Preventing alcohol-related harm in Aboriginal and Torres Strait Islander communities

The experience of an Aboriginal Community Controlled Health Service in Central Australia

CPD

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Background
Alcohol-related harm is a significant health and social issue for Aboriginal and Torres Strait Islander communities. Primary healthcare can play a part in preventing these harms.

Objectives
The aim of this paper is to describe three domains for action in preventing alcohol-related harm in Aboriginal and Torres Strait Islander communities: addressing the social and economic determinants of health; supporting population-level action on alcohol availability; and providing culturally safe treatment for individual clients.

Discussion
General practice has a role in treating and preventing illness both on an individual and at a population level. In preventing alcohol-related harm in Aboriginal and Torres Strait Islander communities, this dual role may include screening and brief interventions; referral pathways and access to multidisciplinary care; cultural safety; support for action on alcohol availability; advocacy on the social and economic determinants of health; reorienting general practice towards population health; and support for Aboriginal Community Controlled Health Services.

HARMFUL USE OF ALCOHOL is associated with a wide range of physical, mental and social problems.[1] While alcohol consumption rates in Australia are falling, they remain significantly higher than in comparable countries; Australia loses over $14.35 billion annually in associated costs to the justice and health systems and as a result of lost productivity and traffic accidents.[2] It is within this national context that the harmful use of alcohol in Aboriginal and Torres Strait Islander communities should be placed.

Despite the determined efforts of Aboriginal and Torres Strait Islander individuals, families, communities and organisations that have resulted in some local successes, alcohol continues to contribute significantly to the total burden of disease and injury. It also significantly undermines progress on social and economic issues, including education, employment and community safety.[3]

Although patterns of drinking vary from place to place, high-risk (binge) drinking rates are similar in remote and urban areas where most (57%) Aboriginal and Torres Strait Islander people live.[1]

Primary healthcare – whether delivered through private general practice, government-run services or Aboriginal Community Controlled Health Services (ACCHSs) – can play a part in preventing alcohol-related harm.

This article outlines the approach to preventing alcohol-related harm developed by Central Australian Aboriginal Congress (Congress), a large ACCHS based in the Northern Territory.

Since the 1970s, Congress has developed a comprehensive model of primary healthcare that delivers evidence-informed services on a foundation of cultural responsiveness. Congress provides primary healthcare services to 15,000 individuals across the region, including Alice Springs and six remote Aboriginal communities. Congress has been active for many years in treating alcohol-related problems and advocating for evidence-based policy approaches.

Congress seeks to act across three domains to prevent alcohol-related harm: first, by advocacy on the social and economic determinants of health; second, through building alliances to drive population-level action aimed at reducing the supply of alcohol; and third, through the provision of culturally responsive treatment and support for individual Aboriginal and Torres Strait Islander clients with alcohol-related issues.

Addressing the social and economic determinants of harmful alcohol use

Inequities in the social and economic determinants of health are associated with increased levels of alcohol consumption and harm.[4] Consequently, addressing disadvantage in Aboriginal and Torres Strait Islander peoples underpins Congress's approach to preventing the harmful use of alcohol, including, especially, advocacy on the following.

- Poverty and inequity: Alcohol-related harm is closely related to economic

disadvantage.[5] While national data show that Aboriginal and Torres Strait Islander incomes are gradually increasing and the gap to non-Indigenous incomes is very slowly narrowing, Aboriginal and Torres Strait Islander peoples continue to have significantly lower incomes than non-Indigenous Australians. In very remote areas, Aboriginal and Torres Strait Islander incomes are falling, and the income gap is rapidly widening.[6]

- Poor housing and overcrowding: Overcrowded, poor-quality, poorly maintained and insecure housing is common for Aboriginal and Torres Strait Islander peoples – two in five (41%) live in overcrowded dwellings in remote areas, and while the rates in urban areas are lower (15%), housing remains a significant health and wellbeing challenge.[1] Children growing up in overcrowded living conditions have poorer psychosocial outcomes and decreased school attendance,[7] which are associated with higher rates of alcohol use later in life. Insecure or overcrowded housing is also associated with stress, depression, anxiety and suicide,[8] which again are associated with increased risk of harmful levels of alcohol consumption.
- Early childhood development: The experience of the child in utero, through birth and into the first few years of life creates the foundation for a healthy life. Adverse childhood experiences are strongly associated with social and economic disadvantage, poor mental and physical health later in life, and an increased risk of addiction and harmful use of alcohol.[9]
- Racism and the 'control factor': There is a strong association between the experience of racism, poor mental health and alcohol misuse. Aboriginal and Torres Strait Islander peoples experience high levels of racism on an individual basis,[10] as well as face institutional racism as a barrier to accessing the services they need.[11] Further, the experience of low levels of control over life events leads to chronic stress, which undermines physical and mental health and is associated with higher levels of alcohol consumption.[12]

Population-level approaches to the prevention of alcohol-related harm

Population-level approaches are the most practical and cost-effective way to prevent alcohol-related harm.[13] Such approaches are not directed at Aboriginal and Torres Strait Islander peoples alone, but instead focus on managing the supply of alcohol for the whole population.

The two main approaches that have shown success in Aboriginal and Torres Strait Islander Australia and elsewhere are reducing both economic availability and physical availability of alcohol. Congress has been active at local, territory and national levels in forming alliances with other organisations and community groups in advocating for the adoption of such evidence-informed approaches.

Reducing economic availability

The most highly cost-effective public policy intervention for reducing alcohol consumption and consequently alcohol-related harm is through increases in the price of alcohol, with a minimum unit price (MUP or floor price) being the most promising of several models. By setting a minimum price per unit of pure alcohol and ensuring that no retailer can sell alcohol below this price, an MUP effectively increases the price of the cheapest alcohol, which is associated with the greatest harms among heavy drinkers and young people.[4]

International studies confirming the effectiveness of this approach[13] are supported by evidence from Aboriginal and Torres Strait Islander communities. For example, in 2006, following lobbying by community groups including Congress, the sale of wine and fortified wine in large containers was banned in Alice Springs, in effect increasing the minimum price of alcohol from 25 cents to 50 cents per standard drink. This led to a fall in alcohol consumption from around 25 to 20 standard drinks per person per week, and significant reductions in hospital admissions, emergency department presentations and anti-social behaviour. The effect on stabilising what had been a rapidly rising number of alcohol-driven assaults on Aboriginal and Torres Strait Islander women was particularly noteworthy.[14]

Reducing physical availability

Restrictions on the physical availability of alcohol, especially through reduced trading hours and licence density, are also known to reduce alcohol-related harm.[13]

Restrictions on trading hours have been applied in numerous settings in Australia – including in remote communities in Western Australia, the Northern Territory and South Australia, as well as in urban areas (eg the so-called 'lockout laws' in Sydney) – and are effective in reducing the amount of alcohol-related violence and other harms.[1,3]

Some Aboriginal and Torres Strait Islander communities have taken action to declare themselves 'dry', prohibiting the consumption of alcohol within their boundaries, which has also shown some effect in reducing alcohol-related harm.[15]

Improved government regulation of licensed clubs in remote Aboriginal and Torres Strait Islander communities also provides good evidence that restrictions on trading hours (along with bans on certain types of alcohol and take-away, but **not** income management) can significantly reduce consumption.[16]

Reducing the number and types of liquor outlets is also an effective approach, as the number of licensed premises in a given area is positively associated with harms through violence, accidents, child neglect and chronic disease.[17]

Effective, culturally safe treatment and support

Aboriginal and Torres Strait Islander people who drink alcohol at harmful levels are likely to do so in a context of marked social and economic disadvantage.[3] They are also likely to have co-occurring mental health issues and complex medical conditions, particularly chronic diseases. These overlapping comorbidities frequently have a common origin in prenatal and early childhood disadvantage and present significant challenges to effective treatment.[18] Integrated multidisciplinary approaches

have been developed to better meet the needs of such clients and have been shown to improve outcomes.[19]

Congress has developed an integrated multidisciplinary non-residential treatment model for Aboriginal and Torres Strait Islander clients with alcohol issues. It is based on three streams of care: social and cultural support; psychological therapy; and medical treatment (Table 1).

This model was developed in response to the complex holistic needs of Aboriginal and Torres Strait Islander clients with alcohol problems, and began with an evidence review of multidisciplinary care coordination in the management of substance abuse and mental health issues in primary healthcare settings.[18]

An evaluation of the model found that over half (55%) of clients decreased their drinking, with those who engaged over a longer period showing the greatest improvements.[20]

Key to the success of Congress's model, as for any treatment model for Aboriginal and Torres Strait Islander clients, has been the provision of culturally responsive services, including an evidence-informed approach adapted to meet local community needs, the employment of significant numbers of Aboriginal and Torres Strait Islander staff, and structures of Aboriginal and Torres Strait Islander community control.[3]

Key points

ACCHSs such as Congress operate under the direction of an Aboriginal and Torres Strait Islander Board with a mix of grant funding and self-generated Medicare Benefits Schedule income. As not-for-profit bodies employing salaried staff across a comprehensive range of services, they provide an ideal platform for preventing alcohol-related harm.

However, general practice can also play a part not just in treating and preventing illness in individual clients, but also in advocating for, and supporting, population-level approaches.[21,22] In relation to preventing alcohol-related harm in Aboriginal and Torres Strait Islander communities, some or all of the following actions may be relevant, depending on the service and community context.

Addressing the social and economic determinants of harmful alcohol use

Advocacy on the social and economic determinants of health

General practitioners (GPs) can advocate individually or through their representative and professional bodies for action to address the determinants of harmful alcohol use, including poverty and inequality, poor housing and poor early childhood experiences. This could include advocacy to address issues of control at an individual level (client empowerment), organisational level (by supporting and working with Aboriginal and Torres Strait Islander organisations), and at a state or national level (eg by supporting Aboriginal and Torres Strait Islander calls for treaties or representative bodies).[3,23,24]

Population-level approaches to the prevention of alcohol-related harm

Support for community action on alcohol availability

The trusted position that GPs occupy means that they are well placed to speak at community forums, engage in debate in the media and write letters to, or meet with, policymakers;[21,22,25] examples include the public advocacy of a Perth Primary Health Network[26] and the People's Alcohol Action Coalition in Central Australia.[27]

Reorienting general practice towards population health approaches

While general practice can incorporate many public health principles into existing practice, the current system of incentives is largely based on the treatment of individual clients. Reorienting general practice to support population-level prevention, including of alcohol-related harm in Aboriginal and Torres Strait Islander communities, will require a shift in remuneration by government.[22-24] The Health Care Homes trials with needs-based capitation funding are an opportunity to enable general practice to be more active in population-level work.

Effective, culturally safe treatment and support

Screening and brief interventions for individual clients

Aboriginal and Torres Strait Islander clients should be sensitively asked, either opportunistically or as part of regular health checks, about their alcohol use. A screening tool such as the Alcohol Use Disorders Identification Test should be used to assess drinking. Brief interventions should be offered as the first line of treatment.[21,25]

Table 1. Summary of the Congress model of three streams of care

Stream	Provided by	Support provided
Social and cultural support	• Aboriginal care management workers • Aboriginal cultural integration practice advisors • Social workers	• Client advocacy • Cultural support • Social support • Access to medical care • Alcohol and other drugs counselling, brief interventions • Case management
Psychological therapy	• Psychologists • Mental health accredited social workers	• Cognitive behaviour therapy and related therapies including motivational interviewing, schema therapy, mindfulness therapies • Brief interventions • Neuropsychological assessment
Medical treatment	• Salaried general practitioners	• Screening for alcohol use • Brief interventions • Chronic disease management • Pharmacotherapies

Referral pathways and access to multidisciplinary care

Given the likely complex needs of Aboriginal and Torres Strait Islander clients with alcohol issues, access to culturally safe multidisciplinary care is a high priority. Developing close working relationships and referral pathways with psychological and social support services is therefore important. In particular, this could include relationships with Aboriginal and Torres Strait Islander organisations such as ACCHSs and residential treatment services.[3,21,23] It is also important that disadvantaged clients can access bulk-billing clinical psychologists, as gap fees can be prohibitive.

Cultural safety

Providing culturally safe, trauma-informed care to address the barriers to care faced by Aboriginal and Torres Strait Islander peoples is foundational, and can include employment of Aboriginal and Torres Strait Islander staff, provision of cultural awareness training for non-Indigenous staff, and collaboration with Aboriginal and Torres Strait Islander organisations.[28]

Support for ACCHSs

ACCHSs have been established by Aboriginal and Torres Strait Islander communities to address health inequity through the provision of culturally safe primary healthcare services, and to be the voice of their communities on health matters. Other service providers could support the role of existing ACCHSs and, where necessary, contribute to efforts to establish or extend ACCHSs to reach unserviced areas.

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