CHAPTER 6: UNIVERSAL OR TARGETED APPROACHES

Public health interventions can be classified as universal, selected or indicated. Universal approaches are aimed at the whole population, selected interventions are aimed at individuals or groups at higher risk than the general population, and indicated interventions are aimed at those who are already experiencing a problem. These last two categories are targeted approaches, as they target specific groups.

As explained by Geoffrey Rose, there are generally more low-risk individuals in the population than high-risk individuals and a large number of low-risk individuals can contribute to more problem cases than a small number of high-risk individuals. Consequently, universal approaches will generally have a greater impact on the population incidence of a problem than targeted approaches because they benefit more individuals, albeit in a small way. Targeted interventions can have a larger impact per person, but they affect only a small number of people, so their population impact is less than the impact achieved with population approaches. [1 2] This phenomenon is known as the 'prevention paradox'.

This line of argument has been used to advocate universal prevention programs. For example, McCain and Mustard argued for universal child development programs in Canada, [3 4] and Barnett and colleagues argued for the provision of universal preschooling in the United States of America. [5] Their arguments are supported by evidence such as that provided by Hertzman and colleagues' mapping project. [6] This project involved mapping the results of developmental assessments of kindergarten children in Vancouver using the Early Development Instrument (EDI),[a] according to the children's neighbourhood of residence. The neighbourhoods were then characterised in terms of their socio-demographic status, developmental risk circumstances and access to services and facilities considered important for child development. Hertzman and colleagues reported:

> Although the highest risk of vulnerability is found in the poorest neighbourhoods of town, the largest number of children at risk is found more thinly spread across the middle class neighbourhoods that, taken as a whole, have a much larger number of young children than the poorest neighbourhoods. If the purpose of an early child development strategy is to increase resilience, decrease vulnerability and reduce social inequality, then a strategy to provide universal access to the conditions that support healthy child development is needed. This may mean addressing issues in different ways in different neighbourhoods, but it does *not* mean focusing exclusively on the highest risk areas. Such a strategy would miss most of the vulnerable children in Vancouver. (p. 34) [6]

As discussed in Chapter 2, countries that have adopted universal programs for child and youth development have demonstrably better outcomes in terms of child health, educational outcomes and behaviour. [7]

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[a] The EDI is a group-level measure of five developmental domains of children: physical health and well-being, social competence, emotional maturity, language and cognitive development, communication skills and general knowledge.

Other researchers have supported targeted approaches. For example, Pollard, Hawkins and Arthur argued that preventive programs should focus on risk reduction in geographic areas or among groups at high risk. [8] They based this argument upon the results of a study of risk and protective factors for substance use, school outcomes and delinquency. This study found that (a) the number of risk factors were exponentially associated with increases in problem outcomes; (b) even high levels of protection did not eliminate problem behaviours; (c) problem behaviours were more related to the number of risk factors than to variation in the number of protective factors; and (d) the benefits of protective factors were significant only at high levels of risk. This was a cross-sectional, individual-level study and might not have included analysis of some important protective factors. However, it does provide good support for reducing risk as well as building protection, particularly among high-risk groups.

Rhodes presented a slightly different argument for targeted interventions. [9] After reviewing the research on risk factors for drug abuse, Rhodes noted that there were multiple risk factors for multiple problem behaviours and that these occurred within risk environments. He contended that targeting should be based upon problem behaviours (for example, truancy, getting suspended from school or criminal activity) and that the risk environment (for example, the group of drug-using peers) should be the site for intervention and analysis.

The risk approach has been criticised. For example, Jones noted that, with the growth of technologies to identify risk, there is now an ever-increasing list of risk factors, but a lack of critical thought, with the result that some interventions can actually worsen the situation for young people. [10] He described research, such as the research of Beck [11] and Furlong, [12] on how modern society has created a set of risks that make life uncertain for all young people, and how young people need to face these risks on a daily basis. He argued that risk science, which perceives young people as at-risk or vulnerable and responds with 'authoritarian measures to address popular anxieties about a dangerous youth' (p. 370), is often ignorant of the lived experience of young people — how they experience daily life and how drug use fits in their world. In a world in which drug use, even illicit drug use, has become normalised, it is not seen as a risky behaviour by many young people. Further, targeted programs risk stigmatising the target group. Jones' suggestion for researchers was to spend less time identifying risk factors and more time understanding the social construction of risk and context from the perspective of young people. For policy makers, he suggested including young people in policy debates.

Stockwell and colleagues analysed data from the Victorian Adolescent Health and Wellbeing study (cross-sectional, n=2439–2510, depending upon the item, ages 15–16 years) and the Australian Temperament Project longitudinal survey of youth (from ages 11–12 to 17–18, n=1064) to investigate the appropriateness of universal versus targeted approaches. [13] The results were somewhat mixed, perhaps reflecting the different population prevalence of the various behaviours under investigation, hence the different degree of social norms attached to those behaviours. However, the research team recommended a mixed approach, including universal approaches for those behaviours for which the majority of youth were at risk (for example, tobacco, alcohol and cannabis use) and targeted approaches for those behaviours that were concentrated in higher-risk groups (early initiators of drug use, frequent cannabis users and other illicit drug users).

In summary, research strongly supports universal approaches to health promotion and drug prevention. High-risk individuals can benefit indirectly from such programs via the improvement in social climate and directly if such interventions are accessible and appropriate for high-risk individuals. There are, however, also good reasons to support targeted approaches. Four such reasons are outlined below:

1. There can be problems with access or exposure to public health programs for some high-risk groups. For example, drug-dependent people face discrimination and negative attitudes from staff in mainstream health services, [14] and this can be a barrier to attending services (for example, support services for new mothers).
2. Prevention interventions addressing some specific risk behaviours that are practised by a small minority of the population (for example, unsafe injecting practices) can be inappropriate for universal implementation if raising awareness of the behaviour increases interest in experimenting with that behaviour.
3. When groups are disproportionately experiencing a range of negative outcomes as the result of structural disadvantage, there is a social justice argument for targeted efforts to address those inequities. Lloyd, for example, identified high-risk or vulnerable groups as including (but not restricted to) the homeless, children in foster care, young offenders and children from families with drug-dependent parents. [15]
4. Disadvantage tends to persist without intervention. For example, Vinson's longitudinal research on resilient and disadvantaged communities demonstrated that severely disadvantaged communities tend to remain so without intervention. [16]

To illustrate how sustained structural changes can be necessary to address the problems facing disadvantaged and high-risk groups, the situations of sole parents and Australian Aboriginal and Torres Strait Islander peoples are discussed below.

Sole parents

Sole parents are losing their minority status. Between 1976 and 2001, the percentage of sole-parent households increased from 12 per cent to 25 per cent. [17] However, being a sole parent is not always a permanent situation. Sole parents form new relationships, some of which result in children living with new step-parents (whether due to a de facto relationship or a marriage[b]). Around 50 per cent of children experienced living in a sole-parent family in the United States of America [18] and in New Zealand [19] by the age of 15.

This section describes research that documents that children of sole-parent families tend to have worse outcomes than other children. These differences can be explained by a range of factors such as economic disadvantage. As such, researchers and policy makers tend to conclude that it is not being in a sole-parent family *per se* that results in negative outcomes, but it is the problems associated with being in a sole-parent family that contribute to negative outcomes. This line of reasoning has resulted in failure by researchers and policy makers to advocate addressing the needs of this disadvantaged group.

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[b] Problems with blended families will not be addressed here.

Drug use and other problems

Children of sole-parent families have been found to be at greater risk of multiple problems in relation to emotional, behavioural, social and academic development. [18 20-23] Lipman, Offord, Dooley and Boyle reviewed the literature on the effect of single-parent status on child emotional, behavioural, social and academic outcomes [22] and reported that, for those studies where effect sizes were given as odds ratios, the odds ranged from 1.1 to 4.8. That is, a child from a sole-parent family was up to 4.8 times more likely to have an undesirable outcome than a child from a two-parent family. With regard to drug use, higher rates of smoking, [24] heavy drinking [25] and substance abuse [26] have been found among children of sole parents compared with children living with two parents. For example, in Fegusson, Horwood and Lynskey's analysis of longitudinal data from a 15-year study of 935 children in New Zealand, children who were exposed to separation had odds of reporting substance abuse or dependence at age 15 years that were two to four times higher than children who had not experienced separation. [26] The size of the effect depended upon the age at which separation was experienced (Table 1).

Table 1: Rates of problem substance use/dependence at 15 years by parental separation and age periods during which separation was experienced

Age separation was experienced		
0–5 years		
	No separation (*N*=825)	6.9%
	Separation (*N*=110)	14.6%
	Odds ratio	2.29
	95% Confidence Interval	(1.27–4.15)
	p	<.003
5–10 years		
	No separation (*N*=806)	6.7%
	Separation (*N*=129)	14.7%
	Odds ratio	2.40
	95% Confidence Interval	(1.37–4.20)
	p	<.003
10–15 years		
	No separation (*N*=823)	6.1%
	Separation (*N*=112)	20.5%
	Odds ratio	4.00
	95% Confidence Interval	(2.32–6.85)
	p	<.001

Source: Adapted from Table 2 in Fergusson, Horwood and Lynskey, 1994, p. 1126. [26]

Reasons for problems

Lipman and colleagues reviewed the literature on sole parents and child outcomes and reported that the strength of the relationship between sole-parent families and negative child outcomes was lessened to some extent when analyses adjusted for lower family income and other indicators of socio-economic status such as parental education and employment. [22] They presented the results of analyses of the National Longitudinal Survey of Canadian Youth and found that:

> socioeconomic factors can explain only about a third to a half of the disparities associated with poverty and other socioeconomic factors. This suggests that other factors, such as, for example, the amount of time that parents can engage with their child in play or school-related activities, or the stress associated with separation or divorce, may also contribute to the differences in outcomes between children in single- and two-parent families. (p. 241)

Fergusson and colleagues described associations between parental separation and drug use and other problems as 'spurious':

> While the results suggested that children exposed to parental separation had increased risks of adolescent problems, much of this association appeared to be spurious and arose from confounding social and contextual factors that were present in the child's family before parental separation. (p. 1122) [26]

Summarising their research on the effects of parental separation on child psychopathology, Fergusson and Horwood described the multiple contributors to a range of problems experienced by children in sole-parent families:

> This research suggested that while children whose parents separated were at increased risks of later internalizing and externalizing problems, much of this increased risk was due to factors that were present prior to parental separation or divorce. These factors included socioeconomic disadvantage, elevated rates of adverse life events and higher levels of interparental conflict. When these pre-separation or divorce events were taken into account, most of the associations between parental separation/divorce and child adjustment were explained. Nonetheless, even following such control, there were small tendencies for children exposed to parental separation to be at somewhat increased risks of later conduct problems, mood disorder and substance abuse. (p. 291) [19]

Kelly reviewed the literature on divorce, marital conflict and children's adjustment. In relation to the increased use of alcohol, tobacco and cannabis, Kelly described a number of variables that contributed to this effect among children in sole-parent families:

> more reliance on friends and peer groups that use substances, less effective coping skills in divorced children, and impaired parental monitoring and parenting practices. Divorced parents also use more drugs and alcohol than do never-divorced parents. [21]

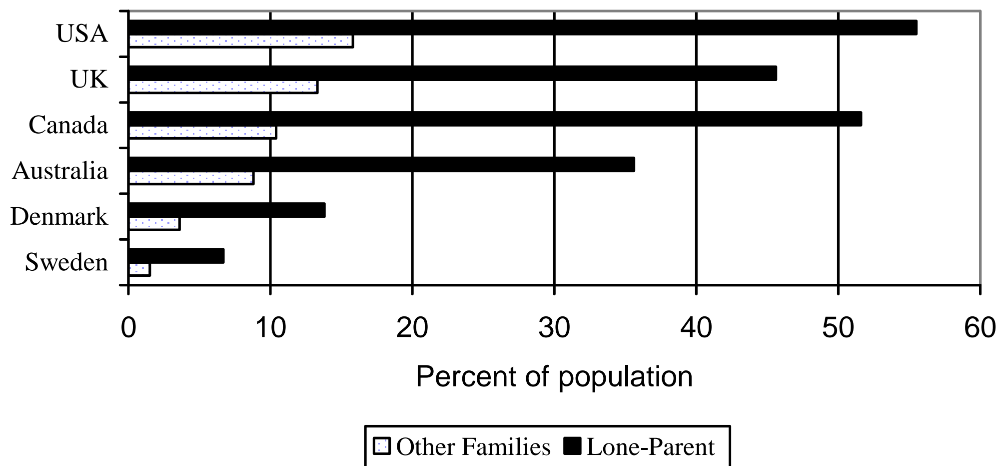
Kinnear reviewed the literature on the impacts of divorce on children and also described a range of contributing variables:

> The extensive research broadly concludes that, compared with children from intact families, children from separated families perform worse on a range of indicators of well-being and development, although, taken as a whole, the extent of the difference is not large. These studies are usually interpreted to mean that separation causes the problems, but in fact this is not necessarily the case. In their exhaustive review, Pryor and Rodgers conclude that the problems are due not to separation itself but to a complex interplay of factors before, during and after separation. Separation can be beneficial for children where the family is one of high conflict, especially if violence is present. Studies also show that the effects of

separation can be ameliorated if the situation is explained to children. A number of factors after separation can heavily influence the well-being of children, including continuing contact with both parents, continuing conflict between parents, reduced income, moving house and repartnering. [27]

Economic disadvantage was commonly cited as one reason for the negative outcomes of children from sole-parent families. Data on the economic situation of sole-parent families illustrate why this is such an issue. The Senate Community Affairs References Committee described sole-parent families and their children as one of the groups in Australia at highest risk of poverty. [28] The Australian Bureau of Statistics reported that, in 2001, over 350,000 families with children aged under 15 years had no employed resident parent. Almost two-thirds (64 per cent) of these families were single-parent families. [17] International data from the Luxembourg Income Study demonstrated that economic disadvantage is common for sole parents in Western countries, although the rates are much lower in Sweden and Denmark than in Australia, the United States of America, the United Kingdom and Canada (see figure below). This difference is likely to reflect the greater support given to parents in Scandinavian countries than in the other countries. [7]

Table 2: Child poverty in sole-parent and other families in Australia and five comparison countries, mid-1990s



Source: Luxembourg Income Study. [29] The poverty line is defined as 50 per cent of national median income after taxes and transfers.

The Senate Community Affairs References Committee described the key causes of poverty among women in general, particularly female sole parents, as including the following factors:

- the continuing inequality of wage levels, with women's wages still being generally lower than those of males
- the nature of the work that women are more inclined than males to do, which is more likely to be part-time or casual or precarious in nature
- the high costs of childcare
- the high costs of education
- lack of access to affordable housing
- insufficient income support for the needs of many sole-parent families
- the impact of 'shared-care' changes to the Family Tax Benefit, and

- lack of wealth accumulation during working life to support retirement incomes (pp. 211–212). [28]

While noting that the financial position of sole parents in Australia had improved in Australia since 1990, the Senate Committee identified a number of other factors that also influence the high rate of poverty of sole parents:

- labour market disadvantages of sole parents, including:
  - the difficulties of one parent combining work with parenting, including the lack of another parent to care for children and therefore a greater reliance on paid childcare
  - the gender and educational disadvantage of sole parents, and
  - discrimination against sole parents in the workforce
- their disadvantaged position after marriage separation. While the introduction of the Child Support Scheme has helped reduce the unequal situations of custodial and non-custodial parents following separation, problems still remain, including the higher costs of separated families
- the discrimination and prejudice that can be faced by sole parents, and
- inadequacy of income support payments (p. 226). [28]

Some structures that aim to support sole-parent families might be contributing to their problems. Gennetian and colleagues conducted a meta-analysis of random assignment studies of welfare and work policies targeting low-income, single-parent families. [30] They found that programs that required parents to work or participate in work-related activities or voluntary activities resulted in negative impacts on their adolescent children's academic outcomes. The authors noted that, while work provided some benefits to families, the net outcomes most likely depended upon factors such as how the program is implemented, the circumstances of individual families, the community context, institutional support and the type of employment in which parents were engaged. Outcomes were most likely to be negative for adolescents when their parents' working meant that they had to care for younger siblings. This study demonstrated that programs that simply place the onus on sole parents to work, without providing supports to do this in relation to childcare, can increase the problems of sole parents and worsen the outcomes for their children.

Implications

The evidence suggests that sole parents are under considerable stress raising children on their own. If they work, they can lose government support and have to juggle work commitments with childcare and supervision. Australian research has demonstrated that sole parents who work did not spend less time with their children than couple parents, which suggests that sole parents likely experience stress and fatigue as they cope with the demands of work and parenting. [31] If they do not work, sole parents face financial disadvantage. The issues for sole-parent families of socio-economic disadvantage and the demands of raising children while working need to be addressed. Phipps' review of social policies (summarised in Chapter 2) described how supportive policies in Norway have been associated with increased employment among sole parents and lower rates of poverty among children of sole parents relative to the less generous policies of the United States of America. [7]

Lipman and colleagues recommended investing in a range of programs, including universal programs, to support sole-parent families:

> programs that provide counselling and academic support to children following a separation or divorce, or programs such as Big Sisters or Big Brothers, which provide strong role models for children in sole-parent families. Investments in more universal programs, particularly sports and recreational programs, may also be more effective in reducing children's emotional behavioral problems. (p. 242) [22]

From their Children's Participation in Cultural and Leisure Activities Survey conducted in 2003, the Australian Bureau of Statistics reported that children of sole-parent families were almost twice (40 per cent compared with 26 per cent) as likely as children of couple families not to have participated in a range of cultural activities or organised sport outside school hours. [32] Such findings, in combination with recent research demonstrating the effectiveness of youth development programs and mentor programs, [33 34] indicate the systematic introduction of such programs should be considered. Such a systematic approach would be an improvement on the ad hoc, occasional and unregulated system currently available for youth programs.

Aboriginal and Torres Strait Islander Peoples

Drug use and other problems

The health and welfare of Australian Aboriginal and Torres Strait Islander peoples are known to be significantly poorer than those of other Australians. [35-42] Data from the Australian Bureau of Statistics that compare Aboriginal and Torres Strait Islander peoples with other Australians on a range of socio-economic and health indicators are presented in Table 3.

Table 3: Aboriginal and Torres Strait Islander (ATSI) peoples compared with other Australians

	ATSI peoples	Other Australians
In school at age 16	57%	84%
In post-secondary education at age 18–24	10%	24%
Adults with post-secondary qualifications	11%	30%
Employed	21%	42%
Median income (employed)	$365	$493
Own house	31%	70%
Sole-parent families	30%	15%
Imprisonment rate per 100,000	1663	139
Life expectancy at birth	Males: 57 Females: 62	Males: 75 Females:81

Source: Australian Bureau of Statistics, 2002 [43]

Further comparisons between outcomes for Aboriginal and Torres Strait Islander peoples and other Australians (listed below) relating to socio-economic status, health and crime were provided by the Productivity Commission, in its report on Indigenous disadvantage. [44]

- The life expectancy of people is around 20 years lower than that for the total Australian population.
- Nationally in 2002, Aboriginal and Torres Strait Islander students were half as likely to continue to Year 12 as other Australian students.
- Post-secondary attainment in 2001 was significantly lower among Aboriginal and Torres Strait Islander peoples, with 13 per cent of Aboriginal and Torres Strait Islander people having attained a level three certificate or above, compared to 34 per cent of other Australians.
- Unemployment in 2001 was 2.8 times higher for Aboriginal and Torres Strait Islander peoples than for other Australians. Participation in Community Development Employment Projects significantly reduced recorded unemployment rates among Aboriginal and Torres Strait Islander peoples.
- In 2001, both household and individual incomes were lower on average for Aboriginal and Torres Strait Islander peoples than for other Australians across all regions, and they were much lower in remote locations. In 2001, 32 per cent of Aboriginal and Torres Strait Islander households owned or were buying their own homes, compared with nearly 70 per cent of other Australian households.
- In 2001, the suicide rate for Aboriginal and Torres Strait Islander peoples (35.5 per 100 000) was considerably higher than the rate for other Australians (13.1 per 100 000) (based on data from Queensland, Western Australia, South Australia and the Northern Territory). Suicide death rates for the Aboriginal and Torres Strait Islander population were particularly high in the 25–34 year age group (67.2 per 100 000, compared with just under 20 per 100 000 in this age group for other Australians).
- During 1999–2001, homicides, as a proportion of total deaths, were ten times greater among Aboriginal and Torres Strait Islander peoples — 2.1 per cent compared with 0.2 per cent in the non-Aboriginal and Torres Strait Islander population.
- Hospital separation rates for assault in 2001–02 were higher for Aboriginal and Torres Strait Islander peoples (13.3 per 1000) than for other Australians (1.0 per 1000). The main category was assault by bodily force.
- On 30 June 2002, Aboriginal and Torres Strait Islander peoples were 15 times more likely than other Australians to be in prison.
- On 30 June 2002, Aboriginal and Torres Strait Islander juveniles were 19 times more likely to be detained than other Australian juveniles.

Aboriginal and Torres Strait Islander peoples also experience higher rates of drug use and drug-related problems, including tobacco, problem drinking (alcohol and kava), illicit drug use and volatile substance abuse. [45-50] For example, data from the National Drug Strategy 2001 household survey (Table 4) identified that, relative to other Australians, Aboriginal and Torres Strait Islander peoples were more likely to smoke; less likely to drink alcohol, but more likely to drink in a risky manner if they did drink (as per the National Health and Medical Research Council guidelines for risky drinking); and more likely to use cannabis and other illicit drugs. Injecting drug use is also more prevalent among Aboriginal and Torres Strait Islander peoples (3 per cent) than in the rest of the Australian population (2 per cent) and the sharing of injecting equipment has increased among Aboriginal and Torres Strait Islander peoples, with one study reporting that 43 per cent of Aboriginal and Torres Strait Islander injectors shared injecting equipment. [45] Problems with volatile substance abuse [50-52] and kava use [53 54] have also been experienced by Aboriginal and Torres Strait Islander communities. However, given the localised nature of these problems, prevalence rates are not readily available.

Table 4: Drug use for Aboriginal and Torres Islander (ATSI) peoples and other Australians aged 14 years and over, Australia, 2001 (per cent)

	ATSI peoples	Other Australians
Tobacco smoker	50	23
Risk of long-term alcohol-related harm		
• Abstainer	21	17
• Low risk	60	73
• Risky/high risk	20	10
Risk of short-term alcohol-related harm		
• Abstainer	21	17
• Low risk	31	48
• Risky/high risk	49	34
Use of illicit drugs in past 12 months		
• Use of any illicit drug	32	17
• Use of any illicit drug except cannabis	13	8
• Use of cannabis	27	13

Source: National Drug Strategy 2001 household survey [55]

Consistent with the patterns of higher rates of use, or problem use,   peoples experience higher rates of drug-related problems. For example, the background paper to the National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003–2006 reported that: [45]

- Aboriginal males are over nine times more likely to be hospitalised for alcohol-related conditions than other Australian males; and Aboriginal females are almost 13 times more likely to be hospitalised for alcohol-related conditions than females in the Australian population.
- Eliminating alcohol consumption would add 5.9 more years of life expectancy to Aboriginal males and 3.4 more years to Aboriginal females.
- Tobacco-related disease is responsible for between 1.5 and 8 times more deaths in the Aboriginal and Torres Strait Islander community than in the non-Aboriginal and Torres Strait Islander community.

Reasons for problems

Why are drug problems more prevalent among Aboriginal and Torres Strait Islander populations than among other Australians? It is evident from the above discussion that Aboriginal and Torres Strait Islander peoples have high rates of risk factors for drug abuse, including rates of sole-parent families, school drop-out, unemployment and poverty. But why do Aboriginal and Torres Strait Islander peoples have these high-risk rates? As Brady has observed, attempts to explain patterns of drug use among Aboriginal and Torres Strait Islander peoples have drawn far more readily on structural explanations than have corresponding explanations for other population sub-groups. [56] Whereas most attempts to explain drug use among youth, for example, look to psychological or social psychological factors (for example, family dysfunction and peer groups), explanations for drug use and related problems among Aboriginal and Torres Strait Islander peoples routinely invoke the historical legacy of colonization and dispossession. This is hardly surprising, since the experience of colonization for Aboriginal and Torres Strait Islander peoples *was* different from

anything that has been experienced by other Australians. [57] Following is a description of historical and structural factors that are likely to have contributed to drug-use problems based on a range of sources. [48 57-60] It is noted that much of this explanation is based upon descriptive research. Longitudinal, multivariate studies of risk and protective factors to explain drug use among Aboriginal and Torres Strait Islander peoples were not found. The discussion below is far from a comprehensive account of the history and culture of Aboriginal and Torres Strait Islander peoples. The characteristics and experience of Aboriginal and Torres Strait Islander peoples before and after European settlement in Australia are much more diverse than the outline below can capture. The intention is to demonstrate that a range of historical and social-structural factors have contributed to drug problems among Aboriginal and Torres Strait Islander peoples.

Upon European settlement in Australia, Aboriginal and Torres Strait Islander peoples were genetically and culturally vulnerable. Genetically, Aboriginal and Torres Strait Islander peoples had no resistance to European diseases, so when diseases infected their communities, many Aboriginal and Torres Strait Islander people died. [59] This was perhaps the first major factor that weakened Aboriginal and Torres Strait Islander families and communities. Aboriginal and Torres Strait Islander culture has also contributed to vulnerability in the face of European settlement. For example, being nomadic, Aboriginal and Torres Strait Islander peoples tended to share available resources and consume food as soon as it was available rather than hoard it. This practice may have contributed to the sharing of alcohol and injecting equipment among Aboriginal and Torres Strait Islander peoples as well as the binge use of alcohol. The nomadic lifestyle also meant that Aboriginal and Torres Strait Islander peoples did not build large cities. Consequently, Europeans regarded Aboriginal and Torres Strait Islander peoples as uncivilised, with no right to the land. Aboriginal and Torres Strait Islander peoples were not treated with respect or considered part of the new community being established by Europeans. Furthermore, being scattered across multiple small communities over a large land mass meant that Aboriginal and Torres Strait Islander peoples did not present a unified force to 'fight' or have equal power against European settlers.

European settlement damaged Aboriginal and Torres Strait Islander communities and families. [58] Historically, the brutality and trauma entailed in the European usurpation of the lands of Aboriginal and Torres Strait Islander peoples was followed by successive policies of 'protection' and 'assimilation', one objective of which was to reshape Aboriginal and Torres Strait Islander societies in the image of the dominant society, with all the undermining of Aboriginal and Torres Strait Islander cultural practices, languages and so on that this entailed. [57] At the same time, Indigenous people were marginalized geographically and socially in missions or simply beyond the boundaries of towns, thereby reducing their access to opportunities in the dominant society. In missions, communities that did not belong together were forced to live together, which reduced social cohesion. People lost their sense of connection to the land, felt they did not belong to the place in which they lived, and lost their sense of self-determination. Traditional languages and cultural practices were banned, so traditional roles and lifestyles were lost. This contributed to a loss of meaning in life, boredom and a loss of traditional social norms to influence behaviour. To varying degrees, elders lost their social status. Probably the most devastating facet of these policies was the practice of removing Aboriginal or part-Aboriginal children from their families, giving rise to the 'stolen generations'. Children were taken from parents, either kidnapped for child labour or removed from families so they could be taught European values. [42 61] Today

many still live with the memory of forced removal from their families. Data from the Western Australian Aboriginal Child Health Survey indicated that 41 per cent of Aboriginal children living in Western Australia live in a household affected by separation or relocation. The disruption to family and community has resulted in intergenerational trauma and a loss of parenting skills [62] and community attachments. The *Bringing Them Home* report noted that children continue to be taken from their parents because of the intergenerational damage:

> Because of their behavioural problems there is a significantly increased risk that these second generation children will in turn be removed from their families or will have their children removed.
>
> > ... as children who grew up under the stolen generations, the fact that we didn't often have our own parents, that we in fact as children when we were raised were not parented by other people and as adults and as women we go on to have children and that those skills and experiences that our extended family would have instilled in us are not there — that puts us at great risk of having our children removed under the current policies and practices that exist today (Joanne Selfe, NSW Aboriginal Women's Legal Resource Centre, evidence 739). [61]

Furthermore, Cunneen has argued that Aboriginal and Torres Strait Islander children are still being separated via the criminal justice system:

> The high levels of criminalisation and subsequent incarceration of Indigenous young people in Australia effectively amounts to a new practice of forced separation of Aboriginal and Torres Strait Islander children and young people from their families. (p. 43) [63]

Having damaged Aboriginal and Torres Strait Islander peoples and their communities, European settlers introduced tobacco and alcohol to Aboriginal and Torres Strait Islander peoples as a form of payment and to procure sexual favours. Then prohibitions were introduced, so the status of alcohol increased to be regarded as a race/class privilege. [60]

From the 1970s, many of these practices and policies were abandoned, as discriminatory legislation was dismantled (including, importantly, a hitherto longstanding prohibition on Aboriginal and Torres Strait Islander peoples' access to alcohol), and policies introduced that ostensibly fostered Aboriginal and Torres Strait Islander peoples' 'self-determination'. Unfortunately, at the same time employment opportunities for Aboriginal and Torres Strait Islander peoples in rural and remote areas deteriorated, largely as a result of the introduction of equal pay for Aboriginal stockmen in the pastoral industry, and Aboriginal people became increasingly reliant on the welfare system. Noel Pearson, an influential Aboriginal thinker, has argued that government policies moved Aboriginal and Torres Strait Islander peoples out of real economies, in which 'if you don't work, you don't get paid' (p. 11) and into passive welfare dependency and that this is at the heart of the social problems, particularly drug problems, in Aboriginal and Torres Strait Islander communities. [64] The 'passive welfare' system, he argued, has sapped the creativity and energies of Aboriginal and Torres Strait Islander peoples. [64-66]

The history of European colonisation of Australia has resulted in feelings of inferiority, powerlessness and hopelessness among Aboriginal and Torres Strait Islander peoples, a loss of positive role models within Aboriginal and Torres Strait Islander communities and a loss of family and community strengths. These factors have contributed to the accumulation of risk factors for problem outcomes, including low educational attainment, high rates of unemployment and socio-economic disadvantage, and physical and mental health problems including self-harm and suicide. The result has been a highly stressed community. In 2002, Aboriginal and Torres Strait Islander peoples were almost one and a half times more likely to experience at least one life stressor in the previous 12 months than other Australians (83 per cent compared with 57 per cent respectively). [42] The most frequently reported stressors were the death of a family member or close friend, serious illness or disability, and inability to get a job. For Aboriginal and Torres Strait Islander peoples living in remote areas, the most frequently reported stressors, after death of a family member or close friend, were overcrowding at home and alcohol and drug-related problems. The resulting problems with violence, drug abuse and crime have added to the problems of Aboriginal and Torres Strait Islander communities, leaving Aboriginal and Torres Strait Islander peoples feeling hopeless, angry, traumatised and ashamed.

Numerous other factors continue to contribute to the health and social problems among Aboriginal and Torres Strait Islander peoples. For example, Aboriginal and Torres Strait Islander peoples are more likely than other Australians to live in remote communities, with less access to important resources (recreation, health services, education and employment). In addition to the problems outlined above, Aboriginal and Torres Strait Islander populations experience racism and social exclusion. Many Australians lack an understanding of the reasons for social problems among the Aboriginal and Torres Strait Islander population and blame Aboriginal and Torres Strait Islander peoples for the existing problems. [67 68]

Phillips described how a series of failed interventions, which have not addressed the fundamental causes of the problems, have contributed to a sense of hopelessness among Aboriginal and Torres Strait Islander peoples and the wider community. [60] Brady traced the history of a number of well-meaning but unhelpful responses to alcohol problems in Aboriginal and Torres Strait Islander communities, for example, a tendency to play down alcohol problems among Aboriginal communities during the 1970s, and inaction or failure to promote 'best practice' due to a bureaucratic fear of making cultural blunders. [69] Brady and D'Abbs have described multiple structural problems in addressing Aboriginal and Torres Strait Islander drug problems, such as the lack of field staff to implement local programs. [52 69] In short, many of the factors that have contributed to drug problems among Aboriginal and Torres Strait Islander communities have historical origins that have damaged families and communities in a compounding fashion across multiple generations. It has been argued that subsequent attempts to address problems have often been ineffective, exacerbated problems or created new problems.

Implications

The Ministerial Council on Drug Strategy has developed a plan for addressing drug problems among Aboriginal and Torres Strait Islander peoples. [45] This plan incorporates the historical context of drug use among Aboriginal and Torres Strait Islander peoples and proposes a holistic approach that incorporates involvement and control by

Aboriginal and Torres Strait Islander peoples at the local level — a commendable proposal. On the basis of research presented in this report, we emphasise the need for an approach that builds strengths, promotes self-help and self-determination, achieves structural changes, is holistic, compassionate, realistic and adequately funded.

In Chapter 1, we emphasised the value of building resilience rather than focusing solely on addressing specific problems such as drug use, suicide, crime, unemployment and domestic violence. Within Aboriginal and Torres Strait Islander communities, a clear need exists to build feelings of hope, family strength and community capital. Publicising and promoting the successes and strengths of Aboriginal and Torres Strait Islander people and communities rather than focusing on the problems can help to build a sense of hope among Aboriginal and Torres Strait Islander peoples and address negative stereotypes held by the broader community. Approaches need to foster self-help and self-determination. However, families and communities that are already disadvantaged and damaged cannot be expected to improve their situation on their own. Non-Aboriginal and Torres Strait Islander people need to give support (material, intellectual and social), but not perpetuate disempowerment by taking control. Phillips suggested a mix of personal and community responsibility, where community members stop blaming others, but heal themselves first, then help others to heal. [60] Pearson's has argued for a new approach to structural change, by seeking to build partnerships involving Aboriginal organisations, government agencies and private sector bodies, thereby fostering 'social entrepeneurs' and gaining for Aboriginal and Torres Strait Islander peoples a place in a 'real economy'. [64-66] Funding a multitude of interventions will not be effective. Aboriginal and Torres Strait Islander communities have a long history of failed interventions that have contributed to a sense of hopelessness. [60 69] Rather, structural changes are needed to change the fundamental conditions that are contributing to drug problems as well as a multitude of other social problems including crime. After his investigation into deaths due to petrol sniffing, the South Australian Coroner concluded that specific sniffing interventions are needed, but: 'All these strategies must be accompanied by strategies to address socio-economic issues such as poverty, hunger, health, education and employment' (paragraph 10.107). [70]

While the range of risk factors to be addressed necessitates a whole-of-government, holistic approach, each government department needs to consider how it can be more effective in addressing risk factors or problems among Aboriginal and Torres Strait Islander peoples. For example, departments responsible for community services, welfare, [71] education, [72] criminal justice [48] and housing [73] all need to be better coordinated and to improve outcomes in their areas of responsibility. [44 74] Improving the system and achieving equity for Aboriginal and Torres Strait Islander peoples will require a substantial investment of funds. Government spending on the health of Aboriginal and Torres Strait Islander peoples is not commensurate with need. [75] Similarly, the existing inequity in drug-related problems experienced by Aboriginal and Torres Strait Islander peoples requires attention. Even with substantial investment, it is important to be realistic. Change will take time and realistic expectations of what individuals and communities can achieve are needed. [76] A failure to meet unrealistic goals will only add to feelings of hopelessness.

Finally and (perhaps) most importantly, empathy and compassion for Aboriginal and Torres Strait Islander peoples in Australia are needed. Pedersen and colleagues suggested that education regarding the history of Aboriginal and Torres Strait Islander Australians following European colonisation, as well as factual information about the current

situation of Aboriginal and Torres Strait Islander peoples, might assist this process. [77] This could include information on the fact that per-capita expenditure on Aboriginal and Torres Strait Islander Australians (once adjusted to reflect their under-utilisation of other programs) is not significantly higher than expenditure on other Australians. [78] As discussed by Maton (Chapter 3), [79] cultural change is difficult, but possible.

Conclusions

In summary, research supports universal programs to promote healthy child and youth development and prevent problematic drug use and related problems. However, for those groups in which disadvantage has become entrenched and who experience an unequal distribution of problems, some targeted effort is recommended. There are sound reasons for this recommendation. Firstly, addressing inequity is consistent with the principle of social justice, a principle to which Australia is committed. [c] Secondly, drug dependence and related problems such as drug-related crime and lung cancer are costly (both economically and socially) [80] and these costs will not diminish unless the causes of problematic drug use are addressed. Thirdly, once problems are entrenched, it takes effort to reverse the trend of intergenerational disadvantage and drug abuse.

[c] See the Human Rights and Equal Opportunity Commission website www.hreoc.gov.au

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