate for the tasks at hand.

In the second ANCD sponsored project (to which I referred earlier) – working in conjunction with various Indigenous community-controlled organisations – we identified some of the key elements in a number of projects that are widely recognised as successful.<sup>5</sup> These reflect a similar list identified in a study conducted in Canada (Round Lake Treatment Centre cited in Health Canada).<sup>12</sup> The elements are:

- indigenous community control, good governance and social accountability, commitment by chief and council;
- a clear set of principles, plan, and strategy, including a realistic time-frame;
- clearly defined management structures, strong managerial leadership and support;
- recruitment of appropriate staff (including native language speakers where appropriate) and staff development and support;
- holistic, multi-strategy, flexible interventions;
- intra- and inter-agency collaboration;
- reporting, monitoring and evaluation procedures; and
- adequate resourcing.

These elements provide:

- a framework for the process evaluation of interventions;
- and a guide for project implementation.

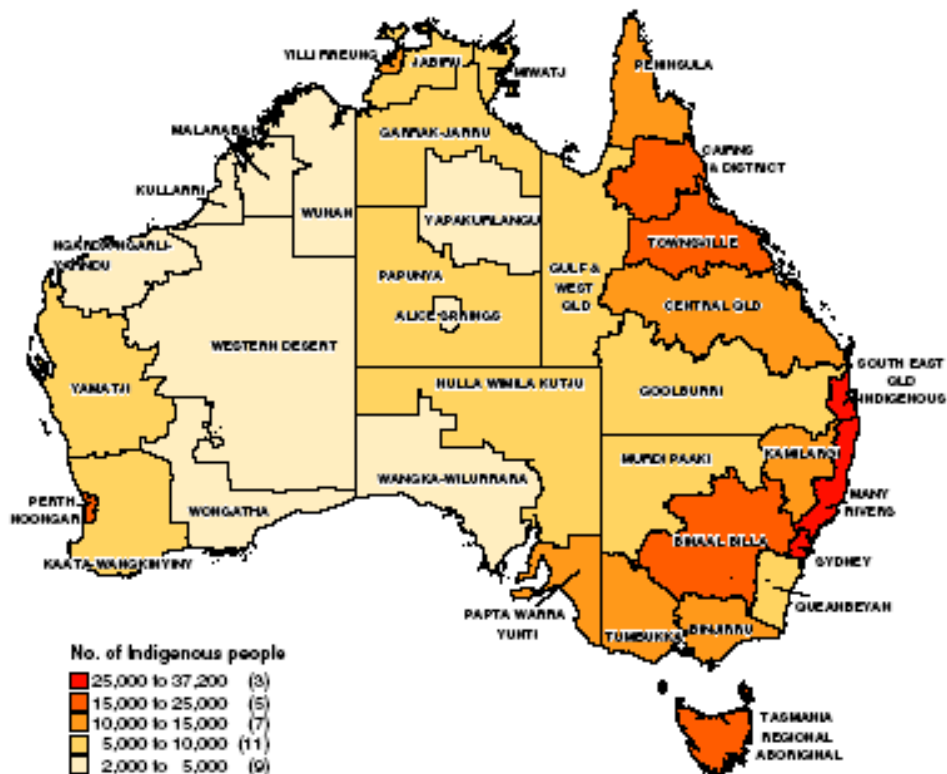
Without good processes in place and without adequate funding it is unrealistic to expect optimal outcomes

## Geographical/population imbalance

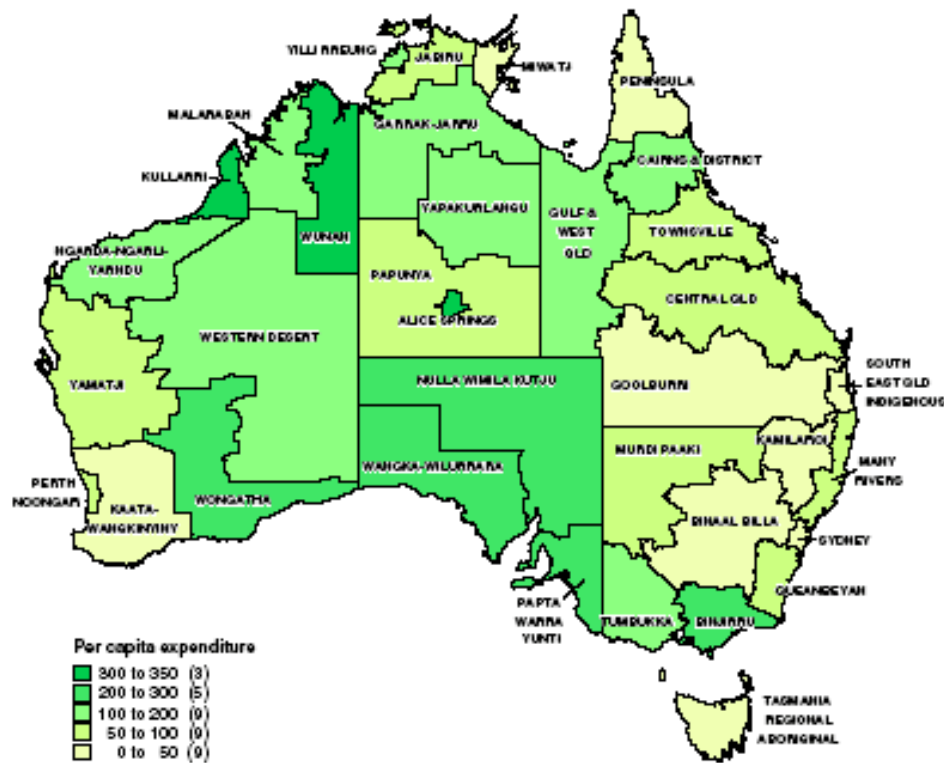
When we go beyond the effectiveness of interventions and look at their distribution it is clear that, within Australia, there is a geographical imbalance. As I indicated previously, we mapped the distribution of intervention projects and allocation of resources to them by ATSI region. In the absence of better epidemiological indicators of need and because of the evidence that indicates high levels of ill-health and substance misuse across geographic regions, it is reasonable to assume that resources should be allocated at least partially in relation to the size of regional populations.

However, we found no statistically significant relationship between regional population size and the distribution of projects and allocation of resources – a point that is evident from the following maps. To a large extent, the allocation of resources reflects historical allocation of funding. That is, treatment services – particularly residential treatment services – which were among the first Indigenous specific interventions attracted, and continue to attract, a significantly greater proportion of funding than other interventions. Thus in part, the geographical/population imbalance of resourcing reflects another imbalance – that is, an imbalance in the type of intervention projects.

**Estimated residential Indigenous population by ATSI region, 1996**



Per capita expenditure on alcohol and other drug misuse intervention projects for Indigenous Australians by ATISIC region, 1999–2000



## Imbalance of intervention types

Of the 277 intervention projects we identified in 1999–2000, over 35 per cent were specialised alcohol or, to a lesser extent, other drug treatment services,\* the foci of which were individuals and families. Well over 50 per cent of the funds allocated by the Australian and state/territory governments to substance misuse interventions in that period was expended on these treatment services – mostly on residential treatment services.<sup>7</sup>

When we examine prevention services the imbalance is even more starkly evident. In 1999–2000, community-based prevention projects accounted for 21 per cent of intervention services. However, only 13 per cent of funding was allocated to those projects; and, of that, half was short-term non-recurrent funding. This reflects a concern frequently expressed by Indigenous community-controlled organisations. That is, they spend considerable time and resources developing funding submissions, wait for considerable time for them to be processed, get the projects up and running, finally begin to achieve results, and the funding cuts out.

The other major imbalance in interventions to address Indigenous substance misuse in Australia is the relatively small proportion of funding for workforce development. Most evaluations of intervention projects in Australia have highlighted the shortage of trained staff and the constraints this places on project effectiveness. However, in 1999–2000, less than two per cent of funding for intervention projects was allocated for workforce development (this is included in the ‘other’ category in Table 1).

\* The interventions identified as ‘multi-service’ in Table 1 are primarily treatment services which provide various out-reach and preventive services which, in terms of resource and/or staffing allocations, could not be clearly separated from core treatment services.

**Table 1 Indigenous intervention project types by percentage of projects and percentage of funds, 1999–2000\***

Project type	% of projects n = 277	% of funds \$35.4 m
Multi-service	9	34
Treatment	17	27
Residential treatment	12	13
Prevention	21	13
Acute intervention	33	11
Other	8	3

\* Source: Gray et al.<sup>3</sup>

## Imbalance in the provision of treatment services

Even though treatment services are allocated the greatest proportion of funds for substance misuse specific interventions, there is an imbalance in the type of treatment that is provided to Indigenous Australians. Of the 277 substance misuse intervention projects we identified in our mapping study, about 40 (15%) were conducted by Indigenous community-controlled health services (as opposed to specialised substance misuse organisations). The more specialised services – although important – reach only a small proportion of those Indigenous people in need. In addition to those community-controlled services that provide specific substance misuse services, the other 80 or so community-controlled health services provide primary medical care for people with substance misuse problems as well as a range of other primary health care interventions for which they are not specifically funded.

Again, however, existing community-controlled services themselves do not reach a significant proportion of the Indigenous population. The reality is that – because of political and economic constraints on the growth of community-controlled services – particularly in large urban centres, many Indigenous people rely upon mainstream general practitioners for medical care. These latter providers have the potential to have significant impacts on Indigenous health in general and substance misuse in particular. However, the available evidence indicates that this impact is not being realised. Staff in this sector often do not have the skills, confidence or resources to address substance misuse issues with their Indigenous patients. Furthermore, there is little integration of mainstream primary health care provision with the services provided by Indigenous community-controlled health and specialist substance misuse services.<sup>5,11</sup>

## KEY FINDINGS AND THEIR IMPLICATIONS

In summary, there are several key findings from the studies I have reviewed:

- there are imbalances in the distribution and range of interventions and the levels of social determinants at which they are directed
- there are relatively few evaluations – but there are indications of success and what makes interventions successful; and
- while not reducing substance misuse, current interventions are probably retarding the growth of substance misuse and related harms.

Arising from these findings are a number of implications for policy and practice. However, I wish to confine myself, broadly, to three of these.

First, is the need to extend primary health care interventions to complement the emphasis on the provision of residential treatment. The latter is important, but we need to better resource Indigenous community controlled health services to provide specific substance misuse interventions and to harness the potential for intervention by practitioners in the mainstream primary health and medical care sector. In doing so, we need to go beyond calls to make greater use of brief interventions and to provide a full range of preventative and therapeutic services in primary health care settings.

Second, we need to ensure adequate resourcing and support of existing intervention projects. The imbalance between treatment and other intervention strategies should not be redressed simply by re-allocating existing resources. The resources available to most specialised Indigenous treatment services are already barely adequate for their needs. What is required is a significant injection of funds into prevention and other services. To say that such funds are not available is sophistry. The Australian government has a record tax surplus and several surveys have shown that, generally, Australians are not averse allocating tax monies for the provision of services to those in need. We must bring pressure to bear on our elected representatives to address a health problem of such magnitude that it would not be tolerated in the wider Australian community.

Third, we need to make a greater, concerted, whole-of-government effort to address the structural factors that underlie the higher rates of substance misuse – and other health and social problems – in Indigenous Australian communities. The apparent increases in substance misuse and the continuing health and social inequalities among Indigenous Australians – as illustrated in the publication *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*<sup>13</sup> – indicate that current substance misuse interventions and broader government programs for Indigenous Australians are having limited effect and are at best are merely 'a holding action'.

Generally, those working in the health sector are not in a position to alter the structural determinants of Indigenous substance misuse. They are, however, in a position to present the evidence for the role of these determinants and to continue to make strong representations to those who are in a position to act. To do less is to fail in our duty as researchers, health workers, public servants and citizens.

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