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**“I want to be heard”**

An analysis of needs of Aboriginal and Torres Strait Islander illegal drug users in the ACT and region for treatment and other services.

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ISBN No: 0-9752400-0-5

Printed June 2004

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Published by National Centre for Epidemiology and Population Health  
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*This report is dedicated to the ninety-five Aboriginal and Torres Strait Islander people we interviewed in the sincere hope that the recommendations will be implemented. The words "I want to be heard", which form the first part of the title of this report, were some of the first words we heard when we were conducting the interviews.*

*We hope we have done justice to all the voices we heard.*

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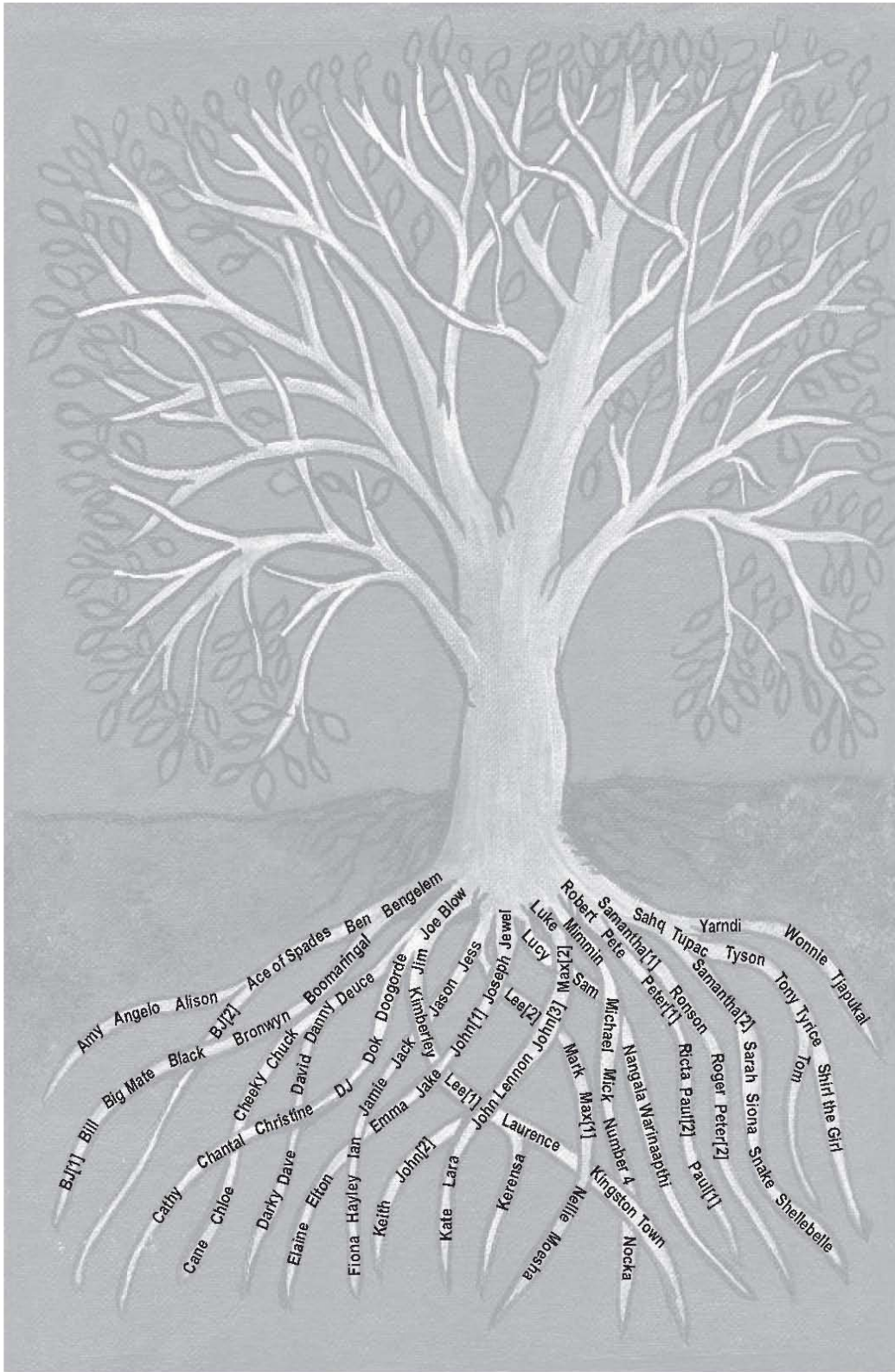
## ACKNOWLEDGEMENTS

### **Funding Body**

The research was funded by a National Health and Medical Research Council, National Illicit Drug Strategy Program Grant.

### **People we interviewed**

We would like to acknowledge our very deep gratitude to the 95 Aboriginal and Torres Strait Islander people who presented for interview and who so openly gave us details of some of the most intimate aspects of their lives. This work would not have been possible without them and we are indebted to them all. We asked the people we interviewed to chose names for themselves so that we could record them in the report. We have included these names (*these are not the real names of the people we interviewed*) in the root of “the tree” on the following page. The significance of “the tree” is explained in Chapter 1 and in Appendix 1.



## The Reference Group

We are immensely grateful to the all members of the Reference Group who provided very valuable advice and support for the project. The Members of the Reference Group, their affiliations and period of membership are listed below.

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Mrs Agnes Shea	Ngunnawal Elder Chief Ministers Award (2003) Medal of the Order of Australia (OAM) (2004)	Duration
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Ms Jeanine Leane	Ngun(n)awal Centre, University of Canberra	June 2001-August 2003

(cont)

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<sup>1</sup> Duration means from June 2001 until June 2004.

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Ms Reneé Rodgers	“	November 2001 – August 2003
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Ms Robyn Staniforth	“	May 2004 – June 2004
Mr Noel Bon	“	May 2004 – June 2004

## **Winnunga Nimmityjah Aboriginal Health Service**

Our thanks to all Winnunga staff, in particular to the Winnunga drug and alcohol workers who participated in many of the interviews and who helped with recruitment:

Harold Chatfield

Glyniss Church

We would also like to thank the other Aboriginal Health Workers at Winnunga who were part of the research team:

Len Barratt

Kacey Boyd

Warren Daley

Dean Jard

Sharon Ingram

George Wilson

The following Winnunga staff members were also very helpful with various aspects of the research:

Liz Daley

Jodie Fisher (Community Health Officer)

Christine Graham

Dr Ann Harrison

Toots Ling

Jane Lynch (The Opiate Project)

Dr Peter Sharp

## **ACT Regional Centre for Social and Emotional Well-being**

We thank the following past and present staff from the ACT Regional Centre for Social and Emotional Well-Being, where we conducted many of the interviews, and who always made us feel very welcome:

Mary Buckskin

Craig Dukes

Pam Frith

## **NCEPH staff**

Our thanks to all NCEPH staff. In particular we would like to thank:

Blanka Baric

Kaye Devlin

Albert Eichholzer

Ros Hales

Olivia Harkin

Bonny Hepp

Alison Humphreys

Omar Ibrahim

Mandy Law

Colin McCulloch

Professor Tony McMichael

Joy Searle

Dr Lyndall Strazdins

**The research process was facilitated by the help of the many other individuals and organisations listed below. We sincerely thank them all for their assistance.**

### *Additional recruitment*

Alcohol and Drug Program, Community Health, ACT Health

Belconnen Remand Centre

Canberra Alliance for Harm Minimisation and Advocacy

Directions

Southern Area Health Service

ACT Corrective Services

### *Advice on various aspects of the research*

Marie Jamieson

Nicole Wiggins, General Manager, Canberra Alliance for Harm Minimisation and Advocacy

### *Data entry*

Virginia Riddle

Charles Roberts (*who also set up the SPSS database*)

### *Estimations of the numbers of Aboriginal and Torres Strait Islander people using drugs in the ACT and region*

ACT Adult Corrective Services

Alcohol and Drug Program, Community Health, ACT Health

Canberra Alliance for Harm Minimisation and Advocacy

Directions

Gugan Gulwan Youth Aboriginal Corporation

Karralika Therapeutic Community, Alcohol and Drug Foundation of the ACT

Mancare Community, Salvation Army

South Eastern Aboriginal Legal Aid

Dr Mark Doverty, representative, Southern Area Health Service

### *Information about drug and alcohol treatment services in the ACT and Region*

Alcohol and Drug Program, Community Health, ACT Health

Dr Mark Doverty, representative, Southern Area Health Service

### *Launch*

The launch of the report was funded by the ACT Office, Australian Government, Department of Health and Ageing

### *Literature review*

Alcohol and other Drugs Council of Australia Resource Centre

Department of Families, Youth and Community Care, Queensland Government, for one of their publications.

*Proofreading*

Dr Cathy Banwell

Professor Colin Groves

Dr Adele Stevens

*Providing information for respondents*

Australian Intravenous and Illicit Drug League

Alcohol and Drug Program, Community Health, ACT Health

Canberra Rape Crisis Centre

Lifeline Gambling and Financial Counselling Service

The Opiate Project

Women's Information Resources and Education on Drugs

*Transfer of skills training*

Aboriginal Health Workers from the Canberra Rape Crisis Centre

Dr Peter Hiscock, The Australian National University's Human Research Ethics Committee

Betty Kitchener, Centre for Mental Health Research, The Australian National University



## **Abbreviations**

ACT	Australian Capital Territory
ANU	Australian National University
MOU	Memorandum of Understanding
NCEPH	National Centre for Epidemiology and Population Health
NHMRC	National Health and Medical Research Council
NIDS	National Illicit Drug Strategy
NSW	New South Wales
OATSIH	Office for Aboriginal and Torres Strait Islander Health
RAWG	Research Agenda Working Group (of the NHMRC)
SPSS	Statistical Package for Social Sciences

## **EXECUTIVE SUMMARY**

### **“I WANT TO BE HEARD”**

#### **AN ANALYSIS OF NEEDS OF ABORIGINAL AND TORRES STRAIT ISLANDER ILLEGAL DRUG USERS IN THE ACT AND REGION FOR TREATMENT AND OTHER SERVICES**

##### **Background**

This is the report of a study, conducted over a three year period, 2001 to 2004, of the needs of Aboriginal and Torres Strait Islander illegal drug users in the Australian Capital Territory (ACT) and its surrounding region for treatment and other services. The study was a collaborative undertaking between The Australian National University’s National Centre for Epidemiology and Population Health and the Canberra-based Winnunga Nimmityjah Aboriginal Health Service. Staff members from both Winnunga and NCEPH composed the research team, and were supported by a broadly-based Reference Group, most of the members of which were Aboriginal people; some were elders of the Ngunnawal Community, the traditional owners of much of the Canberra region. The National Health and Medical Research Council (NHMRC) ‘Darwin Criteria’ of excellence in Aboriginal and Torres Strait Islander health research (community participation and the sustainability and transferability of the research outcomes) were the core principles that guided the development and implementation of the research.

The study was funded by the NHMRC under a special National Illicit Drugs Strategy funding round.

This needs assessment had its genesis in widespread concerns expressed by local Aboriginal organisations and individuals, and others, about the prevalence of illegal drug use among young Aboriginal and Torres Strait Islander people in the region, and the massive impacts it is having on individual, extended family and Community life. Community leaders pointed to severe unmet needs in the areas of prevention (including the upstream social determinants of health and illness), early intervention, and treatment. They also pointed to the serious adverse impacts of the legal drugs, particularly alcohol and tobacco products.

The specific aims of the research were:

- to gather qualitative and quantitative data from Aboriginal and Torres Strait Islander illegal drug users in the ACT and Region about their needs in the areas of drug treatment and those related to culture, health, education, employment and housing;
- to undertake the research in a manner acceptable to, and supported by, local Aboriginal Community organisations and individuals; and
- to disseminate the findings to relevant agencies, including Aboriginal and mainstream service providers and local and federal politicians and public servants.

### **Research methods**

Over a two year period we conducted 95 confidential face-to-face interviews with Aboriginal and Torres Strait Islander illegal drug users from the ACT and Region. This included both people who inject drugs and those who use other routes of administration such as smoking. Both quantitative and qualitative data were collected using a structured questionnaire. Ethical approval was provided by the Human Research Ethics Committees of The Australian National University, ACT Health and NSW Health's South Western Sydney Area Health Service.

Prior to commencing field work, we implemented transfer of skills training, one of the methods employed to implement the NHMRC principles of Aboriginal and Torres Strait Islander health research. The transfer of skills took place between NCEPH and Winnunga Nimmityjah staff (both Aboriginal and non-Indigenous staff) and involved a two-way learning process. It covered such topics as sexual abuse awareness, mental health first aid and interviewing techniques.

The questionnaire that was developed for the study incorporated some standardised scales from other sources (so as to facilitate comparisons of the study population with other groups of drug users) as well as questions specific to this study. It was developed collaboratively by the research team members from Winnunga and NCEPH, along with valuable input from the Reference Group. The final questionnaire contained questions on sociodemographic variables, culture, drug use behaviours, needle using behaviours, general health, sexual behaviour and criminal histories. Specific questions were asked about needs related to culture, treatment, education, employment and health.

Interviewees were recruited from various agencies and by word of mouth; snowball sampling techniques were used and a flyer and a toll-free phone number were also employed.

The comfort and well-being of the interviewees determined how the interviews were conducted: trained Aboriginal and non-Indigenous researchers were present at each interview, interviewees were invited to bring along a support person, where possible, male and female interviewers were available and, whenever sensitive questions were to be asked (eg, about sexual health), the support person was invited to temporarily leave the interview to avoid any breach of confidentiality. The interview process included providing participants with health education information where needed, and referrals to helping services. In one case the interview was terminated early as the process was becoming distressing to the participant.

Of the 95 Aboriginal and Torres Strait Islander illegal drug users we interviewed, 62 were men and 33 were women. Their ages ranged from 16 to 50 years, with a mean of 29 years, and 44 were 25 years of age or younger. In all, 54 stated that they had injected illegal drugs in the 12 months prior to interview and 41 had used other routes of administration, primarily smoking cannabis. The injecting drug users were significantly younger than the non-injectors.

We estimate that we interviewed 10 to 20 per cent of the target population.

### **Drug use histories**

As noted above, 54 interviewees had injected illegal drugs in the 12 months prior to interview and 41 used other routes of administration. The mean age of initiation into illegal drug use of any type was just 14 years, around five years younger than for other Australians who have ever used illegal drugs. Cannabis was the first illegal drug used by most participants. The mean age of first injecting was 20 years; in 63 per cent of the cases the drug involved was heroin and in 35 per cent amphetamines.

Cigarette smoking prevalence among the people we interviewed was far higher than the national prevalence: all but four were current smokers. Some 79 per cent were current drinkers and three-quarters of these were drinking at levels classified by the NHMRC as

placing them at risk of alcohol-related harm. Some 56 per cent of drinkers showed some level of alcohol dependence.

Cannabis (known as ‘yarndi’ by many Aboriginal people) was the illegal drug used by the highest number of people interviewed: all but one had smoked it and just eight had ceased use of this drug. Over one-third smoked cannabis daily, and 27 per cent said it was their most problematic drug. Some 54 of the 70 people currently smoking cannabis at least weekly were assessed as being dependent on this drug.

In all, 74 of the 95 people we interviewed had used opioids (the group of drugs also known as narcotic analgesics which includes morphine, heroin, codeine, Panadeine Forte, Mersyndol, etc). The mean age of first use was 21 years which is similar to that of the national population. Early use of this type of drug was reported, with 27 people stating that they first used it at 16 years or younger. Sixty were current users and 14 had stopped using. Of the 60 current opioid users, 41 (68%) were using these drugs daily or sometimes daily. The 49 current users of heroin had been it for an average of six years, and more than two-thirds of them were assessed as being highly dependent on heroin. A few people showed dependence on other opioids including Panadeine Forte and Mersyndol.

Benzodiazepines were being used by 49 people, with a little less than half having been prescribed these drugs. Sixteen people were dependent on this class of drugs. Amphetamine-type-substances (here ‘amphetamines’) have become of increasing concern in recent years, with large increases in use and harm linked to this class of drugs being reported across the nation.

Eighty of the 95 people we interviewed advised that they had ever used amphetamines and 48 were current users. The mean age of first use was 19 years, two years younger than the national population. Intravenous use was reported by two-thirds of the current users; 14 people (29% of the current users) were taking it daily, almost daily or sometimes daily. Some 42 per cent of the amphetamine users were dependent on the drug.

Some other illegal drug use was reported. Hallucinogens (mainly mushrooms and ‘cardboard trips’) had been used by 48 people but only four were current users. Some

people had experimented with petrol sniffing or cocaine, but there is no evidence of chronic or dependent use of these drugs.

Polydrug use is generally the norm for people who use illegal drugs. The Aboriginal and Torres Strait Islander illegal drug users we interviewed had used an average of five types of drugs over the year prior to interview, with their use ranging from one to eleven drug types. Almost all interviewees smoked both tobacco and cannabis.

### **Treatment history**

It is generally accepted that different people will respond to different treatment modalities at different stages of their drug using careers. No one treatment is ideal for everyone, so a range of approaches and services needs to be available. Since drug dependence is a chronic, relapsing condition, it is important that we accept that relapse is common and needs to be planned for. Treatment has multiple goals, including reduced drug use; less harmful patterns of drug use; improved physical, mental and spiritual health; and improved social functioning including a stronger Aboriginal/Torres Strait Islander identity and connectedness to Community.

In all, 84 of the 95 people we interviewed had accessed some form of treatment service for their drug use or drug-related problems at some stage, although just a few were currently in any form of treatment. Seventy one per cent had accessed an outpatient Aboriginal Community-controlled Health Organisation for services directly related to their drug use. This treatment included medical care, nursing care, and counselling from Aboriginal Health Workers. People were generally pleased with the quality of service they received. Whilst a minority of respondents had obtained treatment from either an Aboriginal organisation or a mainstream organisation, the majority had accessed both.

In other parts of Australia, harm reduction services such as needle/syringe programs are increasingly being provided by and for Aboriginal and Torres Strait Islander people, although most of the injectors we interviewed obtained their sterile injecting equipment from a mainstream needle/syringe program (35 people) or a pharmacy (25 people). An additional 13 had obtained them from a peer-based service and 17 from friends. None reported obtaining injecting equipment from an Aboriginal Health Service.

Pharmacotherapy involves the use of prescribed medication to assist with drug withdrawal, maintenance or recovery from drug dependence. Methadone maintenance is the most thoroughly studied approach and is the optimal treatment approach for the majority of dependent opioid users. Buprenorphine is becoming increasingly available and is used in a similar manner. In all, 41 per cent of the people we interviewed who had used opioids had been prescribed methadone and/or buprenorphine. Most had mixed feelings about this treatment regime, though some were very positive about their experiences of methadone.

Alcoholics Anonymous (AA) provides assistance to many people experiencing severe alcohol-related problems, and 34 per cent of the people we interviewed who had used alcohol had been to AA meetings. They had mixed feelings about this, some finding them very helpful while others found the opposite. The same applied to Narcotics Anonymous which operates in a similar manner.

Residential rehabilitation services are particularly useful for people with entrenched problems who have not been able to benefit from out-patient drug treatment services. Overall, 28 per cent of the people we interviewed had experienced this treatment modality, being residents of either an Aboriginal and/or a mainstream facility. Seventeen had been in an Aboriginal residential rehabilitation service and two of them reported that that they had stopped the use of some drugs as a result of that experience. Similar numbers had experienced non-Indigenous rehabilitation services with similar outcomes. Most people had found the experience helpful in a variety of ways, though some mentioned that the absence of Aboriginal staff in the mainstream services was problematic.

Withdrawal services (usually called detoxification or ‘detox’ for short) aim to provide a safe and comfortable environment while people undergo the effects of withdrawing from alcohol or other drugs. It is not treatment but, for many people, is a first step which later leads to active treatment. Withdrawal services can be either in-patient or out-patient; sometimes drugs are used to relieve the symptoms of withdrawal, sometimes this is not needed. Twenty-seven per cent of the people we interviewed had experienced medicated inpatient withdrawal services either in the ACT or interstate.

Generally these experiences were satisfactory but, again, some would have preferred to have Aboriginal staff available.

Other treatment approaches used by the people we interviewed included out-patient counselling, treatment by general medical practitioners, and treatment services in prison.

Various reasons were given for not being in treatment at the time of interview, despite the fact that people were experiencing diverse problems linked to their drug use. Many simply stated that they did not want or need treatment, and some wanted a specific type of treatment that is not available. While the majority wanted to stop their drug use, others wanted opportunities to continue using, but in a safer, less stigmatised and less expensive manner. This applied particularly to the cannabis users.

Some people had found their own ways of stopping using drugs at various times in the past. In some cases this entailed a spiritual change that was effected with the help of other Aboriginal/Torres Strait Islander people. For some, experimental use ended without moving to dependent patterns of drug use. Some stated that they simply matured out of problematic drug use while others substituted one drug for another.

### **Treatment needs**

We asked people to express their preferences as to what kind of organisation from which they would prefer to receive the various types of treatment, namely: Aboriginal organisations; mainstream organisations with special, culturally-attuned programs for Aboriginal/Torres Strait Islander people; or ordinary mainstream organisations. Overall, a small majority favoured Aboriginal organisations, which emphasises the need for such services to be available within the general range of services. Special mainstream services were also looked on favourably, emphasising that mainstream services need to be attuned to the special needs of their Aboriginal and Torres Strait Islander clients. Only a small proportion of interviewees chose standard mainstream services or expressed no preference. As one might expect, a majority wanted Aboriginal/Torres Strait Islander staff to be involved in their care. Similar proportions favoured completely Aboriginal/Torres Strait Islander staff, on the one hand, and a combination of Aboriginal/Torres Strait Islander and appropriately skilled and culturally



aware non-Indigenous staff, on the other. Only a small number indicated that the cultural background of treatment staff did not matter to them.

Interviewees provided some suggestions for treatment and related interventions that are needed in addition to those mentioned above. These included family services, self-help groups, sobering-up shelters, medically prescribed drugs, nurses attached to Aboriginal Health Services, mentors and weekend treatment.

A number of people highlighted the need, in the Canberra region, for an Aboriginal residential treatment facility. One man stressed that this should be a multi-purpose agency, rather than focus just on drug treatment. A few people argued that we need, in this region, a place where Aboriginal people would be able to 'go bush' as part of a culturally-based approach to their treatment.

Learning about culture, as part of resolving problematic drug use, was highlighted by more than half the people interviewed. Many thought that this was best done in a residential treatment facility. Being supported while in treatment through maintaining family contacts was emphasised by respondents (some of whom had prior experience of residential treatment at locations far from their families) while others pointed to apparently simple things like having personal contact with other Aboriginal people while in treatment, and having ready access to family by means of the telephone.

We asked what other things might enhance the treatment experience and outcomes and received a range of suggestions. These included furthering their education; including education about their culture, while in residential treatment, learning about the effects of drugs, learning about one's self, learning life skills and general activities to forestall boredom.

Many people pointed to the need for more Aboriginal/Torres Strait Islander staff in treatment services. Some felt that the rules applied in many treatment centres are too inflexible. Waiting periods for treatment are a continuing problem, especially with respect to residential treatment. The need for a booklet providing information about alcohol and other drug services for Aboriginal/Torres Strait Islander people was also identified. We are pleased that one will be produced as part of this study.

While our attention here has focused on treatment needs for problematic alcohol and illegal drug use, we do not ignore the issue of tobacco smoking. An epidemic of smoking and of tobacco-related morbidity and mortality is raging within the Aboriginal Community. Recent experience in Canberra and interstate has demonstrated that smoking cessation interventions among Aboriginal people hold promise, and need to be expanded as a matter of priority.

## **Physical health**

The familiar World Health Organization concept of health, namely that physical, mental and social well-being are necessary for people to achieve optimal health, fits well with the Aboriginal holistic concept of health. Accordingly, we report on the physical and emotional health of the people who participated in our study, and on the diverse social determinants of their health status.

Overdoses are a continuing threat to the health of opioid users, particularly those who inject: 23 (31 %) of the 74 people we interviewed who had ever used opioids had overdosed after injecting. All but three of these people were still using opioids, mostly heroin. Of the 60 current opioid users, 20 (33%) had a history of overdosing and most had overdosed on more than one occasion. Fifty-six people (59%) we interviewed had seen someone else overdose (most of whom had recovered). On most occasions this had been a relative or friend but some people said they had witnessed overdoses of people they did not know. Most people had witnessed more than one overdose. While most ACT-based interviewees know that ambulance officers do not notify police when called to a non-fatal overdose, fear of police involvement remains a factor in determining how people respond to others' overdoses. Half of the people we interviewed advised that they knew what first aid to implement in the case of an overdose, and some had participated in full cardiopulmonary resuscitation training. Some pointed out, however, that various factors combine to stop them from trying to assist someone who had overdosed.

The HIV risk behaviour of the injecting drug users we interviewed was assessed. Disturbingly, 18 had high risk scores, although the average score of the respondents was lower than in other groups of injectors studied elsewhere.

All but one of the people we interviewed had heard of HIV/AIDS, and many understood well the risk factors for its transmission. Over half said that they had been tested for HIV during the twelve months prior to interview; none was HIV positive.

Hepatitis viruses are severe health issues for Aboriginal and Torres Strait Islander people generally, and for Aboriginal and Torres Strait Islander drug users in particular. All but two of the people we interviewed had heard of hepatitis C and a little over half knew some of the methods by which it is transmitted. Most said they had been tested for this viral infection at some time, and 59 per cent said they had been tested within the previous twelve months. Twenty-three people said that their most recent test revealed that they were hepatitis C positive and all of these were current injecting drug users (45% of the current injecting drug users).

Condom use was assessed, and we conclude that ten interviewees were engaging in unsafe sex. Most of the women had been screened for cervical cancer by means of a Pap smear within the recommended maximum time interval of two years. None of the interviewees reported any symptoms suggestive of a current sexually transmitted infection.

The needle use behaviour of the 53 participants who inject drugs was investigated. Four said that they injected daily, and an additional 28 sometimes injected every day and sometimes less frequently. Together these made up 60 per cent of the injectors. Almost half said that they never injected alone (a risk factor for fatal overdose) but, worryingly, five people said that they always inject alone. While many injected in safe places such as their own home or a friend's home, some injected in unsafe places such as public toilets or other public places. In research elsewhere in Australia, Aboriginal and Torres Strait Islander injecting drug users reported higher rates of needle sharing than non-Indigenous injecting drug users. In all, 68 per cent of the injectors we interviewed stated that they had always used a sterile needle and syringe in the previous twelve months, though 32 per cent had not. These people also reported a high level of sharing of other paraphernalia used for injecting, a known risk factor for hepatitis C transmission. Most people who had not always used sterile needles and syringes had reused equipment that they had previously used on themselves. The others had shared the injecting equipment, mostly with partners or friends. One reported having shared

with a stranger. The reasons given were the absence of sufficient sterile injecting equipment or the (false) perception that it is safe to share with someone you know well.

Occasional incidents of accidental sharing were reported (eg, picking up someone else's syringe thinking it was your own). Some 20 injectors reported always washing their hands before injecting (an important preventive measure against hepatitis C transmission) and 21 people said they always washed after injecting. None reported discarding used injecting equipment in public places.

Drug use in prison, particularly needle/syringe sharing, is a major public health problem and the people we interviewed confirmed this. Eleven advised that they had injected in prison and most had shared injecting equipment some or all of the times they injected in that situation owing to the absence of sterile needles and syringes.

### **Emotional well-being**

Emotional well-being (or mental health) is an important component of overall health status and is of particular concern to Aboriginal and Torres Strait Islander people. It was with respect to his emotional well-being that one man we interviewed voiced the words we have used in the first part of the title of this report: 'I want to be heard.' He went on to say, 'What I am saying could help someone else, that makes me feel good.'

Other people we interviewed had relatively poor levels of emotional health. Indeed, more than half the sample had scores indicative of emotional health problems and we advised them to seek assistance.

Australia's tragic history of the separation of Aboriginal children from their families and Communities has left its mark on the emotional well-being of Aboriginal and Torres Strait Islander people generally. The psychological reverberations of this removal - the creation of the 'Stolen Generations' - can be seen through the generations. Six of the people we interviewed had themselves been part of the Stolen Generations. Twenty seven people said they had family members who had been part of the Stolen Generations. One referred to a 'Stolen Generation anxiety' that exists throughout Aboriginal Australia. Linked to this are deep problems with personal identity.

Other emotional health issues that interviewees raised included their childhood and ongoing experiences of racism, being victims and/or perpetrators of physical violence, having been sexually abused as a child and having grown up in a family where alcohol and/or other drug abuse occurred.

Pleasingly, some were able to point to positive life events to balance out some of these negatives, including close, nurturing relationships with family and others, and a rewarding school life.

### **The social determinants of health and well-being**

We are conscious of the argument of distinguished Aboriginal and Torres Strait Islander health research policy makers that the internationally accepted social determinants of health may not apply directly to Aboriginal and Torres Strait Islander people. Until the research has been done to identify any Aboriginal and Torres Strait Islander-specific determinants, or different aspects of those already identified, we will use the determinants already well understood from research in other contexts. Attention is given to people's cultural needs, formal education, work, income, relationship with significant others, housing and diet.

On the scale we used to assess people's overall social functioning, the mean score for the people interviewed placed them in the 'average' level of social functioning. Ten had scores indicating poor social functioning. The injecting drug users had higher levels of social dysfunction than the non-injectors.

### *Culture*

We conclude that the most important social determinant of health for Aboriginal and Torres Strait Islander people is their culture. The dispossession of Aboriginal and Torres Strait Islander people of their land, and the impact of the separation of families, has meant that many Aboriginal and Torres Strait Islander people have lost core aspects of their traditional culture. On the other hand, Aboriginal culture is strong and flourishing in even the most heavily settled parts of the nation, albeit in some ways different from the cultures found in localities where people live a more traditional lifestyle. Members of the local Aboriginal Community have pointed out that culture is

further eroded amongst Aboriginal and Torres Strait Islander illegal drug users when they immerse themselves in the way of life of the illegal drug using culture. The concern is that relationships with others who use illegal drugs are not mere fraternising, but immersion in a totally alien way of life in which Aboriginal norms and values have no place.

Almost all of the 95 Aboriginal illegal drug users we interviewed stated that they knew something about their culture but wanted to learn more. The few people who that said they did not want to learn about their culture said something like: “I know what I need to know, I know I’m Aboriginal, where I’m from, my people.” Many interviewees expressed the desire to learn their traditional language, while others were not specific about which aspects of culture they most wanted to learn about, having broad learning needs in this domain. Some expressed their personal needs to learn about their own heritage. Other respondents tied their drug use directly to their loss of, and need for, Aboriginal culture, and expressed the wish to learn about life in the bush as a way of regaining culture.

Two-thirds felt that cultural and spiritual workshops would be useful, including those for younger people. Several mentioned the importance of having their own Elders running such workshops, feeling uncomfortable about the idea of them being conducted by people from other tribal groups.

### *Formal education*

The people we interviewed had generally left school early: almost one-third had left before 15 years of age and a similar proportion had left school at age 15. One-third had attained a Year 10 Certificate and just nine per cent a Year 12 Certificate. About one-third had completed a post-secondary trade certificate or other work-related training.

Most interviewees said that they could read and write well, but the lack of skills in this area on the part of the others was a source of great frustration for them. Four people said that they could not read or write at all. Some two-thirds of the total sample expressed the wish for more formal education, either school or post-secondary courses. They identified both internal barriers to further education, such as continuing to use

drugs, and external barriers such as childcare, transport, financial insecurity and unstable housing.

### *Occupational status*

In all, 65 of the 95 interviewees were on benefits, 18 engaged in home duties, 12 were tertiary students and only nine were in full-time employment. Twenty-two of the unemployed people stated that they usually had a paid job, most frequently labouring or other unskilled work. Half of the people on benefits were receiving unemployment benefits, with others receiving disability, supporting parent, youth allowance or Abstudy benefits.

As one would expect, almost all of the unemployed people advised that they wanted paid employment, and most were able to identify their preferred type of work. We asked what would help the respondents get a paid job and the largest number of responses by far were for 'courses' or something similar such as 'qualifications' or 'reading and writing.' Others mentioned practical issues such as childcare or transport, whereas still others mentioned personal factors such as self-confidence or overcoming the barrier of having a criminal history or dealing with racism. Some acknowledged that drug use is itself an impediment to obtaining satisfying employment, while others reversed the situation, believing that obtaining an education or work qualifications would help them give up harmful drug use.

### *Income*

Many illegal drug users have low incomes and, considering the cost of purchasing illegal drugs, little money left for the necessities of life. Seventy people provided details of their income: their median annual income was \$9,650 (range: zero to \$25,506). The mean weekly income was just \$196.

### *Gambling*

Gambling is an issue for some of the people we interviewed. About half stated that they like to gamble and, among these people, poker machines were the preferred type of gambling. Half of these said that they had become indebted owing to their gambling

and half said that they had sometimes gambled in an attempt to get money to buy drugs. Almost one-third of the gamblers advised that at some time they had felt the need to seek help because of their gambling behaviour. No Aboriginal and Torres Strait Islander-specific help services for gamblers are available in the ACT.

### *Significant others*

Close, nurturing social contacts are a prerequisite of good health. Just over half (54 of 95) of the respondents stated that they were in a relationship, all with members of the opposite sex. Thirty of these were married or in a *de facto* relationship, 12 just said they had a partner and another third said they had a boyfriend or girlfriend. Two-thirds (61 respondents) were parents and some two-thirds of the parents had dependent children. Others had other people, eg, their parents, dependent upon them. The majority of people with dependants were adamant that they did not need help. Such reluctance to acknowledge a need for help may be associated with the fear stemming from Stolen Generations about any intervention, particularly government intervention, in the care of children. On the other hand, it may also be because extensive kinship networks mean that, for the majority, there are other relatives available to help care for dependants.

### *Housing*

Two-thirds of interviewees (61 people) were living in some sort of government-provided public housing. Only five lived in a home that they or their parents owned. Five were homeless itinerants and, in all, more than one-third of the people we interviewed had housing needs. Two-thirds of the people with stable housing advised that they were happy with their accommodation. The others - those dissatisfied with their housing - explained why, giving such reasons as wanting their own place (when living with others), overcrowding, wanting a home with a yard rather than living in a flat, inadequate safety, racist neighbours, etc.

### *Diet*

Food security and food quality are important issues for health, and Aboriginal and Torres Strait Islander people tend to be worse off than others in these domains. Most (83 of 95) of the people we interviewed stated that they ate something every day, but



over a third never ate breakfast, only sometimes ate breakfast or had just a biscuit. Fifteen per cent never or only sometimes ate lunch, and the majority ate a cooked dinner in the evenings. A quarter stated that they do not eat properly and the reasons given include their drug use, financial problems, emotional problems or because of where they were living.

### *Other social issues*

Respondents mentioned some other aspects of life that, if improved, could help them stop problematic drug use. These included a change of environment, diverting pastimes such as sport or art, better transport and a general change in lifestyle.

### **Conclusion**

The 95 illegal drug users we interviewed represent 10-20 per cent of the Aboriginal and Torres Strait Islander drug using population in the region. The evidence gathered supports the need for new and expanded services, and for the improvement of existing services, so as to better address the physical, emotional and social problems of Aboriginal and Torres Strait Islander illegal drug users in our community.

## **RECOMMENDATIONS**

### **Cultural education and development**

1. That Aboriginal organisations be resourced to develop and implement cultural education programs for drug using members of their Communities and others with similar needs. This could include cultural and spiritual workshops, learning about language, traditional ways, history, hunting and bush food, Women's Business, Men's Business, identity, etc.

### **Establishment of an Aboriginal residential treatment centre**

2. That Aboriginal and Government organisations collaborate to investigate how best to respond to Community requests for the establishment of an Aboriginal-run residential treatment centre in the ACT for Aboriginal and Torres Strait Islander drug users and

other people (eg, their family members) affected by their drug use. This should include a focus on learning about culture and Aboriginal identity; include close contacts with family members; and include life skills learning programs. It would need to be staffed by a combination of professionally-trained treatment personnel and Aboriginal facilitators would need to be employed for clients to learn about their culture.

### **Establishment of an Aboriginal Halfway House**

3. That a Halfway House for Aboriginal and Torres Strait Islander people be established so that people can receive help and support on their discharge from withdrawal services. This Halfway House should be linked to existing Aboriginal services.

### **Aboriginal involvement in service development and delivery**

4. That the service mix in the ACT and surrounding region be reviewed to ensure that it is appropriate to the needs of Aboriginal and Torres Strait Islander drug users needing prevention, treatment and harm reduction services. The mix of services should include both Aboriginal-managed and staffed organisations and mainstream organisations which have both Aboriginal and Torres Strait Islander and non-Indigenous staff. The Indigenous staff of such agencies need to be properly trained and culturally aware so as to be able to meet the needs of Aboriginal and Torres Strait Islander clients.

5. That mainstream services continue to actively recruit, train and support Aboriginal/Torres Strait Islander staff.

6. That the ACT be significantly involved in the workforce development initiatives for Aboriginal and Torres Strait Islander drug and other alcohol workers foreshadowed in the *National Drug Strategy Aboriginal and Torres Strait Islander peoples' complementary action plan 2003 - 2006*.

### **School education**

7. That, on account of the two-way relationship between young people's drug use and poor school achievements, increased efforts be made to identify Aboriginal and Torres Strait Islander school students who are failing to achieve their potential in formal education, and to provide them with the remedial education and social supports that they need to overcome barriers to educational success. The 2004 ACT Social Plan provides a sound philosophical and practical foundation for these interventions.

## **Employment**

8. That case managers working with unemployed Aboriginal and Torres Strait Islander people, including current or former drug users, be funded and trained to actively address, with their clients, the particular barriers Aboriginal and Torres Strait Islander people face in gaining entry to work training and to employment, including sometimes low levels of educational attainment, histories of contact with the criminal justice system, stigmatisation and racism.

## **Funding of Aboriginal alcohol and other drug services**

9. That the ACT, NSW and Australian Governments increase the level of financial support they provide to agencies working to improve the quality of life of Aboriginal and Torres Strait Islander people in the ACT and region, including former and current drug users and their families, so that the findings of this study can be fully implemented.

## **Outreach services**

10. That, in light of the high levels of unmet needs adversely impacting on the well-being of Aboriginal and Torres Strait Islander illegal drug users, a markedly increased range and amount of outreach services be funded, and staff trained, to help meet their needs in such areas as health education, access to health care services, adhering to the requirements of treatment programs, work training, employment, connectedness to Community, etc. Preference should be given to outreach services provided by Aboriginal and Torres Strait Islander staff of Aboriginal-controlled organisations. Outreach services would be well placed to provide support to Aboriginal and Torres Strait Islander clients on discharge from withdrawal services.

## **Drug-specific recommendations**

11. That, in light of the extremely high levels of tobacco smoking among Aboriginal and Torres Strait Islander illegal drug users and other Aboriginal and Torres Strait Islander people in Canberra and the region, and new evidence of the effectiveness of quit programs for Aboriginal and Torres Strait Islander people, a new quit smoking program be funded and implemented for this population group, delivered by trained Aboriginal/Torres Strait Islander health workers.

12. That, in light of the heavy use of the non-prescription compound analgesic Mersyndol among some Aboriginal and Torres Strait Islander illegal drug users, and the

adverse side effects of heavy use, its scheduling be re-examined to ascertain if it should be available only on prescription.

### **Treatment issues**

13. That health professionals in contact with Aboriginal and Torres Strait Islander people in Canberra and the region who are concerned about responses to illegal drug use make specific efforts to educate Community leaders and other Community members about the benefits of methadone treatment for opioid dependence, and its effectiveness relative to other treatment modalities. This intervention is needed in light of the misinformation circulating in the Community on these matters, misinformation that could be a barrier to Aboriginal and Torres Strait Islander opioid users obtaining high quality treatment for their dependency.

14. That Governments increase the number and (where appropriate) the size of residential drug treatment centres which cater for Aboriginal and Torres Strait Islander drug users so as to reduce the long waiting periods that are currently such a barrier to accessing treatment.

### **Meeting multiple needs**

15. That, in developing services for Aboriginal and Torres Strait Islander illegal drug users, planners take account of the multiple, interacting needs of drug users identified in this study, and move increasingly to make available multi-function services able to meet the needs of the whole person. Needs identified in this study, in addition to the prevention and treatment of problematic drug use, include cultural education, school education, job training, employment, housing, transport, help with dependants, etc.

### **The information and education needs of current users**

16. That health care workers and injecting drug user peer educators be trained and otherwise resourced to undertake systematic overdose prevention education, including resuscitation. This needs to be provided to drug users and, where appropriate, to their families and friends.

17. That increased efforts be made to address the hepatitis C epidemic in injecting drug users, including increased support for peer educators, education programs about needle sharing, the role of contaminated injecting environments, alternatives to injecting, and increased availability of sterile injecting equipment, particularly for users not in close contact with existing services.

## **Other needs**

18. That the prevention of drug-related harm among Aboriginal and Torres Strait Islander individuals, families and the Community be given more attention and resourcing than it receives at present. Prevention includes addressing the up-stream social determinants of health and illness, case finding, early intervention with people initiating drug use, school and community drug education, patterns of law enforcement that minimise net harm to users and the community, etc.

19. That, considering that gambling is a serious problem for many drug Aboriginal and Torres Strait Islander drug users and their families, Aboriginal/Torres Strait Islander-specific gambling help services be funded and developed.

20. That, in view of the fact that more than half the Aboriginal and Torres Strait Islander illegal drug users we interviewed demonstrated impaired emotional health, increased services be provided to deal with the emotional health needs of Community members generally. This needs to address the inter-generational impacts of the history of Aboriginal and Torres Strait Islander/non-Indigenous relationships in Australia (including dispossession of land, the Stolen Generations and loss of culture). Specific attention should be given to the needs of carers.

21. Prison is a prime place for contracting bloodborne viruses like HIV and hepatitis C, which are then spread into the community. Further investigation and discussion is needed of a range of innovative strategies to combat this hazard

## **Evaluation**

22. That new or expanded policies and programs developed to implement these recommendations are subject to systematic evaluation and modified, as needed, in the light of evaluation research findings.

## CHAPTER 1: INTRODUCTION

### Background

For some time, there has been widespread concern in the Australian Capital Territory's (ACT) and Region's Aboriginal and Torres Strait Islander Communities about the extent of illegal drug use by their peoples (Dance et al, 2000a). The concerns are about the impacts of illegal drug use on the users themselves; on their extended families and friends; and on local Aboriginal Communities more broadly. These concerns indicate that there are unmet needs for drug use treatment, as well as unmet needs for both preventative and healing measures related to the social determinants of health (explained further below).

Both legal and illegal drugs have the potential to create serious problems for individuals, their families and society as a whole. These problems include illness and diseases, 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 the individual and Community level" (Steering Committee for the Review of Government Service Provision, 2002:8.10).

Aboriginal and Torres Strait Islander peoples in other parts of Australia have also voiced concerns about the impact of illegal drug use on their families and Communities. In 2000, these concerns played a part in the National Health and Medical Research Council's (NHMRC), National Illicit Drug Strategy (NIDS) Research Program, which called for expressions of interest for research on illegal drug use by Indigenous people.

In this report we provide findings from research funded by the NHMRC (NIDS) Research Program which was conducted collaboratively between two ACT-based institutions: Winnunga Nimmityjah Aboriginal Health Service and the National Centre for Epidemiology and Population Health (NCEPH) at the Australian National University (ANU). Below, we briefly describe these two institutions.

## **Winnunga Nimmityjah Aboriginal Health Service**

Winnunga Nimmityjah Aboriginal Health Service is generally referred to by the local Aboriginal and Torres Strait Islander Community simply as Winnunga. We subsequently refer to it in this way. Winnunga is part of the ACT-based Regional Centre for Social and Emotional Well-being (hereafter referred to as the Regional Centre). The Regional Centre is a consortium of three Aboriginal Medical Services which, in addition to Winnunga, includes Aboriginal Medical Services in Wagga Wagga<sup>2</sup> and Narooma.<sup>3</sup> The ACT Regional Centre is one of several such centres set up through the Office of Aboriginal and Torres Strait Islander Health for training Aboriginal Health Workers.

Winnunga is:

*a primary health care service initiated and managed by the local Aboriginal Community to provide a culturally safe holistic service to the Aboriginal people of the ACT and surrounding areas. The service is governed by a Board whose members are drawn from and elected by the local Community.*

*In Wiradjuri [the Wiradjuri people are a New South Wales language group] language, Winnunga Nimmityjah means Strong Health. The service logo is the Corroboree frog that is Indigenous and significant to Aboriginal people in the ACT Region. The holistic model of health care provided by Winnunga Nimmityjah AHS [Aboriginal Health Service] encompasses not only medical care, but a range of programs to promote good health and healthy lifestyles. Winnunga Nimmityjah Aboriginal Health Service commenced operations in 1988 as a small-scale service provider in medical treatment on a part-time basis. In January 1990 the service began full-time operations ...*

(Winnunga Nimmityjah Aboriginal Health Service Inc, 2002:3)

Winnunga's services encompass medical, nursing and midwifery care. In addition, there are Aboriginal Health Workers who provide holistic care. Of particular relevance here are the services provided by the Aboriginal Health Workers in the Substance Misuse Team and the Social and Emotional Well Being Team.

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2 Wagga Wagga is situated in New South Wales and is about a three hour drive away from the ACT.

3 Narooma is a town on the South Coast of New South Wales. It is about a two hour drive from the ACT.

## **The National Centre for Epidemiology and Population Health**

The second partner in this collaborative research is NCEPH whose

*main interest is epidemiological research into the patterns and causes of ill health. A broad, multidisciplinary approach is taken, encompassing the social, behavioural, environmental and genetic influences on health. Along with biostatistics, the disciplines of economics, demography, sociology and anthropology are essential to much of our research, as we study how to improve health across different groups in society, and how to use society's health-care resources most effectively. Contemporary questions about sustainable development and population health are also addressed. The key to NCEPH's success in research is its interdisciplinary character and its emphasis upon quality - often achieved via research collaboration. Projects are developed within the general five-themed framework [Communicable Diseases, Environmental Health, Social Determinants of Health, Health Systems Research and Population, Health and Development] and the resulting program of research seeks to advance our understanding of a range of processes and relationships in population health, and their translation into effective social policy.*

(NCEPH, 2004)

The research which we go on to describe here comes under NCEPH's rubric of the "Social Determinants of Health." In the introduction to the recent World Health Organization's publication on the social determinants of health, Wilkinson and Marmot (two experts in the field) point out that

*Even in the most affluent countries, people who are less well off have substantially shorter life expectancies and more illnesses than the rich. Not only are these differences in health an important social injustice, they have also drawn scientific attention to some of the most powerful determinants of health standards in modern societies. They have led in particular to a growing understanding of the remarkable sensitivity of health to the social environment and to what have become known as the social determinants of health.*

(Wilkinson and Marmot, 2003)

Investigators in the NCEPH Social Determinants of Health Research Group examine "health inequalities, Indigenous health, women's health and drug use in the community" (NCEPH, 2004).

## **The partnership between Winnunga and the National Centre for Epidemiology and Population Health**

This current partnership between Winnunga and NCEPH built on a relationship established in the early 1990s when the two organisations conducted collaborative



research for the proposed ACT “heroin trial” (Humes, 1993; Moloney, 1993). More recently, some researchers for the current needs analysis worked with Winnunga on two other projects. The first was a needs analysis where we interviewed 98 older Aboriginal and Torres Strait Islander people in the ACT and Region (Dance et al, 2001b). In 2001, on the basis of our research findings, the Commonwealth Government approved ten Indigenous-specific Community Aged Care Packages for the ACT and ten for the region. Around \$130 000 for ACT Indigenous-specific Home and Community Care has also been provided annually since the completion of that research (Waugh, L. 2003, pers comm, 7<sup>th</sup> November).

The second piece of recent research (conducted simultaneously with the first part of the aged care research) was a provision of estimates of the number of young Aboriginal and Torres Strait Islander people in the ACT and Region using illegal drugs (Dance et al, 2000a). This research also led to positive outcomes in the form of funding for extra local Aboriginal Health Workers specialising in drug and alcohol issues.

When we were still conducting the research for the needs analysis of older Aboriginal and Torres Strait Islander people, the NHMRC called for expressions of interest for research on illegal drug use by Indigenous people. The local research we had done in the Aboriginal and Torres Strait Islander Community, particularly that on illegal drug use, was a springboard for the expression of interest we submitted to the NHMRC. This was successful and was followed by request for a full application where it was necessary to demonstrate our commitment to the “‘Darwin criteria’:

Be *sustainable* within the community on an ongoing basis

Be *transferable* to other communities and

Include appropriate *community participation* in its initiation, implementation and evaluation.”

(From the Menzies report detailing the ‘Darwin criteria.’ This document is referred to as the “Menzies report since it was developed at the Menzies School of Health Research in Darwin. The full extract is included as Appendix 2.)

In order for NCEPH researchers to demonstrate our commitment to these criteria we believed that it was imperative to further develop our successful partnership with Winnunga. We, therefore, approached Julie Tongs, the CEO of Winnunga, with two

requests. The first was a request for Winnunga to be the collaborating organisation for the research, the second, for Julie to be an associated researcher. Julie readily agreed to these requests which allowed us to proceed with the full application. This too was successful. We later formalised the partnership between Winnunga and NCEPH with a Memorandum of Understanding (MOU). The MOU included arrangements for the use of Winnunga premises and for Winnunga staff to recruit respondents for the research (we had similar arrangements with the other non-government organisations which assisted with recruitment and whose premises we used for interviewing).

The essence of the partnership between Winnunga and NCEPH is captured in “the tree” (Appendix 1). The transfer of skills training (discussed further in Chapter 2) was envisioned by Tom Brideson (the chair of our Reference Group – the formation of the Reference Group is also described in Chapter 2) as a tree. We approached Gerard Bennett, a Winnunga artist, to paint a tree to become the emblem for the research. This tree graces the cover of this report and all research documents. Furthermore, the tree became the emblem for the whole of NCEPH. Julie Tongs, the CEO of Winnunga, and Tom Brideson put into words the story of the tree (also included in Appendix 1).

During 2002-2003, this partnership between Winnunga and NCEPH resulted in interviews with 95 Aboriginal and Torres Strait Islander illegal drug users from the ACT and Region about their needs for treatment and other services. We cast a wide net hoping to interview people who inject drugs, as well as those using other routes of administration. We succeeded in interviewing 54 people who had injected in the twelve months prior to interview (57% of the sample) and 41 people (43% of the sample) who, during the same timeframe, had used other routes of administration for their illegal drug use. This was most commonly inhalation (for marijuana).

In this introductory chapter, we start with the aims of our research before providing some statistics about the national and ACT Aboriginal and Torres Strait Islander population. Then we define some terminology before putting forward some caveats. Next, we explain how the research was initiated by Aboriginal Community concerns about illegal drug use. As we go on to further explain in Chapter 2, appropriate “*Community participation* in research initiation, implementation and evaluation”<sup>4</sup> is one

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<sup>4</sup> This quote is from the Menzies report detailing the ‘Darwin criteria.’ The full extract is included as

of the essential criteria for NHMRC-funded research involving Aboriginal and Torres Strait Islander people.

The section on Community concerns is followed by a broad overview of the traditional use of drugs by Aboriginal and Torres Strait Islander peoples. We then review the literature on contemporary drug use, and the prevalence of illegal drug use, by Aboriginal and Torres Strait Islander peoples. Next, we synthesise some views of commentators in the field about reasons for the contemporary use of drugs by Aboriginal Torres Strait Islander peoples, before concluding the chapter with a synopsis of views about treatment modalities for Aboriginal and Torres Strait Islander people with drug-related problems.

### **Research aims**

Our research aims were to:

- gather qualitative and quantitative data from Aboriginal and Torres Strait Islander illegal drug users in the ACT and Region about their needs in the areas of drug treatment and other needs, such as cultural needs and needs related to health, education, employment and housing;
- undertake the research in a manner acceptable to, and supported by, local Aboriginal Community organisations and individuals; and
- disseminate the findings to relevant agencies, including Aboriginal and mainstream service providers and local and federal politicians and public servants.

### **National and ACT Aboriginal and Torres Strait Islander populations**

Aboriginal and Torres Strait Islander people make up around 2.4 per cent of the Australian population (Australian Bureau of Statistics, 2002). Around 1.2 per cent of the ACT population, 3 909 people, identified as Indigenous in the 2001 census (Australian Bureau of Statistics, 2002; Australian Bureau of Statistics, 2003). Based on a great deal of Community involvement, one of us (Julie Tongs) estimates the true number of Aboriginal and Torres Strait Islander people in the ACT to be around 5 000. Whilst more extensive than what is considered to be the local ACT Region, we have

been informed that the population of Aboriginal and Torres Strait Islander people in the Southern Area Health Service catchment area is 4 217 (Doverty, M. Director, Aboriginal Health and Alcohol and Drug Services, Southern Area Health Service 2004, June 11<sup>th</sup> pers comm). Southern Area Health Service “covers an area of 52 214 square kilometres in South Eastern NSW surrounding the ACT. This extends from Crookwell in the north to the Victorian border in the south, from Young and the Snowy River in the west and from Batemans Bay along the coastal strip to Victoria. Its borders are shared with ACT Health, Greater Murray Area Health Service to the west, South Western Sydney Area Health Service to the north and Illawarra Area Health Service to the north east” (Southern Area health Service, nd).

## **Definitions**

In this section, we firstly discuss the terminology we use related to Aboriginal and Torres Strait Islander peoples. We go on to define terms we use related to illegal drug use.

Winnunga is a member of the National Aboriginal Community Controlled Health Organisation. The National Aboriginal Community Controlled Health Organisation is the national peak Aboriginal health body. It has a membership of around 100 Aboriginal Community controlled health services throughout Australia (National Aboriginal Community Controlled health organisation, nd). Aboriginal Community Controlled Health services prefer the use of “Aboriginal” rather than Indigenous to describe their peoples. Torres Strait Islanders prefix the names of their organisations with the use of “Torres Strait Islander.”

Since the research described in this report was conducted as a partnership between Winnunga and NCEPH, we generally use the term “Aboriginal and Torres Strait Islander” unless citing, or referring to the work of others who have used the terms “Indigenous” or “Aboriginal.” When referring to a Community, organisation, or individual identified or recognised as Aboriginal, we accordingly use the term “Aboriginal.”

We use the word Community with an upper case C to denote the Aboriginal and Torres Strait Islander Community. The term “mainstream services” refers to services that are not Aboriginal Community organisations.

In this report, “drug use” means all drug use, from the legal and commonly used drugs, most notably tobacco and alcohol, to illegal drugs such as marijuana and heroin. We also collected data on prescribed drugs (such as methadone, buprenorphine and benzodiazepines) which may be used by people who use illegal drugs strictly according to a physician’s prescription, or they may be used in other ways by the individual who is prescribed them. They may also be given to, or obtained from, friends and acquaintances. There are also drugs which are obtained over the counter, as well as those which users simply go out and gather (such as mushrooms) but whose use is still prohibited. Thus, we use the term “drug use” to denote the use of both legal and illegal drugs, and the term “illegal drug use” to denote the illegal use of any substance even if the substance itself is not prohibited.

Despite the World Health Organization’s recommendation in the early 1980s that the terms “addiction”, “addict”, etc should be abandoned in favour of “dependent”, “dependency” “dependence”, etc (Edwards et al, 1981), these pejorative terms are still in currency. In this report we use the word “addict”, etc, only when quoting the works of others preferring instead to use the term “dependence” (etc). Dependence has been authoritatively defined as “a cluster of cognitive, behavioural and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems” (American Psychiatric Association, 1994). More recently, it has been recognised that neuroadaptation, “an altered physiological state ... produced by the repeated administration of a drug”, occurs when people become dependent (Whelan, 1998). Non-dependent users are those who use occasionally, or in particular contexts (Commonwealth Department of Community Services and Health, 1988). For the sake of convenience we use the terms “dependent” and “non-dependent”, but as Edwards and colleagues noted when they recommended the use of the terms, “no sharp cut-off point can be identified for distinguishing dependence from non-dependent but recurrent use” (Edwards et al, 1981).

We collected data on histories of drug use from initiation until current use of particular drugs. Unless otherwise stipulated, “current”, when used in the context of drug use or

injecting, should be taken to mean during the 12 months prior to interview. When used in the same context, unless otherwise stipulated, “stopped” should be taken to mean no use of a particular drug, or no injecting, for at least 12 months.

### **Some caveats**

We draw attention to the fact that generally the research we refer to throughout this document, including the research we conducted, relies on self identified Aboriginal and Torres Strait Islander status. As far as our own research goes, during our pre-interview screening, we asked potential respondents if they identified as Aboriginal and/or Torres Strait Islander. When potential respondents were referred from Aboriginal organisations we could be confident about their Aboriginal or Torres Strait Islander status. In addition, there was always an Aboriginal researcher who took part in the screening. We are confident that everyone we interviewed was an Aboriginal or a Torres Strait Islander person.

We set the problems related to illegal drug use by Aboriginal and Torres Strait Islander people in context by drawing attention to four important but often (particularly in the light of the understandable concerns about illegal drug use) overlooked facts:

- 1) although there is plenty of evidence (reviewed below) to illustrate that, by comparison with other Australians, larger proportions of Aboriginal and Torres Strait Islander use illegal drugs, as Davis points out, just like the general population, only a minority of Aboriginal and Torres Strait Islander people do use illegal drugs (Davis, 1998);
- 2) “Aboriginal Australians, like other Australians, use and abuse the legal rather than illegal drugs” (Brady, 1995a:6);
- 3) for both Aboriginal and Torres Strait Islander peoples and other Australians, it is the legal drugs, tobacco and alcohol, rather than the illegal drugs which cause most drug related mortality and morbidity. In 1998, for example, 15 per cent of all deaths were related to drug use. “Tobacco and alcohol were responsible for over 93% of the drug-related mortality and morbidity” (Australian Institute of Health and Welfare, 2002a:6);

- 4) the emphasis on deleterious health effects of both legal and illegal drugs can obscure the fact that, for some people, whether Aboriginal and Torres Strait Islander or non-Indigenous people, drug use may be advantageous (for example, Zinberg, 1984; Mugford and Cohen, 1989; Siegel, 1989; Warburton, 1990; Moore and Saunders, 1991; Dance and Mugford, 1992; Dance, 1998). In discussing the use of illegal drugs by Aboriginal people in Brisbane, Larson and colleagues point out that “It is important to stress that most participants viewed their injecting drug use positively”, going on to note, however, that most of the sample (77%) considered themselves to be “only occasional or infrequent users” (Larson et al, 1999:56).

### **Community concerns**

We turn our focus away from the pleasurable effects of drugs to concentrate now on their harmful effects by firstly outlining Community concerns about illegal drug use by Aboriginal and Torres Strait Islander peoples. Illegal drug use and alcohol use often go hand in hand and many commentators talk about both. We begin with a brief overview of concerns voiced in the national arena before reviewing some published localised concerns. The section concludes with a more expansive discussion of concerns voiced by Aboriginal people in the ACT and Region.

#### *National concerns*

Over a decade ago, Lowitja O’Donoghue, a prominent Aboriginal leader, publicly remarked that “Nothing has so thoroughly wasted potential human talent as has the widespread contemporary dependence on alcohol and other harmful substances among our Indigenous population” (O’Donoghue, 1990).

More recently, problems due to the use of alcohol and other drugs by Aboriginal and Torres Strait Islander peoples have been referred to by several Aboriginal leaders; perhaps most famously, by Noel Pearson. For example, in an interview with Maxine McKew he is quoted as saying:

*Addiction and passivity... what we're facing now is an epidemic. An epidemic of grog and drug addiction. It's like a whirlwind in the Communities. It sucks in everyone. Even kids from stable families. We're talking about a social contagion. It's spreading all the time and dragging more and more recruits. ... It's addiction that is the cause of nearly all our problems.*

(McKew, 2001:38)

In 2003, the National Aboriginal Community Controlled Health Organisation summed up the situation with these words:

*Substance misuse is a major problem and one of the biggest challenges facing many Aboriginal and Torres Strait Islander communities today. It affects almost all Aboriginal and Torres Strait Islander people either directly or indirectly and is now the cause, as well as the symptom of much grief and loss.*

(NACCHO [National Aboriginal Community Controlled Health Organisation], 2003:594).

In the 1994 national Aboriginal and Torres Strait Islander survey, over 15 700 people were interviewed. Fifty nine per cent “perceived alcohol to be one of the main problems in their area. This general view was held across all age groups as well as in capital cities, other urban and rural areas. Drugs [that is illegal drugs] were seen as the next major health problem, by 30 per cent of persons” (Australian Bureau of Statistics, 1995a:14).

### *Community concerns in Queensland, Victoria and South Australia*

Community members were interviewed as part of a study on injecting drug use by Aboriginal people in Queensland. The study revealed that family problems were common. Those surveyed identified a need for services directed towards Aboriginal families, as well as towards Aboriginal injecting drug users (Larson and Currie, 1995).

A Victorian study, which involved interviews with 30 Community members who inject and around 30 who did not, led the authors to conclude that almost all Aboriginal families had been affected by drug use in some way (Edwards et al, circa 2000). Consultants interviewed for a recent South Australian study were united in perceiving the extent of injecting drug use in the Aboriginal Community to be widespread, with



nearly all Aboriginal families in suburban Adelaide affected in some way (Holly and Shoobridge, 2002).

### *Community concerns in the ACT and Region*

In 1994, the Australian Bureau of Statistics conducted a national survey of Aboriginal and Torres Strait Islander people. This included people in the Queanbeyan Aboriginal and Torres Strait Islander Commission region (the area in which this study was conducted). Twenty eight per cent of 4 575 people aged over 13 years believed drug use was one of the major health problems in the region's [Aboriginal and Torres Strait Islander] Community. Forty six per cent believed alcohol to be a problem (Australian Bureau of Statistics, 1995b).

In the context of the Feasibility Research into the Controlled Availability of Opioid conducted by NCEPH researchers in the early to mid-1990s (for example, National Centre for Epidemiology and Population Health, 1991; McDonald et al, 1993; Bammer et al, 1995; Bammer et al, 1996; Dance et al, 1997), Aboriginal Community leaders as well as both Aboriginal and non-Aboriginal service providers were interviewed. This research revealed Community concerns about the continuing and, on some indicators, increasing levels of problematic drug use by Aboriginal people in the ACT and region (Humes, 1993; Moloney, 1993).

As part of her research for a report prepared for the ACT Department of Health and Community Care's Alcohol and Drug Program, Carrick held discussions with workers from Winnunga and Gugan Gulwan Youth Aboriginal Corporation (an ACT-based support agency for young Aboriginal and Torres Strait Islander people). Workers in both agencies believed that there was "reason for concern about high levels of heroin consumption amongst young Aboriginal people in the ACT region" (Carrick, 1998:12). From her discussions with Indigenous "key informants", Carrick later reports that there was a "view that there has been a trend away from alcohol amongst the youth and more of a tendency towards illicit drugs" (Carrick, 1998:26).

In *The Sunday [Canberra] Times* on December 5th 1999, Jeffrey Centenara reported the moving stories told by Hilary Crawford and Muriel Brandy, two Aboriginal Elders from the ACT. These two mothers, who are also shown photographed, had decided to speak

out about “the epidemic of drug abuse in the Canberra Aboriginal Community.” They had each lost two children to drug and alcohol problems. According to these women, their stories were not unusual in the Aboriginal Community. Mrs Crawford, who buried two sons on the same day in 1999, is quoted as saying “I don’t know any family in our Community that hasn’t been touched by drugs or alcohol.” Indicating that problems due to heroin use had a long history in the ACT and Region, eight years before the 1999 Canberra Times article Mrs Brandy had lost a daughter and a son from heroin overdoses within six months of each other.

Both women were now concerned about the next generation. At the time of the report Mrs Crawford had one grandson in Quamby Correctional Services, another in Belconnen Remand Centre and a third whom she said was a “heavy drug user.” Mrs Brandy told of her two grandsons “who used the money she gave them to pay for their drug habits” (Centenara, 1999:2).

Aware of concerns within the Community, shortly before this newspaper article the ACT Office, Australian Government, Department of Health and Ageing had asked NCEPH researchers to prepare a background paper with estimates of the number of young Aboriginal illegal drug users in the ACT and Region (Dance et al, 2000a). We achieved this by contacting people working in local drug and alcohol services or corrective services and asked them if they had any data on the number of young Aboriginal people in contact with their service.

We were about to start the needs analysis of older Aboriginal and Torres Strait Islander people and as part of this study asked them for their views on the extent of the problem. We had already been informed by members of the Aboriginal Community that illegal drug use, particularly heroin use, was a huge problem in the Community. One Elder who was personally affected by the problem said: “You can’t do anything to help the old people unless you do something about the drug problem in young people. Old people are constantly worried about children or grandchildren using drugs.”

Most of the 98 older Aboriginal and Torres Strait Islander people we interviewed during 1999 to 2000 voiced concerns about the extent of illegal drug use in the local Community. Many were adversely affected by illegal drug use among their children, grandchildren and extended family. The illegal drugs of most concern were heroin,

amphetamine and marijuana, although some people mentioned problems associated with overuse of prescription drugs. From one woman's account, 32 family members living in the ACT were using heroin. Another woman said: "There are relatives galore that are on drugs, including heroin. It used to be alcohol, now it's drugs. All the kids [used to die] young from grog, now it's all drugs." Four people talked about children who had died due to illegal drug use. From the evidence gathered for our report, it was apparent that the majority of Aboriginal and Torres Strait Islander people using illegal drugs were polydrug users and that for many of them this polydrug use included heroin (Dance et al, 2000a).

Drawing from these discussions with people in the Aboriginal Community, and with service providers and from published accounts, we concluded that the most parsimonious estimate was that there were one hundred or more young Aboriginal and Torres Strait Islander people using heroin in the ACT and Region.

### **Traditional use of drugs by Aboriginal and Torres Strait Islander peoples**

We now set these Community concerns into the context of what is known about drug use by Aboriginal and Torres Strait Islander people beginning with a brief overview of traditional use of drugs.

Prior to colonisation, Aborigines, especially men of ritual standing, chewed (rather than smoked) at least four plants containing nicotine (Watson, 1991; Brady, 2003). Brady reports that there are "numerous descriptions of [the] opium like effect" of pituri (Brady, 2003:35). Many Aboriginal peoples also made intoxicating beverages from local flora (Brady, 2003). The major difference between that long pre-settlement history of drug use and the period since colonisation is that the monitoring and distribution of drugs was previously in the hands of the Aborigines rather than in the hands of the Europeans (Brady, 1991a).

### **Non-traditional use of drugs by Aboriginal peoples**

Below, we provide a brief overview of non-traditional drug use by Aboriginal peoples. In the discussion of our findings in subsequent chapters, where possible, we compare

the results from the people we interviewed with those from other researchers briefly reviewed in this section.

### *Tobacco*

Tobacco was initially brought into Australia by Macassan traders from around 1700 (Brady, 2003). Through the process of colonisation, tobacco became a highly valued commodity as many Aboriginal peoples first came into contact with it through missionaries, miners, fishermen, anthropologists and cattle station workers (Briggs, 2002). As further elaborated in Chapter 4, the proportion of Aboriginal and Torres Strait Islander people who currently smoke tobacco is much higher than in the general population (51% and 24% respectively) (Australian Bureau of Statistics, 2002).

In general, Aboriginal and Torres Strait Islander people die 20 years earlier than other Australians (Australian Bureau of Statistics, 2003). Three out of four deaths result from circulatory diseases, injury, poisoning, respiratory disease, cancer and endocrine disease (mainly diabetes) (House of Representatives Standing Committee on Family and Community Affairs, 2000). Tobacco is a known contributor to some of those illnesses, especially circulatory disease and cancer, which lead to a shortened lifespan for Aboriginal and Torres Strait Islander people.

### *Alcohol*

When the first white settlers arrived they brought with them alcohol, usually in the form of rum. Aborigines were sometimes forced to drink alcohol for the “amusement” of the settlers, and white men gave it to Aboriginal women as payment for sexual favours (Brady, 1992).

In 1838, NSW (New South Wales) became the first Australian colony to pass legislation prohibiting alcohol use by Aboriginal people. Over the next 80 years similar legislation was passed in other Australian jurisdictions, including, in 1929, the ACT (Gray et al, 2002). (that is, soon after its formation). Following the adoption of assimilation policies, this legislation was gradually revoked during the 1960s and 1970s (Hunter, 1992).

As we later show, previous research has revealed that, by comparison with other Australians, a smaller proportion of Aboriginal and Torres Strait Islander people consume alcohol. This previous research, as well as the research we report here, has demonstrated that many of those Aboriginal and Torres Strait Islander people who do consume alcohol, tend to consume large amounts. Brady points out that Aboriginal people learned a “cultural norm of excess from white recreational drinking. The white male drinking style was to ‘knock down a cheque’ in drinking binges of uproarious proportions” (Brady, 1991b:282). There is now a plethora of evidence demonstrating the detrimental effect alcohol has had on Aboriginal and Torres Strait Islander individuals, their families and their Communities (for example, Brady, 1992; Hunter, 1992; Brady, 1994; Brady, 2002). As a consequence, in some Aboriginal and Torres Strait Islander Communities there have been sanctions against the use of alcohol for a number of years now (for example, Rowse 1993; Brady, 1995b; Brady 1996; Gray and Saggars, 2003).

### *Petrol*

A minority of people we interviewed had ever inhaled petrol. Those who had done so had generally used it in the past on an infrequent or experimental basis (as we discuss further in Chapter 4, twenty people had ever inhaled petrol and just one person had used it once in the 12 months prior to interview). Because the practice of petrol inhalation has had such a damaging effect on Aboriginal peoples elsewhere (for example, Brady, 1991c; Chalmers, 1991; Burns et al, 1995; d’Abbs and Maclean, 2000; Maclean and d’Abbs, 2002) we briefly make mention of it here.

According to Brady, the first use of petrol as an inhalant by Aboriginal people was in 1950 in a timber mill in Northern Australia (Brady, 1989). Inhalation of petrol by Aboriginal people still occurs mainly in remote Communities where there are may be relatively high proportions of chronic sniffers, most of whom are males, and most of whom are between eight and 30 years of age (d’Abbs and Maclean, 2000).

### *Kava*

No one we interviewed reported use of kava but given the associated problems reported elsewhere in Australia, such as liver damage and malnutrition, we mention it briefly

here. In the hope that it would reduce alcohol consumption amongst local Aboriginal people, kava was introduced from Polynesia (where it is used for both ceremonial and recreational purposes) into the Northern Territory in 1982 (Watson et al; 1988; Gray and Sagers, 2003). Whilst there are now health problems in Aboriginal people in the Northern Territory due to its use (Clough et al, 2002a), kava does not appear to be widely used by Aboriginal people in urban areas. It is not surprising, therefore, that its use was not reported by the people we interviewed.

### *Cannabis*

In 1991, in the context of writing about cannabis use by Aboriginal people, Brady noted that “Data on illegal drug use by Aboriginal people are minimal and one can only rely on newspaper reports that occasionally mention it” (Brady, 1991b:285). She then refers to a newspaper article of 1987 which reported that marijuana use had “overtaken alcohol” among Aboriginal people in Western Australia (Brady, 1991d:286).

In the section on prevalence below, we note the current available evidence indicating a higher prevalence of cannabis use among Aboriginal and Torres Strait Islander than among other Australians. This use does not appear to be restricted to urban Indigenous peoples. In a 2002 letter to the editor of the *Medical Journal of Australia*, Clough and colleagues write of their concerns about the use of cannabis amongst traditional people in north-east Arnhem Land “74% are current cannabis users and, of these, 60% are former petrol sniffers.” Clough and colleagues go on to mention social effects, such as increased family violence, drug-alcohol psychosis, self-harm and suicide, and Community disruption. They highlight a “particular concern ... that persistent cannabis use may compound any residual cognitive impairment from petrol sniffing” (Clough et al, 2002b:395-6). In addition to petrol and cannabis use, there was evidence that small numbers of people in the Northern Territory Community under study were experimenting with other illegal drugs (Clough et al, 2002a). As we go on to show, most people who use illegal drugs are polydrug users.

## *Opioids*

Opium was imported into Australia in the nineteenth century by the Chinese (Gray and Siggers, 2003) and European and Chinese immigrants introduced the drug to Aboriginal peoples (Brady, 1991b). In the nineteenth century “European colonists’ concerns about the use of opium by Indigenous people were entangled with racist scapegoating of the Chinese” (Gray and Siggers, 2003:160). In the late nineteenth century, legislation was introduced prohibiting opium use by Aboriginal people, then later by Chinese immigrants (Kunitz, 1994; Barber et al, 1988; Brady 1991b; Manderson, 1999). Several commentators, most notably Manderson (for example, Manderson, 1999), have drawn attention to the racism which underpinned this legislation.

Despite the legislation, opium, just like the illegal drugs of today, was still used by Aboriginal people. Large numbers of them died because of this use, not so much because of the drug itself but because Aboriginal peoples were sold an inferior form of the drug, the charcoal ash remaining after the opium had been smoked (Brady, 1991b; Gray and Siggers, 2003).

In 1904, the Commonwealth Government stopped the legal importation of opium but “Opiates as a linctus, the form preferred by Europeans” was available until the mid 1950s” (Wodak, 1997:13). Australian laws restricting the use of heroin, morphine and cocaine built upon the opium control laws. In the 1950s the Australian Commonwealth Government enacted legislation prohibiting the use of heroin for any purpose, including for medical reasons (Wodak, 1997).

Bringing the history of the use of opioids to more recent times, according to the National Aboriginal Health Strategy Working Party, as early as 1982, heroin use had become a notable problem in Aboriginal Communities in Sydney (National Aboriginal Health Strategy Working Party, 1989).

## *Injecting drug use*

In a 2002 literature review for the Australian National Council on Drugs, Gray and colleagues concluded that injecting drug use amongst Indigenous people had been “largely overlooked as a research topic and there is limited literature available on its

prevalence and associated harms” (Gray et al, 2002:11). We turn now to a brief review of the current available literature on the topic.

Our review of the literature indicates that the first research on injecting drug use by Aboriginal people was conducted in South Australia at the beginning of the 1990s by Lane, who accessed 124 Aboriginal injecting drug users (Lane, 1992-93). Subsequent research in South Australia by Holly and Shoobridge resulted in 307 interviews with Aboriginal people who inject drugs. This is the largest study of Australian Aboriginal injecting drug users conducted so far (Holly and Shoobridge, 2002).

Larson and colleagues conducted a series of investigations in Queensland (Larson and Currie, 1995; Larson, 1996; Larson et al, 1997; Larson et al, 1999), the last of which resulted in interviews with 77 Aboriginal injecting drug users (Larson et al, 1999). Interviews with 30 Aboriginal Community members who inject and around 30 who did not were conducted in Victoria in the 1990s (Edwards et al, circa 2000). In West Australia, Gray and colleagues interviewed 74 Aboriginal people who inject drugs (Gray et al, 2001).

Whilst we make reference below to other studies where ACT Aboriginal and/or Torres Strait Islander people have been interviewed as part of general studies of illegal drug use we are aware of only one previous study which specifically aimed to recruit only Indigenous illegal drug users. This was a small study conducted by Dobson as part of her work for her Honours degree in 2000. Her sample included eleven Indigenous illegal drug users who were asked about their drug use patterns, and their knowledge and use of various health services (Dobson, 2000). Five of the people interviewed by Dobson injected heroin and five injected amphetamine.

### **Research indicating disproportionate use of illegal drug use by Aboriginal people**

As noted above, according to the 2001 census, Indigenous people make up 2.4 per cent of the Australian population. We now bring together some Australian pieces of research which provide evidence of the disproportionate use of illegal drug use by Aboriginal people. We begin with an overview of national research and research from other States



and Territories before focusing on a more detailed discussion of relevant research from the ACT and Region.

### *National research*

We start this section on national research with results from the 1994 National Drug Strategy household survey of urban Aboriginal and Torres Strait Islander peoples which to date is the only national household survey focusing on illegal drug use by Aboriginal people. In this survey, face to face interviews were conducted with almost 3 000 urban Aboriginal and Torres Strait Islander people (Commonwealth Department of Human Services and Health, nd). Findings from other relevant research are then outlined.

The 1994 survey of Aboriginal and Torres Strait Islander people revealed that, at 3.5 per cent, the proportion of Aboriginal and Torres Strait Islander people who had ever injected was slightly higher than the 2.5 per cent from the general population sample who had ever injected (Commonwealth Department of Human Services and Health, nd). Loxley and colleagues found that five per cent of the 872 injecting drug users surveyed in the national 1994 Australian Study of HIV and Injecting Drug Use sample were Indigenous (Loxley, 1995).

Almost half of the people interviewed for the 1994 survey of drug use by Aboriginal and Torres Strait Islander people had tried marijuana, this compared with around one third in the general community. Twenty two per cent were current users, compared to 15 per cent in the general community. There was also a slightly higher rate of experimentation with other illegal drugs: 19 per cent in the Aboriginal and Torres Strait Islander sample had tried at least one other illegal drug, compared to 16 per cent in the general community (Commonwealth Department of Human Services and Health, nd).

Utilising previously unpublished findings from four surveys of clients of Needle and Syringe Programs, conducted between 1995 and 1998 by the Australian Needle and Syringe Program, Correll and colleagues found self-identified Indigenous status in 5.4 per cent of participants. As the authors note, this was “more than double the [then] 2.1% of the Australian population who identify as Indigenous” (Correll, 2000:52).

The Illicit Drug Reporting System been conducting annual surveys of illegal drug use in all Australian States and Territories since 1999 (McKetin et al, 2000). The surveys aim to “provide a coordinated approach to the monitoring of data associated with the use of opiates, cocaine, amphetamines and cannabis, and act as a strategic early warning system for the emerging illicit drug problems” (Fleming, 1999:1). Data are collected in two ways: interviews with people who are professionals in the field of illegal drug use, and interviews with people who inject drugs (McKetin et al, 2000).

Since 2000, the Illicit Drug Reporting System has collected data on Indigenous status. These results consistently demonstrate disproportionately high percentages of between 11 and 14 per cent of the sample who identify as Indigenous (Topp et al, 2001; Topp et al, 2002; Breen et al, 2003; Breen et al, 2003; Breen et al, 2004). We note here, however, that like other samples of people who use illegal drugs, these samples are opportunistic samples.

In the 2001 National Drug Strategy household survey, almost 27 000 Australians aged 14 and over, 1.6 per cent of whom identified as Indigenous, were asked about their attitudes towards drugs and their drug consumption histories and related behaviours. We report here just findings related to reports of illegal drug use during the 12 months prior to the survey. As shown in Table 1.1, compared to their non-Indigenous counterparts, higher proportions of Indigenous people reported use of any illegal drug; use of marijuana, and any illegal drug except marijuana (Australian Institute of Health and Welfare, 2002a).

**Table 1.1: Comparison of prevalence of illegal drug use between Indigenous and non-Indigenous people sampled in the 2001 National Drug Strategy household survey**

Illicit drug use previous 12 months	Indigenous people	Non-Indigenous people
	%	%
Any illegal drug	32	17
Use of marijuana	27	13
Any illegal drug except marijuana	13	8

### *National treatment samples*

Whilst data from clients of national treatment samples include people with problematic alcohol use, as well as illegal drug use, some indicators of patterns of illegal drug use can be found. For example, in a report of the 1995 census of treatment agencies, Torres and colleagues observed “an increase in the absolute numbers as well as in the percentage of Aboriginal and Torres Strait Islander people ... In 1990, 8.8% of substance users were Aboriginal and Torres Strait Island people, in 1992 ... 10.3% and in 1995 ... 11.8%.” They noted, however, that “The changes may reflect a real increase in the number of Aboriginal and Torres Strait Island people presenting to treatment or more accurate identification by treatment agencies” (Torres et al, 1995).

As part of the report of the 2001 census of treatment agencies, Shand and Mattick reviewed three phases of treatment census data collected since 1990. Their work revealed that the percentage of substance using treatment clients who were Indigenous, whilst always disproportionately high increased from 8.8 per cent in 1990, was 19.3 per cent in 1992, and had declined to 11 per cent in 2001 (Shand and Mattick, 2002). This review also showed that, whilst there had been a decrease in the percentage of clients seeking treatment for alcohol use who were Indigenous, the number in treatment for problems other than alcohol almost tripled: from 78 in 1990 to 233 in 2001. Statistically significant increases over time in the percentages of Indigenous clients receiving treatment for “opiate, cannabis and amphetamine” use were found (Shand and Mattick, 2002:354). This historical review by Shand and Mattick also demonstrated an increase in injecting drug use by Indigenous clients, as well as an increase in the proportion of Indigenous clients who were women (Shand and Mattick, 2002).

Reports to the National Minimum data set have also revealed an over-representation of Indigenous clients. Of the 120 869 closed treatment episodes<sup>5</sup> from 1st July 2001 to 30

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<sup>5</sup> For the purposes of the National Minimum data set a closed treatment episode is defined as “one or more of ... (a) a client’s treatment plan has been completed; (b) no contact between client and treatment agency for a period of 3 months, unless that period of no contact was planned; (c) the client’s Principal drug of concern has changed; (d) the client’s Main treatment type has changed” (Australian Institute of Health and Welfare, 2003:65). Agencies whose sole activity is to prescribe and/or dose methadone or other opioid maintenance treatments are excluded from the data collection for the National Minimum data set, inferentially because of the definition of a closed treatment episode.

June 2002, 8 per cent (n=9 615) involved people who identified as Indigenous. The authors point out that the proportion of Indigenous people in treatment was probably higher, firstly because data were not provided by Indigenous services, and secondly because in 7 per cent of cases Indigenous status was not stated (Australian Institute of Health and Welfare, 2003).

### *Localised reports*

We report briefly below on localised reports of illegal drug use by Aboriginal and Torres Strait Islander peoples. Some reports are State-based and some are regionally based. We conclude this section on localised reports with a more extensive discussion of what is known about illegal drug use by Aboriginal and Torres Strait Islander people in the ACT and Region.

In their West Australian study of substance use by Aboriginal people aged 8-17 years, Gray and colleagues found that 30 per cent had ever used cannabis and 14 per cent had used other illegal drugs. Seven per cent had injected drugs (Gray et al, 1997). Three per cent of injecting drug users surveyed in West Australia in the mid-1990s said they were Aboriginal and/or Torres Strait Islander (Lenton and Tan-Quigley, 1997).

A study conducted with clients of the Darwin needle and syringe program in 1998 revealed that the proportion of self-identified Aboriginal clients was 14 per cent while only 8.2 per cent of the Darwin population was Aboriginal (Roberts and Crofts, 2000).

Since we recruited some respondents from NSW, we briefly provide here some statistics on the State's Aboriginal and Torres Strait Islander population before providing a more in-depth overview than provided above for other jurisdictions. Whilst NSW is the state with the largest number of Aboriginal and Torres Strait Islander people (135 319) the proportion of the NSW population that is Indigenous is, at 2.0 per cent, similar to the national proportion of 2.4 per cent (Australian Bureau of Statistics, 2002). There is, however, evidence that Aboriginal and Torres Strait Islander people in NSW are even more over-represented in illegal drug users populations than in other parts of Australia. In order to better present these results we divided them into findings specifically on

injecting drug use, findings on general illegal drug use, and findings from treatment samples.

In the 1994 Australian Study of HIV and Injecting Drug Use, despite similar recruitment methods for all states and territories, 13 per cent of the NSW sample was Indigenous, compared to five per cent of the nationwide sample (Rutter et al, 1996).

Day and colleagues examined data to work out proportions of Aboriginal injecting drug users in three cross-sectional Sydney studies (the Illicit Drug Reporting System, the Australian Prevalence and Estimate of Treatment Study and the Australian and Blood-borne Virus and Injecting Drug use study) conducted by the National Drug and Alcohol Research Centre since 1997. They concluded that Aboriginal people were over-represented in all three studies, constituting 15-19 per cent of the three samples (Day et al, 2003).

An examination of other results from the Illicit Drug Reporting System has consistently demonstrated that, compared with other jurisdictions, NSW has the highest proportion of Indigenous respondents who inject drugs. In 2000, of 100 people surveyed, 25 per cent were Indigenous (Topp et al, 2001); in 2001 29 per cent of 163 people were Indigenous (Topp et al, 2002); and in 2002, 28 per cent of 158 people surveyed were Indigenous (Breen et al, 2003).

According to Helen Orcher, an Aboriginal Liaison Officer at the Kirketon Road Centre in Kings Cross, Sydney<sup>6</sup>, since the early 1990s an increasing number of Aboriginal injecting drug users have been accessing the service. Fifteen per cent of all clients attending the Kirketon Road Centre, and more than 30 per cent of the clients on its

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<sup>6</sup> The Kirketon Road Centre provides services to people at particular risk, such as those less than 25 years of age with a street-based lifestyle in Kings Cross, sex workers and injecting drug users. “[It] operates a comprehensive medical, counselling and social welfare service including methadone access and needle syringe programs. [An] Aboriginal health education officer is employed to explore and address any specific needs with respect to HIV prevention, sexual health and illicit drug use that Aboriginal clients among [the] target populations may have. The Aboriginal worker is also actively involved in community education efforts to sensitise mainstream HIV and drug services to Aboriginal-specific needs, and Aboriginal-specific services to needs with respect to HIV prevention, sexual health and illicit drug use” (Kirketon Road Centre, nd).

Methadone Access Program, are Aboriginal (Orcher, 2001). We point out here that the Kirketon Road Centre provides services in a culturally appropriate way, in this context particularly its flexible Methadone Access Program. This may increase the proportion of Aboriginal clients.

The Central NSW Coast Needle and Syringe Program's data collection system provides a profile of sociodemographics, including Aboriginal and Torres Strait Islander status. In 2002, of the 1 415 clients registered on the Program 8 per cent identified as Aboriginal or Torres Strait Islander. The authors note that of the total Central Coast population, just two per cent identify as Aboriginal or Torres Strait Islander (Sheather-Reid et al, 2002).

Perkins and colleagues compared their findings on both legal and illegal drug use from two urban samples of Aboriginal people (n=531) in NSW with proportions of non-Aboriginal participants from a national study. They found, that when compared to respondents in the non-Aboriginal national sample, significantly greater proportions of Aboriginal people used marijuana and heroin (Perkins et al, 1994).

In surveys conducted in NSW schools in 1989 and 1992, Aboriginal Torres Strait Islander students were 2.4 times more likely than other students to use cannabis, and 1.9 times more likely to use inhalants (Forero et al, 1998).

The Ted Noffs Program for Adolescent Life Management offers up to three months of residential treatment and three months of continuing care for 14-18 year olds across the "three metropolitan and two rural settings in eastern Australia." Twenty one per cent of the 125 clients in 2001-2003 were Indigenous. The drug of most concern was marijuana (used by 46% of the Indigenous sample). Others, of what were termed as "problem drugs", for the Indigenous clients were "amphetamine-type substances" (considered by the Alcohol and other Drugs Council of Australia to be amphetamine, methamphetamine, ecstasy and cocaine [Alcohol and other Drugs Council of Australia, 2003]) (19%), heroin (15%), alcohol (15%) and tranquillisers (4%) (Arcuri and Howard, 2003).

### *The ACT and Region*

Of 121 fourteen to eighteen year olds in residential treatment in Sydney and the ACT accessed via phone interviews by Spooner and colleagues, 11 per cent reported that they were Aboriginal (Spooner et al, 2000). In keeping with national findings reported above, higher proportions of Indigenous people have consistently been found amongst illegal drug users interviewed for the ACT illicit drug reporting system. In the 1999 ACT Illicit Drug Reporting System document, Fleming and colleagues make several references to reports of increased illegal drug use, particularly heroin use, amongst Indigenous people in the ACT. The authors considered this to be one of their major findings (Fleming, 1999:50-2).

In the 2000 to 2003 Illicit Drug Reporting System of injecting drug users in the ACT, between 8 and 14 per cent of the 100 people interviewed for each of the four surveys identified themselves as Indigenous (Topp et al, 2001; Topp et al, 2002; Breen et al, 2003; Breen et al, 2004).

Approximately four per cent of all ACT treatment clients reported to the National Minimum Data Set during 2000-2001 said they were of Aboriginal or Torres Strait Islander origin (Australian Institute of Health and Welfare, 2002b). As with the national treatment reports (outlined above), some of these clients would have been in treatment for alcohol-related problems.

### **Estimations of the numbers of Aboriginal and Torres Strait Islander people in the ACT and Region using illegal drugs**

During research on estimations of the number of Indigenous illegal drug users in the ACT and Region undertaken at NCEPH in 2000, we concluded that quite large numbers of young Aboriginal and Torres Strait Islander people had experienced legal problems as a consequence of their drug use (Dance et al, 2000a). This was in keeping with studies which have found that Aboriginal and Torres Strait Islander people have a higher proportion of contact with Legal Services and the Criminal Justice System than their non-Indigenous counterparts (for example, Mukherjee et al, 1998; Levy and Butler, 2000; Australian Bureau of Statistics, 2001).

Our earlier research also demonstrated that only small numbers of Aboriginal and Torres Strait Islander people who use illegal drugs were accessing agencies which provide services such as drug detoxification, drug rehabilitation or methadone. Aboriginal organisations reported increasing contact with quite large numbers of people. Some mainstream organisations also reported a quite extensive, as well as an increasing, contact with young Aboriginal and Torres Strait Islander people. These organisations were generally those which provided services such as needle exchange, client advocacy or some form of education or skills enhancement.

As part of the current research we recontacted the agencies from which we had gathered data in 2000 for up to date estimations of the numbers of Aboriginal and Torres Strait Islander people in the ACT and Region using illegal drugs. (A list of all drug and alcohol treatment service providers in the ACT is included as Appendix 3; a list of drug and alcohol treatment locations for Southern Area Health as Appendix 4; and a list of Indigenous organisations located within the Queanbeyan region as Appendix 5.). In 2000 we succeeded in accessing all relevant Aboriginal organisations in the ACT and a majority of mainstream organisations. In 2003 to 2004, we succeeded in obtaining data from all but one of the agencies we collected data from in 2000.

In 2000 we were asked by our funding body (the ACT Office of the Commonwealth Department of Health and Aged Care) to provide estimates of the numbers of *young* Aboriginal and Torres Strait Islander people using *heroin*. For the data we collected in 2003 and 2004 we were interested in obtaining estimates for any illegal drug use by Aboriginal and Torres Strait Islander people, regardless of age. We did not, therefore, stipulate an age or type of illegal drug for these estimates.

As for the 2000 data collection, staff of some organisations analysed their data following our request, then reported their findings back to us. A table with both the 2000 and 2003 and 2004 estimations is included as Appendix 6. Where there were no available data, we asked the most experienced staff members to provide us with estimations. We also asked for an estimation of the total client base. The status of the numbers (whether precise or estimations) is also indicated in the table in Appendix 6. Some of the total client base of service organisations consisted only of illegal drug users. In others, the client base was comprised of polydrug users, including people whose main problem was alcohol use.



The clients of some organisations were a mixture of people experiencing drug-related problems and people experiencing problems which were not drug-related. The first two organisations listed in the table are Aboriginal service providers and the client base consists mainly (Winnunga) or only (Gugan Gulwan Youth Aboriginal Corporation) of Aboriginal and Torres Strait Islander people. Apart from the Aboriginal Legal Service, the other client bases consist of both Aboriginal and Torres Strait Islander people and non-Indigenous people. The table included as Appendix 6 also includes the timeframes on which the estimations or calculations were based. These are very variable.

The process of data collection was iterative and sometimes required a number of contacts to ensure the accuracy of our reporting. This process included providing a penultimate copy of these findings to the most senior members of organisations. Any requested corrections were made.

As shown in the table in Appendix 6, the numbers obtained from Winnunga (an estimate of 500) and Gugan Gulwan Youth Aboriginal Corporation (a precise number of clients: 29 for a quarter in 2000, and 55 for half a year in 2003) are similar for 2000 and 2003.

Fifteen Aboriginal and Torres Strait Islander *clients* were in contact with the ACT Alcohol and Drug Program during a three month period: November and December 1999 and January 2000. (*Corrigendum 12.8.04, although the dates were correct, as provided by the Alcohol and Drug Program on 7th February 2000, and as reported in Dance et al 2000a, in the first print of this report this period was miscalculated by the first report author as a 14 month period.*) There were 230 “*occasions of service*” for Aboriginal and Torres Strait Islander clients during a seven month period between November 2003 to 24th May 2004. We asked Sally Pink (the Director of the Alcohol and Drug Program) if she could amplify these findings. Sally said that there “has indeed been an increase in the number of Indigenous clients accessing the Alcohol and Drug Program.” She explained that not only had there been a change in the way the data were collected (in 2000 the number we were given was based on the number of *clients*, whereas in 2004 the number relates to “*occasions of service*”) the employment of Aboriginal staff, which commenced in 2000 and continues to the current time (11th June 2004), has resulted in an increase in the number of Aboriginal and Torres Strait

Islander clients accessing the Alcohol and Drug Program. The diversion program (which provides programs which aim to divert people apprehended for drug use or drug related offences from the judicial system into the health system) has also increased the Program's number of Aboriginal and Torres Strait Islander clients (Pink, S. Director, Alcohol and Drug Program, Community Care, ACT Health 2004, June 11<sup>th</sup> pers comm).

Addendum 21.9.04: Data from the National Minimum Data Set reveal that 72 Aboriginal and Torres Strait Islander *clients* accessed the Alcohol and Drug Program over an eight month period between 1<sup>st</sup> November 2002 and 30 June 2003 (Pink, S. Director, Alcohol and Drug Program, Community Care, ACT Health 2004, August 29<sup>th</sup> pers comm).

In 2003, in addition to the number of clients admitted to Karralika Therapeutic Community (Alcohol and Drug Foundation of the ACT) we were provided with the number of people screened by that organisation. Overall, there was an increase from 16 contacts in 2000 (when we received data only on the number of Indigenous people admitted to Karralika, not the additional number who were screened and not admitted) to 26 in 2003: 10 admissions, and a further 16 Indigenous people who were screened.

In 2003 Mancare Community (Salvation Army) informed us that two to three of its estimated 157 clients a year were Aboriginal and Torres Strait Islander people. In 2003 the number of Aboriginal and Torres Strait Islander clients had increased slightly to 8. There was also an increased number of total clients, from around 157 in 2000 to around 250 "individual encounters" in 2003.

The Director of the Alcohol and Drug Program of Southern Area Health Service estimated that this service had six Aboriginal and Torres Strait Islander clients in January 2000 and 30 between June 1998 and June 1999. For the calendar year 2003, there were 104 "new referrals" to the Alcohol and Drug Program of Southern Area Health Service. An additional 43 people were receiving treatment, generally opioid agonist treatment [buprenorphine] (Doverty, M. Director, Aboriginal Health and Alcohol and Drug Services, Southern Area Health Service 2004, June 11<sup>th</sup> pers comm). Overall then, in 2003 this service had 147 Aboriginal and Torres Strait Islander clients. A big increase in the number of 30 Aboriginal clients estimated between June 1998 and June 1999.

The findings from these four mainstream services point to increases between 2000 and 2003 to 2004 in the number of Aboriginal and Torres Strait Islander people in contact with mainstream drug treatment agencies in the ACT and in the Southern Area Health Service.

The estimates from out-patient mainstream services (providing services such as needle and syringe exchange and peer-based education) are fairly comparable for 2000 and 2003.

There also appears to be an increase between 2000 and 2003 in the number of Aboriginal and Torres Strait Islander clients using illegal drugs who were in contact with the Aboriginal Legal Service. In 2000 we asked the Aboriginal Legal Service to provide use with estimates of young Aboriginal and Torres Strait Islander clients who were using heroin and were provided with estimates of between 60 to 200. In 2003, the estimates we received was 450 to 600 for Aboriginal and Torres Strait Islander clients of any age, using any illegal drug. The difference between the 2000 and 2003 estimates may be because we did not specify age or type of illegal drug in 2003 whereas in 2000 we were interested in obtaining estimates of young heroin users.

The difference may also be explained by an expansion in the ACT Aboriginal Legal Service, which increased its scope to become the South Eastern Aboriginal Legal Service and is so doing increased its catchment area. In 2000 the estimates we were given were for the ACT and Region. In 2003 we were informed that the estimate included clients in the “ACT, Queanbeyan, Goulburn and Yass.” In addition, there was an increase in the number of legal staff employed in the Legal Service between 2000 and 2003 (Newman, N, 2004 pers comm, 16<sup>th</sup> June). Whilst there may be some differences in the client catchment area between 2000 and 2003, as well as an increase in staff numbers, the estimation of 450 to 600 for 2003 indicates that there are a large number of Aboriginal and Torres Strait Islander people using illegal drugs in the ACT and surrounds. This estimate is in keeping with the estimate of 500 made by one of us (Julie Tongs) in both 2000 and 2003.

There was also an increase in the number of Aboriginal and Torres Strait Islander people using drugs in contact with ACT Adult Corrective Services: from 25 in 2000 to 59 in 2003.

### *Limitations of these estimations*

Obtaining accurate total estimations of the number of illegal drug users, or the types of drugs they use, is not possible. Here we discuss the particular problems associated with the estimations provided above. Most Aboriginal and Torres Strait Islander drug users probably access more than one service provider. There is very likely, therefore, to be a lot of overlap in the estimations given to us. Some people were able to give us a precise number of clients and a precise number for their client base. Others provided us with estimations. In addition, the composition of the people in the client bases was very varied. Whilst the majority of timeframes were current at the time of contact, others dated back over varying period of time. This leads to the other problem with the timeframes: they often covered different periods. From the information available to them, some agencies were unable to distinguish clients who had used alcohol or prescription drugs (whether misuse of prescription drugs, or drugs prescribed for treatment of problematic drug use, such a methadone) from those who used illegal drugs.

Of particular relevance to the comparisons between the 2000 estimates and the 2003 and 2004 estimates is that in 2000 we were asked to provide estimate of the numbers of young Aboriginal and Torres Strait Islander people using heroin. In 2000, however, some agencies provided us with estimates of Indigenous clients of “all ages.” They also provided information about Indigenous people using drugs other than heroin. We did not stipulate an age or type of illegal drug for the estimates we obtained during 2003 and 2004.

### *Conclusion on estimations*

These comments notwithstanding, the estimates do provide us with some information about the numbers of Aboriginal and Torres Strait Islander people in the ACT and Region using illegal drugs. As reported earlier in this chapter, in our 2000 paper we suggested that that there are one hundred or more young Indigenous people using illegal drugs in the ACT and Region (Dance et al, 2000a). In this earlier paper, we went on to expand on this estimate by reporting that four experienced service providers (Paul Brandy and Jim Jeffery from the ACT Aboriginal Legal Service, Maureen Cane from Assisting Drug Dependents Inc and Tarquin McPartlan from Canberra Injectors Network) believed that the figure could be as high as 200. We also made mention of the

fact that, according to one source (Julie Tongs) who has a great deal of contact with the problem, there may be as many as 500 Aboriginal and Torres Strait Islander illegal drug users across all ages in the ACT.

Based on the estimations received in 2003 and 2004, and tying these in with other ACT (as well as regional and national) reports of the prevalence of illegal drug use by Indigenous people, we conclude that there may currently be as many as 500 Aboriginal and Torres Strait Islander people of all ages in the ACT and Region using illegal drugs. Some of these people may only use marijuana. Others are polydrug users whose illegal drug use may include injectable heroin and/or amphetamine.

As in our 2000 paper on estimations, our conclusion based on the 2003 to 2004 estimates is that there is a need for further drug preventative programs for young Aboriginal and Torres Strait Islander people. Despite the increase in the number of Aboriginal and Torres Strait Islander people accessing mainstream drug treatment services, particularly the ACT Alcohol and Drug program, we also conclude, as we did in 2000, that there needs to be increased access to, and adequate resources for, appropriate treatment (Dance et al, 2000a). We further substantiate this conclusion in some of the results chapters of this report.

### **Context of contemporary drug use by Aboriginal peoples**

We have so far documented information from most Australian states and territories (all except Tasmania; we have not found any studies from this state) which when put together tell the same story. In comparison with other Australians, higher proportions of Aboriginal and Torres Strait Islander people use illegal drugs.

We begin this section on possible reasons for this by setting the use of illegal drugs by Aboriginal and Torres Strait Islander people in the contemporary framework of illegal drug use in the general community. Since the 1960s there has been in Australia, as in other Western nations, a widespread increase in drug use (McAllister et al, 1991). Indigenous people probably started experimenting with substances such as marijuana, heroin and amphetamines in the 1960s when their use started to become widespread in Australia (Gray and Saggars, 2003). Some commentators have offered specific

explanations for the use of drugs by Aboriginal and Torres Strait Islander people. We turn now to an overview of some of these explanations.

We agree with Gray and Siggers' statement that it is necessary to "know the historical context and recognise the link between disadvantage, poor health and substance use ... [there is, increasingly] a tendency to blame Indigenous communities for their own ill health and substance use" (Gray and Siggers, 2003:177). The National Aboriginal Community Controlled Health Organisation persuasively argues that modern-day drug use by Aboriginal people is "an expression of serious underlying issues. Many of these can be traced back to the doctrine of *terra nullius* [a land of no peoples] - a doctrine that negated Aboriginal people's existence and rights while it confirmed and sought to legitimise white racism" (National Aboriginal Community Controlled Health Organisation, 2000). The National Aboriginal Community Controlled Health Organisation elaborates on the consequences of *terra nullius*. These consequences:

*include the trans-generational impacts of the Stolen Generations, loss of land, law, culture, and language, forced removals and racism. Unemployment, inadequate housing and infrastructure as well as poor educational outcomes also contribute to the problems faced by Aboriginal communities. These are some of the true causes of substance misuse, and until they are addressed, the best substance misuse services will remain fundamentally 'band aid' solutions.*

(National Aboriginal Community Controlled Health Organisation, 2000)

Lest this view be considered extreme, we point out that several other commentators had earlier identified similar underlying issues to those outlined above. For example, the Commonwealth Department of Health and Aged Care noted in a 1999 report that:

*Substance misuse is the cause and effect of much pain and suffering in Aboriginal and Torres Strait Islander society. Its origins lie in poverty, prejudice and pain. Dispossession from language, culture and land go hand in hand with substance misuse.*

(Commonwealth Department of Health and Aged Care, 1999:15)

Some experts in the field have made comments similar to those made by the authors of the Commonwealth Department of Health and Aged Care report. Matthews, for example, noted in 1991 that, just as in "white society, alcohol and substance abuse can be interpreted as symptoms which reflect deeper problems of social and personal adjustment"(Matthews, 1991:36). He goes on to stress specific issues related to drug use by Aboriginal peoples:

*the disruption of the traditional Aboriginal society by the dominant white culture is held to be the primary cause of social problems and consequential problems of substance abuse amongst Aboriginal people today. This interpretation (which rightly emphasises the cultural dissonance between Aboriginal and white societies) is valuable because it implies that it would be of limited value to treat the symptoms (eg, alcohol abuse or petrol sniffing) without also trying to improve the other underlying social problems ([eg,] ... unemployment, boredom, poverty, poor housing, malnutrition and ill-health).*

(Matthews, 1991:36)

Based on a great deal of research experience in the area, Brady concludes that:

*to some extent all Aboriginal and Torres Strait Islander youth could be considered to be 'at risk' of engaging in harmful drug and alcohol use ... because they are the most disadvantaged group in Australia today on a range of social indicators (health, housing, education, employment, income, criminal justice); because they all experience to some degree the impact of being a minority population in a country which was once wholly their own; and because the families to which they belong are, to varying degrees, struggling to deal with this legacy.*

(Brady, 1995a:2)

We report in Chapter 9 on the needs articulated by the people we interviewed about some of the social indicators referred to above.

### **Alcohol and drug treatment services for Aboriginal people**

In 1991 the Royal Commission into Aboriginal Deaths in Custody concluded that the National Campaign Against Drug Abuse (now the National Drug Strategy) had not gone far enough in the area of alcohol and other drug services for Aboriginal peoples, especially in terms of their control of those services. The Commission captured this concern in Recommendation 287:

*higher priority [should be given] to the provision of alcohol and other drug prevention, intervention and treatment programs for Aboriginal people which are functionally accessible to potential clients and are staffed by suitably trained workers, particularly Aboriginal workers. These programs should operate in a manner such that they result in greater empowerment of Aboriginal people, not higher levels of dependency on external funding bodies.*

(Johnston, 1991)

A decade later, a review by the Alcohol and Other Drugs Council of Australia reached similar conclusions (Alcohol and other Drugs Council of Australia, 2000).

Following a 2002 review for the Australian National Council on Drugs, Gray and colleagues concluded that “Information about interventions that focus on illicit drug use among Indigenous Australians is extremely limited, and our search of the literature revealed only 18 articles on the topic. Most of the literature ... describes its prevalence and patterns of use, rather than interventions. There have been no evaluations of projects that target illicit drugs, and the few available articles on illicit drug use and intervention focus on either cannabis use or [injecting drug use]” (Gray et al, 2002:11).

In addition to her interviews with 11 Aboriginal and Torres Strait Islander illegal drug users in the ACT, Dobson interviewed 20 staff employed in local drug and alcohol treatment services. Dobson concluded that, due to a complex variety of historical and cultural reasons, Indigenous illegal drug users are often reluctant to access mainstream services in Canberra. She also argued that “The structural framework of rules, policies and outside political and legal constraints, within which mainstream drug and alcohol services operate, poses a significant barrier” to Indigenous illegal drug users accessing and using these services effectively (Dobson, 2000:54). The lack of culturally appropriate services was a consistent theme, mentioned in 18 interviews with consultants for the recent South Australian study (Holly and Shoobridge, 2002). Studies in Brisbane (Larson et al, 1999) and Western Australia (Gray et al, 2001) have found a poor knowledge and utilisation of services amongst Aboriginal illegal drug users. In later chapters we report findings from the people we interviewed on treatment histories (Chapter 5) and treatment needs (Chapter 6).

## **Conclusion**

The research we conducted in 2000 was a motivation for the research we describe here. We have demonstrated that both that earlier research and the present research had its genesis in Community concerns about illegal drug use.

We have made reference to a plethora of national and local data which indicate that in contemporary Australia higher proportions of Aboriginal and Torres Strait Islander peoples, compared with other Australians, use illegal drugs. Based on findings such as these, the figure of 500 Aboriginal and Torres Strait Islander illegal drug users for the ACT (around 10 per cent of the ACT’s Aboriginal and Torres Strait Islander



population) which was estimated by one of us (Julie Tongs) both in 2000 and currently (in 2003) is very plausible.

We interviewed Aboriginal and Torres Strait Islander illegal drug users in the ACT and Region about their treatment needs and a range of other needs, including those related to culture, education and employment. Ninety five people were interviewed, which means if the estimate of 500 Aboriginal and Torres Strait Islander illegal drug users for the ACT is indeed reasonable, that we interviewed around 10 to 20 per cent of the target population in the ACT and Region. It is never possible to obtain a random sample of people who use illegal drugs, and caution about extrapolating from non-random samples is always necessary. We believe, however, that a sample of 10 to 20 per cent of the target population provides a good evidence-base on which to implement research findings.

The Aboriginal and Torres Strait Islander illegal drug users we interviewed presented for interview because, to paraphrase the words we use in the first part of the title of this report, they wanted “to be heard.” Throughout the report we give voice to the people we interviewed. In Chapter 2 we detail the process and methods for the research. Chapter 3 provides a brief overview of sociodemographic findings before we report on drug use behaviours in Chapter 4. This chapter sets the scene for Chapters 5 and 6. In Chapter 5 we report on histories of treatment for alcohol and drug use before reporting in Chapter 6 preferences and needs for drug use treatment. There are then three chapters focusing on the on health of the people we interviewed: in Chapter 7 we present an overview of physical health, including findings related to bloodborne viruses and sexual health; in Chapter 8 we focus on emotional well-being; and in Chapter 9 on the social determinants of health including a variety of needs related to this domain. Chapter 10 concludes the report with a summary of the findings and some reflective pieces by some of the researchers as well as the chair of the Reference Group.

## CHAPTER 2: PROCESS AND METHODS

### **Introduction**

In this chapter we give a brief overview of the process and methodology for the needs analysis we conducted with 95 ACT and Regional Aboriginal and Torres Strait Islander people who use illegal drugs. As indicated in the previous chapter, we interviewed 54 people who had injected in the twelve months prior to interview (57% of the sample) and 41 people using other routes for their illegal drug use. We begin the chapter with an overview of the collaborative aspects of the research. This is followed by ethical considerations and a description of the questionnaires we used. We move on to discuss piloting of the questionnaires, recruitment of respondents and data collection before giving a brief description of the interviews themselves. There is then a short description of how the data were analysed and how the findings are presented. The chapter concludes with the ways we are disseminating the findings and informing the Aboriginal and Torres Strait Islander Community, service providers and stakeholders of the research.

### **Collaborative research**

Needs analyses in public health take diverse forms, including community self-surveys, those conducted collaboratively between researchers and the affected communities, and those conducted by external professional researchers (Cox et al, 1984). In recent years, considerable attention has been drawn to the importance of conducting needs assessments in the drugs field that are strategically linked to the development of responses to the problems (Stimson et al,1988).

The needs analysis we report here was a collaborative investigation undertaken by researchers in a tertiary institution and a Community-based Aboriginal Medical Service. In the previous chapter, we described the pivotal partnership between Winnunga and NCEPH. Here we provide an overview of the transfer of skills training before describing the formation of the research team. We then make mention of the support received from other relevant agencies before discussing the formation of the Reference Group. The research incorporated many of the principles of Action Research. Action research “suggests the possibility of a form of social action which involves people in a

process of change, which is based on professional, organisational or community action, and which is thus no longer beset by the age-old problem of the gap between ‘theory’ and ‘practice’” (Winter and Munn-Giddings, 2001:5). Winter and Munn-Giddings further define Action research as “the study of a social situation carried out by those involved in that situation in order to improve both their practice and the quality of their understanding” (Winter and Munn-Giddings, 2001:8). The collaborative work between Winnunga and NCEPH is epitomised in a quote from Lilla Watson, a Murri woman involved in Community Action:

*If you have come here to help me, you are wasting your time. If you have come because your liberation is bound up with mine, then let us work together.*

(University of the Poor, nd)

### *Transfer of skills training*

Transfer of skills training is one of the ways of implementing the ‘Darwin criteria’ (included as Appendix 2). Throughout the duration of the project there was extensive transfer of skills training between the NCEPH and Winnunga researchers, in particular between the Aboriginal and non-Aboriginal interviewers. In order to allow Winnunga to be adequately staffed, and to also include as many interested Aboriginal Health Workers as possible, two sessions of training were conducted. (The transfer of skills training will be fully described in a paper we are preparing for publication.) We have included a list of all training undertaken by members of the research team as Appendix 7. Where relevant, the training is also alluded to throughout this chapter. As we reported in Chapter 1, the transfer of skills training was envisioned by Tom Brideson (the chair of our Reference Group, described below) as a tree (please see Appendix 1). We make mention here of the need for the training we did in issues related to sexual abuse in the Aboriginal and Torres Strait Islander Community and in mental health first aid.

### *Training in issues related to sexual abuse*

Other researchers have demonstrated that there is a correlation between illegal drug use and physical and sexual abuse (for example, Dembo et al, 1988; Howard, 1993). In previous research conducted by one of us it became apparent that interviewing people about their drug use has the potential to trigger painful memories, sometimes related to

childhood trauma such as sexual abuse (Dance, 1998). This led to the very strong conviction, shared by everyone who was to take part in the interviews, that interviewers must be prepared to deal with issues of abuse raised by people they were interviewing.

The two day training was organised by NCEPH researchers and provided by Aboriginal Health Workers from the ACT Rape Crisis Centre. All Winnunga and NCEPH interviewers undertook the training (a total of 31 people undertook the training, the remaining trainees being mainly from other Aboriginal Medical Services in the ACT and Region) which provided us with the necessary skills to deal with issues related to sexual abuse raised by some of the people we interviewed.

### *Mental health first aid training*

Concerns were expressed by members of the Reference Group that the interviews might be damaging for respondents, some of whom might already be very troubled. The training in mental health first aid provided by Betty Kitchener from the Centre in Mental Health First Aid at ANU (<http://www.anu.edu.au/cmhr/>) was also undertaken by all interviewers. The training initially assisted us in judging if potential respondents were in a fit mental state to undertake the interview and then, if they were, to assess them throughout the interviews.

### *Training for interviewing*

Considerable thought and discussion between NCEPH and Winnunga staff went into what would be covered in the transfer of skills training to prepare the Winnunga researchers for interviewing, and how the sessions would work. It was important not to remove a large section of Winnunga's workforce from its core activity of health provision to the local Aboriginal and Torres Strait Islander community. As a consequence, NCEPH-based sessions were held across three alternate days, Monday, Wednesday and Friday, each a half day's duration, commencing with a working lunch. Two cohorts were trained at about one month intervals. Our broad objective was to break down barriers that (*can*) exist between academic institutions and community organisations by creating a comfortable "learning community" that would facilitate multi-directional learning between and amongst the health workers and the NCEPH-based researchers. We aimed, moreover, to build participants' general knowledge of the

research process, and their more specific knowledge of the local study, through training in areas of direct relevance to them. While allowing for flexibility to accommodate those areas of relevance, the training placed particular emphasis on background to the study, action research, ethics principles and processes, questionnaire design, and interviewing techniques.

We organised a range of topics. Peter Hiscock [then] Chair of the ANU Human Research Ethics Committee gave an overview of the ANU ethics approval process, and the several iterations in the approval process that were necessary for this particular project. To put the project in its larger context, we covered the NHMRC Committee and sub-committees structures. In addition, we looked at certain technical aspects of research including basic epidemiological and biostatistical concepts, research planning generally, and practical aspects of interviewing and questionnaire design. The training culminated with participants thinking about what would go in a “kit bag” for taking to interviews, both generally and more specifically for this project.

Fourteen people took part in the training - ten in the first cohort and four in the second. The training concluded with all participants receiving certificates of completion of the skills transfer training. Participants were also given the opportunity to provide feedback on how they felt the sessions went. Feedback was overwhelmingly positive, as illustrated by these four comments below:

*[I] still need more training and talking but it has been absolutely wonderful to have participated in this training. It has opened my eyes. I feel energised and enthused.*

*Thank you for sharing your training skills. I am looking forward to working with you during the interviews.*

*Very comprehensive, covered everything I wanted to know. Very interesting. Covered six weeks work in three half-days!!*

*Thank you. Training was very informative and rewarding.*

### *The research team*

In addition to Julie Tongs being an associated researcher, the transfer of skills training resulted in another nine Winnunga staff also being associated researchers. Eight of these other Associated Researchers are Aboriginal Health Workers: Len Barratt, Kacey

Boyd, Harold Chatfield, Glyniss Church, Warren Daley, Sharon Ingram, Dean Jard, George Wilson. The ninth is Jane Lynch, the Opiate Project Nurse<sup>7</sup> based at Winnunga. All ten associated researchers took part in the transfer of skills training and all except two of the took part in the interviews. Bringing their wealth of experience with them, much of which they shared with the NCEPH researchers, these associated researchers took on the task of interviewing in addition to their other workloads.

The NCEPH research team was composed of two Aboriginal researchers (Jill Guthrie and Carmen Cubicle) and four non-Indigenous researchers (Phyll Dance, David McDonald, Rennie D'Souza and Gabriele Bammer [as an associated researcher]).

### *The interviewers*

At least one of the two people always present at interview was Aboriginal (one of the Winnunga researchers and/or one of the NCEPH Aboriginal researchers, JG or CC) and at least one was from NCEPH (JG, CC or PD). One of the NCEPH researchers (PD) was present at all 95 interviews conducted. The three NCEPH interviewers brought a combination of skills to the interviews. Jill Guthrie holds a Masters of Applied Epidemiology-Indigenous-Health degree. At the time, Carmen Cubillo held an undergraduate degree with a major in psychology. During her employment on the project she completed an ANU Psychology Department/NCEPH Diploma in psychology. In February 2004, Carmen started her Masters degree at the University of Canberra. Phyll Dance is a Registered Nurse with recent nursing experience in the ACT's Alcohol and Drug Program. She has conducted research with people who use illegal drugs since 1989 gaining both her honours degrees then her doctorate in this area. Phyll was also part of the two recent investigation on Aboriginal health referred to in the previous chapter (Dance et al, 2000a; Dance et al, 200b).

Since all three NCEPH interviewers were women it was important that we were able to offer male respondents from Winnunga the possibility of a male interviewer. For reasons of confidentiality the Winnunga researchers did not take part in any of the

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<sup>7</sup> The Opiate Program is a service which provides nurses experienced in drug and alcohol work and who are "based within general practice to improve the care and treatment of people who are experiencing problems with opiates in the community" (ACT Division of General Practice, circa 2002).

interviews conducted outside of Winnunga premises. All male respondents recruited from outside of Winnunga were informed that the NCEPH interviewers were women and encouraged to have a male support person with them at interview.

### **Other support for the research**

During the grant application process, members of the research team approached a range of agencies in the ACT and region to request their support for the research. We received letters of support from Aboriginal organisations, non-Indigenous agencies in close contact with local Aboriginal and Torres Strait Islander people who use illegal drugs, ACT Policing, ACT Corrective Services and ACT Youth Justice Services and Government Agencies (a full list of people who provided letters of support is included as Appendix 8).

### **The Reference Group**

Shortly after we commenced the research (March 2001) we went about forming a Reference Group whose overall purpose was to guide the research. The Aboriginal and Torres Strait Islander members of the Reference Group also provided appropriate cultural advice. We succeeded in forming a Reference Group which met our aims of including Community representatives from the ACT and Region, as well as representatives from relevant Aboriginal and mainstream organisations. The names and affiliations of the Reference Group members are included in the acknowledgements.

The first meeting of the Reference Group was held in June 2001, three months after receiving the grant. Seven meetings of the Reference Group were held over the three year span of the research project. Staff from Directions (a non-government out-patient organisation providing needle and syringe exchange and other services to people who use drugs) attended one of these meetings and staff from the Alcohol and Drug Program, Community Health, ACT Health attended two of these meetings. The staff from these organisations presented information about their services, and answered questions from Reference Group members.

We have already made mention of some of the valuable contributions made by Reference Group members. Others are discussed in their relevant places below.

## **Ethical considerations**

The key ethical implications of the study related to privacy of personal information, the informed consent of individual participants, and the special ethical issues pertaining to Aboriginal and Torres Strait Islander health research. Since the people we wished to interview were engaged in at least one illegal activity (using illegal drugs), strenuous efforts had to be undertaken to ensure that everything possible was done to protect them from prosecution resulting from the data collection. Below, we briefly outline some particular ethical considerations.

### *Ethical guidelines*

In addition to the ‘Darwin Criteria’ (Appendix 2) we conducted the research according to the Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health Research (NHMRC, 1991) and the National Statement on Ethical Conduct in Research involving Humans (NHMRC, 1999).

### *Identifying information*

We did not record any identifying information. We asked the people we interviewed to chose a name other than their own. This proved to be a good ice breaker as we prompted people to chose, for example, a name of a favourite pop star or sports star. If this failed, we looked in a book of names we had brought with us. There was also some amusement as we subsequently referred to people by their chosen names. The names respondents chose for themselves (*not their real names*) are included on “the tree” in the Acknowledgements but, as recommended by members of the Community, these names are not linked to their quotes when we report some of the qualitative data in subsequent chapters.

Although the NCEPH researchers did not know the names of the people they interviewed, the Winnunga researchers did. The Reference Group members helped us deal with this complex aspect of the process when they pointed out that respondents were likely to be less distressed by the interview if they had a staff member from Winnunga and/or another support person present at the interview. There was also



general agreement, generated by comments from members of the Reference Group representing the Aboriginal Legal Service and Gugan Gulwan Aboriginal Youth Corporation, that we have our own confidentiality protocols and these protocols would be adhered to during the research.

We then developed a procedure, which we discussed during the transfer of skills training, whereby Winnunga researchers left the room when we asked questions with potentially legal ramifications, particularly those relating to criminal behaviours. Others who also presented as support persons were asked to leave the room for these questions. Respondents were informed of these measures during the consent procedure.

#### *First contact screening/provision of initial information*

We developed a first contact screening/provision of initial information (the document is included as Appendix 9). This process often took place over the phone when a potential respondent first contacted a member of the NCEPH research team (discussed further in the section on recruitment below). The screening questions included questions about the age and Aboriginal and Torres Strait Islander status of the potential respondent and, as part of the screening for emotional well-being, whether there had been recent contact with a psychologist or psychiatrist.

If the responses to these questions indicated that the person was suitable for interview we provided them with some initial information such as the names of the interviewers. If respondents said they knew any of the NCEPH interviewers, arrangements were made such that that person would not be present at interview. If the potential client was a client of Winnunga we asked if they would like to have a Winnunga researcher with them. We asked everyone if they would like to have a support person with them at interview. We also informed them that there would always be an Aboriginal interviewer.

At the start of the research we knew of other research being conducted in the ACT and region with people who use illegal drugs. To monitor the potential for respondent fatigue, we also asked potential respondents whether they had recently been interviewed about their illegal drug use. None of the people we interviewed had been involved in any of the three other pieces of research which we were aware were taking place during the period in which we were conducting interviews.

### *Face to face screening/provision of information*

If we had not been able to undertake an initial phone screening, questions and information contained in that document were covered during face to face screening. Additional screening which required face to face contact, such as assessment for signs of withdrawal or intoxication and respondent's mental state, was also undertaken (Appendix 10).

The process of screening and informing potential respondents about the interview took around 15 minutes.

### *Consent for interview*

After the face to face screening, and when we were satisfied that the respondent was fully informed about the interview, we read out the consent for interview form (Appendix 11). Because we did not want identifying information, consent was in the form of oral consent whereby, in the presence of a witness, respondents ticked a tick box on the consent form. Respondents were given a copy of the consent form.

### *Reciprocity*

Recognising that an interview takes up a lot of respondents' time, other researchers have raised the question of reciprocity (Fetterman, 1989; Power, 1989). As with research conducted in the ACT and Region with older Aboriginal and Torres Strait Islander people (Dance et al, 2000b) and in common with other researchers in the field of drug research who have also used an honorarium (Darke et al, 1991a; Spooner and Flaherty, 1993; Yu et al, 1999; Larson et al, 1999), we provided respondents for this research with an honorarium of twenty dollars. This information was provided on the recruitment flyer (described further below and included as Appendix 12) and during the initial and face to face screening. The honorarium may have been one of the reasons people presented for interview. Whilst it is possible that payment is a form of inducement we believe that we acted correctly in compensating the people we interviewed as doing so did not impact on the voluntary nature of participation.

During the interviews we provided light refreshments. For some of the longer interviews we also provided lunch. We know that an important part of the Action

Research methodology was for us to be prepared to provide people who requested them, or for whom we thought it appropriate, with referrals. As already indicated, where necessary we supplied referrals to people who solicited help or information or who we thought needed professional help. Prior to commencing the interviews we accumulated a wide variety of printed information from a comprehensive range of organisations (the Australian Intravenous and Illicit Drug League, the Alcohol and Drug Program, the Canberra Rape Crisis Centre, Lifeline Gambling and Financial Counselling Service, the Opiate Project and Women's Information Resources and Education on Drugs). In the following chapters, we make note of any information we handed out at interview.

#### *Interview follow up*

The members of the Reference Group recommended that we have a system in place to follow up respondents the day after the interview to check that they were not suffering any untoward effects because of the interview. Before we obtained consent for interview we therefore informed respondents that either someone from the agency would contact them the following day to check that they "were OK", or if this was not possible, respondents were asked to use the free call number to phone a member of the research team. For the people recruited from the ACT Alcohol and Drug Program, a member of the research team contacted a senior staff member to check the welfare of people recruited from that agency. One of us contacted the Aboriginal Liaison Officer at Belconnen Remand Centre to check the welfare of the people we had interviewed there. Apart from one instance where we were asked to shred the interview data (detailed below), we did not receive any negative reports about the interview.

#### *Protection of data*

As required by the ANU, data will be retained for a minimum of five years. The hard copies of documents are kept in locked storage facilities at NCEPH. Audiotapes used at interview (discussed below) were erased as soon they had been transcribed. Until that time they were also kept in locked stored facilities at NCEPH. Access to the data is limited to four members of the research team (PD, JG, DM and CC).

### *Ethics approvals*

We submitted four separate ethics proposals to three Human Research Ethics Committees. The first, for interviewing people over the age of 16, was approved by the ANU's Human Research Ethics Committee on the 6th March 2002.

Based on evidence from the first 39 interviews demonstrating an early age of 13.8 years for initiation into illegal drug use, we subsequently obtained separate approval on 30 May 2003 from the ANU's Human Research Ethics Committee for interviewing people aged 13-15 years. As it turned out, we were not successful in recruiting from this age group.

We received approval on the 8th September 2003 from the ACT Health and Community Care's Human Research Ethics Committee. This allowed us to recruit from the ACT's Alcohol and Drug Program.

On the 17th September 2003 we received approval from South Western Sydney Area Health Service which allowed us to recruit Aboriginal and Torres Strait Islander people accessing Southern Area (of NSW) Health Services.

### **The questionnaires**

Our focus was on ascertaining the needs of the Aboriginal and Torres Strait Islander illegal drug users in the ACT and Region. A central feature of the study was that drug users themselves were given an opportunity to express their experiences and needs. We wanted to investigate needs in the areas of treatment, and other strategies to minimise drug-related harm. Below we provide a brief outline of the questionnaire developed by the Winnunga/NCEPH research team. (Only selected parts of this questionnaire are included in this report. The full questionnaire is available at the following Website address: [http://nceph.anu.edu.au/Research/Social\\_Det/Dance\\_project\\_qnaire.pdf](http://nceph.anu.edu.au/Research/Social_Det/Dance_project_qnaire.pdf) or by contacting NCEPH.) We also briefly discuss the other instruments we used (all of which are already in the public domain): the Severity of Dependence Scale (Dawe and Mattick, 2002:98), the Opiate Treatment Index (Darke et al, 1991a) and the General Health Questionnaire (which is incorporated into the Opiate Treatment Index).

### *The "Winnunga/NCEPH questionnaire"*

We developed a comprehensive range of both qualitative and quantitative questions aimed at ascertaining needs of the people we interviewed. Some questions were stimulated by earlier work one of us did in interviewing people in the ACT who use illegal drugs (Dance, 1998). Others were suggested by the Aboriginal and other non-Aboriginal members of the NCEPH and Winnunga research team. Some were suggested by Reference Group members and a few by respondents interviewed during the piloting of the questionnaire. The questionnaire went through several drafts before all parties concerned (the researchers, the members of the Reference Group and the ANU's Human Research Ethics Committee) were satisfied that it was suitable for piloting. The final questionnaire contains questions on sociodemographic variables; these include the importance of culture, drug use behaviours, needle behaviours, general health, sexual behaviours and criminal histories. In relevant domains we asked questions about needs related to culture, treatment, education, employment and health.

### *The Severity of Dependence Scale*

The Severity of Dependence Scale has been specifically designed as a research instrument and has been found to be applicable in Australian samples of heroin, cocaine and amphetamine users (Gossop et al, 1997). Although no specific reliability tests have been performed in samples of Aboriginal and Torres Strait Islander people, the Severity of Dependence Scale was successfully applied in a recent South Australian study of Aboriginal people who use illegal drugs (Holly and Shoobridge, 2002).

As recommended by Dawe and Mattick, we used cut off scores for dependence of 4 for amphetamine, 3 for cannabis and 6 for benzodiazepines (Dawe and Mattick, 2002). The Severity of Dependence Scale was not originally designed to measure alcohol dependence but its applicability for use with alcohol users has subsequently been reported following a study by Gossop and colleagues in the United Kingdom (Gossop et al, 2002). We followed the example of Gossop and colleagues' scoring system for heroin and alcohol using scores of 0 for non-dependence, 1-5 for low dependence 6 and above for high dependency (Gossop et al, 2002).

### *The Opiate Treatment Index*

The Opiate Treatment Index was developed in Sydney for both research and clinical applications and has been found to be reliable and valid (Darke et al, 1991a; Darke et al, 1991b). It has been used for people both in and out of treatment (Darke et al, 1991b; Baker et al, 1994). As Darke and colleagues indicate, a major problem in most drug-related research is the inability to compare results (Darke et al, 1991a; Darke et al, 1992). Since we did want to make comparisons we administered the Opiate Treatment Index in addition to the questionnaire we developed. Although no specific reliability tests have been undertaken, parts of the Opiate Treatment Index have previously been used with Aboriginal and Torres Strait Islander people. Brown and colleagues used some domains to follow up a small sample of 16 Indigenous people with drug and alcohol problems on their discharge from prison (Brown et al, 1999). It was also used by Freeman as part of an evaluation of the NSW drug court where 10 per cent of the 202 people who participated in the baseline interviews identified as Aboriginal or Torres Strait Islander (Freeman, 2001).

The Opiate Treatment Index has been structured so that the higher the score, the greater the degree of indicated “dysfunction.” During its development, results obtained in the HIV risk behaviour scores, as well as the social, criminal, physical, and psychological health domains, were divided by Darke and colleagues into quintiles. This, then, allows for a clinical interpretation of the degree of “dysfunction” for each of these domains. The degrees of “dysfunction” were classified by the researchers who developed the Opiate treatment index as High, Above Average, Average, Below Average and Low (Darke et al, 1991a:23-24). We also analysed the data according to these degrees of dysfunction (also defined in Appendix 13) but the results must be viewed with some caution since, as Darke and colleagues indicate, the degrees of dysfunction are based solely on the distribution of the scores of respondents interviewed during the development of the Opiate Treatment Index (Darke et al, 1991a).

Due to concerns voiced by members of the Reference Group, and by the ANU’s Human Research Ethics Committee (the first Human Research Ethics Committee to see the proposed questionnaires), we eliminated the specific questions about murder and rape from the Opiate Treatment Index (Darke et al, 1991a). This did not interfere with the scoring.

### *The General Health Questionnaire*

The General Health Questionnaire-60 was developed by Goldberg with the aim of detecting people with a current diagnosable non-psychotic psychiatric illness (Goldberg, 1972). Several scaled versions were subsequently designed including the General Health Questionnaire –28 (Goldberg and Hillier, 1979). This has been found to be a valid and reliable instrument for measuring psychopathology (Goldberg and Hillier, 1979; Goodchild and Duncan-Jones, 1985). Since it is primarily concerned with the detection of psychological illness, the items in the General Health Questionnaire appear to have cross-cultural relevance (Dawe and Mattick, 1997). According to Dawe and Mattick “in the absence of studies in which the GHG [General Health Questionnaire] has been used with Aboriginal and Torres Strait Islander people, it is possible to suggest that the items on the GHQ [General Health Questionnaire] reflect universal aspects of psychological illness and are equally relevant to particular cultural groups” (Dawe and Mattick, 1997:52). We, therefore, used the General Health Questionnaire-28 to measure psychological health.

Goldberg and Hillier broke items in the General Health Questionnaire-28 down into a somatic symptoms area, an anxiety area, a social dysfunctional area and a depression area. Each area has seven self-completed questions and respondents are informed that the questions relate to “medical complaints ... and how your health has been in general over the past few weeks” (included in the Opiate Treatment Index, Darke et al, 1991a). There are four possible responses to each of these questions. Either of the first two responses are scored as zero, and either of the second two responses are scored as one (Goldberg and Hillier, 1979).

After administering the General Health Questionnaire one of us examined the score and the two interviewers then used our combined skills (some of which were gained during the training in mental health first aid) to judge whether it was appropriate to continue or stop the interview and whether we needed to offer referral. We followed Goldberg and Hillier’s advice that scores of 0 to 4 should be regarded as low scores and those between 5 and 28 should be regarded as high (Goldberg and Hillier, 1979).

## **Piloting of the questionnaires**

The completion of the first round of training in June, 2002 allowed us to begin piloting the questionnaires with interviewers from both NCEPH and Winnunga. Piloting lasted until September when we had piloted the questionnaire with 22 people. Although there are a few missing values due to questions added during piloting, we have used the data from these 22 people in the report of the findings.

At the request of the Reference Group we asked these first 22 people additional questions about how they felt about the interview. In particular, we asked how they felt about the length of the interview and whether any questions had “made them feel bad in any way” and, if so, which they would have preferred not to have been asked. We moved on to ask if there were any sorts of questions “you thought we should have asked and didn’t?”, finishing with whether there was anything else respondents wished to say about the interview itself (Appendix 14).

A majority of 19 respondents (86%) felt that the length of the interview was “OK” but 3 (14%) believed it to be “too long.” Two people (9%) felt that we had asked inappropriate questions. One felt that we should not have asked questions related to sexual behaviours and one person said some of the questions had upset him adding that we should inform potential respondents of this. Several changes were made to the questionnaire based on the comment of this respondent. After appropriate lengthy consultations with professionals we did add his suggestion to the face to face screening (Appendix 10). We also added that we would stop the interview if we deemed it necessary and that we would at that time, or any other time, offer referral to professionals. We also said that whilst there would be an opportunity for people to talk about things they wanted to talk about, the interviewers were not trained in areas that might be important to the respondent.

We were pleased that this interview had taken place early on so that we were able to make the necessary adjustments to the questionnaire. Having one of the Winnunga researchers present at that interview, where there was subsequent mutual contact, and where we were able to learn that the respondent had recovered from the interview, made this early experience easier for everyone than it might otherwise have been.



During the piloting phase, three people made suggestions for questions. We added two, one to “Ask about cultural and spiritual workshops” and another to “Ask people what they think about methadone.” We did not add a third person’s suggestion that we ask a “bit more about women’s business.”

Six people responded, three very positively, to the question “Is there anything else you’d like to say about the interview itself?” with a comment such as “I [liked] contributing to this. It’s got to help [Aboriginal] people ... [I felt] comfortable.” Two people indicated that they thought the interview was “alright, no stress, no dramas” and “It wasn’t bad.” For the respondent discussed above it “brought up a bit of anxiety, brings back memories.” He did, however, add that he was “very satisfied with [the] interview.”

We presented the results of the specific piloting questions, as well as some provisional interview findings, to the satisfaction of the members of the Reference Group, showing them the necessary changes which had been made to the questionnaire based on feedback received from respondents during piloting.

## **Recruitment**

We were interested in interviewing people who use illegal drugs, regardless of the route of administration. Given our target population, probability sampling was not possible. Alternative sampling methods, therefore, had to be found. With the assistance of the Reference Group, who recommended the catchphrase “Caring, Sharing Family” and the inclusion of the photograph taken at a [then] recent National Aboriginal and Islander Day of Celebration Ball of Hilary Crawford, a Ngunnawal elder and Muriel Brandy, a Wiradjuri elder, we prepared recruitment flyers (Appendix 12). These contained details of the interview and a free call number. In order to maximise access, this number was always diverted to a mobile phone. (We stopped the free call number and diversion when we had completed recruitment.)

Between June 2002 and October 2003, we distributed 430 recruitment flyers through a range of relevant Aboriginal and mainstream organisations in the ACT and Region. At least 150 were distributed via Winnunga.

Table 2.1 reveals that the most successful method of recruitment was via an agency. Although the majority of these recruitments were from Winnunga (n=53), between them the other agencies recruited around a third of respondents (n=30).

We also used snowballing, a method of sampling through referrals made among people “who share or know of others who possess some characteristics of research interest” (Biernacki and Waldorf, 1981:141). Snowballing is particularly appropriate when the focus of study is sensitive (Biernacki and Waldorf, 1981), and when exploring populations about whom we know little (Kaplan et al, 1987). The method has previously been widely used for obtaining samples of people who use illegal drugs (for example, Zinberg, 1984; Power, 1989; Australian National AIDS and Injecting Drug Use Study, 1991).

We asked 80 of the people we interviewed if they knew other Aboriginal and Torres Strait Islander people who used illegal drugs and who might be willing to be interviewed (15 people were not asked: 7 because they were in remand, 5 because they did not complete the interview, and 3 because we were at the end of the interviewing process). Fifty seven of the people we asked (71%) said that they did.

We went on to ask these 57 people if they would be willing to pass on recruitment flyers. Forty one people said they would. Between them these 41 people took 223 flyers (range 1-20). Four of the other sixteen people said they did not want to pass on flyers and 12 people (all except one, from interview 29 onwards) said that everyone they knew was already aware of the study. This gives us reason to believe that we succeeded in informing the pool of potential respondents about the interviews.

In total, therefore, we distributed 653 flyers to organisations and individuals. We believe that some organisations made photocopies of the flyers so the number disseminated into the Community may have been larger than 653. We know that the majority of the 150 flyers left at Winnunga were distributed. We also know that 11 people who presented for interview had heard about the survey from previous respondents (Table 2.1).

**Table 2.1: Recruitment of respondents**

<b>Recruitment</b>	<b>n</b>	<b>%</b>
<i>Agency</i>		
Winnunga	53	56
Directions	9	10
Canberra Alliance for Harm Minimisation and Advocacy	5	5
Belconnen Remand Centre (Aboriginal Liaison Officer)	7	7
ACT Alcohol and Drug Program	4	4
Southern Area Health (Aboriginal Liaison Officer)	5	5
<i>Individuals</i>		
Other respondents	11	12
“Friend”	1	1
<b>Total</b>	<b>95</b>	<b>100</b>

Other Australian research with people who use illegal drugs has shown snowballing via previous respondents to be a very successful method of recruitment (for example, Marsh and Loxley, 1992; Dance, 1998). In previous research with people who use illegal drugs conducted by one of us in the ACT a majority of 68.3 per cent of 139 people (98% of whom were non-Aboriginal/Torres Strait Islander people) were recruited via snowballing (Dance, 1998). Just 12 per cent of referrals for the current research were via other respondents; more than half were via Winnunga (56%) and a further 12 per cent were via Aboriginal Liaison Officers. Potential respondents from Winnunga generally contacted NCEPH researchers for an interview after they had discussed the project with a Winnunga researcher. In other NCEPH research conducted in the ACT and Region with Aboriginal and Torres Strait Islander people, around 56 per cent of respondents were accessed via personal contact with the Aboriginal member of the research team (Dance et al, 2000b). Personal contact with an Aboriginal researcher would seem to be a crucial aspect of recruitment in the Aboriginal and Torres Strait Islander Community.

## **Data collection**

There was a long recruitment period of 17 months from June 2002 to November 2003. During this time we succeeded in obtaining usable data from 95 people. Data from six people were not usable. In one case the respondent contacted the interviewer the day after the interview to request that the interview schedules were shredded (which they immediately were). Examples of reasons for the data from the other 5 people being unusable included no data on current illegal drug use (defined as in the 12 months prior to interview), conflicting information, and the interviewers stopping the interview because the respondent was becoming distressed.

Twenty three people made interview bookings and then did not appear for interview. We are aware that at least four of these people made subsequent bookings and were eventually interviewed. Our experiences of “no shows” is comparable with previous experiences one of us had in recruiting 139 people from the ACT who use illegal drugs (most of whom were non-Aboriginal/Torres Strait Islander people) when there were 28 “no shows” (Dance, 1998).

Six people contacted the interviewer for a second interview. One of these people tried twice. The first time he said that he thought it was a different interview and the second time he said that his story had changed and that he would like to be interviewed again. Given the long period of 17 months for data collection it is perhaps surprising that more people did not, for similar reasons, try for a reinterview. Two attempts at reinterview were identified during phone screening. Phone screening was not possible for the other three people but, since one of us had been present at all interviews, recognising people who re-appeared for interview was possible. The other attempts at reinterview may have been because others also thought that a different interview was involved, or it is possible that people thought it worth retrying because of the incentive of the honorarium.

## **The interviews**

We now turn to matters related to the interviews themselves, where we provide information about the interview venue, support for the respondents at interview, the length of the interviews, simultaneous interviewing and audio taping of the interviews.

### *Interview venue*

Ninety people were interviewed in Canberra and the remaining five in Goulburn (Table 2.2). As shown in the following chapter, 16 of the people interviewed in Canberra said they “usually” lived in NSW. Several were Queanbeyan residents. This NSW city is adjacent to Canberra. It functions, in part, as a suburb of Canberra since residents treat the cities as an extension of one another for services such as housing and shopping and some medical services, including treatment for alcohol and other drugs.

A flat belonging to the Regional Centre was provided for interviews (the Regional Centre is situated very close to Winnunga and, as described previously, Winnunga is one of three Aboriginal Medical Services which form a consortium for the ACT-based Regional Centre). At first contact potential respondents were informed this was available but that they could, if they wished, chose another service provider venue. Not unexpectedly, given that Winnunga was the collaborating organisation for the research, a majority of 70 per cent of interviews took place there. The Goulburn interviews took place in facilities in premises belonging to Southern Area Health Service. Two people were interviewed whilst in-patients in the ACT Alcohol and Drug Program’s Withdrawal Unit and seven in Belconnen Remand Centre. The other three Canberra venues were non-residential facilities.

**Table 2.2: Interview venue**

<b>Venue</b>	<b>n</b>	<b>%</b>
Winnunga	66	70
Directions	9	10
Southern Area Health Services, Goulburn	5	5
Canberra Alliance for Harm Minimisation and Advocacy	4	4
ACT Alcohol and Drug Program Withdrawal Unit	2	2
ACT Alcohol and Drug Program out-patient unit	2	2
Belconnen Remand Centre	7	7
<b>Total</b>	<b>95</b>	<b>100</b>

### *Interview length*

Interview time averaged almost 2 hours (115 minutes) and ranged from 30 minutes (usually because people stopped the interview at around this time because of other engagements [n=4]) to three and three quarter hours. The data from those who did not complete their interviews were usable but resulted in some missing values. The longer interviews generally took place when more than one person presented for interview (discussed below) and it was impossible to distinguish individual interview times. In some cases, however, it seemed that people were enjoying talking about themselves and we did not hurry them along.

### *Support person at interview*

A trained Winnunga researcher was present for 39 per cent (n=37) of all interviews and for 56 per cent of the 66 interviews conducted at Winnunga (Table 2.3). The Winnunga researcher combined this role with that of a support person. As indicated above, during the first screening/provision of information, all potential respondents were advised that they could bring a support person with them to interview. In some cases (n=24, 25% of the total interviews and 36% of the interviews conducted at Winnunga) the Winnunga researcher was the sole support person present at interview. In addition to the support person from Winnunga, 13 people had another support person with them. Some people had only a partner, other relative or friend with them as a support person. As with the Winnunga researcher/support person, other people who were present as a support person were asked to leave the room when questions with potential legal ramifications were asked.

Almost a third of the people interviewed chose not to have a support person. It bears reiterating that there was always an Aboriginal researcher present at interview and potential respondents were informed of this during the first screening/provision of information.

**Table 2.3: Support person at interview**

Support person	n	%
Winnunga researcher	37	39
Partner	13	14
Other relative	17	18
Friend	10	11
Not wanted	31	32

N = more than 95 since some people had more than one support person with them at interview.

### *Simultaneous interviewing*

Sometimes more than one person presented for interview. Where possible we organised two teams of interviewers and conducted the interviews in adjacent rooms. In some instances respondents wished to be interviewed in the same room as the other person/people they presented with. A total of 12 people were interviewed in this way. We informed people who wished to be interviewed when another person was present that there would be parts of the interview where we would need to be one to one, for example when we asked questions about criminal or sexual behaviours or if we believed it necessary to offer referrals. Everyone accepted this.

### *Audio taping*

Notes were taken for some of the unstructured questions where we anticipated short responses. We asked for permission to audiotape responses to the longer unstructured questions during the consent procedure (Appendix 11). Because it would have made transcribing and distinguishing responses from more than one respondent difficult, it was not feasible to use an audiotape for the 12 people who chose to be interviewed simultaneously with another person. Nor could we audiotape a further three people who presented for an unbooked interview, along with someone who had booked (thus resulting in two interviews being conducted - by different teams of interviewers), when we had only one audiotape recorder with us. A further three people were not asked for permission to audiotape, two because they had children with them (which would have

made transcription very difficult) and one because we conducted the interview out of doors.

After these considerations, we asked 79 people for permission to audiotape, and 52 agreed. Having two interviewers facilitated the task of note taking in those 43 cases (overall) where the qualitative data could not be audiotape. There was, however, variability in the richness of the qualitative data between the data from interviews where we were able to audiotape and those where we were not. In addition, due to interviewer error, qualitative data from one person was completely missing and two were partially missing. Poor sound quality led to data on a further three interviews being partially missing.

### **Data analysis**

The quantitative data were analysed with SPSS Version 11.5, and the qualitative data with QSR NUD\*IST Version 4.

### **Presentation of the findings**

In some cases, specifying too much detail may have identified an individual. Where we were concerned that might have been possible we collapsed the findings in to a category of “Other” and do not specify any detail. We have also taken note of Brady’s caution that there can be some unintended outcomes of publications such as discredit to a Community (Brady, 1991e). The danger of doing this has been minimised by close Community involvement and advice from Aboriginal members of the Reference Group and research team.

People frequently offered multiple responses to open-ended questions and the report is written to do justice to the richness of these data. In order to be true to the voices of respondents, quotes are written as spoken. This includes the use of some swearwords. Some people we interviewed spoke in what Aboriginal members of the research team and Reference Group refer to as “Aboriginal Australian.” Their view was that it was more respectful to include the quotes as spoken by respondents rather than tamper with their voices.



Because we will disseminate the report to a wide variety of organisations, including Aboriginal and mainstream service providers, we will make the report as accessible as possible. Most of the quantitative findings are documented in the form of descriptive statistics such as percentages and means. We have rounded off percentages to the nearest decimal point. As a consequence some of the percentage totals in the tables do not reach an even 100 and are thus left blank.

We have also performed some t tests and Chi<sup>2</sup> tests respectively to investigate differences in needs related to treatment, culture, employment by continuous variables (for example, age and Severity of Dependence Scale Scores) and categorical variables (for example, gender and geographical location). The statistical findings are generally presented in tables. (In preparation for presentation in peer reviewed journals, multiple regression will be used to identify factors that predict the use of different types of needs related to treatment, culture, employment etc.)

Noting that some samples we make comparison with are composed solely of injecting drug users, whilst we studied both injecting drug users (n=54) and illicit drug users using other routes of administration (n=41), throughout the document we make some comparisons with other relevant studies.

### **Informing the Community, service providers and stakeholders**

We asked the 90 people who completed the interview if they would like to see a copy of the completed report, and 72 said they would. In order for them to be able to access the report we shall, as we informed them we would, distribute copies to Winnunga and all other agencies involved in the research. We have been provided with funding by the ACT Office, Australian Government, Department of Health And Ageing, to provide a more accessible general Community document.

### **Dissemination of results**

We have already presented aspects of the research at conferences and a seminar (listed in Appendix 15). At the time of writing (June, 2004) we are working towards peer reviewed and other publications.

We conducted this research with the aim of working with relevant bodies to implement the findings. Throughout the duration of the project we have endeavored to inform the local Aboriginal and Torres Strait Islander Community, service providers and stakeholders of the research. This has been achieved in a variety of ways (listed in Appendix 16). We will continue to keep the Community, service providers and stakeholders informed by disseminating this final report to all those listed in Appendix 16, as well as other relevant individuals and organisations.

## **Summary**

In this chapter we have presented the process and methods for this complex research project. In the following seven chapters we present the findings from the qualitative and quantitative data on sociodemographics, drug use histories, treatment histories and treatment needs and findings related to physical health and social and emotional well-being and needs related to these domains.

## CHAPTER 3: SOCIODEMOGRAPHIC CHARACTERISTICS

### Introduction

In this chapter, we provide an overview of some sociodemographic characteristics beginning with a brief description of culture and place of residence. This is followed by findings related to gender and age.

In keeping with the Aboriginal holistic concept of health, and the importance to this of social and emotional well being, we have included other sociodemographic findings, such as needs related to culture and those on education, employment, housing and relationships, in the chapter on the social determinants of health (Chapter 9).

### Community

Questions related to community were some of the most difficult to develop. They progressed through many stages before the Aboriginal members of the research team and the Reference Group were satisfied that they were suitable. We have included all these questions as Appendix 17. Below we report briefly on cultural background. Findings on cultural needs can be found in Chapter 9.

We interviewed both Ngunnawal people, who have a traditional heritage connection to the ACT and region, as well as other Aboriginal and Torres Strait Islander people who have moved to the region from other parts of Australia. Ngunnawal land is not restricted to the ACT but extends to areas in New South Wales. There is a high degree of mobility between the ACT and surrounding areas (McConnell, 1998). The people we interviewed came from a number of locations encompassed by Ngunnawal land.

There seems to be no information on the relative proportions of Ngunnawal people and Aboriginal and Torres Strait Islander people from other communities. Thirty seven respondents (39%) identified as Wiradjuri, a NSW language group, and seven (7%) identified as Ngunnawal. Five people (5%) did not know their origins (Table 3.1). The rest come from other Communities. The results on Community reflect the heterogeneity of the Aboriginal and Torres Strait Islander population in the ACT and we experienced a dilemma about naming other tribal groups. Whilst we considered it important to name

all tribal groups or areas which respondents identified with, those not listed were named by either just one person or a small number of people. The categories have been collapsed to avoid the possibility of identifying individuals or families.

**Table 3.1: Community**

<b>Community</b>	<b>n</b>	<b>%</b>
Wiradjuri	37	39
Wiradjuri/Other	5	5
Ngunnawal	7	7
Other	41	43
Don't know	5	5
<b>Total</b>	<b>95</b>	<b>-</b>

### **Usual place of residence**

As seen in Table 3.2, a majority of 73 per cent of respondents (n=69) said their usual place of residence was the ACT. About one fifth (n=21) said they usually resided in NSW. A small proportion of 6 per cent (n=6) said they usually resided in other states.

**Table 3.2: Usual place of residence**

<b>Place</b>	<b>n</b>	<b>%</b>
ACT	69	73
NSW	20	21
Other States	6	6
<b>Total</b>	<b>94<sup>a</sup></b>	<b>100</b>

<sup>a</sup>One missing value

We also asked respondents how long they had been living in the city where the interview was taking place (which apart from one person; excluded from the analysis reported below, was where they were residing at the time of interview). This averaged out at approximately 10 years (range 1 month to 39 years). Most people had lived in that city, which was generally Canberra, for 12 months or more (n=73, 81%) (5 missing values). This result indicates a high degree of stability as far as living in a particular city goes and it is probably related to kinship ties within the area.

## **Gender**

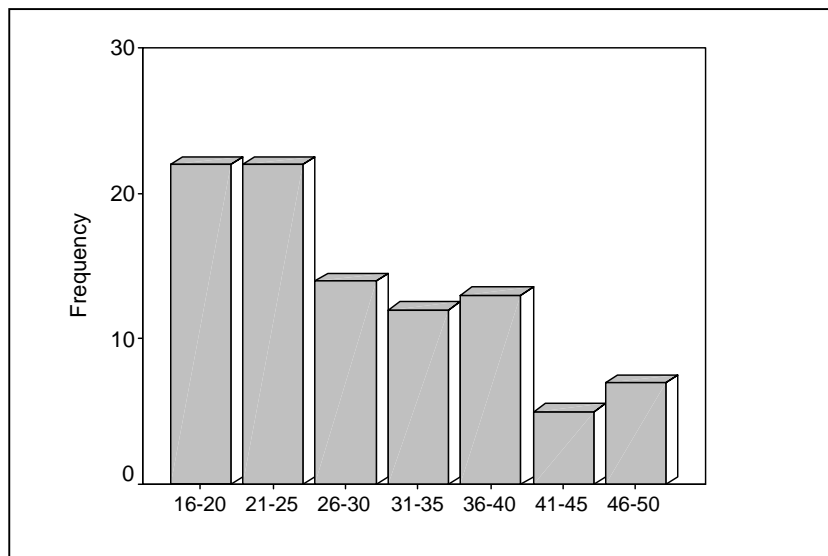
We interviewed a greater proportion of men (65.3%, n=62) than women (34.7%, n=33). This is typical for general surveys of people who use illegal drugs which generally reveal greater proportions of men than women (for example, Stevens and Wardlaw, 1994; Crofts and Aitken, 1997; Dance, 1998). This finding also holds true in the few recent studies which have focused on illegal drug use by Aboriginal and Torres Strait Islander peoples. The gender differential in the people we interviewed is not too dissimilar from the one found in the South Australian study of 307 Aboriginal injecting drug in which 60 per cent of this sample was male (Holly and Shoobridge, 2002); to a West Australian study of 74 injecting drug users where 57 per cent of the sample was male (Gray et al, 2001); and to a Queensland study of 77 injecting drug users where 69 per cent of the sample was male (Larson et al, 1999).

By contrast, three studies in Sydney found almost equal proportions of male and female Aboriginal injecting drug users (Day et al, 2003). These studies did not, however, focus solely on Aboriginal And Torres Strait Islander injecting drug users. This may explain some of the discrepancy since those that have find similar gender proportions to those found in general overall samples of people who use illegal drugs. There may also be differences related to geographical location of Aboriginal and Torres Strait Islander peoples, as well as to types of drugs and routes of drug administration.

## **Age**

The people we interviewed had a mean age of 29 (SD 9.3, median 27, mode 19, range 16-50). The wide standard deviation is reflected in Figure 3.1 which also demonstrates that the largest numbers of respondents were in the younger age groups of 16-20 and 21-25 (n=22 in each).

**Figure 3.1: Age group**



The average age of the people we interviewed is a little younger than the one of 32 years (range 14-54 years) reported from the South Australian study of Aboriginal injecting drug users (Holly and Shoobridge, 2002). Gray and colleagues found a younger mean age of 26 (range 16-48) in the West Australian sample of Aboriginal injecting drug users (Gray et al, 2001). Half of the 77 Queensland injecting drug users interviewed by Larson and colleagues were 21 or under (Larson et al, 1999). A smaller proportion, 28 per cent, of the people we interviewed fell in to this age category.

We interviewed both injecting drug users and non-injecting drug users. In order to make better comparisons with these other samples we looked at just the age of the 54 people who were current (defined as having injected in the 12 months prior to interview) injecting drug users. There was a mean age of 27 for the current injecting drug users, a similar mean age to the one of 26 found by Gray and colleagues, and a little younger than the total sample of people we interviewed (29). Thirty one per cent of the injecting drug users we interviewed were aged 21 or less. This is similar to the finding for the total sample of people we interviewed (28% were aged 21 or under).

We hypothesised that since injecting drug use in Aboriginal and Torres Strait Islander peoples appears to be a relatively recent phenomenon, the injecting drug users we interviewed would be younger than those using other routes of administration. Our findings supported this hypothesis: compared to a mean age of 26.7 years (SD 7.5) for

the 54 people who were currently injecting, there was a mean age of 32 years (SD 10.6) for the 41 non-injecting drug users. This difference was significant (t test,  $p=01$ ).

There was no significant difference in the mean age between men (29.0 years) and women (28.5 years). The Brisbane study by Larson and colleagues also found the ages of men and women to be very similar (Larson et al, 1999).

As reported in the previous chapter, based on our preliminary finding of an early mean age of initiation into illegal drug use of 13.8 years (after 39 interviews), we approached the ANU's Human Research Ethics Committee and succeeded in obtaining permission to interview people aged 13-15 years. We were not, however, successful in accessing anyone in this younger age group.

## **Conclusion**

This chapter has very briefly covered some sociodemographic characteristics as a prelude to the following chapter on drug use behaviours.

## CHAPTER 4: DRUG USE HISTORIES

### Introduction

In Chapter 1 we provided some background information about the traditional and post colonisation history of drug use by Aboriginal and Torres Strait Islander people. We followed this with an outline of what is known about current use and prevalence. In this chapter we concentrate on the drug use histories of the people we interviewed. This sets in context the following chapter on drug treatment needs. Findings related to injecting drug use are included in this chapter. Those related specifically to injecting practices can be found in Chapter 7. We also discuss in detail findings related to other routes of administration.

We conducted the interviews during 2002 to 2003. As in other parts of Australia, the end of 2000 saw the beginning of a heroin drought in the ACT (Smithson et al, 2003). According to some published reports, amphetamine and cocaine use increased in some parts of Australia during this drought (Wodak, 2002; Darke, 2004). As noted by Darke (Darke, 2004), as we have found in previous research (Dance, 1998), and as we report below, available evidence suggests that there is very little cocaine use in Canberra.

We approached Nicole Wiggins, the General Manager of Canberra Alliance for Harm Minimisation and Advocacy (a peer-based organisation for people who use illegal drugs which provides services such as needle and syringe exchange, education and referrals) for some local information about the local impact of the drought. Nicole provided us with these written comments:



*The drought began about Christmas 2000 and reached a peak about the end of February early March 2001. Up till about June 2001, it was still difficult to obtain heroin with there being not many dealers and long waiting times, up to a few hours, to obtain heroin. From July 2001 the availability steadily increased, as did the quality, and the price remained high for most of 2001. By early 2002, availability was high with numerous dealers and waiting times being fairly short. From this time to the present time [May, 2004] there has been a steady increase in availability and quality and a drop in price. There has not been a return to pre-drought price although it is getting fairly close. The same goes for quality with it still being below pre-drought but getting fairly close.*

*[During the drought] there was also a massive increase in use of other substances such as ice [methamphetamine] benzodiazepines and alcohol.*

(Wiggins, N. General Manager, Canberra Alliance for Harm Minimisation and Advocacy 2004, May 17<sup>th</sup> pers comm)

By the time we commenced data collection in the middle of June 2002, the Canberra heroin drought had, therefore, been over for some time. The impact of the heroin drought on the drug market may have affected histories of drugs ever used by the people we interviewed (such as age of initiation into use of particular drug). It may have led to fluctuations in use of some drugs (in particular heroin and amphetamine) over time. The drought, may, to a lesser extent, have had an effect on current (defined as in the 12 months prior to interview) drug consumption histories.

Where possible, when reporting our findings, we make some comparisons with other research involving Aboriginal and Torres Strait Islander people who use illegal drugs. We do, however, point out that making these comparisons is somewhat problematic since:

- drug use patterns are likely to vary across Communities;
- the dynamics of the illegal drug market over time and across geographical areas are very variable;
- different sampling methods have been used;
- the studies have been undertaken across different time frames;
- the composition of samples (ours consisted of both injecting and non-injecting illegal drug users whilst others we refer to consisted solely of injecting drug users);
- variabilities in types of questions asked and the way they were asked. As we explain below, our focus was on problem drugs. Other researchers who have interviewed Aboriginal and Torres Strait Islander people who use illegal drugs

have, for example, asked respondents about their drug of choice (Day et al, 2003); which drugs they were injecting (Lane, 1992-93); which drugs they preferred (Gray et al, 2001); their most frequently used drugs (Larson et al, 1999); or which drugs had been used most often in the previous six months (Holly and Shoobridge, 2002).

We also report some findings from, and make some comparisons with National Drug Strategy household surveys. National Drug Strategy household surveys are one of the most useful ways in which information about patterns of drug use are gathered. Before making our comparisons, we do, however, indicate several potential biases in household surveys. In a publication on the National Drug Strategy Household Surveys, the Australian Institute of Health and Welfare note their limitations:

*Excluded from sampling were non-private dwellings (hotels, motels, boarding houses etc) and institutional settings (hospitals, nursing homes, other clinical settings, such as drug and alcohol rehabilitation centres, prisons, military establishment and university halls of residence). Accordingly, homeless person were also excluded. The Territories of Jervis Bay, Christmas Island and Cocos Island were excluded as well.*

*Illicit drug users, by definition, are committing illegal acts. They are, in part, marginalised and difficult to reach. Accordingly, estimates of illicit drug use and related behaviours are likely to be underestimates of actual prevalence.*

(Australian Institute of Health and Welfare, 2002a:47)

Other commentators have noted some additional potential biases:

- people may be unwilling to participate in a survey for fear of the consequences of admitting to an illegal activity;
- if people do agree to participate, they may not be inclined to give truthful answers;
- even if the investigators can get honest answers, it is likely users will underestimate both the frequency of their use and the quantities they consume;
- since the use of illegal drugs is quite rare, even large surveys identify only a small number of users.

(Donnelly and Hall, 1994; Larson and Bammer, 556)

These biases may lead to underestimations of drug use, particularly illegal drug use by Aboriginal and Torres Strait Islander people. As a consequence, the comparisons we make need to be viewed with some caution.

We begin this chapter with an explanation of some of the complexities of the data collection related to illegal drug use before presenting an overview of polydrug use including polydrug scores from the drug use domain of the Opiate Treatment Index. We go on then to provide detailed histories of the use of particular drug classes.

### **Data collection related to drug use**

Almost two decades ago, Wilkinson and colleagues demonstrated that there are variations in drug concentration among pharmacological classes (Wilkinson et al, 1987). We designed the drug use section of our interview guide so that data were collected on specific drugs within a pharmacological class. We collected data on nine designated classes: tobacco, alcohol, cannabis<sup>8</sup>, inhalants, amphetamine-type substances, hallucinogens, opioids<sup>9</sup>, benzodiazepines<sup>10</sup> and barbiturates. We nominated a class of drug then asked respondents which drugs within this class they had used. We did not read out the list of drugs because we did not want to alert respondents, particularly younger ones, about drugs which they had never heard of. It was also important that we minimised the chance that people might report use of drugs that they had not actually used. Consequently, particularly where we were asking about drugs ever used, rather than drugs being currently used, there may have been under-reporting. We report below under the sections on particular classes of drugs the number of drugs ever and currently (defined as during the 12 months prior to interview) used within that class.

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<sup>8</sup> We considered cannabis as a separate class but it may also have hallucinogenic properties.

<sup>9</sup> The terms “opiate/s” and “opioid/s” are often used interchangeably, but unless referring to the work of others, we use the terms “opioid/s” rather than “opiate/s” since strictly speaking opiates are just the natural compounds (such as opium), and not semi-synthetic compounds (such as heroin), or synthetic compounds (such as methadone). The term “opioid/s” encompasses natural, synthetic, and semi-synthetic types compounds.

<sup>10</sup> Though benzodiazepines are not generally recognised as a class of drugs, they are termed as such for the purposes of this work. Benzodiazepines were originally listed on the questionnaire as “tranquillisers” but, apart from one mention from an older respondent of former use of Mandrax, all drugs named as tranquillisers were benzodiazepines. We then included Mandrax in the “other” drugs category. Mandrax was formerly prescribed as a Central Nervous System depressant. It contained methaqualone (quaalude) and diphetamine (Blum, 1984). Because it also had euphoric qualities it became popular among illegal drug users (Tyler, 1986) which led to it being removed from the market.

We collected data on drugs which were taken for their mood-altering effects (such as tobacco, alcohol, some opioids, cannabis, amphetamines, hallucinogens and inhalants). In addition, we collected data on drugs that people may be prescribed, or may use illegally, to assist with problems associated with illegal drug or alcohol use (for example, methadone or benzodiazepines).

In addition to the drugs which fell into the nine designated classes, we also asked respondents about any other drugs that had been used for their psychotropic effects. A few people then named “cocktails” of drugs, or miscellaneous drugs. Below, we also briefly report on the use of these “Other” drugs.

Previous research has demonstrated that the frequency of drug injecting varies widely, even for the same individual (Wodak and Des Jarlais, 1993). Earlier research by one of us found this to be true for many of the drugs used by the people she interviewed, regardless of their mode of consumption (Dance, 1998). The coding for levels of use was, therefore, planned to allow a range of drug use consumption levels.

Recent non-medical use of prescription drugs (such as analgesics and tranquillisers) was reported by around 3.0 per cent of those surveyed for the 2001 National Drug Strategy (Australian Institute of Health and Welfare, 2002a). In addition, for some time now a link has been established between illegal drug use and benzodiazepine use (Darke, 1994). According to the Steering Committee for the Review of Government Service Provision, when the Aboriginal Drug and Alcohol Council consulted with rural Indigenous Communities they found concerns about the misuse of prescription drugs (Steering Committee for the Review of Government Service Provision, 2003).

We report here relevant findings from our urban sample of Aboriginal and Torres Strait Islander people on the following prescription drugs:

- opioids, such as methadone and buprenorphine, which are prescribed as pharmacotherapies for opioid, usually heroin, dependence;
- opioids used as analgesics, such as Panadeine Forte (we collected data on these opioids only if they had been obtained illegally, or used in ways other than prescribed and not, for example, if they had been prescribed to relieve back pain, and had been taken only as prescribed);
- benzodiazepines;

- Ritalin - a central nervous system stimulant. “It has effects similar to, but more potent than, caffeine and less potent than amphetamines ... it is commonly used for treatment of attention deficit hyperactive disorder ... Because of its stimulant properties there have been reports of non-prescribed use of Ritalin” (National Institute of Drug Abuse [NIDA], 2003); and
- “Other” drugs which had been taken for their psychotropic effects.

We asked those who had used these drugs if they had been prescribed or if they had been obtained illegally. If they had been prescribed to the respondent we then asked whether they had been taken in doses as prescribed.

Based on previous research by one of us which revealed misuse of Mersyndol by a few of the illegal drug users interviewed (Dance, 1998), we also collected data on the use of this drug. Mersyndol is available from pharmacies without a prescription and contains an opioid (codeine), as well as paracetamol. As we explain below, we found a few people who used this opioid in much larger doses than recommended by pharmacists distributing the drug. These findings on the use of prescription and over the counter drugs are mentioned in their relevant sections below.

After obtaining a drug use history we then asked respondents about “Any drugs you think you have a problem with, or a family member, your partner, a doctor or nurse or someone else has ever said you had a problem with.” We followed this question by asking: “Which drug you think you have the biggest problems with? Perhaps we can start with the one you use the most?” We did not record this information about tobacco use, but we did for all other drugs including alcohol, illegal drugs and prescribed and over the counter drugs. Seventy five people mentioned at least one problem drug, 36 people named two problem drugs and nine people mentioned three problem drugs.

We administered the Severity of Dependence Scale (described in Dawe and Mattick, 2002:98) for the drugs respondents named as problem drugs. Regardless of whether they were mentioned as problem drugs, we administered this Scale for everyone currently using heroin, for most current alcohol drinkers and for drugs which, even if not mentioned by respondents as problem drugs, we considered the use to be potentially problematic. The findings related to individual “problem drugs”, followed by the results of the Severity of Dependence Scale, are reported in their relevant sections

below. In the conclusion of this chapter we summarise the findings from the Severity of Dependence Scale.

### **Overview of polydrug use**

Before presenting the findings on particular classes of drugs we first present those related to initiation into illegal drug use. We follow this with a description of the total numbers of *classes* ever and currently used followed by numbers of *drugs* ever and currently used.

#### *Initiation into illegal drug use*

We examined data on the age of first use of all classes of illegal drugs (reported in detail below) to estimate the age of first illegal drug use. This resulted in a finding of a mean age of 13.8 years for initiation into illegal drug use (SD 3.1, range 6-23). We did not differentiate between first ever use and first regular use of a particular drug. According to the Commonwealth Department of Health and Aged Care, there is increasing evidence of Aboriginal and Torres Strait Islander “people taking up drug use at a younger age” (Commonwealth Department of Health and Aged Care, 1999:5).

In the 2002 National Drug Strategy household survey the mean age for first use of any illegal drug was 18.6 years (Australian Institute of Health and Welfare, 2003b:17): around five years older than for the people we interviewed. In earlier ACT research conducted in the ACT by one of us, where almost all those interviewed were non-Indigenous, a median age of 14 years for first use of illegal drugs was found (Dance, 1998). This is very similar to the mean of 13.8 years we found for this research. In the earlier ACT research women first used illegal drugs at a median age of 14 years and men at 15 years (Dance, 1998). This previous finding led us to examine whether there was a gender difference for the 95 Aboriginal and Torres Strait Islander people whose results we are reporting here. In contrast to the non-Indigenous sample, we found that the 33 women we interviewed for the present research had started using illegal drugs at a mean age of 14.6 years and the 62 men at the age of 13.5 years. (This gender difference was not significant.)

We report now on the first illegal drug used by the total sample. As seen in Table 4.1 this was most frequently cannabis (n=82, 88%).

**Table 4.1: First illegal drug class**

<b>Class</b>	<b>n</b>	<b>%</b>
Cannabis	82	88
Stimulants	3	3
Hallucinogens	2	2
Inhalants	6	7
<b>Total</b>	93 <sup>a</sup>	100

<sup>a</sup>Two missing values

### *Classes of drugs used*

For some time, there has been a wealth of evidence from overseas, within Australia in general and the ACT in particular (examples from the ACT include Latukefu; Sevens and Wardlaw; Dance, 1998), to demonstrate that polydrug use is common among people who use illegal drugs. For example, a mean of eight classes of drugs ever used was found in illegal drug users interviewed by one of us in the 1990s (Dance, 1998). Research conducted with Aboriginal injecting drug users has also revealed high levels of polydrug use (Gray et al, 1997; Shoobridge, 1997; Larson et al, 1999; Gray et al, 2001). Pooled data from national surveys of needle and syringe program clients revealed polydrug use to be significantly more common in Aboriginal and Torres Strait injectors than in non-Indigenous injectors (Correll et al, 2000).

Amongst the people we interviewed for this research, out of the possible total of ten drug classes (including “Other” drugs) a mean of six had ever been used (SD 1.5, range 3-10). In the 12 months prior to interview a smaller mean number of four classes was used (SD 1.4, range 1-7). This quote from a man who was still smoking tobacco, had controlled his heavy alcohol use and was trying to control his amphetamine use, offers some insight into polydrug use:

*Yeah. I had speed and then I went to heroin and then I went back to speed and I have always been on it ... Then, like have an occasional cone and just havin' heaps of shots [of amphetamine].*

### *Number of drugs used*

When we looked at the total number of drugs ever used (that is, all drugs ever used within all classes), we found a mean number of ten (SD 4.4, range 2-24). During the 12 months prior to interview a mean of five drugs had been used (SD 2.4, range 1-11). The research by Larson and colleagues found that a “relatively small range of drugs” was injected by the people they interviewed (Larson et al, 1999). We can not make a direct comparison with this finding since we did not look separately at the numbers of drugs injected and those used via other routes.

### *Opiate Treatment Index polydrug use score*

Opiate Treatment Index polydrug use scores are compiled by collecting data on heroin, other opiates, alcohol, cannabis, amphetamines, cocaine, tranquillisers, barbiturates, hallucinogens, inhalants and tobacco used in the four weeks prior to interview, then counting the number of all of these classes used in that period (Darke et al, 1991a). The Opiate Treatment Index contains similar classes to those we used with these minor exceptions. We have outlined these in Appendix 18.

The mean Opiate Treatment Index score for the 95 respondents we interviewed was 3.4 (SD 1.4, range 0-7) compared to a slightly higher mean score of 4.1 reported by Darke and colleagues among the 290 injecting drug users interviewed when they compiled the Opiate Treatment Index. When looking at the scores of just the injecting drug users among the people we interviewed, we found a mean score of 3.7. This is more comparable to the one reported by Darke and colleagues.

### **Overview of injecting drug use**

Sixty one people (64%) had ever injected drugs. Seven of these people had stopped injecting (that is, they had not injected for at least 12 months). This leaves 54 people who had injected in the twelve months prior to interview (57%) and 41 (43%) who were using other routes of administration for their illegal drug use. As will be shown below,



for the majority, this route was inhalation; in most cases the drug inhaled was marijuana - more usually referred to in the Aboriginal Community as “yarndi.”

Due to a combination of factors, mainly a flaw in questionnaire design and addition of the questions during piloting, there are eleven missing values for age of initiation into injecting drug use and first drug injected. Because of the problems with the data collection for these variables, we did not perform any comparative tests on these findings.

The findings for the 50 people for whom we did have these data showed a mean age of 20 years for first illegal injection (SD 6.2, range 9-38). Some studies have pointed to an earlier age of initiation into injecting for Aboriginal injecting drug users than found in our study. Larson and colleagues, whose sample consisted solely of injecting drug users (n=77), and who also interviewed a larger proportion of people aged under 21 years than we did, found a mean age of 17.8 years for first injection. Thirty nine per cent had started to inject before the age of 16 (Larson et al, 1999). According to Larson and colleagues there is some evidence that the age of first injecting drug use is getting younger (Larson et al, 1999). A 2001 survey of over 300 Aboriginal injecting drug users in South Australia found a similar average age (to that found in the Brisbane study) of 18 years for first injecting drug use (Holly and Shoobridge, 2002).

Heroin was the first drug injected by a majority of 63 per cent (n=31) of the 49 people for whom we had data on first drug injected (1 extra missing value) and another opioid (morphine) by one person. The remaining 35 per cent (n=17) had first injected amphetamine. In the unlikely event that all 12 people for whom there were missing values had first injected amphetamine, there would still be a greater proportion of people who had first injected heroin. This would be in contrast to the study of Aboriginal injecting drug users conducted by Larson and colleagues where 64 of the 77 participants reported that the first drug they injected was amphetamine (Larson et al, 1999).

### **Drug use histories**

The bulk of the rest of this chapter examines the histories of the use of individual classes of drugs in order of frequency of current use (defined as used in the 12 months prior to interview).

## *Tobacco*

In the 2001 National Health Survey approximately 500 Aboriginal and Torres Strait Islander people were enumerated in the main sample, and a further 3 200 Aboriginal and Torres Strait Islander adults and children from across remote and non-remote areas of Australia were included in an Aboriginal and Torres Strait Islander supplementary. After adjusting for age differences, Aboriginal and Torres Strait Islander adults aged 18 years and over were more than twice as likely than other Australian adults to be current smokers (51% and 24% respectively) (Australian Bureau of Statistics, 2002b).

### *Ever use of tobacco*

All but two people we interviewed had ever smoked tobacco. There was a young median age of 13 years for first use (SD, 4.4, range 2 [*sic*, n=1] to 38 [*sic*, n=1]).

### *Current use of tobacco*

At the time of interview, only four people we interviewed had stopped smoking. Thus 94 per cent were current smokers compared with 51 per cent found in the National Health Survey. We asked the 89 current smokers to estimate the lowest and highest number of cigarettes they smoked a day during the previous 12 months. The mean lowest number was 13 (SD 11, range 0-50) and the highest was 17 (SD 12, range 1-50).

## *Cannabis*

Cannabis contains the psychoactive chemical delta-9-tetrahydrocannabinol (THC). Its concentration varies in the three most commonly used forms: marijuana, hashish and hashish oil (Hall, 1995). Users may experience several psychoactive effects. These can be pleasant, such as euphoria, relaxation and self confidence, or unpleasant, such as paranoia, panic and fear (Australian Crime Commission, 2003).

The 2002 National Drug Strategy household survey found “marijuana/cannabis” to be the most commonly used illegal drug. Thirty three per cent of the sample said they had ever used it and 13 per cent said they had used it in the past 12 months (Australian Institute of Health and Welfare, 2003b:17). It was also the most commonly used drug

in the survey of 74 Aboriginal people in Western Australia where 88 per cent reported its use in the previous 12 months (Gray et al, 2001).

### *Ever use of cannabis*

In keeping with these findings, cannabis was the most common class of drug ever used by the people we interviewed since all but one person had ever used it. There was a mean age of 14 years for first use (SD 3.1, range 6-25). This is much younger than the mean age of 18.5 years reported for age of initiation into “marijuana/cannabis” in the 2002 National Drug Strategy household general population survey (Australian Institute of Health and Welfare, 2003b:16).

All 94 people we interviewed had smoked cannabis the first time they had used it (as opposed to the other possibility of taking it orally, generally cooked into a biscuit). Most people had used two types of cannabis (out of the possible 3). This was most commonly marijuana.

Just eight people (9% of those who had ever smoked it) had stopped smoking marijuana, mostly without the help of treatment. This man explains why he had stopped “about seven years ago now”:

*I had a cone, and this had been about the first I'd had in about five months ... and just freaked out. This is probably about the middle of winter. And I jumped up with just me boxers on and just walked straight out the door and went down the main street of [place] with me eyes closed. In the middle of winter. It was freezing. Didn't care about the cold. [I was] tripping out on it. And just walked down to the intersection and headed back home. I thought 'Nah, this is not right. It's not me', you know what I mean? [And I thought] 'I don't do that shit' ... And just give it up from that day on.*

### *Current use of cannabis*

The 86 people who were currently using marijuana were all smoking it. A few people had occasionally used other forms of cannabis (such as hashish or hashish oil) during the 12 months prior to interview. Overall, a mean number of 1.2 types were used (SD 0.6, range 1-3).

Table 4.2 shows that 38 per cent of the people (n=32) who had used cannabis in the 12 months prior to interview had used it every day. An aggregation of these findings reveals that 79 per cent of cannabis users could be described as heavy users since either they had smoked it every day, or they had periods of smoking it every day, or most days.

**Table 4.2: Current frequency of cannabis use**

<b>Frequency</b>	<b>n</b>	<b>%</b>
Always every day	32	38
<i>Around 3-6 times a week</i>	18	21
Sometimes every day, sometimes less than that, or none a week	16	19
Sometimes 1 to 4 times a week, sometimes none a week	5	5
More than occasionally but less than weekly	5	6
Occasionally/once only	8	9
None for 4 months, prior to that, daily	1	1
<b>Total</b>	<b>85<sup>a</sup></b>	<b>-</b>

<sup>a</sup> One missing value.

Many people talked about mixing their cannabis with tobacco. As the National Aboriginal Community Controlled Health Organisation points out, most people tend to do this “thus increasing the amount of chemicals being inhaled” (NACCHO [National Aboriginal Community Controlled Health Organisation], 2003:596).

Forty three per cent of the 86 cannabis users (n=37) mentioned cannabis as a problem drug. Twenty of the 75 people (27%) who mentioned at least one problem drug mentioned marijuana as their number one problem drug. Of the 36 people (44%) who mentioned at least two problem drugs, 16 mentioned marijuana as their second most problematic drug. One person out of the nine people who named a third problem drug named marijuana.

A woman told us about some of the problems she had with marijuana use:

*Yeah, I got in a spot where I was buyin' a hundred dollars worth of dope a day. I was borrowin' money, you know. 'Cos' I was really addicted. Full on. Because I had to smoke a hydro', hydroponic dope. And once you have that in your system that's it you're cravin.' I was pawnin' things ... and I thought, 'Fuck me dead I've got to go to the pawn shop today instead of doin' this [her domestic duties].' And I did.*

### *Severity of Dependence Scale score for cannabis*

We administered the Severity of Dependence Scale to everyone who named cannabis as a problem drug. We also administered it to those who, even if they had not mentioned it as a problem drug, were currently using it more than once a week. This resulted in 70 of the current 86 cannabis users responding to these questions (3 missing values). Using the criterion of a cut off score of three for cannabis dependence recommended by Dawe and Mattick (Dawe and Mattick, 2002), 65 per cent (n=54) of the total sample of marijuana users could be considered dependent with scores between 3 and 14 (out of a possible score of 15).

### *Alcohol*

Although some Aboriginal and Torres Strait Islander Communities have a far lower level of alcohol-related problems than others, in general, alcohol has had a negative impact on Aboriginal and Torres Strait Islander health and well being. Citing several sources in a chapter ("The Well Person's Health Check") in *Aboriginal Primary Health Care* (Couzos and Murray, 2003) the National Aboriginal Community Controlled Health Organisation and the chronic disease alliance of Non Government Organisations document alcohol-related problems such as "death, family disruption, child abuse, unemployment, depression, suicide, violence, homicide, road deaths ... incarceration ... sexually transmitted infections ... injuries ... mental health problems ... cancers ..[and] foetal alcohol syndrome" (NACCHO [National Aboriginal Community Controlled Health Organisation], 2003a:114). In a later chapter ("Substance Misuse") in *Aboriginal Primary Health Care* the National Aboriginal Community Controlled Health Organisation adds to this litany of problems associated with alcohol use by pointing out that "liver damage in those infected with hepatitis C is likely to be accelerated" by its

use (NACCHO [National Aboriginal Community Controlled Health Organisation], 2003b:597).

The NHMRC points out that contemporary problems associated with alcohol use amongst Aboriginal people “stem from both volume and patterns of drinking [which] is, in large measure, an expression of, and further contributor to severe socio-economic disadvantage and this, in turn, has its deeper roots in the ongoing experience of dispossession, spiritual and cultural dislocation” (NHMRC, 2001:51).

Other research has revealed that smaller proportions of Aboriginal and Torres Strait Islander than non-Indigenous people consume alcohol. For example, 62 per cent of Indigenous people interviewed for the National Drug Strategy (Urban Aboriginal and Torres Strait Islander Supplement) said they had consumed alcohol during the previous 12 months (Commonwealth Department of Human Services and Health, nd). A 1990s study of alcohol consumption patterns amongst Aboriginal people in Western Australia found 58 per cent had consumed alcohol during the previous 12 months (Blignault and Ryder, 1997). Higher proportions are found in general population surveys. In the 2001 National Drug Strategy national household survey, 82 per cent reported consumption of alcohol during the previous 12 months (Australian Institute of Health and Welfare, 2002a).

Whilst the proportions are lower amongst Aboriginal and Torres Strait Islander people than among non-Indigenous people, higher proportions of Aboriginal and Torres Strait Islander people who do consume alcohol do so at harmful levels (for example, Australian Institute of Health and Welfare, 2002a). This is cause for concern since high levels of use are associated with high levels of morbidity and mortality (Hunter, 1992). One woman we interviewed put it like this when we asked her what she thought was good and bad about alcohol: “There is no good about alcohol mate. Just not for our people I don’t think. ‘Cos’ I don’t know many Aboriginals that can stop at one or two mate, you know what I mean? Like, it just doesn’t happen.”

#### *Ever use of alcohol*

Just two of the people we interviewed had never consumed alcohol. The mean age of first use was 13.9 years (SD 4.3, range 4-44) for the majority of the 93 people (97%)

who had. Eighteen of these people had stopped drinking at the time of interview. Some people who had stopped drinking or cut down credited Alcoholics Anonymous. Others, such as a woman who had experienced numerous alcohol-related problems and who said in the past she had been “Drinkin’ every day. I gave it up ... I used to drink casks like they was water ... [I didn’t go into treatment, I stopped] to look after me kids ... ”

A woman, who had stopped drinking, summed up her years of use like this:

*The first time I was ever offered alcohol I was about fourteen ... and I remember getting in the car and we went and drank ... And it tasted like vinegar from first memory and it was so gross. But after that first coupla’ glasses I remember ... mentally I could do anything, things that I was too shy to do before. I was terrified of boys and I could talk .. you know. It was so good. I didn’t feel shame any more and I didn’t feel anything. But the end of that night when I was absolutely blind, this is the big of it ... I guess I had a lot of anger at Mum inside ... I was going to stab them all and drinking [became] just an every week thing. I could consume a bottle of [spirits] no problem at all ... But I guess then there reached a point where I had kids see, and I couldn’t go out any more because I had a baby and Mum started taking him, which just left me wide open to do basically anything. And then it wasn’t until my spouse, he used drugs, so then I was introduced to that world. But yeah, I guess it was from one thing to another. And that’s what I’m focusing on now through healing, why did I explode and why the need to drink? And because, yeah it gets rid of everything.*

Another respondent explained how he had stopped drinking:

*You just feel like you are ten foot tall when you drink ... [I was] schitzing out I suppose being on the piss .. And she [partner] ran away ... So I had to make a decision the grog or whatever. So yeah I give it up and moved back down here too. I used to cause too much shit when I [was] drinking.*

The man’s story reported below had much in common with others who had stopped their alcohol use:

*I’ve got into heaps of fights from alcohol. I just know meself that I’m a hopeless drunk and all the time I had got in trouble with the law when I was a young fella’ was always bloody grog ... I get blackouts too, and I don’t remember things. See that’s another reason I don’t drink now.*

### *Current use of alcohol*

Seventy nine per cent (n=75) of the people we interviewed had consumed alcohol during the previous 12 months. As reported above, recent surveys of the overall population of Indigenous people have found a prevalence of alcohol consumption of around 58 to 62 per cent. These proportions are rather lower than the one found in our

sample. This is perhaps because we interviewed urban Aboriginal and Torres Strait Islander people: there may be a higher prevalence of alcohol use amongst Aboriginal and Torres Strait Islander people than in remote areas. Our findings have more in common with national surveys. The 2001 general population survey found a similar level of alcohol consumption of 82 per cent (Australian Institute of Health and Welfare, 2002c) to the one of 79 per cent in our urban sample of Aboriginal and Torres Strait Islander people who use illegal drugs.

A man whose polydrug use included alcohol said of his continuing alcohol use:

*Sometimes I drink just because I am stressed out, or you know, could be thinkin' about family sorta' matters and things like that and that stresses me out and makes me worried. That's when I feel like a drink, ya' know, just to calm me down or things like that. But sometimes I get a bit hyperactive on it and feel like I've got Superman powers on it, ya know, don't talk stupid to me or nothin' unless I will go violent ya' know ... it happens sometimes like that.*

An older man said he did not want to stop drinking because: "I can't go without, drink because I want to drink. I drink because of depression." A young teenager explained what was good for him about alcohol by saying: "Well with alcohol you've got no shame. Like you are not afraid to do things or say stuff." Talking about the bad things he added: "You know sometimes you just walk around and smash windows and stuff like that, and get into fights and stuff." This young man was also struggling with his heroin use.

One of the older respondents summed up for him what were the good and bad things about alcohol:

*For me being a painkiller straight up as quick as I can get drunk, the quicker the bad thoughts go away. But then the next morning, ya' know, fuck I'm that guilt-ridden and hung over and, ya' know - chuck me up a hollow log and set fire to it, ya' know. What have I done? What did I do? I blacked out and got no idea what went on, ya' know.*

We turn now to levels of drinking: as with other drug consumption patterns, levels of alcohol use can vary quite widely over a period of time. Since we were asking people about a 12 month period, the estimates needed to be able to reflect that variation. We used the NHMRC's guidelines to estimate standard drinks. Using here as examples the alcoholic beverages most commonly consumed by the people we interviewed, there are, according to the NHMRC guidelines, 1.5 standard drinks in a can or stubby of 375



millilitres of full strength beer, 22 in a 700 millilitre bottle of spirits and seven in a 750 millilitre bottle of wine (NHMRC, nd).

We asked respondents to estimate both the lowest and highest number of standard drinks they had consumed a day during the 12 months prior to interview. A majority of 67 of the 75 current drinkers (89%) answered “None” when we asked what was the lowest number of drinks they had consumed a day during the previous 12 months. Of the remaining eight people, people had one standard drink (8%), one had two standard drinks and one gave a high number of 18 standard drinks as their lowest number (this man said that he drank very heavily every day - we worked out that he consumed between 18 and 27 standard drinks every day).

A woman who had been a heavy drinker and now drank very occasionally (one or two drinks at celebrations) wanted to us to report what Elders say about blackouts:

*Can I tell you what our Elders say about that [blackouts]? [we responded “Yes”]  
It’s when your soul leaves you and someone else comes in. That’s what it feels like. You are not you. It’s when you lose your spirit to guide you. The pub is the devil. The devil is in pubs. That’s what they told me.*

We found a mean of 15 drinks for the highest number of drinks consumed a day (SD 14.4, range 1-64 amongst the 72 people who were able to quantify this amount. Some of the people who gave a very high number of drinks said they had been drinking “in a session” over more than one day and that it was impossible for them to estimate their highest daily number of drinks. These people just gave a number of drinks for a heavy drinking session. We were careful to record the number of drinks respondents had personally consumed rather than the total number drunk by all who were present. A man who regularly had very heavy drinking sessions recalled his most recent use of alcohol: “I drunk two litres of bourbon on [date]. I don’t know, that’s regular now ... I drunk a few litres and I wanted more.” He later added: “I got no stability at all because of alcohol and illicit drugs.”

Using NHMRC guidelines, we wanted to determine how many people we interviewed were drinking at risky levels. Since we did not gather information on the number of standard drinks consumed on an average day or weekly, we could not determine those whose drinking patterns might, according to the NHMRC guidelines, be risky in the

long term. We did, however, collect data on the maximum number of standard drinks consumed a day during the previous 12 months and so we are, using the NHMRC guidelines, and with the proviso outlined below, able to say something about short term “risky” and short term “high risk” alcohol consumption.

The NHMRC defines short term risk as “the risk of harm (particularly injury or death) in the short-term that is associated with given levels of drinking on a single day” (NHMRC, 2001:4-5). The NHMRC guidelines go on to stipulate that “levels assume that overall drinking patterns remain within the levels set for long term risk, and that these heavier drinking days occur infrequently, and never more than three times per week. Outside these limits, risk is further increased” (NHMRC, 2001:4-5). The proviso we alluded to above is that we do not know how frequently risky or high risk drinking days occurred.

We worked out short term risky levels of alcohol consumption according to gender. The NHMRC guidelines stipulate that consuming seven to ten drinks a day is a risky short term level of drinking for men and that 11 or more is a high risk level. For women, five to six drinks a day is considered to be a short term risky level. More than this is considered to be short term high risk. Our findings reveal that in the 12 months prior to interview, seven women and three men (overall, 14% of the people who had consumed alcohol in the previous 12 months) had consumed alcohol at short term risky levels. Nine women and 28 men (overall, 51% of the people who had consumed alcohol in the previous 12 months) had consumed alcohol at short term high risk levels. In addition, two men could not quantify their alcohol consumption but described themselves as “bingers.” Three quarters of the subsample of current alcohol consumers can, therefore, be described as either short term risky or high risk alcohol drinkers.

Before we further discuss problematic drinking we point out that some people we interviewed were drinking at levels considered to be safe. Low levels of alcohol consumption are now thought to be protective against diseases such as hypertension and cardiovascular disorders (Australian Institute of Health and Welfare, 2003b). As indicated in the introduction to this chapter, after recording drug use histories we asked about “problem” drugs. Fourteen of the 75 people (19%) who mentioned at least one problem drug mentioned alcohol as their number one problem drug and four of the 36 people who mentioned at least two problem drugs mentioned it as their second most

problematic drug. Overall, 24 per cent of the 75 current drinkers (n=18) mentioned alcohol as a problem drug. (No one mentioned alcohol as their third most problematic drug.)

#### *Severity of Dependence Scale score for alcohol*

As a back up for respondents' self-identification of alcohol as a problem drug we administered the Severity of Dependence Scale. We used the scoring system outlined by Gossop and colleagues of zero for non-dependence, 1 to 5 for low dependence 6 and above for high dependency (out of a possible score of 15) (Gossop et al, 2002). According to the levels used by Gossop and colleagues, 28 per cent of the people who had consumed alcohol in the previous 12 months (n=21) had a low dependence on alcohol and another 28 per cent had a high dependence. This resulted in 56 per cent of the current alcohol drinkers with some degree of alcohol dependence. (We did not administer the scale to five people whose minimum *and* maximum numbers of standard drinks were zero or one, 1 missing value.)

#### *Opioids*

Opioids are either natural compounds derived from unripe seed capsules of the Oriental poppy (such as opium), or semi-synthetic compounds (such as heroin) or synthetic compounds (such as methadone) (Goodman Gilman et al, 1990). In this section we provide a broad picture of the use of opioids in general before zoning in to look at heroin use in particular.

In the 2002 National Drug Strategy household survey the largest proportion reported for lifetime use of any opioid was 1.6 per cent (for heroin use). During the previous 12 months 0.2 per cent reported use of heroin, 0.1 per cent methadone and 3 per cent "other opiates" (Australian Institute of Health and Welfare, 2003b:17).

#### *Ever use of opioids*

Seventy four of the people we interviewed (78%) had ever used an opioid. There was a mean age of 21 years for first use (SD 6.8, range 10 [n=1] to 42. In the 2002 National Drug Strategy household survey the youngest mean age for first use of opioids was 20.7

years (this was for heroin) (Australian Institute of Health and Welfare, 2003b). Given Community reports of the use of opioids by young Aboriginal and Torres Strait Islander people, we analysed age of initiation into opioids more deeply than we did for other classes of drugs. Overall, 27 people (36% of the opioid users and 28% of the total sample) had commenced opioid use at the young age of 16 or less. Another 19 (26% of the opioid users and 20% of the total sample) had started using opioids at the age of 20 or less. An aggregation of these age groupings results in 46 people (62 per cent of the opioid users and 48 per cent of the total sample) commencing opioid use at the age of 20 or less.

Returning now to our analysis of the findings from all 74 people who had ever used an opioid, the route for first use for exactly half this subsample was inhalation. This was described as “smoking” by 29 people (39%), “snow coning”<sup>11</sup> by six people (8%) and “chasing” by two people.

One man described his “snow coning” of heroin before he moved on to “chasing” it:

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<sup>11</sup> “Snow coning” a mix of cannabis and marijuana should really be consider as a cocktail. We have included the discussion of this mode of use here because it related to initiation into heroin use. In addition, in our previous report on the estimations of the number of Aboriginal and Torres Strait Islander people in the ACT and region using heroin, we were told that many young Aboriginal teenagers had commenced heroin use by “snow coning” (Dance et al, 2000a).

*Me and another mate, who was a coupla years older than me, he used to smoke it, snow coned and that. I used to go to school and they'd say 'try this bong<sup>12</sup>.' I said 'Oh yes I'll try this, I'll have a go at this.' I put it [the heroin] on top of the cone<sup>13</sup> ... And I used to go around and see him, like three days a week, and then that turned into daily, every day I was around at his place snow coning. And then I ran into me cousin [and he said] 'Try and do this', showed us how to do it so we started chasing the dragon<sup>14</sup>.*

Apart from inhalation (which accounted for 50% of first routes), other routes for first use of an opioid were the intravenous route, by 26 people (35% of the opioid users); the oral route by nine people (12% of the opioid users); and intranasally (or, as described more colloquially by the people we interviewed, “snorting”) by two people.

A mean number of 1.9 types of opioid (SD 1.1, range 1-7) had ever been used. Just one of the opioid users had ever used only an opioid which they had been prescribed. Almost half of the sample of opioid users (49%, n=36) had ever used just non-prescribed opioids. Twenty two (30%) had ever used both illegal opioid/s and one (or more) which had been prescribed to them. The rest of the sample had used combinations of illegal opioids or a prescribed opioid which had been obtained illegally, or had been used in a way other than prescribed (such as injection of methadone).

### *Current use of opioids*

Looking now at current use of opioids, 60 of those who had ever used an opioid (81% of ever opioid users) had used one or more types in the 12 months prior to interview and 14 (20%) were no longer using them. The 60 current opioid users had used a mean number of 1.5 types (SD.6, range 1-3). As seen in Table 4.3, just 12 per cent (n=7) had always used an opioid every day during the previous 12 months. More than half (n=34, 57%) did, however, have period/s of daily use.

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<sup>12</sup> A bong has been “defined as a long cylindrical tube made of various material used to smoke marijuana (and other smokeable plants)” (Urban Dictionary, 2001). The design of a bong can range from quite sophisticated glass models to home made ones utilising old plastic containers and parts of garden hose pipes.

<sup>13</sup> Inferentially, on top of the marijuana he had already put in the cone - the cone is the part of the bong into which marijuana is put for smoking.

<sup>14</sup> Chasing the dragon”, often shortened to just “chasing”, involves placing the drug, usually heroin, on silver foil, placing a flame under the foil then inhaling the smoke, commonly through a rolled piece of cardboard or an empty plastic biro insert.

**Table 4.3: Current frequency of opioid use**

<b>Frequency</b>	<b>n</b>	<b>%</b>
Always every day	7	12
Sometimes every day, sometimes less than that, or none	34	57
Around 3-6 times a week	1	2
Sometimes 2-4 times a week, sometimes none	3	5
Around 1 or 2 times a week	4	7
More than occasionally, but less than weekly	7	12
Occasionally/once only	3	5
“Stopped” 4 months ago, prior to that daily	1	2
<b>Total</b>	<b>60</b>	<b>-</b>

A majority of 55 per cent (n=33) of current opioid use was of just an illegal opioid. Most of the rest of the subsample had taken both an illegal opioid and a prescribed<sup>15</sup> one in an illegal fashion. Eight per cent (n=5) were using a prescribed opioid which they had also obtained illegally or were using in a way other than prescribed. The rest of the current opioid users were either using both prescribed and illegal opioids (18%, n=11) or both an illegal opioid and a prescribed opioid which they had obtained illegally (10%, n=6). Just eight per cent (n=5) were using only a prescribed opioid.

During the previous 12 months, a majority of opioid users had injected one of the drugs in this class (Table 4.4): Forty eight per cent (n=29) had only used this route and 25 per cent (n=15) had used both the intravenous and oral routes. One person had used three routes (intravenous, inhalation and oral).

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<sup>15</sup> We are using “prescribed” as a general term to denote either drugs that were either prescribed by a physician or were bought over the counter.

**Table 4.4: Current route/s for opioids**

<b>Route</b>	<b>n</b>	<b>%</b>
Intravenous	29	48
Intravenous/oral	15	25
Oral	8	13
Inhale	4	7
“Snow cone”/oral	3	5
Intravenous/inhale/oral	1	2
<b>Total</b>	<b>60</b>	<b>100</b>

### *Heroin*

Because of factors such as heroin-related deaths, a range of deleterious health effects and negative social repercussions, including criminal behaviours, heroin is the opioid which causes most concern in the local Aboriginal Community, as well as in other Australians and the western world in general. For these reasons we discuss it separately here. Heroin was first synthesised from morphine in 1874. On entering the body it is transformed into morphine and most users experience intense feelings of euphoria.

In the 2002 National Drug Strategy household survey, 1.6 per cent of those surveyed reported that they had ever used heroin. A small proportion of 0.2 per cent reported use of heroin in the past 12 months (Australian Institute of Health and Welfare, 2003a). In the Western Australian study of injecting drug users by Gray and colleagues, 62 per cent of the 74 people sampled had ever used heroin. Half had not used any in the previous 12 months. Those who were using it were generally using it on a less than weekly basis (Gray et al, 2001).

This is how one of the women we interviewed explained heroin’s allure:

*[With] every other drug there’s a choice, with heroin, there’s no choice, you can go after other drugs, but heroin goes after you. You need it and you’d do anything to get it.*

Another woman, who had now stopped her use said of heroin “It’s not an alternative to life.” A man who had tried heroin once said he did not like it because:

*I hated the smell. I hated like not being in control. I hated, yeah, I just hated not being there. Because heroin took away so much of my own self that I couldn’t even feel me. And I didn’t like that. I didn’t like not feeling me because that’s what heroin did, that just took what was in here [tapping his heart] out of me ...*

A teenager’s story of initiation into heroin use at the age of 15 had much in common with that of other people we interviewed. Before his first use, when he had smoked it, the young man said he was scared of heroin: “Scared because of the overdoses and stuff and I didn’t know how it was goin’ to effect me.” We asked why he had decided then to try some and he said: “I don’t know. At first I just wanted to see what it was like. How it feels and stuff like that. And I did and I liked it so I just kept doin’ it.” We asked how he felt after he’d had it and he said: “I wanted more.” Soon afterwards he was injecting it and he then “had it every day because it was doin’ good.”

Subsequently, this young man had experienced several heroin-related problems, such as loss of friendships, because of his heroin use. After trying home withdrawal and a brief period of methadone treatment, this young man had recently gone “cold turkey.”<sup>16</sup> He said that when he “stopped it was hard. I mean I just feel like my nerves were all jittery and stuff so I couldn’t sleep and ... I was spewin’ up a bit.” He now had ambivalent feelings about heroin believing it to be “bad, what it does to you. I reckon it’s good because it relaxes you and you don’t think about all your problems.”

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<sup>16</sup> Cold turkey is a colloquial term for withdrawal without treatment - so called because the piloerection (goosebumps) that accompanies withdrawal from opioids is likened to the skin of a plucked turkey. People experiencing withdrawal may be pale, like a dead turkey, and they frequently have hot and cold spells, the coldness thus being also being like that of a dead turkey.



This is a story from one woman who had stopped using heroin with the help of a pharmacotherapy:

*Cos' when I used to hang out from heroin, I couldn't move ... I couldn't get out of bed in the morning to go to the toilet ... between five and five-thirty every morning I'd wake up and vomit. I'd have to roll over make up a mix [of heroin for injection] and put it in me arm while I was still in bed otherwise I wouldn't be able to move. Like and then [I thought] 'This is no life.'*

The 49 people we interviewed who had used heroin in the twelve months prior to interview had used it for a mean period of 6 years (SD 5.5, range 1-31). As we indicated in Chapter 1, according to the National Aboriginal Health Strategy Working Party, heroin use became a significant problem in Aboriginal Communities in Sydney as early as 1982 (National Aboriginal Health Strategy Working Party, 1989). The data we collected in 2003 showing that someone had been using it for 31 years indicate that heroin was being used by Aboriginal people as early as 1972. This is in keeping with the “Substantial growth” in heroin use which occurred in Australia in the 1960s, when USA soldiers brought it into the country when they were on leave from fighting the Vietnam war (Pennington, 1999:27).

#### *Opioids named as problem drugs*

Twenty four of the 75 people (31%) who mentioned at least one problem drug named an opioid. Twenty three named heroin and one named Panadeine Forte (generally prescribed as an analgesic) as their number one problem drug. Eight of the 36 people who mentioned at least two problem drugs named an opioid: six named heroin and two named Mersyndol (22%) as their second most problematic drug. Two out of the nine people who named a third problem drug named heroin.

#### *Severity of Dependence Score for heroin*

Regardless of whether or not people named heroin as a problem drug, we administered the Severity of Dependence Scale to all current heroin users except one person who had used it just once in the previous 12 months and who said it had been an experiment they were not going to repeat (3 missing values). We used the scoring system of Gossop and colleagues for heroin: namely zero for non-dependence, 1 to 5 for low dependence 6 and above for high dependence (Gossop et al, 2002). More than two thirds (69%, n=31) of the 45 heroin users had a score indicating a high dependence on heroin. Another 20

per cent (n=9) had a score indicating a low level of dependence. Overall, 89 per cent of the heroin users (n=40) could, according to the Severity of Dependence Scale levels used by Gossop and colleagues, be considered to be dependent on it.

In a recent South Australian study where the Severity of Dependence Scale was also used, of those (n=133 out of a sample of 307) who nominated heroin as the drug of most concern to them, a similar high proportion of 90 per cent were likely to be dependent on it (Holly and Shoobridge, 2002).

#### *Severity of Dependence Scale Score for other opioids*

Recognising that its use has not been validated for opioids other than heroin, we also administered the Severity of Dependence Scale to seven people who nominated an opioid other than heroin as a problem drug, or whose other opioid use we considered to be high. The results revealed a high dependent score of 12 for one person's use of Mersyndol. Afraid that a health professional "might laugh" at her because of her "unusual habit", this woman had never sought help for the problems she experienced due to her Mersyndol use. We reassured her that the problem would be taken seriously. She was then happy to take the information we offered about possible treatment sources. Another woman scored three on the Severity of Dependence Scale (indicating low dependency) for her Mersyndol use. This respondent also used Valium and Panadeine Forte. She explained that she used these three drugs as "Substitutes for drinking, I use them when I'm not drinking, just to calm me down."

The woman who scored three had this to say about how she started Mersyndol. She had gone to the doctor's with a migraine and "[I told him] Panadol didn't do anything and he told me to take Mersyndol. That's how I got into them. They made me feel relaxed."

One person had a high dependency score of nine for their codeine use and one a high score of 14 for Panadeine Forte. Another had a low dependency score of one for their morphine use. The final two people had scores of zero (non-dependence) for their opioid use.

### *Benzodiazepines*

Since they were first used in clinical practice in the USA in 1961, many different benzodiazepines have been synthesised (Goodman Gilman et al, 1990). These drugs largely replaced barbiturates for the relief of anxiety and depression but, like barbiturates, they are now known to have a variety of adverse effects, including a potential for dependency (McAllister et al, 1991). As a consequence restrictions have recently been put on prescribing practices.

Just over three per cent of the sample in the 2002 National Drug Strategy household survey reported ever using “tranquillisers/sleeping pills” and 1.1 per cent reported using them in the past 12 months (Australian Institute of Health and Welfare, 2003b:17).

#### *Ever use of benzodiazepines*

Among the people we interviewed, 64 (67%) had used benzodiazepines. Everyone had taken it orally at first. There was a mean age of 20.1 years for first use (SD 5.6, range 10 [n=1]-40). This is a little younger than the mean age of 22.8 years reported for age of initiation into “tranquillisers/sleeping pills” in the 2002 National Drug Strategy household survey (Australian Institute of Health and Welfare, 2003b:17).

A mean number of 1.7 different types of benzodiazepine had been used (SD 1.1, range 1-5). Forty two per cent of the sample had only ever used a benzodiazepine which had been prescribed to them (n=25). Thirty one per cent (n=18) had only ever used ones which had been prescribed to others. The rest of the sample (27%, n=16) had various combinations of legal and illegal use (5 missing values). Overall, 68 per cent had ever used illegal benzodiazepines. This is somewhat higher than the 55 per cent in the Western Australia sample of 74 injecting drug users who reported ever using benzodiazepines for non-medical reasons (Gray et al, 2001).

#### *Current use of benzodiazepines*

Forty seven of the 49 people who were currently using benzodiazepines were taking them orally (96%). One person had used it both orally and intravenously and the final person had just taken it intravenously. A mean number of 1.4 types were being used

(SD 0.7, range 1-4). Forty four per cent of the sample were currently only using benzodiazepines which had been prescribed to them (n=21) and 25 per cent (n=12) had only ever used ones which had been prescribed to others. The rest of the sample (33%, n=15) had various combinations of legal and illegal use (1 missing value).

We aggregated the total from those who had sometimes used a benzodiazepine every day in the past 12 months (46%, n=22), with that from the one person who had always used them daily (Table 4.5). This showed that almost half the sample had periods of using a benzodiazepine daily. There was, however, also a large proportion of 38 per cent (n=18) who had used a benzodiazepine occasionally or just once.

**Table 4.5: Current frequency of benzodiazepine use**

<b>Frequency</b>	<b>n</b>	<b>%</b>
Always every day	1	2
Sometimes every day, sometimes less than that, or none	22	46
Around 3-6 times a week	2	4
Around 1 or 2 times a week	1	2
More than occasionally, but less than weekly	4	8
Occasionally/once only	18	38
<b>Total</b>	<b>48<sup>a</sup></b>	<b>100</b>

<sup>a</sup>One missing value.

Three of the 75 people who mentioned at least one problem drug named a specific benzodiazepine, or just said “benzo’s” when we asked about their number one problem drug. Two of the 36 people who mentioned at least two problem drugs named a benzodiazepine (6%) as their second most problematic drug. Four of the nine people who named a third problem drug named benzodiazepine.

#### *Severity of Dependence Scale score for benzodiazepines*

Overall, 18 per cent of current benzodiazepine users (n=9) mentioned a benzodiazepine as a problem drug. We administered the Severity of Dependence Scale to these nine people as well as to another seven people whose use was high. As recommended by Dawe and Mattick, we used cut off Severity of Dependence Scale score of 6 for benzodiazepine dependence (Dawe and Mattick, 2002). Of the 16 people to whom we

administered the scale, nine could be considered to be dependent with scores of six to ten (out of a possible score of 15).

### **Amphetamine-type substances**

We followed the Alcohol and other Drugs Council of Australia's example and considered amphetamine-type substances to be amphetamine, methamphetamine (which was in the form of "ice" by the people we interviewed), ecstasy and cocaine (Alcohol and other Drugs Council of Australia, 2003). We also include here findings on prescribed use of Ritalin, which was mentioned by a few people and Medislim<sup>17</sup> which had ever been used by one person. For the sake of simplicity we subsequently refer to amphetamine-type substances as "amphetamines."

Below we make some comparisons with data on amphetamine use collected for the 2002 National Drug Strategy household survey but point out that, unlike our data collection, the Australian Institute of Health and Welfare considered cocaine and ecstasy separately from amphetamines (Australian Institute of Health and Welfare, 2003b:17). Since the majority of people we interviewed who had used an amphetamine had used amphetamine and/or methamphetamine as well as, in a few cases, ecstasy and/or cocaine, we believe that it is appropriate to make the comparisons between findings from the people we interviewed and the 2002 National Drug Strategy household survey.

In the 2002 National Drug Strategy household survey, 8.9 per cent reported ever using "amphetamines" (Australian Institute of Health and Welfare, 2003b:17). Amphetamines had been used at some time by a vast majority of 84 per cent of the people we interviewed (n=80). In the Western Australia study of 74 injecting drug users conducted by Gray and colleagues, a majority of 99 per cent reported that they had ever used amphetamines (Gray et al, 2001).

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<sup>17</sup> Medislim used to be available over the counter as an appetite suppressant. Since these tablets contained both ephedrine and caffeine they were sometimes used as stimulants (Groves (now Dance), 1979). It is no longer possible to obtain drugs over the counter which contain ephedrine (Williams, L. Pharmacist, ANU ACT, 1997, November, 13 pers comm). This drug is different from Medislim Natural, which contain an array of natural substances and is still available (Medislim Natural Advance, 2004).

### *Ever use of amphetamines*

The mean age for first use for any amphetamine amongst the people we interviewed was 18.5 years (SD 4, range 9-35). The 2002 National Drug Strategy household survey found an older mean age of 20.4 years for first “amphetamine” use (Australian Institute of Health and Welfare, 2003b:17).

Amongst the people we interviewed almost equal proportions of around one third had first used amphetamines intravenously, orally, and intranasally (“snorting”) (Table 4.6).

**Table 4.6: Route first amphetamine use**

<b>Route</b>	<b>n</b>	<b>%</b>
Intravenous	28	36
Oral	24	31
Intranasal/“snorting”	24	31
Inhale (smoking)	2	3
<b>Total</b>	<b>78<sup>a</sup></b>	<b>-</b>

<sup>a</sup>Two missing values.

A mean of 2.2 types of amphetamines had ever been used (SD 1.1, range 1-4). A majority of 98 per cent (n=78) of the 80 people who had used this class of drugs had used only illegal amphetamines. Two people had obtained Ritalin illegally and had also used illegal amphetamine. Cocaine had ever been used by 35 people (44% of the amphetamine users and 37% of the total sample). For most people this had been experimental or opportunistic use.

### *Current use of amphetamines*

During the previous 12 months, 3.4 per cent of those interviewed for the 2002 National Drug Strategy household survey reported use of “amphetamines” (Australian Institute of Health and Welfare, 2003b:17). Forty eight of the people we interviewed were currently using amphetamines (51% of the sample). A mean of 1.6 types were currently being used (SD 0.7, range 1-3). Just three people reported cocaine use in the 12 months prior to interview. Two people had used it on an occasional/once only basis and the

third person's frequency of use had ranged from zero for long periods to second daily use.

Table 4.7 shows that over two thirds of amphetamine users were always using the intravenous route to administer it (68%, n=32). One person had used the intramuscular route. Another 3 people were also injecting amphetamine sometimes or always.

**Table 4.7: Current route/s for amphetamine use**

<b>Route</b>	<b>n</b>	<b>%</b>
Intravenous	32	68
Oral	8	17
Intravenous/oral	2	4
Oral/intranasal	2	4
Intravenous/intranasal	1	2
Intramuscular	1	2
Oral/inhale	1	2
<b>Total</b>	<b>47<sup>a</sup></b>	<b>-</b>

<sup>a</sup>One missing value.

Of the 47 people who had used amphetamines in the 12 months prior to interview, 36 had injected it (67% of the current 54 injecting drug users). Sixty people were currently using opioids and 45 had injected it (83% of the current 53 injecting drug users). This is different to findings reported by other researchers in the field. Larson and colleagues found amphetamine to be the most commonly injected drug by the 77 Aboriginal injecting drug users they interviewed in Brisbane (Larson et al, 1999). Similarly, the West Australian study by Gray and colleagues of 74 Aboriginal injecting drug users found a preference for amphetamine over heroin (Gray et al, 2001).

As seen in Table 4.8, one third of the current amphetamine users (n=16) had used it occasionally or once only during the previous 12 months. One person said they had used it every day and 13 people had periods of using it daily, or almost daily. This results in 14 people, 29 per cent of the current amphetamine users, taking it daily, sometimes daily or almost daily.

**Table 4.8: Current frequency of amphetamine use**

Frequency	n	%
Always every day	1	2
Sometimes every day, sometimes less than that, or none	10	21
Around 3-6 times a week	2	4
Sometimes up to 2-4 a week, sometimes none	4	8
“Binges”	1	2
Around 1 or 2 times a week	8	16
More than occasionally, but less than weekly	3	6
Occasionally/once only	16	33
“Stopped” 4-6 months ago	3	6
<b>Total</b>	<b>48</b>	<b>-</b>

Some respondents had only good things to say about amphetamine. One man, for example, said:

*I know I've wasted some good money on it, but it's never ever caused me any problems. It's helped me if anything. Cos' you're chirpy as Larry, you get somethin' in your head, you've had somethin' bottled up for days [then you use it]. It's like counselling yourself really.*

For the man we quote below, his first use of amphetamine was enjoyable but he had mixed feeling about his current occasional use. The first time he used amphetamine, it was:

*Totally different. Made me just so confident, so ... it made me be the person that I wasn't actually. It made me this person that I never was. It still does. It made me so confident and ... It give me what I wasn't gettin', like in confidence. Yeah it's amazing on speed actually, yeah. Um I get ... I get the rushing feelings, I don't get that feeling no more. It's not true. But speed made me believe that it could give me all that. But after havin' it for like fifteen years you soon realise that, yeah, it's always been there, it was just that drug that brung it out of me. Yeah. I didn't really need that crap to bring it out. I still have it today but it's a habit today, yeh. Because I know how mentally and emotionally the damage that it can do to ya. It's took a lot of money from me. I've had family breakdowns from it. Because what comes with speed is secrets because you've got to hide it, you've gotta' hide the money, you've gotta' hide the tracks, the needle tracks that you have to do it. And it's all one big lie really ... And that's what ate me away with speed was that I had this secret that was chewin' and eatin' my insides out. Like yeah, even though it give me confidence to do what else I wanted to do but also it give me a lie that chewed my insides out. Which was more damaging than the actual confidence that it give me to do all this other stuff. So it give me one thing in one hand, but also in the other hand it give me misery.*



The man quoted above was one of the 23 current 48 amphetamine users (48%) who mentioned it as a problem drug. Fifteen of the 75 people (20%) who mentioned at least one problem drug mentioned it as their number one problem drug. Of the 36 people who mentioned at least two problem drugs six (17%) said amphetamine was their second most problematic drug. Two of the nine people who named a third problem drug named an amphetamine.

#### *Severity of Dependence Scale score for amphetamines*

We then administered the Severity of Dependence Scale to all 23 people who had mentioned amphetamine as a problem drug, as well as to three other people whose use we considered to be high. Using the cut off score of four recommended by Dawe and Mattick (Dawe and Mattick, 2002), 20 of the people we administered the Severity of Dependence Scale to were dependent scoring between 4 and 14 out of a possible score of 15. Based on the cut off score recommended by Dawe and Mattick, 42 per cent of the sample of amphetamine users were dependent.

In the recent South Australian study where the Severity of Dependence Scale was used, 77 per cent of the 89 people who nominated amphetamines as the class of drugs that were of most concern to them were considered dependent (Holly and Shoobridge, 2002).

#### *Hallucinogens*

Several drugs can induce alterations of mood and thinking in such a way that people see or hear things that do not exist. Examples of these include natural plant substances, such as mushrooms; extractions from natural substances, for example, LSD (lysergic acid diethylamide, which is a synthetic agent – its chemical structure mimics the parasite fungus ergot); and anesthetic agents, including GHB (gamma-hydroxybutyrate) (Australian Crime Commission, 2003). Some drugs sold as LSD may be adulterated with a variety of other substances such as ketamine and GHB (Australian Crime Commission, 2003). These may be referred to as “designer drugs” (Australian Crime Commission, 2003) or, as we have heard them described by people who use them, as “cardboard trips.”

During the 2002 National Drug Strategy household survey, 7.6 per cent of those surveyed reported that they had ever used hallucinogens and 1.1 per cent reported use during the previous 12 months (Australian Institute of Health and Welfare, 2003b)<sup>18</sup>.

### *Ever use of hallucinogens*

Among the people we interviewed, 48 had tried an hallucinogen of some sort, mainly mushrooms or “cardboard trips.” GHB is a central nervous system depressant and in recent years there have been increasing reports of its use (Degenhardt et al, 2003). Following media reports of GHB-related deaths, this drug has recently gained some notoriety (Australian Crime Commission, 2003). No one we interviewed reported its use.

The mean age of first use of hallucinogens was 17.6 years (SD 4.1, range 10 [n=3]-28). Everyone had first administered it orally. Those interviewed for the 2002 National Drug Strategy household survey who reported use of hallucinogens had a mean age of 19.1 years for first use (Australian Institute of Health and Welfare, 2003b).

The 48 people we interviewed who had ever used hallucinogens had used a mean of 1.5 types (SD 0.6, range 1-4). For most people their hallucinogen use had been on an experimental basis more than 12 months ago.

### *Current use of hallucinogens*

Just four people had used an hallucinogen during the 12 months prior to interview. For three, that use had been on a once only or occasional basis. The fourth person’s use had ranged from a couple of times a week to none a week. Three people had taken the drug by mouth and a person who had once used a “cardboard trip” during the previous 12 months had injected it.

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<sup>18</sup> The 2001 National Drug Strategy household survey report contains categories related to hallucinogens which do not exactly tally with our categories. One was “Hallucinogens” and one was “Ecstasy/designer drugs” (Australian Institute of Health and Welfare, 2003:17). We included designer drugs as hallucinogens. As we rationalised above, we included ecstasy as an “amphetamine-type substance.”

## *Inhalants*

Inhalants can be grouped into four basic classes:

- volatile solvents, such as petrol, correction cleaning fluids, felt tip markers, glue and paint thinner;
- aerosols, solvents contained in spray cans such as spray paints, deodorants and hairsprays;
- gases, household or commercial gases such as that found in butane cigarette lighters and gas bottles; and
- nitrates such as video head cleaners and amyl nitrite.

(State Government of Victoria circa 2003)

“Chroming” is a method of inhalation which appears to be fairly recent and has received quite a lot of publicity. This is due to the fact that in addition to a range of psychoactive effects it can cause immediate cessation of breathing. “Chroming” involving spraying chrome paint into a plastic or paper bag and breathing in the contents (State Government of Victoria circa 2003). No one we interviewed had histories suggesting that they had “chromed” paints.

### *Ever use of inhalants*

Twenty nine people we interviewed (31%) had used one or more of these types of inhalants, leaving a majority of 66 (69%) who had not. In the 2002 National Drug Strategy Survey 2.6 per cent of the sample reported ever using inhalants (Australian Institute of Health and Welfare, 2003b). The mean age of first use for inhalants amongst the people we interviewed was 14 years (SD 4.4, range 7-29). This is much younger than the mean age of 17.6 years reported for age of initiation into inhalants in the 2002 National Drug Strategy household survey (Australian Institute of Health and Welfare, 2003b).

Between them, the 29 people we interviewed who had used inhalants had used a mean of 1.7 types (SD 0.8, range 1-3). For the majority of these people, inhalants had been used on an experimental basis during their teenage years.

### *Current use of inhalants*

Just three people (10% of those who had ever used inhalants and 3% of the sample) were currently using inhalants. All three were using just one inhalant and had used it on an occasional or once only basis during the twelve months prior to interview. Less than one per cent of those interviewed for the 2002 National Drug Strategy household survey reported using inhalants in the past 12 months (Australian Institute of Health and Welfare, 2003b).

### *Inhalation of petrol*

As noted in the first chapter of this report, inhalation of petrol is of considerable concern in some Aboriginal Communities. During research we conducted in 2000 there were anecdotal reports of petrol sniffing by Aboriginal people in Canberra (Dance et al, 2000a). According to Maclean and d'Abbs, "Recent reports suggest that it is occurring in some urban settings and alongside other forms of alcohol and drug use" Maclean and d'Abbs, 2002:66). We were interested to discover whether petrol sniffing was a problem in the ACT and Region's Aboriginal and Torres Strait Islander Community. We highlight reports of its use below.

Twenty of the people we interviewed (21% of the sample and 69% of those who had ever inhaled a substance) had ever inhaled petrol. In the twelve months prior to interview just one person, one of the younger respondents, had once inhaled petrol and inferred he was not going to repeat the experience. Based on evidence from the people we interviewed we conclude that petrol sniffing does not seem to have taken hold amongst Aboriginal and Torres Strait Islander people in the ACT and Region.

### *Conclusion - inhalant use*

Our results concur with d'Abbs and Maclean's view that: "Among urban people volatile substance misuse appears to involve a relatively large number of experimental users." They go on to say that urban areas may contain "a very small number of chronic users" (d'Abbs and Maclean, 2000:17). We did not interview any chronic users. This may be because there are no chronic users in Canberra, but even if there were any, the effects of petrol inhalation are such that it is unlikely they would appear for interview.

We did not interview any young people below the age of 16. If we had managed to do so we may have found a larger proportion of the sample currently using inhalants.

### *Barbiturates*

Barbiturates were previously used extensively for their sedative-hypnotic properties (Goodman Gilman et al, 1990). In the 1960s they gained a reputation both for dependence and as the drug most often used for suicide. As a result, restrictions were placed upon their use in Australia, and they have since been prescribed primarily for the treatment of epilepsy (McAllister et al, 1991). In keeping with this history of restrictions, just seven people we interviewed had ever used barbiturates and no one was currently using them.

### *“Other” drug use*

Fourteen per cent of the sample (n=13) had ever used “Other” drugs for their psychoactive effects (these are documented in Appendix 19). Just five people had used one of these drugs in the 12 months prior to interview. One person had used one daily, two people’s use had ranged from daily to none, and two people had used one of these drugs occasionally or just once. Four people had taken these “Other” drugs orally and one had used the intravenous route.

### **Conclusion**

We found an early age of initiation into both legal and illegal drugs. This is of concern, particularly since Johnson found that the earlier the initiation into illegal drug use, the more likely there are to be long term adverse effects (Johnson, 2001). We did try to access respondents aged 14 to 16 but were unsuccessful. If we had been able to do so we may have obtained different data on the types of illegal drugs being currently used. For example, there may have been higher proportions currently using inhalants or hallucinogens.

Most people we interviewed were polydrug users which for most people included tobacco and marijuana, often mixed together. We have demonstrated that the proportion of current alcohol drinkers in our sample was more comparable to the higher

general Australian population rather than to lower proportion found in samples of Aboriginal and Torres Strait Islander peoples. In addition, a majority sometimes consumed alcohol at risky levels. Thus, the overall sample of people we interviewed could be described as being at risk in terms of the proportion who were drinking. In addition, individuals were placing themselves, as well as others, at risk because of their high levels of alcohol consumption.

As well as the dangers associated with alcohol and tobacco use, the people we interviewed are at increased risk because there is no quality control on most of the other drugs they used. In keeping with Community concerns about young Aboriginal and Torres Strait Islander people using heroin, a large proportion had started opioid use at the age of 20 or less. Whilst some people had stopped use of particular drugs, overall there was a long history of illegal drug use in the sample.

The statements on the Severity of Dependence Scale worked very well with the people we interviewed. This Scale has also been used by other researchers measuring drug dependence in Aboriginal and Torres Strait Islander people (Holly and Shoobridge, 2002). We recommend its use with other Aboriginal and Torres Strait Islander populations of people who use illegal drugs. As summarised in Table 4.9, we found large proportions of users of these particular drugs were dependent on cannabis, alcohol, heroin and amphetamines. A few people had problems due to Mersyndol use and we recommend that its suitability as an over the counter drug be examined.

**Table 4.9: Summary of Severity of Dependence Scale scores**

Drug	Dependent	Dependent		Total users
		n	%	
Cannabis		54	65	83 <sup>a</sup>
Alcohol	42		56	74 <sup>b</sup>
Heroin		40	89	45 <sup>c</sup>
Amphetamines		20	42	48
Benzodiazepines		9	19	48
Other opioids		5	71	7

<sup>a</sup> Three missing values.

<sup>b</sup> One missing value.

<sup>c</sup> One of the 49 current heroin users had used heroin once on an experimental basis in the 12 months prior to interview. We did not administer the Scale to them. Three missing values.

In the following chapter we report findings related to experiences with treatment for drug use.

## CHAPTER 5: HISTORIES OF TREATMENT FOR DRUG USE

### Introduction

Before discussing findings on histories of treatment for drug use, we provide a very brief overview of some of the general literature on treatment modalities. We follow this with a brief history of alcohol and other drug treatment services for Aboriginal people. We then go on to report on the treatment histories of the people we interviewed by order of frequency of proportion of utilisation. As we do so, we provide a condensed description of each treatment modality used by respondents. (A wealth of comprehensive information exists about treatment modalities. Much of this is available via the Internet, as well as in hard copy (for example Alcohol and other Drugs Council of Australia, 2003). We then offer some findings on why people had not tried treatment and how, other than trying different forms of treatment, they had stopped use of particular drugs. In our conclusion to this chapter we summarise respondents' experiences of treatment.

### Overview of some of the general literature on treatment modalities

People experiencing problematic alcohol or other drug use may attempt to achieve abstinence through withdrawal, followed by either residential or out-patient treatment. Comments made by Gossop and colleagues about the UK treatment scene - that treatment interventions offered for problematic alcohol and other use are complex, diverse, and frequently ill defined (Gossop et al, 1997) - apply equally to Australia. One type of treatment does not suit everyone and it is generally acknowledged that a range of drug and alcohol treatment programs should be available for Aboriginal and Torres Strait Islander people [as well as other people] (Commonwealth Department of Health and Aged Care, 1999; Ministerial Council on Drug Strategy, 2003). McMahon suggests that most treatments provide opportunities for clients to have time out from their daily lives and a supportive environment that builds self-esteem and optimism, and it is these commonalities that are important (McMahon, 1998).

In parallel with the recognition of alcohol-related harm, as well as the increase in the use of illegal drugs, there has been a huge expansion of treatment models and options (Kirsch and Bohnenblust, 1990). "The choice of one specific intervention in preference



to another one is usually guided by common sense, intuition, wisdom gleaned from experience, ideology and, to a lesser extent, evidence” (Davioli et al, 2000:1473). The criteria of the success of treatment will differ depending on treatment goals and the needs of the users themselves. The goal may be abstinence from the use of a particular drug or drugs. Some people chose to continue their drug use. The goal then be may be controlled or non-problematic use. Part of the philosophy of harm reduction (discussed below) is to provide services which will allow them to do this as safely as possible.

Treatment often requires a range of interventions and services to address a multitude of other problems. People who present for treatment for their alcohol or other drug use with illnesses other than those directly related to drug use *per se* are said to have a dual diagnosis. More correctly, this is known as “co-morbidity.” This has been defined as the co-occurrence of one or more diseases or disorders in an individual (Teeson and Burns, 2001).

Service providers, need, therefore, to be trained to address not only treatment of problematic drug use itself, but a range of other problems. These may be problems that precipitated problematic drug use (Fletcher and Battjes, 1999). People may also present with concurrent problems, particularly mental health problems, or with other health problems unrelated to drug use itself. The co-occurrence of mental disorders and substance use disorders is common and often associated with poor treatment outcomes, severe illness, and high service use (Teeson and Proudfoot, 2003).

Not surprisingly, given the complexity of problems people may be experiencing, relapse is common and needs to be planned for. Clients often undergo multiple treatments, as well as a broad range of different types of treatment, during their drinking or drug-taking careers. This is seen by some as “a revolving door syndrome.” Others view alcohol and other drug dependence differently. They see it as a chronic relapsing disorder that requires lifelong treatment and vigilance. There is scant evidence of the effectiveness of forms of treatment other than methadone maintenance (discussed below) (Wodak, 2001).

The above comments notwithstanding, longitudinal studies of treatment for illicit drug use have found that treatment is beneficial for individuals, their families, and for society in general (Fletcher and Battjes, 1999; Gossop et al, 2002). Part of the Drug Abuse

Treatment Outcomes study in the United States of America examined treatment outcomes of illegal drug users who had either long term residential treatment, short term in-patient treatment, methadone maintenance or outpatient drug-free treatment. With few exceptions, there were reductions in the use of illegal drugs for all treatment modalities (Hser et al, 1998; Hubbard et al, 2003).

### **Special treatment needs of Aboriginal and Torres Strait Islander illegal drug users**

Because of the need to address relative disadvantages, resources required for treating Aboriginal and Torres Strait Islander people who use illegal drugs can be greater than for other clients (Jonas, 2002). Service providers in Aboriginal organisations are aware that programs designed to deal with people with drug problems must address a range of other issues including “a pride in ... identity” (Western Australian Network of Alcohol and other drug Agencies, 2001:1).

As detailed in Chapter 1, there are specific and profound issues for Aboriginal and Torres Strait Islander people such as “Dispossession from language, culture and land” (Commonwealth Department of Health and Aged Care, 1999:15). This is how one of the people we interviewed put it. His polydrug use included amphetamine and heroin, which at the time of interview he was trying to control. When we asked him how he was doing this he alluded to complex issues to do with colonisation:

*It's about finding your spirit ya' know. Because a lot of people, especially Indigenous people, got no spirit, got no drive. A lot of things happened a long time ago ya' know, there's not much being done now.*

Another man who was working towards stopping his marijuana use enhanced the non-Aboriginal interviewer's understanding of the special needs of Aboriginal and Torres Strait Islander people who use illegal drugs when he said:

*Koories have to mix with Koories and like in a drug rehabilitation centre. I believe it should be set up like Indigenous rehabilitation because on the grounds that we have a far wider special need for more assistance than what actually is there. Because as I can see it these rehabilitation centres are sheep stations, they are not discriminate on colour or anything, if you are a Chinese man they will take you in, whatever, they will take you in, but there is no individualism, ya' know. And with the Koorie people we need a lot more individual [treatment] the fact that we are dealing with these problems. Personally I believe that the only way to get a rehabilitation for the Aboriginal people is to set it up under an Aboriginal organisation. Because ... we know how to care for our own, where the government is still trying, and they can't.*

In Chapter 8, we return to this theme of added complexities involved with treating drug use in Aboriginal and Torres Strait Islander people when we present some qualitative data from people who shared with us some of the difficulties of their lives: difficulties which are intertwined with the effects of colonisation.

### **A short history of alcohol and other drug treatment services for Aboriginal and Torres Strait Islander peoples**

Australia's first Aboriginal service for treatment of alcohol dependency dates back to the early 1970s when Val Bryant founded, and personally funded, Bennelong's Haven in NSW. Over the next decade, small scale residential rehabilitation services emerged run by Community controlled groups. Later, government funding was provided for treatment of people with alcohol dependence (Commonwealth Department of Health and Aged Care, 1999).

### **Current drug treatment services for Aboriginal and Torres Strait Islander peoples**

Gray and colleagues report that, for the 1999 to 2000 financial year, there were 277 alcohol or other drug "intervention projects" conducted by, or, for Indigenous Australians. They give as examples of "intervention projects" treatment, prevention, acute intervention - such as night patrol, support referral, staff and program development, and sobering up shelters (Gray et al, 2002:21). Around 87 per cent (n=226) were conducted by Aboriginal Community Controlled organisations (Gray et al, 2002).

During the 1999 to 2000 financial year, \$35 429 530 was directly expended in alcohol and other drug intervention projects for Aboriginal people (Gray et al, 2002). Looking at treatment from purely an economic viewpoint, several researchers have demonstrated that due to savings from averted crimes, as well as savings associated with reductions in drug-related adverse health problems (such as bloodborne viruses), treatment is cost effective (Fletcher and Battjes, 1999, citing several sources).

The Office of Aboriginal and Torres Strait Islander Health administers the Aboriginal and Torres Strait Islander Health Substance Misuse Program. From 1988 to 2000 this program provided \$18.4 million towards the operation of 69 Community-controlled health and substance misuse services nationally. These services are located across urban, rural and remote locations. They deliver education and prevention programs, early intervention strategies, as well as treatment and rehabilitation within non-custodial settings. Some Community-Controlled health services funded by the Office of Aboriginal and Torres Strait Islander Health also provide substance misuse services as part of their overall service (House of Representatives Standing Committee on Family and Community Affairs, 2001).

The report from the 2001-2002 National Minimum data set (which does not include data from Aboriginal Medical Services) showed similar patterns for the type of main treatment received by Indigenous and non-Indigenous people. Compared with their non-Indigenous counterparts, however, Indigenous clients had higher proportions of treatment services for counselling (43.3% versus 38.1%) and lower proportions for withdrawal management (15.8% versus 20.0%) (Australian Institute of Health and Welfare, 2003).

### **Specific treatment services for Aboriginal and Torres Strait Islander illegal drug users**

As we documented in Chapter 1, there is plenty of evidence pointing to an increase in illegal drug use by Aboriginal and Torres Strait Islander peoples. We also demonstrated that many surveys have shown disproportionate use of illegal drugs by Aboriginal peoples. Treatment services have generally not adapted to this increase. The National Aboriginal Community Controlled Health Organisation maintains that “It is widely accepted that programs and services offered through ‘mainstream’ service providers are

difficult to access and are often not culturally sensitive to the needs of Aboriginal and Torres Strait Islander peoples” (NACCHO [National Aboriginal Community Controlled Health Organisation], 2003b:598). The Central Australian Aboriginal Congress holds a similar view:

*the problem of substance misuse can only be effectively addressed in the long term by the Aboriginal community controlled organizations ... taking responsibility for tackling the health, welfare and justice problems that our people face. We therefore hold that government have a duty to support our people and our organization in setting up programs to address the problem.*

(Central Australian Aboriginal Congress Inc, 2001:1)

Aboriginal and Torres Strait Islander people are said to have a poor record of attendance in mainstream alcohol and drug treatment (Davis, 1998; Jonas, 2002:73). Meyerhoff’s review of the relevant literature on injecting drug use in Indigenous Communities led him to conclude that fears around confidentiality, as well as shame, can be major reasons why injecting drug users may not access either mainstream or local Community health services (Meyerhoff, 2000).

Recent research has identified a lack of appropriate detoxification and rehabilitation facilities for Aboriginal injecting drug users. This is particularly true for young injecting drug users, and for those living in rural and remote areas, who are hesitant to seek treatment if it means they will have to be away from family and country (Health Infonet, 2003). Gray and colleagues report that a majority of 51.6 per cent (n=143) of “intervention projects” for Aboriginal and Torres Strait Islander people target alcohol alone. The 73 projects identified as alcohol or other drugs focused “mainly on interventions for alcohol-related problems and on other drugs as needed” (Gray et al, 2002).

The study by Larson and colleagues identified that only 26 per cent of the 77 Aboriginal injecting drug users they interviewed in Queensland had used a service for a drug-related problem. At the time of interview, just three were still attending (Larson et al, 1999).

In a report on drug treatment services for Aboriginal and Torres Strait Islander people, Brady noted the increase in opioid use as the principal drug problem for those receiving services. She also noted that residential programs need to be informed and competent in

order to respond to these changes (Brady, 2002a). After reviewing previous research (such as Perkins, 1994; Gray et al, 1997; Alati, 1999), Alati and colleagues conclude that the development of a “drug” scene amongst Indigenous youth in urban and rural centres has “highlighted further inadequacies in drug treatment with Narcotics Anonymous as the only intervention offered in many Indigenous agencies” (Alati, 2000:56).

A survey in Victoria of current and past Aboriginal injecting drug users found high levels of dissatisfaction with mainstream services (Lehman [Clarke] and Frances, 1998). As we show in the following chapter some of the people we interviewed had preferences for mixed Aboriginal and non-Aboriginal services. A majority, however, wanted detoxification and rehabilitation services run by an Aboriginal organisation. Currently, Aboriginal people in the ACT and region who want this type of service, just like their counterparts in rural and remote areas, have to move away from their family and country for their preferred type of treatment.

### **Treatment histories of the people we interviewed**

We begin each of the subsections below, where we report respondents’ experiences with drug treatment services, with a brief overview of each type of treatment modality. Whilst the question of what is meant by treatment has become controversial since the introduction of needle and syringe programs (Power, R. 1996, September 9, pers comm), we include below respondents’ contacts with needle and syringe programs, as well as with peer-based organisations.

Just a few of the people we interviewed were currently in any form of treatment. Because we do not want to identify these people, we have combined ever and current treatment histories of the sample. In addition, we thought it invidious to name particular mainstream treatment agencies in a local report of this nature. We were also concerned that mentioning the names of agencies, whether mainstream services or interstate Aboriginal rehabilitation services, might identify individuals. Because Winnunga is the major service provider for Aboriginal and Torres Strait Islander people in the ACT and Region, we did not have fears about issues related to confidentiality when naming this service. Winnunga is also one of the collaborating organisations for this research. We

have, therefore, identified Winnunga by name in the few instances where we report mention of it.

As a consequence of these considerations, we have included type of treatment under broad subject headings. We have also combined types of treatment received in the ACT and received elsewhere. With the exceptions of Alcoholics Anonymous, Narcotics Anonymous and pharmacotherapies (where we recorded only drugs used for treatment of opioid dependence) our data collection did not distinguish between treatment for alcohol and treatment for other drug use.

Some of the services provided treatment other than those related to alcohol and other drug use (for example, mainstream general practitioners). Apart from contacts with Aboriginal Medical Services, we report only contacts related to respondents' drug use.

#### *Treatment of problematic alcohol and other drug use offered by Aboriginal Community Controlled Health Organisations*

The National Aboriginal Community Controlled Health Organisation describes the way Aboriginal Community Controlled Health Organisation treat problematic alcohol and other drug use by Aboriginal people in the following manner:

*The problem of substance misuse has its origin (and consequently its solution) in historical, social and economic factors. The Aboriginal community response to substances misuse has therefore been holistic and intersectoral and does not just comprise the delivery of pharmacological or counselling treatment. Aboriginal and Torres Strait Islander Community Controlled Health Services ... offer a range of substance misuse programs. Despite the breadth and variety of such programs, their common and distinguishing feature is that they are bottom up rather than top down—they are community initiated, owned, and driven responses to substances misuse problems.*

(NACCHO [National Aboriginal Community Controlled Health Organisation], 2003b:594)

The Western Australian Network of Alcohol and other Drug Agencies also highlight the holistic care provided by Aboriginal organisations when they point out that Aboriginal organisations dealing with clients with drug and alcohol problems must also help deal with other needs services such as “stable accommodation and home environments”

(Western Australian Network of Alcohol and other Drug Agencies, 2001:1). In Chapter 9 we report some findings in these domains.

*Respondents' out-patient experiences with Aboriginal Community Controlled Health Organisations*

Seventy one per cent of people we interviewed (n=67) had accessed an out-patient Aboriginal Community Controlled Health Organisation for services directly related to their drug use. This treatment included medical care, nursing care, and counselling from Aboriginal Health Workers. The complexity of treatment definitions is apparent in the fact that some services offered by Aboriginal Medical Services (for example, counselling, pharmacotherapies [such as methadone] and out-patient withdrawal) overlap with some specific services described below. Whilst a minority of respondents had obtained treatment from either an Aboriginal organisation[s] or a mainstream organisation[s], the majority had accessed both.

Because Aboriginal Medical Services offer holistic treatment, we decided to look at all the relevant data to find out what proportion of the sample accessed an Aboriginal Medical Service for any reason. In addition to the data we collected for drug and alcohol treatment, we added any from people who, for example, had picked up an interview recruitment flyer from an Aboriginal Medical Service, thus indicating contact with the service. We also added data we had about contact with Aboriginal Medical Services for physical health and social and emotional well being. The aggregation revealed that 86 per cent (n= 82) of the sample had accessed Aboriginal Medical Services. This may be an under estimation since the data collection on contact with Aboriginal Medical Services for problems other than those due to drug use was restricted to the 12 months prior to interview.

We did not ask questions about how people felt about their experiences of out-patient Aboriginal Medical Services. None-the-less, 29 people did make additional comments about these services. With five exceptions, they were all positive. Just one person said they were concerned with issues to do with confidentiality and would not seek help from any service, whether it was mainstream or Aboriginal. Two people felt they had not got enough help from Aboriginal Medical Services. Two people had ambivalent feelings about Winnunga. One of these people said that the service was "Good"



because there was “A relaxed atmosphere and I know everybody.” She also said that one staff member had once been “funny” about her about drug use. The other person was generally positive. They “Felt part of the culture at Winnunga ... Through Winnunga Health I am still breathing mate, hey.” At another point in the interview this person indicated, however, that they were not getting the help they needed from some aspects of the service.

We will turn now to get a flavour of the overall majority of 24 positive comments about Aboriginal out-patient services. For another man, Winnunga was also beneficial for medical and cultural reasons: “Winnunga is trying to learn us about our culture.” Another respondent focused on the medical help she received from Winnunga: “Winnunga is the best medical service in Australia and I’ve been to a lot of medical services.” She later added “[I feel no need to try other treatment services] because I get plenty of help from Winnunga.”

Another respondent said he went to Winnunga because he wanted “support from people I know.” In the presence of one of the Winnunga researchers, he laughingly added “[I come to] annoy people at Winnunga.” One woman said “It’s better to go to your [Aboriginal] treatment services. I go to Winnunga now, I wouldn’t go anywhere else now.” A young woman said she came to Winnunga for treatment because “They had the resources.”

Talking about a different Aboriginal Medical Service another respondent said:

*I go down to [service] where [Aboriginal Health Worker] is and you have a talk to them ... I started to get together with Uncle [Aboriginal Health Worker], he goes, ‘What are ya’ doin’? [I say] Just come in, ya’ know, come into [service] for a coupla’ hours a day just to keep us off the street and that.’*

Unless otherwise stipulated the services we discuss below are mainstream organisations (rather than Aboriginal organisations).

### *Harm reduction*

Following reports of what is now known as HIV/AIDS amongst injecting drug users in other Western countries, Australia was quick to take measures to help prevent its spread among injecting drug users in this country (Rumbold and Hamilton, 1998). There were

also fears that HIV/AIDS could spread into the general community (Wellbourne-Wood, 1999).

The principle of harm minimisation has formed the basis for Australia's drug strategies since the inception of the (then) National Campaign Against Drug Abuse (now National Drug Strategy) in 1985 (Ministerial Council on Drug Strategy, 2004). Harm minimisation is a three pronged approach defined by the Ministerial Council on Drug Strategy as "policies and programs designed to prevent and reduce harm associated with both licit and illicit drugs and encompasses:

- Supply reduction strategies to disrupt the production and supply of illicit drugs and the control and regulation of licit substances;
- Demand reduction strategies to prevent the uptake of harmful drug use, including abstinence orientated strategies to reduce drug use; and
- Harm reduction strategies to reduce drug related harm to individuals and communities."

(Ministerial Council on Drug Strategy, 2004)

Some people use the term harm minimisation interchangeably with harm reduction. As indicated above, strictly speaking, harm reduction strategies are aimed at reducing drug-related harm to individuals and communities and is one part of a three pronged approach of harm minimisation. In the context of treatment, harm reduction aims to reduce the social and health-related harms associated with drug use, by stabilising its use. In such an approach, controlled or non-problematic alcohol and other drug use may be the goal (Trinder and Keene, 1997).

In response to the accelerating problems associated with use of alcohol and illegal drugs the harm reduction philosophy has been accepted by some sectors of the Aboriginal Community (Alati et al, 2000). Ted Wilkes is a Nyungar man who has been involved in Aboriginal affairs all his working life. A recognised Aboriginal leader and activist, he describes himself as "a social scientist with a focus on the social determinants of Aboriginal health ... [he chaired] the Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2006 which was released in mid-2003, as part of the

National Drug Strategy” (Moss, 2004:3). With reference to alcohol in particular, Ted Wilkes is reported as saying that:

*we are not excluding abstinence as a proper way for some Aboriginal communities or some people to go [but it] was just one avenue. Harm minimisation involves more avenues than abstinence ...*

(Moss, 2004:4)

The harm reduction approach continues, however, to be heavily criticised, by both Aboriginal and non-Aboriginal people. In the context of Aboriginal commentators, Brady puts it like this: “Among many Indigenous people ... including Noel Pearson, harm reduction is still disavowed: it is perceived as a soft option that tolerates drug use and unrestrained drinking” (Brady, 2002a:151). As Brady pointed out, the “most publicised” Aboriginal commentator in the context of criticism of harm reduction is Noel Pearson (Brady, 2002a:147). Noel Pearson believes that “If we let the progressivists and the libertarians win now and make harm minimisation the main social response to substance abuse, the change into a drug society would be irreversible” (Pearson, 2001:6). He goes on to maintain that there

*must be enforced treatment, because we need a cure for the current epidemic. The absolute intolerance of illicit drugs, absolute enforcement of social order, and mandatory treatment is the core of the strategy. In order to cure an epidemic there must be involuntary, mandatory and human treatment of people who are engaged in abuse. Everything that the addicts encounter must be designed to force them into that treatment.*

(Pearson, 2001:6)

### *Needle and Syringe Services*

The provision of clean injecting equipment to people who inject drugs has been part of Australia’s harm reduction strategies since 1987 (Feachem, 1995). Several reports point to the fact that this has proven to be cost effective since they decrease rates of risky needle use, leading to a lower incidence of HIV amongst injecting drug users than found in locations where there are no needle and syringe programs (for example, Hurley, 1997; Commonwealth Department of Health and Aging; MacDonald, 2003). There is an alarming prevalence of hepatitis C in injecting drug users: over 160 000 cases were reported to state and territory surveillance systems by the end of 2000. Around 80 per cent were in injecting drug users (Australian National Council on AIDS Hepatitis C and

Related Diseases Hepatitis C sub-committee, 2002). In Chapter 7, we discuss the prevalence of hepatitis C among the people we interviewed.

All Australian states and territories have fixed needle and syringe sites and pharmacy programs (Thein et al, 2003). Free injecting equipment is available from peer-based organisations and some mainstream services. In these types of services, whilst not mandatory, there is an emphasis on needle exchange whereby clients are encouraged to return their used equipment so that it can be safely disposed. There is also commercial sale of needles and syringes by pharmacies where exchange, or the return of used equipment is not required. In some jurisdictions there are also needle syringe vending machines (Thein et al, 2003).

One of the first Australian Needle and Syringe Programs was established in Sydney during the 1980s at the Redfern Aboriginal Medical Service (Shaw et al, 2001). In 1992 the Nunkuwarrin Yunti Aboriginal Community controlled health service in Adelaide also set up a needle and syringe program. According to Gray and colleagues, in 1999-2000 there were six needle exchanges specifically for Indigenous people. There is also an unknown number of Indigenous health services which provide injecting equipment (Gray et al, 2002).

Edwards and colleagues found that members of the Victorian Community they consulted were often nervous about harm reduction as an approach to substance use, particularly in relation to needle and syringe programs. As they note, however, Community attitudes are changing and some Elders now recognise that access to needle and syringe programs reduces the rate of HIV infection and leads to safer disposal of injecting equipment (Edwards et al, circa 2000).

The National Aboriginal Community Controlled Health Organisation notes that “Access to appropriate services that distribute needles and syringes is seemingly one of the biggest barriers to Aboriginal and Torres Strait Islander people using safe injecting techniques” (NACCHO [National Aboriginal Community Controlled Health Organisation], 2003b:594). Gray and colleagues found that the majority of Aboriginal injecting drug users they interviewed in Western Australia obtained their needles and syringes from pharmacies (Gray et al, 2001). Similarly, the Brisbane study by Larson and colleagues revealed that the usual source for sterile injecting equipment for the

majority of Aboriginal injecting drug users they interviewed was a pharmacy (Larson et al, 1999). Holly and Shoobridge report that injecting equipment was usually obtained from pharmacies and needle and syringe programs (Holly and Shoobridge, 2002).

The provision of sterile injecting equipment by pharmacies is to be applauded. But, as the National Aboriginal Community Controlled Health Organisation points out, use of pharmacies limits injecting drug users' access to information on safe injecting (NACCHO [National Aboriginal Community Controlled Health Organisation], 2003b). In their study comparing injecting behaviours of Australian injecting drug users at needle and syringe programs and pharmacies, Thein and colleagues found that in the month prior to interview, respondents from pharmacies were more likely than respondents using needle and syringe programs to report sharing of injecting equipment other than needles and syringes (such as alcohol swabs or spoons [used for mixing drugs] and filters [used for filtering a drug as it is drawn up into the syringe]). This finding led them to conclude that there was a need for pharmacies to provide education to injecting drug users about the dangers of sharing these sorts of injecting paraphernalia (Thein et al, 2003).

To these comments we add that whilst some needle and syringe programs charge for some injecting paraphernalia, such as sterile water, they supply free needle and syringes whilst pharmacies do not. In addition, needle and syringe programs provide safe and easy disposal of used equipment.

### *Respondents' use of needle and syringe services*

Aggregating the numbers of people who had used particular needle and syringe services (whether sometimes, often or always) reveals that, during the 12 months prior to interview, the biggest number of injecting drug users we interviewed (7 missing values from the 54 current injecting drug users) obtained their needles and syringes from a mainstream out-patient drug and alcohol treatment service (n=35, 74%) (Table 5.1). The next most popular place was a pharmacy (n=25, 53%). Thirteen people (28%) had accessed a peer-based service for their injecting equipment. Seventeen people had obtained their injecting paraphernalia from their friends. No-one reported obtaining needles and syringes from an Aboriginal Medical Service.

Overall, these results demonstrate that most injecting drug users we interviewed were accessing mainstream services and/or peer-based organisations for their injecting equipment. These are agencies which also provide services such as education about safer use of drugs and referral, and which also provide safe disposal of injecting equipment. Two people always obtained injecting equipment from their friends. Just one person always bought them from a pharmacy.

**Table 5.1: Use of needle and syringe services during the 12 months prior to interview**

Needle and Syringe Service	Some-times		Often		Always		Never		Total <sup>a</sup>	
	n	%	n	%	n	%	n	%	n	%
Mainstream out-patient drug and alcohol treatment services	12	26	14	30	7	15	14	30	47	-
Pharmacies	19	40	5	11	1	2	22	47	47	-
Peer-based organisations	9	19	4	9	0	0	34	72	47	-
Friends	11	23	3	6	2	4	31	66	47	-

<sup>a</sup> There are 7 missing values. The percentage columns are left blank since rounding of the percentages meant that totals did not equal 100.

We also asked injecting drug users if they had experienced any problems in obtaining clean injecting equipment in the 12 months prior to interview. Thirty one people said they never had problems, 13 people said they sometimes had problems, two people said they often had problems and just one person, who was from interstate, said they always had problems.

We did not collect any qualitative data on respondents' experiences of needle and syringe programs. In Chapter 7 we report other findings related to injecting behaviours.

### *Peer-based services*

Services targeted specifically towards injecting drug users, such as needle and syringe programs and peer support and education, are part of harm reduction strategies. In 1984, the Australian Government instituted the National AIDS Task Force. This evolved into the Australian National Council on AIDS (Feachem, 1995). The first National AIDS Strategy was developed in 1989 and its community based programs

facilitated the formation of peer-based drug user groups (Crofts and Herkt, 1995). Peer based organisations provide, for example, education, advocacy, referral and needle and syringe exchange. Some organisations also provide these services on an outreach basis.

In 1988, a national umbrella user organisation, the Australian IV League (now known as the Australian Injecting and Illicit Drug Users' League) had its first meeting (Crofts and Herkt, 1995). Several other researchers have remarked upon the importance of continuing with peer education to disseminate harm reduction strategies (for example, Power, 1994). Australian peer-based organisations have been especially recognised: “They have been a key element in Australian [harm reduction] efforts” (Friedman and Ward, 1993). In recognition of this vital role, the Australian IV League was awarded the national Rolleston award at the 1996 *7th International Conference on the Reduction of Drug Related Harm*, in Hobart. There are now peer-based drug user organisations or networks in all Australian States and Territories (Byrne J. 2004, pers comm, 5<sup>th</sup> May).

#### *Respondents' contact with peer-based services*

Twenty five people had ever used a peer-based service for services other than, or in addition to, needle and syringe exchange. These services included peer-based education, referral and/or counselling. Sometimes people had used these services as a “drop in” centre where they could be comfortable and relax with other injecting drug users.

Since everyone who had accessed this type of service was an injecting drug user, we worked out the proportion of people who had visited this service based on the 61 people who had ever injected drugs. We found that 41 per cent of those who had ever injected had accessed a peer-based service for services other than needle and syringe exchange (findings on needle and syringe services are reported below). We did not collect any qualitative data on respondents' experiences of peer-based services.

## *Pharmacotherapies*

Pharmacotherapy involves the use of prescribed medication to assist recovery from drug dependence. As we mention below in our discussion of withdrawal services, some people undergo medicated withdrawal where they may be offered a range of prescription drugs to assist them with withdrawal. Pharmacotherapies may also be used as part of a maintenance program. Those used for opioid dependence by the people we interviewed as part of a maintenance program are listed below (for other examples see Alcohol and other Drugs Council of Australia, 2003).

### *Methadone*

Methadone is a synthetic opioid which was developed as an analgesic in Germany in 1941. It was first used as a treatment for heroin dependency in the United States of America in 1964 (Dole, 1966). It was subsequently introduced to Australia for the same purpose in 1969 (National Drug Strategy, 1997). Its use as a substitute opioid “provided a legal and controlled supply of an orally administered drug which had to be taken only once a day because its long duration of action eliminated opiate withdrawal symptoms for 24 to 36 hours (Ward et al, 1994:2).

Soon after the first cases of HIV amongst injecting drug users were reported in New York, there was recognition of how vast the personal, epidemiological, economic and social costs were going to be (Drucker, 1986). Concerns about preventing an epidemic of HIV (such as the one that had occurred in New York) were often expressed when responses to the threat of HIV amongst Australian injecting drug users were being developed (Wodak, 1995). These concerns were accompanied by concerns about the rise in other illnesses, crime and death associated with injecting drug use.

In 1985, the (then) National Campaign Against Drug Abuse (now National Drug Strategy) endorsed methadone maintenance as an “appropriate and useful method” of treatment for heroin dependence (National Drug Strategy, 1997:4). During the interim, there has been a growth in the number of individuals receiving methadone treatment in most Australian jurisdictions.<sup>19</sup> Methadone is currently “the benchmark” for treating

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<sup>19</sup> The Northern Territory is an exception to this since methadone can only be prescribed there “in special



heroin dependence in Australia (Alcohol and other Drugs Council of Australia, 2003). It may be dispensed to registered drug users at government clinics, or through community pharmacies.

Methadone maintenance is one of the most thoroughly investigated treatment for heroin dependence and has been found to be cost-effective (Wodak, 2001). Following an extensive review of the international literature from both randomised controlled trials and observational studies, Ward and colleagues found that methadone maintenance is an effective harm minimisation strategy (Ward et al, 1994). Methadone treatment has a positive impact on physical, social and emotional well-being. The positive outcomes include reductions in heroin use, crime, injection-related risk behaviours, premature mortality from, for example, overdoses and the effects of bloodborne viruses (HIV or hepatitis B or C), reductions in crime, increased employment and increased education and employment opportunities (Ward et al, 1994; Darke, 1996; Hser et al, 1998; Wodak, 2001). As many as 85 per cent of people receiving methadone maintenance will stay on the program for 12 months (Wodak, 2001). For treatment to be effective it is essential that clients receive enough methadone to stop them experiencing the effects of withdrawal. According to Wodak, the morale of staff dispensing methadone is also important (Wodak, 2001).

Despite its advantages, methadone treatment is not a suitable treatment for all dependent opioid users (Wodak, 2001). This again reinforces the need for a range of treatment services to be available. Methadone treatment has been subjected to criticism, largely because it is seen as replacing one drug of dependence with another (Wodak, 2001). According to the Commonwealth Department of Health and Aged Care, Indigenous people requiring methadone treatment may encounter difficulties with some Community controlled services which object to programs seen as simply substituting one drug for another (Commonwealth Department of Health and Aged Care, 1999). In 1992, the first methadone maintenance program specifically for Indigenous injecting drug users was established by Nunkuwarnin in Adelaide (Health Infonet, 2003). Methadone prescriptions are available for treatment of opioid dependency via mainstream services and some Aboriginal Medical Services.

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circumstances following approval by the Chief Medical Officer, under strict guidelines approved by the Minister for Health Services” (National Drug Strategy, 1997:4).

### *Buprenorphine*

The other form of pharmacotherapy maintenance mentioned by the people we interviewed was buprenorphine. It is taken orally and is one of the newer pharmacotherapies aimed at blocking the effects of heroin use. It is a partial opioid agonist recently registered for use in Australia for treatment of opioid dependence, as well as for detoxification treatment (Alcohol and other Drugs Council of Australia, 2003). It has been used extensively in France and evaluations show it to be generally comparable to methadone maintenance (Wodak, 2001).

### *Respondents' experiences of pharmacotherapies*

We worked out the percentages of people who had experience with pharmacotherapies for opioid use based on the number of people who had ever used opioids (n=74). This revealed that 41 per cent (n=30) of this subsample said they had ever been prescribed methadone and/or buprenorphine.

A majority of 87 per cent (n=26) of this subsample of the 30 people who had been treated with a pharmacotherapy had received methadone (35% of the opioid users). Most people who provided additional comments about methadone had mixed feelings about it. For example, the man we quote below believed that it was good because:

*It stopped me from hangin.<sup>20</sup> I didn't have to steal, I wasn't sick [but it was bad] because you wouldn't get stoned. They wouldn't put you up [increase the methadone dose] so you got two habits [inferring that he was still using heroin whilst on methadone].*

Another man who also had mixed feelings about methadone said it “helped me break up me habit a bit. And then I just got sick of it, gettin’ up and goin’ over to get it.” Another man had had not enjoyed methadone at all. He described it: “As like a chastity belt on a bloke, ya’ know.”

Some people, such as this woman (who was one of those who had completely stopped her heroin use since she was on it) had only good things to say about methadone:

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<sup>20</sup> Hanging out, that is, unpleasant opioid withdrawal symptoms.

*I was a mess. I refused to use it [heroin] again. I just refused. I said I've been out scrub I have gone that cold turkey<sup>21</sup> thing or whatever and this is the state I am in. And [health worker] came straight and got me and took me to the doctor's and got me on this program. As soon as I drunk that stuff in the cup [methadone] I felt so much better ... So this is my hope at it the end of the rainbow where I can say to the family that I am now off it. Say like, 'Yehhh.'*

A teenager, who had stopped her heroin use for some time, was also very positive about methadone:

*Basically, it's prescribed by a doctor, you are watched over by people every day, you get it every day so you get the same dose every day. You are not gettin' different doses or gettin' sick off it ... it's in a controlled area. Basically nothin' can happen to you while you're gettin' it.*

As part of the winding down we did for the interview, we asked people to tell us what they would like to be the same and what they would like to be different in twelve months' time. A young woman, who was going to try to re-enter the methadone program, said "I would like nothing the same. I would like to stop using and methadone would help achieve that."

Seven people said methadone had helped them stop using heroin. On of these people expressed, it simply, but powerfully: "It saved me life."

### *Buprenorphine*

Only small numbers of people reported use of buprenorphine. For reasons of confidentiality, we synthesise their comments by simply reporting that they had all had only positive things to say about it.

### *Views on methadone*

At the request of Community members, as well as at the suggestion of one of the respondents, we added questions about respondents' views about methadone. We asked this only of people who were currently using opioids and who had not experienced methadone treatment (views of people who had been treated with methadone are reported above). Thirty of these people offered their views on methadone. Most

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<sup>21</sup> "Cold turkey" is defined Chapter 4.

comments were negative. One young woman summed up many of these negative opinions with these words:

*Like I know what methadone is all about. It's just like morph' [morphine] tablets, it's just a substitute for heroin anyway except you don't get smashed like you do on the proper stuff, heroin. Methadone, I wouldn't touch that, I'd never touch that. They tried to get me on it but I won't touch it 'cos' it just rots your teeth. That's why a lot of people have got ugly teeth and that.*

Another man made similar comments:

*Yeah, I have heard, I have seen it and seen what it does to people. It's a worse drug than heroin or any drug on the street, because if you are goin' to get off any drugs ... it's got to be a stronger drug than the drug you are just jumpin' off. So I reckon methadone should be fucken banned.*

A young woman had tried other pharmacotherapies, which she found helpful. She said she would not try methadone because: I've seen some friends in so much pain, 'cos' they reckon that it soaks into your bones and I knew this guy, after two months, still hanging out, I don't want that."

Other peoples' negative comments were along the lines that "it's more addictive" than heroin. Two people criticised it as being a "white man's drug." Two people disparagingly referred to methadone as "Hitler's drug." (methadone is frequently referred to in this way because it was developed in Germany during the second World War).

A young man had tried to get on to the methadone program and admitted to a withdrawal service but had given up on both because of the waiting period. He had good things to say about methadone:

*Most of the people that I have heard that are on it, you know, are really having a go at staying off the heroin because it [heroin] just wrecks your life, you know, the way you live your life. And with the methadone, you know, like people I have heard say, it trashes you, you know, you get high and that like heroin and that. But that's not what it's about, you know what I mean. Methadone is about trying to, you know, help your addiction, as well by not using heroin and that so you don't get diseases, so you don't steal, and it helps you come down instead of just jumping straight off and gettin' real sick and that.*

Some people who are dependent on opioids are not suitable for methadone treatment or are unwilling to consider it as a form of treatment (Wodak, 2001). As we reported above, methadone has been shown to be a beneficial form of treatment for many people.

As we have also demonstrated, many people we interviewed who had experienced this form of treatment had very positive things to say about it. The negative views about methadone that we have reported above indicate a need for informing Aboriginal and Torres Strait Islander people who are dependent on opioids about the advantages of methadone treatment.

### *Alcoholics Anonymous*

Alcoholics Anonymous is an international self help network which supports people to be abstinent. This service (also known as one of the 12-step programs) may be delivered in a community setting. It is also often a part of treatment in residential rehabilitation settings. Alcoholics Anonymous is seen as a “helpful adjunct treatment or treatment aftercare measure for many individuals” (Alcohol and other Drugs Council of Australia, 2003:5).

Following the approach of many mainstream treatment agencies, services for Aboriginal and Torres Strait Islander peoples have predominantly adopted an Alcoholics Anonymous approach (Brady, 1995; Commonwealth Department of Health and Aged Care, 1999; Alati, 1999; Gray et al, 2000). Of the 79 treatment services for Indigenous clients identified by Gray and colleagues, the majority were based on Alcoholics Anonymous or abstinence principles (Gray et al, 2000). Noting that the self-help network may be valuable, the Commonwealth Department of Health and Aged Care points out that “despite its widespread use, there has been little evaluation of the appropriateness of [Alcoholics Anonymous] for Indigenous Communities nor of its longterm benefits” Commonwealth Department of Health and Aged Care, 1999:78).

### *Respondents' experiences with Alcoholics Anonymous*

Thirty four per cent (n=32) of the 93 people we interviewed who had ever consumed alcohol had attended Alcoholics Anonymous meetings. Generally, people had mixed feelings about their experiences of these meetings. This man summed up the good and bad things about it: “[It was good] learning, listening to others and how they escape that vicious circle, how they got out of it [but it was bad] when people rave on, just keep talking.” Another young man made a similar comment “I left, I wasn’t ready to listen, they just yamble [pretend] how they come across.”

Another man gave credit to Alcoholics Anonymous because he “gave up grog for two years through AA.” But he also had mixed feelings about the meetings. “Just a crutch [you don’t] need to tell everyone you’re an alcoholic every time you go to a meeting.” One woman said she went into Alcoholics Anonymous because “I had to ... my parents were humbugging me.” Although she said what was bad about it was “God and the 12 steps to sobriety”, she had learnt a lot about her drug use behaviours there:

*When I went into AA it [my alcohol use] was like systematic, I realised there was a pattern, like I just realised then there is a pattern in my marijuana smoking. I used to drink every Tuesdays and every Thursdays but I used to get paid Wednesdays see. So I used to go and get a beer from my mates on the Tuesdays and say I’d pay them back on the Thursday, because I used to have a hangover on Wednesday. See, and I’d have another drink on the Thursday. But I didn’t have drinks in between those. And that was my pattern, you know you get drunk because you’re broke at the end of the week and your sister girl has got a carton of beer and that will get you over to the next day, you know, encourage that waiting for money game.*

Some people had only been to one or two meetings such as a man who talked about his only Alcoholics Anonymous experience. He had attended with his partner

*Back in [the nineties, we] were drinking to blackout stage three or four times a week for maybe two or three months, and we realised that we’ve got to do something about it and AA is very well known. And we went there just for one meeting but I think because what ... well I can only speak for myself really, because in my heart I didn’t really want to give it away it was just an ambit sort of effort ... A token sort of thing. So we went there, and I think I went to the pub straight afterwards actually.*

A young man had this to say about his one-off experience of Alcoholics Anonymous:

*[The counsellor] instructed me that I should go into AA and like I just thought it was a complete waste of time because ... I was sittin’ in a room, like there was an American bloke running the alcohol and drug program, there was a Canadian woman, there was ... what was there? ... There was like Fijians, Tongans, Samoans, New Zealanders, Chinese, Japanese, Malaysians, and there was only one Aboriginal and Torres Strait Islander person there and that was me ... If there was a, say like AA meetings that was run by Aboriginal people, I’d be more than happy to go to and I reckon most people would go and do it as well.*

Whilst there is obviously some tongue in cheek exaggeration in this young man’s description of the multiculturalism of the Alcoholics Anonymous meeting he had attended, his point about the need for Aboriginal and Torres Strait Islander-specific meeting may be valid. It is one we return to in the following chapter.

Several other respondents, had, however, found Alcoholics Anonymous to be only beneficial. Five people said that Alcoholics Anonymous had helped them stop or control their drinking. One of these people said “It was interesting at first because I never experienced anything like it. Just hearin’ people’s stories, and relating to most of it. I enjoyed it. It was good.”

### *Narcotics Anonymous*

Narcotics Anonymous is a 12-step abstinence-based program which operates along the same lines as Alcoholics Anonymous. “Anyone who wants to stop using drugs may become a member of Narcotics Anonymous” (Narcotics Anonymous, 2003).

### *Respondents’ experiences of Narcotics Anonymous*

Whilst Narcotics Anonymous is “a service for those who feel they may have a problem with drugs, legal or illegal, including alcohol” (Narcotics Anonymous, 2003). the people we interviewed had used this service for opioid use. Of the 74 people in our sample who had ever used opioids, 30 per cent (n=22) had ever attended a Narcotics Anonymous meeting.

As with Alcoholics Anonymous, there were mixed feelings about this related service. Some people just did not enjoy the experience, such as this young woman who had been to just one Narcotics Anonymous meeting. She said: “Never again. I thought *I* had problems. It was goin’ round the circle and it come to me, and [I was asked], ‘Do you want to say anything?’ And I said, ‘No.’”

Another young woman, (who had tried most treatments for her drug use) said of Narcotics Anonymous that she did not like it “at all. I’m very touchy about talkin’, hey. I can only talk when I’m in situations like this [the interview] when I know it’s not goin’ anywhere. Like this is the first time I’ve spoken to anyone [about my drug use] for ages.”

For another man (who had stopped his use of heroin) Narcotics Anonymous had been good for him:

*I just liked it. You know I had a guy that sponsored me and he was a nice guy and I didn't mind gettin' up and sharin', you know what I mean. I guess it just depends on the individual ... But I didn't mind NA.*

Another man was still using a variety of drugs but, after not finding Alcoholics Anonymous or residential rehabilitation useful, had found Narcotics Anonymous helpful the times he had attended:

*I connected, not straight away because I felt y'know, I wasn't a drug addict either because I never stole from anybody or I never robbed or I never did any of that stuff so I didn't think that I was a drug addict. But then I went for a coupla' times and then realised ... well I am a drug addict but different, a different drug addict I suppose. But I found that NA helped me when it suited me from, yeah, when it didn't help me, it didn't. But it was good to know that there's other people out there goin' through what I've gone through. And that was the best thing about NA is that you're not alone. And that there is other people out there that do go through what you go through. ... I went to NA a fair bit but not a lot. I only went the nights that I had to go [as part of another treatment].*

### *Rehabilitation services*

Residential rehabilitation services provide 24 hour staffed community based residential treatment programs. Treatment periods may range from one month to 18 months. Many incorporate Alcoholics Anonymous routines. Residential rehabilitation programs are offered to those who have undergone a drug withdrawal program or other alcohol and drug treatment programs. It is particularly useful for those who have not been successful in reducing or overcoming their drug use problem and for those who are not suitable for an out-patient program (Victorian Government, 2004).

Many rehabilitation services are Therapeutic Communities. This type of service originated in California in 1958. Some Therapeutic Communities are based on the Alcoholics Anonymous routine. The first Therapeutic Community in Australia was WHOS (We Help Our Selves). This had its origins in 1974 in New South Wales (Gowing et al, 2002).

### *Respondents' experiences of rehabilitation services*

“At the tertiary level of prevention, treatment is usually understood by Aboriginal people to be residential treatment” (Brady et al, 1998:70. Twenty eight per cent of the sample (n=27) had ever been a resident of either an Aboriginal rehabilitation treatment



service and/or a mainstream rehabilitation service. All but one person defined which type of organisation had provided this service.

### *Respondents' experiences of Aboriginal rehabilitation services*

Twenty six of the Aboriginal and Torres Strait Islander Health Substance Misuse Program services funded by the Office of Aboriginal and Torres Strait Islander Health provide residential rehabilitation (House of Representatives Standing Committee on Family and Community Affairs, 2001).

Seventeen people we interviewed had been admitted to an Aboriginal residential rehabilitation service (65 per cent of those who had been admitted to a rehabilitation service and 18% of the sample). Two said that they had stopped use of some drugs because of the time they had spent in an Aboriginal rehabilitation service.

A few people made additional comments about the treatment. Most of these were positive. They are encompassed in the following extract from one respondent who, at the time of interview, was struggling with a relapse into heroin dependence and associated problems. He reminisced in detail about his experiences of an Aboriginal Rehabilitation Service. As we report in the following chapter, several people identified a need to be kept occupied whilst in residential treatment. This particular service had a good range of indoor and out door recreational activities:

*And they had pool tables and ping pong tables. There was even a swimming pool there. Every morning they'd get us up, you had to be outa' bed by seven [in the morning] and then you had to go for a three kilometre walk, they'd make us walk down, right down the road and up the road up to the corner and then come back ... After I'd been there about a month and half I started gettin' real healthy and had no heroin in me system or no Valiums, started joggin' and gettin' fit and that again. Started puttin' heaps of weight back on ... And they had two counsellors there to help you out if you needed somebody to talk to. Go and sit down and have a good yarn. ... Say how 'ya' goin', see how ya' feel, and 'are you feelin' depressed today', or 'how do you feel this week.'*

*Like, if I was goin' to go back to a rehab' that's where I'd want to go back to this rehab.' So it weren't like we were stuck in jail or anything like that. We could do what we wanted to do ... like I said it helped me to meet a lot of people with the same sorta' problems, I seen people with bigger problems than what I had. It makes you realise that life is not that bad, it's not worth takin' ya life for.*

In response to a question about whether anything was bad about this rehabilitation centre this young man replied: “No I don’t think there was really any bad things about it. Only sort of, the only downfall about it was like, you miss your family.” At the time of interview this man was concerned about complex family problems. All of which, he said, made it impossible for him to go interstate for further treatment.

Other people made brief comments about their experiences of Aboriginal Rehabilitation Services: “I liked it there, it was good for me”, or “It was good with other Koories”, “it was good to learn about culture.”

### *Respondents’ experiences of non-Aboriginal rehabilitation services*

Seventeen people (the same number of people - but not always necessarily the same people - who had experience of an Aboriginal rehabilitation service) had been admitted to a mainstream residential service. One of these people said: “The staff were excellent, they were cool people.” But, he added, “It was bad because it was too far away from my daughter.” This man had completed his treatment. When he presented for interview, however, he was, again heavily dependent on injectable heroin.

Another man explained why he had not completed his treatment:

*I come out of rehab’, because I was in jail in [place] and they sent me to rehab.’ And I was up there and one of the young blokes that was with me, me and him went to the [place] and we had a smoke, we smoked some pot. And this other bloke he was goin’ back to [place] for court, and he ended up goin’ down and gettin’ some heroin and having a shot, and he came back and had a shot on the premises, and then they all knew about it and they pulled him into the office and then he decided that he wasn’t goin’ down for that alone. So he dobbed me and me mate in for smokin’ pot as well. And I was a bit angry at that. And we ended up leaving at three am and jogging into town and stayed in town for a coupla’ nights drinkin’ and that. And then I left and come back to Canberra and I had some money on me and I run into an old mate of mine and I was just angry at the situation I was in and I just decided to have a shot.*

One of the older respondents, who was still using some non-injectable prescribed drugs, as well as occasional non-injecting illegal drugs, had these very positive things to say about his experiences of a non-Aboriginal rehabilitation service: “Well, I can sort of recommend it to anybody who wants to get clean [name of service] is a very good place for both alcoholics and drug addicts ... like, I was run down a heap, you know what I mean.”

A man who had completed a long treatment period in a mainstream rehabilitation service had been drug and alcohol free for many years afterwards. He had, however, since relapsed into using alcohol and other drugs. He had these things to say about the way a staff member had treated him when he was in residential treatment:

*The kindness I felt from [a staff member] The first time that I was ever asked, 'How do ya' feel mate?', ya' know. 'How are you feelin?' Ya' know.? [the staff member said] 'You're a good person, hey, don't get around with your lip down like that, hey. Give us a smile, ... you're a good bloke,' No one ever come at me like that before, and [it was] really ... from the heart ya' know. He was a good bloke this fella. Do anything for me, ya' know.*

Although he had not completed his treatment another man said it was “Good. Hearing about how to live, about life, your own being – learning about God.” But, again, emphasising the mixed feelings so many people had about any of their treatment experiences, he said it was “Bad because people who didn't want to learn were bringing others down.” Another man was critical of “the God thing” at his treatment service.

One woman who wanted to have Aboriginal staff for any future treatment told us of her difficult time in an interstate non-Aboriginal Rehabilitation centre. She wanted us to tell of her experiences in our report. Whilst she had found some aspects of the treatment “Good”, she went on to say:

*There was no Aboriginal staff, I stayed for a couple of months, they treated me like dirt, saying that we're nothing but a bunch of coons and drunks and of course I'll stand my ground, I don't like my people being degraded. The first time I went there, they put me into a room with three gentlemen and told me to take off all my clothes, and I said 'I'll do it, but when there is a female staff member.' My people are still suffering and treated like third class citizens. Aboriginal staff would have made it better for me and would have made me complete the treatment.*

Two people said they had stopped the use of some drugs due to their treatment in a mainstream rehabilitation service.

### *Halfway Houses*

Some rehabilitation services also offer “Halfway Houses.” These are bridges between residential based treatment, such as a hospital or rehabilitation stay, and the “normal” world to which the recovered person may return. It has been suggested that the concept of the Halfway House arose out of the Alcoholics Anonymous approach when it was

recognised that people recovering from alcohol dependency, and who were without social or economic support, were in need of a supportive environment (White, 2000). People in Halfway Houses may also receive out-patient counselling, and/or attend Alcoholics Anonymous meetings.

### *Respondents' experiences of Halfway Houses*

Three of the people we interviewed had spent some time in a Halfway House after they had finished their period in a rehabilitation service. One person, who, at the time of interview, had not used illegal drugs for some time, credited his time in rehabilitation, followed by a period in a half way house, with helping him to achieve this. Another man said that he had not finished his treatment because he “was asked to leave.” A man said of the time he had spent in a Halfway House “It was too strict. They played God.”

### *Withdrawal services*

Withdrawal (more commonly referred to as detoxification, usually shortened to “detox”) may be the first stage of a treatment process, but is also often operates separately from other treatments. The aim of in-patient withdrawal services is to provide a safe and comfortable environment while people undergo the effects of withdrawing from alcohol and other drugs (Wodak, 2001). Usually, in-patient treatment for alcohol and other drug withdrawal occurs in the same location. Management of withdrawal symptoms “can not be considered a treatment itself but it is often the first step for many forms of longer-term treatment” (Amato et al, 2004:219).

Some treatment for withdrawal relies on natural therapies. People who have a history of consuming large amounts of alcohol, or who already have a history of seizures, are at risk of alcohol withdrawal seizures. These people need to be admitted to an in-patient withdrawal unit since they require expert medical and nursing supervision and treatment. Treatment often involves the administration of prescribed medications, such as benzodiazepines, to prevent seizures and to alleviate symptoms of withdrawal.

People who have a history of heavy benzodiazepine use are also at risk from serious side effects of withdrawal. As in the case of people withdrawing from heavy alcohol

consumption, the chief serious side effect is seizures. Like heavy drinkers, these people require a medically supervised in-patient withdrawal.

Treatment of heroin dependency often begins with withdrawal followed by maintenance treatment (Wodak, 2001). While withdrawal from heroin (and other illicit drugs) is unpleasant, in the absence of a severe underlying disease it is less risky than withdrawal from alcohol or benzodiazepine use. If people who are dependent on opioids do not have an underlying illness they may be suitable for treatment by admission to withdrawal services offering natural remedies. Alternatively, clients may choose, or be recommended by practitioners, to undergo medicated withdrawal where they can be prescribed a variety of medications to alleviate the (often quite profound) discomfort of withdrawal. Opioid withdrawal symptoms include “joint pain, diarrhoea, abdominal cramps, muscle aches, hot and cold flushes, nausea and vomiting” (Novak et al, 1997). Medications that may assist with withdrawal symptoms include paracetamol for bone pain, loperamide to control diarrhoea and hyoscine to control abdominal cramps (Wodak, 2001).

Depending on other factors (see below), withdrawal may be on an in-patient or out-patient basis.

### *Respondents' experiences of in-patient withdrawal*

We collected data on respondents' experiences of withdrawal for alcohol and/or other drug use. Twenty six people (27%) had ever experienced either medicated in-patient withdrawal in the ACT and/or interstate. Some had experienced several episodes of this type of treatment. Several people had experience of both medicated withdrawal and withdrawal using natural therapies.

Many of those who had undergone withdrawal treatment had good things to say about their experiences. Five people credited withdrawal services for helping them stop or control their alcohol or other drug use. One man, for example, who had tried several different withdrawal services said “They were excellent. Yeah, I like detox.’ Detox’ is good.” A respondent who was trying very hard to control his drug use said of his experience in withdrawal: “Detox’ was good and gave me lots of information about my problem that you are never going to get unless you go into ... detox.” Another man

also had only positive things to say about a withdrawal service, not only because he had access to an Aboriginal Liaison Officer, but because:

*We all got up and had a talk about problems and that. Everybody was real supportive. Help ya' out talkin' and find out what's wrong. There was a lot of good friends that I made.*

Whilst some people did have contact with Aboriginal Health Workers during their time in in-patient withdrawal, others did not. Most would have liked this contact but others said that it was not important to them. One woman commented that, it did not “worry” her that she did not have contact with Aboriginal Health Workers “because there were like a coupla’ workers in there that knew a lot about our culture and that. It was alright in there.”

Some people who had tried withdrawal using natural therapies were happy with this type of withdrawal. Others, such as the man we quote below, preferred medicated withdrawal:

*[Natural therapy is] alright for some people who have got small habits, but people coming off big habits or methadone, they need medical, you know, whatever it may be, Valium or whatever they're goin' to bring them down on. Not herbal.*

One person who had undergone a non-medicated withdrawal dismissed it as “Just herbs.”

Whilst generally finding their experiences of in-patient withdrawal beneficial, some people were critical about aspects of their treatment and a few were completely negative. Some of these people said they had been the only Aboriginal person there which had made it difficult. One of these people said she had a sense of “Not belonging.”

We return to some of these major points in the following chapter when we report on the sorts of things people said they would like if they were to go into treatment.

#### *Home-based/out-patient withdrawal*

Home-based withdrawal may be provided for clients who can be appropriately managed without admission to a residential service. Usually, the clients are those whose

symptoms are mild to moderate. The service is provided by experienced nurses in conjunction with a medical practitioner (Commonwealth Department of Health and Aged Care, 1999). Home-based withdrawal may be provided through either mainstream or Aboriginal Medical Services.

### *Respondents' experiences of home-based/out-patient withdrawal*

Five people (5%) we interviewed had received home-based withdrawal service. For all five people, this was for withdrawal from opioids. Whilst home-based withdrawal works for some people, Gray and Siggers point to the fact that there may be “practical problems with home detoxification” (Gray and Siggers, 2003:176). One young woman said she had tried out-patient withdrawal interstate and for her:

*It wasn't very good because I was livin' in motels. I had to go like to the chemist to get me Valiums and all that. And I used to save 'em. Have a shot and then go up to the chemist and get them and get more whacked off me face. And then go home and have some sleeping pills and things like that.*

This story highlights the need for clients who are receiving home-based services to have a stable home environment, as well as the constant support of non-drug using family members or friends.

### *Counselling*

There are many types of treatment loosely referred to as “counselling” which aim to change people’s behaviour towards alcohol and other drugs. These treatments may be based on the learned behaviour model and include cognitive-behavioural therapy<sup>22</sup> and motivational interviewing.<sup>23</sup> These therapies are often provided as part of an in-patient

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<sup>22</sup> “Cognitive behavioural therapy refers to a broad range of therapeutic interventions and includes training in specific social skills and adaptive living skills, as well as cognitive interventions. This approach assumes that drug use is preceded by poor skills in coping and living and that improvements in such skills will lead to a reduction in the need for substance use” {Ritter, 1998 #678:254}.

<sup>23</sup> Motivational interviewing aims to “enhance the client’s motivation for changing their behaviours. The primary strategies are examination of the positive and negative consequences of drug (or alcohol) use and evaluation of the short- and long-term impact of the client’s substance-related behaviour. It is a rational, discursive process rather than an advice-giving process and is based on the understanding that motivation come from within. Ideally, it results in clients developing their own conclusions regarding the desirability of their substance-related behaviours” {Dietze, 1998 #679:279}.

program, where people are treated in hospital or in a rehabilitation unit. They are also often provided through out-patient services.

### *Respondents' experiences of mainstream counselling*

Twenty three people (24% of the sample) had tried mainstream counselling. Some people made additional comments about this treatment. For the majority, the treatment had been helpful. Five people said that counselling had helped them either by directly stopping or controlling their alcohol or other drug use, or had helped them deal with underlying issues. Most of those who had found it helpful said something along the lines of , “It helped’ or “It was good.” One man, said: “Bein’ able to talk to her. Because I could relate to [her]. It was good.” Whereas for another man “It was only helpful for the hour I was there.” A woman, who had tried several forms of treatment (and who was still struggling with amphetamine dependency) said about her experiences of counselling “It didn’t cut it either.”

One of the teenagers we interviewed said “I can’t stand talking to them people. They say the same shit to everyone. They’re not normal people.” Whilst a counsellor had helped this respondent in the past, at the time of interview he had ambivalent feelings about further treatment “It’s too hard to get there. I’m just not comfortable. I do want to go back to them. [But] I feel shameful, the stuff that’s happened.” When we encouraged him to seek treatment, and offered referral to various sources he refused saying “It’s no use opening a can of worms.”

### *General practitioners*

General practitioners are often involved in the treatment of alcohol and other drug use (Bennett and Wright, 1986; Robertson, 1989; Roche and Richards; Griffiths et al, 1994). We, therefore, asked the people we interviewed if they had seen general practitioners, other than those at an Aboriginal Medical Service, for treatment related to their drug use.



### *Respondents' contact with mainstream general practitioners for treatment for drug related problems*

Eighteen per cent of the sample (n=17) had ever seen a mainstream general practitioner for treatment related to their alcohol or other drug use. We did not ask for any qualitative data about these experiences.

### *Treatment in prison*

Some people had treatment for alcohol and drug problems while they were incarcerated, as well as in Aboriginal and/or mainstream services. Two men said they had only ever had treatment for drug use when they were in prison. One of these men said: “[There’s] more help in jail, they put you straight onto treatment. [On the outside] if you ask for help they tell you that it’s too full.” In the following chapter, we report other comments respondents made about the waiting period for residential treatment.

### *Support network*

One young man had spent some time in an interstate program which he called a “a support network” for people who use illegal drugs.

### *Reasons for no treatment*

We also asked those who had not tried particular sorts of treatments, or who were not currently in particular forms of treatment, if there were any reasons for this. (Those associated with opioid users’ negative views about methadone were reported above.) Other comments were related more to needs for treatment. These are reported in the following chapter. Below we document some other reasons given by the people we interviewed for not going in to treatment.

Fifty four people provided data about why they had not tried particular treatments. Some just said “No” when we asked them if they had thought about treatment and did not expand on their responses. Others amplified their reasons. Most were of the nature of: “I don’t believe in rehab”; “No treatment can help me; “I don’t want to go”; “I’ve never been really interested in it”; “I’ve been too lazy to go”; “I don’t need to go.” For one young man shame had stopped him from going for counselling, in particular “I

wouldn't see a counsellor, Aboriginal or white, because of the shame [associated with his drug use]." For four people, fears around confidentiality had stopped them from entering treatment. In relation to withdrawal services in particular, one woman said: "I don't know what's there, I don't know what's going to happen." For some parents, "being too busy with the kids" had stopped them. We informed these people of services where they could be admitted with their children.

Some people believed they did not require treatment. One was a woman who had tried several forms of treatment but was still very dependent on amphetamine. She was experiencing a lot of problems because of this but still believed "I can do that on me own mate." A few comments of this nature were tied in with culture such as one man's comment that: "I believe in my own ability to rebuild, spiritually, emotionally and socially." Another young man had tried some out-patient treatments but had never been an in-patient. The reasons he gave were related to services not being Aboriginal specific:

*Yeah, I have thought about that [treatment], but quite frankly I don't think it would do me any good. It would probably do me worse than more good ... Because I'd go in there, you know, and bloody, there'd be like thirty, forty, fifty year old, you know, white males, you know and like they'd just be saying, you know, like 'What are you doin' in here?' And just harass me more and more and more, you know, and that would have been the reason why I would have went in there is because I was getting harassed and them forcing me into doing those things, you know, so if I go in there it would just make it worse.*

One teenager wanted a service for young people:

*Yeah, I have thought about it but some stories I've heard off other people, like other people go there and stuff. I haven't really wanted to. Practically all of them are practically older than what I am. And so it's a bit hard for me. If there was [one] for younger people to go to, I'd probably go to that one.*

Two men correlated their reasons for not going in to treatment with jail. One had tried out-patient treatment but had never gone into rehabilitation because

*when I was gettin' sentenced to jail and that to go to rehab' and that. They mentioned they wanted me to go to rehab' after jail, you know. [I said] 'There's no way in the world mate. If you want me to go to rehab' you have to send me to rehab' now.' You get into jail and you don't worry about it. I don't like that. You know, I don't like the way that they, 'We'll help you when you've done a bit of time' or, you know ... I said to 'em', 'You do it now don't ask me to go through all this bullshit in jail and that and then get out and have to recommend [I go to rehab'] no way in the world mate.'*

Another man (who had never been in any form of treatment) had a similar reason: “I tried to get into rehab' [the times I went] to jail but ... it's just been jail or nothing. [I was told] ‘You ain't goin' to no rehab', you're going to jail buddy.’”

Whilst the majority of people we interviewed wanted to stop their drug use, just like other users of currently illegal drugs, some did not want treatment for their drug use. Instead, they wanted to continue to use drugs that are presently illegal, albeit in a way that is safer, less stigmatised and less expensive than they are currently able to. In particular, marijuana was discussed in this way. One man, for example, said: “To me, it does people more benefit than what prescribed does. It's natural mate, you know.” A comment of a similar nature came from a young woman who said she would never give up her marijuana use:

*'Cos' hey if it wasn't meant for us mate, our mother she wouldn't have put it there. It comes from the earth anyway so, you know what I mean. Like to me that's natural. All this other shit that's gettin' around that's, you know, that's what they need to get rid of.*

One woman believed that “Yarndi helps me with compassion for my Community.” Another woman told us about her first and subsequent use of marijuana:

*Yeah I liked that laughin.' I just felt like no one else was around, you know. In a world of me own. I wanted to have that feelin' all the time you know. So I just ... from then I just started smokin' whenever I could. Once I got the hang of it. Like I still can't smoke properly. I choke every time I have a cone. Never been able to smoke it properly. It hasn't stopped me. I don't know, it just relaxes me. It just blocks everything, you know.*

A man, who did not want to stop his use of heroin or marijuana, said this about marijuana:

*It makes me think ... it helps me to have understanding about the different problems or anything that you are talking about. It gives me time to reflect, you know, and actually absorb what the conversation or what people are talking about, yeah. I can actually think logically, yeah. It calms me mind.*

For this woman, her last use of marijuana was typical: “I had it in the bath, in the spa bath. Take a bottle of wine and a joint. Just sort of feel relaxed, so that you can put your guard down.” Another woman said:

*It keeps the household a bit more peaceful when I'm on it. To be honest ... I can go without it, but when I've got it set in me head that I'm goin' to have it today, I'm goin' to have it today. And like I'm goin' to have it today and when I get home I'm going to have it, you know? Whether I have the interview or see the doctor or whatever, I'm goin' to have it. Because I need it today. Because I've had a rough morning, and I think 'Well by the end of the day I am goin' to have it', and that's it.*

Some people talked about the way marijuana relieved their pain. One man said it was: “Pretty good I reckon for like pain and that.” Most marijuana users who found the drug beneficial, had views that it was necessary to “Decriminalise” it and look at it “as like a medicine.”

### **Stopping use of particular drugs without treatment**

We asked people how they had gone about stopping use of particular drugs. Responses related to particular types of treatment are reported above. We now provide a very brief overview of some other responses.

#### *“Culture as treatment”*

Some people credited improvements in their drug use behaviours to their culture. Brady has, however, argued “that cultural and spiritual enactments in themselves (culture as treatment) will be ineffective unless they succeed in helping clients to form peer groups (both adolescent and adult) which disvalue drug and alcohol use and which assist individuals to deal with the persuasive pressures of their kin and associates” (Brady, 1995:1495).

With the help of other Aboriginal people a man was managing to control his extensive polydrug use: “Only about the last year. I found an inner peace. I found a good spiritual life. And that has eased with the spirits watchin' over me just makin' sure I'm all right.”

Going out bush is frequently suggested as a solution to problems related to alcohol and other drug use (Brady, 1995:1495). Whilst non-Aboriginal users talk about “doing a geographical” (that is moving away from their drug using friends and environment), for Aboriginal people “going bush” is intertwined with traditional beliefs and customs. One woman said that after trying Alcoholics Anonymous, she was still drinking heavily. She then managed to control her drinking so that she now only had one or two drinks at celebrations such as Christmas “When I did it [stopped drinking heavily] I went back to the bush.” Another man talked about stopping his heroin use by “going bush.” This was precipitated by legal problems:

*Instead of going to court on this Friday I caught a bus and went interstate. And I went bush. Just on me own. And I stayed ... no food, just what was on me back and the money I had in me pocket. And I stayed in the bush for three months. Haven't touched a needle since.*

This had a cascade effect and he had then stopped his use of all illegal drugs except marijuana.

#### *Experimental use*

For the majority of respondents, many drugs that they had used during their drug taking careers had been used on a one off or experimental basis. When he was younger, one of the older respondents had access to barbiturates. He described how he stopped their use:

*Well it was more like a party thing. Especially at universities going to see a band or something I was given them. All of a sudden I was super human strong, and I'd lift all the bands gear down to their trucks and stuff like that. And I couldn't even remember. I thought, 'Oh, this is bullshit mate.' And I just stopped hey.*

#### *Maturing out*

Some people manage to control their dependency on alcohol and/or other drugs, or may even become abstinent, or “mature out” of their drug use without entering treatment (Winick, 1962; Snow, 1973; Waldorf, 1979; Waldorf and Biernacki, 1979; Stall and Biernacki, 1986). A young man explained why he had stopped using amphetamines: “I’ve just sort of matured. I’ve grown up. Sort of figured that that’s not the sort of thing that you should be doin’ if you want to start a family.”

## *Substitution*

Whilst drug users may stop using particular drugs, they may substitute them with others. An example is a man had stopped heroin use, but had substituted it for alcohol and amphetamine. Here is his abbreviated history. The first time he used heroin he felt:

*Good. I didn't really know what it was like so and then it just knocked me out and then I just slept until the next day. And then after that I just got a habit off it. Yeah. I was spending like three hundred fucken dollars a day. The bad thing was hangin' out. If I couldn't get it I'd just start schitzing and goin' thievin.' [I stopped when] I went back home [and] I just drunk and stuck to the speed to keep myself occupied from the heroin.*

## *Independence*

Some people said they had stopped using drugs just by themselves. In the case of heroin, a few people said they had stopped by themselves by going “cold turkey” (defined in the previous chapter). A man who had not used heroin for three months explained that he had achieved this by willpower and now:

*Yeah. It's like you know fifteen years of doin' it, ya' know, when do ya ... like I found peace within meself, I found a lot of happiness, and ya' know just little things in life, trees, birds, and getting back to it all. The first time I've been happy in a long time.*

## **Conclusion**

An amalgamation of the data for all sorts of treatment experiences revealed that 84 people (88%) had accessed some sort of treatment service for their drug use (this includes peer-based services). Table 5.2 summarises respondents' treatment experiences of treatment related to their drug and alcohol use demonstrating that the biggest proportion had accessed an out-patient Aboriginal Medical Service (86%, n=82). As reported above, we considered the Aboriginal holistic concept of health an included all contacts the people we interviewed had with these services. The next biggest proportion of respondents (74% of the 47 current injecting drug users, n=35) had accessed one of the needle and syringe programs. Forty one per cent of the current 47 injecting drug users (n=13) had accessed peer-based services. Of the 74 people who had ever used opioids 41 per cent (n=30) had experience of pharmacotherapy treatment. As Wodak notes, pharmacological interventions attract and retain many more drug users than non-pharmacological interventions and are also better supported by the evidence

(Wodak, 2001). Other types of treatment services had been used by 18 to 34 per cent of respondents.

**Table 5.2: Summary of respondents' experiences of treatment related to their drug and alcohol use**

<b>Treatment type</b>	<b>n</b>	<b>%</b>
Out-patient Aboriginal Medical Services	82	86
<i>Needle and syringe programs</i>		
Mainstream out-patient drug and alcohol treatment services	35	74 <sup>a</sup>
<i>Pharmacies</i>	25	53 <sup>a</sup>
Peer-based organisations	13	28 <sup>a</sup>
Other peer-based services	25	41 <sup>b</sup>
<i>Pharmacotherapies</i>		
Methadone Maintenance and/or buprenorphine	30	41 <sup>c</sup>
<i>Twelve-step programs</i>		
Alcoholics Anonymous	32	34 <sup>d</sup>
<i>Narcotics Anonymous</i>	22	30 <sup>c</sup>
<i>Rehabilitation Services</i>		
<i>Any type of Rehabilitation Service</i>	27	28
Aboriginal Rehabilitation Services	17	18
Mainstream Rehabilitation Services	17	18
Halfway House	3	3
<i>Withdrawal Services</i>		
In-patient withdrawal	26	27
Out-patient withdrawal	5	5
Counselling	23	24
Mainstream General Practitioners	17	18

<sup>a</sup> These percentages are based on the number of current injecting drug users we had data for (7 missing values, n=47).

<sup>b</sup> This percentage is based on the number of people who had ever injected drugs (n=61)

<sup>c</sup> These percentage are based on the number of people (n=74) who had ever used opioids.

<sup>d</sup> This percentage is based on the number of people (n=93) who had ever consumed alcohol.

In general, people who had received any form of treatment had, to greater or lesser extents, used both mainstream and Aboriginal services. But at the time of interview, everyone was still using illegal drugs. As we showed in the previous chapter, many were dependent and were experiencing the plethora of problems associated with illegal drug use. As we also showed in the previous chapter, there was a high prevalence of alcohol use in the sample and many people were dependent on alcohol.

A wide variety of treatment experiences was reported. Some people had only positive things to say, others reported only negative aspects of their treatment. Most reported mixed experiences of treatment.

Writing specifically about treatment for Aboriginal and Torres Strait Islander people who use illegal drugs, Gray and Saggars pose this question: “Which interventions work?” They provide their own response – there are no simple answers to this difficult question. One of the reasons for this is that there have been “few formal evaluation of interventions” (Gray and Saggars, 2003:176) but the few evaluations that have been undertaken (by themselves and others) reach similar conclusions. The “First and foremost conclusion is a very important one: “interventions should be supported and controlled by local communities” (Gray and Saggars, 2003:177). They go on to synthesise the evaluations of interventions for treatment of alcohol and other drug problems by Indigenous peoples:

*Given the diversity within the Indigenous population, interventions must be tailored to the needs of particular communities. As many of those people who misuse psychoactive substances are poly-drug users, interventions are more likely to be successful if they target substance misuse generally rather than the misuse of a particular drug or drugs. There tends to be a synergistic effect between interventions, and an intervention is more likely to be effective if it is implemented in conjunction with others. It is important that interventions be adequately resourced and supported; this entails not only funding for project activities, but appropriate staff training and support.*

(Gray and Saggars, 2003:177)

Jonas makes some similar points: “Service delivery needs to be flexible and undertaken on the basis of partnerships and shared responsibilities with Indigenous people in a culturally and locationally appropriate way” (Jonas, 2002:71). He later added: “Where mainstream services are unable to effectively meet the needs of Indigenous people, additional Indigenous-specific services are required” (Jonas, 2002:72).



The National Aboriginal Community Controlled Health Organisation maintains that “Like all other Aboriginal health programs, drug and alcohol funding has not been commensurate with need. Substantial progress can be made if resource inequities are addressed” (NACCHO [National Aboriginal Community Controlled Health Organisation, 2003b:594).

Whilst we were conducting our research, the Ministerial Council on Drug Strategy completed the Aboriginal and Torres Strait Islander peoples Complementary Action Plan. This provides a valuable framework for evaluation (Ministerial Council on Drug Strategy, 2003). Bearing in mind the imperative to evaluate the implementation of the treatment findings, in the following chapter we describe and discuss the treatment needs and preferences for treatment services identified by the people we interviewed.

## CHAPTER 6: DRUG TREATMENT NEEDS

### Introduction

Before reporting on drug treatment needs, we document comments respondents made about the need for preventative measures. Most of the rest of this chapter focuses on drug treatment preferences for, and needs identified for, treatment by the people we interviewed. Treatment preferences are considered in two main sections. Each begins with an explanation of how the data were collected. In the first section we report on whether respondents favoured treatment services to be managed by Aboriginal or mainstream organisations, or a mixture of both. In their relevant subsections, treatment modalities that were not mentioned in the previous chapter are briefly described. In response to an open-ended question about what would help them stop using illegal drugs, some people mentioned particular types of treatment. These responses are also included in this section. (Other types of responses to this open-ended question are reported in Chapter 9.)

In the second major section, we document preferences for cultural background of staff for treatment for drug and alcohol problems. We then report on other needs related to types of drug treatment services and on residential treatment needs before reporting on needs for information, and referrals for drug treatment services. Each of the two major sections and the sections on needs related to drug treatment services concludes with a summary table and discussion.

Our investigation focused on illegal drug use and we did not ask people about treatment for tobacco use. Towards the end of the chapter we do, however, emphasise the need for continued efforts to control tobacco smoking in the Aboriginal and Torres Strait Islander Community.

### Prevention

We acknowledge the imperative of preventative measures but since our focus was on treatment needs we not ask questions about prevention. Never-the-less, a few people did make suggestions relevant to prevention and we begin this chapter by documenting those.

A young woman (who was herself less than 20 years of age) was thinking of people younger than herself when she said:

*The younger generation. Something needs to be done more than for older ones. Giving them interesting things to do. Things that will benefit them. Things to look forward to. More hands-on fun things.*

Another young woman (who was trying to control her polydrug use) said no one had told her how bad a heroin “habit” was. She added: “They need counselling for young Aboriginals; they all turn to the gear [heroin]. They need some sort of support, to explain what a habit is.” Another young woman said that what was needed was “More education in schools, not just textbooks, real hardcore stuff [about drugs].”

This young woman voiced a similar need:

*[There needs to be] prevention in schools, they [young people] look up to us, and they need to realise that it's not all fun, that we have to go through a lot of stress [to] give it [drug use] up.*

### **Preferences for types of organisations for treatment modalities**

We wanted to know if, in general, when receiving treatment for their drug and alcohol use in the future, respondents would prefer that their care was delivered by an Aboriginal or non-Aboriginal organisation. We were not specific about particular organisations, but we were specific about treatment modalities. So that we did not lead respondents to pick particular choices, we prepared six A4 sized coloured “show cards.” Each of the “show cards” contained one of the following descriptions for an organisation (black and white versions of the “show cards” are included as Appendix 20):

- Aboriginal/Torres Strait Islander managed;
- Mainstream;
- Special mainstream, for Aboriginal/Torres Strait Islander people and non-Aboriginal/Torres Strait Islander people where a culturally appropriate service is provided for Aboriginal/Torres Strait Islander people<sup>24</sup>;
- Other [if people chose this option we asked them to please specify];
- Don't mind [that is, the respondent did not mind whether their treatment was managed by an Aboriginal organisation, a mainstream organisation, or a special mainstream service];
- Don't know.

A few people were adamant that they didn't want particular types of services so we added "Doesn't want this" as a coding category.

We shuffled the "show cards" so they were presented to respondents in random order. For those people who could not read, we read out the choices on the "show cards." We then firstly asked: "If you were to need detox, what sort of organisation would you feel was best for you?"

Interviewees responded to the "show cards" very well. Whilst some made their choice immediately after seeing the "show card" with their preference on it, most spent some time looking through them carefully before answering. There was a tendency for people to choose the same response for each treatment modality but a few did vary their responses.

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<sup>24</sup> We got the idea for this type of service from our work with older Aboriginal and Torres Strait Islander people in the ACT and Region where several people said that if they were to need aged care facilities, they favoured a "clustering system" (Dance et al, 2000b). In turn, we had been inspired to add this as a choice to the people we interviewed then following discussions with Matthew Jackson (then, Director of Planning and Access, Commonwealth Department of Health and Aged Care). In September, 1999, before we commenced the data collection on older Indigenous people, he informed us that it had recently been proposed that Indigenous and non-Indigenous people work with an existing provider of aged care to "cluster" Indigenous people together in the same facility as non-Indigenous people. The provider would then offer culturally appropriate services to the Indigenous residents. We explained a "Special mainstream service" to the people we interviewed for the research being described here in a similar fashion, but in the context of appropriate services for treatment of drug use.

After recording the response for “Detox” we then repeated the procedure for these treatment modalities:

- “Rehab”;
- “Counselling”;
- “AA” (Alcoholics Anonymous);<sup>25</sup>
- “NA” (Narcotics Anonymous);<sup>2</sup>
- “Drug and Alcohol Helpline”;
- “Outreach Drug and Alcohol Workers”;
- “Outreach Home Visits.”

Finally, we asked: “Is there any other sort of service related to your drug and/or alcohol use [as relevant] which you’d like?” We report below on preferences for each type of service (there is one missing value for all findings related to preference for management and preferences for cultural background of staff [ reported below]).

#### *Withdrawal services*

The responses for withdrawal services showed a small majority of 53 per cent (n=50) favoured an Aboriginal/Torres Strait Islander organisation for provision of this service (Table 6.1). The next biggest proportion of people (29%, n=27), had a preference for “Special mainstream” (defined above).

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<sup>25</sup> We note here that we recognise that there is no management or staff as such for Alcoholics Anonymous and Narcotics Anonymous. We were, however, trying to ascertain whether respondents would find Aboriginal and Torres Strait Islander-specific 12-step services useful for them.

**Table 6.1: Preferences for type of organisation for withdrawal services**

<b>Organisation</b>	<b>n</b>	<b>%</b>
Aboriginal/Torres Strait Islander	50	53
Special mainstream	27	29
Don't mind	9	10
Mainstream	5	5
Don't know	2	2
<i>Doesn't want this</i>	1	1
<b>Total</b>	<b>94</b>	<b>100</b>

In response to the open ended question about what might help them stop their drug use one person mentioned general withdrawal services. Five other people said they thought that home withdrawal would work for them. Recognising the need for a wide repertoire of treatment services, one of these people said “Home detox’ would suit me better. I believe it comes down to each person.” Although this service was provided by Winnunga at the time, another person mentioned a specific need for home withdrawal services to be provided by an Aboriginal and Torres Strait Islander organisation.

#### *Rehabilitation services*

The responses for rehabilitation services were very similar to the ones for withdrawal services. A small majority of 53 per cent (n=50) favoured an Aboriginal/Torres Strait Islander organisation for provision of this service. The next biggest proportion of people (30%, n=28) had a preference for “Special mainstream” (Table 6.2).

**Table 6.2: Preferences for type of organisation for rehabilitation services**

<b>Organisation</b>	<b>n</b>	<b>%</b>
Aboriginal/Torres Strait Islander	50	53
Special mainstream	28	30
Don't mind	9	10
Mainstream	4	4
Don't know	2	2
Doesn't want this	1	1
<b>Total</b>	<b>94</b>	<b>100</b>

*Rehabilitation as a means of stopping illegal drug use*

When we asked the open-ended question about what people thought would help them stop illegal drug use, there were two comments directly related to rehabilitation services. One man was on a waiting list for this treatment. Another said he believed rehabilitation could help him change his life but “There’s no point havin’ a rehab’ in the middle of town because it’s too easy to walk out.”

*Counselling services*

The proportions for preferences for type of organisation for counselling services were almost identical to those for withdrawal and rehabilitation services except that two more people than for other services were adamant that they did not want this service (Table 6.3). One of these people had said that she did not trust either mainstream or Aboriginal services to respect her confidentiality (reported in the previous chapter).

**Table 6.3: Preferences for type of organisation for counselling services**

<b>Organisation</b>	<b>n</b>	<b>%</b>
Aboriginal/Torres Strait Islander	49	52
Special mainstream	28	30
Don't mind	8	8
Mainstream	4	4
Doesn't want this	3	3
"People you can relate to" ("Other")	1	1
Don't know	1	1
<b>Total</b>	<b>94</b>	<b>-</b>

Following our question about what people thought would help them stop illegal drug use, there were eleven comments directly related to a need for counselling. For some people, this was not only for counselling to help stop drug use, but counselling for underlying trauma. Although the man we quote below said he did not want any treatment, when we asked what he thought could help him stop his polydrug use (which included injectable heroin) he indicated a need for more counselling, as well as approval for research, by saying:

*More interviews like this I suppose. It gives you the chance to relay some of your problems or issues that you are faced with, and that way you guys then have got the chance to take all the information and get what knowledge you need out of it. And that way you can know which direction to move in.*

One woman had told us about a lot of problems she had experienced before adding:

*I've been asking for that [counselling] since I was nine. You know, and ... maybe if I had gotten the help that I so needed before and felt heard I might not have led that life [of using heroin and other drugs] ... I feel there's so much ... things should have been done so differently.*

After informing us that he would never go into residential treatment, a man said "It should be all right just to go and talk to someone hey."

Whilst not directly articulating a need for counselling, comments from three other people might be interpreted as a need for this help. In the context of stopping their drug use these three people talked about "own will", "self determination, I think it's all in your head" and "I have to do it myself." Another respondent indicated a definite need for counselling. After checking the results of his General Health Questionnaire (these



findings are reported in Chapter 8), we spent some time talking to him about his high score. He said that he had a lot of pain and the “Idea of taking my own life has crossed my mind. Sometimes I feel as though life is hard to get through.” One of the Winnunga researchers who was present followed up on this young man after the interview.

### *Alcoholics Anonymous*

We asked 68 people about their preferences for type of organisation for Alcoholics Anonymous. (We did not ask questions about Alcoholics Anonymous of those people who had not consumed alcohol in the 12 months prior to interview, or who had only consumed one or two drinks on an irregular basis.) The proportions shown in Table 6.4 for these 68 people are very similar to the ones reported above for other treatment modalities.

**Table 6.4: Preferences for type of organisation for Alcoholics Anonymous**

<b>Organisation</b>	<b>n</b>	<b>%</b>
Aboriginal/Torres Strait Islander	36	53
Special mainstream	17	25
Don't mind	7	10
Mainstream	5	7
Doesn't want this	1	2
“People you can relate to” (“Other”)	1	2
Don't know	1	2
<b>Total</b>	<b>68</b>	<b>-</b>

### *Narcotics Anonymous*

As we explained in the previous chapter, Narcotics Anonymous is a service for people who wish to achieve abstinence from a range of drugs. Amongst the people we interviewed only opioid users had used this service and we restricted our questions about this service to people who had used opioids in 12 months prior to interview. This resulted in us asking 59 people about their preferences for Narcotics Anonymous.

Table 6.5 shows that a slightly smaller proportion of people chose an Aboriginal/Torres Strait Islander organisation for management of Narcotics Anonymous than for other treatment modalities (46%, n=27). A slightly higher proportion of people than for other treatment modalities (10%, n=6) opted for “Mainstream.” Some people who said they wanted this service to continue to be “Mainstream” commented that they had experience of Narcotics Anonymous and did not see any reason to change the way it was presently run. The young woman who suggested a Narcotics Anonymous service for young people rationalised it like this:

*Yeah I have thought about it but some stories I've heard off other people, like other people go there and stuff. I haven't really wanted to. Practically all of them are practically older than what I am. And so it's a bit hard for me. If there was a group for us younger people to go and talk about it, I'd probably go to that one.*

**Table 6.5: Preferences for type of organisation for Narcotics Anonymous**

<b>Organisation</b>	<b>n</b>	<b>%</b>
Aboriginal/Torres Strait Islander	27	46
Special mainstream	17	29
Don't mind	5	9
Mainstream	6	10
Doesn't want this	1	2
“People you can relate to” (“Other”)	1	2
“A group for young people” (“Other”)	1	2
Don't know	1	2
<b>Total</b>	<b>59</b>	<b>-</b>

### *Phone help line*

A range of government, non-government and voluntary organisations provide 24 hour phone help lines for people who use illegal drugs, and for their families and friends. The service helps those who access it in numerous ways, including providing support, advice and referral.

The responses for what type of organisation should operate a phone help line again shows a small majority of 51 per cent (n=48) favouring an Aboriginal/Torres Strait Islander organisation to run such a service (Table 6.6). Anecdotal evidence from Aboriginal family members of people who use illegal drugs suggests that they too

would find a helpline managed by an Aboriginal organisation beneficial. The next most favoured option for type of organisation for a helpline was, again, “Special mainstream” (30%, n=28).

**Table 6.6: Preferences for type of organisation for helpline**

<b>Organisation</b>	<b>n</b>	<b>%</b>
Aboriginal/Torres Strait Islander	48	51
Special mainstream	28	30
Don't mind	9	10
Mainstream	5	5
Doesn't want this	1	1
“People you can relate to” (“Other”)	1	1
“One for young people” (“Other”)	1	1
Don't know	1	1
<b>Total</b>	<b>94</b>	<b>100</b>

### *Outreach workers*

Outreach workers go out to a variety of community venues to provide services; some specialising in Aboriginal clients with problems related to alcohol and drug use operate from Aboriginal Medical Services in Canberra and the Region.

Preferences for type of organisation for outreach workers followed a similar pattern to the majority of those described above: 53 per cent (n=50) favoured an Aboriginal/Torres Strait Islander organisation to manage this service and 29 per cent (n=27) stated a preference for a “Special mainstream” service (Table 6.7).

**Table 6.7: Preferences for type of organisation for outreach workers**

<b>Organisation</b>	<b>n</b>	<b>%</b>
Aboriginal/Torres Strait Islander	50	53
Special mainstream	27	29
Don't mind	8	9
Mainstream	5	5
Doesn't want this	2	2
Don't know	1	1
"People you can relate to" ("Other")	1	1
<b>Total</b>	<b>94</b>	<b>100</b>

*Outreach home visits*

Very early in the piloting phase of the investigation one respondent distinguished between outreach workers and outreach home visits by saying that home visits would be a service he would find particularly beneficial. Although there is some overlap of this service with outreach worker services, we then added this choice for subsequent interviews. The responses followed a similar pattern to the majority described above: 53 per cent (n=50) favoured an Aboriginal/Torres Strait Islander organisation to manage this service. Twenty nine per cent (n=27) stated a preference for a "Special Mainstream" service (Table 6.8).

**Table 6.8: Preferences for type of organisation for outreach home visits**

<b>Organisation</b>	<b>n</b>	<b>%</b>
Aboriginal/Torres Strait Islander	50	53
Special mainstream	27	29
Don't mind	8	9
Mainstream	5	5
Doesn't want this	2	2
Don't know	1	1
"People you can relate to" ("Other")	1	1
<b>Total</b>	<b>94</b>	<b>100</b>

## **Summary of respondents' preferences for types of organisation for treatment modalities**

In this section, we summarise respondents' preferences for types of organisation for treatment modalities. Table 6.9 shows that, a small majority of respondents favoured management by an Aboriginal/Torres Strait Islander organisation. Apart from Narcotics Anonymous (46%) (where the difference is largely explained by the fact that a few more people chose a mainstream organisation) the proportions for this preference ranged between 51 and 53 per cent. This finding indicates a need for treatment services managed by Aboriginal and Torres Strait Islander people to be part of the treatment choices for Indigenous people who use illegal drugs. The need for this type of management is summed up in the quote from a woman, who said that she would only go into treatment if it was "through an Aboriginal organisation."

This majority choice for management of treatment modalities by an Aboriginal/Torres Strait Islander organisation was, in all treatment modalities, closely followed by quite large proportions of people: 25 to 29 per cent, who chose a "Special mainstream" service (a mainstream organisation, where culturally appropriate services would be provided for Aboriginal and Torres Strait Islander people). This finding indicates a need for Aboriginal and mainstream organisations to continue to work together to provide these services.

For each type of treatment, a small proportion of respondents chose "Mainstream": 10 per cent for Narcotics Anonymous, seven per cent for Alcoholics Anonymous and between four and five per cent for other types of services. Between five and ten per cent of the sample indicated they did not mind whether drug treatment services were managed by Aboriginal or non-Aboriginal organisations. One to two people said they did not know.

We compared these results with findings for a generic preference for management of community and residential aged care services expressed by older Indigenous people in the ACT and Region (Dance et al, 2000b). Management of community care by an Indigenous organisation was preferred by 43 per cent of these older Indigenous people. Thirty two per cent chose an Indigenous organisation for provision of residential care. Both are somewhat smaller proportions than we found in the illegal drug users we interviewed.

Twenty four per cent of the older Indigenous people favoured a non-Indigenous organisation for community care. This is fairly comparable to the proportion we found in the Aboriginal and Torres Strait Islander illegal drug users we interviewed. No one chose this option for residential care.

Fifty per cent of the older Indigenous people chose “clustering” (a system similar to the “Special mainstream service” for illegal drug users). A rather higher proportion than found for similar types of service amongst the illegal drug users we interviewed (25-29%).

The most striking difference between the older Indigenous people and the Aboriginal and Torres Strait Islander illegal drug users we interviewed is the difference in the “Don’t mind” category for community care. Twenty eight per cent of older Aboriginal and Torres Strait Islander people said they did not mind whether their community care was managed by an Indigenous or a non-Indigenous organisation, compared to five to ten per cent of the illegal drug users who said they did not mind who managed drug treatment modalities. This comparison suggests more strongly held views amongst Aboriginal and Torres Strait

**Table 6.9: Summary of respondents' preferences for types of organisation for treatment modalities**

<b>Organisation</b>	<b>With-drawal</b>		<b>Rehabilitation</b>		<b>Counselling</b>		<b>AA<sup>1</sup></b>		<b>NA<sup>2</sup></b>		<b>Help-line</b>		<b>Outreach workers</b>		<b>Outreach home visits</b>	
	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>
Aboriginal/Torres Strait Islander	50	53	50	53	49	52	36	53	27	46	48	51	50	53	50	53
Special mainstream	27	29	28	30	28	30	17	25	17	29	28	30	27	29	27	29
Don't mind	9	10	9	10	8	8	7	10	5	9	9	10	8	9	8	9
Mainstream	5	5	4	4	4	4	5	7	6	10	5	5	5	5	5	5
Don't know	2	2	2	2	1	1	1	2	1	2	1	1	1	1	1	1
Doesn't want this	1	1	1	1	3	3	1	2	1	2	1	1	2	2	2	2
People you can relate to "Other"	-	-	-	-	1	1	1	2	1	2	1	1	1	1	1	1
One for younger people ("Other")	-	-	-	-	-	-	-	-	1	2	1	1	-	-	-	-
<b>Total</b>	<b>94<sup>a</sup></b>	<b>100</b>	<b>94</b>	<b>100</b>	<b>94</b>	<b>-</b>	<b>68<sup>b</sup></b>	<b>-</b>	<b>59<sup>c</sup></b>	<b>-</b>	<b>94</b>	<b>100</b>	<b>94</b>	<b>100</b>	<b>94</b>	<b>100</b>

<sup>1</sup> Alcoholics Anonymous.

<sup>2</sup> Narcotics Anonymous.

<sup>a</sup> One missing value for all these findings.

<sup>b</sup> We did not ask these questions of people who had not consumed alcohol in the previous 12 months prior, or who had only consumed one or two drinks on an irregular basis.

<sup>c</sup> We restricted these question to people who had used opioids in the previous 12 months.

Islander illegal drug users about the type of organisation they want to manage drug treatment modalities than older Indigenous people held for management of community aged care services. Eight per cent of the older Aboriginal and Torres Strait Islander people, however, said they did not mind whether their residential care was provided by an Indigenous or non-Indigenous organisation.

### **Staffing treatment services**

We preface this section by drawing attention to the fact that there is, in general, a paucity of alcohol and drug treatment workers for both Aboriginal and mainstream services. We also note that several commentators have pointed to the lack of adequate training for Aboriginal Health Workers dealing with clients with drug and alcohol problems. In addition, many Aboriginal Health Workers feel isolated and overwhelmed, under constant pressure to answer a myriad of problems with scant resources, no professional support and often limited training opportunities and skills development (Commonwealth Department of Health and Aged Care, 1999). The Commonwealth's review of the Substance Misuse Program found that many rehabilitation services for Aboriginal and Torres Strait Islander people developed in response to problematic drug use and now "encounter difficulties" because of "changing trends in drug use." The authors of this report go on to suggest that addressing misuse of different substances (and polydrug use) may mean specific training for staff (Commonwealth Department of Health and Aged Care, 1999:77).

One of the six key results born out of the Aboriginal and Torres Strait Islander Peoples Action Plan was that there was a need for "workforce initiatives to enhance the capacity of Aboriginal and Torres Strait Islander community-controlled and mainstream organisations to provide quality services" (Ministerial Council on Drug Strategy, 2003:65).

Finally, we draw attention to, and offer support for, the following Standing Committee on Aboriginal and Torres Strait Islander Health's proposed strategy:

*The Commonwealth, States and Territories will consider measures to deliver specific training for [Aboriginal and Torres Strait Islander] men's women's and sexual health workers and alcohol and substance misuse workers.*

(Standing Committee on Aboriginal and Torres Strait Islander Health, 2002:Strategy27:12)



## **Preferences for cultural background of staff for treatment services**

In order to ascertain preferences for cultural background of staff for treatment services, we went through a similar process to the one described above for management of treatment modalities. We began with: “Could we now ask about your preference for the cultural background of staff, if you were to go into treatment.” As for treatment organisations, we shuffled through coloured “show cards” each with a different choice for cultural backgrounds of staff. Each “show card” contained one of these choices (black and white versions of the “show cards” are included as Appendix 21):

- Aboriginal/Torres Strait Islander staff;
- Both Aboriginal/Torres Strait Islander Staff and appropriate non-Aboriginal/Torres Strait Islander staff<sup>26</sup>;
- Non-Aboriginal/Torres Strait Islander staff;
- Other [if people chose this option we asked them to please specify];
- Don’t mind [that is, the respondent did not mind whether they were cared for by Aboriginal/Torres Strait Islander staff, non-Indigenous staff or a mixture of both];
- Don’t know.

The interviewers presented the cards to respondents in random order before we first asked: “If you were to need detox’, what would be your preference for the cultural background of staff?” We then repeated the questions for the other treatment modalities.

### *Withdrawal services*

The responses for withdrawal services showed that at 45 per cent (n=42), the biggest proportion of responses was for “Both Aboriginal/Torres Strait Islander staff and appropriate non-Aboriginal/Torres Strait Islander staff.” Following very closely behind this choice was a preference for Aboriginal/Torres Strait Islander staff (41%, n=39)

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<sup>26</sup> We amplified what we meant by “appropriate non-Aboriginal/Torres Strait Islander staff” by saying that we meant people who had appropriate cultural training and knowledge.

(Table 6.10).

**Table 6.10: Preferences for cultural background of staff for withdrawal services**

<b>Cultural background</b>	<b>n</b>	<b>%</b>
Both Aboriginal/Torres Strait Islander staff & appropriate non-Aboriginal/Torres Strait Islander staff	42	45
Aboriginal/Torres Strait Islander staff <sup>1</sup>	39	41
Don't mind	10	11
<i>Doesn't want this</i>	1	1
“Whoever is best for the problem” (“Other”)	1	1
Don't know	1	1
<b>Total</b>	<b>94</b>	<b>100</b>

<sup>1</sup> For this response, and all those below referring to Aboriginal and Torres Strait Islander staff, two people mentioned that they wanted these staff to have a history of “using” (ie, of using illegal drugs).

### *Rehabilitation services*

The responses for rehabilitation services almost mirrored those for withdrawal services. The biggest proportion of responses for staff for this treatment modality was also for “Both Aboriginal/Torres Strait Islander Staff and appropriate non-Aboriginal/Torres Strait Islander staff” (45%, n=42). Again, coming a very close second, was a preference for only Aboriginal/Torres Strait Islander staff (40%, n=38) (Table 6.11).

**Table 6.11: Preferences for cultural background of staff for rehabilitation services**

<b>Cultural background</b>	<b>n</b>	<b>%</b>
Both Aboriginal/Torres Strait Islander staff & appropriate non-Aboriginal/Torres Strait Islander staff	42	45
Aboriginal/Torres Strait Islander staff	38	40
Don't mind	11	12
Doesn't want this	1	1
"Whoever is best for the problem" ("Other")	1	1
Don't know	1	1
<b>Total</b>	<b>94</b>	<b>100</b>

*Counselling*

Minor differences to those so far reported were found for preferences of staff for counselling services. Forty four per cent (n=41) had a preference for "Both Aboriginal/Torres Strait Islander Staff and appropriate non-Aboriginal/Torres Strait Islander staff" and 41 per cent (n=39) had a preference for Aboriginal/Torres Strait Islander staff (Table 6.12).

**Table 6.12: Preferences for cultural background of counselling staff**

<b>Cultural background</b>	<b>n</b>	<b>%</b>
Both Aboriginal/Torres Strait Islander staff & appropriate non-Aboriginal/Torres Strait Islander staff	41	44
Aboriginal/Torres Strait Islander staff	39	41
Don't mind	9	10
Doesn't want this	2	2
"Whoever is best for the problem" ("Other")	1	1
Non-Aboriginal/Torres Strait Islander staff	1	1
Don't know	1	1
<b>Total</b>	<b>94</b>	<b>100</b>

### *Alcoholics Anonymous*

We found fairly similar proportions for choice of personnel for Alcoholics Anonymous to those documented above for other services. (As for preferences for treatment organisations, we only asked the 68 people who had consumed alcohol in the 12 months prior to interview more frequently than one or two drinks on an irregular basis.) The exception was that slightly more people chose “Aboriginal/Torres Strait Islander personnel” (n=29, 43%) than “Both Aboriginal/Torres Strait Islander personnel and appropriate non-Aboriginal/Torres Strait Islander personnel” (n=26, 38%) (Table 6.13).

**Table 6.13: Preferences for cultural background of personnel for Alcoholics Anonymous**

<b>Cultural background</b>	<b>n</b>	<b>%</b>
Aboriginal/Torres Strait Islander personnel	29	43
Both Aboriginal/Torres Strait Islander personnel & appropriate non-Aboriginal/Torres Strait Islander personnel	26	38
Don't mind	9	13
Doesn't want this	1	1
“Whoever is best for the problem” (“Other”)	1	1
Non-Aboriginal/Torres Strait Islander personnel	1	1
Don't know	1	1
<b>Total</b>	<b>68</b>	<b>-</b>

### *Narcotics Anonymous*

Almost half of the 59 people we asked (we only asked this question of people who had used opioids in the 12 months prior to interview) chose “Both Aboriginal/Torres Strait Islander personnel and appropriate non-Aboriginal/Torres Strait Islander personnel” (49%, n=28) for Narcotics Anonymous (Table 6.14). A smaller proportion of 37 per cent (n=22) favoured just Aboriginal and Torres Strait Islander people. This finding is in keeping with the preference for management of Narcotics Anonymous.

**Table 6.14: Preferences for cultural background of personnel for Narcotics**

**Anonymous**

<b>Cultural background</b>	<b>n</b>	<b>%</b>
Both Aboriginal/Torres Strait Islander personnel & appropriate non-Aboriginal/Torres Strait Islander personnel	28	49
Aboriginal/Torres Strait Islander personnel--	22	37
Don't mind	4	7
Doesn't want this	1	2
"Whoever is best for the problem" ("Other")	1	2
Non-Aboriginal/Torres Strait Islander personnel	2	2
Don't know	1	2
<b>Total</b>	<b>59</b>	<b>-</b>

*Phone help line*

As with other preferences for staff, a slightly larger proportion of people chose "Both Aboriginal/Torres Strait Islander Staff and appropriate non-Aboriginal/Torres Strait Islander staff" to provide a phone helpline service (44%, n=41) than chose Aboriginal/Torres Strait Islander Staff (40%, n=38) (Table 6.15).

**Table 6.15: Preferences for cultural background of staff for a phone helpline**

<b>Cultural background</b>	<b>n</b>	<b>%</b>
Both Aboriginal/Torres Strait Islander personnel & appropriate non-Aboriginal/Torres Strait Islander staff	41	44
Aboriginal/Torres Strait Islander staff	38	40
Don't mind	11	12
Doesn't want this	1	1
"Whoever is best for the problem" ("Other")	1	1
Non-Aboriginal/Torres Strait Islander staff	1	1
Don't know	1	1
<b>Total</b>	<b>94</b>	<b>100</b>

*Outreach workers*

Table 6.16 shows similar findings for cultural background of staff for outreach workers to those so far reported for staff preferences. A slightly larger proportion of people chose "Both Aboriginal/Torres Strait Islander Staff and appropriate non-Aboriginal/Torres Strait Islander staff" to be outreach workers (44%, n=41) than chose Aboriginal/Torres Strait Islander Staff (40%, n=38).

**Table 6.16: Preferences for cultural background for outreach worker staff**

<b>Cultural background</b>	<b>n</b>	<b>%</b>
Both Aboriginal/Torres Strait Islander personnel & appropriate non-Aboriginal/Torres Strait Islander staff	41	44
Aboriginal/Torres Strait Islander staff	38	40
Don't mind	10	11
Doesn't want this	2	2
"Whoever is best for the problem" ("Other")	1	1
Non-Aboriginal/Torres Strait Islander staff	1	1
Don't know	1	1
<b>Total</b>	<b>94</b>	<b>100</b>

*Outreach home visits*

Again, there was very little difference between the proportion favouring "Both Aboriginal/Torres Strait Islander Staff and appropriate non-Aboriginal/Torres Strait Islander staff" (43%, n=40) for outreach home visits and the proportion favouring Aboriginal/Torres Strait Islander staff (41%, n=39) (Table 6.17).

**Table 6.17: Preferences for cultural background of staff for outreach home visits**

<b>Cultural background</b>	<b>n</b>	<b>%</b>
Both Aboriginal/Torres Strait Islander staff & appropriate non-Aboriginal / Torres Strait Islander staff	40	43
Aboriginal/Torres Strait Islander staff	39	41
Don't mind	10	11
Doesn't want this	2	2
"Whoever is best for the problem" ("Other")	1	1
Non-Aboriginal/Torres Strait Islander staff	1	1
Don't know	1	1
<b>Total</b>	<b>94</b>	<b>100</b>

### **Findings related to cultural background of staff from qualitative data**

Thirty eight people amplified the quantitative data on needs related to cultural background of staff with qualitative data. Some made more than one comment. Twenty four wanted Aboriginal Health Workers to be there when they were in treatment, either only Aboriginal Health Workers or a combination of both Aboriginal and non-Aboriginal Health Workers. Another person specified the need for an Aboriginal doctor "Like if there was an Aboriginal doctor, the fear of the unknown would be gone." One person drew particular attention to the need for clients and staff to be members of the same "tribal group."

The following comment was made by a man who thought it necessary to have only Aboriginal staff employed in treatment services. He gave these reasons:

*See us Aboriginals, we feel very comfortable around our own race. We feel a lot more comfortable being asked to do something or you know, or asking questions. Well I find it to be a lot easier anyway. I can't talk for every Aboriginal in Australia, but I find it a lot easier.*



One of the people who thought residential treatment should be run by an Aboriginal organisation and staffed by Aboriginal people expressed it this way. She wanted “An environment for healing run by Aboriginal people. Aboriginal staff know how we feel, we can’t have people who don’t know about our culture.” Another woman, who also wanted the staff to be ex-users of illegal drugs, made a similar comment:

*And blackfellas who’ve been in that situation to counsel us, not somebody who’s studied it from a book or from interviews or whatever, you know, Who has been in a real situation, you know, who are reformed.*

A man (who had experienced several types of treatment over his drug taking career) saw an imperative for both Aboriginal and non-Aboriginal drug and alcohol workers to be employed in treatment services. He embellished this by saying:

*We can employ Aboriginal people to work [in a multipurpose centre, explained below]. ‘Cos’ we’ll get them from [the cities]. There’s not many of them [Aboriginal Health Workers] in that profession. But we will get them type of people. We definitely need more Aboriginal workers in the field. Definitely. ‘Cos’ so far it’s just all white people. That’s alright, they might know all the medicine side, but what about the culture side? They don’t know that. They come and say ‘Here’s your tablets and that, see ya’ later.’ What if that person [the Aboriginal client] is feelin’ low and he wants to talk to his family or whatever his problem is, they will not discuss it with a white person. If there’s a black face there they will discuss their problems. Not with a whitey. [quickly adding for the benefit of the non-Aboriginal interviewer, as most people did after an unguarded comment such as this] No offence.*

A man who had tried several mainstream rehabilitation services was thinking of other Aboriginal clients he had seen in treatment, as well as the impact that the lack of Aboriginal workers had on him when he said:

*I found I stayed and stuck it out because whether black or white I was in it for me and, yeah, and that’s all that really mattered, but ... I seen a lot of Koories come and go because there weren’t no Aboriginal workers, and they did feel isolated and all that kind of stuff. And I tried to get ‘em to stay there through my own experience and ... how I survived in there for that long. But ... like I was tryin’ to be a counsellor and a survivor myself. And I was tryin’ to do that just to try to get ‘em to stay. But that never worked ... Yeah, I was in there for myself and trying to get myself well. But I did see a lot of Aboriginals come and go from [rehabilitation services].*

Seven people who added qualitative data to their choices for treatment staff said that, if they were to go in to treatment, having Aboriginal or Torres Strait Islander workers employed there would not be important to them. One man whose comment epitomises

these views said that although he believed there should be a treatment service specifically for Aboriginal people he “Wouldn’t mind who runs it.’ He added “It would be good to have both [Aboriginal/Torres Strait Islander staff and non-Aboriginal staff]. As long as they’re good to me, I’ll be good to them. I’m not racist, I don’t mind.” Another man, who had also been in a mainstream therapeutic community, said he had received enough support there from non-Aboriginal people. The importance of staff being “medically trained” was mentioned by one man. Whilst placing a high priority on this, he indicated that the cultural background of staff was not important to him.

Three people made ambiguous comments. One such comment was from a woman who said in one part of the interview that she wished there had been an Aboriginal worker there for her when she had been in residential treatment. But in another part of the interview she said “I can’t relate to Aboriginal workers. I don’t know why, I just can’t.”

### **Summary of respondents’ preferences for cultural background of staff for treatment modalities**

As shown in Table 18, for all sorts of treatment modalities, a majority of people wanted Aboriginal and Torres Strait Islander staff to be involved in their care. Depending on the type of treatment modality, just having Aboriginal and Torres Strait Islander staff to care for them was favoured by between 38 and 44 per cent of the sample. Both Aboriginal and Torres Strait Islander staff and appropriate non-Aboriginal staff was the choice of between 38 and 49 per cent of respondents. Seven to 12 per cent indicated that the cultural background of staff was not important to them.

These findings indicate a need for more Indigenous people to be employed in organisations which provide services to Aboriginal and Torres people who use illegal drugs. This point has been made by several other commentators (reported above) who have also noted the lack of available staff to provide such services. Many people also wanted non-Aboriginal/Torres Strait Islander people (who have appropriate cultural training and knowledge), to be part of their treatment care.

Relatively small proportions of between seven to 13 per cent said they did not mind about the cultural background of staff for drug and alcohol treatment services.

A much larger proportion of 54 per cent of the older Aboriginal and Torres Strait Islander people in the ACT and Region did not have a preferred cultural background for staff of age care services (Dance et al, 2000b). In that study, we did not, however, specifically ask people if they wanted both Indigenous and non-Indigenous staff to care for them, or whether they wanted only non-Indigenous people to care for them. The “Don’t mind category” for the older Indigenous people is, therefore, more closely aligned with the choice we offered to the illegal drug users of having both Aboriginal and Torres Strait Islander staff and appropriate non-Aboriginal and Torres Strait Islander staff to care for them.

Most of the rest of the older Indigenous people (43%) had a preference for other Indigenous people to care for them. This is comparable to the findings for the illegal drug users we interviewed.

### **Suggestions for other sorts of treatment**

Some people made suggestions for other sorts of treatment they thought were required. These suggestions were made either after immediately going through the part of the interview where we were asking about preferences for management of organisations, in response to our open ended question about what respondents thought might help them stop using, or at some stage later in the interview. These suggestions are included in thematic subsections below. Some people made suggestions related to culture. These are discussed later in this chapter in the separate pivotal section which deals specifically with treatment issues related to culture.

**Table 6.18: Summary of respondents' preferences for cultural background of staff for treatment modalities**

Cultural background	With-drawal		Rehab-ilitation		Couns-elling		AA <sup>1</sup>		NA <sup>2</sup>		Help-line		Outreach workers		Outreach Home visits	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Both Aboriginal/Torres Strait Islander staff and appropriate non-Aboriginal/Torres Strait Islander staff	42	45	42	45	41	44	29	43	28	49	41	44	41	44	40	43
Aboriginal/Torres Strait Islander staff	39	41	38	40	39	41	26	38	22	37	38	40	38	40	39	41
Don't mind	10	11	11	12	9	10	9	13	4	7	11	12	10	11	10	11
Don't know	1	1	1	1	1	1	1	1	2	1	1	1	1	1	1	1
Doesn't want this	1	1	1	1	2	2	1	1	2	1	1	1	2	2	2	2
Whoever is best for the problem "Other"	1	1	1	1	1	1	1	1	2	1	1	1	1	1	1	1
Non-Aboriginal/Torres Strait Islander personnel	-	-	-	-	1	1	1	1	1	2	2	1	1	1	1	1
<b>Total</b>	<b>94<sup>a</sup></b>	<b>100</b>	<b>94</b>	<b>100</b>	<b>94</b>	<b>100</b>	<b>68<sup>b</sup></b>	<b>-</b>	<b>59<sup>c</sup></b>	<b>-</b>	<b>94</b>	<b>100</b>	<b>94</b>	<b>100</b>	<b>94</b>	<b>100</b>

<sup>1</sup>Alcoholics Anonymous.

<sup>2</sup>Narcotics Anonymous.

<sup>a</sup>One missing value for all these findings.

<sup>b</sup>We did not ask questions about Alcoholics Anonymous of those people who had not consumed alcohol in the 12 months prior to interview, or who had only consumed one or two drinks on an irregular basis.

<sup>c</sup>We restricted these question to people who had used opioids in the 12 months prior to interview.

### *Family services*

Three people mentioned the need for family services. One man suggested “Family group therapy. Where they (family) can come and tell you what you’ve done wrong and how it’s hurt them. The family sit with the drug users and have therapy.” Another man spoke about the need for “Family therapy prior to treatment from a mix of Aboriginal and non-Aboriginal people.” One woman mentioned the need for a non-hospital-based service for couples. She said she would “Like to be able to sleep in same bed as my partner [and] go through [withdrawal] with each other.”

### *Self help groups*

- Two people mentioned the need for self help groups. “Just knowing other people are doin’ it. Knowing other people are going through what I’m going through” commented one man.

### *Proclaimed place/sobering up shelters*

The terms proclaimed places and “sobering-up shelters” are used interchangeably. They “provide temporary haven for and supervision of intoxicated people at risk of causing harm to themselves or others, and divert intoxicated people from police custody” (Gray and Siggers, 2003:176).

Two people who had experienced problems with alcohol use in the past said they believed a “proclaimed place” was needed in Canberra. One had experienced alcohol-related problems due to her own use as well as her partner’s use. She summed up her feelings in these words: “We need a proclaimed place in Canberra, for when people are drunk, to keep drunken people away from the family, for youths.”

### *Prescription drugs as a way of stopping drug use*

Two people believed that prescribed Valium could help them stop their illegal drug use. A woman believed that repeated methadone treatment would help her stop using heroin.

A man whose main problem drug was amphetamine believed that a course of prescribed “dexies”<sup>27</sup> would help him overcome his dependence.

### *Nurses attached to Aboriginal Medical Services*

One woman believed that having “Drug and alcohol workers – just people, like nurses attached to AMS’s [Aboriginal Medical Services] would be a good help to people.” Shortly before we did this interview (we did the interview in the second half of 2002) a Registered Nurse specialising in drug and alcohol services had been appointed to work at Winnunga. There have been similar appointments in mainstream general practices in the ACT. The appointments are part of “The Opiate Program” (The Opiate Program is described in Chapter 2).

### *Mentor*

One person said a mentoring scheme was needed. He wanted this to be run by a mainstream organisation.

### *Weekend treatment*

One man had the idea that weekend treatment could assist him: “If I could go [into treatment] for weekends I would.”

## **Culture as treatment**

This term “culture as treatment” was coined by Brady (Brady, 1995:1495). In the context of people saying their culture had helped them control some of their drug use, we also made reference to this in the previous chapter. Below, we report on the inter-related needs of culture and drug use. In Chapter 9 we go on to report on other needs related to culture.

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<sup>27</sup> Dexamphetamine is commonly referred to as “Dexies.” Dexamphetamine substitution programs are available for amphetamine users in the United Kingdom but the efficacy and safety of this treatment has not been evaluated (Shearer and Gowing, 2004, citing several sources). Whilst this may be prescribed for hyperactive behaviour disorder, the use of dexamphetamine in Australia is contraindicated for those with a history of “drug abuse” (Monthly Index of Medical Specialities, 2001:96).

### *Need for local service*

We thought it would be too leading if we asked specifically if people wanted an Aboriginal Residential service in Canberra. Some people, did, however make comments about this. One man who had experience of an Aboriginal Rehabilitation service said “I’d like something like that here.” Another man who had been to an interstate Aboriginal rehabilitation service said: “And [a rehabilitation service] needs be closer to family too. You just need that family support really. It’s no good sending us all interstate, got nobody up there.” Whilst not relating the need to her own drug use one woman said “I think it would be good to have Aboriginal treatment centre in Canberra. There’s lots of boys going round in circles.”

When we asked about any other needs related to culture and drug use, one person (who had experienced a variety of treatments for his continuing polydrug use) had a very specific idea of what was needed for the ACT and region. Because this was something that he had thought about for a long time, he expanded on it at length. We assured him that, apart from removing identifying information, we would report his ideas verbatim. This man was insistent that there was a need for:

*A special Aboriginal and Torres Strait Islander facility where people have training in mental health first aid. A multi-purpose centre which will consist of all organisations under the one roof, detox’, rehab’, sexual assault, half way house, all under one roof so we’re pulling funding from everywhere, not just drug and alcohol [it could be based in Canberra or in the region].*

### *“Going bush”*

In the previous chapter we referred to comments people had made about how “going bush” had helped them control or stop the use of some drugs. In the part of the interview where we asked people about any services (other than those we had mentioned) related to treatment for their drug use, one man said he wanted somewhere like the Aboriginal Medical Services in the ACT, but out of the city and where there would be “culture, a learning place, hunting.” Another man mentioned the bush in the context of the needs for a rehabilitation service “away from the city, go to the bush get away from the alcohol and that, it would be alright if we had a rehab’ twenty kilometres out in the bush.”

Another man (whose polydrug use included injectable heroin and amphetamine) believed that several things could help him stop all his drug use. These included getting to see his family, being with people who did not use illegal drugs, being in a different environment and the bush: “Because I’m used to goin’ out bush, just go fishin’, huntin.’ I miss all that stuff.”

Another comment was made by teenager whose polydrug use included injectable heroin. He had never been in treatment and had said he believed no treatment currently available could help him stop his drug use. As part of our winding down for the interview we always asked people what their short and long term goals were. This teenager simply poignantly said his goal for this time next year was “to still be alive.” When we asked what he thought might help him get interested in treatment he expressed it like this: “There should be cultural camps run by Aboriginal staff, take them [Aboriginal people who use drugs] away from the city to the land [this will] help them heal.”

One man said that what he needs to do to stop using drugs was to “Go back home.” Superficially, this could have just meant him moving away from Canberra. Home could also be interpreted as having a wealth of cultural meaning linked with the land.

#### *The “Pathways Program”*

As we neared the end of the interviewing process, Winnunga commenced a program called Pathways which provides participants with training to enable life skills. Jodie Fisher, one of the Winnunga staff, provided us with a description of this service:

*Pathways is a program run in partnership with the CET (Community Education and Training). The main component is called Road Ready and supports clients to get their driving permit. Underlying this, however, is improving literacy skills with the driving permit as the incentive. Participants are supported in paying off any existing fines and the final exam for the driving permit is done at Winnunga. Gaining the permit has clearly given many of the participants a real sense of achievement and self esteem and in some cases a few have enrolled in other courses at CIT [Canberra Institute of Technology] or have started looking for paid work.*

(Fisher, J. 2004, pers comm, 5<sup>th</sup> May)

One person who had heard of “Pathways” mentioned it as a continuing need for herself and others.



## Summary of other needs for treatment

Table 6.19 summarises other needs for treatment expressed by the people we interviewed. Most were identified by small numbers of people. As such they can be considered as “grounded theory.”<sup>28</sup> We draw particular attention to the need for a multipurpose centre which one man who had given a great deal of thought to the problem of illegal drug use in the Community expressed.

**Table 6.19: Summary of other needs for treatment**

Type of services	n	%
Local Indigenous Service	3	3
Family services	3	3
Self help groups	2	2
“Proclaimed place”	2	2
Prescription drug	2	2
“Pathways Program”	1	1
Nurses employed in Aboriginal Medical Services	1	1
Mentor	1	1
Weekend treatment	1	1
Multipurpose Centre	1	1

There are five missing values for all additional types of service.

## Residential treatment needs

We asked people about what they thought would help them in residential treatment. For all open-ended questions related to treatment needs, several people said they did not know enough about residential treatment to make any suggestions about what was needed there. As reported in the previous chapter, some people made comments along

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<sup>28</sup> “A **grounded theory** is one that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. Therefore, data collection, analysis, and theory stand in reciprocal relationship with each other. One does not begin with a theory, then prove it. Rather, one begin with an area of study and what is relevant to that area to allow it to emerge” (Strauss and Corbin, 1990).

the lines that they would not go in to residential treatment. Some people did not make suggestions because they were content with their current treatment, or had been satisfied with previous treatment experiences. Other people said they did not want to go in to residential treatment because they wanted to continue using drugs. In the main, these were people who were using marijuana which they believed was beneficial to them (we reported these findings in the previous chapter). As also reported in the previous chapter, some parents said that they could not go in to treatment because of childcare responsibilities and they did not respond to these questions. (There are five missing values for questions on needs. This is because either the interviewers or the respondents curtailed the interview).

### *Cultural needs*

Following recommendations made by members of the local Aboriginal Community, we asked respondents whether they would like to learn about their culture when they were in “detox” or “rehab”, and if they would like a support person with them. We used these prompts only when respondents did not immediately offer ideas they had for needs in treatment.

### *Learning about Aboriginal/Torres Strait Islander culture in residential treatment.*

When we asked respondents if they would like to learn about culture whilst they were in a residential treatment, a small number of people said they already knew enough about their culture. A few people said that a residential treatment modality would not be a good place to learn about their culture. One woman commented: “You’re too worried about your own life.” A man also explained why he believed a rehabilitation setting would not be a good place to learn about his culture:

*Because you know like why I said “No” about the culture part is because you are there to address your problem, you know what I mean, and having too many things on your mind would be just too much, you know.*

For some parents, having a setting where their children could be with them was more important to them. Other people placed a higher priority on having a support person with them while they were in treatment, or more activities being provided. We discuss some of these other needs further below.

Forty nine people said they would like to learn about their culture in a residential treatment setting. Another person said that although he would not like to learn about his culture whilst in residential treatment, he thought it would be good to learn it on whilst “rehabilitating on methadone.”

Most people who supported the idea of learning about their culture in a residential treatment modality gave a brief affirmative response such as “That would be good.” One man put it more strongly when he said treatment “would probably be the only place [to learn about my culture].” When we asked him to clarify he said:

*See if you were put into a place like that, a dry-out zone, you can't leave, you gotta' stay there until that contract's up. And so whether you want to hear it or not you've gotta hear it.*

We again asked for clarification: “So you think that would be good?” He responded “Yeah.” Another man made a comment along similar lines: “It would be good because I'd have time to think about it.”

Another person who thought there was a need for culture to be taught in a residential setting put it like this:

*Yeah well particularly for Aboriginal people I think they should have some sort of cultural thing goin' to help people get through and give 'em more things to think about than just sort of gettin' on<sup>29</sup> and drinkin' or shootin' up or whatever.*

What underlies many people's cultural concerns about drug use is epitomised in the comment of a woman who was trying to control all her drug use, including occasional injection of amphetamine. She believed culture needed to be taught as part of treatment: “Yeah, because I mean smoking cigarettes and drinking ain't part of the Aboriginal culture. Yeah that would be good.”

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<sup>29</sup> “Getting on” means to acquire and use drugs.

Another woman empathically said:

*Aboriginal people we celebrated our youth, we celebrated life, that's through our ceremonies, and until such time that we are allowed to celebrate that in the way that we used to do - like the tribes used to meet down here, from down the coast and everywhere, I don't think we're going to get anywhere with our youth because now in this society, white man's society, our youth are frightened to be a teenager, they are frightened to get out there, and then they turn to crime and drugs ... until such time our people are really allowed to say our culture is a spiritual thing, a spiritual reality, that's the time. And we can't do that without the land.*

Summing up the needs expressed by respondents for culture to be taught in a residential setting, one woman said “That is a definite.”

Whilst Elders may be able to provide some assistance to those experiencing problems related to drug and alcohol use (McKelvie and Cameron, 2000) including teaching people in treatment about their culture, it is worth bearing in mind that Elders are often over-burdened. Whilst offered in a different context, this Elder's view is also relevant here:

*I find that a lot of people like to use me as an information person. It places a strain, it costs money, it's something you need to be aware of. I have people coming saying 'Can you help me walk the spiritual path' ... Elders are informative sources. It costs money. The paper, the ink. Other Elders are doing the same things, it's an additional task Indigenous people have more so than non-Indigenous. It's a role they perform, a role they increasingly play.*

(Dance et al, 2000b)

The above quote epitomises the need for Elders who may provide cultural training, either whilst people are in residential treatment, or in the general community, to be properly compensated.

### *Support when in residential treatment*

Twenty nine people said they wanted family contact when in residential treatment. Some people expressed more than one type of need about family contact. Twelve people spoke generally about a need for continued family support. Nine people said they would like to be with their partner whilst in treatment and seven said they would like their children with them (we provided these people with information about, or referrals to, family rehabilitation services). A man who had been in treatment, and wanted both his partner and children with him for any future treatment said: “I hated

being separated from me family. I hated that. But I realised it was for good reasons ... Being with my family would have made it better, yeah.”

Three other people said they would be content with family visits. Another said he would like his “kids” to visit.

Without being specific, nine other people who had experienced treatment said they would have liked to have been with other Aboriginal people. Another person specified a need for a “sponsor” whilst in treatment and one woman spoke of a generic need for support. Whilst not directly saying he wanted support in treatment, another man inferred a need for this. He said of his experiences of in-patient withdrawal services: “I just didn’t feel like I belonged there. It’s just I didn’t feel like, there was [any] similarity.”

The need to make phone calls to family whilst in residential care was mentioned by four people. One was thinking of the particular need for Aboriginal clients to make phone calls when he said:

*Well some rehabs’ say you know you’re not supposed to have contact with your people for X amount of time. That might be alright for a white person, but an Aboriginal person wants contact with their family, they might want to discuss something private that they can’t discuss with this white person. So why can’t they ring up and have that phone call? If they’re ringing their family, they’re not ringing a drug dealer. What’s the problem?*

In Chapter 9, we report on general needs related to culture.

### **Other specific needs for residential treatment**

In addition to needs related to culture, we asked people what else they thought would help them in residential treatment. We report below on the variety of responses. In addition to prompts related to culture and support whilst in treatment, we used these two other prompts: “Further your education” and “Understand more about drug effects.” As with other prompts (related to culture and support people) these were used at the request of Community representatives. We used these two prompts only when respondents did not spontaneously indicate what they would like in treatment.

### *Furthering education*

Nineteen people made comments directly related to a need for education whilst in residential treatment. Many people were general about their education needs, such as “Something to keep my mind busy.” Some people specified particular needs such as that for formal education or the use of the Internet. One man said he would like to “Catch up with reading and writing.” Another said he would “To do more educational stuff, like school stuff, things like that.” Two people linked a need for education whilst in treatment with learning skills that would improve their job opportunities. As we go on to show in Chapter 9, many people identified a generic need for more formal education. We also show that a large number of people were unemployed, that most wanted to be employed and most had specific employment aspirations.

A man we now go on to quote was an example of those people who were interested in less formal intellectual pursuits: “Yeah, I love learning hey. I’d watch a documentary over some stupid comedy any day. And read. That’s what I’d do.” One man suggested that treatment services could show “people the good things about life.”

### *Learning about drug effects*

Three people said they would like to learn more about drug effects while they were in treatment. These comments are best expressed by a man who said “Through [the] program you’d have to [talk about the] ... substances I suppose ... you talk about that a bit and how they effect your body.”

A related comment came from another person who had never been in treatment, but said he would go if it could help him with his needle fixation. For one man the “Problem is the needles, injecting, doing anything – injecting anything.” As far as his treatment was concerned he believed:

*[The] main problem is to concentrate on the addiction of the needle. I’d try a rehab’ program [and there would be] a bit more of an initiative for it to happen [if they treated] the addiction of the needle, how to overcome the addiction of the needle.*

A needle “fixation” was described by one of people we interviewed as “the feel of the steel.” It has been defined as:

*Repetitive puncturing of the skin with or without the injection of psychoactive drugs via intravenous, subcutaneous or intra-muscular routes, irrespective of the drug or drug injected or the anticipated effects of the drug.*

(McBride et al, 2001:1049)

After providing this definition, and based on interviews with 24 injecting drug users, McBride and colleagues reach the same conclusion as the man we interviewed: treatment interventions are required to address needle fixations (McBride et al, 2001)

### *Other activities whilst in rehabilitation treatment*

Ten people identified a need for general activities (other than those related to education and training) to be provided in residential treatment. Some people simply said they had been “bored” whilst in treatment. A man’s comment sums up these needs: “More outings, bush walks, things to do, meetings.” Another man said:

*Say for instance, because I couldn’t draw or couldn’t paint I’d be able to, I don’t know, sit down and play a board game or be able to play with a deck of cards or something like that. Yeah, which would sort of take your mind off using drugs and stuff like that, and then you’d be talking to people as well and, you know, like the conversations wouldn’t be about drugs, you know ... it would just be about life in general.*

Three people indicated a particular need for life skills to be taught in a treatment setting. One woman said she wanted to learn

*ways of making new friends, ways to cope when the urge [to use drugs] might come or when you’re in a certain situation or outings, social life, how to get back out there and make the right choices and the right friends.*

A similar need was expressed by a man who said he wanted “to learn about myself.” Another man was alluding to a need to learn life skills when he reported this conversation he had with treatment staff:

*‘I don’t know how to survive out in the real world’ I said. ‘I take drugs and I take alcohol ... that’s a part of it. But actually to survive out there in the real world, it’s mainly problems more than drugs and alcohol I think.’*

## *Other clients*

Pointing out that detoxification and rehabilitation services are for treatment of both illegal drug users and alcohol users, the only need one man expressed in terms of treatment in the future was to educate the clients who were there for treatment of alcohol problems:

*I'd like to explain to people ... 'cos' most of them [clients in residential treatment] are alcoholics ... and heroin addicts ... I am that, I am a heroin user, you know, and pill user and that. I don't use it because I want to, I use it to forget things, you know what I mean? But in the end I've realised that it doesn't ... you never forget, you'll never ever forget. It's just that when you're smashed and that you're not thinking of it, you know what I mean? And you have got to explain this to them, you know what I mean? You're not a junkie, you're not, you know, ... [it's not a choice]. Don't classify anybody, you know what I mean? - if you don't know 'em.*

## *Staff issues*

In addition to the need for Aboriginal staff, there was a variety of comments about other issues to do with staff. Two people identified a need for staff to have cultural awareness training. One woman had found her experiences of an interstate rehabilitation centre difficult because she was the only woman there. She identified a need for more female staff to be employed in residential treatment. Based on her experience of one type of treatment modality, one woman said she would have liked “better staff.”

Four people believed that ex-users were the best people to look after them while they were in treatment. This comment encapsulates this need:

*People that have actually been there and been through it, not these doctors that read through a book, and you know, they know all about heroin because they have read about it. People that have actually been there and gone through it would help.*

Six people made negative comments associated with what they saw as being controlled, being told what to do, or about with the rules in treatment settings. One man, who had benefited from his experiences some time ago in several different mainstream rehabilitation centres is an example. He believed that staff needed to be less controlling: “A lot of controlling stuff goes on within [rehabilitation services].” In a small study of ACT Aboriginal illegal drug users, Dobson also found that the people she interviewed wanted rules in residential treatment to be more flexible (Dobson, 2000).



### *Needs related to treatment itself*

There was a variety of disparate comments related to residential treatment itself. Eight people indicated that they did not like “being locked up.” One woman who had spent time in a rehabilitation setting put it like this “I was locked up all the time you know,. I can’t handle bein’ locked up. It drives me crazy.” Another woman said: “I did not like it at all, feels too much like a prison.” One man put it very comprehensively:

*they lock you up ... which I understand too in lots of ways, although you do feel something’s missing. You feel because you’re locked up, it’s not like jail because ... you know, you can walk out whenever you want, but then there’s a part of you that feels taken away. There’s a part of you that feels empty, or there’s a part of you that feels a waste ...*

Seven people made comments to do with more individualised treatment. Although he had, on the whole, been satisfied with his several experiences of mainstream residential treatment, one of these people said:

*Another thing I didn’t like about [residential treatment] was they do all put ya’ in the same category even though you’re different. Well I felt different, and I know that I am different. Even though they try and put you all in the same category, is which I feel a little bit not sure about.*

Two of the six people who wanted more individualised care wanted one-to-one care. Another man felt that there was a need for more “group counselling.” One woman simply identified a need for “therapy.”

Two heroin users had comments to make about the need for heroin-specific services. One said:

*I have been to rehabs’ for my heroin addiction but to me they weren’t addressing heroin, it was more alcohol, it was addressed to alcohol ... And they try and put it under the one thing. But of course alcohol and heroin are totally different drugs. So how can it be one and the same.*

The other man said of his treatment experiences:

*My situation anyway. It was different to most of them up there ... they were there for alcohol. Yeah up there they should have had something for [the heroin users]. It doesn’t matter if alcoholics go there. Just have different courses and all that you know. [Have] different days ... for alcoholics and ... [different days for people who use] narcotics.*

Two people identified a need for residential treatment services which allowed them to continue using methadone or buprenorphine. Two other people said they felt that the drugs used when they were in experiencing in-patient withdrawal had not been strong enough.

As reported in the previous chapter, some people had said they did not like the way some services they had been admitted to, or the 12-step programs they had attended, were Christian based. For others, this was an important part of their treatment. One person who had not been in residential treatment said he did not want to go to a service that was “Christian-based.”

### **Needs related to waiting period for residential treatment entry**

At the suggestions of members of the Community, we asked about respondents’ experiences with waiting periods for getting into residential treatment. Twenty eight people responded to this question. Others had never tried to get admitted into residential treatment. Seven people had never experienced problems. One of these people said: “The longest wait for [service] has been three days.”

The man’s story we report below was typical of those who voiced problems:

*I approached [service] and they said ‘We have a different system now and you have got to wait around a couple of days.’ And I got assessed ... and by the stage that they rang me up and said ‘Do you want the bed?’ I was sort of like .. the will had gone ... I guess if it had been that day or the next ... immediately after use, and then because you have been a bit sort of calmed down a couple of days and then you start to think ‘I don’t really need this now.’*

Another man (who after a long period in rehabilitation had relapsed into heroin use) said that in the past, before he had managed to get admitted into an interstate rehabilitation treatment he had

*tried everywhere. All the other rehabs' they all were full. They were all packed out. I was going to commit suicide on Valiums and that, felt suicidal and felt like killing meself ... I don't really think that's fair for a lot of young people. For some people it could be too late. They should have - I reckon meself, I reckon they should have more rehabs.' For Indigenous people or for any people with a drug problem. If they want help I reckon they [rehabilitation services] are the best places for em.'*

Another man (who had a lot of positive things to say about his times in residential treatment) also spoke about suicidal feelings because of the wait to get into treatment:

*Like you know, 'Can you ring back' and all this. By the time you just know that you are gonna' get into more of whatever you're up to, and once you hear that you can't get in well then [you think] 'I might as well go out and have some more before I actually do get in.' And by that time you're even more wrecked up. And you could die between that time. It only takes ... yeah a split second of your decision, which doesn't take long when you are at a crisis in life. The time it takes, just a second ...*

A Winnunga researcher, who was at the interview as a co-interviewer/support person, asked “You are talking about suicidal or - ?” This man responded: “Yeah. Suicidal, the whole works that comes with suicidal thinkin.’ Yeah, you just get right into the thinkin.’”

As with people who had juxtaposed their reason for not going into treatment with criminal activities, one man said

*You have got to ring up every day for the next two weeks. Well that's no good if the court says, you know, you have got to be in there within three days. And it's not your fault, you've rang up, you're lookin' everywhere ... Well what happens if there are no vacancies? You go to the court ... the court's not going to believe ya', they hardly ever believe ya', unless you take one of the field officers [from place] and [they've said] 'We started today to come to court and said there are no vacancies yet, but we've been trying.' Then they might believe. But if he [the magistrate or judge] stands up and says 'Blah blah blah' and he says, 'Yeah right, off to jail, see ya' later.' There's no choice.*

### **Summary of other needs identified for residential treatment.**

Table 6.20 reveals that the biggest need identified for treatment was for cultural education (n=49, 54%). A large numbers of people also identified a need for family support when in treatment (n=29, 32%). Several people also expressed a need for a shorter waiting period (n=21, 23%). These were all needs that, when necessary, we used prompts for. Other needs were expressed by between one and 10 people. As with other findings these may be considered as grounded theory (defined above) (Strauss and

Corbin, 1990). We also point out that many needs identified by respondents, such as group counseling and therapy, are already provided in treatment services.

**Table 6.20: Summary of other needs identified for residential treatment.**

<b>Residential treatment needs</b>	<b>n<sup>a</sup></b>	<b>%</b>
Cultural education	49	54
Family support	29	32
Reduced waiting period	21	23
Other Aboriginal people (general)	10	11
General activities	10	11
Furthering education	9	10
Not being “locked up”	8	9
More individualised treatment	7	8
More flexible rules	6	7
Phone calls to family	4	4
Ex-drug users being employed	4	4
Learning about drug effects	3	3
Learning life skills	3	3
Staff being culturally aware	2	2
Group counselling	2	2
Heroin-specific services	2	4 <sup>b</sup>
Being able to continue to use pharmacotherapies	2	4 <sup>b</sup>
Stronger pharmacotherapies for opioid withdrawal	2	4 <sup>b</sup>
Educating non-opioid using clients about heroin use	1	1 <sup>b</sup>
Learning about “needle fixations”	1	2 <sup>c</sup>
<i>Therapy</i>	1	1

<sup>a</sup> There are five missing values.

<sup>b</sup> These percentages are worked out on the number of opioid users we had data for.

<sup>c</sup> This percentage is worked out on the number of injecting drug users we had data for.

### **Need for information**

We followed questions about management and cultural background of staff for treatment modalities with questions about needs for information. These were based on questions we asked of older Aboriginal and Torres Strait Islander people about their need for information about aged care services (Dance et al, 2000b). Firstly, we asked

respondents if they would find “A booklet specifically for Aboriginal and Torres Strait Islander people, which tells you about alcohol and drug services, useful?” We asked a similar question about a video. A majority of 83 per cent of the sample (n=78, one missing value) said they would find a booklet useful. A slightly smaller proportion of 80 per cent (n=75, one missing value) said they would find a video useful.

A woman who had a polydrug using history and was (with medical help) trying to control her drug use specified a need for “More information for Aboriginal mothers, there’s none there.”

Holly and Shoobridge have indicated a need for development, through consultation with Aboriginal drug users, of information presented in a variety of formats (written, posters, visual, through workshops etc) on safer using, drug treatment options (Holly and Shoobridge, 2002). In keeping with this, and based on the need for such information identified in our research, we have successfully applied for funding from the ACT Office, Australian Government, Department of Health and Ageing, for the production of a booklet for distribution into the Community, particularly to the people we interviewed. We will achieve this by continuing to work with the Reference Group and other Community representatives. This booklet will contain information about drug and alcohol treatment services, as well as some information about this research. It will be written in such a way that it will be accessible to as many Community members as possible. We will distribute the booklet via Winnunga, other Aboriginal organisations as well as via mainstream organisations providing services to Aboriginal and Torres Strait Islander people who use illegal drugs.

### **Referrals for treatment services**

We carried a comprehensive range of available printed matter with us to hand out to interested participants. Either when people requested information, or we when deemed it appropriate, we offered this material to respondents. Sometimes we referred people to an Aboriginal Medical Service *or* a mainstream service. Generally, however, we offered information about all available services so that respondents could choose what was best for them. Without being specific about particular mainstream services, we report on these referrals below.

### *Referrals to Aboriginal Medical Services*

As shown in the previous chapter, the majority of respondents were in contact with Aboriginal Medical Services. During the interviews we did, however, refer some people to particular types of services offered by Aboriginal Medical Services. In addition, we interviewed a few people who had recently arrived in Canberra who were not in contact with Winnunga. We informed all these people about the service and, with the permission of respondents, made a few on the spot appointments. Overall, we referred 14 people (15% of the sample) to a particular type of treatment offered by an Aboriginal Medical Service.

### *Referrals to mainstream drug treatment services*

We provided information about a variety of mainstream services for treatment of alcohol and other drug problems to 12 people (13% of the sample).

### *Distribution of "Handy Hints"*

"Handy Hints" is a booklet which provides "comprehensive information for people who inject drugs" (Australian Intravenous League, 2001:1). Thirty one of the current injecting drug users (57% of this subsample) accepted one or more copies of this booklet when we offered it. Most of the other injecting drug users already had a copy, or had already seen it.

### **Treatment for tobacco use**

Brady has noted that "After years of inattention, smoking cessation projects designed for Indigenous Australians are beginning to emerge" (Brady, 2002c:120). As we documented in our introductory chapter, tobacco is associated with many of the illnesses which contribute to the shortened lifespan of Aboriginal and Torres Strait Islander people. As reported in Chapter 4, a large proportion (94%) of the people we interviewed were tobacco smokers. We also referred to findings demonstrating that, by comparison with other Australians, a much higher proportion of Aboriginal and Torres Strait Islander people smoke tobacco. We make some mention here, therefore, of the work of other researchers regarding treatment for tobacco use.

Following a rare study of treatment of tobacco use for Indigenous people, Ivers and colleagues cautiously concluded that free nicotine patches might benefit small numbers of Indigenous smokers (Ivers et al, 2003). As part of a non-smoking campaign known as “No More Bundah” (bundah is a Wiradjuri word for tobacco) run at Winnunga, nicotine patches are offered to participants. We asked Jodie Fisher, a Winnunga staff member who is involved with running “No More Bundah” to tell us more about it:

*‘No More Bundah’ is an eight week quit smoking program run in partnership between Winnunga and the ACT Cancer Council. This program uses a supportive group approach and the use of combination NRT [Nicotine Replacement Therapy] (patches, puffers and gum) and information. The last group in November [2003] had 30 people start with 30 per cent (n=9) not smoking at the end of the 8 weeks.’*

(Fisher, J. 2004, pers comm, 5<sup>th</sup> May)

Given its success, there are good grounds to continue running this program, and to also institute similar no smoking campaigns specifically for Aboriginal and Torres Strait Islander people.

## **Conclusion**

As long ago as 1989 the National Aboriginal Health Strategy Working Party advocated that adequate funding be provided for Aboriginal services across the spectrum of interventions. This included funding for existing Aboriginal drug and alcohol services, the establishment of Aboriginal detoxification and rehabilitation services and funding for primary health care funded through Aboriginal and Torres Strait Islander Community Controlled Health Services (National Aboriginal Health Strategy Working Party, 1989). Since the time of that report, several investigations have demonstrated that there has been an increase in the prevalence of illegal drug use among Aboriginal and Torres Strait Islander people (reported in Chapter 1). Comments made by the people we interviewed support other research which has also identified a need for more detoxification and rehabilitation facilities for Indigenous people (Frances and Edwards 1996; Holly and Shoobridge, 2002; Gray and Saggars, 2003). In the context of illegal drug use in the general population, Shewan has argued that if the “aim is to both reduce crime *and* the prisoner population then it is not inconsistent to look for alternatives to

custody which involve rehabilitative treatments which includes drug treatment interventions” (Shewan and Davies, 2000:243).

A majority of people we interviewed wanted Aboriginal and Torres Strait Islander-specific treatment services for all treatment modalities except Narcotics Anonymous. There were also large proportions who favoured a “special mainstream service.” Almost everyone wanted either just Aboriginal and Torres Strait Islander staff, or both Aboriginal and non-Aboriginal and Torres Strait Islander staff and appropriate non-Indigenous staff to care for them when they were in treatment.

A limitation of the findings on specific needs related to treatment is that we only used some prompts, and only used these when respondents did not spontaneously articulate their needs. We suggest that the other needs identified by the people we interviewed are used for further research where all these needs identified by the people we interviewed could be used as prompts.

Despite the limitations, our results do give a clear indication of some needs. Large numbers of people said they would like to learn about their culture when in residential treatment and large numbers also said they would like to have the support of family. Several people also spoke about the need for more activities whilst in treatment, including activities that would further their education and job opportunities. We return to these needs in Chapter 9.



## CHAPTER 7: PHYSICAL HEALTH

### Introduction

The World Health Organization maintains that physical, social and mental well-being is necessary for people to achieve optimum health (World Health Organization, 1986). This definition sits very comfortably with the Aboriginal holistic concept of health. These domains, are not, of course mutually exclusive, particularly for the Aboriginal framework of holistic health. For ease of reporting, we have, however, divided the findings on health into three chapters. This chapter mainly concentrates on findings related to physical health. The following chapter is concerned with mental well-being (emotional well-being). Chapter 9 focuses on social well-being (the social determinants of health).

### *General introduction to findings on health*

The introduction to this chapter serves as an overall introduction to all three chapters reporting findings on health. We begin with a brief historical discussion about the impact that colonisation has had on Aboriginal and Torres Strait Islander health before reviewing the particular problems associated with illegal drug use.

Prior to colonisation, Aboriginal and Torres Strait Islander people lived within “a structured, inclusive society with a comprehensive system of governance and law. There were extensive intact family kinship networks and Aboriginal people appeared to enjoy a relatively good state of health” (Zubrick et al, 2004:xxiii). The impact of colonisation resulted in dispossession from traditional lands, massacres, exposure to introduced diseases, incarceration of men, women and children, legislative control, radical changes in diet, nutrition and physical activity, fragmentation of families, discrimination and exclusion from health care and education (Zubrick et al, 2004). Problems that are seen to be a consequence of colonisation include family breakdown, high rates of incarceration, financial problems, early age of death (when compared with other Australians), poor health, psychological problems and substance use (Memmott, et al, 2001).

According to the 2001 Census, just 6.9 per cent of Aboriginal and Torres Strait Islander people were aged 55 or more. This compares with 22.4 per cent of the general Australian population who were aged 55 or more (Australian Bureau of Statistics, 2003b). Tatz has remarked that “In many respects, Aboriginal youth becomes older sooner than non-Aboriginal youth: there is earlier sexual development and experience, earlier exposure to danger, disease, and death” (Tatz, 1999:53).

According to Ring:

*The really exceptional feature of Aboriginal and Torres Strait Islander health is the enormously high adult mortality, particularly in middle age, and I have been unable to find any other population in the world [for whom figures are available] that has rates as high – with estimates ranging from 6 to 12 times that of the total population in various parts of Australia for those in their forties and late thirties.*

(Ring, 1995)

Many previous studies have indicated that people who use illegal drugs are at increased risk of physical, emotional and social morbidity. As noted in Chapter 1, tobacco and alcohol, rather than illegal drugs, cause most drug related mortality and morbidity (Australian Bureau of Statistics, 2002a:6). In 1998, approximately 1023 drug-related deaths were, however, due to illegal drugs (Australian Institute of Health and Welfare, 2003b). Following a review of the literature, Darke and Zador conclude that, because of deaths due to overdoses, bloodborne viruses, and violence, the excess mortality among heroin users is six to 20 times more than amongst peers of the same age and gender (Darke and Zador, 1996).

In 2001, the overall drug related death rate in the Indigenous population was estimated to be 8.1 per 100 000. This is somewhat higher than 5.1 per 100 000 in the non-Indigenous population (Steering Committee for the Review of Government Service Provision, 2003, citing unpublished Australian Bureau of Statistics data).

Despite the seriousness of the health problems in the Aboriginal and Torres Strait Islander people they underutilise specialist healthcare, both as in-patients and out-patients. This situation is exacerbated by demonstrable underfunding of primary care services for Indigenous Australians (Fisher and Waramunthri, 2002).

We used the Opiate Treatment Index to measure different aspects of health. All three chapters on health report findings from the Opiate Treatment Index, as well as other findings relevant to health. Over many decades, general population studies have demonstrated that women report more illnesses than men (Wadsworth et al, 1971; Wingard, 1984; Broom, 1990; Kawachi et al, 1999). Some studies of people who use illegal drugs suggest a similar gender differential (Mondanaro, 1981; Singh et al, 1994). When reporting health findings from the Opiate Treatment Index we report, therefore, on gender differences.

### *Introduction to the findings on physical health*

As with other findings, our imperative was to respect respondents' confidentiality. We provide in this chapter, therefore, a composite picture of general physical health findings from the Opiate Treatment Index (Darke et al, 1991a). We then focus on findings on overdoses. We follow this by reporting findings on the Opiate Treatment Index HIV Risk Behaviours Scores, before reporting on other findings related to bloodborne viruses, sexual health and needle use behaviour. Information about drug use whilst incarcerated is also reported here. Throughout the chapter we indicate the education we provided to respondents about unsafe behaviours.

### **Findings from the Opiate Treatment Index physical health domain**

The Opiate Treatment Index physical health section consists of a checklist of 51 symptoms within eight subcategories. There is a range of possible scores from 0 (best) to 51 for women (including 2 gynaecological symptoms) and 49 for men (worst) (Darke et al, 1991a). The questions are mainly confined to symptoms experienced during the month prior to interview.

Breaking the total score down to the quintiles recommended by Darke and colleagues, scores of 19-52 are high, 14-18 are above average, 10-13 are average, 6-9 are below average and 0-5 are low (Darke et al, 1991a:24).

The mean Opiate Treatment Index physical health score for the people we interviewed (4 missing values) was 8.5 (range 0-31, median 7, mode 0, SD 7.6). The 60 men whose Opiate Treatment scores we were able to calculate had a mean score of 7.7 compared to 10.1 for the 31 women. This difference was not significant. According to the quintiles set by Darke and colleagues, nine of the people we interviewed (9%) had an above average score of 14-18 (indicating an above average level of poor health) and twelve (13%) had a high score of over 19 (indicating a high level of poor health).

The overall score of 8.5 we found is somewhat lower (that is, indicating better health) than the 12.6 reported by Darke and colleagues from their research with injecting drug users during the development of the Opiate Treatment Index (Darke et al, 1991a). Macleod and colleagues also used the Opiate Treatment Index in a longitudinal study of drug users in a clinical setting in Scotland. They reported a high physical score of 19 at clients' first assessment (Macleod et al, 1996). The injecting drug users (n=50) had a score of 8.3 compared to 8.8 for the non-injecting drug users (n=41).

## **Overdoses**

We wanted to identify respondents' experiences of overdoses so that we could identify needs in this area. We began these questions by asking "Can we move on now and talk about any bad drug effects you've had or seen?" Below, we first report on the overdoses which respondents had experienced before going on to report those they had witnessed or been affected by.

### *Respondents' experiences of overdosing*

In many countries, deaths from overdoses are the most common cause of deaths among people who use heroin (Darke and Zador, 1996). As we showed in Chapter 4, most of the people we interviewed were polydrug users. For many, their polydrug use included both alcohol and heroin. Several studies have demonstrated that many heroin-related deaths are due to concurrent use of other drugs, most notably alcohol and benzodiazepines (Concool et al, 1979; Kreek, 1984; Kreek, 1987; Bammer and Sengoz; Zador et al, 1996).

Twenty one per cent of the 307 Aboriginal injecting drug users interviewed in South Australia (n=63) had overdosed after injecting. Of the 74 people we interviewed who had ever used an opioid, thirty one per cent (n=23) had ever overdosed. All but three of these people were still using opioids, mainly heroin. Of the 60 current opioid users 20 (33%), therefore, had a history of overdosing (Holly and Shoobridge, 2002).

Most people who had overdosed had done so on more than one occasion. We asked people to tell us about their most recent experience. This is the most recent experience of a man who had overdosed

*heaps of times. I ended up in hospital, with Narcan<sup>30</sup> – it kills a good shot. It's a non win situation. The closer you get to dropping<sup>31</sup>, the better, it's the edge.*

Another man who had overdosed “countless times” also told us about his most recent experience. This had been a few years prior to the interview. He had taken

*forty Valiums and shot up a half weight of heroin. Just walked fifty metres from the toilet [where I had injected] and then fell straight back over. Me cousin [was with me] and that [he] rang the ambulance ... They had to give me about four or five shots of Narcan.*

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<sup>30</sup> Narcan is a drug used by ambulance officers and other health personnel to counteract the effects of opioids.

<sup>31</sup> “Dropping” means to overdose.

We warned this man of the dangers of doing this, as we did with everyone who told us they had used combinations of drugs, particularly those who had done this prior to overdosing. We also gave them other information about preventing overdoses, such as not using drugs alone and being careful when they had used a different source to obtain their drugs (which makes users even less knowledgeable about the concentration of heroin than usual).

Another man explained what it was like the last time he had overdosed:

*Didn't even finish pushing the plunger [of the syringe] into me. [Then I] fell on a piano. This was at a friend's house. There was him and another bloke, the other bloke just ran. Me mate, I had known him since we were kids. And he sorta' got me out in the back yard and sprayed water on me and walked me around and that. Got me goin' again. So that was the scariest.*

### *Witnessing others overdosing*

The majority of deaths attributed to overdoses occur in the company of others (Darke and Zador, 1996). Nine of the Aboriginal injecting drug users interviewed in South Australia were present when someone else had not recovered from an overdose (Holly and Shoobridge, 2002). Fifty six people (59) we interviewed had seen someone else overdose: most had recovered. On most occasions this had been a relative or friend but some people said they had been witness to an overdose or overdoses of people they did not know. Most people had witnessed more than one overdose.

A man (who had also overdosed several times himself) discussed his most recent experience of seeing someone overdose:

*It was me cousin. He was ... just whacking<sup>32</sup> it [heroin] every day you know. And we was sitting [at place], he was ... having a shot, and he dropped<sup>33</sup> and he was goin' all blue and all that in front of me. And I thought he might come around but when I seen his face was going blue and that I just thought 'Oh what's goin' on?' I didn't know what to do. All I knew was to put him on his side and that was all I basically knew and started waving people down and the ambulance come. I heard the ambulance, someone must have seen me waving and gone for help. And the ambulance came and I just kept on talking to him. I was just talking to him while he was OD'd.*

A woman we interviewed talked about how she had become inured to seeing people overdose:

*I've seen a lot ... Death doesn't shock you after a while. Nothin' shocks you after a while. It happens nearly every week, every day. Like seein' someone drop now is nothin.' It doesn't even faze me any more. I don't give a shit. Like before I used to freak out, like someone's dropped someone help 'em. After a while you just go cold, you just lose your emotions. And that shows in me.*

Thirteen people we interviewed (14%) had lost a family member or a close friend due to an overdose. This is how one woman (who had stopped her heroin use) put it: "I was so sick of burying people from dropping you know like when we first started it was [name] and now everyone I knew at [name] they're all dead."

Another respondent (who had also had several overdoses himself) had seen "Heaps of people drop there used to be a group of thirty mates, there's only three alive today."

Other research has shown that witnesses to overdoses, who are commonly other heroin users themselves, appear reluctant to seek assistance (Darke and Zador, 1996, citing several sources). ACT residents we interviewed were generally aware that ambulance officers do not notify the police when they are called to non-fatal overdoses. One man from a regional town had up to date resuscitation training. He had not called an ambulance to attend the most recent overdose he had witnessed. The person who had overdosed was a relative who, in addition to using heroin, had been drinking alcohol:

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<sup>32</sup> "Whacking" means injecting.

<sup>33</sup> Dropped is a colloquial term for overdosing.

*Me and [name] were there. We'd had this shot. He had his shot. He went in the bedroom and started smokin' cones [marijuana]. Went lookin' for him. He was purple as. Twenty-five minutes I worked on him [before he was revived].*

In response to our asking why he had not called an ambulance this man replied:

*Well, in my opinion, country towns, and I know for a fact in this town, confidentiality and all that shit, as soon as something [like] that happens ... [the ambulance officers] pull in on the way down and says [to the police] 'I've just been so and so, so and so.' So that's why everyone is paranoid of ambos'<sup>34</sup> here. They're not supposed to do it, but I know they do it. They all work together, they're all mates and this rubbish. Drink together etc. It's not on.*

### *First aid training*

Less than a quarter of the Aboriginal injecting drug users interviewed by Holly and colleagues described some knowledge of basic first aid they could apply in an overdose situation. Lack of knowledge of resuscitation techniques amongst Aboriginal users was also believed to be a contributing factor in overdose deaths (Holly and Shoobridge, 2002).

We asked everyone we interviewed if they knew what to do if they saw someone overdose. Forty seven people (49%) said they would know what to do. Some people had participated in full cardiopulmonary resuscitation training. Other people knew they should place the affected person in the recovery position, clear their airway and then phone an ambulance.

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<sup>34</sup> Ambulance officers.



A man who had been present at several overdoses, and who also had cardiopulmonary resuscitation training, explained how he reacts to seeing other people overdose:

*The first thing is don't panic because in that scene ... seein' someone drop it's normal, not normal, but you become desensitised to things like that, you know, so you just know what to do. Just check that they're breathing, you know. Even if it's a slight gurgle, you know, if they're still breathing, that's fine. You're right. Either bring them around or lie them on their side so they don't choke. Check that they're breathing and they've got a pulse ... then ring the ambulance. Yeah. Then they'll come and sort 'em out. The best thing is watch the person because you can see that they're goin' to go on the nod<sup>35</sup> and if they're gonna' slip away ... And once they go on the nod you can't let 'em get to that stage, so you tell 'em to stay awake ... you're pretty safe after about twenty minutes, and then they can go on the nod after that, have a chance for the drug to work around their body.*

A woman who knew how to resuscitate explained why people who know how to perform cardiopulmonary resuscitation may not do it:

*Yeah, I did First Aid. Twice when I've seen it [someone overdose] happen it hasn't helped me at all. You are in such a state ... it's sorta' like [you think] 'Get straight away from this place', that's the first thing you think. 'He's dropped.' It's sad but that's the first thing that goes through your mind. 'The cops are comin', you know. You're more worried about getting busted doin' it ... the bloke that dropped out there in [name of place] by ... the time they got the ambulance the dude died ... And it's very sad ... When I was on the heroin then. I understood why that happens because they either panic because of police or like just like 'Oh shit man', and then they go sit down and go to sleep. And by then it's too late. Or they run. They got no soul left [because of their heroin use]. 'Ohhh, where's your heart?'*

### *Referrals for first aid training*

Towards the end of the interviewing period we became aware of a program called "Project Survival." This is a free program run by St John's Ambulance which "teaches basic first aid skills to young people who live on the street or in refuges in the ACT" (St John, 2001). We provided information about this service to two of the people we interviewed.

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<sup>35</sup> To "go on the nod" is a heavy sleep due to heroin use - people in this state may be unconscious, on the verge of unconsciousness or be experiencing the effects of heroin that they desired.

## **Opiate Treatment Index HIV Risk Behaviour Scores**

Before reporting our findings on bloodborne viruses and sexual health below, we report the HIV Risk Behaviour Scores from the Opiate Treatment Index. Some of the questions in the score are related to condom use and some to the sharing of needles and syringes. We supplemented these findings with qualitative data about needle use and sexual behaviours. These are discussed in detail in separate sections below.

The HIV Risk Behaviour Score was “designed to measure the behaviour of injecting drug users that puts them at risk of either contracting or passing on HIV” (Darke et al, 1991a:9). Each of the eleven items has a possible score of 0 to 5 concerned with risk behaviours in the month prior to interview. Overall there is a possible score of 55 (0 equals best and 55 equals worst).

Since this scale was meant for application to injecting drug users we analysed the data of just the 50 current injecting drug users for whom we had scores (4 missing values). We found a mean HIV Risk Behaviour Score of 7.7 (range 0-30, median 6, SD 6.7). Men had a mean score of 8.4 and women a lower mean score of 6.3. This difference was not significant. All scores are lower than the mean score of nine found in the sample of 290 injecting drug users interviewed by Darke and colleagues during the development of the Opiate Treatment Index (Darke et al, 1991a). They are also lower than the mean score of 11 found by Macleod and colleagues in treatment entry clients (Macleod et al, 1996).

According to the quintiles recommended by Darke and colleagues, HIV Risk Behaviour Scores of 15-55 are high, 9-14 are above average, 7-8 are average, 2-6 are below average and 0-1 are low (Darke et al, 1991a:24). Eleven of the people for whom we had scores had an above average score of between 9 and 14, and seven had a high score of between 15 to 30.

## **Bloodborne viruses**

Studies of Aboriginal people who inject drugs in Brisbane (Larson et al, 1999) and Western Australia (Gray et al, 2001) identified that there was a poor knowledge about bloodborne viruses. We begin this section on bloodborne viruses with a review of relevant findings for HIV/AIDS before reporting on findings for the people we interviewed. We then go on to discuss and report on findings related to hepatitis A, B

and C. Firstly we asked people if they had heard of these viruses, then, if so, what they knew about each one. Most people who had poor knowledge about how the viruses were transmitted accepted our offer of information. We then asked respondents if they had ever been tested for these viruses and if they had, when they had last been tested and what the results of their last test were. We then asked people if they had ever been immunised against hepatitis A and hepatitis B. Reports of the prevalence in the sample of all these viruses, and of immunisation status, rely, therefore, on self-reports. Unless otherwise stipulated, there are four missing values for all findings on bloodborne viruses (from three people who, because of other engagements had to leave the interview before we got to these questions, and from one person where the interviewers stopped the interview because we feared the respondent was becoming distressed).

### *HIV/AIDS*

Australia has a low incidence and prevalence of HIV infection in the general community. This is reflected in the injecting drug population, which has a prevalence of less than three per cent (Crofts, et al, 1999). This has been primarily attributed to the wide implementation of preventative measures, including needle and syringe programs and education targeting those at risk (Coutinho, 1998).

Costello has identified several factors that place Aboriginal and Torres Strait Islander people at higher risk of HIV infection than their non-Indigenous counterparts. These include high rates of sexually transmitted infections, social dislocation resulting from colonisation, sexual abuse, high rates of alcohol and other drug use, and the proximity of many Indigenous Communities to the epidemic of HIV in Papua New Guinea and Indonesia (Costello, 2003). According to Davis, there are more than seven million people living with HIV/AIDS in the Asia Pacific. In recent years, both Papua New Guinea and Indonesia have experienced major increases in the prevalence of HIV/AIDS (Davis, 2003).

Guthrie and colleagues examined national HIV and AIDS notification data by Indigenous status between 1992 and 1998. The annual HIV diagnosis rate per 1000 000 population amongst Indigenous people (excluding Victoria and the ACT where Indigenous status was not available) was similar to non-Indigenous people. The rates of diagnosis of HIV during this period were stable amongst Aboriginal and Torres Strait Island people but declined amongst non-Indigenous people. A significantly ( $p < 0.001$ )

higher proportion of Indigenous people with HIV were female (26.8% versus 8.9% in non-Indigenous people). A history of heterosexual contact only was reported more frequently by Aboriginal and Torres Strait Islander people. Male homosexual contact *and* injecting drug use was reported for 10 per cent of Indigenous people - higher than the 4.2 per cent for non-Indigenous people. Injecting drug use as a single category was reported for five per cent of Indigenous cases compared to 3.9 per cent in non-Indigenous cases (Guthrie e al, 2000).

Following a later examination of available data collected between 1993 to 2002, the National Centre in HIV Epidemiology and Clinical Research also reports that there is little difference between overall rates per capita of HIV and AIDS diagnosis in Indigenous and non-Indigenous people. There are, however, differences in recent route of transmission.

Among new HIV diagnoses in 1998 to 2002, the most frequently reported route of transmission was male homosexual contact in the non-Indigenous population: sixty five per cent compared to 36 per cent in the Indigenous population. Thirty seven per cent of the reports for Indigenous people were for heterosexual contact compared to 21 per cent in the non-Indigenous reports. A higher proportion of infections amongst Indigenous people was attributed to injecting drug use: 20 per cent versus four per cent in the non-Indigenous reports. There was also a higher proportions of infections reported amongst Indigenous women: 35.6 per cent versus 10.6 per cent for the non-Indigenous cases (other/undetermined cases were 7% for Indigenous people and 10% for non-Indigenous people) (National Centre in HIV Epidemiology and Clinical Research, 2003).

All but one of the people we interviewed had heard of HIV. Thirty eight correctly said they knew it could be transmitted through “blood and sex.” Eighteen people just said that it could be transmitted through “blood” and seven people mentioned just sexual transmission. The comments from five people were related to the disease itself. For example, “it’s bad”, or “It’s a slow killer.” Seventy five people (82%) had been tested for HIV. Ten (11%) said they had never been tested and six people (7%) did not know whether they had been tested. A majority, 58 per cent of the total sample, had been tested during the 12 months prior to interview. No one reported that they were HIV positive.

### *Hepatitis A virus*

Hepatitis A is “an acute infection of the liver caused by the hepatitis A virus” (NHMRC, 2003:109). It is predominantly transmitted via the faecal-oral route. The NHMRC lists communities of injecting drug users as one of the at risk groups for outbreaks of hepatitis A (NHMRC, 2003). According to Delpech and colleagues, identified routes of transmission amongst injecting drug users include injecting, and ingestion of contaminated drugs (Delpech et al, 2000). They postulate that behaviour associated with sharing drug use equipment, as well as sexual contact and poor personal hygiene, are also likely contributors to transmission of hepatitis A in the injecting drug using population (Delpech et al, 2000).

Harkess and colleagues have reported some additional risk factors for transmission of hepatitis A amongst people who use illegal drugs: contaminated needles, inferior living conditions, faecal contamination in rectally carried drugs and contamination of marijuana with faeces while preparing it (Harkess et al, 1989). Gilroy and colleagues believe that transmission of hepatitis A amongst injecting drug users is most commonly via the faecal oral route, although transmission may occur through blood. They conclude that the role of needle sharing in the transmission of hepatitis A is not clear and requires further investigation (Gilroy et al, 2000).

There were reported outbreaks of hepatitis A among injecting drug users in the ACT in 1997 to 1998 and in South Australia in 1998 to 1999 (Gilroy et al, 2000). Delpech and colleagues report that from December 1998 to 30 May 1999 there were 31 notifications of hepatitis A to South Eastern Sydney Public Health Unit. Forty per cent were among people reporting illegal drug use in the previous two months (Delpech et al, 2000).

Between 1998 to 2002, the acute notification rates per 100 000 for hepatitis A for combined notifications from NSW, Western Australia and the Northern Territory were 52.9 for the Indigenous population compared to only 10.1 in the total population (Australian Bureau of Statistics, 2001b).

Eighty one of the people we interviewed (89%) said they had heard of hepatitis A. Thirty four people had some knowledge about how the virus was transmitted. Most of these people said something along the lines of: “You can get it through bad hygiene”, or through “body fluids”, or through “drink bottles and bongs.” Four people

commented that it would be caught through contact with blood, or through injecting drug use. Rather than commenting on how hepatitis A was transmitted, six people made comments about the effects of the disease, such as “You go yellow.”

Seventy two people (79%) said they had been tested for hepatitis A, six (6%) believed they had not been tested, ten people (11%) said they did not know if they had been tested and three said they had contracted hepatitis A. Of those who had been tested, 61 per cent (n=44) had been tested in the 12 months prior to interview.

### *Hepatitis A immunisation*

Several types of hepatitis A vaccines have been approved for use in Australia. These are thought to provide a very high protective efficacy for at least ten years after the recommended schedule of three doses (NHMRC, 2003). Forty three people (48%, 6 missing values) said they had been immunised against hepatitis A. Combined hepatitis A/hepatitis B vaccines are recommend for those at risk of acquiring both infections. Twenty of the people we interviewed believed they had received two doses of the combined hepatitis A/hepatitis B vaccine. Fifteen people said they had been immunised but were unsure of the schedule. A further 22 people did not know whether they had been immunised against hepatitis A. Most people who had been immunised had been vaccinated during the five years prior to interview.

### *Hepatitis B virus*

A virus now known as the hepatitis B virus was discovered in the serum of an Australian Aboriginal person in 1965. For this reason the virus was first known as the Australia antigen. It was soon recognised that hepatitis B is transferred efficiently via sexual and blood contact (as well as by maternal-foetal transmission) (Batey and Bollipo, 1996). Most people infected with hepatitis B experience few symptoms. Adults who become infected have a six to ten per cent chance of becoming chronic carriers but infants who become infected have a 70 to 90 per cent chance (Oman et al, 1997, citing Maynard 1990). Some chronic carriers of hepatitis B develop sequelae such as cirrhosis of the liver and hepatocellular carcinoma (Gust, 1992). It has been estimated that, in Australia, around five per cent of deaths from cirrhosis of the liver,

and 80 per cent of deaths from primary hepatocellular carcinoma, are secondary to infection with hepatitis B (Antioch et al, 1993).

Australia is considered to be a low prevalence country since less than one per cent of the population are chronic carriers of the virus. Based on data from NSW, Western Australia and the Northern Territory, there are indications, however, that hepatitis B infection is much more common amongst Aboriginal and Torres Strait Islander people than among non-Indigenous people. During 1998 to 2002 the acute notification rates per 100 000 for acute hepatitis B were 16.7 for the Indigenous population compared to 2.8 in the total population (Australian Bureau of Statistics, 2001).

Injecting drug users are also known to have a much higher prevalence of hepatitis B than found in the general population (NHMRC, 2003). For example, in a 1995 national survey of 1 005 clients of needle exchange programs, 30 per cent reported a diagnosis of hepatitis B (MacDonald et al, 1997).

Most people we interviewed had heard of hepatitis B (n=87, 96%). Twenty five people (28%, 7 missing values) said they knew that it could be contracted through “drug use”, “blood”, “needles” or “syringes.” Nine people (10%) mentioned that it could be transmitted through “blood and sex” and three people mentioned just “sex.”

Seventy six people (84%) said they had been tested for hepatitis B. Eight people said they did not know if they had been tested and seven people believed they had never been tested. A majority of 53 per cent of the sample (n=48) had been tested during the 12 months prior to interview. A further 14 (15%) people had been tested in the previous two years. Six people said their last test for hepatitis B had been positive (7%, 5 missing values). A further five people were awaiting test results. Two people said that they did not get their last test results.

### *Hepatitis B immunisation*

In the early 1980s a vaccine became available that was safe and effective and would prevent hepatitis B infection (Gust, 1992). This vaccine was originally given to persons who were identified as those most at risk of infection including injecting drug users and Indigenous infants and adolescents (Gust, 1992). In 1996, the NHMRC recommended

that a universal hepatitis B vaccination programme for infants and adolescents be implemented (NHMRC, 2003).

In addition to the 20 people we interviewed who had received a combined hepatitis A /hepatitis B immunisation (reported above), a further 28 people said they had received immunisation against hepatitis B. The NHMRC recommends that adults and older adolescents should receive three doses of hepatitis B vaccine. Seroconversion progresses from approximately 35 per cent after the first injection to more than 90 per cent after the third (NHMRC, 2003).

Six people we interviewed had received the recommended three doses of hepatitis B vaccination, six had received two doses, and two had received one dose. Twelve people said they had been immunised but were unsure of the schedule. Fifteen people believed they had not been immunised.

### *Hepatitis C virus*

On average, one in four people who contract hepatitis C will clear their infection within one year. The other 75 per cent will have a chronic liver infection. After 20 years, of 100 people with chronic hepatitis C, 45 may never develop serious liver damage; 47 may develop moderate liver damage; seven may develop cirrhosis of the liver, and one may develop liver cancer (Hepatitis C Council of NSW).

The prevalence of hepatitis C is a major global public health issue. It is estimated that there are 50 million people infected worldwide with the virus. In Australia it is the most reported notifiable infection. Over 160 000 diagnoses of hepatitis C were reported to state and territory surveillance systems by the end of 2000. Around 80 per cent of prevalent infections were through injecting drug use (Australian National Council on AIDS, Hepatitis C and Related Diseases, Hepatitis C Sub-committee). One of the reasons for this high prevalence is the increase in the number of young people who inject drugs (Hall et al, 2000). Around 20 per cent of injecting drug users are infected within three years of commencing injecting (National Centre in HIV, Epidemiology and Clinical Research).



According to Crofts and colleagues the reason for the large disparity between the number of injecting drug users infected with HIV and hepatitis C can be attributed to the high prevalence of HCV. Thus even the occasional sharing of injecting equipment carries a high risk of HCV infection, even before taking into account the risk attributable to any environmental contamination (Crofts et al, 1999).

In 1998 to 2000 notification rates for Indigenous people were higher than for the total population in NSW, Western Australia and the Northern Territory for recent cases of hepatitis C: 19.2 versus 5.9 (Australian Bureau of Statistics, 2001). An analysis of data from clients of needle and syringe programs by Correll and colleagues shows that, amongst injecting drug users who were aged less than 25, reports of hepatitis C in Aboriginal and Torres Strait Islander people is significantly higher than in non-Indigenous people (38% versus 23%,  $p < 0.001$ ). Based on these findings Correll and colleagues conclude that hepatitis C has the potential to have a substantial impact among Indigenous injecting drug users (Correll et al, 2000).

All but two of the people we interviewed had heard of hepatitis C. A majority of 51 people (56%) indicated that they knew it could be transmitted “through blood”, or the “sharing of needles”, or through “drug use.” Eight people mentioned “blood and sex.” (Whilst the risk of sexual transmission of hepatitis C remains controversial [Gore et al, 1999] unprotected sex involving blood or trauma is “a plausible means of transmission” [Thompson et al, 2003:603].)

The vast majority of respondents ( $n=75$ , 82%) said they had been tested for hepatitis C. A small majority of 59 per cent of the total sample ( $n=54$ ), had been tested during the 12 months prior to interview. Twenty three people said that their last test revealed that they were hepatitis C positive. All these people were current injecting drug users (45% of the current injecting drugs users).

## **Sexual health**

We spent a lot of time during the transfer of skills training sessions on the development of the questionnaires focusing on questions about sexual health. The best ways to ask these questions were discussed in gender-specific groups. Participants then provided the NCEPH staff with their written responses on how they believed the questions could be most appropriately asked.

All the NCEPH interviewers were women (PD, JG and CC). When possible, there was a Winnunga male researcher present when we were interviewing men, and the female interviewers left the interview room when the questions on sexual health were being asked. We had phrased the questions in ways that were both culturally appropriate and understandable for lay people. To those people who could read and write we offered the choice of reading and filling out the responses to the questions themselves. It was not always possible to have a male interviewer present when we were interviewing men. We were surprised to find that most male respondents were happy for the female interviewers to ask the questions and that only one person chose to “Pass” on these questions. (There are seven missing values for questions on sexual health).

### *Use of contraceptives*

We firstly asked questions about use of contraceptives in the 12 months prior to interview. Fourteen people (16%) said they were sometimes abstinent, six people said they had always been abstinent, and five people said they had often been abstinent.

Nine people said that they (in the case of women) or their partner (in the case of men) had always, or sometimes, used a chemical form of contraception, or that “their tubes [were] tied.”

A small proportion (22 %) of the sample of the people who had been sexually active during the twelve months prior to interview (n=18) had always used condoms. Forty eight of the sexually active people said they never used condoms (59%), 17 per cent (n=14) sometimes used condoms and three people often used condoms. We asked people who had not always used condoms: “If you had sex without a condom in the past 12 months, would you mind writing below about the last time. For example, because you’re in a monogamous (one to one) sexual relationship, because you’re wanting to have a baby, because you don’t like condoms, or ... .”

Some people offered multiple reasons for not using condoms. A majority of 85 per cent (n=45) of 54 people who were in a relationship said it was a monogamous relationship (1 missing value). The lack of condom use was best summed up in the words of one man: “[It’s] one to one and I love her.” Another man simply said “It’s a marriage.” A man who had used condoms for some of the time in the 12 months prior to interview said that he had used condoms at the beginning of a new relationship but “then I stopped after a check-up [we infer for bloodborne viruses and sexually transmitted infections] with the doctor. I was sick of the rubbers.”

Seven people had not used condoms because either they or their partner was pregnant or a pregnancy was planned. Four people had relied on contraceptives other than condoms.

Some might regard any lack of condom use to be unsafe sex, but if we discount the people who said they were in a monogamous relationship, only ten people could be considered to be having unsafe sex. These people offered explanations such as “My ladies have always been clean”; “I don’t like them [condoms]”; “I don’t want to”; “I don’t need to”; “I’m stupid”; “They sometimes run out”; “If I’ve got one, I’ll use it, if I really want to and I haven’t got one [is when I have unsafe sex].” We reminded these people about the importance of using condoms by saying that they could prevent a lot of diseases, as well as pregnancy.

### *Pap smears*

A Pap smear is a cervical screening test offered to women in an attempt to reduce the incidence of cancer of the cervix. It is currently recommended that, until they reach their sixties, all women who are or who have ever been sexually active should have a smear at least every two years (Mitchell and Hocking, 2001).

A majority (88%) of the women we interviewed had ever had a Pap smear (n=29, one missing value). Twenty four of these women (83%) had their last Pap smear within the recommended maximum time interval of two years, and a further four within three years. It had been five years since one woman had her last Pap smear. We reminded

women who had gone longer than two years without having a Pap smear that it was time for them to make an appointment for a repeat smear.

Just one woman reported that her last Pap smear had been abnormal. She had then received appropriate treatment.

### *Sexually transmissible infections*

The Australian National Council on AIDS and Related Diseases reports that many Aboriginal and Torres Strait Islander Communities have extremely high rates of sexually transmissible infections. They also note that these infections increase the likelihood of HIV transmission. Compared with the non-Indigenous population the rates of notification for all bacterial sexually transmissible infections among Aboriginal and Torres Strait Islander people are substantially higher. There is also a younger age distribution and a higher proportion of female cases amongst Aboriginal and Torres Strait Islander people than amongst their non-Indigenous counterparts (Australian National Council on AIDS and Related Diseases, 1997). A Central Australia study of 1034 Aboriginal people aged 12-40 by Miller and colleagues found that the risk factors for gonorrhoea included alcohol and petrol use (Miller et al, 2001).

A few people we interviewed had been treated for sexually transmitted infections in the past. No one reported any symptoms suggestive of a sexually transmitted infections when we went through the genital symptom check list on the Opiate Treatment Index.

### **Needle use behaviours**

There are data on needle use behaviours from 47 of the 54 current injecting drug users we interviewed. Because of pressure of time, three injecting drug users curtailed the interview before we reached the questions on injecting drug use, and we stopped another because we were afraid the respondent was becoming distressed (discussed further in the following chapter). Previous experience has taught us that asking questions of people who are trying to stop injecting can trigger an urge for needle use. We did not, therefore ask questions about needle use behaviours of three people who had not injected for six months or more.

### *Transition to injecting*

Our previous research on the use of illegal drugs by Aboriginal and Torres Strait Islander people in the ACT revealed that, whilst many young Indigenous people started using heroin by smoking it, there was often a rapid change to injecting (Dance et al, 2000a). One man we interviewed for the current research explained the reason for his transition from smoking heroin to injecting it:

*I was smoking a fair bit of weed<sup>36</sup> a quarter to half an ounce a day, and once I had that heroin I had to cut it down a lot. Like I smoked about six bongos in one dragon<sup>37</sup> So I give me yarndi<sup>38</sup> away and started smoking heroin. I didn't think I was goin' to get a habit from it but eventually I did. And I needed more and more heroin ... And then I remember my first shot. [I] took a little bit of powder that time from what I was smoking. And started shooting it up. And it saved me money.*

### *Frequency of injecting*

Table 7.1 shows that of the 53 current injecting drug users for whom we had data (one missing value) eight per cent (n=4) always injected daily and 53% (n=28) sometimes injected every day. A further nine per cent (n=5) injected frequently (around 3 to 6 times a week). Three people had not injected for at least six months. In general, the people we interviewed appear to inject more frequently than the 77 Aboriginal injecting drug users interviewed by Larson and colleagues: 38 per cent injected at least daily, and 77 per cent at least once a week. A majority (77%) considered themselves to be occasional or infrequent users (Larson et al, 1999).

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<sup>36</sup> Weed is marijuana.

<sup>37</sup> A "dragon" is defined in Chapter 4.

<sup>38</sup> The Aboriginal people we interviewed used this word for marijuana.

**Table 7.1: Frequency of injecting in the 12 months prior to interview**

<b>Frequency</b>	<b>n</b>	<b>%</b>
Always every day	4	8
Sometimes every day, sometimes less than that	28	53
Around 3 to 6 times a week	5	9
Around 1 or 2 times a week or 0	8	15
More than occasionally but less than weekly	3	6
Occasionally/once only	2	4
“Stopped” $\geq$ 6 to 12 months ago	3	6
<b>Total</b>	<b>53</b>	<b>-</b>

### *Context of injecting*

Injecting while alone is a known risk factor for overdose (Australian Intravenous League, 2001). Almost half the injecting drug users for whom we had further data (n=49, 5 missing values) said they had never injected alone in the twelve months prior to interview (n=23, 49%). Twelve people (25%) said they sometimes injected alone and seven said they often injected alone. Of most concern, five people said they always injected alone. We advised these people about the dangers of doing this.

We then asked where people had injected in the twelve months prior to interview (n=47, 7 missing values). Table 7.2 shows that whilst many people did inject in relatively safe places, such as their home or a friend’s place, there were quite a lot of people injecting in places that could not be considered safe. Twenty three people (49%) injected in public toilets some of the time and seven people (15%) injected there often. Other public places were also used by 17 people (36%) some of the time and by five people (11%) often.

**Table 7.2: Where people injected in the 12 months prior to interview**

Place	Never		Some		Often		Always	
	n	%	n	%	n	%	n	%
Home	16	34	14	30	10	21	7	15
Friend's place	14	30	19	40	13	28	1	2
Public toilets	17	36	23	49	7	15	0	0
Other public place	25	53	17	36	5	11	0	0
“Shooting Gallery”	40	85	5	11	2	4	0	0
Squat	34	72	12	25	1	2	0	0
Car	39	83	4	9	3	6	1	2
Bush	46	98	1	2	0	0	0	0
Anywhere	46	98	1	2	0	0	0	0

### *Use of sterile injecting equipment*

Several studies have indicated risky needle use behaviours (such as sharing injecting equipment) amongst Aboriginal and Torres Strait Islander people. One of the earliest Australian studies of Aboriginal injecting drug users was conducted between 1992 and 1993 by Lane who accessed (along with peer-based workers) 124 respondents. Her findings revealed that Aboriginal injecting drug users were five times more likely to share syringes than their non-Aboriginal counterparts (Lane, 1992-93). Studies in Brisbane (Larson et al, 1999) and Western Australia (Gray et al, 2001) of Aboriginal people who inject drugs have also found a high prevalence of risky needle use behaviours.

In data analysed from four Australian needle and syringe program surveys, significantly more Indigenous than non-Indigenous participants reported sharing injecting equipment in the last month (27% versus 20%,  $p = 0.003$ ) (Correll et al, 2000). A 1997 study of 89 injecting drug users in rural Northern NSW revealed that sharing a spoon, mixing water or a filter with others during the last injection was three times more likely to occur in Indigenous injecting drug users than in their non-Indigenous counterparts (Yu et al, 1999).

Table 7.3 shows that, whilst 68 per cent of injecting drug users (n=32) we interviewed had always used a sterile needle and syringe during the twelve months prior to interview, 32 per cent had not (n=15). Other risky behaviours included sterile water not always being used (to dissolve the powdered form of drugs such as heroin or amphetamine) by 21 per cent (n=10); a sterile spoon not always being used to mix drugs, by 18 per cent of those who had used a spoon for this purpose (n=8), and a sterile filter not always being used to filter drugs into the syringe before injection by 16 per cent (n=7), of those who used a filter.

**Table 7.3: Use of sterile injecting equipment during the 12 months prior to interview**

Type of equipment	Never		Some		Often		Always		Does not use this	
	n	%	n	%	n	%	n	%	n	%
Sterile needle & syringe	0	0	0	0	15	32	32	68	-	-
Sterile water	2	4	3	6	5	11	37	79	-	-
Sterile spoon	1	2	3	6	4	9	36	76	3	6
Sterile filter <sup>a</sup>	2	4	0	0	2	4	40	85	2	4
Sterile cotton wool	0	0	2	4	2	4	39	83	4	9
Sterile alcohol swab	0	0	1	2	1	2	39	83	6	13
A clean/own tourniquet	2	4	0	0	0	0	14	30	31	66

<sup>a</sup>One extra missing value.

We collected qualitative data from people who had not always used clean injecting equipment in the 12 months prior to interview. Most people who had not used sterile needles and syringes had reused needles and syringes they had previously used only for themselves. Four people had shared injecting equipment with one sexual partner, and one had shared with two sexual partners. Three people had shared with relatives and five had shared with friends or associates. One person had shared injecting equipment with a stranger. Most people who had shared with others said something along the lines of “there were no other fits<sup>39</sup> around.” One woman said of her long term sharing of needles and syringes with her partner, “We always said we would use clean needles but we didn’t.” A man who shared needles and syringes with his family rationalised it like

<sup>39</sup> “Fits” are needles and syringes.



this: “If I’m using with my brothers or sisters, I’ll use their needles because they’re family.” Some sharing of injecting equipment had occurred while respondents were in prison (reported fully below).

When sharing of needles and syringes had occurred in the previous 12 months, respondents had injected before one or more people four of these times and after one or more people on nine of these times. On all but three occasions when needles had been reused, either for a respondent’s own reuse or when they had shared, respondents had made an attempt to clean them. Some people provided multiple responses about the way they had cleaned injecting equipment during the previous twelve months. Bleach had been used by nine people, cold water by eleven, sterile water by one and warm water by another. We informed this respondent that, since warm water is likely to make blood congeal, and therefore more difficult to get out of the needle and syringe, it was much safer to use cold water. We also reinforced for those people who had shared injecting equipment that this was a very risky practice.

#### *Accidental needle sharing*

There have been previous reports of accidental needle sharing in the ACT (Dance, 1992b), as well as overseas (McKeganey and Barnard, 1993; Burt and Stimson, nd). We were interested in finding out whether this might have occurred in the injecting drug users we were interviewing for this research. First we asked respondents if they *ever* used their “fit” more than once when other people were also injecting. Fifteen people said they did. We then asked how they knew it was their own “fit.” Most people simply said something along the lines of “I keep it close to me” or “I know where I’ve put it.” Some people marked the syringe by, for example, biting it, or scratching a number on it. We then asked respondents if they thought they might have ever picked up someone else’s used syringe by mistake, in the same way that someone might pick up another person’s glass at a party. Seven people reported that they had ever accidentally picked up and used someone else’s needle and syringe. One case of accidental needle sharing had occurred in the previous twelve months. This man believed that this was how he had contracted hepatitis C.

### *Handwashing*

Careful handwashing before and after injecting is an important preventive measure against transmission of bloodborne viruses. We asked respondents if they washed their hands before and after injecting themselves. Twenty people (44%, 2 extra missing values for findings on hand washing, equalling 3 in total) said they always washed their hands before injecting and 21 (47%) said they always washed their hands after. We also asked about hand washing before injecting other people. Just 16 people always washed their hands before injecting others and 17 people afterwards. Eleven people said another person had injected them with an illegal drug in the previous twelve months. Six people said hand washing by the person who was injecting them occurred always before injecting and seven people said it always occurred afterwards.

### *Disposal of injecting equipment*

In the context of utilisation of treatment services, we reported in Chapter 5 on places where respondents obtained their injecting equipment. We also asked how they disposed of their injecting equipment. As seen in Table 7.4, most people disposed of their injecting equipment safely. Just ten people (21%) said they never used their own needle and syringe disposal bin then returned it to the needle and syringe program. No one had left their injecting equipment in a public place. Rather than using a needle and syringe program bin, some people had devised other ways of disposing of their injecting equipment, such as placing it in the garbage after putting some sort of protection over it. The study by Larson and colleagues found that only 25 of the 77 Aboriginal injecting drug users they interviewed followed the recommended way of disposing of injecting equipment (Larson et al, 1999).

**Table 7.4: Disposal of injecting equipment**

Place	Never		Some		Often		Always	
	n	%	n	%	n	%	n	%
Own disposal bin →NSP <sup>a</sup>	10	21	2	4	8	17	27	57
Friend's disposal bin	40	85	4	9	2	4	1	2
Friend disposed of it	44	93	2	4	1	2	0	0
Own rubbish bin after putting it in a bottle or tin	42	89	2	4	3	6	0	0
Rubbish bin without putting it in a bottle or tin	46	98	1	2	0	0	0	0
Burnt it	46	98	1	2	0	0	0	0
Public NSP disposal unit	41	42	4	9	2	4	0	0
Friend's rubbish bin, after putting in bottle/tin	45	96	2	4	0	0	0	0
Public rubbish bin after putting it in a bottle or tin	45	96	2	4	0	0	0	0
Bin then hopper	46	98	0	0	0	0	1	2
Burn then bin	46	98	0	0	0	0	1	2
Roll in newspaper then bin	46	98	0	0	0	0	1	2
In disposal bin then garbage	46	98	0	0	0	0	1	2
Left it in a public place	47	100	0	0	0	0	0	0

<sup>a</sup>Needle and Syringe Program.

### *Health problems related to injecting*

We asked current injecting drug users about problems other than hepatitis and overdoses (reported above) that they had ever experienced as a result of injecting illegal drugs. Sixteen people (34 of the current injecting drug users) had ever had a “dirty hit.” One man described how unpleasant this is:

*I've had a dirty shot. I wasn't careful enough, yeah. And that made me crook. I had a bad batch of speed. And that was pretty horrifying ... I thought I was a goner. But yeah, and then I came good. It was just ... like you sweat. It was uncontrollable sweat ... I was on the verge. Like I only had half a point.<sup>40</sup> If I had of had a full point I was gone, yeah. Because I was just about to yell out to me girlfriend at the time to tell her to ring the ambulance. And then I came good. Yeah. Nasty*

Ten people had experienced one “dirty hit” and the other people had experienced two or three. For most people their last “dirty hit” had been more than twelve months ago (n=11). The other five people had all experienced one during the twelve months prior to interview.

One person said they had ever been ill from septicaemia due to injecting and that that had been more than twelve months ago. Fourteen people (30%) said they had damaged veins due to injecting, four people had ever injected into an artery, and four people said their injecting had resulted in an embolism.

### **Drug use in prison**

Aboriginal and Torres Strait Islander people are over-represented in prisons (Mukherjee et al, 1998; Levy and Butler, 2000; Australian Bureau of Statistics, 2001; Day and Dolan, 2001; Weatherburn et al, 2003). According to Levy and Butler, “Aborigines and Torres Strait Islanders are incarcerated at a rate of 1 790 per 100 000 adult Indigenous population - over 12 times that of non-Indigenous Australians. One Aboriginal male in 30 is currently incarcerated in an Australian goal” (Levy and Butler, 2000:2).

Literature from overseas (for example, Taylor et al, 1995; Clarke et al, 2001; Boys et al, 2002) Australia in general (for example, Crofts et al, 1995; Crofts et al, 1996; Butler et al, 1997; Dolan et al 1998; Butler et al, 1999; Kevin, 2000; Butler et al, 2003), the ACT in particular (Dolan and Crofts, 2000), and from Aboriginal samples of people who inject drugs (Lane 1992-93; Larson et al, 1999; Holly and Shoobridge, 2002) indicates that injecting of drugs often occurs when people are incarcerated. Because few prisons provide clean injecting equipment (or bleach) the sharing of unsterile injecting

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<sup>40</sup> “A point” equals 0.1 of a gram of an injectable drug, thus, there are ten points to a gram of a drug.

equipment is commonplace (Crofts et al, 1995; Crofts et al 1996; Holly and Shoobridge, 2002; Butler et al, 2003).

Sixty per cent of Australian prisoners are incarcerated because of drug-related offences (Butler et al, 1997). Forty nine people we interviewed (60 per cent of those we had data for, 10 no disclosures, 4 missing values) had ever been incarcerated, either in prison and/or juvenile corrective services/and/or a remand centre. Most of these people had been in prison. Twenty one people had been incarcerated once (43% of those who had been incarcerated). Two people had been incarcerated twice, three people, six times, and the remaining respondents had been incarcerated between four and 30 times.

Twenty eight people were willing to tell us that they had used drugs whilst in prison (62 per cent of those who had been imprisoned and who were willing to tell us about their drug use in prison; 4 extra no disclosures). Eleven people said they had injected in prison. Two people had injected just once, four people between 2 and 5 times, two people 6 to 10 times and three people 20 or more times. Most of these people had shared injecting equipment some or all of the time that they had injected.

There are several reports in the literature about people being initiated into injecting drug use whilst imprisoned. Examples include the general population of prisoners (Gore et al, 1995; Boys et al, 2002), as well as Aboriginal people who have been incarcerated (for example, Lane, 1992-93; Lehman Clarke and Frances, 1998; Wenitong, 2001). One person we interviewed said the first time he injected "I was in jail actually." We confirmed this by asking: "The first time you had heroin you were in jail? And you shot it up for the first time? That was the first injection in prison?" He responded: "Yeah it was just available at the time, yeah." We asked "And why did you decide to try it?" To which he replied "Um I suppose because everyone else was on it."

A review of the literature by Dolan and colleagues identified 19 needle and syringe programs operating in prisons throughout the world. Six of these have been evaluated and the outcomes were very positive (Dolan et al, 2003).

The high prevalence of injecting, most of which involves sharing injecting equipment, currently occurring in Australian prisons is a public health issue. Bloodborne viruses contracted in prison not only harm the affected individual, there is also the potential for

bloodborne viruses contracted in prison to spread into the general community. More innovative approaches are needed.

## **Conclusion**

Our findings indicate that substantial proportions of the people we interviewed had experienced adverse health effects as a direct result of injecting. Almost half had contracted hepatitis C. Others had experienced other serious consequences of injecting such as a “dirty hit.” Whilst most injecting drug users were not sharing injecting equipment, some were and this is cause for concern. In Chapter 6, we documented evidence about a need for increased treatment options to assist Aboriginal and Torres Strait Islander injecting drug users who wish to stop injecting to do so. The results we have documented in this chapter indicate a need for more education about the dangers of sharing injecting equipment, education about means of administration other than injecting, and improved access to sterile injecting equipment.

There were also large proportions of respondents who had overdosed and/or who had witnessed an overdose. Several had lost loved ones from overdoses. Following their research with Aboriginal people who use illegal drugs, Holly and colleagues identified a need for development of information presented in a variety of formats about the prevention of the transmission of bloodborne viruses, prevention of overdoses and other harm reduction information (Holly and Shoobridge, 2002). Our research has also identified this need. As we documented in Chapter 6, part of the next phase of this research will be to produce a Community booklet. This booklet will provide education about resuscitation procedures, and the prevention of overdoses and of bloodborne and sexually transmissible infections.

## CHAPTER 8: EMOTIONAL WELL-BEING

### Introduction

In this second chapter related to the health of the people we interviewed, we discuss findings related to emotional well-being. (The term “emotional well-being” rather than “mental well-being”, as used by the World Health Organization in its Ottawa Charter [World Health Organization, 1986], is preferred by Aboriginal people. We will, therefore, subsequently use this term.) It was with respect to his emotional well-being that one man we interviewed voiced the words we have used in the first part of the title of this report: “I want to be heard.” He then added “What I am saying could help someone else, that makes me feel good.”

We begin this chapter by reporting findings from the General Health Questionnaire. We then go on to report some negative life events. We then put the lives of the people we interviewed into some context by relaying some stories of positive life events. We conclude the chapter with the sorts of things respondents believed could, in addition to those identified in previous chapters (on the needs for treatment and the needs related to social determinants of health) improve their lives.

Previous experience has told us that when people are talking about their lives, particularly issues that may have been a precursor for the use of alcohol and other drugs, memories of painful events may be triggered. We considered it best to give people an opportunity to talk about any good and bad things that had happened to them and then, if they needed it, to offer appropriate referrals. After consulting a psychologist and psychotherapist about the best way to express this, as part of the screening for interview we informed everyone:

*Before we begin we'd like to let you know you don't have to answer any questions you don't want to. Some people find it hard to answer some of these questions. Let us know if you'd like us to repeat any questions. If you don't understand any questions, please say so and we'll try to put them in a better way. You may find the questions trigger something. Some might be painful and you might find you become woolly headed or vague. If you want to stop at any point please tell us. If we think the questions are causing you distress, we may also stop the interview and offer you advice about referrals. If you want to talk about things that are important to you, there will be an opportunity for you to do so. But we'd like to let you know that we're researchers and this is not a therapeutic situation. We're not trained in areas you might want to talk about but, if you like, we can help you contact professionals who may be able to assist you.*

Some people starting talking about good and bad things that had happened to them even before we reached the part of the interview where we gave them the opportunity to talk about anything that was important to them. We began by reminding people that they could, as with any other questions we asked, chose to pass on these questions. Then we informed them

*As we said at the beginning, although we can offer referrals, this isn't a therapeutic situation, and we're not trained in areas that might be important to you. But if there's anything important in your life that you want to talk about, perhaps when you were a child or growing up, or recently, we'd like to give you an opportunity to do so. Do you feel you'd like to talk about any good or bad things you've experienced?*

Several people chose the option to pass on these questions but, as we go on to show, many did talk about bad and good things that had happened to them. For those that did want to talk we then asked "Do you feel you had a reasonable childhood?" Some of the prompts we used for the questions we asked in this domain were related to family being part of the Stolen Generations, family being taken away by welfare, drug and alcohol use in the family, and violence that they had perpetrated or been a victim of. If there were any bad things that people talked about we also asked what had helped them deal with these bad things, and if there was anything we or they needed to do to make things better. Where necessary we provided referral for people who indicated that they would like some assistance, or who we thought needed assistance. As with the information we gave at the beginning of the interview, the phrasing of these questions was developed with the assistance of a psychotherapist and a psychologist.



## **Findings from the General Health Questionnaire**

The General Health Questionnaire is included in the Opiate Treatment Index (Darke et al, 1991a). Goldberg and Hillier (who developed the General Health Questionnaire) advise that scores of 0 to 4 should be regarded as low and those between 5 to 28 should be regarded as high (Goldberg and Hillier, 1979). There was a mean score of 7.8 (SD 8.0, median 5, mode 0, range 0-26) for the 92 people for whom we had data. Looking only at the injecting drug users, we found a similar mean score of 8.0. Darke and colleagues found a slightly higher mean score of 8.6 among the 230 injecting drug users they interviewed for the Opiate Treatment Index (Darke et al, 1991a). Macleod and colleagues report that the 114 methadone maintenance clients they studied had a mean General Health Questionnaire Score of 12 at their first assessment (Macleod, 1996).

The men we interviewed had a mean score of 6.9 compared to a somewhat higher score of 9.4 for women. This difference was significant (t test,  $p=0.019$ ). Darke and colleagues also found that the General Health Questionnaire scores among the women they surveyed (during the formulation of the Opiate Treatment Index) were significantly higher than those of the men (Darke et al, 1992). Similarly, Corney found higher scores among women than men in a sample of general practitioner clients (Corney, 1990).

Based on Goldberg and Hillier's definitions (a score between 0 to 4 being low and a score of 5 to 28 being high), more than half the sample of people we interviewed had a high General Health Questionnaire score: 52 per cent ( $n=48$ ). After we had administered the General Health Questionnaire we scanned the results to ascertain if anyone was in need of immediate assistance. We advised everyone with a high score to seek assistance. In particular, we were careful to scrutinise and offer feedback on these four questions related to suicide ideation:

“Have you recently:

Question 24 (D3)<sup>41</sup>. Felt that life was not worth living?

Question 25 (D4). Thought of the possibility that you might do away with yourself?

Question 27 (D6). Found yourself wishing you were dead and away from it all?

Question 28 (D7). Found that the idea of taking your own life kept coming into your mind?.”

(Goldberg and Hillier, 1979:144)

The training that all interviewers had undergone in mental health first aid at the Centre for Mental Health Research at ANU (please see Appendix 7) equipped us to ask the appropriate questions to judge whether or not the people who scored any points on these questions were in need of immediate assistance. Although we considered one young man who presented for interview to be in a fit mental state for the interview during screening, as the interview progressed he talked about recent events that were distressing him. After administering the General Health Questionnaire, and discussing the findings related to suicidal tendencies with him, we made the correct judgement to stop the interview and organise immediate referral to an Aboriginal Health Worker from Winnunga (who was also an associated researcher). We followed up this referral with the Aboriginal Health Worker who assured us that the young man was now well.

### **Negative life events**

In Chapter 5 we alluded to some of the added complexities in treating Aboriginal and Torres Strait Islander people for problems related to illegal drug use. As a background to reporting some of the negative life experiences told to us by the people we interviewed, we refer to relevant findings on deaths related to mental disorders and of deaths from suicide amongst Aboriginal and Torres Strait Islander people.

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<sup>41</sup> The question numbers refer to the numbers in the versions of the General Health Questionnaire we used (Darke et al, 1991a) and those in parentheses refer to the way they are numbered in the paper on the General Health Questionnaire-28 by Goldberg and Hillier (Goldberg and Hillier, 1979).

For Indigenous people there were over twice as many deaths in 1997 to 1999 from mental disorders as expected, based on all available Australian rates. The majority of these deaths (78%) were attributed to psychoactive substance use (Australian Bureau of Statistics, 2001b). According to Tatz, youth suicide amongst Aboriginal and Torres Strait Islander people is now double or treble the rate of that of non-Indigenous people. He links the high suicide, in part, to cannabis use (Tatz, 1999). Between 1994 and 1995, ACT Mental Health Services recorded 27 suicide attempts by Aboriginal people in the ACT (Legislative Assembly for the Australian Capital Territory).

### *Stolen Generations*

Justification for the forcible removal of children (particularly children who were described as “half castes”) often came from the appalling conditions in which Aboriginal and Torres Strait Islander people were living, and a paternalistic belief that it was necessary to blend Indigenous people with the white populations to assimilate and “civilise” them (Raphael et al, 1998:328). Peter Read introduced the term “Stolen Generations” in 1982 to refer to this policy (Read, circa 1982).

The National Inquiry into the separation of Aboriginal and Torres Strait Islander children from their homes found that many forcibly removed children had “lost their languages, their heritage and their lands, as well as their families and communities” (Human Rights and Equal Opportunity Commission, 1997:20).

*Indigenous children have been forcibly removed from their families and communities since the very first days of the European occupation of Australia. In that time, not one Indigenous family has escaped the effects. Most families have been affected in one or more generations by the removal of one or more children. Nationally, the Inquiry [the National Inquiry into the separation of Aboriginal and Torres Strait Islander children from their families] concludes that between one in three and one in ten children were forcibly removed from their families and communities between 1910 and 1970.*

(Human Rights and Equal Opportunity Commission, 1997:4)

As part of this separation from their families, children could be institutionalised, fostered or adopted. Moves between types of setting were common. As part of the so called “assimilation” policy, children and their families were discouraged or prevented from contacting each other. Excessive physical abuse was common, and sexual abuse was reported by one in five children who were fostered and one in ten people who were

institutionalised. (Human Rights and Equal Opportunity Commission, 1997:20). “Psychological reverberations” from such painful events as this have an intergenerational impact (Raphael et al, 1998:31).

In the 1994 Australian Bureau of Statistics National Aboriginal and Torres Strait Islander People Survey in the Queanbeyan Aboriginal and Torres Strait Islander Commission region (the area in which this study was conducted), twelve per cent (n=296) of the 2 390 respondents aged over 25 years said they were taken away from their families as children by a mission, the government or welfare (Australian Bureau of Statistics, 1995).

Six people we interviewed had themselves been Stolen. An older respondent said:

*All us kids were taken off Mum when we were little kids, we were Stolen. I remember the day they came and took me. I was a teenager when I met up with my brothers and sisters and Mum.*

This is part of the story of a man who wanted to know:

*Why my Mother was Stolen off a mission? Why was I Stolen from her? Me brother and I were taken off me Mum by the government, for no reason. I found out, just in recent years that it was sort of comes under care and protection. I was living in the city with me father who was working, with Mum, and I don't know why we were taken off for that reason ... [my son] was the one who first took me out to the mission. So I found out about me Mum, how she was Stolen, from a mission. She was brought up by nuns in the city ... I went and saw these nuns and they refused to even say that she was a resident. We can't shake your hand and say we're sorry. Our cash tin is empty. I didn't want that. I just wanted to know what my Mum was like as a resident. And I felt me Mum's pain and shame. Plus me own. Tried to end it. Tried to hang meself. Fuckin branch broke. Excuse me swearing. And ever since then ... I couldn't stay in [city where he had met the nun]. It's just a bad place for me so I came up here to Canberra ...*

A man in his mid thirties had been, to use his term, “assimilated” into a non-Aboriginal family. We report his story about being Stolen in full since it exemplifies other stories that were told to us about being Stolen.

*And [adoptive father] become very physical. Very physical. I could take a hiding ... that's probably one good thing that come out of it, I could take a hiding. He made my life very difficult. I should be old enough to say that I can ... big enough to get over it and all the rest of it, but I've still got that thing in the back of me head that if he was a better man maybe I would have been. I don't know. I don't know who to blame or what to blame. But he pissed me off. He really give me the shits ... He's just a prick. Just a stinkin' prick that just, ya' know, he kept my life a lie. He kept my life very well a lie because I didn't even know I was Aboriginal ... We were avoided from any contact with any other Aboriginal children ...*

*Once I remember my Nanna sayin' 'Don't play with 'em [Aboriginal children] they're no good. And we were dragged off ... I just left home, basically I'd told Mum I couldn't live at home, and like overnight it was like whack straight into [Aboriginal Hostel] ... I was looking around the place to look for another whitefella', because I thought I was white. Come to the point that everyone said that if I was white there was no point me being here because this is for Aboriginals. So I thought 'Oh shit, there you go, I am Aboriginal.'*

After discovering his birth certificate, which helped confirm his Aboriginality, this same man found out:

*Well I was the last born on my mother's side, so I've been told, from what I am told, and none of us stayed with her, not one of us. Not one of us stayed. All the rest was in homes and the story goes, I was grabbed at six weeks old, floated for the next six months. I was six months to three years old ... So I had the first three years of my life shunted every six months ... Now there was no legal documentations of adoption or foster or anything, it was just can you take care of this. 'Here's a package can you look after it for us.' So they did. And they did do it, and all gratitude to them, but it would have been nice to have known all this stuff before I was old enough to get angry.*

*Yeah it's confusing more than tough because sometimes I find it very difficult myself to actually make understanding out of how this all happened and why did it all happen. Why is the biggest question. Why did it happen, and why did it happen to me?*

This history helps illuminate the complexity of issues related to being Stolen, to being physically abused, to having identity problems to do with Aboriginality, and having to deal with the anger emanating from these problems. The man we quoted above later added: "Well you know, I'm not the only one, there are a thousand more kids out there with the same problems."

*"Stolen Generations anxiety"*

Twenty seven people said they had family members who had been part of the Stolen Generations. Most then talked about the subsequent effects on them. One man used the term "Stolen Generations anxiety ... that's all through Aboriginal society I think, that sorta' thing."

This is a story from a woman who had controlled most of her drug use:

*When we were kids on the station ... I remember my Grandma and Granddad locked us up [to hide us]. [They said] 'The missionaries are coming.' Where I grew up was a very racist town ... Some things Pop [Granddad] told us, it was very bad for him. Pop made it clear to lock us away [from the missionaries]. One [relative] who was taken turned up last year ... she told me what had happened [that she'd been Stolen] ... all those missed years. The years of drug using took a lot from me, but I'm different now and I can talk about it. And I'm strong for my people. I know now I can relate to other people's problems.*

A woman whose grandmother had been part of the Stolen Generations expressed the need for people such as herself. She said she felt:

*Angry. So angry that I started research in ... and I found her country, , so I am pretty lucky, I would be one of the lucky ones for that but what I try and ... that's what we need, we have got to go back before we can go forward.*

A teenager said that although no one in his family had been Stolen, there was always the "feeling that something could happen."

*Referrals to the Family History Unit*

We provided folders we had been given by staff from the Family History Unit at the Australian Institute of Aboriginal and Torres Strait Islander Studies, containing detailed information about this Unit, to three young people who said they had Elders from the Stolen Generations in their family and wanted to learn more.

## *Welfare*

Some people consider that removal of children by welfare services is part of the Stolen Generations. Five people we interviewed said they had been “taken away by welfare.” Seven talked about other family members “being taken away by welfare.”

## *Identity*

Twelve people either indicated or directly said that they had identity issues. A young female respondent said:

*My Nanna ... her father was the one that was Aboriginal. And her mother left her and they were bought up in a convent. And she didn't know her father till she was eighteen and he come to see her to say, 'I'm your father and ra ra ra.' He only visited her once. So she was brought up by nuns. It was never talked about. It's sort of hush hush about us having Aboriginal blood in us. I didn't find out I had an Aboriginal Grandfather until I went to [late secondary education]. I didn't know me brothers or sisters till I was about ten. It's not your normal upbringing.*

This same woman said that her non-Aboriginal mother had told her not to tell anyone she was Aboriginal and that she did not meet her biological father until she was in her early twenties. The depth of meaning in this history was manifested when this woman told us that she had Aboriginal children. The interviewers gently reminded her that she herself was Aboriginal.

A man experiencing problematic drug use and who had been reared by a non-Aboriginal father said:

*But I think what I need to do is to get to the root cause of it. Because up until recent times I've kept everything in, I've never really talked about it and as I say it's just up until now that I am starting to really reach out, reach out to people and try and overcome things. You see I grew up with my Dad, as I said. There wasn't any sort of sort of emotional support there. So basically, essentially a white person in a sense living a white society, with an Aboriginal background, with Aboriginal blood and that sort of things as well ... And you know they all conflict. They all conflict. And in my head it's like, where am I, where am I? That conflict that's there. You know, I've probably grown up in one society and I am just discovering the Aboriginal heritage side of it ... you know, it's just like a big soup in your life.*

This young man was already in contact with appropriate services.

## *Racism*

Thirty five people said that one of the bad things about their life was racism. Several people wanted to tell us about the racism they had experienced at school. One woman told us that

*I didn't grow up with racism. Because we had multicultural people in [place]. But like when ... I went to [school in another place] yeh, that's when I knew what a boong was. Yeah, I was a boong and I was never called that in my life until that time. They put dead birds in the lunch boxes [at school]. But that happened to all us ... kids.*

A young man believed that the reason that he got “kicked out of school” was because of racist teachers. Another young man said he wanted an education because “I left school at fifteen because of my negative attitude towards school. There was racism all over the place.” A young woman said of her time at school, “There was racism, just not to say it to your face. It was written on desks and walls everywhere. Just little comments. Made it so you wanted not to be in that place.”

A man said he had experienced racism “All me life. I have even had to lie going for a job. I had to tell them I was friggen Greek. You know, people say ‘You don’t look Aboriginal because you haven’t got the big lips or the big nose.’” One woman told us that “Bad racism made me hard.”

Some people from interstate who said they had experienced racism talked more generally about the racism of the town they were living in.

## *Violence*

“Ongoing cultural dispossession and its consequences, taking different forms over the past 200 years, have impacted on Indigenous people socially, economically, physically, psychologically and emotionally, to the point that today, violence in some Aboriginal communities has reached epidemic proportions.” This violence has its roots in colonisation (Memmott et al, 2001:11). Memmott and colleagues point out that under such conditions and experiences, alcohol consumption may provide the only relief from emotional pain (Memmott et al, 2001). The use of substances other than alcohol are also often used as a relief from this emotional pain. According to Flick, anecdotal evidence suggests that in most cases the perpetrators of violence are likely to be under



the influence of drugs and alcohol at the time of the abuse, or may have a dual diagnosis of substance use and emotional health problems (Flick, 2001). Citing the Secretariat of the National Aboriginal and Islander Child Care (1996), Memmott and colleagues have indicated that one of the predisposing factors for violence in Indigenous Communities is the lack of services for counselling (Memmott et al, 2001). As indicated in Chapter 6, eleven people we interviewed articulated a direct need for counselling and another three people made comments indicating a need for this help..

### *Physical violence*

Twenty nine people said they had been physically violent themselves. Most of these people talked about getting into fights, often when they had been drinking. A few mentioned other types of violence they had committed. We asked these people if they knew about anger management courses. Some had already participated in these courses.

In addition to being at the receiving end of fights, another eleven people said they had been physically abused when they were growing up or that they had been the victim of domestic violence.

Eight people said they had witnessed a lot of violence when they were growing up.

### *Sexual abuse*

Sexual abuse of children is subdivided into three categories:

- 1) non-contact abuse includes sexual solicitation or exposure by an older person;
- 2) contact abuse involves genital touching or fondling; and
- 3) penetrative abuse includes oral, anal or vaginal intercourse by an older person.

Studies on child sexual abuse in Australia show that the adjusted prevalence estimate in males was 5.15 and 27.5 per cent in females. Onset occurs at a mean age of 10, with most starting before age 12 (Andrews, 2002).

We did not specifically ask people if they had been sexually abused, but at some stage during the interview, in some instances when asking a seemingly innocuous question, such as the age of leaving school, seven people we interviewed volunteered information about being sexually abused, mostly as children. Some were already in contact with appropriate services. Others were not. Although we made it clear that the interview was not a therapeutic situation, some people told us that they had come to be interviewed because they saw it as a way of getting help.

A man we interviewed had been both sexually abused and physically abused by a family member as a child. This is part of his painful story:

*Being abused when I was a kid. Getting held up by me throat because something went missing from the house. I don't even know what it was. But I was the one that got the blame for it. Being smashed from back gate to front gate for no apparent reason. I could go on. Sexual abuse, physical, I'll say that. Not just being knocked out or nearly choked. Sexually abused by that person ... too ... That has turned into my pain and shame.*

The stories of sexual abuse we heard reinforced for us the need for people who conduct interviews with illegal drug users to be trained to deal with people who choose to disclose this history. The training all interviewers did with Aboriginal Health Workers from the ACT Rape Crisis Centre put us in good stead.

### *Referrals for sexual abuse*

We gave referrals to four people for rape crisis counselling. One of them said:

*Yeah that's fantastic. Rape crisis and things. And I certainly had those ideas. I thought perhaps I need to go back to what made me do drugs in the first place. When someone says to me, 'That person uses a drug' I generally say, 'And what made them do that?' ... because it's not really a choice that you make it's more about feeling. Because we all know it's a stupid choice but it's the feelings.*

### *Family history of alcohol and other drug use*

We asked respondents if there was a history of alcohol or other drug use in the family. Including people who had lost a relative due to alcohol or drug use, 59 people reported family use of alcohol or illegal drug use. People commonly responded with a short affirmative “Yeah” when we asked them about family alcohol or drug use and we did not probe further. Most people who provided fuller answers said that alcohol use had been a problem. Twenty people mentioned illegal drug use. One man told us that “Quite a few cousins have had lots of drug and alcohol problems.” A woman told us that “Seventy per cent of my family members are drug and alcohol users.”

### **Positive life events**

We now place the negative stories we heard in some context by reporting that thirty one people talked about good things that they had experienced in their childhood. A young woman, whilst she was currently injecting drugs, said: “I was a spoiled little girl. I got everything I ever wanted.” One man told us how

*My Dad worked himself to death for us, you know, like he wanted us all to have a home, for all you children to call your home. I guess I was Mummy’s little boy you know what I mean. All the other boys are sort of yeah, going out and helping Dad with the garden and I used to wash up and sew and you name it, I could do it.*

Another man told us that “I was more or less spoilt actually. I was the first child. Me father worked all his life. He still works today. I never went without nothin.’ Neither did my brothers and sisters.” What one woman liked about her childhood was that “I got taught a lot, things my Grandfather and Father told me about [traditional ways].” For one woman, her outings had been a good part of her childhood: “We went campin’ and fishin’ and all that sorta’ stuff. It was great.” Some people mentioned good things about school, such as one woman who said “I absolutely loved school.” Other people more simply said something like “I had a good childhood.”

## **Conclusion**

More than half the people we interviewed scored highly on the General Health Questionnaire. This chapter has given some insight into some of the difficulties of the lives of the people we interviewed: difficulties which adversely impact on their emotional well-being. Some people chose to “Pass” on questions about life events so the number we have reported here are likely to be under-estimations. People caring for Aboriginal and Torres Strait Islander people who use illegal drugs must be provided with a deep understanding of the traumatic histories that Aboriginal and Torres Strait Islander people often have: histories that are even more complex than those often found in non-Indigenous people who use illegal drugs. The painful histories of Aboriginal and Torres Strait Islander peoples have their origins in colonisation.

## CHAPTER 9: SOCIAL DETERMINANTS OF HEALTH

### Introduction

In this, the third of three chapters reporting findings on health, we focus on the social determinants of health of the people we interviewed. The Aboriginal and Torres Strait Islander Research Agenda Working Group of the NHMRC have identified a need for “Defining social determinants of health in an Aboriginal and Torres Strait Islander context ... [since] it may be different from general community definitions” (The Aboriginal and Torres Strait Islander Research Agenda Working Group of the NHMRC, 2002:23). Until such time that the necessary work that RAWG has called for has been undertaken, we rely on international work in the area, as well as that of some Australian commentators.

Wilkinson and Marmot point out that “While medical care can prolong survival and improve prognosis ... more important for the health of the population as a whole are the social and economic conditions that make people ill and in need of medical care in the first place” (Wilkinson and Marmot, 2003:7). Talking about the problems of drug use in particular, the World Health Organization refers to the fact that:

*Drug use is both a response to social breakdown and an important factor in worsening the inequalities of health. It offers a mirage of escape from adversity and stress but only makes their problems worse. Alcohol dependence, illicit drug use and cigarette smoking are closely associated with markers of social and economic disadvantage ... Work to deal with problems of both legal and illicit drug use needs not only to support and treat people who have developed addictive patterns of use, but also to address the patterns of social deprivation in which the problems are rooted.*

(World Health Organization, 2003:24 and 25)

Disadvantages in the social determinants of health include having “few family assets, having a poorer education during adolescence ... having insecure employment and living in poor housing” (World Health Organization, 2003:10). Thomson and colleagues discuss these social determinants of health in the context of Aboriginal health (Thomson et al, 2003). Disadvantage can also include “social exclusion which results from racism, discrimination, stigmatization [and] hostility” (World Health Organization, 2003:16). Social exclusion is an important social determinant of health for Aboriginal and Torres Strait Islander peoples, particularly those who use illegal drugs.

We turn now to findings in the social determinants of health for the people we interviewed. The most important social determinant of health for Aboriginal and Torres Strait Islander peoples is their culture. We begin with an extensive discussion of findings on needs related to this domain (findings on cultural background are reported in Chapter 3). Findings related to education, occupational status and income (where we also briefly discuss findings on gambling), relationships (including dependants), and housing and living arrangements are then outlined. We then report some findings on diet. We intersperse the findings by reporting referrals we offered. Needs identified by respondents are included in each of their appropriate subsections. Some people said improvements in particular aspects of their social well-being would help them stop using drugs. These findings are also included in the relevant subsections below. Those that do not fit into these subsections are included separately. At the end of each subsection, all needs identified by respondents are discussed and summarised in a table.

### **Aboriginal and Torres Strait Islander culture**

Before reporting findings on cultural needs we provide a very brief background to the loss of culture for many Aboriginal and Torres Strait Islander peoples. Indigenous peoples have been present in Australia for some 55 000 to 60 000 years (Roberts and Jones, 1994). Their rich and varied cultures represent possibly the oldest continuous cultures of people in the world today. Because of the doctrine of *terra nullius* “which allowed unowned land to be claimed and owned by the first person who ‘finds’ it, from the time of first settlement by the British, there was a denial that the land they had inhabited for thousands of years belonged to the original inhabitants” (Day, 1996:30). Aboriginal social structures were broken down by removing people from their traditional lands to reserves or missions. Disempowerment was achieved through the banning of traditional ceremonies and the banning of traditional languages (Memmott et al, 2001:11). Dispossession and denial of the rights of Aboriginal and Torres Strait Islander people was followed by a denial of human rights. This included in its most appalling form, the massacre of Indigenous peoples (Day, 1996). The loss of culture due to settlement was further compounded by the impact of the Stolen Generations (discussed in the previous chapter).

Members of the local Aboriginal Community have pointed out that traditional culture is further eroded amongst Aboriginal and Torres Strait Islander illegal drug users when they immerse themselves in the way of life of the illegal drug using culture. The concern is that relationships with non-Indigenous people who use illegal drugs is not mere fraternising, but immersion in a totally alien way of life in which traditional norms and values are thrown away.

This anecdotal evidence from Community members has been substantiated by previous research. In her work with Aboriginal injecting drug users in the early 1990s, Lane found that there was a “Crossover between Aboriginal and white IDUs [injecting drug users]” (Lane, 1992-93:4). In the Brisbane study by Larson and colleagues, three quarters of the people interviewed said that at least half of their friends were non-Indigenous (Larson et al, 1997). We did not ask the whole sample about what proportions of their friends were non-Indigenous. But we did ask 47 injecting drug users whether they usually injected with Aboriginal and Torres Strait Islander people, non-Indigenous people or a mixture of both. We found that just 5 people (11%) said they only ever injected with Aboriginal and Torres Strait Islander people. This finding is in keeping with anecdotal evidence from members of the local Aboriginal Community and with the work of other researchers reported above. It contrasts, however, with the research conducted in Western Australia by Gray and colleagues where 66 per cent of respondents reported that the groups they injected with most often consisted solely of Aboriginal people, 18 per cent said they sometimes injected and 16 per cent that they only injected with non-Aboriginal people (Gray, 2001). These differences between the samples emphasise the importance of conducting locally-based studies.

### **Cultural needs of the people we interviewed**

Given the history and the cultural changes of the past 216 years it is not surprising that some Aboriginal and Torres Strait Islander people have lost touch with their traditional culture. In their paper on the social determinants of health in the Northern Territory Indigenous population, Devitt and colleagues note that “Cultural change powerfully effects the structure of social relationships; in particular, it redefines the things that mark or indicate social standing.” (Devitt et al, 2001:3).

We wanted to find out what the people we interviewed knew about their culture, and what their cultural needs were.

The first open ended question we asked about culture was “Do you feel you know a lot about your heritage?” (as indicated in Chapter 3, questions about respondents’ cultural background were some of the most difficult to develop, they are all included as Appendix 17). A small number of people, most of whom simply said “No” when we asked the question, indicated that they knew nothing about their culture. Others amplified their “No” response, usually with a comment about separation. Such examples include: “I was assimilated”; “I was Stolen”; “My mother was part of the Stolen Generations.”

Most people said they know something about their culture, but almost all of them wanted to learn more. The few people who said that they did not want to learn about their culture said something like: “I know what I need to know, I know I’m Aboriginal, where I’m from, my people. I’m not right into politics.” Or: “I know a bit about it because my Grandparents pump it into me, about the land, the people, how we are supposed to look after the land.”

In response to us asking everyone we interviewed “Would you like to learn more about your ... culture?”, the biggest number of responses was for learning language. This was mentioned by 39 people and was generally succinctly expressed as a one or two word response of “Language”, or “Speakin’ lingo”, generally of the respondent’s identified cultural background. Some people linked their need to learn a language with historical events which followed colonisation. One such person said: “I’ve lost my language because Mum grew up in the mission. She knew it, but I wasn’t allowed to talk to my Mum, and I feel I’ve lost the language.” One woman expanded on her need to learn the language of her husband’s family (who lived outside of the ACT and Region): “I would like to be able to speak fluently. Most of his [partner’s] family don’t speak English and it’s real hard. They don’t understand me, and I don’t understand them.”

Many people were unspecific about their cultural needs, mentioning simply a need to learn about history (13 people), or general culture, customs or traditional ways (29 people). A young woman who was trying very hard to “stay clean” said:



*Yeah, I'm learning more [about my culture] now because I've got kids. I've gone back to Nan [to learn] because she's getting on now ... I want to understand more about why we don't have our own government why we're living in tents. I just went through a bad time with my kids, and they ask me stuff and I don't know the answer, you know, just little things.*

A young man said he wanted to learn

*More than white history, migrations, you hear about Homo sapiens but what about what happened here? It's lost. It wouldn't hurt to do that here. England has its own ethnic people and they would get taught about it, why not us? New Zealand seems to have their culture respected more because of Treaty, they stood up and fought ... but here, they were wiped out. I have an interest in ... the pictures, rock art, landscape. I would like to learn more about that.*

Gender specific needs included a desire to learn about “men’s business” or to “learn about traditional weapons” (6 men) or “women’s business” (4 women). Eight people said they would like to learn about hunting or bush food.

Six people personalised their needs: five to discover where they were from and one to find out more about issues related to the Stolen Generations. In addition to their own needs, five people said that children needed to know and another said more generally “others need to know about traditional Aboriginal culture.”

Some people felt very strongly about their loss of culture. A young man, who was a very heavy cannabis smoker and had already had some legal problems, was one such example. He said: “I’m civilised, I grew up in the eighties, but it’d be good to know camping ... I feel like we’re mongrels, being who we are, not Alice Springs people” [inferentially, this young man was referring to the fact that there are people in the Alice Springs region who still follow a traditional way of life].

Other respondents tied their drug use directly to their loss of, and need for, Aboriginal culture. One young man, whose polydrug use included heroin, said: “We’ve already got Koorie painting, but real Koorie painting is natural, I’d like to learn the truth about things, they should teach us how to make didges [didgeridoos], take us out of the city, there’s nothing to [do, so I] take drugs.”

A comment in accordance with this perceived nexus between loss of culture and drug taking came from another young polydrug using male:

*I don't know [my heritage], just the tip of the iceberg. I would like to learn [my] language. I would like to learn from Elders ... Elders need to come and pass it on young people that use drugs and stuff like that. People are lost and bored. Then it's easier to step into that world [of drug taking].*

Another young man said “Yes, it would be good to start learning a few things about how we was. A start anyway. Not just paintings, or just sit there. Go to the bush, get [out of] the city.”

As mentioned in Chapter 2, at the suggestion of one of the people interviewed during early piloting, we added a question about whether or not respondents thought cultural and spiritual workshops would be useful. Two thirds (n=66) said they would find such workshops useful, generally with a short affirmative response of “Yes” or a comment like “That would be wonderful” or “Yes, great, that’s what we need.” Some people gave more fulsome responses such as a young man who told us he had been “A chronic alcoholic at a young age.” His drug use history revealed that he was now in the throes of problematic heroin use. Another young man hoped that cultural and spiritual workshops might restore some equity to race relations:

*Yes, we need more of this in this part of Australia – we are the original owners. Aboriginal people have been suppressed for too long now. Never mind where you go, there's good and bad in every race. But society has chosen the Aboriginal race to suppress and use as an excuse.*

Although not seeing a need for workshops for themselves, a few people talked about the benefits of holding workshops for younger people. A man who had thought a lot about the needs of his people said:

*That'd be good for the younger people. They would get to see the other side of the fence. It's a white man's world. They [young Aboriginal people] know how to steal, break in. They're losing touch with their heritage.*

Several people mentioned the importance of having Elders from their own Community running the workshops, rather than Indigenous peoples from other tribal groups, with a comment such as “I wouldn’t like anybody telling me about my culture [it would need to be] somebody from my own group [culture], not someone from outside.” One man

gave a proviso of a similar nature: “If people are fair dinkum about traditional culture, I would [like workshops].”

Table 9.1 summarises cultural needs identified by respondents. This table reveals that the biggest need is for cultural and spiritual workshops. Sixty six people (70%) identified this as a need for themselves and five people (5%) identified this as a need for children. In terms of specific cultural needs a need to learn their traditional language was expressed by 39 people (41%). There were also quite large numbers of people who talked about a general need for learning “traditional ways” (n=39, 31%). As shown in the previous chapter, some people believed that residential rehabilitation services would be an appropriate place for them to learn their culture. In addition, there is a need for cultural workshops to be offered in Community settings.

**Table 9.1: Summary of cultural needs identified by respondents**

<b>Need</b>	<b>n</b>	<b>%</b>
<b>Own cultural needs</b>		
Cultural and spiritual workshops	66 <sup>a</sup>	70
Language	39	41
Traditional ways	29	31
History	13	14
Hunting and bush food	8	8
“Men’s business”	6	10 <sup>b</sup>
“Where I’ve come from”	5	5
“Women’s business”	4	12 <sup>c</sup>
<i>Cultural needs for others</i>		
Children	5	5
General “others need to know”	5	5
Cultural and spiritual workshops for young people	4	4

<sup>a</sup>One missing value for cultural and spiritual workshops.

<sup>b</sup>This percentage is based on the number of men we interviewed.

<sup>c</sup>This percentage is based on the number of women we interviewed.

The Aboriginal and Torres Strait Islander Research Agenda Working Group of the NHMRC, emphasised that

*an Aboriginal and Torres Strait Islander health research agenda should:*

*put Aboriginal and Torres Strait Islander culture and values at its centre by:*

*- focusing on how culture impacts on the resilience and wellness of individuals and communities, and*

*- embracing self determination and cultural respect as part of the research endeavour ... .*

(The Aboriginal and Torres Strait Islander Research Agenda Working Group of the NHMRC, 2002:1).

## Secondary education

No one we interviewed was still at school. “Educational attainment, particularly for women, is strongly correlated with population health” (Thomson et al, 2003:52). Overall, 61 per cent of the people we interviewed had left school at the age of 15 years or less; almost one third left before the age of 15 years (n=28) and a similar proportion had left at the age of 15 years (n=29) (Table 9.2). There was no significant gender difference in age of school leaving.

**Table 9.2: Age left school**

Age	n	%
<15	28	30
15	29	31
16	21	22
17	10	11
18	6	6
≥19	1	1
<b>Total</b>	<b>95</b>	<b>-</b>

Our findings on early age of school leaving are in accordance with studies of Australian Aboriginal injecting drug users where an average for school leaving of 15 years has been reported (Larson et al, 1999; Holly and Shoobridge, 2002).

The 2001 Census found that around 32 per cent of Indigenous people did not complete Year 10 (which for most people would be at the age of 15 years). This compares with a lower proportion of 18 per cent for non-Indigenous people (Australian Bureau of Statistics, 2003b). Thus, at 61 per cent, the people we interviewed had an even higher rate of early school leaving than found amongst Aboriginal and Torres Strait islander people in general, and more than three times higher than found in the non-Indigenous population. Compounding this disparity, Canberra has higher school retention rates than the national average (ACT Government, 2002).

Reflecting the generally early age of school leaving, a majority of 63 per cent (n=59) of respondents had obtained neither a Year 10 School Certificate or Year 12 Higher School Certificate. One third had acquired a Year 10 Certificate (28%, n=26), but just 9 per cent (n=8) a Year 12 Higher School Certificate (n=93, 1 missing value and 1 no disclosure).

The South Australian study of 307 Aboriginal injecting drug users found a bigger proportion (49%) who had completed a Year 10 Certificate (Holly and Shoobridge, 2002). In the West Australian study by Gray and colleagues “the majority ... had either completed Year 10 (38%) or less (46%) of schooling” ) (Gray et al, 2001:36).

General studies of Australians who use illegal drugs have revealed higher proportions of people who had completed a Year 12 Higher School Certificate than found either in our sample or in the other samples of Australian Aboriginal and Torres Strait Islander people who use illegal drugs. General studies of illegal drug users have reported levels of 27 per cent (Lenton and Tan-Quigley, 1997); 34 per cent (Loxley et al, 1995); 40 per cent (Australian National AIDS and Injecting Drug Use Study, 1991); 49 per cent (Spooner et al, 1993) and 66 per cent (Dance, 1998).

## **Post-secondary education**

We asked respondents if they had participated in any courses or training programs since leaving school and, if so, whether they had completed the course (some people had participated in more than one course). Table 9.3 shows that 30 per cent (n=28) had completed trade certificates or work-related training. This table also shows that only small numbers of people had completed any other forms of post-secondary education.

Findings from national data reveal that Indigenous people who participate in post secondary education usually enrol in technical or further education courses rather than university courses (Australian Bureau of Statistics, 2003b). The proportion of participation in further education among the people we interviewed is somewhat higher than nationally; the 2001 Census revealed that 18 per cent of the Indigenous population had a “non-school” qualification (Australian Bureau of Statistics, 2003b:49).

Larson and colleagues found that one half of the Aboriginal injecting drug users they interviewed had had no further education since leaving school. Those who had (20%) had generally participated in apprenticeship or on the job training (Larson et al, 1999). Holly and Shoobridge found one third of their sample had studied since leaving school but this was also mainly in technical or trade areas (Holly and Shoobridge, 2002).

**Table 9.3: Courses or training programs since leaving school**

<b>Courses since leaving school</b>		
	<b>n</b>	<b>%</b>
<b><i>Return for Year 10 Certificate</i></b>		
Completed	2	2
Current	1	1
Uncompleted	9	10
Not applicable ( <i>ie, already achieved at least this level</i> )	11	12
<b><i>Return for Year 12 Certificate</i></b>		
Completed	2	2
Current	1	1
Uncompleted	1	1
Not applicable ( <i>ie, already achieved at least this level</i> )	3	3
<b><i>Cultural awareness/training</i></b>		
Completed	2	2
Current	1	1
Uncompleted	6	6
<b>Trade certificate or training</b>		
Completed	28	30
Current	8	6
Uncompleted	18	19
<b><i>Professional</i></b>		
Completed	1	1
Uncompleted	1	1
<b>Undergraduate degree/diploma</b>		
Current	1	1
Completed	5	6
Uncompleted	7	7
<b><i>Postgraduate diploma</i></b>		
Completed	1	1
<b><i>Other courses (eg, life skill courses)</i></b>		
Completed	6	6
Current	1	1

### *Education needs*

The majority of people we interviewed said they were able to read and write well: 85 per cent (n=81) and 84 per cent (n=80) respectively. There were, however, quite large proportions of people who said they had poor reading and writing skills: 11 per cent (n=10) and 12 per cent (n=11) respectively. One of these people said:

*I'm frustrated if can't put it together, I rack my brain, but I can't do it. I was always good at maths plus good with my money, but spelling [is bad]. I'm embarrassed to ask for help."*

A further four people said they could not read or write at all.

Where appropriate, we asked people if they would like to return to school, or if they would like to study for or complete (if they had "dropped out") any post secondary courses. Fifty four (63%) indicated a desire to do one or the other (we did not ask 10 people, either because they had already completed tertiary studies or because there were circumstances which precluded them from participating in further education). One person, who was very articulate, said she wanted to learn communication skills:

*I like communicating but I have trouble getting across what I have to say. You see, I've been through so much, I've lost everything now, because of the drugs. I have to go back and learn how to communicate again. You see, when I can't communicate, when I get upset and angry I just can't [communicate] and they think I'm dumb, and when you put Aboriginal in it and they say 'Oh well.' And that's not right, that's why I've got to go back and learn how to communicate. I'm scared of it now.*

Two people were ambivalent about returning to school.. The remaining 35 per cent did not want to undertake further studies.

We then asked open ended questions about the sorts of subjects those who wanted to further their education hoped to study. Reflecting the general early age of school leaving, the Year 10 School Certificate formed the biggest category containing almost a quarter of the responses (24%, n=13) of those who said they would like to participate in further study (Table 9.4). Smaller numbers of people named Year 12 Higher School Certificate and particular subjects such as "reading", "writing", "maths" and "art."



**Table 9.4: What respondents would like to study**

<b>Subject</b>	<b>n</b>	<b>%</b>
Year 10 School Certificate	13	24
Reading/spelling	6	11
Year 12 Higher School Certificate	5	9
Writing	5	9
Arts	5	9
IT	4	
Trade	4	7
Maths	3	6
Science	1	2
Aboriginal studies	2	4
Sport	1	2
Unspecified	12	22

Some people mentioned more than one area of study.

A few people talked about what would help them participate in further education. Internal reasons such as “stopping drugs” were mentioned by nine respondents. A need for childcare, mentioned by nine people, was the most frequently mentioned external factor. Other external factors such as help with transport, finances and stable housing were mentioned by a few people. Four people said they would need help such as special tutoring or a “Koorie teacher.” Factors related to education itself, “that it must be interesting” or, for one person, an “Aboriginal only” school were spoken about by small numbers of people. One young man talked about a combination of internal and external factors: “I can help myself get back to school but the schools have to let me in [adding] the hours would make it difficult.” One young man alluded to current legal problems as being an impediment to him returning to school.

### *Referrals for education*

We provided contact details for means of accessing further education to seven people including two young men (interviewed simultaneously) who had been suspended from school and wanted to return. One said “I got caught smoking cigarettes and fighting. It wrecked my whole life, my education, my future.” During the interview we contacted the appropriate Winnunga researcher who came to talk to these young men.

## Occupational status

As shown in Table 9.5 a majority of respondents (68%, n=65) were on benefits. Gray and colleagues report a similar finding: 70 per cent were receiving benefits in their sample of 77 West Australian Aboriginal injecting drug users (Gray et al, 2001). Despite around a third of the people we interviewed having completed a trade certificate or training, only 9 (8%) were in full time paid employment.

There were higher rates of unemployment in the people we interviewed than found in the overall national population of Indigenous people, where there is an unemployment rate of 22 per cent for Indigenous men and 18 per cent for Indigenous women (compared to 8 per cent for non-Indigenous men and 7 per cent for non-Indigenous women) (Australian Bureau of Statistics, 2003b).

The study by Larson and colleagues report similar high rates of unemployment to those we found. Just six per cent of the 77 injecting drug users they interviewed were in full time paid employment (Larson et al, 1999). Holly and Shoobridge report an even smaller proportion, three per cent (Holly and Shoobridge, 2002). Samples of mainly non-Indigenous people who use illegal drugs also report higher rates of unemployment than those found in the general population (for example, Loxley et al, 1995; Lenton and Tan-Quigley, 1997; Dance, 1998).

**Table 9.5: Current employment situation**

Situation	n	%
Benefits <sup>1</sup>	65	68
Home duties <sup>2</sup>	18	20
Tertiary student <sup>c</sup>	12	13
Full time paid job <sup>1</sup>	9	8
Corrections	7	8
Casual paidjob <sup>1</sup>	4	4
Volunteer work <sup>1</sup>	5	6
Part time paid work <sup>1</sup>	1	1
Self employed <sup>1</sup>	1	1
Unemployed no benefits <sup>1</sup>	1	1

<sup>1</sup>Four missing values.

<sup>2</sup>Three missing values.

<sup>3</sup>Includes those who have returned to school for certificates; trade certificates; diplomas; cultural awareness training; numeracy and literacy.

Twenty two of the people we interviewed who were not in paid employment said they usually had a paid job. For most of these people (n=16) the usual paid employment was labouring or unskilled work.

Sixty four of the 65 people who were on benefits provided us with information on the type (Table 9.6). Over half were on unemployment benefits (53%, n=34), and over a quarter were on disability benefits (27%, n=17).

**Table 9.6: Type of benefit**

<b>Benefit</b>	<b>n</b>	<b>%</b>
Unemployment	34	53
Disability	17	27
Supporting parent	10	16
Youth Allowance	2	3
Abstudy	1	1
<b>Total</b>	<b>64</b>	<b>100</b>

The length of time people had been on benefits of any kind had a wide range, from one month to 20 years (mean 4 years and 9 months). Accordingly, there was a very wide standard deviation of around four and a half years (n=63, 1 missing value).

### *Employment aspirations*

The World Health Organization points out that

*Unemployment puts health at risk ... Evidence from a number of countries shows that, even after allowing for other factors, unemployed people and their families suffer a substantially increased risk of premature death. The health effects of unemployment are linked to both its psychological consequences and the financial problems it brings – especially debt.*

(World Health Organization, 2003:20)

We obtained information from 80 people who were not in paid employment about whether they would like a paid job (11 people were not asked, either because they were already in paid employment or because there were circumstances which precluded them from employment; 4 missing values).

Seventy three people (92%) said they wanted paid employment, and one person said they did not want a job but wanted to study. Just six people (8%) said they did not want employment. These were generally people who were on disability pensions.

We went on to ask people who said they wanted work, what sort of work they would like. The responses are shown in Table 9.7. Most were able to name a particular job. Some sort of work which involved working with people was favoured by 24 per cent of respondents (n=19). Other types of skilled work formed the next largest category (20%, n=16). A minority of 15 per cent (n=12) did not specify a particular job they wanted.

Of the 73 people who wanted paid employment, a majority of 75 per cent had applied for work (n=53, 1 missing value). Ten people (14%) who were currently unemployed had applied for a job in the past month and another 27 people (38%) had applied for a job in the past 12 months. Eighteen people (25%) who said they wanted employment had never applied for a job.

**Table 9.7: Employment aspirations**

<b>Type of work</b>	<b>n</b>	<b>%</b>
Cultural (eg, work with own people, cultural awareness, “anything Indigenous”)	7	9
Working with people (14 Social work/Counselling/Welfare, 1 “work with kids”, 1 child educator, 1 general nursing, 1 nursing home, 1 “work with people”)	19	24
Other skilled (2 computer work, 1 bricklaying, 1 building, 1 fork lifting, 1 car mechanic, 1 hospitality, 1 house painting, 1 stonemason, 1 receptionist, 1 office work, 1 woodwork, 1 tourism, 1 beautician, 1 “law and drugs”, 1 archaeology)	16	20
Unskilled (4 labourer, 1 cleaning, 1 kitchen hand, 1 stores)	7	9
Out doors work (2 “outdoors work” 2 park ranger, 2 gardening, 1 “fauna and flora”)	7	9
Arts (1 “artist”, 1 “making movies” 1 musician, 1 visual arts, 1 writer)	5	6
Work with animals	3	4
Sport (1 football, 1 rugby league)	2	3
Other (1 consultancy, 1 politician, 1 research and development)	3	4
Not specified (6 “anything”, 5 don’t know, 1 “hands on stuff”)	12	15
Does not want paid employment, wants to study	1	1
Does not want paid employment	6	8

Five missing values, a few people mentioned more than one type of employment.

Next, we asked those who were not in a paid job, and who wanted work and who were capable of paid employment, “What would help you get a paid job?” In keeping with the findings on education needs, by far the biggest number of responses (n=24) were for “courses”, or something similar such as “qualifications and stuff like that”, or “reading and writing.” One of these 24 people was already enrolled in a course and another had suspended her course. Another woman, who already had a lot of training and who believed she had a lot to offer her Community, expanded on her needs:

*Well, basically, I am more of an experience person than a person with a piece of paper. And just for anyone to give me a chance. Because I am a Community person. But like, the problem that I have is because in our society if you have a personal fight with [someone in management], or something like that, it effects ... this is across the board, I am not talking about any particular ... organisation ... but that stops you, and I am a controversial person and I've a lot to contribute, and I don't like that.*

A few people mentioned just external reasons such as one man's explanation that “People with innovations and ideas need support in their endeavours to achieve their objectives.” Others were more specific: five people needed help with transport, and three women believed they would need help with childcare, before they could get a job. Some people gave both internal and external reasons such as “[I need] support [as well as a] ... bit more of me committing myself to it” or “I'd get references from people who know me out bush, people from my own tribe.” Some people linked their inability to get a job with criminal histories or their Aboriginal status. Some, such as this man, mentioned both: “It's really hard for Aboriginal people and people with a criminal history to get a job.” Another man said he had not been able to find paid employment “Because I'm a Koorie with tattoos.”

Fourteen people linked drug use with employment. There were seven direct mentions of the need to stop using drugs linked to what people thought might help them find paid employment. Another person mentioned that he needed to stop drinking alcohol before he could find a job. Some people articulated a need for treatment, or a need to sort out problems related to their drug use.

The other seven responses (all different people to those reported above) emerged following the question about what people thought might help them stop using drugs. One young man was one example of these seven people: I'd stop if I had a job or TAFE [Technical and Further Education] or somethin' I reckon I could probably stop."

Perhaps indirectly related to the nexus between drug use and employment were the 12 mentions from other people of reasons such as "Up to myself"[to find a job] or "Gotta' go and look for the right one."

### **Income**

Other researchers have noted the social costs of drug use: the expense involved may lead to the user not spending money on everyday essentials such as rent, food and other living expenses "a situation that often exacerbates relationship problems" (Lintzeris and Spry-Bailey, 1998:236). We moved on from questions about employment to try and get an idea of income for the 12 months prior to interview. Recognising this to be a sensitive area, we reminded respondents that they could "Pass" on this question if they chose to. Seventeen people chose to do so. Three people said they did not know their income (5 missing values).

We thus received information from 70 people about their income. The median annual income for these 70 people was \$9 650 (range \$0 [*sic*, n=1] to \$25 506). Actual amounts were frequently difficult to estimate because some people said that some of their bills or rent were taken out before they received their benefits.

Nationally, a mean weekly income of \$364 is reported for Aboriginal and Torres Strait islander people compared to a much higher one of \$585 for non-Indigenous people (Australian Bureau of Statistics, 2003b). The mean weekly income for the people we interviewed worked out to be \$196. Factors such as the higher levels of unemployment in our sample may partially explain the lower than average income. Other research has also found a much lower income for people who use illegal drugs when compared with the general population (for example, Dance, 1998). Given the difficulties we experienced in collecting these data, we recommend that our findings on income be treated with caution.

## *Gambling*

As for other Australians, whilst gambling for some Aboriginal people may have benefits, for others it is problematic. Gambling has recently been included with alcohol and other drug dependencies as a problem that may be amenable to formal treatment (Pitts and Hale, 1998). Treatment for gambling usually follows the abstinence-based models used in other 12-step programs (Alcoholics Anonymous and Narcotics Anonymous). Other treatment approaches are generally outpatient-counselling, based on behavioural change models which teach coping skills, and management of cues that trigger gambling.

Firstly, because of research indicating a connection between drug use and gambling (for example, Leisur and Blume, 1991; Kausch, 2003), and secondly, because of some findings which indicate Aboriginal people spend more on gambling than non-Aboriginal people (Holden, 1995), we also collected a small amount of data on gambling behaviours. We began by asking people if they liked to have a gamble. Forty eight people said they did (51%, one missing value). Next, we asked these 48 people what type/s of gambling they liked. As seen in Table 9.8 a majority of 81 per cent of these people (n=39) said they liked poker machines (“the pokies”).

**Table 9.8: Types of gambling**

<b>Type</b>	<b>n</b>	<b>%</b>
Poker machine	39	81
Horses	12	25
Cards	8	17
Lottery	4	8
Keno	3	6
Snooker	1	2
Roulette	1	2
Bingo	1	2
“Scratchies”	1	2
Dogs	1	2



We were then interested in finding out if anyone had become indebted because of their gambling. Exactly half the gamblers said they had (n=24). One woman, for example, summed up the bad things that had happened to her with “Just bad luck, bad at gambling and drinking.” She also mentioned problems with her family’s gambling, her friends’ gambling, and, most particularly, her husband’s gambling:

*My husband would gamble a lot. I said ‘Before you gamble go buy something for the house and whatever you have left in your pocket feel free to piss it up or put it in a fucken machine’ ... He used to hide the receipts from gambling in his socks ... And he denied it ... hey all the fights were about kids, money, gambling, drugs.*

When we asked if anyone had ever gambled to get money to buy drugs, again, exactly half the subsample said they had. Most importantly, we wanted to know if anyone had ever felt like they needed help because of their gambling. Fifteen people (31% of the people who gambled) responded “Yes” when we asked this question.

Some people offered additional comments about their gambling. For one woman, who at the time of interview had not used any amphetamines for six months and had also controlled her gambling: “[The] gambling went with the speed use. I never was one to gamble, but with the speed use [I had the confidence] to go into pubs and gamble.” When talking about her amphetamine use she said:

*The coming down is really bad and I decided to stop using – you think you’re on the top of the world, gambling, drugs in one hand, money in the other. You just don’t realise, you come down [from the amphetamine use] and you crash.*

A man who was a polydrug user also linked his amphetamine use to his gambling. He said he mainly used heroin “Just to come down from the goee [amphetamine]. Just so I can get a sleep and that out of it.” When we asked him what was good for him about amphetamine he responded: “Like I said, I’m a gambler, I like stayin’ up all night at the [venue] until three or four [in the morning].” When we clarified this by asking: “So amphetamine helps keep you awake for the gambling?”, he responded “Yeah.”

We asked 37 people who gambled (we did not ask those who stipulated that they only occasionally gambled, for example if they, like most other Australians, just had a bet on the Melbourne Cup) if they had knew of services for treatment of gambling. Sixteen people (43% of those we asked) said they did. Just two of the 37 people we asked the question of had, however, used any form of treatment for gambling. One offered additional comments about the treatment:

*Well actually meeting the person. And he was a wonderful guy and he rang me up every day and just talked to me about gambling and [asked me] if I've been to the club, and if I had [he said] 'That's OK, and don't get upset.' And he told me how much money I've lost. He adds it all up [and now I gamble less].*

There are no specific gambling services for Aboriginal and Torres Strait Islander people in the ACT. Whilst some services offer face to face contact, others rely on phone contact. It is possible that due to a combination of cultural and language differences Aboriginal and Torres Strait Islander people are less likely than other Australians to access phone services (Australian Institute of Gambling Research, 2001).

Our findings indicate a need for specific gambling help lines and counselling for Aboriginal and Torres Strait Islander people.

### *Referrals for gambling*

We asked everyone who said they currently had problems due to their gambling if they wanted information about available services. Five people took the information pamphlets we offered.

### **Significant others**

In this section we present results on whether or not respondents were in a relationship, and whether they had children and other dependants. We also briefly report on the few needs people had in this area.

## Relationships

A small majority of respondents (59%, n=54) were in a relationship, all of these being with a member of the opposite sex. One third of these people (n=30) said they were either married or in a *de facto* relationship, 12 people just said they had a partner and another 12 said they had a boyfriend or girlfriend. A man believed that his partner, who was already offering him a lot of support, would help him stop using illegal drugs. A majority, 85 per cent (n=45) of the 54 people who were in a relationship of any sort, said it was a monogamous relationship (1 missing value).

As shown in Table 9.9, over a third of the people in the sample were not in a relationship: 30 were single (33%) and 5 (5%) were separated or divorced. One of these people believed “a girlfriend” could help him stop using illegal drugs.”

**Table 9.9: Relationships**

<b>Relationship</b>	<b>n</b>	<b>%</b>
<b>In a relationship</b>		
Married/de facto	30	33
Partner	12	13
Boyfriend/ girlfriend	12	13
<b>Not in a relationship</b>		
Single	30	33
Separated/divorced	5	5
<i>Other</i>	3	3
<b>Total</b>	<b>92<sup>a</sup></b>	<b>100</b>

<sup>a</sup> Three missing values.

## Dependants

We asked respondents if they had any children and, if so, how many. If there was just one child, we asked the age of that child. If there was more than one child we asked for an age range. We moved on to ask how many children were dependent on the respondent. In case respondents had lost any children, for example, due to bereavement or to foster care, we asked these questions very sensitively and did not probe. We then asked about other dependants.

### *Children*

Two thirds of respondents were parents (n=61, 66%, 3 missing values). These 61 people had a mean number of around three children (range 1 [n=15]-12[n=1]). Childrens' ages ranged from less than one year to 37 years. Noting that many respondents had grown up children, around two thirds of parents (n=40) had children who were dependent on them (4 missing values). The number of dependent children ranged from one to five.

### *Other dependants*

Eight people said they had other dependants (4 missing values). Seven of these people said they had between one and six family members (most commonly parents) who were dependent on them. The eighth person did not specify relationships, or the number, but simply said he had "lots of people" who were dependent on him.

### *Combined number of dependants*

The combined results for children and other dependants showed that, overall, almost half of the respondents (48%, n=43) had people who were dependent on them (6 missing values). The number of dependants ranged from a mode of 1 (n=18) to a maximum of 7 (n=2). A greater proportion of women (58%, n=19) than men (39%, n=24) had dependants. This difference was significant (Chi<sup>2</sup>, p=0.003).

### *Needs related to dependants*

Using, as appropriate, prompts such as "work, study, parenting skills, time out" we then asked whether those with dependants needed any help. The majority of people with dependants were adamant that they did not need help. These respondents made a comment such as "I don't need help with parenting, I don't need any help with the children or my [relative]" or "I get a lot of support looking after [relative]." Such reluctance to acknowledge a need for help may be associated with the fear stemming from Stolen Generations about any intervention, particularly Government intervention,

in the care of children. It may also be because extensive kinship networks mean that, for the majority, there are other relatives available to help care for dependants.

Just four women said they needed help with childcare; one of these said she also needed help with other dependants. Although the number was small, the comments were heartfelt. One single mother, for example, said: I would like help, I'm just hanging in. My son needs a male role model."

### *Family*

In the context of what could help them stop using drugs, five people mentioned their family.

### *Friends*

Two people believed that their friends could help them stop using drugs. Another three people said that they needed to get away from their drug using friends before they could stop using drugs.

## **Housing**

A majority (66%, n=61) lived in some sort of government housing. There are low rates of home ownership for Aboriginal and Torres Strait Islander peoples (Thomson et al, 2003). Just five per cent (n=5) of the people we interviewed lived in a home they or their parent/s owned (Table 9.10). This is in keeping with findings from the 2001 National Census which revealed that households with Indigenous people were over twice as likely than "Other"<sup>42</sup> households to be in rental accommodation: 63 per cent compared with 27 per cent (Australian Bureau of Statistics, 2003b).

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<sup>42</sup> We use the term "Other" here and elsewhere in this section following its usage in the Australian Bureau of Statistics publication we refer to.

**Table 9.10: Type of housing**

<b>Housing</b>	<b>n</b>	<b>%</b>
Government	61	66
Itinerant	5	5
Other rented	6	7
Owned/parents' owned	5	5
Other	10	11
Not specified	5	5
<b>Total</b>	<b>92<sup>a</sup></b>	<b>-</b>

<sup>a</sup> Three missing values.

We asked 82 people about their access to amenities (we did not ask the 5 people who were itinerant, 8 missing values). Table 9.11 shows that between 92 (n=75) and 99 per cent (n=81) of these 82 respondents always had access to hot and cold water and garbage removal. Just two thirds (n=54), however, had guaranteed access to a phone.

**Table 9.11: Access to amenities**

<b>Amenity</b>	<b>Always</b>		<b>Sometimes</b>		<b>Never</b>		<b>Total</b>	
	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>
Hot water	75	92	1	1	6	7	82	100
Cold water	81	99	1	1	0	0	82	100
Garbage removal	81	99	1	1	0	0	82	100
Electricity	77	94	0	0	5	6	82	100
Phone	54	66	9	11	19	23	82	100

### *Living arrangements*

After asking people about if they were living with anyone, we asked the nature of the relationship. As seen in Table 9.12, most people shared their home with someone else, most commonly children, and/or a partner and/or other family. Only eight per cent of respondents (n=7) lived alone. A further five people were homeless. Eight per cent were in corrective services (n=7) or residential drug treatment (n=1).

Some of these findings are fairly similar to those reported by Larson and colleagues: 27 per cent of the Aboriginal injecting drug users they interviewed lived with one or both parents, 15 with other relatives, 12 with a friend, and only five lived in a squat or a hostel (Larson et al, 1999).

**Table 9.12: Living arrangements**

<b>Who lived with</b>	<b>n</b>	<b>%</b>
Child/ren <sup>1</sup>	30	33
Other family <sup>1</sup>	30	33
Partner <sup>1</sup>	29	32
Parent/s <sup>1</sup>	19	21
Friend/s/housemates/other <sup>2</sup>	13	14
Corrective services/residential treatment	8	8
Alone <sup>1</sup>	8	8
Homeless <sup>1</sup>	5	7

<sup>1</sup> Five missing values.

<sup>2</sup> Seven missing values.

Kinship ties often lead to Aboriginal and Torres Strait Islander people sharing their homes with extended family members for some of the time. In order to estimate how many people the respondents lived with, we first asked how many others (mentioning, as relevant, partner, parents, children siblings, other family, friends, etc) they always lived with and then how many they sometimes lived with. Taking into account both these totals, respondents lived in households where there was a mean number of 4.5 people (median 4, range 1-13) (we excluded those who were in corrective services, in residential drug treatment and those who were homeless, 8 missing values).

Aboriginal people often experience high levels of overcrowding (Thomson et al, 2003). There is a general Australian average of 3.5 people in households with Indigenous people, compared to a lower average of 2.6 people in “Other” households.” The ratios vary very little by remoteness (3.2:2.6 in major cities to 3.6:2.5 in remote areas), except in the case of very remote areas (where they are 5.3:2.5) (Australian Bureau of Statistics, 2003b). The somewhat larger number we found may be due to an artefact of sampling, or may be because we asked about people who always *and* sometimes lived in the home.

### *Housing needs*

We asked 81 people if they were satisfied with their housing (we did not ask the 5 people who were itinerant and we deemed it inappropriate to ask one person; 8 missing values). Fifty three people (65%) said they were satisfied. We went on to ask the 28 people who were unsatisfied open ended questions about their housing needs (some people mentioned more than one need). Because they were currently living with others such as parents or friends, almost half of these 28 people (n=13) said they wanted their “own place.” Five people, mostly with children, said their home was “too small” or that it was “overcrowded.” One man, who had extended family living with him on a permanent basis, said “There’s six living in a three bedroom house.”

Four people made general comments such as “I’m not satisfied ... [I’ve] been on a waiting list for four years” and three people said they would like a home with “a yard.” Safety issues, generally related to children and concerns about steep stairs, were also mentioned by four people. Comments of a different nature, but which were also related to safety, were detailed by one man who was distressed, not only about finding needles and syringes when he moved into his home, but by his “racist” neighbours. Another man wanted to move because of “a neighbourhood dispute.”

Two people talked about housing needs related to their Aboriginality. One woman simply wanted “Aboriginal housing” and another said of her home “Basically it’s just not spiritually or culturally appropriate.”

If we take account of the five people who were homeless, as well as the 28 people who were not satisfied with their current living arrangements, more than a third of the people we interviewed had housing needs.

Three of the five people who were homeless said that one of the things that could help them stop using drugs was, as this man put it, having a “stable place to live.”



## **Diet**

In a paper on food insecurity in the ACT Aboriginal Community, Bellis Smith pointed to a number of factors related to food insecurity for Aboriginal people in the ACT. These include transport problems, financial problems, housing problems, level of education, chronic diseases, drug use and gambling (Bellis-Smith, 2001). During the session we held on the development of questionnaires in our transfer of skills training, questions around diet proved to be the most difficult to refine. These questions were asked as recommended by the Winnunga researchers.

A majority of 89 per cent (n=83, 2 missing values) said they ate something every day. We then asked people what they ate for breakfast, lunch and dinner. Thirty eight per cent of the sample (n=35, 4 missing values) either never ate breakfast (n=30), sometimes had breakfast, or just ate a biscuit. The remaining majority of respondents ate a good or reasonable breakfast. Fourteen people (15%) never or only sometimes had any lunch. The majority had a reasonable or good lunch. Food eaten at lunchtime varied from a cooked meal, or a salad or, for the majority, a sandwich. Just three people said they never had an evening meal and just two people said they only sometimes had an evening meal. The majority of respondents ate a “cooked dinner” in the evening.

In response to being asked “Do you think you eat OK?”, 22 people, (24%) responded “No.” Three people said they did not know whether they ate properly and one person replied “Sometimes.” We asked those people who said they did not think they ate well what they thought the reasons for this might be (some gave multiple answers). Eighteen people believed that they did not eat properly because of their drug use, nine people said they did not eat properly because of financial problems, three people mentioned problems to do with their emotional well-being, and two people said it was because of where they were currently living. The following reasons were each named by one person: dental problems; “too much junk food”; “I’m not hungry”; “My stomach has shrunk”; “I’m too busy” and “I eat whenever I can.”

## **Other social changes respondents believe would help them stop using drugs**

In the appropriate sub-sections above, we interspersed some respondents' comments about how improvements in their lifestyle could help them stop using drugs. Those that did not fit into any of those major themes are included below.

### *Change of environment*

We discussed earlier (in Chapters 5 and 6) the way some people talked about moving to “the bush” as a form of “culture as treatment.” A change of environment is what eight people believed would help them stop using illegal drugs. These eight people did not tie these comments about a change of environment in with their culture. To give an example of the nature of these comments: “Probably just to get out of Canberra so I know it’s not around me. Like I would have to get right away from it to stop me.”

### *Activities*

Memmott and colleagues have indicated that a predisposing factor for violence in Indigenous Communities is the lack of services for recreational activities (Memmott et al, 2001, citing the Secretariat of the National Aboriginal and Torres Strait Islander Child Care, 1996). Eight people we interviewed believed activities would help them to stop using illegal drugs. One young man’s simple response to our question about what would help him stop using illegal drugs was that he wanted to be more involved in “Sport.” Another young man said “I use [illegal drugs] ‘cos there’s nothing else to do. There’s nothing for kids in [place].” In a similar vein, another young man said “having things [to do], artworks, as long as I’m occupied I won’t do it.” A young woman said “Occupied. That’s it. Instead of takin’ it.”

### *Lifestyle*

Two people believed that a general change in their lifestyle would help them stop using their illegal drugs.

## *Transport*

One person believed several lifestyle changes were necessary for him to stop using illegal drugs; these included having a car. This need is in addition to those from five people who mentioned either a need for transport to help them find paid employment, or that a car was on their wish list for improvements they wanted in their life.

### **Summary of other needs for social determinants of health identified by respondents**

As shown in Table 9.13 the biggest need related to social determinants of health identified by respondents was a need for employment (n=73, 91%). As we demonstrated above, most people who wanted employment were specific about the type of employment they would like. Further underscoring the need to provide employment opportunities to Aboriginal and Torres Strait Islander people, Memmott and colleagues have linked unemployment to violence in Indigenous Communities (Memmott et al, 2001).

There was an early age of school leaving amongst the sample: 61 per cent had left school at the age of 15 years or less . Many people who identified a need for employment linked it to a need to further their education. Here, we point to Tatz's finding that "The majority of Aboriginal youth showing suicidal behaviour can not read or write, or can not read sufficiently well to absorb other than the most elementary popular materials, like picture magazines" (Tatz,, 1999:74).

Thirty seven per cent of the sample had housing needs, of these, five per cent were homeless.

**Table 9.13: Summary of other needs for social determinants of health identified by respondents**

<b>Need</b>	<b>n<sup>a</sup></b>	<b>%</b>
Employment	73	91 <sup>b</sup>
Education	54	63 <sup>c</sup>
Housing	33	37
Transport	5	6
Help with dependants	4	9 <sup>d</sup>

<sup>a</sup> There are five missing values for all these needs except for education where there are four missing values.

<sup>b</sup> Eleven people were not asked, either because they were already in paid employment, or because there were circumstances which precluded them from paid employment.

<sup>c</sup> We did not ask 10 people about their education needs, either because they had already completed tertiary studies, or because there were circumstances which precluded them from participating in further education.

<sup>d</sup> This proportion is based on the number of people with dependants (n=43).

Small numbers of people linked particular aspects of the social determinants of health with their ability to stop drug use. Most are related to personal needs. Others, such as culture, housing and employment are linked to needs, already identified above.

Table 9.14 summarises the social determinants of health which respondents linked to them stopping drug use. As with some of the needs whilst in residential treatment (discussed in Chapter 6), some of the needs identified may be considered as grounded theory (Strauss and Corbin, 1990). (Grounded theory is defined in Chapter 6.)

**Table 9.14: Summary of social determinants of health which respondents linked to them stopping drug use**

<b>Need</b>	<b>n<sup>a</sup></b>	<b>%</b>
Activities	8	9
Change of environment	8	9
Employment	7	8
Family	5	6
Get away from drug using friends	3	3
Stable home	3	3
Lifestyle	2	2
Friends	2	2
Culture	2	2
Wants a girlfriend	1	1
Current girlfriend	1	1
Transport	1	1

<sup>a</sup>There are 5 missing values for all these needs.

### **Opiate Treatment Index Social Functioning Domain**

The Opiate Treatment Index Social Functioning domain contains 12 questions which measure employment, residential stability, interpersonal conflict and involvement of the respondent in the drug-use subculture. The general reference time period is six months (Darke et al, 1991a). The five possible responses to each question are scored from 0 to 4, giving a possible total score of 0 (best) to 48 (worst) for this domain. Breaking the total score down to the quintiles recommended by Darke and colleagues, scores of 27-48 are high, 23-26 are above average, 19-22 are average, 15-18 are below average and 0-14 are low (Darke et al, 1991a:24, Appendix 13).

The mean Opiate Treatment Index social functioning score for 87 respondents (6 missing values, 2 no disclosures) was 16.7 (range 2-37, median 17, mode 20, SD 7.4). According to the quintiles set by Darke and colleagues, ten of the people we interviewed (11%) had an above average score of 23-26 (indicating an above average level of dysfunction) and seven (8%) had a high score of over 27 (indicating a high level of dysfunction).

The mean Opiate Treatment Index Social Functioning score we found is a little lower (ie, indicating less social dysfunction) than the mean of 20.5 reported by Darke and colleagues from their research with injecting drug users during the development of the Opiate Treatment Index (Darke et al, 1991a). Macleod and colleagues also used the Opiate Treatment Index in a longitudinal study of people in a clinical setting in Scotland, reporting a Social Functioning score of 21 at their first assessment (Macleod et al, 1996).

We hypothesised that the 48 injecting drug users for whom we had Social Functioning Scores would have higher scores than the 39 non-injecting drug users for whom we had scores. We found that injecting drug users had a mean score of 19.0 compared to a mean of 14.0 for the non injecting drug users. This difference was significant (t test,  $p=0.001$ ). This score of 19.0 is comparable to the one reported by Darke and colleagues and Macleod and colleagues.

Based on the research (referred to in Chapter 7) which demonstrates that women have poorer health than men, we hypothesised that women's Opiate Treatment Index Social Functioning Scores would be higher (that is, indicating a greater degree of dysfunction) than their male counterparts. This was not the case: women had a score of 17.4 compared to a slightly lower (ie, less dysfunctional) one of 16.4 for men. This difference was not significant.

## **Conclusion**

We have made reference to national and ACT studies which demonstrate that Indigenous people are worse off in many social domains than are non-Indigenous people. We have also demonstrated that the people we interviewed are in an even more parlous state of social health than the general Aboriginal and Torres Strait Islander population. These findings have much in common with other studies of Aboriginal and Torres Strait Islander people who use illegal drugs. We have also offered some insights into some of the needs of the people we interviewed in terms of their culture, further education, job opportunities and housing. These all need to be addressed to give those who want to stop their use of illegal drugs any hope of doing so. We draw particular attention to the need for the provision of cultural workshops. As Mick Dodson (Professor at the ANU's Institute for Indigenous Australia since 2002) has put it "The

repossession of our past is the repossession of ourselves” (Dodson, 1994:12).

We conclude this chapter as we began it, with an apposite quote from the World Health Organization: “If policy fails to address these facts, it not only ignores the most powerful determinants of health standards in modern societies, it also ignores one of the most important social justice issues facing modern societies” (World Health Organization, 2003:10).

## CHAPTER 10: SOME REFLECTIONS

### Introduction

In this final chapter we document some comments made by the people we interviewed about what would make their lives better. We then present a summary of the referrals we offered followed by some personal reflections from the Chair of the Reference Group, and members of the Winnunga and NCEPH research team.

### What would improve the lives of the people we interviewed?

The responses we report below emerged either when we asked the people we interviewed what they thought would make them healthier, or when, as part of the winding down we did for the interview, we asked them what they would like to be the same and different about their lives “this time next year.” We have incorporated some other responses to these questions together with needs identified in previous chapters. Below, we report comments related to a desire to stop the use of drugs.

In response to these questions, thirty seven people said they would like not to be using drugs. These comments are summed up in the response of one man who said he would like to be “Drug and alcohol free. To have a sense of normality. To not be using any substance.” Another man said that he wanted to have stopped using cannabis in a year’s time so that he could go “Forward to be a better member of society.” One man said that in a year’s time “I don’t want anything to do with drugs. They’re mates, I love them, but they’re not really mates.” One woman said she wanted a lot of things to be different “Just life itself really. Be clean<sup>43</sup>, get a job.”

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<sup>43</sup> To “be clean” in this sense means to be drug-free.



A woman told us that, because of her problematic alcohol and marijuana use, she had been advised by a family member to come and talk to us. This time next year she said that she wanted to be sober and “to better myself as a person I guess. I know my goals, and being on alcohol, I won’t realise my goals. I need help.” We offered this woman several referrals for treatment, and in our presence she made an appointment to see a health professional.

## Referrals

Table 10.1 summarises the referrals we made at interview. We have no way of knowing how many people followed up on these referrals but hope many of them did. We also offered education during the interviews and that was always welcomed.

**Table 10.1: Summary of referrals we offered**

<b>Referrals</b>	<b>n</b>	<b>%</b>
Aboriginal Medical Service	14	15
Drug treatment services	12	13
Education	7	7
Gambling services	5	5
Sexual abuse counselling	4	4
Family history unit	3	3
First aid training	2	2

The level of unattended immediate problems we found suggests that an outreach service could make a valuable contribution to improving the health of Aboriginal and Torres Strait Islander people who use illegal drugs. In New Zealand, outreach is seen by third sector providers (that is, community orientated, non-government, non-profit service providers) as an important part of service provision, and it is increasingly being recognised as an important aspect of primary health care (Sibthorpe, 2000-2001).

## Some personal reflections

We include below some personal reflections from Tom Brideson, Julie Tongs and some NCEPH research team members.

### *Reflection from the Reference Group*

The study into the needs of Aboriginal and Torres Strait Islander illicit drug users in the ACT and Region for treatment and other services has been a very important project. Throughout the project there have been many highlights and as the Reference Group Chair I would like to draw your attention to some of the important principles that have contributed to the engagement of the Aboriginal and Torres Strait Islander community in this project:

Collaboration;

Partnerships;

Control and ownership;

Whole community problem;

Building the evidence to enable action; and

Building the capacity of the Aboriginal community and researchers.

Each of the above principles has been clearly demonstrated throughout this project report and has been the essence of the project's success. The building of the capacity of the Aboriginal community has been a cornerstone of this project. The transfer of skills arm of the project has enabled the building of specific skills to deal with some of the issues that may have arisen throughout this project. For example, the training of Aboriginal workers across difficult issues of sexual assault and mental health, as well as specific training on research issues, has enabled ownership and trust to foster.

All members of the Reference Group have contributed enormously to the project in a variety of ways. Some having experience at the service level, some in the policy area, some playing very important roles at the front end of the destruction illicit drugs have within the family, and some from an education and research level. The variety of experiences greatly enhanced the contribution to the discussions and guidance of this project. The Elders (many of whom are dealing with these issues within their own families) provided valuable insights into the issues from their perspective. Each member was committed to making improvements in this very important project. It has been a pleasure to be the Chair of such a dynamic and committed group of individuals.

The highlights included:

Securing agreement on ways to progress the complex set of issues confronting illicit drug users;

The building of skills in the Aboriginal community to enable effective and sustainable action; and,

The collaborative way that researchers and the community came together to build a respectful appreciation of a very difficult issue.

A tree symbolises this project and was used as the basis for a broader perspective. Harmony within all aspects of this symbol enables the fullness of growth and development of a healthy tree. Likewise, the harmony across the variety of interests enables more effective responses that support the broad requirements to deal with illicit drug issues. There can be no single quick fix response that will resolve the illicit drug problem within Aboriginal and Torres Strait Islander Communities. This needs to come from a variety of interventions and actions.

Most importantly, the 95 participants of the project have provided information that looks specifically at their needs in regard to treatment and services. The information gathering process enabled the participants to voice their opinions and to provide, at times, very detailed personal information. The Reference Group wishes to express its deepest appreciation each of the 95 participants made to this project. Like you we also hope your suggested improvements can be made to the treatment and services you receive and that this makes a healthy improvement to your life.

The Reference Group would like to thank all people involved in this project but in particular the staff of Winnunga and NCEPH for the way in which this project was instigated and rolled out.

We hope the participants are heard.

***Tom Brideson, Chair***

*Julie Tongs*

I am so proud to have been involved in this much needed and ground-breaking research which is for the most disadvantaged and marginalised group of people in the community. They all have something to offer and we will see this through the implementation of the recommendations from this vitally important research. People from all walks of life need to remember that the people we speak for are someone's mother, father, aunty, uncle, brother, sister, son, daughter, grandchildren or part of the Winnunga Nimmityjah AHS [Aboriginal Health Service] extended family who have had to endure extreme suffering through trauma and all forms of abuse in their lives. This research is the beginning of the next chapter in their lives.

This has been a wonderful working partnership between the Winnunga Nimmityjah AHS staff and NCEPH staff. We have built lasting relationships and strengthened existing ones with the NCEPH Researchers, Dr Phyll Dance, Jill Guthrie, Carmen Cubillo, Dr Gabriele Bammer, Dr Rennie D'Souza and David McDonald.

It was important for Winnunga staff to be involved in the research as we have processes in place for Winnunga staff to debrief with the psychiatrist Dr Ann Harrison and we knew that the stories of abuse - physical, sexual and emotional - would impact on the researchers; but Winnunga staff work with many families every day who have these issues, but I knew that for the researchers it would be out of the norm.

I didn't realise what a lengthy process this would be, particularly when we were in the early stages of the research project; it was overwhelming developing questions then having to get them approved through the ANU Ethics committee (Phyll did a great job of keeping us on track in relation to the research protocols and processes), training staff, organising interviews and having all the day to day pressure of work. The research was an added component to what we were already doing at Winnunga. I believe that this research will have enormous benefits in the end for the illegal drug users in the ACT and region.

Not for one minute did we think that it would be easy for us to do such research because of the nature of the research and the participants we wanted to interview. I knew that we would get a good percentage of people to be interviewed and had hoped for 200. I am sure that if we could have had staff just working on the research project we could have hit the 200 mark, but the crises keep coming at Winnunga and the staff had to balance their demanding workloads with the research.

My advice to anyone wanting to do similar research is to do it in partnership with an Aboriginal Medical Service as it is vital that the people that you are interviewing are followed up after they are interviewed to make sure that they are okay. This needs to happen because of the information that is disclosed in such research; it certainly does bring back painful memories for many of the people interviewed.

A message to all politicians at all levels of government - now we have the evidence we will be lobbying long and hard to have all the recommendations from this report implemented.

***Julie Tongs, CEO***

*Jill Guthrie*

Being involved in this study has been a journey of learning and insight for me. It's been wonderful working with everyone. I owe a great deal to Phyll for everything I've learned from her throughout the life of the study. Her care for the respondents and her patience and wisdom in her approaches during the project have been exemplary. I also owe a great deal to Julie, Tom, Carmen, David, Rennie and Gabriele for their company and friendship and for the way they have shared their many skills with me. Thank you also to NCEPH's administrative staff and management who have been unstinting in their support for the project. Our Winnunga co-researchers were always a source of great wisdom and knowledge and I feel that the relationships that we have built during the study will flourish. Finally, I would like to thank all the respondents for sharing some very personal and important aspects of their lives with us. I sincerely hope that they find comfort and support in the outcomes.

*Carmen Cubillo*

I regard this as one of the most important things I'll probably have to write for this project and it's so close to my heart that I still can't get the words together. I'll just say that it was the biggest experience of my life to work on this project, and the significance of it is justified in every life we touch. More importantly, the stories will stay with me for life, for it was an honour to hear them, and I will spend time in my future helping to heal those wounds. I also have to thank the researchers for welcoming me to the team. I have felt truly blessed to have the opportunity to learn from the research team and I hope that I have earned my place in the team.

*David McDonald*

My involvement in the study was mainly in its development, initial management and report preparation. The study was funded by the National Health and Medical Research Council (NHMRC) and I wish to reflect on this partnership. What partnership, you may ask? Doesn't the NHMRC just give you the research grant and that's it? Well no, is my response; at least not in this case.

NHMRC is a huge organisation, an alphabet soup of acronyms and a maze of committees and sub-committees and sub-sub-committees. They set up a special sub-sub-committee specifically for a new research program concerned with illicit drug problems, using funds provided for this purpose by the National Drug Strategy. The Committee members took on this task over and above their already heavy work loads, and we are grateful to them for that. We submitted an expression of interest in a grant and were thrilled to be short-listed and invited to submit a full application. We were even more thrilled when we found out that our application was successful!

Then it was time to start implementing the study. I won't go into details in this brief reflection, but just wanted to say that things did not go exactly as planned. (Do they ever in research into real world social problems!) For various reasons the study started slowly. That meant that we were missing the milestones set out in the application. It would not be finished on time. The funds allocated for the researchers' salaries would not last the distance.

We went back to the Office of the NHMRC and discussed our problems with the great staff they have there. We explained that, in doing Aboriginal and Torres Strait Islander health research and taking seriously the national Aboriginal and Torres Strait Islander health research ethics principles, this type of study could not be rushed. We needed time to further develop the collaboration between the University and Winnunga Aboriginal Health Service team members. Time was needed to convene a genuinely representative Aboriginal and Torres Strait Islander Reference Group. Staff changes occurred and the project management approach also changed, and these were other sources of delay.

We explained all this to the NHMRC staff and they listened carefully. They also took seriously the principles underlying Aboriginal and Torres Strait Islander health research, including the need to move at the speed of the Community and not try to force the Community to adapt to our (perhaps artificial) timetables. The staff briefed the Committee members and they agreed to extend the time of the study so that it could continue to a successful conclusion.

That's what I mean by a partnership between the researchers and the funding body. We were true collaborators, working together to ensure the successful completion of the study, as we all believed that it was worth doing because of its potential to enhance the well-being of some of the most disadvantaged and stigmatised people in the Canberra region, Aboriginal and Torres Strait Islander illicit drug users. For me, it has been a privilege to be a participant in this process.

*Rennie D'Souza*

I had been involved with research in the area of alcohol and drugs indirectly through students I was supervising. This project gave me a greater understanding of the difficulties associated with carrying out research in this area, and more so in an Aboriginal setting. I admired the patience, persistence and dedication of the people doing the interviews and the interviewees who shared their experiences with them which would have been quite difficult at times. When I read the various chapters of the report, the richness of the qualitative and quantitative data made it all seem worthwhile. This research will provide valuable information to Winnunga and will inform policy makers.

## *Phyll Dance*

First and foremost, I would like to thank the 95 people we interviewed. They more than compensated for some of the more difficult aspects of the research. There was a lot of sadness in the interviews but, perhaps what has not come through in this report, there was also a lot of laughter. There were also heart-warming stories from people who talked about the good things in their lives. I gained immediate benefits from giving people referrals and education. And there were plenty of examples of positive feedback about the interview itself, such as a comment from a man who, when we were winding down the interview and we asked him how he felt, said: “Actually I’m feelin’ good after doin’ this little interview to tell you the truth ... With that little bit that came off my chest now. That makes me feel good, yeah.” Several people said they had come to be interviewed because they wanted to talk about their problems.

Another man said after we had asked him how he felt at the end of the interview “I feel good and that. I’ve just got a few problems and that’s why I come here to talk about [them].” A third man said the interview was: “Good - to get it off your chest.”

We have already referred to evidence which documents that, on average, Aboriginal and Torres Strait Islander peoples die around 20 years earlier than their non-Indigenous counterparts. Unless there are appropriate measures to address drug use, and the underlying problems that lead to problematic use, my fear is that due to mortality from drug-related causes, such as overdoses and bloodborne viruses, even more Aboriginal and Torres Strait Islander people will continue to die before their time.

I’ve been a nurse for almost 40 years, and have been working with people who use illegal drugs, as a researcher and a nurse for 15 of those years. During these 15 years, I have also been involved in various community activities in the illegal drug field. I am also a member of Families and Friends for Drug Law Reform and have worked actively as volunteer for the ACT AIDS Action Council. Before this project started I had some experience as a researcher in Aboriginal and Torres Strait Islander health. I knew this research process was going to be challenging and I am grateful that I have a happy and stable life outside the work arena.



Despite my experience, and the additional training we had done beforehand, I was still not prepared for some of the complexities of the research. The most traumatic of these occurred before the interviews commenced. At that time I almost gave up on the research. One of the many things that kept me going was the knowledge that no matter what the difficulties were that I was experiencing, they were not as difficult as those of many Aboriginal and Torres Strait Islander people, especially (as I was to discover at first hand when we started the interviews) those who use illegal drugs have to constantly face. The rewards have more than compensated for the difficulties. I would, however, advise anyone who is going to do such challenging work - this is a difficult arena in which to work and you need to make sure you seek professional counselling. I did, and Marie is one of the many people who helped me see through the three years of this research.

I would like to endorse the comments David made about the NHMRC. I thank them for funding the research and their patience and understanding.

Although the research took longer than anticipated, it is appropriate that we are launching it on “Indigenous Day” of Drug Action Week (an initiative of the Alcohol and other Drugs Council of Australia).

My thanks to members of the Reference Group who provided valuable advice and cultural guidance. Tom Brideson chaired the meetings with wisdom and sensitivity, and offered great support to the members of the Reference Group and research team.

When so many of the people we interviewed said that they felt they were part of a family at Winnunga, I understood what they meant. Although this research meant a great deal of extra work for the Winnunga and Regional Centre staff, I was always welcomed when I visited, either to conduct interviews, or at the many informal activities I was invited to at Winnunga. The generosity of this hospitality was extended to other NCEPH staff and students since they were always invited to celebrations such as the National and Aboriginal and Torres Strait Islander Day of Celebrations at Winnunga. Julie’s passion for the research and her wisdom and generosity of spirit enabled us to successfully manoeuvre through some difficult times.

I would also like to thank the other Winnunga researchers. I felt confident when I was doing the interviews with them and, when they weren't, I knew they were only a phone call away if we felt respondents were experiencing any problems during the interviews. It was very reassuring to have the Winnunga researchers follow up respondents after the interviews.

We received a lot of support from a range of Aboriginal and mainstream agencies in the ACT and Region and I thank them all for responding to my queries.

I have learnt a lot from both my Aboriginal and non-Aboriginal colleagues during the three years I have been involved in this research. I would like to thank you all. Jill and I became, and will remain, great friends. We so enjoyed our debriefing sessions about the research, as well as about the Masters of Applied Epidemiology Indigenous Health Course where we were both supervising Indigenous students.

Carmen's enthusiasm for the research was a joy to behold. If her skill at interviewing is anything to judge by, I know she'll do well in her chosen professional field of psychology.

Gabriele, who had been my main supervisor for my PhD, was an excellent mentor and was always available to offer advice. Even when she was at the other end of the world, the responses to my emails were always prompt. Despite her frantic schedule she always returned drafts of the chapters very promptly. There was not quite as much work to do following her comments as there were on the drafts of my chapters of my PhD, but just like those comments, although they always did mean extra work, they added enormously to the overall quality of the document.

David has a wealth of experience in the drug field and the field of Aboriginal and Torres Strait Islander health. He has helped steer the research from the beginning of the grant application stage to the final executive summary and recommendations. If I needed a quick answer to a question, whether it be a definition, a better way of expressing something, or a bibliographic query, David was there. He was also a very careful and critical reader of the draft chapters of the report.

Rennie and I did our PhD together at NCEPH. She kept me on the straight and narrow as far as statistical analyses went and was also a careful and critical reader of the draft chapters.

Michael Wright, a Masters of Applied Indigenous Health student I supervised for two years of this project, taught me a lot, in ways, that I will one day sit down and have a yarn to him about. I was also grateful for the support from my other MAE colleagues, Mary Deeble and Gill Hall.

I enjoyed working with Cathy Banwell (on a separate project for the Construction Forestry Mining Energy Union during the early stage of the research) and I look forward to working with her in the future.

The research meant a great deal of extra work for some NCEPH staff members and I thank them all. The final month or two had particular problems with a very recalcitrant computer and I received so much help and support from everyone at this time, as well as during other periods of the research when there were other sorts of difficulties. I would also like to thank all NCEPH staff and students for their hospitality during the transfer of skills training and for Reference Group meetings.

I have a wonderful family and friends and I thank them all. I didn't see enough of Bob, Claire and Charlotte over the past few years and will now start catching up on family visits.

Charles and I had some fun together while he was setting up the SPSS database and entering the data. Richard and Lee-Anne's friendship has always been important to me.

Most of all, I would not have been able to complete this research without the loving support of my husband Colin Groves. He also read drafts of every chapter and made suggestions for improvement. Coincidentally, the day of the launch (24th June) is his birthday. I don't think I could give him a better birthday present than finishing this research. Thank you Colin, I couldn't have done it without you.

## Conclusion

The “clear message” from the Aboriginal and Torres Strait Islander Research Agenda Working Group of the NHMRC was that “intervention research, looking at practical ways to improve health, needs particular attention” (The Aboriginal and Torres Strait Islander Research Working Agenda (RAWG) of the NHMRC, 2002:1). We set out with the goal of conducting research that would improve the health of Aboriginal and Torres Strait Islander people who use illegal drugs. We will continue to work towards implementing our research findings.

Recently, Henry and colleagues reminded us that:

*Aboriginal communitarian preferences must drive Aboriginal health services, their funding and their performance indicators. Unless the governance of Aboriginal organisations is based on Aboriginal cultural values, these services will not function effectively or efficiently.*

(Henry et al, 2004)

We began the report by demonstrating that the research was instigated by Community concerns. Through the collaboration between Winnunga and NCEPH, and through the Reference Group, the research has continued to be driven by the Community.

The ACT Legislative Assembly’s Standing Committee on Health and Community Care’s Inquiry into Aboriginal and Torres Strait Islander Health in the ACT stated a belief that “high quality quantitative research is required to track the extent of illicit drug use in the ACT Indigenous community” (Legislative Assembly for the Australian Capital Territory, 2001:76). This collaborative research between Winnunga and NCEPH sought the views of Aboriginal and Torres Strait Islander people who use illegal drugs on needs for treatment and other services. We have provided a wealth of quantitative and qualitative information about drug use behaviours, as well as physical health, emotional well-being, and the social determinants of health.

The completion of the report is just the beginning of the Action Research, not the end of the research process. We will continue to work with service providers and policymakers with the aim of ensuring that the voices of the 95 people we interviewed will be heard and that the findings of our research will be implemented.

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