

ANCD Report

Cape York Indigenous Issues

Introduction:

This report is based upon a recent visit to the Cape York region by members of the Australian National Council on Drugs (ANCD), and has been prepared partly in response to the recently conducted Cape York Justice Study Report, which was released by Justice Fitzgerald on behalf of the Queensland State Government late last year.

Given that the ANCD visit was undertaken independently of the study by Justice Fitzgerald, this report is not specifically tailored to respond to the issues provided in the Cape York Justice Study Report. Rather, this document provides an opportunity for the collective experience of ANCD members in alcohol, drug and Indigenous issues to be brought forward such that they may be used to assist the Queensland Government, and others, in their consideration of the issues facing this Region and indeed many other communities.

The ANCD wishes to acknowledge the assistance of the ATSIC Regional Council Chair, Mr Robbie Salee, the ATSIC Regional Council and the Apunipima Cape York Health Council, all of whom supported the ANCD's visit to the region in September 2001.

'Cape York - The Land'

Travelling in this land, talking to members of local communities, watching, listening and smelling the bush, as well as observing references to the land and the 'belonging' elements in every sheet of butcher's paper during a community planning meeting in Wujul Wujul, leaves one with a strong understanding of the symbolic, political, economic and human relevance of the land to Indigenous Australians. This brief report is a reminder that sorting out issues to do with land and reconciliation are a vital part of responding to alcohol and drug issues if we are to properly understand and appropriately construct a framework of cooperation.

Prof. Margaret Hamilton – ANCD Executive

Part One - Background:

Prior to embarking on a description and analysis of the many issues facing the Cape York Region it is important to present some contextual information regarding the nature and dimensions of drug and alcohol use amongst Indigenous Australians, as well as the availability of specific drug and alcohol services.

Even at this early stage of the report the ANCD would like to highlight the paucity of published data on current rates of drug and alcohol usage amongst Indigenous Australians. Nonetheless the following information is presented.

Alcohol

There is a range of issues to consider in regard to alcohol use amongst Aboriginal and Torres Strait Islander (ATSI) communities. Firstly, it is important to note that despite the public perception of high rates of alcohol use in ATSI communities the actual level of ATSI drug and alcohol use is often comparable or below the levels in the non-Indigenous community (see table below). This public misperception of high alcohol use is created by the disproportionate level of harm caused (to the individual and community) by those drinking at very high levels in public.

Summary of Drug Use by Indigenous and Non-Indigenous Australians Aged 14 Years and Over.

Substance	Never Used		Ever Used		Used in the past 12 months	
	Indigenous	Non Indigenous	Indigenous	Non Indigenous	Indigenous	Non Indigenous
Alcohol	6	4	94	96	81	84
Tobacco/Cigarettes	24	23	77	77	50	25
Marijuana	45	59	55	41	22	19
Any Illicit Drug	42	54	59	46	23	23
Any Illicit Drug other than Marijuana	74	75	26	25	10	11

Source: National Drug Strategy Household Survey 1998

Despite a greater level of abstinence amongst ATSI people, there are clearly higher levels of risks for those who do consume alcohol:

Alcohol Risk Level in Indigenous People and Non-Indigenous People Aged 18 Years and Over.

Alcohol Risk Level	Indigenous Australians	Non-Indigenous Australians
Low	34	47
Medium	7	5
High	8	3
Did not consume	51	45

Source: Australian Bureau of Statistics (Cat No. 4806.0) 1999

As illustrated by the above table the incidence and effects of high alcohol misuse in Indigenous communities is of considerable concern. ATSI peoples were identified under the National Alcohol Strategy as a group who are at higher risk of harm as a result of their own or others' patterns of alcohol consumption (Ministerial Council on Drug Strategy, July 2001). Partially attributable to its impact on the Indigenous family unit and sense of community, alcohol and other drug use is contributing to an over-representation of Indigenous people in our prisons, and poorer health standards when compared to non-Indigenous populations.

Tobacco

In contrast to alcohol use, the prevalence of tobacco use amongst Indigenous people is much higher than amongst non-Indigenous people. Nationally, approximately 54% of Indigenous people smoke, compared with 22% of non-Indigenous Australians.

- In some regions, up to 83% of Indigenous men and up to 73% of Indigenous women use tobacco.
- The prevalence of tobacco use by Indigenous people is also higher than for other ethnic groups within Australia, as well as being higher than Indigenous populations elsewhere, where data is available.
- Indigenous smokers use about the same amount of tobacco as smokers in the general population.
- Some Indigenous people chew tobacco.
- As with the general population, Indigenous people are more likely to smoke if they have a low level of education or are unemployed.
- Indigenous people are exposed to environmental smoke (passive smoke).

The high prevalence and incidence of tobacco smoking amongst ATSI people and the failure to achieve any real reductions in these smoking rates despite significant decreases in the general community, is a significant health concern. This concern is further highlighted by recent research suggesting there are links between parental tobacco smoking and subsequent drug use by their children. This emphasises the need for appropriate and targeted interventions to reduce its use in the Indigenous population.

Indigenous Australians and Tobacco: A literature review, Rowena Ivers 2001

Cannabis

There is little national data available on drug use amongst ATSI people. Based on the 1998 National Drug Strategy Household survey, illicit drug use is more widespread among the ATSI urban community than in the general population, though the low number of ATSI people interviewed needs to be acknowledged. Nonetheless it is reported that 50% have tried an illicit drug compared with 38% in the general community. 24% are current users compared with 15% in the general population with marijuana being the most popular illicit drug.

The ANCD has received an increasing level of anecdotal and other evidence to suggest that the use of cannabis, particularly amongst young ATSI people, is becoming more prevalent. Obviously the use of any drugs by young people can have a negative impact on their development. The advice received by the ANCD, that there is a general belief amongst young people that cannabis is harmless, is a further cause for concern.

Heroin

Again there is increasing anecdotal evidence (particularly from drug and alcohol workers) of increasing use of heroin amongst young ATSI people. This appears to have begun to cause some deep generational divisions within the community. The increased use of heroin is also leading to an increased risk of a number of diseases such as HIV and hepatitis for this group.

Recent research by the National Drug Research Institute (NDRI) estimates that between 3% and 4% of Aboriginal people aged 15 years or more, and who live in towns or cities, have injected drugs in the past year. This contrasts to approximately 0.7 % of all Australians (1998 National Drug Strategy Household Survey, Australian Institute of Health and Welfare)

The NDRI research also indicated that while Indigenous injectors appeared concerned about the social impact of their use on their immediate and extended families, there was a worrying lack of awareness about the potential health risks involved in injecting drug use. The lack of awareness of the potential health risks associated with injecting, coupled with the difficulty of obtaining clean needles quickly and cheaply in some areas, has led to an increase in the sharing of injecting equipment with all the associated health problems.

(National Drug Research Institute Media Release 6 March 2002)

Petrol Sniffing

The following information provided has been sourced from 'Petrol Sniffing in Aboriginal Communities: A Review of Interventions, (Peter d'Abbs & Sarah MaClean). All references made in the following section can be found in the aforementioned book.

In general terms petrol sniffing is marked by a majority of male participants, although this appears to be changing slowly. The age of sniffers is also changing. In the 1980's and early 1990's most people started sniffing around the 10-14 year age range, and this group had the highest prevalence rates. This is now changing as sniffers who started in these years grow older, and in many areas there are fewer new recruits in the 10-14 year age bracket.

Estimates of numbers of petrol sniffers are notoriously imprecise and often conflict with one another. This is partly because in some communities sniffing is a semi-clandestine activity carried out at night and also because in most communities where it occurs, its prevalence fluctuates widely even within a period of a few weeks. In some places the problem becomes quiescent for periods of time, perhaps with a small group of chronic sniffers maintaining their habitat in an almost invisible way, and then it will re-emerge, often as a result of movements of young people and their families between communities.

It is interesting to note that petrol sniffing occurs in some Aboriginal communities and not others. Brady (1988), using Department of Aboriginal Affairs 'community profiles', reported petrol sniffing in 1985 as being present in 29 Aboriginal communities in the Northern Territory, and 26 communities in other Pilbara regions of Western Australia, or in the Barkly Tablelands, Northern Territory. It occurred mainly in Arnhem Land, and in Central Australia among desert Aborigines, and had also been reported in the Riverina region of New South Wales. There appears to be little available information on why petrol sniffing occurs in some communities and not others.

Because of the fluctuations in the prevalence of petrol sniffing, and variation between communities, it is extremely difficult to draw conclusions about whether it is increasing. In one central Desert community where prevalence data is available, sniffing reduced and is also less intensive, although the practice still remains entrenched (Shaw 1999).

However, some communities which had previously been free of petrol sniffing are now reporting the practice. Petrol sniffing has been reported in some communities in the Katherine region of the Northern Territory, Cape York in Queensland, south west Queensland, western New South Wales and northern Victoria (Garrow 1997, Commonwealth Department of Health and Family Services 1998, viii).

Overall it appears that since 1994 there has been a reduction in intensity of sniffing in some of the areas where it had been prevalent for a long time, particularly in Central Australia, although some communities still experience high levels. This has occurred alongside a spread of Aboriginal volatile substance misuse to new localities in Australia, presenting a new and frightening problem for families and workers in these communities. There also appears to have been an increase in prevalence within some urban communities.

Petrol Sniffing in Aboriginal Communities: A Review of Interventions, Peter d'Abbs & Sarah MacLean

AOD Services Issues

Based on a number of rural and regional consultation forums conducted by the ANCD, as well as direct contact between communities and members of the ANCD, the following issues are raised for consideration:

- The lack of culturally specific drug and alcohol services for Indigenous people;
- The lack of Indigenous drug and alcohol workers (this is also a problem in the general health sector);
- The need for the proper evaluation of Indigenous drug and alcohol programs, particularly in regard to ongoing funding decisions; and
- The need for greater consultation with, and involvement of, local communities on the development and implementation of drug and alcohol programs.

Indeed, in a soon to be released report commissioned by the ANCD the levels of available specific AOD services for Indigenous people are reported as such:

Alcohol and Other Drug Intervention Projects for Indigenous Australians by Project Type by ATSI Region and State/Territory 1999-2000

Region and State/Territory	Multi-Service	Treatment	Resid. Treatment	Prevention	Acute	Other	Total
Peninsula (Cape York)				1	1		2
Cairns and District		3	3		1		7
Gulf and West Qld			1		2		3
Townsville			2	1			3
Central Qld		1	2	1	1		5
South East Qld	1		1	1	2	4	9
Goolburri			1	1	1		3
Queensland	1	4	10	4	9	4	32

*Source: ANCD Report - Intervention projects for Indigenous Australians, 1999-2000
Denis Gray; Brooke Sputore; Anna Stearne; Deidre Bourbon; Phillipa Stempel*

Estimated Resident Population, Index of Access/Remoteness, and Total and Per Capita Expenditure on Alcohol and Other Drug Intervention Projects for Indigenous Australians by ATSI Region, 1999 - 2000

Region	Estimated resident population	Access/remoteness index of Aust	Total Expenditure \$	Per capita Expenditure \$
Peninsula	12,838	5	50,000	3.89
Cairns and District	16,144	3	2,033,636	125.97
Gulf and West Qld	7,306	5	1,110,002	151.93
Townsville	16,107	3	1,102,821	68.47
Central Qld	12,436	3	992,880	79.84
South East Qld	30,325	1	1,159,782	38.25
Goolburri	9,661	3	301,196	38.25

*Source: ANCD Report - Intervention projects for Indigenous Australians, 1999-2000
Denis Gray; Brooke Sputore; Anna Stearne; Deidre Bourbon; Phillipa Stempel*

Broader Social Causes and Effects

Substance misuse has complex social, health and economic impacts on the individual, family and community. It is also widely recognised that substance misuse within communities is linked to a broad range of social and economic factors; 'Indigenous people are about two to three times more likely to be impoverished than the non-Indigenous population. The depth of disadvantage of ATSI people is described in terms of a range of welfare indicators, such as poor health, over crowded housing, high arrest rates, unemployment and lack of educational qualifications (ANCD Report No. 2 - Spooner et al 2001:20). It is no longer appropriate to look at substance misuse in isolation from the broad range of structural and other factors that influence it. Substance misuse has also been linked to gambling in Indigenous communities, particularly alcohol misuse.

Drug use can affect the social behaviour of the individual and community. Social health issues can include:

- Suicide;
- Trauma or loss;
- Family breakdown;
- Family violence;
- Child abuse or sexual abuse;
- Poor educational opportunities;
- Socio-economic depression or repression;
- Difficulty obtaining satisfying employment or financial security; and
- Discrimination.

Indigenous injury death rates were about four times the non-Indigenous rates for both males and females (AIHW: 1995). Motor vehicles accidents, fire, drowning, poisoning, violence and other causes of injuries were the second largest contributor to Indigenous mortality.

There is a need for research which directly measures many of the plausible differences in exposure to risk in Indigenous populations or how these vary from community to community.

Epidemiological data on mental health in the Indigenous community is scarce. However, the incidence of substance misuse may be an indicator of the general emotional and social well being of a community.

(Source: Review of the Commonwealth's ATSI Substance Misuse Program, December 1999)

Part Two - Lessons from Cape York

Anyone who is aware of, or affected by alcohol and other drug problems, describes alcohol addiction in Cape York as an epidemic. A massive, bewildering contagion that has invaded their communities. As a contagious plague, alcohol use and harm has been watched as it has spread through a susceptible population. In particular there is a lack of experience in managing the commercial supply of alcohol.

An Epidemic

Aboriginal leaders and elders can tell you of the cases at the onset of the epidemic (outbreak cases of epidemiology). Sporadic (sentinel) cases next marked the communities soon to be invaded and then there was an exponential take-off as alcohol harms compounded with social and health inequalities.

The elders remember when it was not like this; they grieve for what is lost; they know how it started and when; they know what fed the epidemic. Above all they know what "grog" has done and is doing to their communities. And they want to be rid of it.

Prof. Ian Webster – ANCD Member & Alcohol Education and Rehabilitation Foundation Chair

The problems with alcohol are obvious as they pervade the communities in the Cape. Alcohol has taken on many meanings in these communities, including:

1. The Right to Drink

During our visit to Cape York it became apparent that alcohol and access to alcohol stands as a symbolic indicator of equal rights for Indigenous people in these communities. There were strong statements about the association of the right to drink alcohol with the 1967 referendum and a determination among some to retain this as a right.

2. Social Practices

Alcohol use pervades many of these communities and while there are more people who are total abstainers than amongst the general Australian population, for those who do drink alcohol the tendency is to drink very heavily and frequently. While much of the drinking might be convivial and while there might be some who clearly limit their alcohol intake, it is apparent that alcohol consumption for many is a combination of stress relief, boredom, treatment of symptoms (including withdrawal) and a general social habit/practice. Whilst on our visit we saw people who were intoxicated in the late morning, early afternoon and late afternoons, this is also a phenomenon which may be observed in and around heavy drinking venues in mainstream Australia.

Nevertheless,

'Alcohol use in Cape York communities today is not under effective control either by individuals, families, or communities, or by statutory bodies such as police and liquor licensing. This is the nub of the problem that must be addressed as a matter of urgency'.

Submission to the Fitzgerald Inquiry (d'Abbs, September 2001).

Noel Pearson, whom we met during this visit, suggests that alcohol consumption is now embedded in the social structure and culture of these communities.

Data on alcohol sales information estimates per capita consumption in Cape York communities to be around 4 to 4.5 times the national average. (Martin) [35-43 litres of absolute alcohol per annum in persons over the age of 15 compared with a Queensland rate of 10.9 litres and an Australia wide rate of 9.4 litres].

The 'Well persons health check' conducted in Cape York communities jointly by Queensland Health and Apunipima Health Council in 1998 and 1999 found that 74% of males and 44% of females over 15 had consumed alcohol in the past week. In addition, 83% of these males and 84% of females had drunk at levels defined as harmful by the NH&MRC, (only 10% of males and 6% of female drinkers had consumed within responsible guidelines (d'Abbs, September 2001).

These drinking patterns are now part of the local social systems and are self-sustaining. They have implications for policymaking and service delivery:

- Individuals and families live in a day to day world of intoxication, injury, violence and ill health;
- Efforts to address social, health and other problems are undermined; and
- The system of excessive alcohol consumption is self-sustaining.

(adapted from d'Abbs 2001 and in consideration of Pearson, 2001).

Alcohol consumption is thus a central and explicit part of every day life in these communities. The negative consequences of it are also part of everyday life. The consequences that we heard about or witnessed during our visit included violence, mental illness including suicide, neglect and 'role atrophy' – especially neglect of parental and other familial roles and responsibilities. A further consequence is an increase in the risk and apparent prevalence of foetal alcohol syndrome.

During our visit we were struck by the extent of alcohol related injuries that are the mainstay of the health services in these communities. In Aurukun, which has a population of about 1,100 – almost wholly Aboriginal – around 90% of the work at the health centre consists of responding to accidents, injuries and illnesses arising principally from alcohol. In addition, there are significant nutritional disorders related to excessive alcohol consumption. Many of the accidents and injuries are quite serious with serious assaults being common. As a result, there is little time for health promotion initiatives or any preventative work.

The threat to these communities posed by the misuse of alcohol is far greater than the contemporary risks of infectious disease. Urgent and drastic measures are needed if the cycle of addiction is to be broken.

3. The Grog Economy

Most of the communities we visited had a canteen that sold alcohol (only beer). The only community we visited that was 'dry' (no alcohol was sold in the actual community) was Hopevale, which is only a 40 minute drive from Cook Town, where local people go to purchase their alcohol. Thus all of the communities we visited have ready access to alcohol.

We did not explore or examine either the Queensland Liquor Act or the provisions for regulation and control. There is a layer of project officers working under the Liquor Licensing Division who traditionally would have had responsibility for policing the Liquor Act. They are now involved in supporting and helping communities formulate local alcohol management plans. The role of the police in these communities and other crime prevention officers is not something we pursued. There is, however a sense in which policing in these communities is likely to reflect the perceived realities of the situation, that is, a sense of not wanting to act outside the norms and social boundaries set by the communities themselves, for example, it is unlikely that serving alcohol to intoxicated people, will be attended to or addressed. The view that the processes of justice needed strengthening and greater independence required was also expressed.

Some communities reported significant income from the sale of alcohol at the canteens. In some, one is left with the impression that this is one of the small components of discretionary income for these communities, most other resources arriving in the form of tied grants or program specific funding. In Aurukun for example, it was reported that about \$2.4m income was received from the tavern.

Sly grog is a significant issue. We were advised that in Weipa, a stubby of beer could be sold to Aboriginal people as sly grog for about \$10 and a 'slab' (24 cans/stubbies) of beer for about \$200, in comparison to about \$30 in metropolitan Australia. There appears to be an undercurrent of difficulty with policing sly grogging. It has sometimes been alleged that these communities have some powerful members/leaders who are, themselves, involved in some sly grog trade. We did not directly hear about or witness these ourselves.

We did not undertake any detailed data collection or investigation of the economics of alcohol in the Cape York Peninsula communities. However, it is important to note that understanding the function of sly grog is an important aspect of understanding the place of alcohol within communities.

Epidemic conditions

In other scourges of public health, not only is the agent attacked but also the means of transmission. The questions that must be addressed include: To whom is alcohol available? Who profits? Can supply be modulated? What are the pressures (and needs) to consume – environmental – social, cultural and economic?

The impact of the environment must not be underestimated. Antibiotics alone cannot eradicate tuberculosis (TB). It will only disappear when poverty, poor nutrition and over-crowding are eliminated. Thus, with alcohol the environment (social, cultural and economic) must be addressed, as the Fitzgerald recommendations propose. The starting point must be to look at the range of community plans, which are currently in development and foreshadowed.

Most significantly there are the people and their susceptibility, for alcohol and drug problems there are protective and risk factors for a whole community and for an individual person. These factors lie in the domains of social and mental well being. Thus childhood and youth, family and kinship connections, emotional and social well being are the substrata upon which alcohol and substance misuse problems can both germinate or be dealt with positively.

The imperative to respond immediately is absolute. The cycle of addiction in individuals and communities has to be broken. To do this the full range of factors that impact on addiction needs to be addressed.

Prof. Ian Webster – ANCD Member & Alcohol Education and Rehabilitation Foundation Chair

4. The Environment

Consideration of alcohol use in the Cape requires an understanding of the environmental conditions prevalent. These are complex. It is our understanding that there is sub-standard education, high unemployment and little entertainment. Often the biggest building in the community is the canteen. A large part of income is spent on beer, with less spent on food, clothing and other necessities. Many parents are consistently intoxicated. The most important issues affecting the young people are violence, sexual abuse and young motherhood. As a result the children in these communities undoubtedly have diminished life chances.

The Economy/Enterprises/Employment

These communities have very limited opportunities for money generating enterprises and industries. The land has historically been used for mining, broad acre farming and in some locations tourism or fishing. These are of variable sustainability. All have the potential for exploitation as well as enterprise. Industries such as tourism offer potential but may bring with them new and different problems.

Although there is considerable energy and endeavour among some communities to create jobs and develop economic enterprises, it is hard to see that this can be viable in many instances. While one can applaud the efforts of local communities to develop up ideas – in the cold hard reality of internationalised competitive markets, it is difficult to be optimistic.

Most of these communities are dependent on CDEP funding (social welfare payments) from the Federal Government. This is supplemented by grants from ATSIC along with program and purpose specific funding. In addition, the communities themselves generate funds through the operation of local stores, canteens taverns and, for some communities, access to mining royalties offers some opportunity for income.

'The Aurukun Community'

The Aurukun Community has five clan groups, it has a population of about 1100 almost wholly Aboriginal. It was founded in 1904 as a Mission by Scottish Presbyterians who relinquished their control in 1978.

The Shire has an income of about based on funds that come from the store, from the Tavern the community, from Government grants and from ATSIC. In addition, this community receives some mining royalties from the Comalco Bauxite operations of which 60% is to go to investments and 40% is available for distribution...

The canteen was started in 1987/88 and closed in 1991. There was a plebiscite in 1996-1997 in which 60% believed that alcohol should be available, it was said this was because alcohol related problems continued despite closing the canteen. Indeed there was the problem of 'sly grog' running. Everyone recognises that alcohol is a serious problem and wants it stopped.

Last year the Tavern profits were used to seal the airstrip, build a swimming pool and to re-furbish a multipurpose hall. The community also has an arts and craft centre.

There seems to be sufficient money to employ staff in key areas but they have great difficulty attracting staff. Comalco runs a bauxite mine nearby and has undertaken to employ 30% Aboriginal workers. There are at present three Aboriginal people employed by Comalco. There is also a desire to employ Aboriginal staff by the Council but there have been difficulties in facilitating the attendance of Aboriginal people.

There are no substance abuse programmes in Aurukun. There have been some preventive programmes such as '100% in Control' and youth camps for petrol sniffers.

There is a strong sense that money itself is not particularly a problem although this is all relative and clearly if these communities were to be provided with appropriate and adequate housing, food, health programs including prevention, education, transportation and roads etc. then this would probably be the case. Nonetheless, the very real issue of the provision of rewarding work and a way of structuring time in a day to day sense that is consistent with more productive activity, satisfaction and cultural support and growth is much more difficult to achieve than simply the provision of more money.

This is also linked to issues regarding rights to land and to harvest of the sea. Whilst this is a complex area and beyond the scope of the visit we appreciate that access to resources from the sea, for example, is contentious. While these communities are certainly allowed to fish – so too are commercial groups from elsewhere who travel up and down the coastline with commercial operations based elsewhere.

These communities struggle. Their economic base is poor and opportunities for enterprises are extremely limited. These people live in some of the most marginalised land in our country. If we recognise that rural and remote Australia is struggling to find a sound economic future then we must note that these communities are even more disadvantaged. The very industries that might provide income are at the same time potentially destructive of Indigenous culture. Unfortunately, it is likely to be hard to identify industries or enterprises that can be constructive, empowering and economically beneficial without some dysfunctional aspects.

Health

There are clear issues regarding health in these communities. They share the same problems as many other Indigenous communities – with lower years of life expectancy, poorer health overall and poor nutritional status. A visit to the local stores suggests that much of the food that is available is canned food or dried food. The fresh fruit and vegetables on sale in one store during our visit were old, wilted and, in one instance, rotten. There was very little discussion in these communities about growing fruit and vegetables although in some locations there were fruit trees planted. It is apparent that the nutritional value of the food consumed is a factor in the overall poor levels of health.

Issues of mental health arose frequently in discussions. Stories of depression, anxiety and suicide were common among adults and also children. Levels of specialist service are extremely limited. Most communities have a health clinic with a nurse who attends to the serious physical trauma that occurs on a daily basis. There are apparently spasmodic information and prevention 'campaigns' but little sustained strategic and timely attention to the long term prevention of major physical, social and psychological health problems.

'The Weipa Community'

We were told that there had been two suicides in Weipa; the most recent was a thirteen year old girl who hung herself from the church and before that a 30 year old male. There appears to be only one psychologist for the whole of the Cape.

Where these communities do have members appointed to important health roles, they are often lone workers or working in great isolation. They lack knowledge, skills and most importantly, the support and ongoing training and supervision, which might provide them with an opportunity to be more strategic and effective. Two workers we spoke to highlighted their isolation, burn out and the lack of mentoring, support and supervision they receive. These two workers have a very sound understanding of the issues they are tackling, of their own community and of some of the ways forward, what they lack is solid, ongoing and systematic support.

'The Hopevale Community'

Hopevale is a community without a canteen, but Cooktown is not far away so alcohol is readily available.

In discussions on programmes for young people it became evident that young people need to be given responsibilities and need to be able to develop worthwhile outlets. In regard to substance use there was a view that there was 'speed' in Hopevale (young people put this in their cola drinks), panadeine was also used in this way and there are some petrol sniffers.

Some locals held a view that the 'homelands movement' would help young people to have some productive activities, and we met an Aboriginal leader who had just returned from working on a building in one of these homelands. Camps are also run for those with troubles such as mental health issues or suicidal thoughts. The camps include both young people who are troubled along with those who are not affected by such issues. The people in these camps study the environment and go fishing this helps to facilitate more caring relationships.

There are four people in the district to whom the Mental Health Act applies and local health officers support three of these people.

It appears that suicide attempts have only become an issue in the past ten years: there have been approximately 15 suicide attempts in males and 20 attempts in females in the past 2 years.

A health officer spoke of the need for further training, particularly a need for materials to assist with education and support of people in the community. We discussed the flip charts that they had developed on smoking and others we had taken on alcohol intervention. We also learnt of the Feeling Chart that Noel Pearson had proposed, and of a similar model that was used by health officers in the community.

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The nature of the work performed by some health officers means that they are always available and on duty. This makes the need for de-briefing and supervision acute, presently it occurs only in a haphazard way at other centres or conferences. There needs to be a system put in place to effectively deal with this need.

A significant and positive impact since the introduction of life promotion officers in Hopevale has been their success in 'talking people down' when they are alcohol affected and/or violent. As a result of this the gaol has not been used for over a year now, even the locks have rusted.

Generally, staffing continuity across all services is problematic. In some instances, workers come and go regularly. In other places workers have remained for a long time and become entrenched in the local communities. This can have both positive and negative effects. Firstly, they get to know the group, they develop a very good understanding of the issues, the problems, the people, along with the strengths and weaknesses in the community. However, it is not clear if they are kept up to date with current information and supported to develop new and innovative programs.

As has been stated previously there are a number of broad issues that have a direct impact on both the health of individuals as well as communities. Many of these have been identified in the ANCD report – Structural Determinants of Youth Drug Use (Spooner et al 2001), which illustrates that macro economic policies have an impact on the uptake and subsequent problems associated with alcohol and drugs. Unemployment, development, education, transport and other government policies all impact on the social and physical environment which in turn has a direct impact on the health of these communities.

Whilst health officers in these communities are doing their best, the focus is on reacting to and responding to trauma with very little time left to spend on general health screening and early identification of problems. There is a lack of health education and promotion, with practically no work on any ongoing primary prevention.

The effects of drinking of pregnant Aboriginal Women are particularly concerning. It is extremely difficult to get accurate data regarding the diagnosis of Foetal Alcohol Syndrome (FAS). (See other reports on FAS re complexity of diagnosis and identification). However, there is a strong emerging picture of an increased prevalence of this condition among Aboriginal children in Australia. A study that was conducted in Cairns recently examined a cohort of pregnant Aboriginal women from Northern Queensland communities (N=96) and a comparison group of pregnant non-Aboriginal women attending the Cairns Base Hospital. This study found that 30.2% of the Aboriginal women reported consuming two or more standard drinks of alcohol at least five days per week during their pregnancy compared with 1% for the non-Aboriginal group. Whilst we do not have accurate information on the actual impact of this, it is clear that "alcohol use in Aboriginal women was associated with lighter birth weights and shorter babies, with smaller head circumference, abdominal

circumferences and mid arm circumferences when compared with babies of mothers who did not use alcohol. These associations were seen in the babies of non Aboriginal women but were of much lower magnitude” (Humphrey, M.D., Holzheimer, D.J. Differing influences on Aboriginal and non Aboriginal Neonatal Phenotypes: A Prospective Study. Medical Journal of Australia. 2001: 174:503-506).

While not all of these children would be diagnosed as exhibiting FAS or Foetal Alcohol Effects they clearly start life disadvantaged. The Apunipima Cape York Health Council has a worker specifically trying to address the issues of FAS who accompanied us on the trip.

Education

The education system in these communities is sub-standard. Many children only get to school intermittently. Many share problems seen in other poor communities such as hunger – with young people coming to school with no breakfast. Also, some children attending school find it difficult to stay awake, after nights spent in a home environment made chaotic by alcohol abuse. When they do attend, the nature of the school programme, the capacity of the teachers to assert discipline and the curriculum offered all appear to leave much to be desired and are not comparable to the standard expected in mainstream Australia. This leaves these young people disadvantaged for life.

These young people cannot fully participate in secondary and further education. Where they do, they are to be congratulated – this only happens with extreme effort on the part of the young person along with support from teachers, family and others in the community. The young people that succeed in this system are exceptional. Young people must leave their homes and communities to be able to access secondary school. They must leave their known land, culture, family and friends and travel to distant and unfamiliar places, where many struggle. They must also contend with the added impediment of administrative and bureaucratic arrangements.

There is a need to work with the community builders to seek ways to reconnect youth to education including the introduction of more flexible forms of education (environments and curriculum that is relevant but still streams in to main education system for future opportunities); enhanced resourcing of schools with more senior experienced teachers; increased efforts to get youth ready for school and education from birth; preparing parents for parental roles and cooperation with schools; and so on.

Education is fundamental – if education is inadequate then other aspects of life become difficult. Any effort expended toward promoting continuity of culture, enterprises and employment, let alone alcohol response programmes, will be futile without solid fundamental education incorporating sound acculturation and accompanying structures.

Efforts to Address Alcohol Problems in Cape York

There are a number of individuals, organisations and community groups who are working on a range of alcohol management action plans and other strategies at local, regional and state level.

In the Cape York Peninsula for example, there are a range of Aboriginal regional organisations. These include:

- The Peninsula Regional Council of ATSIC;
- The Cape York Land Council Aboriginal Corporation;
- Apunipima Cape York Health Council;
- Balkanu Cape York Development Corporation;
- Cape York Aboriginal Charitable Trust;
- The Cape York Corporation Pty. Ltd.; and
- The Apunipima Cape York Health Council's Grog Working Party.

These all come under, or are linked to the Cape York Partnerships which provides a whole of government approach in the Cape to the range of government programmes that impact on the communities. Each group has a separate vision statement, objectives, membership, management structure, administration and offices. There are also various Queensland and Commonwealth health, welfare, housing and transport departments that are not included in the above list.

In addition, the bodies within Australia that specifically attend to Aboriginal matters have a range of subgroups, working groups or committees that relate to these communities at various levels on alcohol and drug related matters.

This is a complex web of interlocking and overlapping organisations, allegiances and efforts. The very complexity and nature of these organisation and their relationships may itself constitute a problem; or at least pose a puzzle that requires more careful planning. Many are calling for whole of government efforts and as a result the Cape York partnerships have been developed within Queensland to address this issue. There is clearly a need for more 'upstream' planning and resource allocation – that can bring attention to some of the major structural deficits, fundamental service needs such as health and education, housing and transport as well as programme specific funding. The Cape York Partnerships Program is a potential vehicle for much of this within Queensland.

Within the National Drug Strategic Framework environment, the National Drug Strategy Reference Group on Aboriginal and Torres Strait Islander Peoples is currently responsible for overseeing the development of a parallel action plan to address tobacco, alcohol and illicit drugs. We understand Indigenous members of the Cape York community will be consulted with as a part of its development. There is some concern about the viability and levels of support and activity of this advisory committee currently. It is expected however that a parallel strategy will be developed.

Considering the various structures for governance, resource distribution and policy development, it might be important to examine the nature of leadership. There are clearly some elected bodies and there are other groups who have been appointed either by government or by community groups to act as advisors and leaders. We had the opportunity to meet with the key leaders of the Apunipima Cape York Health Council. This is a significant vehicle for Mr Noel Pearson who also chairs the Cape York Partnerships. This Health Council was formed in 1994 with a mandate to carry the health related issues to both the Cape York Land Council and ATSIC Regional Council. It includes representatives from the various Cape York communities. It is predominantly an information sharing and advocacy organisation working in collaboration and cooperation with mainstream services. Their own role statement says “our role is to identify deficiencies in services and activities influencing health, and to push for solutions”.

The precise ‘place’ of this Health Council vis a vis other bodies, elected officials, governance structures etc. remains unclear. This group was very supportive of our visit (providing both a vehicle and two of their senior personnel to accompany us together with ATSIC regional personnel) and they appear to have good knowledge of the communities and the issues.

Solutions from Within

Linked to these ideas, it is important to note that we saw many communities working hard to come up with their own problem analysis and accompanying responses. Clearly, these communities share the same aspirations as many other communities for their children, families, people, and culture. They have profoundly fewer resources to address them and this is not just an issue of money. They lack skilled, supported and knowledgeable people. They lack ongoing committed infrastructure. Nevertheless, they have a strong positive belief and energy to respond to issues and develop solutions and initiatives within their own communities. There is a strong belief that they have opportunities and some power over decisions affecting their future.

Epidemic solutions

Whilst much has been said before, there is a real perception that little has been done. It is too easy to recount a litany of problems (as many have) with depressing and oppressive outcomes when, in effect, the focus should be on devising practical and realistic ways to move forward. The key to addressing alcohol and other substance misuse is in both effective and appropriate implementation. To be effective, any implementation process must coordinate efforts from the policy level through to grassroots action and pivot on the autonomy of Aboriginal communities in decision-making.

However, it is important to note that to successfully address alcohol and other substance misuse, the structural issues that have and continue to impact on this misuse must also be addressed. If they are not then it is unlikely that implementation of any programs will be prove to be successful, particularly in the long term.

Prof. Ian Webster – ANCD Member & Alcohol Education and Rehabilitation Foundation Chair

It would probably be naïve to merely support these sentiments and provide verbal support and even resources on the assumption that these communities can and will find their own pathway through the difficulties they face. We were not in any of these communities long enough to appreciate or understand the extent to which leaders and service providers (not always the same) are representative of the communities we visited. We do not know the extent of support and the number and extent of people who are similarly committed to a different and more prosperous future. We did not explore and did not understand the pressures on those who are elected and their efforts and more particularly their continuity in these positions.

It is clear that to address the problem of substance misuse more than money alone is required. We need to listen to what these communities are saying and work with them to generate responses, this, however, must occur at the invitation of the communities for the partnership to be successful. We need to work with communities, combining our skills and knowledge with the skills and knowledge of community members in order to successfully plan, and implement projects and to develop culturally appropriate and specific resources.

‘Community Participation’

During our visit to Cape York we had the unique experience of participating briefly in a community planning exercise at Wujul Wujal. It was an impressive and thought provoking process. Similar to community planning exercises we have seen in metropolitan areas, and as sophisticated.

Most of these communities receive little or no information about specific alcohol and drug related funding opportunities. It is foolish to think they will read advertisements in newspapers or respond to website addresses. Much more targeted information and strategic communication is needed.

Extreme care must be taken with funding programmes, to ensure they are consistent with local services, expectations and needs. There is some suggestion that funding of a new facility occasionally swamps an older facility or service and can create a significant imbalance in the local community. There needs to be better knowledge about these communities and the services that are desirable, viable and provide some hope for continuity, as well as exploration on how best to provide such services (e.g. through partnerships or mentoring and linkage with other service providers).

There needs to be a greater understanding on the accessibility and potential of programmes to utilise funding and the flexibility they will require (e.g. in one facility we visited where two staff are employed, a house was provided for the programme but very little furniture. The provision of a computer and a table and a chair in one room with three other rooms that are empty leaves some doubt about the rationality of the funding decisions).

An examination of the balance of funding between problem focussed programmes and/or capacity building and long-term prevention efforts would be of great benefit, including a focus on continuity and long term investment as part of an overall planned strategy. These communities have a long history as recipients of short stop/start funding of particular projects, which might help one or two people for a short time but leave little of value behind.

Key issues from visit to Cape York Peninsula

A coordinated approach

- The alcohol problem in Cape York and related issues requires a “whole of government” and “whole of community approach”. The Cape York Partnerships can be a key vehicle for this.
- At a national level the Australian National Council on Drugs, Alcohol and other Drugs Council of Australia, National Indigenous Substance Misuse Council, , National Expert Advisory Committee on Alcohol, Department of Health and Ageing, Office of Aboriginal and Torres Strait Islander Health, the Alcohol Education and Rehabilitation Foundation, National Drug Strategy Reference group on ATSI People and the National Aboriginal Community Controlled Health Organisation need to work collaboratively and target defined areas of policy and development in their sphere of influence.
- It is important to build on work already undertaken so as to not “re-invent the wheel”.

Community input and ownership

- It is important to recognise the efforts and motivation that exists in these communities. Resilience is strong in some of these communities and can be fostered by sensible government in collaboration with the people and their leaders.
- Any response needs to have meaning and ownership by the local community. It should be flexible and the range of initiatives should support each other. There are already many government programmes that are specific in their goals and thus overlap. These programmes need to cooperate at a local level if not centrally.
- It is important to develop a plan, and to provide an opportunity for everyone to provide feedback.

Access to information, education and support

- Resource materials are needed in many of the communities. These materials need to be user friendly to Indigenous people and preferably developed by Indigenous people.
- There is a strong request by Aboriginal people for further training in the area of alcohol and other drugs and in emotional and social well being, particularly mental health issues.
- Education and development of young people and the opportunities for their future meaningful employment is an absolute key priority.
- Leadership and mentoring needs to be fostered.

Achievable results

- Outcomes must be practical and achievable.
- It is important to have a long-term view rather than be preoccupied by the short-term.

Part Three – ANCD Observations and Recommendations

Many people believe that the services and supports for rural and regional communities are diminishing. This creates a sense of community degradation, with many young people forced to leave their community to access employment, education and other opportunities

The separation that is occurring between generations (both physical and culturally) is creating a loss of connectedness with ATSI culture and community.

The extremely high rates of unemployment that exist amongst ATSI communities appears to be creating a real crisis of identity and culture, particularly for young people who struggle to find appropriate or accessible role models.

The high incarceration rates for ATSI people, particularly amongst young men, appear to be having a disturbing impact. The perception of a passage for young men from adolescence to adulthood seems to be determined by their presence in a prison.

There are increasing reports of a high incidence (usually alcohol related) of violence and sexual violence inflicted upon women and children within Aboriginal communities, this will obviously have disturbing effects on younger people experiencing and viewing such incidents.

Factionalism at the local community level is stifling the development and implementation of effective programs and services to address specific drug and alcohol issues, as well as some important structural issues. This leads to increased perceptions of problems with corruption and accountability in the community.

General Recommendations by the Council

- Recognition that solutions/strategies that have best chance of success in communities come from the communities themselves, and that any programs and initiatives need to support, complement and empower local community action.
- The development of structural/organisational relationships with existing Indigenous planning and delivery organisations
- The development of strategies to effectively deal with the level of factionalism and division (perceived and real) within some local communities.

- Specified ATSI allocations for drug and alcohol initiatives (such as those made available to the wider community for Community Partnership Initiative and the Non-Government Organisations Treatment Grants Programs) should be considered.
- The development of closer inter-sectoral engagement with key ATSI bodies and drug and alcohol bodies with the aim of pursuing and achieving common goals, such as liaising with the National Drug Strategy Reference Group for ATSI People which has recently appointed a consultant to develop an ATSI drug and alcohol strategy.
- An emphasis on the provision of ongoing training, clinical supervision and support for drug and alcohol workers in these communities.
- The development of better nutritional opportunities and outcomes as well as providing productive work and the promotion of life skills and self esteem through the development of sustainable, and possibly profitable, community controlled and possibly organic agriculture programs and industries.
- Further research on the impact of establishing dry communities and dry zones, particularly the impact on nearby towns and communities.
- Specific strategies and community encouragement for increasing school attendance, improving curriculum options and a range of other strategies to enhance educational outcomes for children, as well as support for teachers.

Part Four – Response to the Cape York Justice Study

Terms of Reference

On Friday, 13 July 2001, the Premier, the Honourable Peter Beattie, MLA, announced this Study with the following terms of reference for the Study as approved by Cabinet on Monday, 13 August 2001:

- a) Identify the causes, nature and extent of breaches of the law in the Cape York Indigenous communities;
- b) Identify the causes, nature and extent of alcohol and substance abuse in the Cape York Indigenous communities;
- c) Determine the extent of the relationship between alcohol and substance abuse and breaches of
- d) the law in the Cape York Indigenous communities;
- e) Identify strategies, including effective current practice, to address factors contributing to breaches of the law in Cape York Indigenous communities, in particular alcohol and substance abuse; and
- f) Report to the Premier by November 2001 that recommends strategies to:
 - reduce breaches of the law in Cape York Indigenous communities;
 - reduce alcohol and substance abuse in Cape York Indigenous communities;
 - protect members of Cape York Indigenous communities from violence, especially women, children and the aged;
 - prevent young people from becoming involved in alcohol and substance abuse and offending;
 - rehabilitate offenders and provide appropriate interventions for those at risk of offending.

The recommended strategies must:

- be achievable only through the smarter use of existing State resources; and
- support the continuing development of partnerships between the Queensland Government and Cape York Indigenous communities.

In effect, the study was to focus on the “causes, nature and extent of breaches of the law, and alcohol and substance abuse in Cape York Indigenous communities, the relationship between them, and the identification of strategies to reduce breaches of the law, alcohol and substance abuse, to protect citizens against violence, to prevent young people becoming involved in substance abuse and violence, and to rehabilitate offenders” (Fitzgerald report, p9).

A new temporary unit, funded by the Queensland Department of Premier and Cabinet Study, was established to undertake the study undertaken by under the supervision of Associate Professor Christine Zorzi and Adjunct Professor Ian Siggins. The study was conducted between August to October 2001 resulting in a brief to Government in November 2001.

Although narrower in its inquiry, it is not surprising to find that the lessons learnt by ANCD members during their visit to Cape York closely reflect those of the Fitzgerald report. Recognising the ANCD's narrower ambit it is our intention in this response to focus primarily on the recommendations relating to alcohol and violence.

Having said that, the ANCD concur first and foremost with the Justice Fitzgerald's statement "the ideas and recommendations which can make a difference are all available in earlier reports. The problem is with a lack of effective implementation" (Fitzgerald Report, p7). Our observation and comments from communities and individuals consistently demonstrated that historically substantial effort and resources have been directed at these same issues with minimal results. The message the ANCD would like to clearly enunciate is that the key to addressing issues of alcohol and other substance abuse is not only by effective implementation of specific programs but also by addressing the underlying structural determinants that have a significant impact on alcohol and drug misuse.

The goals of the Cape York Partnerships group align closely with, and build on, the recommendations contained in the Fitzgerald report. Expressly, they are: to form partnerships between the Government and the Indigenous people of Cape York; to work with families and communities to overcome the disadvantaged position of the Indigenous people of Cape York in comparison to other Queenslanders; to narrow the 20 year gap in life expectancy between the Indigenous people of Cape York and the wider community; to achieve better health through partnerships between communities and Government agencies responsible for those factors which influence health; to reach better educational outcomes through improved education services; to build better family support networks that recognise traditional Indigenous values, to build a skilled labour force; and, to generate jobs through economic development.

The ANCD also agrees with the principal of coordination to a central authority and resources for the range of Government initiatives associated with Cape York to one group, and, that any group responsible should be located in Cape York. Where possible The ANCD supports the avoidance of establishing yet another layer of bureaucracy, therefore the ANCD supports an organisation which has a whole of government approach in the Cape to a range of government programmes that impact on the communities there, be considered for this role.

Alcohol and Violence

The ANCD supports the proposals to establish acceptable community practices and values concerning the use of alcohol through: the development of simple, tailored and achievable community action plans on alcohol management; the provision of targeted prevention and intervention strategies developed in consultation with communities; supporting women to take leadership and mentoring roles in the community; and the provision of residential, non-residential and relapse support facilities and services.

Our visit to Cape York clearly demonstrated the failure of current health services, through no fault of their own, to do much other than react to daily incidents. The need for a planned strategic approach and the provision of culturally sensitive prevention services is fundamental to the long-term goal of changing attitudes and values regarding alcohol consumption. Particular attention needs to be focused on early childhood development (family formation), education and opportunities for young people. Treatment services, especially primary care services, in Indigenous communities need to be involved. Successful and proven interventions should be made available to those experiencing problems. We must be extremely careful when we are funding services in any of these areas that it is consistent with local services and local expectations and needs.

Structural changes and interventions

The ANCD recognises the conflicting pressures on Councils and Council officials as the suppliers of alcohol. During our visit, a number of communities reported significant income from the sale of alcohol at canteens. The ANCD supports the transfer of responsibility for the supply of alcohol to the proposed coordinating unit on the proviso that the Councils are paid proper compensation.

The ANCD strongly supports the proposal that compensation paid to communities is calculated as a per capita sum which increases as the per capita consumption of alcohol in the community decreases. The combined effect of these two proposals is a clear incentive to community councils to discourage excessive alcohol consumption with clear and positive health benefits. The ANCD further suggests that consideration be given to tying a proportion of the funds returned to communities to fund the provision of treatment and rehabilitation services as recommended above. Services, hence funds, required will be relative to the levels of alcohol misuse in the community providing additional incentives for council and community members to discourage hazardous levels of consumption.

The ANCD supports the proposals addressing the illegal supply of alcohol and drugs while acknowledging that punitive measures, such as a loss of supplier's license, should be agreed in consultation with communities and law enforcement agencies. The ANCD supports an immediate examination of best practice in alcohol supply and demand reduction strategies in the region so that they can be tailored and adopted by other communities in the region as appropriate.

Law enforcement resources provide a range of services, one component of which is to respond to issues relating to the misuse of alcohol and other substance abuse. Law enforcement resources are therefore best administered in the hands of appropriate agencies. The ANCD encourages high level partnerships between the proposed coordination unit and law enforcement agencies so that resources can be diverted as required.

The ANCD strongly agrees with the proposal to provide safe areas, accommodation and protection strategies to those exposed to danger as a result of alcohol misuse. These areas must be adequately resourced and should focus, as proposed, on women, children and the elderly.