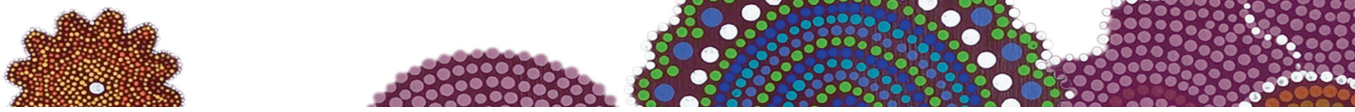
8

Harmful Substance Use and Mental Health



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OVERVIEW

In this chapter, we briefly examine harmful substance use and mental health among Aboriginal Australians. We explore a range of issues including current substance use and related harms, social and emotional wellbeing and comorbidity, and the social determinants of mental health and harmful substance use. We examine the range of services that have been developed to address these issues, through the National Drug Strategy's demand, supply and harm reduction framework. We argue that a multi-systemic strategy is required that addresses issues of cultural security, evidence-based practice to enhance treatment outcomes, better service coordination, and attention to the development of the Aboriginal substance use and mental health workforce. Some evidence-based treatments to help with mental illness and harmful substance use are adaptable to work with or along-side local, culturally appropriate, interventions. However, we reiterate that until the social and structural determinants of good mental health are addressed, the comorbidity of harmful substance use and mental health among Aboriginal Australians will linger.

This chapter will explore these issues in more detail and focus specifically on four important areas of concern. What are the problems? What are the underlying issues? What is, and can be done, to address harmful substance use among Aboriginal people? What else needs to be done?

THE BACKGROUND

For over 200 years, colonisation, racism and domination have left a legacy of marginalisation and mental anguish that is still with us today. Few Aboriginal Australians have been spared that anguish or the self-destructive behaviour associated with the harmful use of alcohol and other psychoactive substances. While harmful use of alcohol and other substances is represented as the problem of Aboriginal Australia, the source of all or most of its ills, especially poor physical and mental health, is influenced by many factors—including as an escape mechanism and a focus of socialising—and the causes and effects of alcohol and other drug use need to be better understood. Otherwise, there is a great risk that policy interventions will be simplistic and ineffective and the current opportunity for change will be lost.

The search for effective answers to today's problems with the harmful use of alcohol and other substances must start with the facts—each Aboriginal person has a lived experience and story that should be told by them. The experience of assimilating into Western ways or retaining Aboriginal ways creates anxieties that reverberate through the families that make up the Aboriginal Australian world. While Australia now has racial vilification laws, Aboriginal Australians are still made to feel uncomfortable or denied access to public places where others are welcomed.

The apology by the Prime Minister of Australia on 13 February 2008, recognising past wrongs against the Stolen Generations of Aboriginal Australians, cannot be a solution on its own until the demeaning stereotype of Aboriginal and Torres Strait Islander peoples is dismantled.

The prevalence of substance use in the wider population is thoroughly documented[1] and the *National Survey of Mental Health and Wellbeing*[2] has documented the high prevalence of comorbid harmful substance use and mental illness in that population. The authors of the latter report concluded that their is growing evidence for some direct causal relationships between harmful substance use and poor mental health, in particular cannabis use leading to psychosis in the vulnerable.[2] They also demonstrated that regardless of whether substance use complicates psychiatric disorder or vice versa, the prognosis is poorer for both conditions together than for either condition alone.

Comorbid Harmful Substance Use and Mental Health Problems

Several reports document high rates of substance use among Aboriginal people in general and young people in particular.[3-5] There is evidence that comorbidity is more common than in the wider population, although as Hunter[6] observes, identifying disorders of social and emotional wellbeing (SEWB) in Aboriginal and Torres Strait Islander populations is problematic. He notes that Aboriginal people's mental health disorders and substance use problems continue to be treated separately and this contributes to poor prognosis.[6] The three main approaches to managing comorbid harmful substance use and mental health problems are:

1. ***serial treatment***—managing the psychiatric disorder and harmful substance use in separate settings and services, one after the other;
2. ***parallel treatment***—managing both concurrently, but by different staff and in different settings; or,
3. ***integrated treatment***—when the same staff treat both disorders in the same setting.[7]

Both serial and parallel treatment models have limitations with high rates of patient withdrawal or people not getting treatment at all. Increasingly, integrated treatment is regarded as the preferred model, and although the evidence is evolving, this model is most in accord with the approach of many Aboriginal community controlled health services.

SUBSTANCE USE AND RELATED HARMS

It is important to note that not all substance use is harmful.[8] Here we use the term 'harmful substance use' in the public health sense, meaning any use of a psychoactive substance that causes harm to users or to others. This is a broader definition than the psychiatric definitions of 'substance abuse' or 'substance dependence' used in the Diagnostic and Statistical Manual of Mental Disorders.[9] See also Gray et al.[8]

For methodological reasons it is far easier to ascertain the prevalence of use of various psychoactive substances than it is to document the frequency and levels of such use, and whether or not individuals are using those substances at harmful levels[10]. Nevertheless, the levels of each are related and estimates of the prevalence of substance use provide an indicator of likely levels of harm. The figures on current prevalence (that is, any used in the previous 12 months) presented in Table 8.1 and used for comparison with older data in Table 8.2 were compiled from AIHW publications (2005, 2006) for the year 2004[1]. Unfortunately, later published figures are either not directly comparable or are not reliable. However, there is little evidence to suggest that, since that time, there has been significant change.

Table 8.1(a): Current Substance Misuse (previous 12 months) — Persons Aged 14 Years or Older, by Aboriginal Status, 2004

Substance	*Aboriginal/ Torres Strait Islander (%)*	*Non-Aboriginal/ Torres Strait Islander (%)*
Tobacco	52.0	22.5
Alcohol		
Abstainer	21.3	16.1
Short term high risk	52.0	35.5
Long term high risk	22.7	9.7
Cannabis	23.0	11.3
Meth/amphetamines	7.0	3.2
Pain killers/analgesics (non-medical use)	6.0	3.1
Inhalants	approx. 1.0	0.4
Heroin	approx. 0.5	0.2
Injected drugs	approx. 3.0	0.4

(a) Note the limited Aboriginal sample size for the National Drug Strategy Household Survey (NDSHS) (AIHW, 2005).

- *The NDSHS had a sample size of 29,445 Australians aged 12 years and older with a response rate of 46 per cent.*
- *The NDSHS does not have an enhanced Aboriginal sample—only 460 Aboriginal and Torres Strait Islander participants.*

Source: AIHW (2005, 2006)

There have been dramatic reductions in tobacco use among the Australian population over the past two decades. In 2004, approximately 23 per cent were current smokers. Among Aboriginal people, however, the rate was more than double, at about 52 per cent. Smoking is a significant and preventable contributor to global death and burden of disease and this burden is placed even more upon Aboriginal people.[11]

Alcohol is the most widely used substance among Aboriginal and other Australians. Among those aged 14 years or older, more Aboriginal people abstain from alcohol use (about 21 per cent compared with about 16 per cent). However, the higher rate of current abstention reflects that more Aboriginal people are ex-drinkers (rather than lifetime abstainers); many have given up because of the serious health consequences of their drinking.[12,13] They consume alcohol in a manner that poses high risks to their health in both the short (52 per cent compared with 35.5 per cent) and long term (22.7 per cent compared with 9.7 per cent).

When we consider the use of illicit drugs, or the harmful use of licit pharmaceutical drugs, the prevalence of use among Aboriginal people is about twice other Australians (cannabis 23.0 per cent compared with 11.3 per cent; amphetamine-type stimulants 7 per cent compared with 3.2 per cent; non-medical use of painkillers and analgesics 6 per cent compared with 3.1 per cent; inhalants, including petrol, about 1 per cent compared with 0.4 per cent; and heroin about 0.5 per cent compared with 0.2 per cent). Furthermore, about 3 per cent compared with 0.4 per cent had injected drugs in the previous 12 months.

In Table 8.2, we have estimated changes in the prevalence of use of various substances by comparing the data in Table 8.1 with that for Aboriginal people in 1994 and 1993, and other Australians for 1993.[13] Apart from increases in the use of amphetamine-type stimulants (10 per cent) and the non-medical use of painkillers and analgesics (7 per cent), in the period 1993–2004, there were significant reductions for other Australians in the use of tobacco (down 22 per cent), alcohol (down 14 per cent) and cannabis (down 13 per cent). In 1994–2004, however, apart from a small reduction in the proportion of tobacco users, among Aboriginal people, there were increases in the percentage of users of alcohol (15 per cent) and cannabis

(5 per cent) and, in particular, amphetamine-type stimulants (204 per cent) and painkillers and analgesics (107 per cent). Similarly over the same periods, while there was a reduction of 20 per cent in the prevalence of injecting drug use within the Australian population, there was about a 50 per cent increase among Aboriginal Australians.

As highlighted in several studies, poly-drug use is common among Aboriginal Australians.[13-16] For many, this is confined to the use of alcohol and tobacco, but for others this is extended to include cannabis and the use of other substances. Other harmfully used substances that are less likely to be used by other Australians, such as kava (banned since 2007 in the Northern Territory (NT) by the Australian government) and petrol, are usually in specific areas.[17]

Table 8.2: Changes in Prevalence of Substance Use — 1993–94 to 2004, by Aboriginal Status

Substance	*Aboriginal/ Torres Strait Islander (% change 1994–2004)*	*Non-Aboriginal/ Torres Strait Islander (% change 1994–2004)*
Tobacco	– 4	– 22
Alcohol	15	– 14
Cannabis	5	– 13
Meth/amphetamines	204	10
Pain killers/analgesics (non-medical use)	107	7
Injected drugs	50	– 20

Source: Commonwealth Department of Human Services and Health (CDHSH) 1996; AIHW2005, 2006.

Although confined to Western Australia (WA), the results of the *Western Australian Aboriginal Child Health Survey*[5]—the most comprehensive study undertaken of Aboriginal children and young people—indicate levels of substance use among young Aboriginal people. Young people aged 12–17 years were asked about cigarette smoking, alcohol, and marijuana (cannabis). Of the 17 year-olds in the survey, 58 per cent smoked regularly, over 61 per cent of males and 43 per cent of females were drinking alcohol, and 45 per cent of males and 21 per cent of females were using marijuana at least weekly. These rates are a major concern, particularly the high level of cannabis use.

Social Problems Associated with Harmful Substance Use

Alcohol and other drugs are the cause of, or contribute to, a wide range of social problems among Aboriginal Australians. These include violence, social disorder, family breakdown, child neglect, loss of income or diversion of income to purchase alcohol and other substances, and high levels of imprisonment. In addition, these substances have a significantly deleterious impact on the health of Aboriginal Australians.[3]

Studies over the past two decades have shown that Aboriginal people are much more likely than their non-Aboriginal counterparts to suffer from conditions caused by harmful substance use, and tobacco smoking has been identified as the single most preventable cause of death among Aboriginal people.[3, 18-20] Harmful use of alcohol causes about 7 per cent of Aboriginal deaths and Aboriginal people die at much younger ages from these conditions than non-Aboriginal Australians.[3, 21] Alcohol contributes to the hospitalisation of Aboriginal people[3]. There is little published data on Aboriginal deaths and hospitalisation associated with illicit drug use. In WA, however, between 1994–2000, the crude rate of hospital admissions for conditions caused by psycho-stimulants and drug psychoses increased eight times from 2.8 to 22.4 per 10,000 persons among Aboriginal males, and 3.6 times from 4.3 to 15.5 among Aboriginal females. For the period July 2004 to June 2006, there were 4,214 hospitalisations of Aboriginal Australians for substance use in New South Wales, Victoria, Queensland, WA, South Australia (SA) and the NT—around twice the rate of other Australians[22].

Mental Health and Intellectual Disability due to Harmful Substance Use

There is growing acknowledgement that excessive harmful substance use can lead to permanent acquired brain injury. This is discussed in further detail in Chapter 18 (Parker and colleagues).

SOCIAL AND EMOTIONAL WELLBEING AND COMORBIDITY

There is a high prevalence of comorbid harmful substance use and mental health problems within the Australian population.[23, 24] For example, it is estimated that among those with an alcohol-dependence disorder, 20 per cent have an anxiety disorder, and 24 per cent an affective disorder.[23] The evidence shows that there are causal pathways in both directions between these problems. For example:

> *there is a causal pathway from depression to substance use in males, and from daily cannabis use to depression and anxiety in females. There is also evidence that cannabis use precipitates psychosis in persons who are vulnerable because of a personal or family history of psychosis.*[25(p43)]

These shared risk factors for mental health and harmful substance use have implications for prevention and treatment, with potential comorbidity issues needing to be addressed as soon as symptoms of one disorder appear.[25] While there has been no comprehensive study of rates or prevalence of comorbidity in the Aboriginal population, evidence of the relationship comes from a number of sources. In Table 8.3 the ratios of observed rates of hospitalisation (the rate of actual cases) to expected rates of hospitalisation (those to be expected if the rates were the same as in the non-Aboriginal population) for mental and behavioural disorders are presented.[3] Table 8.3 shows the ratio of observed to expected cases among Aboriginal males and females. In 2005–06, Aboriginal men are over four times, and Aboriginal women over three times as likely to be hospitalised for 'mental disorders attributable to harmful psychoactive substance use' than their non-Aboriginal counterparts.

Table 8.3: Hospitalisations for Mental and Behavioural Disorders, 2005–06

	Male			Female		
Disorder	*Observed*	*Expected*	*Ratio*	*Observed*	*Expected*	*Ratio*
Mental disorders due to psychoactive substance misuse	2,436	538	4.5	1,331	400	3.3
Schizophrenic, schizotypal and delusional disorders	1,517	558	2.7	1,035	412	2.5
Mood and neurotic disorders	1,111	906	1.2	1,816	1,790	1.0
Disorder of adult personality and behaviour	93	51	1.8	143	168	0.8
Organic mental disorders	81	34	2.4	71	30	2.3
Other mental disorders	266	186	1.4	183	264	0.7
Total	**5,504**	**2,273**	**2.4**	**4,579**	**3,064**	**1.5**

Source: Australian Bureau of Statistics (ABS) and AIHW 2008.

Aboriginal suicide is covered in detail in Chapter 9 (Silburn and colleagues), but we highlight it here because of its relationship to harmful substance use. In the period 2001–05, the suicide rate among Aboriginal males in Queensland, SA, WA and the NT was almost three times that among non-Aboriginal males, and among Aboriginal females aged less than 44 years was over twice that among non-Aboriginal females.[3] The relationship between harmful substance use—specifically alcohol—and suicide is evident in Table 8.4, which shows that suicide was the most common cause of alcohol-related deaths among Aboriginal males and the fourth most common cause among Aboriginal females.[21] Intentional injury is not the most common cause of alcohol related death in non-Aboriginal population.[26]

Table 8.4: Alcohol-attributable Death Among Males and Females, 1998–2004

Condition	*n*	*%*	*Mean age at death*
		Males	
1. Suicide	222	19	29
2. Alcohol liver cirrhosis	210	18	56
3. Road traffic injury	87	7	30
4. Assault injury	70	6	34
5. Haemorrhagic stroke	60	5	27
Total	**649**	**56**	**35**
		Females	
1. Alcohol liver cirrhosis	136	28	51
2. Haemorrhagic stroke	78	16	25
3. Assault injury	48	10	32
4. Suicide	33	7	27
5. Road traffic injury	18	4	36
Total	**313**	**65**	**34**

Source: Chikritzhs et al., 2007.

The hospitalisation and suicide data are the tip of the iceberg. A study of cannabis use in remote Aboriginal communities in the NT found that some mental health symptoms increased as cannabis use increased.[27] Specifically with regard to children, the *Western Australian Aboriginal Child Health Survey* states:

> *The ages of 12–17 years represent an important period in the social and emotional development of young people. The transition to adulthood brings with it a range of demands, pressures and temptations. Compared with earlier generations, today's young people are under great pressure, with a more competitive labour market requiring higher education standards and greater skills. Aboriginal young people, like other groups in society who are sometimes marginalised and subject to discrimination, are potentially more vulnerable to harmful health risk behaviours.*[5(p207)]

This study, and other research on the frequency of mental health problems, and high levels of harmful substance use[3, 5, 28] indicate that levels of comorbidity are likely to be significant.[29-32] In turn, this highlights the need for interventions which address both sets of morbidities to enhance the efficacy of interventions.

SOCIAL DETERMINANTS OF MENTAL HEALTH AND HARMFUL SUBSTANCE USE

Poor Aboriginal mental health and risky health behaviours are related to the social determinants of health.[33] The extensive international evidence for the role of social factors in determining health status and the harmful use of alcohol and other drugs has been summarised by Wilkinson and Marmot.[34] The social, cultural and historical contexts of Aboriginal and Torres Strait Islander Australians are discussed in detail in Chapter 1 (Dudgeon and colleagues).

Turrell and colleague have demonstrated that Australians in low socioeconomic positions suffer more ill health at all stages of life.[35] Social factors which cause or protect against ill health and harmful substance use occur at all levels, from the macro-social to the individual, and are at play at all stages of the life course, from before birth to old age.[36] These social determinants have important implications for interventions. With respect to harmful substance use, for instance, macro-level policies such as increasing the price of alcohol through taxation at the national

level, and state and territory laws pertaining to the minimum drinking age are proven strategies for limiting alcohol-related harm.

Like harmful substance use, many mental health problems are influenced by social factors outside the control of individuals and their immediate contexts.[29] It is not simply about 'individual problems with individual psyches'.[37] Many of the factors that can lead to mental health problems also affect the risk of harmful substance use. Some of the overlapping vulnerabilities for psychiatric disorder and substance use disorders include common genetic vulnerability, brain development, exposure to substance use and stress.[38]

Contemporary Social Indicators

The history of oppression and repression has contemporary consequences for the structural position and health status of Aboriginal Australians.[39,40] Despite improvements in recent years, Aboriginal Australians continue to lag behind the general population on virtually every social indicator. Education is a key social indicator for improving the health and wellbeing of Aboriginal Australians, assisting them to deal with psychologies and social hardship. In the 2011 National Assessment Program – Literacy and Numeracy (NAPLAN) results, the proportion of Aboriginal children meeting national minimum standards in literacy and numeracy were significantly lower than the wider population.[41] These disparities give reason for concern. In addition, Aboriginal adults are more than twice as likely as other adults to be unemployed, and Aboriginal household incomes are only 59 per cent of that of adults in the wider population. Overcrowding and poor housing quality are experienced by a greater proportion of the Aboriginal population. These factors are implicated in poorer general health, lower life expectancies, higher harmful substance use and higher reported mental health problems.[3]

Dispossession and the Stolen Generations

Government policy towards Aboriginal people has fluctuated between attempts to protect Aboriginal people from European violence and the consequences of settlement, to assimilation, which saw the forced removal of many Aboriginal children from their families. The *National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families* reported that 'between one-in-three and one-in-ten Indigenous children were forcibly removed from their families and communities in the period from approximately 1910 until 1970'.[42(p37)] This history of separation is strongly implicated in the poor mental health and harmful substance use problems of many Aboriginal Australians.[28]

From the early 1970s to the mid-1990s, there was bipartisan support for policies of Aboriginal self-determination and self-management at the national level. Although implementation of these policies was under-resourced, they provided for the growth of Aboriginal community-controlled services, including health and substance use services. However, it is apparent that Australian governments are reticent to fully commit to Aboriginal self-determination. This came to a head in 2007 with the Australian Government's Northern Territory 'Intervention' (*Northern Territory National Emergency Response Act 2007*), which was one of several measures introduced in response to the *Little Children are Sacred* report on child abuse.[43] Many Aboriginal people have supported the need for the input of resources and action. But there was considerable disquiet about the fact that the Act facilitating the Intervention overrode provisions of the Commonwealth Government's *Racial Discrimination Act 1975*. Furthermore, many claim that consultation with, and involvement of, Aboriginal people was inadequate, and that the Intervention is a 'new paternalism' that risks contributing to existing abuse and neglect.[44-46]

WHAT IS BEING DONE?

It is important to note that while funding comes from the Australian and state and territory governments, most alcohol and other drug interventions among Aboriginal Australians have been initiated and conducted by Aboriginal people themselves,[47] such as that conducted by Benelong's Haven.[48] In 1985, the Australian and state and territory governments agreed to a coordinated effort to address alcohol and other drug use. This was initially known as the *National Campaign Against Drug Abuse*. This umbrella strategy, now known as the *National Drug Strategy* (NDS),[49] is based on the principle of harm minimisation:

> *Harm minimisation does not condone drug use, rather it refers to policies and programs aimed at reducing drug-related harm. It aims to improve health, social and economic outcomes for both the community and the individual, and encompasses a wide range of approaches, including abstinence-oriented strategies.*[50(p2)]

The NDS focuses on minimising the harms of substance use by: demand, supply and harm reduction. In non-Aboriginal populations, there have been extensive reviews of these strategies and their effectiveness.[49, 51-53] To complement the NDS, a plan focusing specifically on substance use among Aboriginal Australians has also been developed; the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan (CAP)*.[54] The 'CAP', as it is commonly known, identifies six key result areas for the focus of intervention. It is not intended to be prescriptive in terms of specific interventions, but provides a framework for intervention with which each state and territory jurisdiction can implement strategies they deem appropriate to their own situation. Like the NDS itself, the CAP is based on demand, supply and harm reduction strategies, and this provides a useful framework for the review of current interventions. At the time of writing this, the Aboriginal and Torres Strait Islander sub-strategy was being developed in line with the CAP and the current NDS.

Demand Reduction

As the name implies, demand reduction strategies are designed to reduce or prevent substance-related harm by reducing demand for those substances.[54, 55] They include broad-based prevention projects and both community-based and residential treatment services.

Prevention and early intervention programs to address harmful substance use among Aboriginal people are mostly conducted by Aboriginal community-controlled organisations. They include health promotion projects, recreational activities and community development projects. Research conducted for the 2006–07 financial year on behalf of the National Indigenous Drug and Alcohol Council identified a total of 144 such projects nationally.[56] Even though this is an increase from 1999–2000,[47] only 48 per cent of all projects operating in 1999–2000 were still operating in 2006–07.

Over the past decade, various services have responded increasingly to calls for a more diverse range of treatment options or alternatives to an abstinence-only approach.[12] One example is the residential treatment service in WA, Milliya Rumurra, which employs a diverse approach to meet the needs of individual clients.[57] Although the number of evaluations of such interventions is relatively small, there are clear indications of their effectiveness.[8, 58]

Supply Reduction

Generally, the greater the availability of a particular substance, the higher the level of use and related harm. Supply reduction strategies are those that aim to reduce availability and thus the levels of harm, and target both illicit and licit substances. In the case of illicit drugs, such as amphetamine-type stimulants, these include outright prohibition. In the case of licit substances, such as tobacco and alcohol, they include taxation and other price control measures, and constraints on who may or may not purchase particular substances and under what circumstances.[54]

In the general population, a combination of taxation, purchase age restrictions, and health promotion campaigns (a demand reduction strategy) has significantly reduced tobacco consumption. In the Aboriginal population, however, such measures and the few Aboriginal-specific strategies have had limited success.[59, 60]

Under various pieces of state and territory legislation, over many years, Aboriginal people have undertaken a range of strategies to reduce the supply of alcohol. In discrete communities, these include declaring their communities 'dry' (prohibiting alcohol) and establishing wet canteens to regulate availability. In towns, supply reduction strategies include working with non-Aboriginal residents and liquor licensing authorities to impose additional restrictions on the availability of alcohol. Of these, the least successful has been the establishment of wet canteens[61] and the most successful has been licensing restrictions—particularly those related to price.[62, 63]

Supply reduction strategies have also been used to considerable effect in the reduction of volatile substance use, particularly petrol sniffing. Evaluations, first of the 'Comgas' Scheme under which non-sniffable aviation fuel (avgas) was substituted for regular petrol and more recently the substitution of non-sniffable Opal fuel for regular petrol, have demonstrated the effectiveness of these strategies.[64, 65] Law enforcement is an essential component of strategies to reduce the supply of both volatile substances and illicit drugs. Best practice strategies and their impact have been reviewed in studies commissioned by the National Drug Law Enforcement Fund.[66, 67] While supply reduction strategies can be useful in reducing harm from drugs, such strategies can contribute to increased harm to the individuals and a greater cost to society if not better managed.[68]

Harm Reduction

Harm reduction strategies are those designed to decrease immediate harms associated with harmful substance use. The most common of these strategies have been developed in response to the acute harm caused by alcohol intoxication.

Night patrols, or mobile assistance patrols, are aimed at removing intoxicated persons from public to safe places to minimise the likelihood of them causing harm to themselves or others. The first such patrol was established by Julalikari Council in Tennant Creek in the mid-1980s. The numbers of these patrols expanded rapidly following recommendations made by the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) that they be supported.[40] Although the current number of operating patrols is not known, in 2006–07 there were 47.[56] Sobering-up shelters provide safe surroundings for intoxicated people following the RCIADIC, by 2006–07 they were expanded to 36 nationally.[56] Like night patrols, sobering-up shelters are effective but must be properly resourced and have sustainable Aboriginal involvement.

Needle and syringe programs (NSPs) are designed to reduce the harm associated with injecting drug use, particularly the spread of blood-borne viruses such as hepatitis C and HIV. Although they are sometimes contentious, the evidence in the wider Australian population shows that they have been effective.[69]

In Aboriginal communities, NSPs are also an issue of contention. Nevertheless, there are several operating around the country and innovative and successful strategies have been established to also link Aboriginal people who inject drugs into NSPs.[70, 71]

Addressing Comorbidity

As discussed above, a mental illness concurrent with substance use tends to exacerbate both the mental illness and harmful substance use. Often mental health services do not adequately assess substance use well, as alcohol and other drug services do not assess mental illness. Despite the funding of the 'National Comorbidity Initiative' by the Australian Government Department of Health and Ageing from 2006 to 2011, as yet there are very few interventions that specifically

address comorbidity in Aboriginal contexts. An example of a program that does so is operated by the Warlpiri Youth Development Aboriginal Corporation. One of the objectives of this NT-based program is to prevent suicide and petrol sniffing among the young people in the community.[72]

Aboriginal community health services have also attempted to address this gap in services for those suffering from comorbidities. The Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) has developed a model for integrating treatment of substance use, mental health, and primary health care services.[73] One of AMSANT's member organisations, the Central Australian Aboriginal Congress, is trialling this model. Another service commissioned a study examining the service needs of Aboriginal women experiencing both mental health and substance use issues. The study identified, amongst other factors, the need for improved service coordination, education for families and carers, and access to local treatment options.[74]

Recent Initiatives

A report published by the Australian National Council on Drugs (ANCD) showed that, over the period from 1999–2000 to 2006–07, there was a significant increase in the number of alcohol and other drug intervention services specifically for Aboriginal people, and a doubling of funding for such projects.[56] In 2006–07 few of the substance use services were specifically addressing issues of comorbidity, and a study of services in Queensland found that the staff of many services felt they did not have the expertise to do so.[75] Since 2006–07, resourcing of both Aboriginal substance use treatment and mental health received a significant boost under agreements reached by Council of Australian Governments (COAG). Up to $98.6 million has been allocated to increase drug and alcohol treatment and rehabilitation services in regional and remote Indigenous communities under two new measures announced by COAG in July 2006 and December 2007.

WHAT NEEDS TO BE DONE?

As we have discussed, harmful alcohol and other drug use plays a significant role in the disruption of Aboriginal people's lives. Having also established that harmful substance use often co-occurs with mental health disorders and problems of emotional and social wellbeing, it is important to plan appropriate treatment and rehabilitation services to complement broader interventions. Generally, intervention requires a multi-systemic approach; however, this is not always utilised. While it appears that much is being done, epidemiological evidence indicates that, in many respects, things are getting worse, not better.

Cultural Security

Cultural competence is addressed in considerable detail in Chapter 12 (Walker and colleagues), but it is worth reiterating here that a fundamental principle when working with Aboriginal people is to ensure that engagement is maintained in a culturally secure manner.[76] The term 'culturally secure' describes a guiding principle that ensures respect for cultural difference. Cultural security is central in the development of programs, services, policies and strategies. Aboriginal leadership, community consultation and involvement form an essential part of this process. In our efforts to reduce alcohol and other drug-related harm, a culturally secure approach is imperative.

The development and delivery of culturally secure alcohol and other drug programs should be based on recognition of the following principles:

- a holistic concept of health and wellbeing grounded in an Aboriginal understanding of the historical factors that have influenced alcohol and other drug-related harm;

- culture as a central core component;
- reinforcement of Aboriginal family systems of care, support and responsibility; and
- Aboriginal ownership and control.

There also needs to be recognition of the diversity within and between Aboriginal Australian communities in remote, regional and urban areas.

Practical Approaches

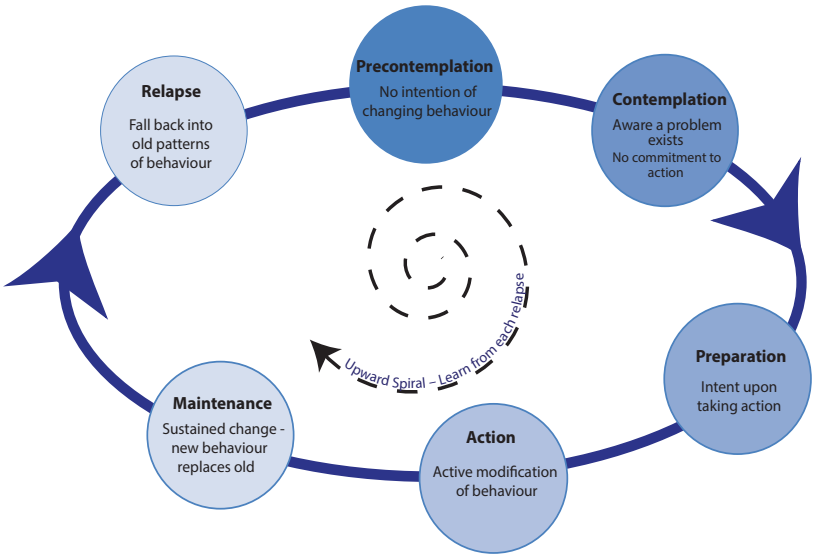
As acknowledged, many people report not having the expertise to deal with both substance use issues and mental illness, and Aboriginal and Torres Strait Islander peoples often have limited access to culturally specific and secure services. Recognising the stage of change and using motivational interviewing concepts can be useful in addressing both mental illness and substance use issues.

Stages of Change Model

Working with clients with a mental illness and who are harmfully using substances can be challenging. A useful approach when intervening in such complex situations is to consider what the client is ready to do to help themselves. Prochaska and Diclemente developed a Stages of Change model.[77] It considers how people respond to different interventions, based on their readiness to change. These stages are known as: Precontemplation, Contemplation, Preparation, Action and Maintenance.

This approach acknowledges that relapse is 'normal', and that people often may go through the five stages several times before making lasting change. Different people will be at different stages of insight and readiness to change with respect to both substance use and management of their mental illness. Those with mental illness may go through similar stages with respect to recognising any mental health problem or need for medication or counselling. The stages of change are represented in this diagram below:

Figure 8.1: Stages of Change Model



Source: Prochaska and Diclemente[77]

Precontemplation: Individuals do not feel that there are any problems with their use.

Contemplation: Individuals recognise that there may be some problems, but are not sure that they are ready or able to make the necessary changes. At this stage being too confrontational or directive will usually increase their resistance to any change. A brief intervention can be helpful.

Preparation: Individuals are preparing to make a change or are already taking action. They recognise a need to change.

Action: Individuals are doing something. They might need help with completing a plan and support to stick to their plan, perhaps with appropriate referrals to support groups etc.

Maintenance: Individuals are continuing the positive lifestyle changes needed to keep going.[77]

These stages, and recognition of them, allows for the use of different interventions. Table 8.5 lists different strategies for each of the stages. For example, running a support group that mixes people taking action with precontemplators may not help either group. The stages also acknowledge progress that may otherwise be difficult to recognise. An awareness of these stages and appropriate targeted interventions can: reduce conflict with patients, set realistic expectations, and reduce burnout for workers.[77]

Table 8.5: Stages and Differentiations

Stage	*Instructional Strategies*
Precontemplation No intention of taking action in the next 6 months	Engage the individual with information about need for change
	Provide personalised information about risks if no change and benefits of change
Contemplation Intends to take action in the next 6 months	Motivate and encourage the individual to set goals and make specific plans
Preparation Intends to take action in the next month and has taken some steps to change behaviour	Help the individual create and implement specific action plans and set realistic goals
Action Has changed behaviour for less than 6 months	Provide problem-based (action-oriented) learning experiences
	Provide social support, feedback
Maintenance Has changed behaviour for more than 6 months	Continue to provide social support, assist with problem solving, positively address slips and relapses if necessary
	Employ reminder systems/performance support tools

Motivational Interviewing

Motivational interviewing (MI) is a useful tool to help move people through different stages. It has been defined as 'a person-centred counselling style for addressing the common problem of ambivalence about change … by eliciting and exploring the person's own reasons for change'.[78 (p410)] MI can be difficult to master but an understanding of the key concepts can still be helpful. The aim is to get the person to express his or her thoughts about their issue (drug use and/or mental illness) and its effects, ultimately saying how their issue is a problem, expressing willingness to change. Techniques include: using open-ended questions, listening and reflecting their own responses, affirming the positive and negative points raised and summarising. This approach is characterised by the following five principles:

1. ***Express empathy:*** try to understand their point of view. A good start is to ask 'What are the good things about using?' and also 'What are the not so good things about using?' Very often health workers underestimate the 'benefits' of substance use. This approach can build some rapport and get a real understanding of what is motivating someone to continue using. These points are summarised in Table 8.6.

Table 8.6: Advantages and Disadvantages of Using Drugs and Not Using Drugs

	Using Drugs	*Not Using Drugs*
Advantages	Feels good	Better relationships
	Helps with socialising	Not depressed
Disadvantages	Problems at home	Loss of drug-using friends
	Legal problems	Nothing to do
		Cravings

2. ***Deploy Discrepancy:*** While summarising what has been said, helps to show where there might be areas that conflict. Help them to recognise that substance use is not all good. Clough[79] has reported some of the 'advantages' and 'disadvantages' of cannabis use in Aboriginal and Torres Strait Islander populations in Northern Australia, as well as reasons people want to give up, including health, family, work.[80]

3/4. ***Avoid Argumentation and Roll with Resistance:*** Arguing with people about what to do often does not improve engagement or assist clients in hearing what you are trying to say to them. An understanding of harm minimisation principles helps.

5. ***Support Self-Efficacy:*** Linked to eliciting self-motivational statements supporting self-efficacy, also includes recognising that only they are able to control their substance use. Even in gaol, substances are obtained and used. There is still a role for harm minimisation strategies and monitoring, counting pills, and minimising access to drug use.

The Stages of Change model and MI are useful for comorbid disorders; for example when assessing and motivating someone to take medication, they may perceive some advantage to not taking medication. These approaches are inclusive of an individual's beliefs and culture. For example MI-based resources developed by Menzies School of Health Research's Australian Integrated Mental Health Initiative (AIMhi) in the NT are useful for engaging Aboriginal and Torres Strait Islander peoples .[81] AIMhi uses tools specifically developed to apply MI principles in an Aboriginal Australian context.

Brief Interviews (BI)

Although there can be some difficulties in delivery, even brief interventions can be culturally appropriate[82] and have a significant impact.[83] To not attempt a BI may be seen as condoning behaviour.[84]

The 5A's strategy is used as a brief intervention guideline for smoking cessation that is broad enough to be applied in multiple contexts.

1. ***Ask*** – many patients who present to mental health services are not asked about their substance use, and conversely patients presenting to drug and alcohol services do not have their mental health assessed. If everyone is asked the same questions then it normalises the enquiry reducing clients' defensiveness.

2. ***Assess*** – any concerns need to be assessed. The potential harms need to be assessed carefully, as do the client's readiness for change.

3. ***Advice*** – should be given, tailored to their 'stage of change'. Motivational interviewing techniques can be used to guide the patient to 'advise themselves'.[85]

4. ***Assist*** – clients with the process, extra information and support.

5. ***Arrange*** – a follow up review or referral to appropriate services. Many people with mental health and substance use problems 'slip through the cracks', hence the No Wrong Door policy.[86, 87]

Practice to Enhance Treatment Outcomes

Social Learning Theory[88] also provides a culturally secure framework for understanding hazardous and harmful alcohol and other drug use. It acknowledges that people learn to use alcohol and other drugs within their social environments. Expansion of support programs that assist Aboriginal families to break the cycle of harm is essential for intergenerational change.

In the development of any intervention strategies, recognition of the historical, socioeconomic and political factors must be considered. Harmful alcohol and other drug use cannot be seen in isolation from other factors because there is always a multiplicity of causes.[89] In the RCIADIC report, Pat Dodson clearly articulated the principle that alcohol and other drug problems:

> *must be approached on a community basis and not with an individual disease ideology in mind … and … need[s] to be linked to a broader approach which deals with the structural determinants.*[39(p738)]

Australian governments do have programs in place to address underlying structural factors such as poor housing and educational outcomes and high unemployment, and over past decades some improvements have been made. Under the *Closing the Gap* initiative $4.6 billion is provided to address these gaps. The Australian government is working in partnership with Aboriginal and Torres Strait Peoples, state and territory governments, business, and community organisations to improve health and wellbeing outcomes. However, there is a need for significantly increased levels of investment in such programs otherwise, at present levels, the gaps between Aboriginal and non-Aboriginal Australians are likely to continue.[90]

The evidence indicates that individuals and families who seek treatment and support for substance use problems are more likely to succeed if change can be seen as worthwhile. Saunders and Allsop[91, 92] highlight the important role that factors such as improved housing and employment play in sustaining post-change lifestyles. They further state that changing behaviour in an environment of limited support and high temptation is challenging.

Improved Linkages Across Services and Local Partnerships

Although integrated treatment programs are ideal, given the often complex problems with which Aboriginal people regularly present, the need for streamlined clinical referral pathways to other specialist services is essential. Models of shared care and case management support a comprehensive and holistic approach to assist Aboriginal people and their families. Concurrent treatment programs need to be coordinated well so that people do not 'fall between the cracks.' Swan and Raphael[28] and Teesson and Proudfoot[24] clearly identify the need for programs to provide both improved identification and service delivery in the assessment, treatment and management of people with comorbid disorders within mental health services, alcohol and other drug services, and by general practitioners and other health care providers; and further program collaboration and inter-agency approach in the shared case management of clients with comorbid disorders.

An example of a working collaboration is that between Milliya Rumurra Aboriginal Corporation (residential alcohol and other drug treatment service) and Kimberley Mental Health Services. A formal agreement outlines each agency's roles and responsibilities in terms of clinical referral pathways, information exchange, and shared management of clients with comorbid presentations. This process was negotiated between the two services and is a demonstration of how working together can enhance treatment outcomes for clients. The development of formal inter-agency linkages is an extremely effective way to support clients and enhance service delivery.

Workforce Development Strategies and Partnerships

Workforce development for the Aboriginal alcohol and other drug sector and mental health continues to be an area that is under-resourced and there is a need to provide support and training for the existing workforce.[56] Gray et al state:

> *Several evaluations of substance misuse intervention programs have reported that program staff believe they have insufficient training and skills to adequately address substance misuse problems at either the individual or community level.*[93(p24)]

Some of the additional complexities relating to an Aboriginal Mental Health Workforce are noted on the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Position Statement on Aboriginal and Torres Strait Mental Health Workers.[94]

Workforce development was a key result area of the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009*. The Complementary Action Plan clearly articulated the need for '[w]orkforce initiatives to enhance the capacity of Aboriginal and Torres Strait Islander community-controlled and mainstream organisations to provide quality services'.[54(p7)] In keeping with national strategic directions to address the issue of workforce development, the Indigenous National Alcohol and Other Drug Workforce Development Program was funded by the Australian Government from 2005 to 2012. Led by the Western Australian Drug and Alcohol Office, the program established partnerships with registered training organisations in each state and territory (with the exclusion of Tasmania) to deliver the Indigenous National Alcohol and Other Drug Worker Training Program, Certificate III in Community Services Work. The resources for this program were customised to reflect culturally secure evidence-based approaches for working with alcohol and other drug problems in the Aboriginal community. The program targeted existing Aboriginal workers within the alcohol and other drugs sector; 209 people were awarded a nationally recognised qualification. Consolidating partnerships across jurisdictions to develop and sustain a competent and skilled workforce enhances service delivery and improves treatment outcomes.

Workforce development measures must include a greater understanding of the comorbidity of substance use and mental health. A skilled workforce is the key to assisting Aboriginal community action and capacity-building processes that can facilitate addressing contemporary needs and sustaining intergenerational change.

CONCLUSION

The poor mental health of many Aboriginal Australians is associated with harmful use of alcohol and other drugs. Aboriginal people's use of alcohol, tobacco and other drugs is much higher than among the general population (within which some significant reductions in use have occurred, as in the case of smoking). The comorbidity of mental health and harmful substance use among Aboriginal people needs to be contextualised by the legacy of colonisation, racism and marginalisation from dominant social institutions. International and Australian research clearly demonstrates that health in general, mental health and harmful substance use are affected by social and structural factors such as housing, education, employment, income, transport and access to supportive social networks. Until Aboriginal people are generally equal in terms of social indicators such as adequate housing, literacy levels, employment and income, the prevalence of harmful substance use and mental health problems among them is unlikely to decline.

Despite the structural impediments, through community-controlled organisations, Aboriginal people are themselves doing much to address harmful substance use by Aboriginal people. The *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009*, provides a framework for reducing the demand for psychoactive substances, the

supply of them and the harms caused by them. It is clear from these endeavours that Aboriginal people themselves acknowledge the importance of tackling harmful substance use if health and wellbeing is to improve.

Despite current efforts, much still needs to be done both for the Aboriginal community-controlled sector and in mainstream service delivery to Aboriginal Australians. Services, wherever they are provided, need to be culturally secure, incorporating holistic concepts of health and wellbeing, with culture at the core, and respecting Aboriginal families and community notions of ownership and control. All services also need to be evidence-based to improve outcomes and to acknowledge the link between better outcomes and the structural determinants of health. Models of shared care and case management are integral to holistic and comprehensive service delivery and these, in turn, are dependent on a competent and effective workforce that is capable of working collaboratively with communities to address the challenges of Aboriginal mental health.

REFLECTIVE EXERCISES

1. Looking at the data presented in this chapter, what are the substance use rates of alcohol and drugs for the Aboriginal and Torres Strait Islander population compared to the wider population? Discuss what you think are the contributing factors of these outcomes.
2. What forms of approaches are in place to address harmful alcohol and drug use?
3. One of the key issues in addressing harmful alcohol and drug use is workforce development. How can this help?

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