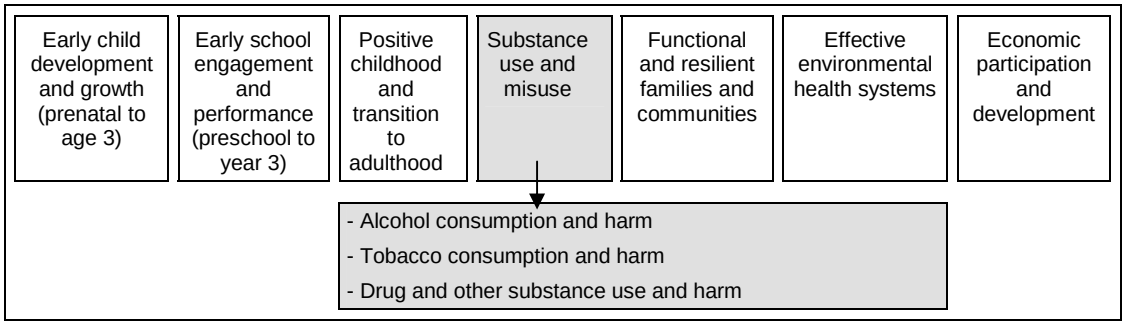
8 Substance use and misuse

Strategic areas for action



Substance use and misuse has the potential to affect all the headline indicators discussed in this Report. Reducing substance misuse can significantly reduce the level of assaults and homicides and the level of disability, while improving the overall health and wellbeing of a population. A reduction in substance use might also increase children's educational attainment, household and individual income levels, and reduce crime and imprisonment rates.

Health risk behaviours, such as smoking, excessive alcohol consumption and illicit drug use, are strongly associated with many aspects of socioeconomic disadvantage. Health risk behaviours are particularly prevalent in lower socioeconomic groups. The 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) showed that reported rates of substance use among Indigenous people aged 15 years and over in non-remote areas were significantly higher for those without employment. The Survey also showed an increased rate of tobacco use for those over 15 years with lower household income, lower levels of education and who were unemployed (ABS and AIHW 2005).

Poor economic and social conditions can lead to alcohol dependence, drug use and cigarette smoking, In turn, use and misuse of these substances intensifies the factors that first led to their use. Risk factors for problem drug use include family disruption and dependence problems in the family, poor performance at school, social deprivation, young age of onset of substance use, and depression and suicidal behaviour during adolescence (Lloyd 1998). Richard and Payne (2005) also found that risk factors, including childhood abuse and neglect, drug and alcohol abuse among family members, and troubled school education, were all highly interrelated

and important correlates of criminal offending and high frequency substance abuse among 371 juvenile offenders.

A study by Loxley, Toumbourou and Stockwell (2004) found that:

- Social disadvantage particularly as reflected in factors such as unemployment, homelessness or insecure housing and poverty — is clearly linked to health-damaging behaviours, including the misuse of alcohol and other drugs. (p.14)
- Drug use, both licit and illicit, is associated with high health, legal and social costs to communities and families, as well as to users. It is associated with crime and violence, sexual assault and domestic violence. Crime is strongly associated with alcohol and drug use, particularly alcohol with violence and heroin with property crime. Drug use has impacts on families, the workforce and road trauma; and it affects public safety and amenity, not only through perceived threat, but through disturbances such as noise, litter and public intoxication. (p.3)

The relative socioeconomic disadvantage experienced by Indigenous Australians compared with other Australians may place them at greater risk of ill health, which in turn can exacerbate their already disadvantaged socioeconomic positions. Indigenous people generally experience high levels of harm as a result of alcohol, tobacco and other drug use. According to AIHW (2006), which provided data collected from 635 alcohol and other drug treatment agencies across Australia, Indigenous people accounted for almost 10 per cent of total clients who sought treatment for drug and alcohol use in 2004-05.[1] This was almost five times the proportion of Indigenous people in the Australia population [2], Compared with non-Indigenous clients, Indigenous clients were more likely to be in the youngest group (10–19 years), and more likely to nominate alcohol as the principle reason for seeking treatment.

A study by Ridolfo and Stevenson (2001) estimated that in 1998 the use of tobacco, alcohol and other (illicit) drugs caused about 25 per cent (7 000) of the deaths of Australians under 65 years old, among which over 2 000 deaths were related to alcohol (which include alcohol related road injuries), about 4 200 related to smoking and 1 000 related to illicit drug use. However, there is no information available regarding Indigenous status in this study.

[1] The proportion may be even higher because of the relatively high proportion of treatment periods where Indigenous status was 'not stated' (5 per cent) and because the majority of dedicated substance use services for Aboriginal and Torres Strait Islander people were not included in the collection.

[2] These data are not age standardised and consequently do not take into account the larger proportion of younger people in the Indigenous population and the effect this might have on rates of people seeking drug and alcohol treatment.

This chapter examines patterns in, and harms related to, the use and misuse of alcohol, tobacco and other drugs among Indigenous and non-Indigenous people.

Following feedback and comments from consultation on the 2005 Report, this chapter has been restructured. In the 2003 and 2005 Reports patterns in alcohol and tobacco consumption were reported in one section, and alcohol and tobacco related harms in another. This chapter now reports three indicators by type of substance, covering patterns in use and related harms for each type of substance. The three indicators are:

- 8.1 Alcohol consumption and harm
- 8.2 Tobacco consumption and harm
- 8.3 Drug and other substance use and harm.

New data on hospitalisations related to tobacco use and drug influenced homicides are included for the first time in this Report.

Attachment tables

Attachment tables for this chapter are identified in references throughout this chapter by an 'A' suffix (for example, table 8A.1.1). A list of attachment tables is in section 8.5. These tables can be found on the Review web page (www.pc.gov.au/gsp). Users can also contact the Secretariat to obtain the attachment tables.

8.1 Alcohol consumption and harm

Box 8.1.1 **Key messages**

- In 2004-05, after adjusting for age differences, survey results indicated that:
  - a higher proportion of Indigenous adults reported that they did not drink or had never drunk alcohol (53.4 per cent) compared to non-Indigenous adults (36.1 per cent) (table 8.1.2).
  - among those who drank alcohol, the reported rate of long term risky to high risk drinking for Indigenous people was similar to that for non-Indigenous people (figure 8.1.2); the rate of short term risky to high risk drinking for Indigenous people (17 per cent) was nearly double the rate for non-Indigenous people (8 per cent) (table 8.1.3).
- Among Indigenous people living in non-remote areas more Indigenous women reported long term risky to high risk alcohol consumption in 2004-05 (13.9 per cent) than in 1995 and 2001 (6.3 and 9.0 per cent respectively) (figure 8.1.3). There was little change in long term risky to high risk alcohol consumption by Indigenous men over the same periods.
- Over the period from 1999-2000 to 2004-05, Indigenous homicides were more than three times as likely as non-Indigenous homicides to have involved both the offender and victim having consumed alcohol at the time of the offence (figure 8.1.4). However, the overall level of alcohol involvement in Indigenous homicides fell from 85.0 to 70.6 per cent over the period (figure 8.1.5).

Box 8.1.2 **'Things that work' — reducing alcohol consumption and harm**

Groote Eylandt Liquor Management Plan (NT)

In June 2005, the Groote Eylandt Liquor Management Plan was developed in an effort to reduce the number and resultant harm of liquor related incidents on Groote Eylandt and Bickerton Island. Initiated by the President of the Anindilyakwa Land Council, the Plan was developed in collaboration with leaders from Aboriginal communities on Groote Eylandt and Bickerton Island and with representatives from government and community organisations.

Groote Eylandt, like a number of other Northern Territory Aboriginal communities, has experienced unacceptable levels of alcohol related violence and harm for some time. The operation of two licensed premises in Groote Eylandt's largest township (Alyangula) meant that a steady supply of liquor was available in the mining township and the three smaller surrounding Aboriginal communities (Angurugu, Umbakumba and Milyakburra).

(Continued next page)

Box 8.1.2 (continued)

The Plan restricts alcohol consumption on Groote Eylandt and Bickerton Island through the use of a permit system that controls the takeaway of alcohol from licensed premises. Although permits are issued by the Northern Territory Licensing Commission, it is the responsibility of the Management Committee — comprising local community and stakeholder representatives — to recommend when to issue, revoke or place conditions on a permit.

Impacts of the Plan to date have been:

- decreased alcohol related incidents attended by police
- reduced police callouts, especially to the Angurugu community in the evenings
- reduced overtime payments to police officers in Alyangula
- decreased callouts, especially after hours, involving the main health clinic ambulance
- reduced absenteeism within the mining company's Indigenous workforce, with sick leave for Indigenous employees declining from 7.1 per cent before the Plan commenced in 1 July 2005, to 2.4 per cent since.

While details of the full impact of the Plan are yet to be evaluated, it is already clear that progress has been made through community and government groups working together in a sustained and organised manner to develop and implement a community alcohol management plan.

The Northern Territory Office of Alcohol Policy and Coordination is currently organising a consultancy to formally evaluate the Plan.

Source: NT Government Treasury (unpublished).

Alcohol consumption has health and social consequences through intoxication (drunkenness), alcohol dependence and other biochemical effects. In addition to chronic diseases that may affect drinkers after many years of heavy use, excessive alcohol consumption increases the risk of heart, stroke and vascular diseases, liver cirrhosis and several types of cancers (AIHW 2005). It also contributes to disability and death through accidents, violence, suicide and homicide. Alcohol misuse also has impacts that extend to people other than the individual concerned. Apart from directly harming an individual's health, excessive alcohol consumption at the family and community levels contributes to workplace-related problems, child abuse and neglect, financial problems (poverty), family breakdown, interpersonal/domestic violence, and crime (WHO 2000, 2004).

This section examines patterns of alcohol consumption and alcohol related harms, including alcohol influenced crime and alcohol related hospitalisations and deaths.

Patterns of alcohol consumption

The National Health and Medical Research Council (NHMRC) Australian Alcohol Guidelines (2001) outlines drinking patterns associated with risk of alcohol related harm. The low risk level defines a level of drinking at which there is only minimal risk of harm and, for some, the likelihood of health benefits. The risky levels are those at which risk of harm is significantly increased beyond any possible benefits. High risk drinking levels are those at which there is substantial risk of serious harm, and above which risk continues to increase rapidly.

Data on the relative risk levels of alcohol consumption are sourced from the ABS 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and the 2004-05 National Health Survey (NHS). The two surveys collected data on a person's average daily alcohol consumption in the seven days prior to the interview and then grouped them into relative risk levels as defined by the NHMRC (2001) (table 8.1.1).

Table 8.1.1 **Average daily alcohol consumption and associated risk levels**

	Males		*Females*	
	No. of standard drinks[a]	*Volume of alcohol (ml)*	*No. of standard drinks*[a]	*Volume of alcohol (ml)*
Risk of short term harm				
Low risk	Up to 6	<75	Up to 4	<50
Risky	7–10	75–125	5-6	50–70
High risk	11 or more	>137.5	7 or more	>75
Risk of long term harm				
Low risk	Up to 4	<50	Up to 2	<25
Risky	5-6	50-70	3-4	25-50
High risk	7 or more	>75	5 or more	>50

[a] A standard drink is defined as a full serve of alcoholic beverages containing 10 grams of alcohol, equivalent to 12.5 millilitres (ml) of alcohol. For example, a 375 ml can/bottle of mid-strength beer, or a 100 ml glass of wine. All alcoholic beverage containers, by law, state on the label the number of standard drinks they contain.

Source: NHMRC (2001); ABS (2006).

Short term risk is the risk of harm in the short term associated with given levels of alcohol consumption on any one occasion. Long term risk is associated with regular daily patterns of alcohol consumption and defined by the average daily intake of alcohol over the seven days of the reference week. Both short term and long term alcohol misuse can cause harms including illnesses, injuries and deaths. The last section of this indicator, 'Alcohol related hospitalisations and deaths', discusses harms associated with alcohol consumption at short and long term risk levels.

Table 8.1.2 **Alcohol consumption at long term risky to high risk levels, people aged 18 years and over, age standardised, 2004-05[a]**

	Indigenous	*Non-Indigenous*
Alcohol consumption and relative risk level[b]	%	%
Low risk	29.7	49.2
Risky/high risk	15.3	13.5
Total drank alcohol	45.0	62.7
Did not drink alcohol	42.0	27.3
Never consumed alcohol	11.4	8.8

a Data exclude 'time since last consumed alcohol' not known and alcohol risk level not known **b** Data are based on a person's average daily alcohol consumption in the seven days prior to the interview.

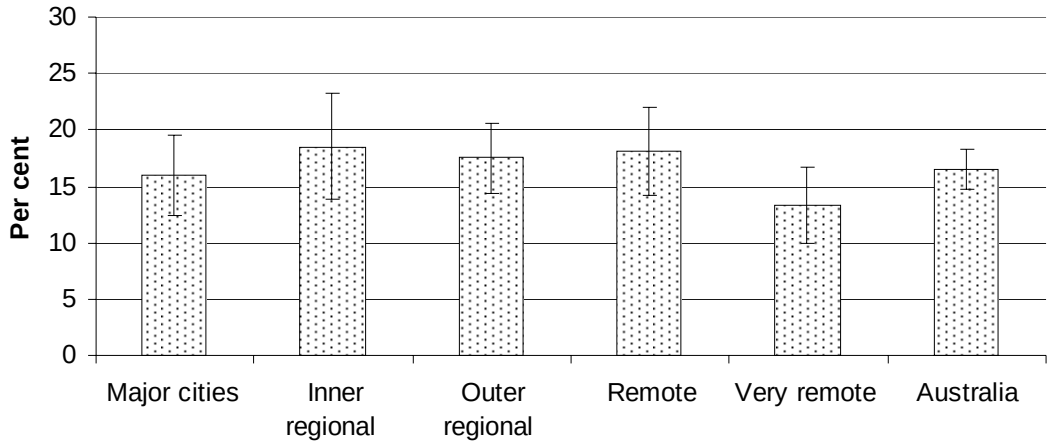
Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 8A.1.1.

In 2004-05, around half (49 per cent) of all Indigenous adults (aged 18 years and over) reported having consumed alcohol in the week prior to the interview, of whom one third (16 per cent) reported drinking at risky to high risk levels in the long term (ABS 2006).

After adjusting for age differences in 2004-05, survey results indicated that (table 8.1.2):

- A higher proportion of Indigenous people reported that they did not drink alcohol in the week prior to the interview (42.0 per cent) compared to non-Indigenous people (27.3 per cent).
- A lower proportion of Indigenous people (29.7 per cent) reported that they drank alcohol at the long term low risk level compared to non-Indigenous people (49.2 per cent). The level of long term risky to high risk drinking reported by Indigenous adults was similar to that of non-Indigenous adults (table 8.1.2).

Figure 8.1.1 **Alcohol consumption at long term risky to high risk levels, Indigenous people aged 18 years and over, 2004-05[a]**



a Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

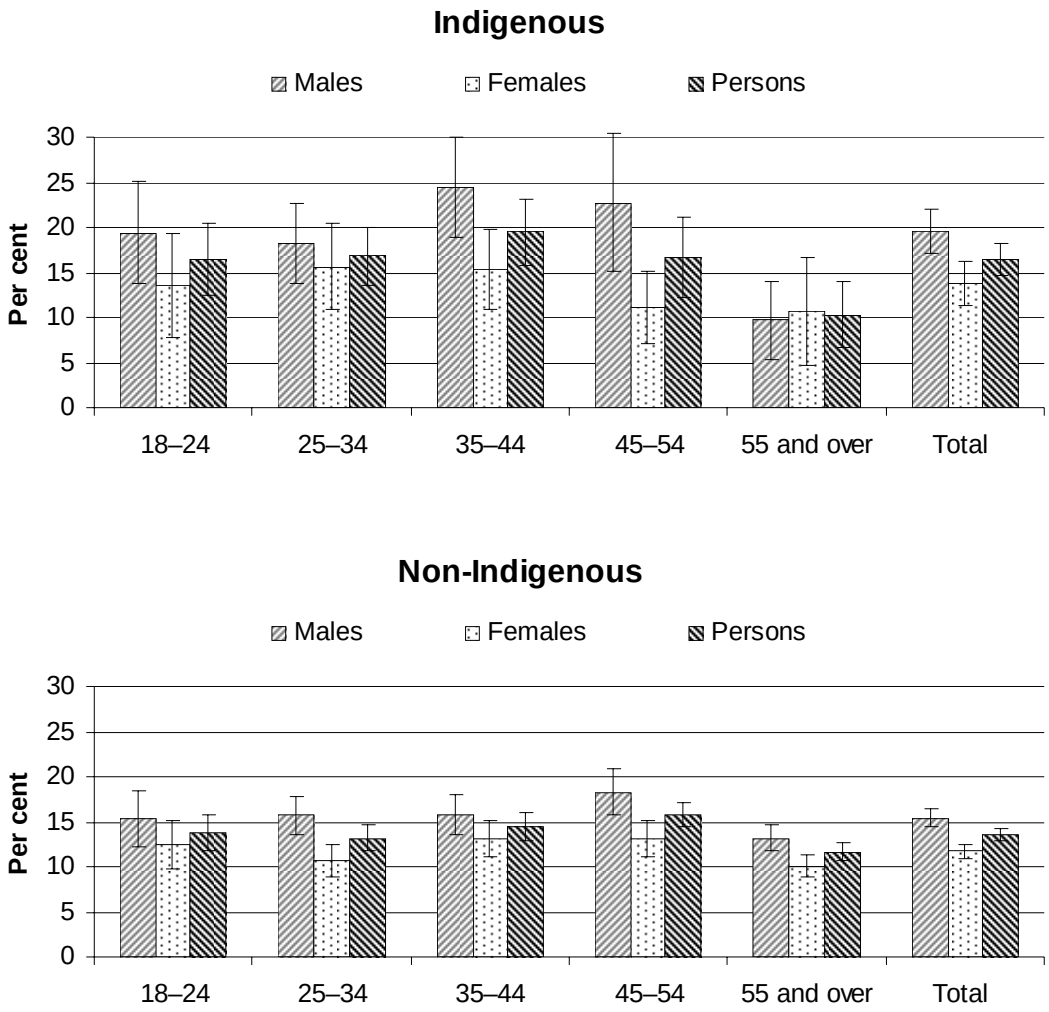
Source: ABS 2004-05 NATSIHS (unpublished); table 8A.1.10.

- In 2004-05, there was little variation in the level of reported long term risky to high risk alcohol consumption by Indigenous people across remoteness areas (figure 8.1.1).

Indigenous and non-Indigenous comparisons are not possible for very remote areas as non-Indigenous data for very remote areas were not collected in the 2004-05 NHS.

- Across remoteness areas (including major cities, inner and outer regional areas and remote areas) for which data are available on a comparable basis, in 2004-05, the level of reported long term risky to high risk drinking among Indigenous adults was similar to that among non-Indigenous adults (table 8A.1.2).

Figure 8.1.2 **Alcohol consumption at long term risky to high risk levels, people aged 18 years and over, 2004-05[a, b]**



a Totals are not age standardised and are not directly comparable between Indigenous and non-Indigenous people. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

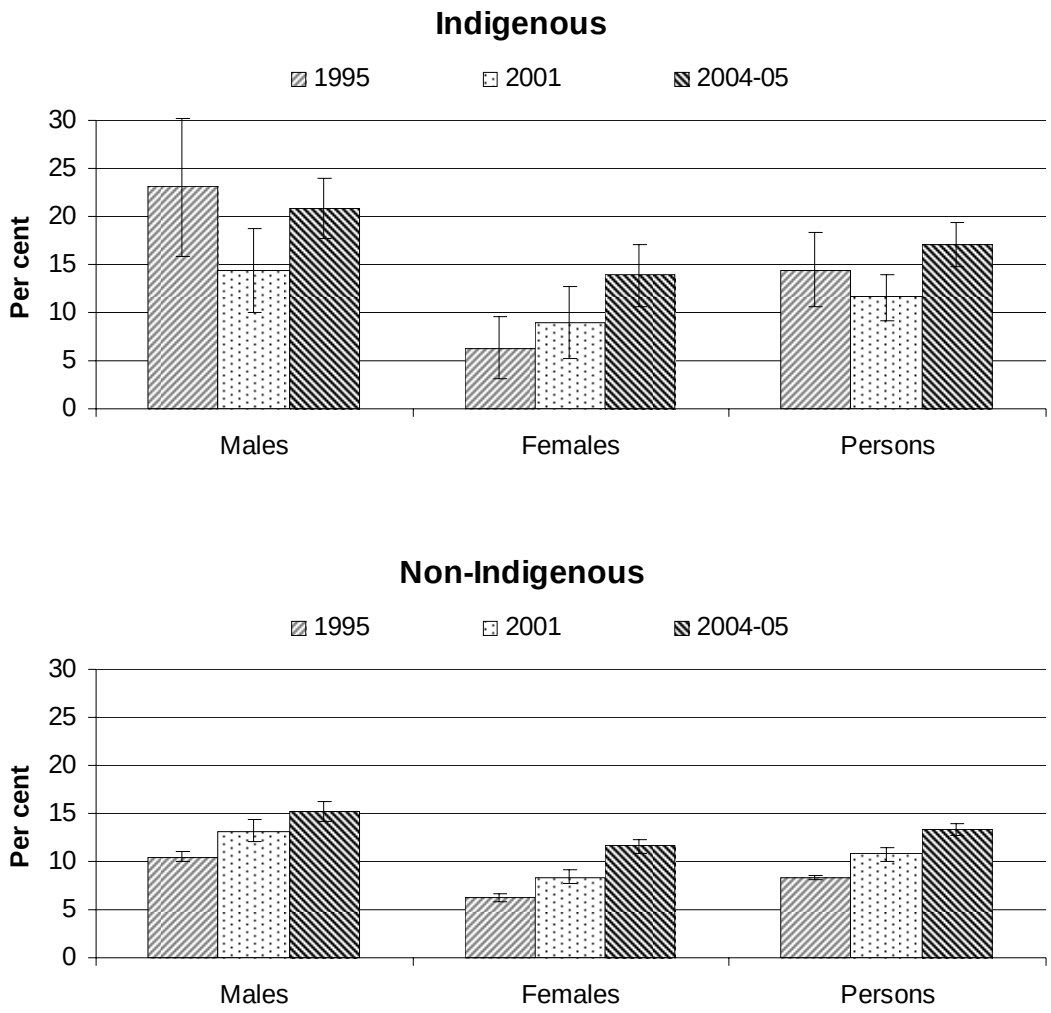
Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 8A.1.11.

In 2004-05:

- Reported rates of long term risky to high risk alcohol consumption in the week prior to the interview for Indigenous and non-Indigenous adults were similar across all age groups for both males and females, except males aged 35 to 44 years where the reported rate for Indigenous people was significantly higher than for non-Indigenous people (24.4 per cent compared to 15.8 per cent) (figure 8.1.2).

- For both Indigenous and non-Indigenous people, men were more likely than women to report consumption of alcohol at long term risky to high risk levels (19.5 per cent compared with 13.8 per cent for Indigenous people and 15.4 per cent compared with 11.7 per cent for non-Indigenous people).

Figure 8.1.3 **Alcohol consumption at long term risky to high risk levels, people aged 18 years and over living in non-remote areas[a, b]**



a Data are not age standardised and are not directly comparable between Indigenous and non-Indigenous people. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2001 NHS(I) and NHS, ABS 2004-05 NATSIHS and NHS (unpublished); table 8A.1.3.

- Nationally, the proportion of Indigenous adults living in non-remote areas who reported drinking at long term risky to high risk levels was higher in 2004-05 (17.1 per cent) than in 2001 (11.6 per cent), but was not statistically significantly different to that in 1995 (14.4 per cent) (figure 8.1.3).

- For Indigenous women living in non-remote areas, the reported rate of long term risky to high risk alcohol consumption increased from 6.3 per cent in 1995 to 13.9 per cent in 2004-05, while the rate reported by Indigenous men did not change significantly over the same period.
- By comparison, the proportion of non-Indigenous adults in non-remote areas who reported drinking at long term risky to high risk levels increased continually from 1995 to 2004-05, for both men and women.

Short term risky to high risk alcohol consumption is mainly associated with 'binge' drinking.

In 2004-05:

- Over half (55 per cent) of Indigenous people adults (aged 18 years and over) reported drinking alcohol at short term risky/high risk levels at least once in the 12 months prior to the interview (table 8.1.3).
- The reported rate of alcohol consumption at short term risky/high risk levels at least once a week was higher for Indigenous people than non-Indigenous people in all age groups.
- After adjusting forage differences in the two populations, the rate of alcohol consumption at short term risky/high risk levels at least once a week reported for Indigenous people (17 per cent) was twice the rate for non-Indigenous people (8 per cent) (table 8.1.3).

Table 8.1.3 **Alcohol consumption at short term risky to high risk levels, people aged 18 years and over, 2004-05**

	Age ranges (years)						
	18–24	*25–34*	*35–44*	*45–54*	*55 +*	*Total*	*AS Total*
Indigenous							
At least one occasion in last 12 months (%)	64	64*	59*	45*	22	55*	47*
At least once a week in the last 12 months (%)	23*	20*	22*	16*	9*	19*	17*
Total[a] (%)	100	100	100	100	100	100	100
Total[a] ('000)	56.7	69.8	5.9	39.6	33.2	258.3	na
Non-Indigenous							
At least one occasion in last 12 months (%)	63	56*	46*	35*	16	39*	40*
At least once a week in the last 12 months (%)	15*	9*	9*	8*	4*	8*	8*
Total[a] (%)	100	100	100	100	100	100	100
Total[a] ('000)	1857.1	2761.4	2899.6	2705.6	4529.7	14753.3	na

AS= Age standardised. *Represents results with statistically significant differences in the Indigenous/non-Indigenous comparisons.

a Total include people who did not drink alcohol in the last 12 months, those who reported time since last drank alcohol as 'not known' and those who drank alcohol in the last 12 months, but the risk levels were reported as 'not known'. **na** Not available.

Source: ABS 2004-05 NATSIHS (unpublished).

In 2004-05:

- Both Indigenous and non-Indigenous males were reported to be more likely than their female counterparts to consume alcohol at short term risky/high risk levels (table 8A.1.12).
- After adjusting for age differences in the two populations, the reported rates of alcohol consumption at short term risky/high risk levels was higher for both Indigenous women and men than their non-Indigenous counterparts. Indigenous women (14 per cent) were almost three times as likely as non-Indigenous women (5 per cent) to consume alcohol at short term risky/high risk levels at least once a week (table 8A.1.12).

Alcohol influenced crime

Research from Australia and overseas suggests there is a strong association between alcohol and violence, crime and anti-social behaviour (Smith 1983 and AIC 1990). One study conducted by the NSW and Queensland police services found that high proportions of street offences (for example, offensive behaviour), assault, malicious damage, domestic violence and noise complaints were related to alcohol use (Ireland 1993).

In a report on the drug and alcohol use and criminal behaviour of 371 juveniles aged 10 to 17 years who were in detention centres in all Australian jurisdictions in 2003-04, Richard and Payne (2005) found that:

- at the time of their last offence, 46 per cent of these juvenile offenders were under the influence of alcohol
- compared with non-regular offenders, regular violent and regular property offenders were three times more likely to be regular users of alcohol.

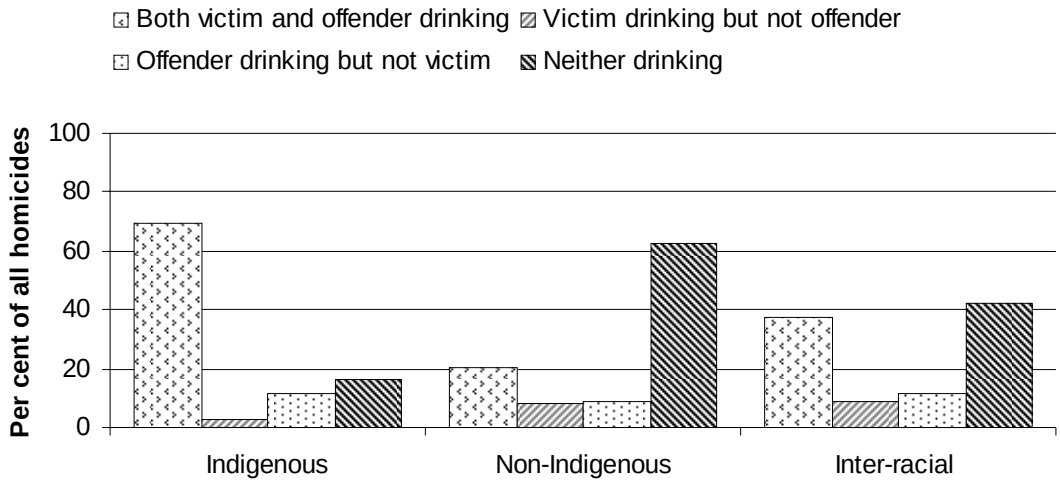
An analysis of data from the Drug Use Monitoring in Australia (DUMA) program in 2004 showed that, among police detainees in seven urban police stations or watch-houses in NSW, Queensland, WA and SA, there was a more pronounced association between alcohol and offending among Indigenous male offenders than their non-Indigenous counterparts (Putt, Payne and Miller 2005).

Box 8.1.2 provides examples of how alcohol related crime and violence is being addressed in some communities.

There are no reliable data on the overall extent of alcohol related crime. This section examines alcohol related homicides.

Data sourced from the Australian Institute of Criminology (AIC) National Homicide Monitoring Program (NHMP) only include alcohol related homicides and no information on offences that do not result in the death of the victim. Other limitations of the NHMP data are discussed in appendix 3.

Figure 8.1.4 **Alcohol involvement in Indigenous and non-Indigenous homicides, total recorded 1999-2000 to 2004-05** [a, b, c, d]



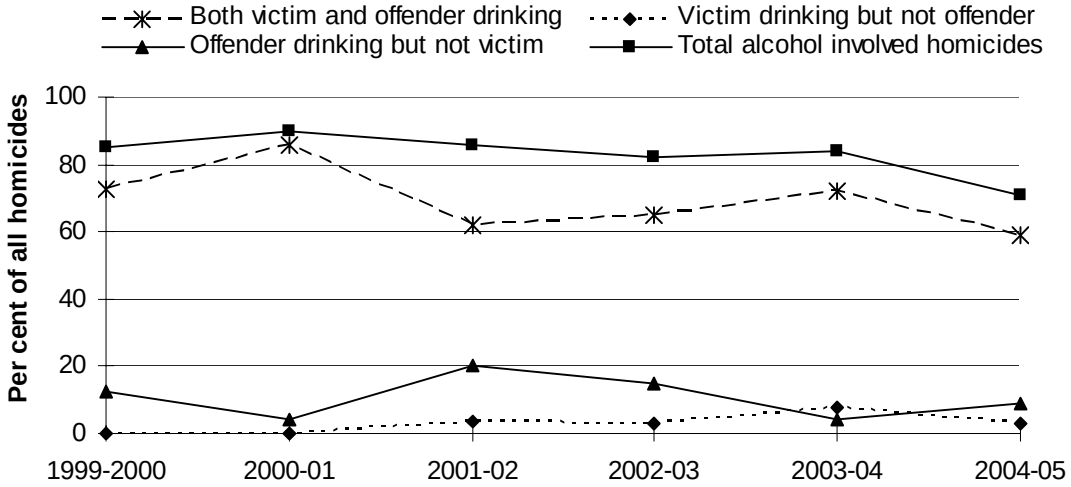
[a] Homicide includes murder and manslaughter, but excludes driving causing death. [b] Indigenous homicides are where both victims and offenders of homicide are Indigenous. [c] Non-Indigenous homicides are where both victims and offenders are not Indigenous, including victims and offenders who are Caucasian, Asian and Maori/Pacific Islanders. [d] Inter-racial homicides are where either the victim or the offender is Indigenous, including homicides involving: an Indigenous offender and non-Indigenous victim, and non-Indigenous offender and an Indigenous victim.

Source: AIC NHMP (unpublished); table 8A.1.5.

Among the total recorded homicides over the period from 1999-2000 to 2004-05:

- 69.6 per cent of Indigenous homicides involved both the victim and offender having consumed alcohol at the time of the offence (figure 8.1.4). In contrast, 20.4 per cent of non-Indigenous homicides involved both the victim and offender being under the influence of alcohol at the time of the incident .
- Where only the offender was under the influence of alcohol in a homicide, the proportion was slightly higher for Indigenous homicides (11.4 per cent) than non-Indigenous homicides (9.0 per cent) (figure 8.1.4).

Figure 8.1.5 **Alcohol involvement in Indigenous homicides, 1999-2000 to 2004-05[a]**



a Total alcohol involved homicides are the aggregate of three categories of homicides involving alcohol: both the 'victim and offender drinking',' victim drinking but not offender', and 'offender drinking but not victim'.

Source: AIC NHMP (unpublished); table 8A.1.5.

The overall level of alcohol involvement in Indigenous homicides fell from 85.0 per cent in 1999-2000 to 70.6 per cent in 2004-05, with a significant decrease between 2003-04 (84.0 per cent) and 2004-05 (figure 8.1.5). This is due to a decrease in Indigenous homicides involving 'both the victim and offender having consumed alcohol' at the time of the offence over the same period (72.5 per cent in 1999-2000, 72.0 per cent in 2003-04 and 58.8 per cent in 2004-05).

Alcohol related hospitalisations and deaths

Both short term and long term alcohol misuse can cause harm including illnesses, injuries and deaths. Short term risk of harm (particularly injury or death) is associated with levels of drinking on any one occasion. Episodes of drinking to intoxication can cause injuries or deaths from violence, falls, road crashes and drowning. Long term alcohol misuse can cause a series of chronic illnesses (for example, various cancers, liver diseases, and chronic gastritis), Some suicides and strokes may be attributable to both short and long term alcohol misuse.

Alcohol use during pregnancy is linked to fetal alcohol syndrome and to a range of other effects, known as fetal alcohol effects. Fetal alcohol syndrome is characterised by various combinations of growth restriction of the fetus, facial anomalies, microcephaly and central nervous system impairment, including intellectual

disability and behaviour problems (World Bank 2000). Foetal-alcohol syndrome, is more prevalent in Aboriginal infants than non-Aboriginal infants (GSA 2003).

There are few data available on alcohol consumption by Indigenous females during pregnancy. One study gathered data through a survey administered as part of a health screening program conducted from 1998 to 2000 at 45 rural and remote locations in north Queensland. The 'Well Persons Health Check' found that 45 per cent of Indigenous women between the ages of 15 and 44 reported having drunk alcohol at hazardous and harmful levels in the week prior to survey. Furthermore, 25 per cent of pregnant Indigenous women continued to report drinking at hazardous and harmful levels (Queensland Health Tropical Population Health Network unpublished).

According to AIHW (2005), alcohol was the second largest cause of drug-related deaths and hospitalisations in Australia (after tobacco) in 2004.

Data on hospitalisations related to alcohol use reported for this indicator are from the AIHW National Hospital Morbidity Database. These data only cover alcohol related illnesses resulting in admission to a hospital. Further data are only available for conditions directly attributable to alcohol consumption and do not include most of the conditions listed above, where alcohol may be a contributing factor but where the link is not direct and immediate. Lastly, identification of Indigenous patients is incomplete and completeness varies across jurisdictions. The AIHW has advised that only data for Queensland, WA, SA and the NT are considered to be acceptable for analytical purposes. Data for NSW, Victoria, Tasmania and the ACT were withheld by AIHW due to high rates of under-identification of Indigenous people (see chapter 2 and appendix 4 for more information). The limitations of using hospital statistics are discussed in appendix 3.

Table 8.1.2 **Hospitalisations related to alcohol use, Qld, WA, SA, and public hospitals in the NT, 2004-05 (per 1000 population)[a, b, c, d, e]**

	Male	*Female*	*All persons*
Indigenous			
Mental and behavioural disorders (F10)	8.7	3.9	6.1
Acute intoxication (F10.0)	3.8	2.4	3.0
Harmful use (F10.1)	0.4	0.2	0.3
Dependence syndrome (F10.2)	1.5	0.6	1.0
Other (F10.3–F10.9)	3.0	0.7	1.8
Alcoholic liver disease (K70)	1.3	1.2	1.2
Other inflammatory liver disease (K75)	0.1	0.1	0.1
Toxic effect of alcohol (T51)	0.1	–	0.1
Accidental poisoning by and exposure to alcohol (X45)	0.8	0.1	0.4
Intentional self-poisoning by and exposure to alcohol (X65)	0.2	0.2	0.2
Poisoning by and exposure to alcohol, undetermined intent (Y15)	0.1	0.1	0.1
***Non-Indigenous*[f]**			
Mental and behavioural disorders (F10)	1.7	1.1	1.4
Acute intoxication (F10.0)	0.5	0.3	0.4
Harmful use (F10.1)	0.1	–	0.1
Dependence syndrome (F10.2)	1.0	0.7	0.8
Other (F10.3–F10.9)	0.2	0.1	0.1
Alcoholic liver disease (K70)	0.3	0.1	0.2
Other inflammatory liver disease (K75)	0.1	0.1	0.1
Toxic effect of alcohol (T51)	–	–	–
Accidental poisoning by and exposure to alcohol (X45)	0.1	0.1	0.1
Intentional self-poisoning by and exposure to alcohol (X65)	0.2	0.3	0.2
Poisoning by and exposure to alcohol, undetermined intent (Y15)	–	–	–

a The hospital separation rates (per 1000 population) were directly age standardised to the Australian population as at 30 June 2001. **b** Hospital separation is the discharge, transfer, death or change of episode of care of an admitted patient (see glossary for a detailed definition). **c** Principal diagnoses of hospitalisations are based on codes of the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM). **d** Data are based on state of usual residence. **e** Overlapping may exist between separations by toxic effect of alcohol and separations based on external causes X45, X65, or Y15. **f** Non-Indigenous data include separations where Indigenous status was not reported.

– Nil or rounded to zero.

Source: AIHW National Hospital Morbidity Database (unpublished); table 8A.1.6.

Based on the data on hospitalisations related to alcohol from the four jurisdictions (Queensland, WA, SA, and the NT), in 2004-05:

- hospitalisation rates for all conditions related to alcohol use were consistently higher for Indigenous people than for non-Indigenous people, and the rates for both Indigenous and non-Indigenous males were consistently higher than females (table 8A.1.7 and table 8A1.8).
- For both Indigenous and non-Indigenous people, mental and behavioural disorders were the most common conditions for both males and females.
- Both Indigenous and non-Indigenous males were more likely to be hospitalised for alcohol-caused illness than females.
- Hospitalisations due to alcohol caused mental and behavioural disorders among Indigenous males (8.7 per 1000) were five times as high as for non-Indigenous males (1.7 per 1000). The rate for Indigenous females (3.9 per 1000) was almost four times as high as that for non-Indigenous females (1.1 per 1000).
- Acute alcohol intoxication was the most common type of mental and behavioural disorder for both Indigenous males and females, while alcohol dependence syndrome was the most common type of mental and behavioural disorder for non-Indigenous males and females.

No comparable Indigenous and non-Indigenous data on alcohol related deaths at the national level are available for this Report.

A study by Chikritzhs et al. (2007) estimated alcohol attributable mortality for Indigenous residents in each of the 17 former ATSIC zones and found that:

- Over the 5 year period from 2000 to 2004, an estimated 1 145 (4.85 per 10 000 population) Indigenous Australians died from alcohol attributable injury and disease caused by drinking.
- In 2004, alcohol attributable death rates for Indigenous people in the Central NT (14 per 10 000) and WA North (10 per 10 000) were more than double the national rate for Indigenous people (4.17 per 10 000) for that year.
- Suicide (19 per cent) and alcoholic liver cirrhosis (18 per cent) are the two most common causes of alcohol attributable death among Indigenous men.
- For Indigenous women, alcoholic liver cirrhosis (27 per cent), haemorrhagic stroke (16 per cent), and fatal injury caused by assault (10 per cent) were the most common causes of alcohol attributable death.
- The average age at death from the most common alcohol attributable conditions was 35 for Indigenous men and 34 for Indigenous women.

8.2 Tobacco consumption and harm

Box 8.2.1 **Key messages**

- Nationally, in 2004-05:
  - 50.0 per cent of Indigenous adults were current daily smokers (figure 8.2.1)
  - after adjusting for age differences, Indigenous adults were more than twice as likely as non-Indigenous adults to be daily smokers (46.3 per cent compared to 21.1 per cent) (table 8A.2.2).
- From 1995 to 2004-05, the proportion of current daily smokers among both Indigenous women and men living in non-remote areas remained constant (figure 8.2.3).

Tobacco use is an important contributor to premature death and ill health. In addition to the long term health risks, tobacco use among low income groups can have immediate, insidious effects, by diverting scarce family resources away from beneficial uses. If a breadwinner becomes ill as a result of tobacco use, the cost of health care and the loss of earnings and productivity can worsen poverty or push families living precariously into poverty.

According to WHO (2004), tobacco and poverty are inextricably linked worldwide. Poor families are more likely to include one or more smokers than richer families, and often allocate a substantial part of the families' total expenditures to these harmful products.

Tobacco use is often associated with other lifestyle related health risk factors, such as excessive alcohol drinking and dietary factors. ABS (2006) found that long term risky/high risk drinkers (both males and females) were more likely to be current smokers than those who drank at a low risk level. The effects of alcohol were often worsened by other risk factors, such as smoking and poor diet (NHMRC 2001).

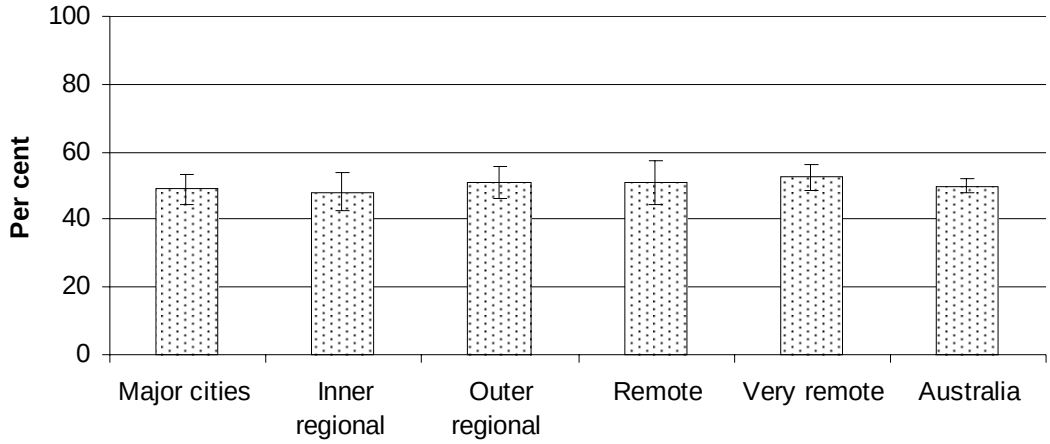
This section examines patterns of tobacco use and its related harm, including hospitalisations and deaths related to tobacco use.

Patterns of tobacco consumption

Data on the tobacco consumption in this chapter are sourced from several ABS surveys, including the 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and National Health Survey (NHS), the 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), and the 1994 National Aboriginal and Torres Strait Islander Survey (NATSIS).

Data on tobacco use in this section refer to smoking of tobacco, including manufactured (packet) cigarettes, roll-your-own cigarettes, cigars and pipes, but excludes chewing tobacco and smoking of non-tobacco products. Current daily smokers refer to people who smoked one or more cigarettes (or pipes or cigars) per day at the time of interview. Data in this section focus on current daily smokers aged 18 years and over.

Figure 8.2.1 **Current daily smokers, Indigenous people aged 18 years and over, 2004-05[a, b]**



a 'Current daily smokers' refers to people who smoked one or more cigarettes (or pipes or cigars) per day at the time of interview. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS; table 8A.2.8.

In 2004-05:

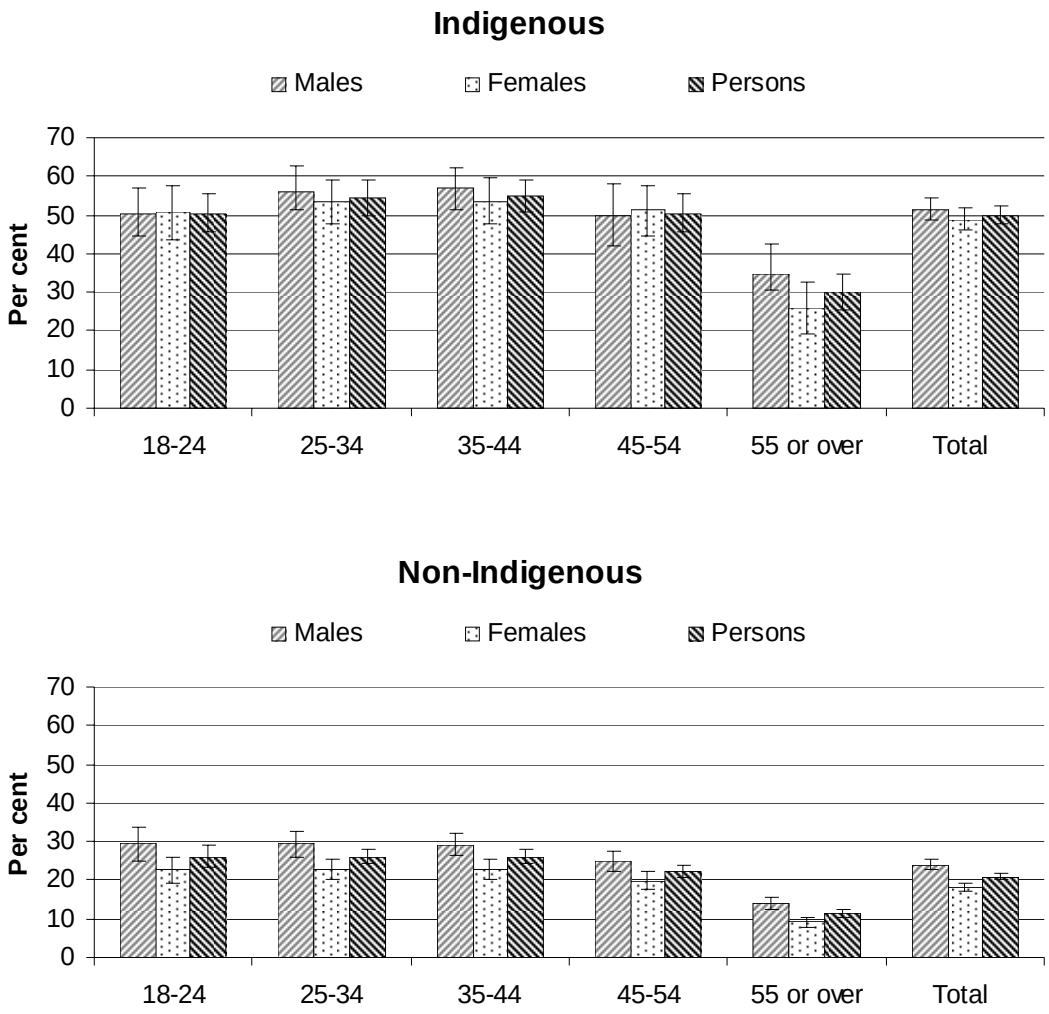
- Nationally, 50.0 per cent of Indigenous adults were current daily smokers (figure 8.2.1).
- The proportion of current daily smokers among Indigenous adults was similar across remoteness areas (figure 8.2.1).

After taking account of the different age structures of the Indigenous and non-Indigenous populations, in 2004-05:

- Nationally, Indigenous adults were more than twice as likely as non-Indigenous adults to be current daily smokers (46.3 per cent compared to 21.1 per cent) (table 8A.2.2).
- The proportion of current daily smokers among Indigenous adults was higher than that for non-Indigenous adults across four remoteness areas (major cities,

inner and outer regional areas and remote areas) for which data were available (table 8A.2.2).[3]

Figure 8.2.2 **Current daily smokers aged 18 years and over, 2004-05[a, b]**



a Totals are not age standardised and not directly comparable between Indigenous and non-Indigenous people. **b** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2004-05 NATSIHS and NHS (unpublished); table 8A.2.5.

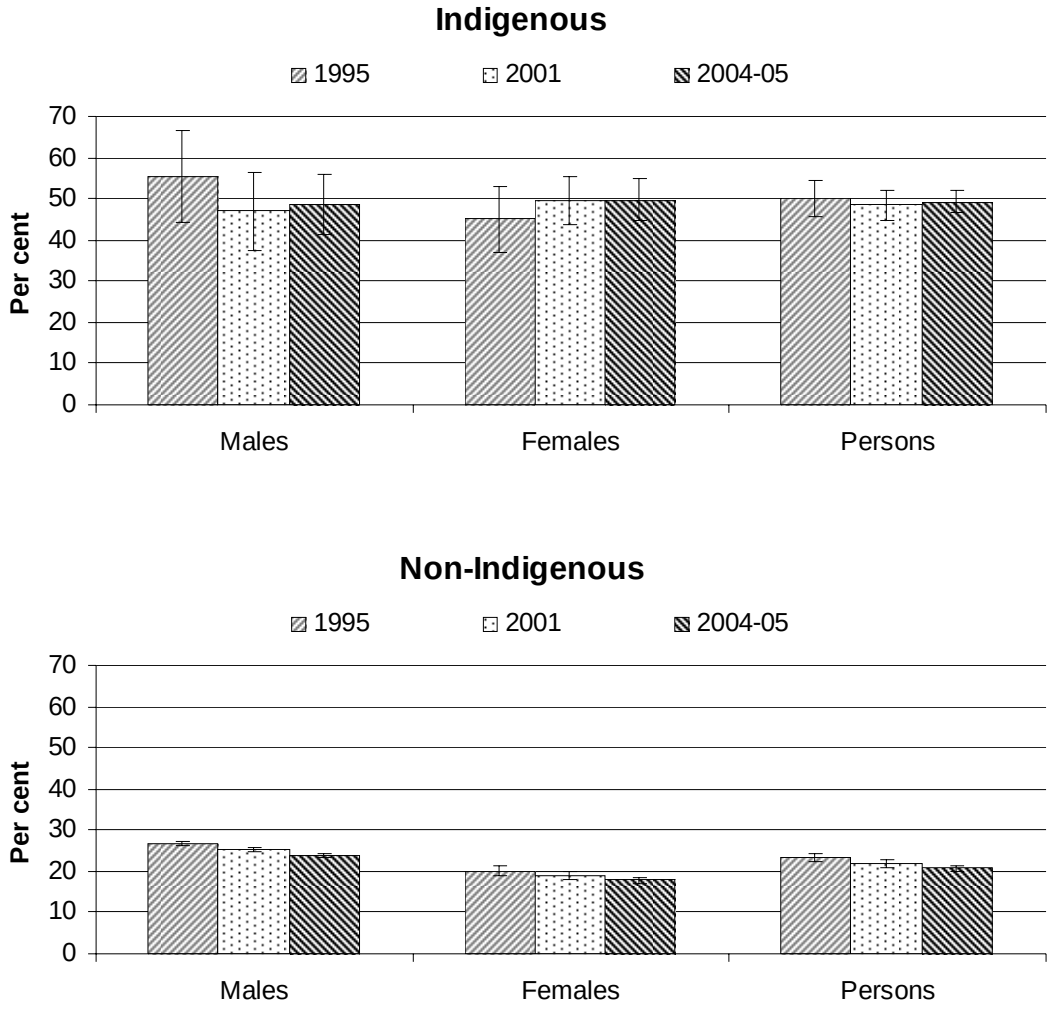
- Smoking was more prevalent among Indigenous adults than non-Indigenous adults, for both women and men, and for all age groups (figure 8.2.2).
- The proportions of current daily smokers among Indigenous women and men were similar. By comparison, non-Indigenous men were more likely to be

[3] Indigenous and non-Indigenous comparisons are not possible for very remote areas as non-Indigenous data for very remote areas were not collected in the 2004-05 NHS.

current daily smokers than non-Indigenous women (24.0 per cent compared to 18.0 per cent).

- Regardless of Indigenous status, smoking was less prevalent among people aged 55 years and over compared to all younger age ranges, although Indigenous people aged 55 years and over were more likely to be current daily smokers than non-Indigenous people in the same age range (30.1 per cent compared with 11.6 per cent) (figure 8.2.2).

Figure 8.2.3 **Current daily smokers, aged 18 years and over, living in non-remote areas[a, b, c]**



a Data are not age standardised and not directly comparable between Indigenous and non-Indigenous people. **b** Comparable data are only available for non-remote areas as data from remote areas were not collected in the 1995. **c** Error bars represent 95 per cent confidence intervals around each estimate (see chapter 2 for more information).

Source: ABS 2001 NHS(I) and NHS, ABS 2004-05 NATSIHS and NHS (unpublished); table 8A.2.3.

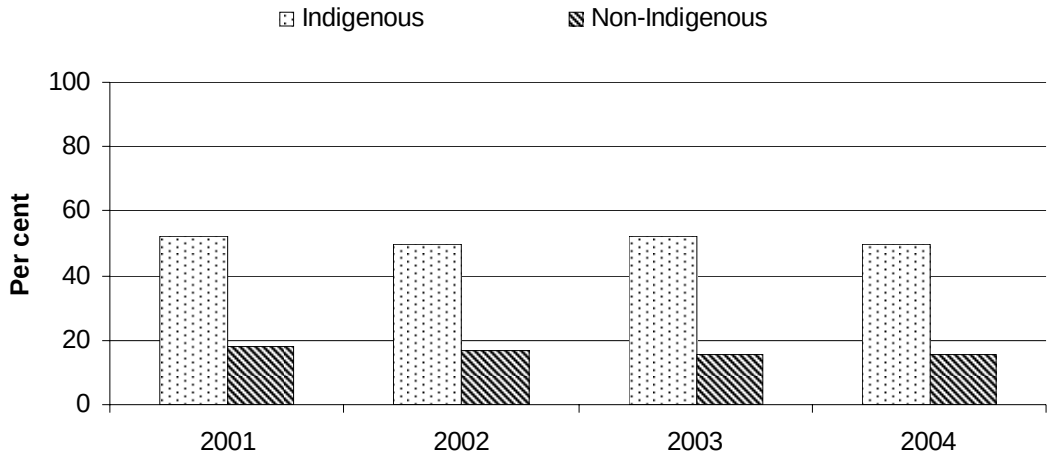
- The proportion of current daily smokers among both Indigenous women and men living in non-remote areas changed little over the period from 1995 to 2004-05 (figure 8.2.3).
- By comparison, the proportion of current daily smokers among non-Indigenous adults in non-remote areas decreased continually from 1995 (23.4 per cent) to 2004-05 (20.8 per cent). This occurred for both women and men.

Tobacco related hospitalisations and deaths

Tobacco smoking is the primary cause of premature and preventable death and disease in Australia. There is a strong causal relationship between tobacco consumption and multiple chronic diseases, including coronary heart disease, stroke, chronic respiratory tract diseases, and pregnancy-related conditions such as low birthweight. Further, passive smoking has been linked with higher rates of respiratory illness, sudden infant death syndrome (SIDS) and asthma in children, and lung cancer and heart disease in adults (DHA 2003, 2004).

Data on hospitalisations related to tobacco use reported for this indicator are sourced from the AIHW National Hospital Morbidity Database. These data only cover tobacco related illnesses resulting in admission to a hospital (figure 8.2.5). Further, data are only available for conditions directly attributable to tobacco and do not include most conditions where tobacco may be a contributing factor but where the link is not direct and immediate. Lastly, identification of Indigenous patients is incomplete and completeness varies across jurisdictions. The AIHW has advised that only data for Queensland, WA, SA and the NT are considered to be acceptable for analytical purposes. Data for NSW, Victoria, Tasmania and the ACT were withheld by AIHW due to high rates of under-identification of Indigenous people (see chapter 2 and appendix 4 for more information). The limitations of using hospital statistics are discussed in appendix 3.

Figure 8.2.4 **Mothers reporting smoking during pregnancy (NSW, WA, SA, the ACT and the NT)[a]**



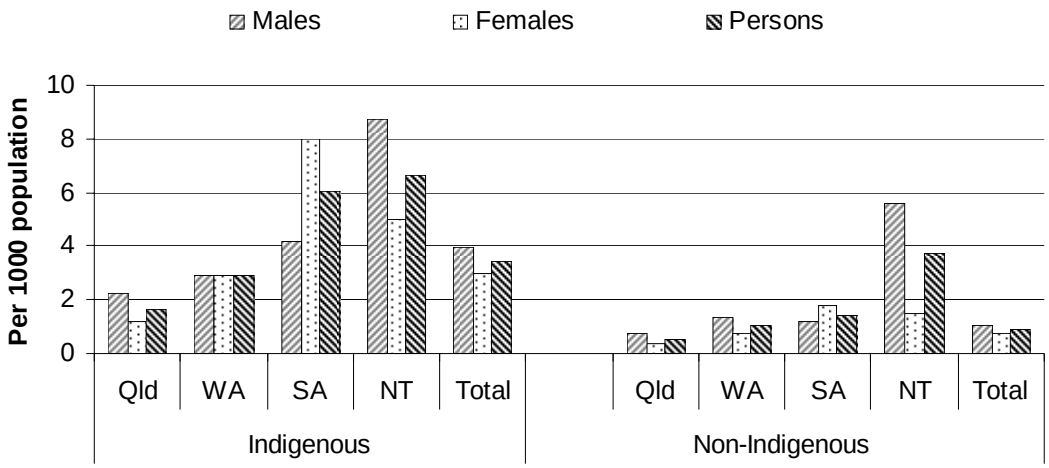
a Smoking during pregnancy data were only available for these five jurisdictions.

Source: AIHW National Perinatal Statistics Unit (2006a, 2006b); table 8A.2.7.

In NSW, WA, SA, the ACT and the NT:

- Indigenous mothers were about three times as likely as non-Indigenous mothers to smoke during pregnancy, in each of the four years from 2001 to 2004 (figure 8.2.4).
- The rate of smoking during pregnancy for non-Indigenous mothers decreased from 17.8 per cent in 2001 to 15.3 per cent in 2004.
- The rate for Indigenous mothers decreased slightly from 51.9 to 49.7 per cent between 2001 and 2004 (figure 8.2.4).

Figure 8.2.5 **Hospitalisations related to tobacco use in Qld, WA, SA, and public hospitals in the NT, 2004-05 (per 1000 population)** [a, b, c, d]



[a] The hospitalisation rates (per 1000 population) were directly age standardised to the Australian population as at 30 June 2001. [b] Principal diagnoses of hospitalisations are based on codes of the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM). [c] Non-Indigenous data include separations where Indigenous status were not reported. [d] Data are based on state of usual residence.

Source: AIHW National Hospital Morbidity Database (unpublished); table 8A.2.4.

In 2004-05:

- Across the four jurisdictions, Queensland, WA, SA, and public hospitals in the NT, the hospitalisation rates related to tobacco use for Indigenous people were consistently higher than those for non-Indigenous people (figure 8.2.5).
- The rates of hospitalisations related to tobacco use in the four jurisdictions for Indigenous people was almost 4 times as high as that for non-Indigenous people, for both males and females (3.9 per 1000 for Indigenous males compared with 1.0 per 1000 for non-Indigenous males; 3.0 per 1000 for Indigenous females compared with 0.8 per 1000 for non-Indigenous females).
- Regardless of Indigenous status, males were more likely to be hospitalised for tobacco-caused illness than their female counterparts in Queensland, WA, and the NT; however, in SA females had a higher rate of hospitalisations for tobacco caused illness than their male counterparts.

No comparable Indigenous and non-Indigenous data on smoking related deaths are available for inclusion in this Report.

8.3 Drug and other substance use and harm

Box 8.3.1 **Key messages**

- In 2004-05:
  - 28.0 per cent of Indigenous adults living in non-remote areas reported illicit substance use in the previous 12 months (table 8.3.1)
  - marijuana (22.5 per cent), amphetamines (7.3 per cent) and analgesics/sedatives (for non-medical purposes) (6.0 per cent) were the most commonly used substances (table 8.3.1).
- For all homicides recorded from 1999-2000 to 2004-05 a lower proportion of Indigenous homicides than non-Indigenous homicides occurred under the influence of drugs (22.5 per cent compared to 34.7 per cent) (figure 8.3.2).

Drug and other substance misuse is a contributing factor to illness and disease, accident and injury, violence and crime, family and social disruption, and workplace problems. Reducing drug related harm will improve health, social and economic outcomes at both individual and community levels.

Illicit substance use can be divided into two categories: use of substances which are illegal to possess (such as heroin) and misuse of substances which are legally available (such as petrol inhalation and misuse of prescription drugs).

In recent years, illicit drug consumption has played a significant role in Indigenous people's involvement in the criminal justice system. According to the Office of the Status of Women, there is a correlation between domestic violence and drug and alcohol use in Indigenous communities, with 70 to 90 per cent of assaults being committed while under the influence of alcohol and other drugs (DHA 2003).

The use of other substances such as inhalants (for example, petrol, glue, paint and butane gas) can lead to serious health consequences, including long term brain damage, disability or even death. It can also cause social alienation of sniffers, violence and crime (the Senate Community Affairs Committee 2006; Access Economics 2006).

Patterns of illicit drug use

It is difficult to obtain accurate prevalence data on the use of illicit drugs. Their illegality and their low prevalence makes them difficult to address with population surveys. Data from use of health systems or interaction with the criminal justice system tend to identify mainly heavy users and those who succumb to the drug's

effects; while the evidence suggests that the majority of illicit drug users use drugs infrequently without becoming addicted (Makkai and McAllister 1998).

In this Report, data on illicit drug use by Indigenous people aged 18 years and over in non-remote areas are from the ABS 2004-05 NATSIHS. No data on drug use by non-Indigenous people are available for direct comparison with these data. However, data sourced from the AIHW National Drug Strategy Household survey provide some comparison between illicit drug use by Indigenous and non-Indigenous people aged 14 years and over in non-remote areas (table 8.3.2)

Data on illicit drug use in the 2004-05 NATSIHS were collected in non-remote areas from private dwellings only, excluding people in institutions, such as hospitals, prisons and hotels, where substance use may be more prevalent. Data on illicit drug use from this survey may be subject to under-reporting.

Table 8.3.1 **Indigenous persons aged 18 years or over residing in non-remote areas: status of substance use (per cent), 2004-05**

	Males	*Females*	*Persons*
Used substance			
Used substances in last 12 months			
Analgesics and sedatives for non-medical use[a]	3.7	7.9	6.0
Amphetamines or speed	10.1	4.9	7.3
Marijuana, hashish or cannabis resin	28.6	17.5	22.5
Kava	1.6*	0.2*	0.8*
Total used substances in last 12 months[b]	32.4	24.4	28.0
Used substances but not in last 12 months	22.4	20.8	21.5
Total used substance[c]	55.6	45.6	50.1
Never used substances	42.4	52.7	48.0
Persons who accepted substance use form[d]	100.0	100.0	100.0
Persons who accepted substance use form (no.)	67 594	81 656	149 250
Persons who accepted substance use form as a proportion of all persons in the survey (%)	78.0	82.6	80.5

*indicates the relative standard error for the estimate is greater than 25 per cent and should be used with caution.

[a] Includes pain killers, tranquilisers and sleeping pills. [b] Includes heroin, cocaine, petrol, LSD/synthetic hallucinogens, naturally occurring hallucinogens, ecstasy/designer drugs, methadone and other inhalants. Sum of components may be more than total as persons may have reported more than one type of substance used. [c] Includes 'whether used in last 12 months' not known. [d] Includes 'whether ever used substances 'not known' and 'not stated'.

Source: ABS 2004-05 NATSIHS (unpublished); table 8A.3.3.

In 2004-05, among Indigenous adults living in non-remote areas who accepted the substance use form, who accounted for 80.5 per cent of all persons in the survey:

- 28.0 per cent reported illicit substance use in the 12 months prior to the survey, which was similar to that reported in 2002 (table 8.3.1; table 8A.3.3).[4]
- 21.5 per cent reported illicit substance use at least once in their lifetime but not in the 12 months prior to the survey (table 8.3.1).
- The substances most commonly used were marijuana (22.5 per cent), amphetamines (7.3 per cent) and analgesics/sedatives (for non-medical purposes) (6.0 per cent) (table 8.3.1).

Table 8.3.2 **Illicit drug use, people aged 14 years and over living in non-remote areas, by Indigenous status, 2004[a]**

		Indigenous	*Non-Indigenous*
Illicit drugs, including marijuana/cannabis			
Ever used	%	44.4	36.8
Used in the last 12 months	%	24.3	14.7
Illicit drugs, excluding marijuana/cannabis			
Ever used	%	22.8*	18.0*
Used in the last 12 months	%	10.3*	8.0*
Marijuana/cannabis			
Ever used	%	21.6	18.8
Used in the last 12 months	%	14.0	6.7
Total sample	**no.**	**463**	**28 982**

* indicates Indigenous and non-Indigenous data are significantly different at the 5 per cent statistical significance level.

a Illicit drugs include: illegal drugs (marijuana/cannabis, heroin, cocaine, LSD/synthetic hallucinogens, natural hallucinogens, ecstasy and other designer drugs, and any injected drugs); volatile substances (inhalants) used inappropriately; and pharmaceuticals used for non-medical purposes. The survey included the following drugs as illicit when used for non-medical purposes: pain-killers/analgesics, tranquillisers/sleeping pills, steroids, barbiturates, amphetamines, methadone (for non-maintenance program) and other opiates.

Source: AIHW National Drug Strategy Household Survey (unpublished); table 8A.3.4.

In the 2004 AIHW Drug Strategy Household Survey, which collected data for people aged 14 years and over living in non-remote areas:

- A higher proportion of Indigenous people than non-Indigenous people reported using illicit drugs (including marijuana/cannabis) in the months prior to the survey (24.3 per cent compared to 14.7 per cent) (table 8.3.2).

4 Questions in the 2004-05 NATSIHS are based on those used in the 2002 NATSISS. However, the difference in non-response should be considered, with the NATSIHS having 22 per cent non-response compared to 10 per cent for the NATSISS.

- Excluding marijuana/cannabis, the proportions of people who reported using illicit drugs in the 12 months prior to the survey were similar for Indigenous and non-Indigenous people.
- Indigenous people were more likely than non-Indigenous people to use marijuana/cannabis (14.0 per cent compared to 6.7 per cent) (table 8.3.2).

The use of other substances such as inhalants (for example, petrol and glue) can lead to serious health consequences, including long term brain damage, disability or even death (MCDS 2006). It can also cause social alienation of sniffers, violence and reduced self-esteem (DHA 2003).

Petrol sniffing is a form of substance abuse that affects a considerable proportion of Indigenous youth in remote areas, particularly in the Western corridor of Central Australia and the Tri State region of SA, WA and the NT. Studies (AIHW 2002, Clough et al. 2002 and 2004) have found that petrol sniffing has been occurring in some remote and urban communities alongside other forms of substance use, notably cannabis, kava and alcohol, and that past inhalant use is a predictor of other substance use.

It is difficult to estimate the prevalence of petrol sniffing in Australia as there is no reliable national data on the number of people involved and the extent of resulting damage to individuals and communities.

Access Economics (2006) estimated that, in 2005, there were 612 sniffers among the Indigenous population of 21 935 in a large region of Central Australia[5], and found that:

- the majority were males
- petrol sniffing was more prevalent among 12-13 years olds than among older teenagers
- there had been an increase in petrol sniffing, especially in the remote regions.

There are also variations within and between, Indigenous communities. Some studies (Burns et al. 1995; Campbell and Stojanovski 2001) have suggested that, associated with the introduction of alternative fuels and community-based

5 The region was defined by the Access Economics for the study on Cost Benefits of Opal Fuel. It covers parts of Northern Territory, SA and WA, comprising the Census statistical areas of Tennant Creek and Central NT in the Northern Territory, the Far North area of SA, and Laverton, Ngaanyatjarraku, Halls Creek, and the communities of Kiwirrkurra and Kunawarritji in WA. The total number of people in the region in 2005 was estimated as 65 037 of whom 21 935 were Aboriginal.

interventions, there had been a reduction in petrol sniffing in some communities where it had been prevalent for a long time (see box 8.3.2 for more information).

Excessive consumption of kava is a concern in some Indigenous communities, as it can lead to health problems such as liver damage and malnutrition. Kava can also have a negative impact on families and communities. Some Indigenous communities have expressed concern that kava consumption is linked to neglecting family and community duties, and spending household income on kava instead of on necessities like food (DHA 2003, DHA 2004, Clough and Jones 2004).

Prescription drugs used in combination with other substances such as alcohol can compound the social, physiological and psychological problems faced by people with a mental illness. Through a consultation process with rural Indigenous communities, the Aboriginal Drug and Alcohol Council of SA found that some Indigenous communities were concerned about the misuse of prescription drugs. These communities stated that prescription drugs such as serapax, codeine and panadeine forte were easily accessible by Indigenous people, and that some doctors freely prescribed these drugs (DHA 2003).

Box 8.3.2 **'Things that work' — reducing drug and other substance use**

Introduction of alternative fuels

The introduction of alternative fuels with low aromatics in some remote Indigenous communities in Central Australia has been successful in reducing the incidence of and harm from petrol sniffing. It is believed that aromatics contained in fuels are what give the "high" when sniffed. Alternative fuels with low levels of aromatics and other toxic ingredients reduce the incidence of sniffing as well as the potential for toxic effects associated with both acute and chronic exposure to aromatic compounds. It has also been recommended that to make it effective in the long term, this strategy needs to be introduced on a regional basis to prevent access to harmful petrol available outside communities. It also needs to be combined with the introduction of sporting and educational activities in remote communities (LANT 2004).

- Since the introduction of Opal fuel in the eleven communities on the Anangu Pitjantjatjara Yankunytjatjara Lands in 2005, the incidence of petrol sniffing on the Lands has fallen by 68 per cent. A survey commissioned by Nganampa Health Council identified 70 petrol sniffers in 2006 compared with 222 in 2004 (SA Government unpublished).

(Continued next page)

Box 8.3.2 (continued)

- As of March 2007, there were 68 communities, 26 roadhouses and service stations and 3 pastoral properties using Opal fuel across Australia. Anecdotal information suggests a 95 per cent decrease in petrol sniffing in the western desert communities in the Northern Territory.
- A recent article in the *Australian* reported that the incidence of petrol sniffing is declining in central Australia (north of the Northern Territory border), with currently around 20 petrol sniffers believed to be present. This is a small fraction of an estimated 600 petrol sniffers eighteen months ago (Wilson 2007).

Mount Theo Program

The Mount Theo program is based out of Yuendumu, a remote Aboriginal community 300 km northwest of Alice Springs, NT. Yuendemu is the largest Aboriginal community in Central Australia, with a total Indigenous population of 585 (based on the ABS 2001 Census).

Petrol sniffing became an increasingly serious problem among the young people of Yuendumu from the 1970s. By 1993, there were up to 70 sniffers in Yuendumu, and the community was plagued with problems caused by the petrol sniffers, including violence and damage to property.

In 1994, after many community meetings, Yuendumu Warlpiri elders decided to send young petrol sniffers to Mt Theo outstation, 160 km northwest in the Tanami Desert. Traditional owners moved out to Mt Theo to help the young people and teach them traditional culture. At Mt Theo, young people were geographically isolated and had no access to petrol, so they had a chance to recover from the effects of sniffing, while people in Yuendumu had some respite from the destructive behaviour of the sniffers.

Around the same time, a program of activities collaborating with Yuendumu School and Youth Challenge Australia was started in Yuendumu to ensure that young people have alternative activities and opportunities when they return from Mt Theo to the community. The Jaru Pirrjirdi (Strong Voices) project engaged young people as leaders, working on community development projects. Night School provided youth development and educational activities. Many of the past clients of the outstation are engaged in Night School as part of the Mt Theo follow-up and after care program.

The Mt Theo Program has been successful in reducing the number of regular petrol sniffers in Yuendumu from 70 to zero within a decade. The success of this program lies in giving young people traditional culture and respite from sniffing at Mt Theo, with diversion through education and recreational activities in the home community of Yuendumu. It has also been attributed to a strong partnership of Indigenous and non-Indigenous skills, drawing strength and experience from both cultures.

Source: Preuss and Napanangka Brown 2006; the Senate Community Affairs Committee 2006; DHA and DIMIA 2006; Wilson 2007.

Drug related crime

Broadly speaking, there are three types of drug related crime: violence associated with illegal drug markets; crimes committed by individuals under the influence of drugs; and petty crime committed by drug users to pay for their drug purchases.

Although the link between drug use and crime is complex, many studies have found that there is clear evidence that drug use and crime tend to be associated — that is, co-existing in the same populations (Richard and Payne 2005; Makkai and Payne 2003; Johnson 2004, Loxley et al 2004, Stevens et al. 2005). Many persistent offenders frequently use illicit drugs, and drug dependence may amplify offending. Both crime and problematic drug use are linked to other factors, including socio-economic deprivations.

Wilczynski and Pigott (2004) found that illicit drugs were associated with both violent and property crime, but most strongly with property crime.

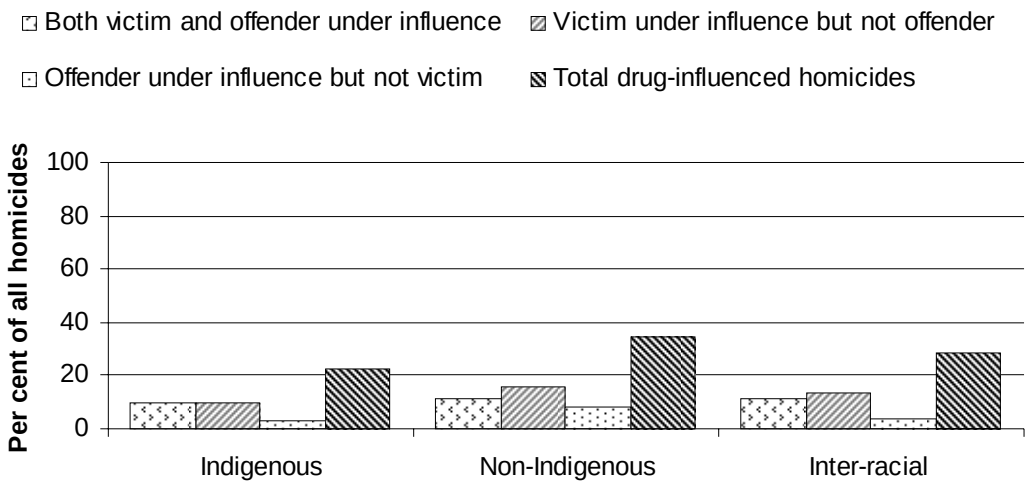
Richard and Payne (2005) found that there was a connection between drug and alcohol use and criminal offending among 371 juveniles aged 10 to 17 years who were in detention centres in all Australian jurisdictions in 2003-04. They found that:

- at the time of their offence, 48 per cent of these juvenile offenders were under the influence of drugs
- 44 per cent of burglars attributed their crimes to the need to obtain money to buy drugs
- almost one third of youths who had been charged with assaulting others attributed the offences to being drunk or high at the time of the offence
- compared with non-regular offenders, regular violent and regular property offenders were twice as likely to be regular users of cannabis
- Indigenous and non-Indigenous youths used similar substances at similar frequencies, although non-Indigenous detainees were significantly more likely to have used amphetamines and ecstasy
- Indigenous youths were more likely to attribute their criminal offending to substance use (35 per cent) than non-Indigenous youths (29 per cent).

An analysis of data from the Drug Use Monitoring in Australia (DUMA) program has shown that among the police detainees in seven urban police stations or watch houses in NSW, Queensland, WA and SA, urban Indigenous adult male offenders have similar experiences with illicit drugs as their non-Indigenous counterparts, including intravenous use, dependency and involvement in the illicit drug trade (Putt, Payne and Miller 2005).

Data on drug influenced crimes from the AIC National Homicide Monitoring Program (NHMP) are included for the first time in this Report. It should be noted that these data may not reflect the full extent of crimes under the influence of drugs as they do not include other forms of crime involving drugs, such as robberies, burglaries and assaults. Other limitations of the NHMP data are discussed in appendix 3.

Figure 8.3.1 **Drug influenced Indigenous and non-Indigenous homicides, 1999-2000 to 2004-05[a, b ,c, d, e]**

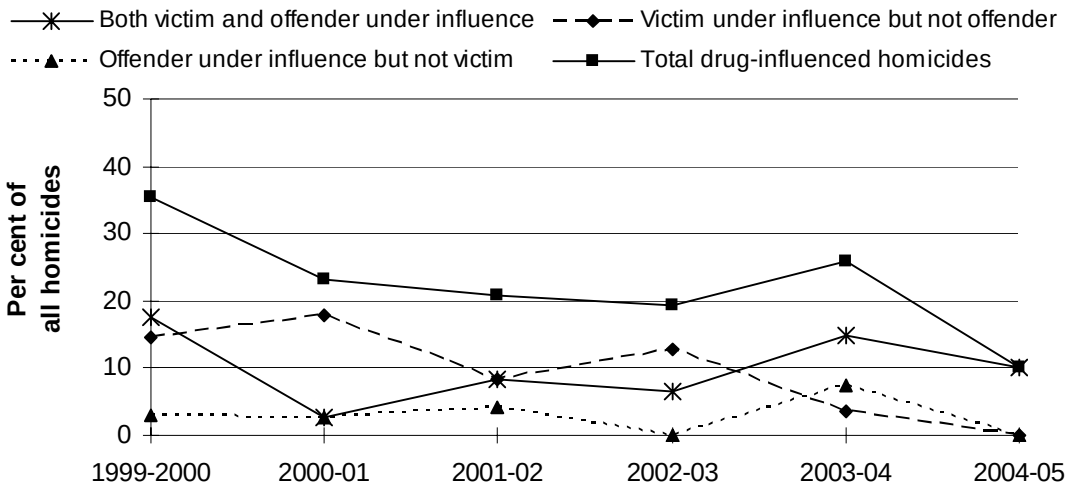


a Homicide includes murder and manslaughter, but excludes driving causing death. **b** Indigenous homicides are where both victims and offenders of homicide are Indigenous. **c** Non-indigenous homicides are where both victims and offenders are not Indigenous, including victims and offenders who are Caucasian, Asian and Maori/Pacific Islanders. **d** Inter-racial homicides are where either the victim or the offender is Indigenous, including homicides involving: an Indigenous offender and non-Indigenous victim, and non-Indigenous offender and an Indigenous victim. **e**Total drug influenced homicides are the aggregate of three categories of homicides under influence of drugs: both the 'victim and offender under the influence',' victim under the influence but not offender', and 'offender under the influence but not victim'

Source: AIC NHMP (unpublished); table 8A.3.5.

- Among all homicide recorded in the AIC NHMP database between 1999-2000 to 2004-05, a lower proportion of Indigenous homicides than non-Indigenous homicides were associated with the use of drugs at the time of the offence (22.5 per cent compared to 34.7 per cent) (figure 8.3.1).

Figure 8.3.2 **Drug influenced Indigenous homicides, 1999-2000 to 2004-05[a]**



a Totals are the aggregate of three categories of homicides under influence of drugs: both the 'victim and offender under the influence',' victim under the influence but not offender', and 'offender under the influence but not victim'.

Source: AIC NHMP (unpublished); table 8A.3.5.

- The overall level of drug-influenced Indigenous homicides fell from 35.3 per cent in 1999-2000 to 10.0 per cent in 2004-05, with significant decreases occurring between 2003-04 and 2004-05, and between 1999-2000 and 2000-01 (figure 8.3.2).

Drug related hospitalisations and deaths

Data on hospitalisations related to drug use reported for this indicator are sourced from the AIHW National Hospital Morbidity Database. These data only cover drug related illnesses resulting in admission to a hospital. Further, data are only available for conditions directly attributable to drug use and do not include most conditions where drug use may be a contributing factor but where the link is not direct and immediate. Lastly, identification of Indigenous patients is incomplete and completeness varies across jurisdictions. The AIHW has advised that only data for Queensland, WA, SA and the NT are considered to be acceptable for analytical purposes. Data for NSW, Victoria, Tasmania and the ACT were withheld by AIHW due to high rates of under-identification of Indigenous people (see chapter 2 and appendix 4 for more information). The limitations of using hospital statistics are discussed in appendix 3.

Based on data from four jurisdictions (Queensland, WA, SA and the NT), in 2004-05 (table 8A.3.1):

- The most common hospitalisations related to drug use for both Indigenous and non-Indigenous people were poisoning, mental and behavioural disorders, and accidental poisoning.
- The rates of hospitalisations for the three common drug related conditions for Indigenous people were all higher than those for non-Indigenous people.
- In particular, Indigenous people (1.5 per 1000) were twice as likely as non-Indigenous people (0.6 per 1000) to be hospitalised for mental and behavioural disorders caused by drug use.

Data on hospitalisations due to drug use by jurisdiction and sex are reported in table 8A.3.2.

Illicit drugs are a direct cause of death as well as being risk factors for conditions such as HIV/AIDS, hepatitis, low birthweight, inflammatory heart disease, poisoning and suicide and self-inflicted injuries. However, no data on illicit drug use related deaths by Indigenous status are available for inclusion in this Report.

8.4 Future directions in data

There are limited data regarding patterns of substance use. In this Report, data on substance use (including tobacco, alcohol and illicit drugs) are sourced from several ABS surveys. Direct comparison of illicit drug use between Indigenous and non-Indigenous people is not possible in this Report, as 2004-05 data on illicit drug use by non-Indigenous people were not collected in the 2004-05 NHS. Comparable data on changes in substance use over time are only available for alcohol and tobacco use in this chapter, with some data available on substance use.

The report, *Drug Use among Aboriginal and Torres Strait Islander Peoples: an Assessment of Data Sources*, was released by AIHW in October 2006. This report suggested many ways to improve current AIHW collections of data on substance use, among which the following are relevant to this chapter:

- continue to improve accurate identification of Indigenous status across all data sources
- improve estimates of substance use among Indigenous people, particularly in relation to illicit substance use in rural and remote locations
- improve information about the number of Indigenous people accessing alcohol and other treatment services, the types of treatment they receive and its outcomes

- develop an appropriate methodology for gathering information about emerging issues relevant to Indigenous substance use, such as petrol sniffing.

This provides some hope for being able to report data with improved quality and comparability in the future when these suggested improvements are in place.

Data on smoking during pregnancy are available for five jurisdictions (NSW, WA, SA, the ACT and NT), but few data on alcohol consumption during pregnancy were available for the Report (although some are available for Queensland). In Victoria, reported alcohol use and smoking status during pregnancy will be part of the Aboriginal Child Health, Development and Wellbeing Survey which is currently being designed. This will enable Victoria to report data on smoking and alcohol use by Indigenous women during pregnancy in Victoria for future Reports.

8.5 Attachment tables

Attachment tables are identified in references throughout this chapter by an 'A' suffix (for example, table 8A.2.2 is table 2 in the attachment tables for section 8.2). The files containing the attachment tables can also be found on the Review web page (www.pc.gov.au/gsp). Users without access to the Internet can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Report).

8.1 Alcohol consumption and harm

Table 8A.1.1	Alcohol consumption for people aged 18 years or over, age standardised, 2004-05
Table 8A.1.2	Risky to high risk alcohol consumption for persons aged 18 years or over, age standardised
Table 8A.1.3	Risky to high risk alcohol consumption for persons aged 18 years or over, non-remote areas only
Table 8A.1.4	Risky to high risk alcohol consumption for people aged 18 years or over, age standardised 2004-05
Table 8A.1.5	Alcohol involvement in Indigenous and non-Indigenous homicides
Table 8A.1.6	Hospital separations related to alcohol use (per 1000 population), Qld, WA, SA, and public hospitals in NT
Table 8A.1.7	Hospital separations related to alcohol use (per 1000 population), Qld, WA, SA, and public hospitals in NT
Table 8A.1.8	Hospital separations related to alcohol use (per 1000 population), Qld, WA, SA, and public hospitals in NT
Table 8A.1.9	Tobacco and alcohol consumption for Indigenous people aged 18 years or over, age standardised

Table 8A.1.10 Risky to high risk alcohol consumption, Indigenous people aged 18 years or over, by sex and remoteness, 2004-05

Table 8A.1.11 Risky to high risk alcohol consumption for people aged 18 years or over, by sex and age, 2004-05

Table 8A.1.12 Alcohol consumption at short term risky to high risk levels, people aged 18 years or over, 2004-05

8.2 Tobacco consumption and harm

Table 8A.2.1 Tobacco consumption for people aged 18 years or over, age standardised, 2004-05

Table 8A.2.2 Current daily smokers aged 18 years or over, by sex and remoteness, age standardised

Table 8A.2.3 Current daily smokers aged 18 years or over, by sex and age, non-remote areas only

Table 8A.2.4 Current daily smokers aged 18 years or over, age standardised, 2004-05

Table 8A.2.5 Current daily smokers aged 18 years or over

Table 8A.2.6 Age standardised hospital separations related to tobacco use (per 1000 population), Qld, WA, SA and public hospitals in NT

Table 8A.2.7 Mothers reporting smoking during pregnancy (per cent)

Table 8A.2.8 Current daily smokers, Indigenous people aged 18 years or over, 2004-05

8.3 Drug and other substance use and harm

Table 8A.3.1 Main types of hospital separations related to drug use, Qld, WA, SA, and public hospitals in NT

Table 8A.3.2 Age standardised hospital separations related to drug use, Qld, WA, SA, and public hospitals in NT

Table 8A.3.3 Substance use for Indigenous persons aged 18 years and over in non-remote areas, age standardised

Table 8A.3.4 Illicit drug use for people aged 14 years and over living in non-remote areas

Table 8A.3.5 Drug involvement in Indigenous and non-Indigenous homicide

8.6 References

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