HEALTH FOR ALL? SOCIAL JUSTICE ISSUES IN THE ALCOHOL AND OTHER DRUG FIELD:

Proceedings from the Sixth National Drug and Alcohol Research Centre Annual Symposium, December 1993

Joanne Ross [Ed]

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HEALTH FOR ALL?
SOCIAL JUSTICE ISSUES IN THE ALCOHOL AND OTHER DRUG FIELD

Proceedings from the Sixth National Drug and Alcohol Research Centre Annual Symposium

held at the Australian Graduate School of Management,
University of New South Wales.
December 3, 1993

Edited by

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PREFACE

Joanne Ross
National Drug and Alcohol Research Centre

This monograph contains eight papers presented at the Sixth NDARC Annual Symposium, held on December 3, 1993. The symposium: "Health for All? Social Justice Issues in the Alcohol and Other Drug Field", was organised by Wendy Swift and Jan Copeland from NDARC. The proceedings, which were chaired by Associate Professor Wayne Hall of NDARC, were opened by the Honorable Kevin Rozzoli, M.P., Member for Hawkesbury and Chairman of the NDARC Board of Management.

As highlighted by the Hon. K Rozzoli, the theme for the 1993 symposium arose because the 1992 Second Task Force on Evaluation of the National Campaign Against Drug Abuse (NCADA) had identified a number of groups which were disadvantaged relative to the rest of the community. The Task Force suggested that these groups required special attention in the proposed National Drug Strategy. The symposium provided a forum in which issues relevant to alcohol and other drug use among the priority groups of NCADA, namely Aborigines, prisoners, people from non-English speaking backgrounds, women and youth, could be addressed from research and clinical perspectives.

The morning session began with a presentation by Joseph Murphy outlining the historical development of the Aboriginal and Torres Strait Islander Commission's (ATSIC's) alcohol and other drug policy, as well as reviewing the current and future directions of ATSICs initiatives. The author stressed that the existing policy and strategies of ATSIC were developed prior to the availability of reports from the National Aboriginal Health Strategy (NAHS) Working Party and the Royal Commission Into Aboriginal Deaths In Custody, the findings of which are considered to have important implications for the revision of ATSIC guidelines. The process by which the updating of ATSICs policy will be achieved was also discussed.

Dr Ingrid van Beek then presented the preliminary findings of a methadone treatment program being piloted, using a randomised control trial, at the Kirketon Road Centre (KRC). The aim of the study is to reduce HIV risk behaviour by providing opioid dependent injecting drug users, who have not sought treatment before or who have experienced trouble accessing existing programs, with access to methadone treatment. The retention rate for treatment at KRC was reported to be promising when compared to that for all methadone programs in NSW at 3 months. The author concluded that KRC had successfully attracted and retained a younger, more criminally involved group of IDUs for whom access had previously proved difficult, and that while it was

too early to assess the effect of treatment on HIV risk taking behaviour, the clinical picture was promising.

Deborah Allen then addressed alcohol and other drug treatment issues in the NSW criminal justice setting. Having described how the rigid prison officer culture has in the past been obstructive and hostile to rehabilitation programs in general, the author went on to say that improvements in officer training and changes in the management of prisoners are slowly bringing about positive change. Evaluation studies of drug and alcohol services in the prison system have revealed that there is a lack of cohesion among gaols in terms of treatment philosophies and options. However, Ms Allen highlighted some significant developments such as the initiation of case management files and the heightened awareness of the differing needs of inmates at various points of their sentence, which represent practical ways in which this problem is beginning to be dealt with. The author concluded by outlining some of the difficulties encountered in attempting to provide a Drug and Alcohol (D&A) service within the unique environment of the prison system.

Bruce Flaherty then presented a paper, co-authored by Nelida Jackson, on the challenge of providing D&A services to a multicultural society. The demographic profile given, of the non-English speaking background (NESB) component of the population of NSW, highlighted the cultural diversity that D&A services have to cope with. Having acknowledged that there is a paucity of literature on D&A issues in relation to people of NESBs, Mr Flaherty gave a broad description of what is known about usage patterns, and treatment services for this group. Barriers to service access were discussed in detail and recognition was given to the strategy being adopted by the Drug and Alcohol Directorate in an attempt to address these problems. The authors concluded that while NSW has made some significant breakthroughs in meeting the `multicultural challenge', a lot of work remains to be done before all Australians can enjoy equitable access to appropriate D&A services.

An overview of alcohol use in Aboriginal Australia followed, presented by Dr Ernest Hunter. It was suggested that the racist legislation prohibiting Aboriginals access to alcohol, which has only relatively recently been repealed, influenced the manner of alcohol consumption among the indigenous people in a way that still impacts upon alcohol use today. The author dispelled many of the stereotypes of Aboriginal alcohol consumption, which are widespread in the broader society, by highlighting some of the similarities between Aboriginal people and other Australians with regard to alcohol use. In terms of differences, it was noteworthy that a greater proportion of Aboriginal people compared to non-indigenous Australians are abstainers, but as Dr Hunter stressed, of greater relevance is the fact that the Aboriginal population experience more extreme harmful consequences. In his discussion of contemporary alcohol use, the author described the problematic nature of its use in remote parts of Australia, and referred to the political importance of alcohol in such regions. In concluding it was proposed that the harmful patterns of alcohol use will continue among Aboriginal Australians until the social and economic disadvantage of Aborigines is redressed.

Kate Dolan then presented the results of a recent study, in which ex-prisoners in NSW were interviewed regarding their HIV risk-taking behaviour during time spent in and out of prison. All subjects had a history of injecting drug use. Both HIV positive and negative people were recruited, allowing interesting comparisons to be made between these two groups. While it was indicated that a low level of HIV infection is known to exist in Australian prisons, particularly relative to other parts of the world, the study revealed that incarceration deterred injecting drug users from injecting safely. Not only were subjects more likely to share needles in prison, but they also shared with a greater number of people. The author concluded that the potential for the transmission of HIV and other infections is now a significant concern in NSW prisons, and proposed several recommendations aimed at addressing the problem.

The treatment needs of women were then discussed in a presentation by Jan Copeland. Several barriers to women seeking treatment for their alcohol and other drug problems were identified. The limited research that has been conducted to date on women's specialist treatment services was described and priority areas for continuing research were highlighted. A brief outline was given of two relevant studies currently in progress at NDARC. One study is seeking to identify alcohol and other treatment issues for women, while the other is examining the relationship between childhood sexual assault (CSA) and substance misuse problems among women. Ms Copeland finished by making some general recommendations regarding the provision of treatment services appropriate to women.

John Howard concluded the symposium with a paper addressing treatment issues for drug-using youth. A review was given of what is known about the extent, origins and progression of drug use among young people, followed by a comprehensive coverage of the obstacles preventing them from gaining relevant treatment. Mr Howard identified several issues that drug and alcohol staff, and program developers should be aware of if they wish to increase the effectiveness of treatment programs and maximise retention of young clients. In closing, the author indicated that while there is currently a scarcity of appropriate treatment options for young drug users, existing programs could alleviate the situation somewhat by being open to the findings of self-appraisal and external reviews, and by willingly experimenting with different approaches to the problem of engaging youth in treatment.

It is hoped that this monograph successfully highlights the need for specialist treatment services capable of catering for the unique needs of women, prisoners, Aborigines, people from non-English speaking backgrounds and youth. The authors have addressed several of the barriers to equality in drug treatment and have made sensible recommendations aimed at improving the efficacy of treatment services.

CURRENT ROLE AND FUTURE DIRECTIONS IN THE DEVELOPMENT OF SUBSTANCE USE PROGRAMS FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

G. Joseph Murphy
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Canberra.

Introduction

This paper will look at the historical development of the Aboriginal and Torres Strait Islander Commission's alcohol and other drug policy, as well as considering the current and future directions of the Aboriginal and Torres Strait Islander Commission's endeavours in the alcohol and other drugs field.

Historically, the Aboriginal and Torres Strait Islander Commission is an enhanced development from the former Department of Aboriginal Affairs.

The Department of Aboriginal Affairs was abolished as of 04 March, 1990, with the Aboriginal and Torres Strait Islander Commission created as of 05 March, 1990. The first Aboriginal and Torres Strait Islander community election of Regional Councils, and through them - the ATSIC Board of Commissioners, was on 03 November, 1990.

The Aboriginal and Torres Strait Islander Commission has adopted the alcohol and other drug policy and strategies effected by the Department of Aboriginal Affairs - but only until such time as the Board of Commissioners is able to revise those policies and strategies, and confirm the policies and strategies it considers appropriate to the contemporary status of Aboriginal and Torres Strait Islander peoples.

Current policy and strategies

The existing policy of the Aboriginal and Torres Strait Islander Commission (see Appendix A) has a number of key elements :

Definitional: The term "substance abuse" refers to harmful, excessive, or non-medical use of any mood-altering substance or drug which results in physical, psychological, and/or social damage to the user and or those closely associated with the user.

Policy Objectives: To minimise the harmful consequences of substance abuse to the Aboriginal population.

Strategic Goals :

(1) The creation of an environment in which Aboriginal people are able to make fully informed decisions about the use of substances, including alcohol and other drugs.

(2) The elimination of all social, educational, and economic inequalities that are conducive to substance abuse.

(3) To ensure, in co-operation with State and Territory Governments and other agencies, the availability of acceptable and appropriate services for the assessment, treatment and rehabilitation of Aboriginal substance abusers. The adaptation of services to Aboriginal need rather than duplication of services should be encouraged, particularly in regard to State-backed residential care programs.

The Program Strategies to be pursued in this policy are to :

(1) Support the development of appropriate community based awareness and preventative programs against substance abuse.

(2) Support the establishment and operation of community based non-residential counselling, referral and support services to assist in the treatment and rehabilitation of Aboriginal substance abusers.

(3) Liaise and co-operate with State and Territory Health Departments, Drug and Alcohol Authorities, and other relevant agencies to ensure that Aborigines have access to residential detoxification, treatment and rehabilitation programs and, where necessary, fund special projects to meet Aboriginal needs.

(4) Encourage and support initiatives that will lead to the availability to the Aboriginal population of positive alternatives to substance abuse. Such initiatives should encourage self responsibility and self management and include improved opportunities for formal and informal education, trade and professional training, and recreational, sporting and cultural activities

that will promote a fulfilling and satisfying lifestyle that does not require substance abuse as a means of escape from reality.

(5) Selective encouragement of research which will provide base line data on the extent and nature of substance abuse by Aborigines, identify appropriate interventions, and measure the success of prevention, treatment and rehabilitation services.

[Source: National Aboriginal Health Strategy (NAHS), 1989: Appendix IX]

As this policy was developed in the mid-1980's, it consequently preceded the very important initiatives of the National Aboriginal Health Strategy (NAHS) Working Party, and later, the Royal Commission Into Aboriginal Deaths In Custody.

Reflecting a personal preference of this author, this paper will give greater emphasis to the National Aboriginal Health Strategy Working Party Report than to the Royal Commission Into Aboriginal Deaths In Custody. This preference reflects that for the former, Aboriginal and Torres Strait Islander peoples sat at the table as equals, whilst at the latter, Aboriginal and Torres Strait Islander peoples were called as witnesses before a predominantly non-Aboriginal and Torres Strait Islander Commission of Inquiry.

Underlying causal and related factors

The NAHS Working Party put the position that `alcoholism' was *caused primarily by political, social, economic and cultural deprivation imposed by non-Aboriginal society*. It continued by saying that, *Alcohol abuse is simultaneously a health problem, a cause of other health problems and a symptom of socio-political related problems* (NAHS, 1989: 192). This view would appear to be supported by the strength of papers put at the recent National Aboriginal Mental Health Conference where issues of the past, contemporary past, and present were identified as components to the health status of modern Aboriginal Australia.

Use of alcohol and other drugs

The NAHS Working Party was pragmatic in its view that *alcohol and other drugs will always be available, and that consequently, there is an urgent need to develop strategies that will facilitate a safe and sensible attitude towards their use, especially towards alcohol use among young people* (NAHS, 1989: 199). Whilst the Working Party noted that *alcohol abuse is not only a specific health problem in itself but that it is also a major contributing factor to the complications of many other medical conditions*, the important *positive and functional role that alcohol plays in contemporary Aboriginal society* was also recorded. *Drinking is usually a group activity which promotes sociability and solidarity, and provides a place, an activity, and a purpose* (NAHS, 1989: 192-193).

Importantly, and as a brief aside, the NAHS Working Party acknowledged the discussion of an Aboriginal and Torres Strait Islander genetic predisposition to alcohol, and stated that, *a genetic basis for understanding supposed differences in the effect of alcohol on Aboriginal people has been discredited* (NAHS, 1989: 194).

One other issue that arises is that of the drugs of choice by contemporary Aboriginal and Torres Strait Islander Australia. The National Aboriginal Health Strategy Working Party made a number of statements that are critical here :

1.0 Alcohol abuse, its complications and manifestations have been identified by Aboriginal communities during the consultation process as one of their major health problems (NAHS, 1989: 192)*;*

2.0 The problem of petrol sniffing has surfaced in a number of Aboriginal communities (NAHS, 1989: 199)*; and*

3.0 Aboriginal drug and alcohol workers (in one state) define heroin addiction as one of many addictions which affects the spiritual, emotional, mental and physical well-being of the Aboriginal person, their families and communities (NAHS, 1989: 200).

To this list, this author is confident to add the almost ever present marijuana (Yandi) solvents, and kava within some sections of Aboriginal and Torres Strait Islander Australia - as some drugs of choice appear to be location specific, and based on convenience and accessibility.

Future Directions

The future direction of ATSIC sponsored alcohol and other drug initiatives will be shaped by the NAHS Working Party Report, the Report of the Royal Commission Into Aboriginal Deaths In Custody, and most importantly, by the wishes of the community in question. This latter point is consistent with the ATSIC Corporate goal to *promote the improvement of the social well-being of our people including access to health services at a level commensurate with that of the wider Australian community* (ATSIC(a), 1992: 8). It is also congruous with the ATSIC Operational Plan objective of *minimising the harmful consequences of inappropriate alcohol and other drug use in Aboriginal and Torres Strait Islander communities. This objective is to be achieved by supporting the evolution of community determined awareness and promotion programs against known inappropriate use of alcohol and other drugs* (ATSIC(b), 1992: 24) (see Appendix B).

The funding guidelines of the ATSIC Royal Commission Into Aboriginal Deaths In Custody Program provide that, within a harm minimisation philosophy, *the Commission through the RCIADIC program will place emphasis on initiatives which empower Aboriginal and Torres Strait Islander people. This will enable these people to make informed*

decisions about appropriate choices in the use of alcohol and other drugs, and about projects which facilitate the taking of personal and community responsibility for alcohol and other drug related action (ATSIC(c), 1993: 3).

These program guidelines, which are a public document, require applicants to commit to :

* *Providing an emphasis on prevention and or early intervention services, drawing upon harm minimisation principles;*

* *Facilitating an environment in which Aboriginal and Torres Strait Islander peoples are able to make fully informed decisions about the use of alcohol and other drugs;*

* *Endeavouring to undertake interventions in the client's home community/ environment, with special emphasis on projects which utilise self-help and community support principles;*

* *Seeking to develop means by which skills aimed at preventing the inappropriate use of alcohol and other drugs (or at least ones promoting intervention at an early phase), are transferred to community members who seek such skills in the alcohol and other drug area;*

* *Having an internal project monitoring process, and a process of project review at least once each five years;*

* *Promoting selective community driven research which provides baseline data on the extent and nature of alcohol and other drug use by the target Aboriginal and Torres Strait Islander communities; and*

* *Providing an accurate measure of activities in terms of operational outcomes, as well as activity indicators.*

(ATSIC(c), 1993: 4-6)

Program Strategies

The NAHS Working Party recorded that as *Aboriginal communities are not homogeneous ... there cannot be an across-the-board single solution to substance abuse or a "package deal" that can be applied nationwide. Each and every community needs to look at the causes and solutions taking into account individual pathology, physical, social, psychological, and cultural factors* (NAHS, 1989: 196).

Consistent with this, a range of initiatives have been developed. Rather than provide a tedious listing of initiatives that have been established following the availability of Royal Commission Into Aboriginal Deaths In Custody Substance Abuse program funds, this paper identifies the type of initiatives and evolving themes.

The types of initiatives being developed include:

- cultural self-healing centres;
- petrol sniffing intervention and prevention programs;
- alcohol after-care programs;
- night patrol programs;
- sobering-up centres;
- counselling and bail facilities;
- prevention and sporting programs; and
- youth programs.

Particular State and Territory approaches have each been unique, for example: the trend in Victoria has been to purchase buildings, or to renovate existing buildings conducting alcohol and other drug programs - thus meeting infrastructure needs. In the Northern Territory, cultural self-healing facilities has been the preferred method of addressing alcohol and other drug issues. South Australia has sought to blend a researched and focussed approach through the development of a state plan, with simultaneous commitment to enhancing existing treatment initiatives.

Strategies to be pursued by ATSIC through other agencies

A common but highly erroneous belief is that ATSIC is responsible for all things `Aboriginal or Torres Strait Islander'. Improvements to Aboriginal and Torres Strait Islander health will only occur if all stakeholders accept their respective responsibilities, and assist community initiatives. To this end, the Aboriginal and Torres Strait Islander Commission will need to pursue a number of strategies through these other stakeholders.

Provided below, and in unranked order, are just five of the National Aboriginal Health Strategy Working Party strategies being pursued - most of which were re-iterated by the Royal Commission Into Aboriginal Deaths In Custody. These strategies form a part of the essential and broader set of inputs necessary to bring about change.

Strategy 1: that *funds be made available for accredited courses for Aboriginal drug and alcohol workers employed by Aboriginal health services and rehabilitation services throughout Australia* (NAHS, 1989: 203). This strategy is being supported by both the Department of Education, Employment and Training and the Aboriginal and Torres Strait Islander Commission through various funding contributions.

Strategy 2: that *positive media campaigns using well known Aboriginal role models, be designed and promoted throughout Australia to dissuade Aboriginal youth from using alcohol, cigarettes, or any other drugs of addiction* (NAHS, 1989: 203). This initiative has been commenced by the Media Campaigns Unit of the Department of Health, Housing, Local Government and Community Services.

Strategy 3: that *people suffering problems of addiction should not, wherever possible, be removed from their community environment to obtain treatment* (NAHS, 1989: 203). This principle has been an essential thrust of the Aboriginal and Torres Strait Islander Commission since its inception, and is one of the cornerstones of the current program guidelines.

Strategy 4: that *all existing and future Aboriginal alcohol and substance abuse programs be monitored and evaluated for effectiveness* (NAHS, 1989: 205). ATSIC clearly recognises the financial limitations of its budget in light of identified needs, and consequently, actively seeks to maximise programming dollar effectiveness and efficiency. It is an understatement that public accountability is also commonly mentioned in the same breath as the acronym ATSIC, and as such, the Substance Abuse Program guidelines specifically seek program impact statements, as well as activity indicators.

Strategy 5: that *information about the types of programs being used to reduce alcohol or substance abuse should be readily available to other communities* (NAHS, 1989: 205). The need for program information sharing has quickly been identified by the Aboriginal and Torres Strait Islander Commission as a priority if program dollar efficiency is to be obtained, and as such, has entered discussions with the National Drug Strategy (formerly the National Campaign Against Drug Abuse) funded National Centre for Research into the Prevention of Drug Abuse in order to devise such a mechanism.

It should also be noted that the 1992 Task Force on Evaluation (commissioned by the Ministerial Council on Drug Strategy) report - *No Quick Fix. An evaluation of the National Campaign Against Drug Abuse* - also highlighted the absence of NCADA, and NCADA initiatives, from the Aboriginal and Torres Strait Islander arena (Task Force on Evaluation, 1992: 80-83).

A new ATSIC Alcohol and Other Drugs policy

As stated in the opening of this paper, the events that have taken place since the writing of the current ATSIC alcohol and other drug policy are significant, and warrant the updating of Commission policy.

The Substance Abuse Section within ATSIC is therefore in the process of researching and drafting a series of Research/Issues Papers, Discussion Papers and finally, draft Policy Position Papers. These Research/Issues Papers, Discussion Papers and draft Policy Position Papers will all be submitted to Aboriginal and Torres Strait Islander community agency; Commonwealth, State and Territory alcohol and other drug agency; and general public comment.

Presently, a number of papers are under preparation, these include:

- Tobacco in Aboriginal and Torres Strait Islander Communities;

- Kava;
- Women and Substance Abuse;
- Prescribed Drugs;
- Mental Health;
- Evaluations;
- Marijuana; and
- Health Worker (including Alcohol and Other Drug Workers) Training.

Assisting and guiding this process is the Task Force on Substance Abuse - an ATSIC initiative which was first nominated by the National Aboriginal Health Strategy Working Party, and re-iterated by the Royal Commission Into Aboriginal Deaths In Custody. This Task Force was established under the Aboriginal and Torres Strait Islander Commission Act, and is charged with responsibility to *advise the Board of the Aboriginal and Torres Strait Islander Commission and the Council for Aboriginal Health on a range of issues relating to substance abuse. In particular :*

- *examine the social and health problems which Aboriginal people experience as a consequence of alcohol and substance abuse;*
- *assess the needs in this area and the means to fulfil these needs;*
- *recommend on the distribution and type of substance abuse services Australia wide;*
- *develop program performance indicators and evaluation methodology; and*
- *advise on possible strategies for negotiations with Governments regarding substance abuse funding responsibilities.*

(Task Force on Substance Abuse, 1993 :1)

Conclusion

The revision of ATSIC's alcohol and other drug policy will therefore draw upon these papers, the deliberations of the Task Force on Substance Abuse, and the contribution of peer alcohol and other drug workers, and essentially, the Aboriginal and Torres Strait Islander community at large.

This revised policy document, in conjunction with the lessons learnt from initiatives commenced through the Royal Commission Into Aboriginal Deaths In Custody Substance Abuse Program, should assist the Commission meet the challenge that alcohol and other drugs pose Aboriginal and Torres Strait Islander Australia.

CAVEAT

The views expressed within this paper are those of the author, and do not necessarily reflect those of either the Aboriginal and Torres Strait Islander Commission or the National Drug and Alcohol Research Centre.

The author does however thank the Aboriginal and Torres Strait Islander Commission for the freedom to express the views put within this presentation.

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Appendix A

CURRENT SUBSTANCE ABUSE PAPER

The term "substance abuse" refers to harmful, excessive, or non-medical use of any mood-altering substance or drug which results in physical, psychological, and/or social damage to the user and or those closely associated with the user.

Substances seen to be of danger to the Aboriginal population of Australia include alcohol, volatile substances such as petrol, glue and aerosol propellants, kava, prescribed drugs such as valium, serepax and other tranquillisers, analgesics and tobacco, and such illicit drugs as heroin, cannabis, cocaine and amphetamines. All of these substances represent a potential health threat to the Aboriginal population.

Policy Objective

To minimise the harmful consequences of substance abuse to the Aboriginal population.

Strategic Goals

(1) The creation of an environment in which Aboriginal people are able to make fully informed decisions about the use of substances, including alcohol and other drugs.

(2) The elimination of all social, educational, and economic inequalities that are conducive to substance abuse.

(3) To ensure, in co-operation with State and Territory Governments and other agencies, the availability of acceptable and appropriate services for the assessment, treatment and rehabilitation of Aboriginal substance abusers. The adaptation of services to Aboriginal need rather than duplication of services should be encouraged, particularly in regard to State-backed residential care programs.

Program Strategies

(1) Support the development of appropriate community based awareness and preventative programs against substance abuse.
(2) Support the establishment and operation of community based non-residential counselling, referral and support services to assist in the treatment and rehabilitation of Aboriginal substance abusers.
(3) Liaise and co-operate with State and Territory Health Departments, Drug and Alcohol Authorities, and other relevant agencies to ensure that Aborigines have

access to residential detoxification, treatment and rehabilitation programs and, where necessary, fund special projects to meet Aboriginal needs.

(4) Encourage and support initiatives that will lead to the availability to the Aboriginal population of positive alternatives to substance abuse. Such initiatives should encourage self responsibility and self management and include improved opportunities for formal and informal education, trade and professional training, and recreational, sporting and cultural activities that will promote a fulfilling and satisfying lifestyle that does not require substance abuse as a means of escape from reality.

(5) Selective encouragement of research which will provide base line data on the extent and nature of substance abuse by Aborigines, identify appropriate interventions, and measure the success of prevention, treatment and rehabilitation services.

Project Instructions

In selecting projects for support, preference should be given to those which:

- provide logical and attainable aims and objectives.
- are community initiatives under community control;
- are staffed by suitable Aborigines with suitable training and experience in substance abuse services, a criteria is that employees are sober and that Aboriginal ex addicts are given a high priority for employment;
- plan for Aboriginal staff to be trained to take over executive administrative, training and counselling positions presently filled by non-Aboriginal staff;
- have an educative prevention role;
- are directed towards the young;
- complement rather than duplicate existing services;
- encourage responsible attitudes and behaviour towards substance abuse;
- provide non-residential services at community level rather than residential care in institutions;
- are linked to the development of youth, sport and recreational programs where possible;
- encourage the use of residential treatment and rehabilitation services provided for the general community; and
- are willing to provide to the Department such data as are required to allow assessment of the effectiveness of the project.

Performance Indicators

(1) Macro Indicators (Outcomes) - Statistics on national incidence of alcoholism and other forms of substance abuse by age and sex to be provided by the Department's Statistical Unit from State and Federal epidemiological and sociological research sources.

(2) Project Indicators

Program Title ....

Location ....

Aboriginal Population.............................

Nearest Detoxification Service (Name & Location..............)

Service Provided (underline) Treatment Rehabilitation,
Halfway House Community Counselling
Support Service Other (Specify)............

Type of Service (underline) Residential/Non-residential

Staff Employed (M/F) Classification - Qualifications held

No. of Clients Treated Males Females

- Daily Average ....
- Shortest Stay ....
- Longest Stay ....

No. of Clients Admitted to Program ....

No. of Clients Completing Program ....

No. of Group Counselling Sessions per week

No. of Individual Counselling Sessions Per Week

No. of Referrals to Program ....

No. of Referrals from Program ....

No. of AA Meetings Per Week ....

No. of Clients Retaining Sobriety for 3 months.

No. of Clients Retaining Sobriety for 6 months

No. of Clients Retaining Sobriety for 12 months

No. of Clients who have dramatically reduced their alcohol intake since involvement with this program

Other Activities

List of associated Agencies with whom regular contact maintained.

Brief description of weekly program activities.

Appendix B

ATSIC Responsibilities

The role and responsibilities of ATSIC are determined by the Aboriginal and Torres Strait Islanders Act of 1989 as amended in 1993. Section 7.1 states that among the functions of the Commission, it is to develop policy proposals to meet National, State, Territory and Regional needs and priorities of Aboriginal persons and Torres Strait Islanders.

The Commission's Corporate Plan defines its health objective as being *to promote the improvement of the health and physical well-being of Aboriginal and Torres Strait Islander peoples to a level commensurate with the wider Australian community* (ATSIC(a), 1992: 8).

As this will occur through a process of community empowerment, ATSIC will ensure that the Commission and Regional Councils have the capacity, including information and data bases, to plan, determine priorities, and allocate resources to projects which serve to enhance the lifestyle of Aboriginal and Torres Strait Islander peoples.

The 1992/96 ATSIC Operational Plan details the process by which it will strive to minimise the harmful consequences of the inappropriate use of alcohol and other drugs. The Operational Plan commits the Substance Abuse Section to *minimising the harmful consequences of inappropriate alcohol and other drug use in Aboriginal and Torres Strait Islander communities by:*

- *supporting the evolution of community determined awareness and promotion programs against known inappropriate use of alcohol and other drugs;*

- *supporting the establishment and operation of non-residential Aboriginal and Torres Strait Islander community based early intervention, treatment and community support programs;*

- *ensuring that Aboriginal and Torres Strait Islander peoples have access to appropriate clinical and rehabilitation programs, and where necessary, fund special projects to address these needs;*

- *liaison with Government agencies and community organisations involved in the provision of services and intervention programs to minimise or treat substance abuse; and*

- *appropriate research activities.*

(ATSIC(b), 1992: 24)

METHADONE AT KRC: THE EXPERIENCE SO FAR

Ingrid van Beek
Kirketon Road Centre, Sydney.

The Kirketon Road Centre (KRC) in Sydney is a primary health care centre targeting youth, sex workers and injecting drug users (IDUs). It is involved in the prevention and treatment of HIV and other transmissible infections.

In August 1993 KRC commenced a Methadone Treatment Program, integrated into its primary health care service, on a pilot project basis. The Program aimed to provide access to methadone treatment to opioid-dependent IDUs who had not sought treatment before or who had experienced difficulty accessing existing methadone programs, with the aim of reducing HIV risk behaviour. The program would follow the low intervention/high supervision model and operate within the harm minimisation framework at KRC. The program is being evaluated by NDARC as a Randomised Controlled Trial over a six month period with clients interviewed at the outset, 3 and 6 months. Important outcomes included reduction of HIV risk behaviour, increased utilisation of primary health care services at KRC and improvement of overall health status.

Program eligibility criteria:

*Clients had to be known to KRC for more than three months, registered as either clinic or needle syringe exchange clients and be 16 years of age or over.

*Clients had to be opioid-dependent judged by self-reported history of drug use, attempts to discontinue drug use, and psychosocial dysfunction such as illegal activities and involvement in sex work associated with the use of illegal drugs. Such self-reported history was corroborated by cutaneous manifestations of needle injection and signs of drug intoxication/withdrawal. Clients may also have had a history of risk-taking behaviour ie. needle sharing/unsafe sex, possibly corroborated by HIV/HBV/HCV seropositivity.

Program exclusion criteria:

*Clients enrolled on a another methadone program within the past 4 weeks, (however, for clients discharged from a program involuntarily, this 4 week exclusion period could be waived).

*Clients required to enter a methadone program as a condition of bail/parole.

*Clients with serious criminal charges pending likely to result in incarceration for more than 1 month in the six month study period.

*Clients who resided outside of the Eastern and Central Sydney Area Health Services' catchment on a permanent basis.

*Clients with serious mental illness (eg schizophrenia).

*Clients with chronic pain conditions.

*Clients specifically seeking a methadone withdrawal program.

nb: Clients who were pregnant at the time of assessment or clients who became pregnant during program enrolment were offered assessment and transfer to the Drugs in Pregnancy Program at KGV.

Preliminary results

72 subjects were recruited to the study from 8 August to 5 October 1993. At this stage only baseline data is available for these study subjects. Methadone treatment retention rate at KRC to date is also known. These data were compared wherever possible to that available for people attending nearby methadone programs (n=185) and the population attending methadone programs in NSW (n=7,868), recruited during the same period.

The 72 people recruited at KRC for methadone treatment were younger and criminally involved at a younger age compared to the other populations. They had less previous experience of methadone treatment, both in terms of the proportion who had had methadone treatment before and the duration of such treatment (see Table 1).

Table 1: Demographics and previous methadone treatment details for individuals presenting for methadone treatment at KRC (N=72) and individuals attending methadone clinics in inner city Sydney (N=185) and all methadone clinics in NSW (N=7868)

Variable name	KRC	Inner city public MM	State MM
Mean Age (years)	25	32	32.5
Median Age (years)	24	-	33.0
Age first drug use (years)	14	15	-
Age first addicted (years)	18	20	-
Age first criminal charge (years)	16	19	-
Gender (%):			
Male	65	-	62
Female	31	-	38
Transgender	4	-	NK
Any previous methadone treatment before current episode (% Yes)	48.5	64	69
Mean total months spent before current episode	7	18	-

Among the 37 subjects randomised to receive methadone treatment at KRC, 24 (65%) subjects were still in treatment after 3 months. This compares favourably to the methadone treatment retention rate of 50.6% after 3 months, for all programs in NSW (see Table 2).

Table 2: Duration of treatment - patient separations

1 July 1993 to 30 Sept 1993

Duration	**Patients**	**Percentage**
< 1 month	231	28.9
1-3 months	165	20.5
3-6 months	107	13.3
6-9 months	67	8.3
9-12 months	61	7.6
1-2 years	91	11.3
2-3 years	32	4.0
3-5 years	34	4.2
5^+ years	15	1.9
Total:	803	100

Conclusion

KRC was successful attracting to and retaining on methadone treatment a younger, more criminally involved population of IDUs for whom previous access was difficult. Whether such access is effective in reducing HIV risk behaviour in this population over time is still being formally evaluated. However, the clinical impression at KRC so far is that this intervention has reduced the chaos and subsequent HIV risk behaviour often associated with the "street" lifestyle of IDU recruited to the Program. Daily contact at KRC has also provided the opportunity to better address the medical and psychosocial needs of these IDU.

It is further considered that methadone at KRC may be regarded as an early intervention, which may be of particular importance in the prevention of hepatitis C virus (HCV) infection among IDUs. Traditionally methadone has been a late intervention, reflected in the older mean and median ages for the population on methadone in NSW. The prevalence of HCV among IDUs has been shown to increase dramatically with age and duration of drug use (Bell 1990; Crofts 1992), limiting the role of methadone treatment in HCV prevention in older IDU populations. HCV infection may have significant clinical implications in the longer term and needs to be addressed with prevention efforts targeting young IDUs early in their drug using careers.

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SOCIAL JUSTICE ISSUES AND DRUG AND ALCOHOL SERVICES IMPLICATIONS FOR CORRECTIONAL PROGRAMMES

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After I agreed to talk here today about social justice and alcohol and other drug issues in prison, I was more than a little apprehensive. Prisons and social justice are not thought to be comfortable partners. When we think of social justice in terms of what components or qualities it consists of, freedom is something that probably springs to mind.

Prisons, by their very nature, restrict individual liberty. This in fact, is what the punishment of receiving a sentence of imprisonment is all about - being deprived of one's liberty. Being deprived of one's liberty means that going down to the pub with your mates is no longer possible, as is going to the corner shop for a pint of milk or going to your child's parent and teacher night. However, it should not mean that you are deprived of adequate medical care, or live in substandard accommodation or that you experience relationships characterised with little care and respect.

This is a central dilemma for probably any correctional system, that is, not to abuse the power of being the institution that puts into effect the deprivation of liberty. It is something that the NSW prison system has grappled with for some time. Slowly, the system is changing to ensure as best it can, that what ever quality of care is available in the community is available in the prison system. However, there are many obstacles including a confused and largely ignorant community perception of what imprisonment is and what should happen to prisoners when they are in gaol, as well as many very old and substandard gaols in which we have no alternative but to place inmates. There are other obstacles as well, particularly for rehabilitation programmes such as drug and alcohol services and I'll talk about them in due course.

It is certainly still true, that some sections of the community believe that prisoners should receive some further punishment while they are in gaol, and the deprivation of liberty is not enough. In this view, the necessities of living which we take for granted such as television, radios, the need to keep one's mind active through books and educational activities are seen as needless luxuries. Of course, people who espouse this view have never had to be locked in a prison cell for possibly 15 or more hours a day.

It is unfortunate that gaol staff sometimes espouse these views as well, although not unexpected. There is no doubt that the role and function of custodial staff is changing so that they are expected to interact and have meaningful contact with inmates rather than stand in towers and at gates. However, this is a very significant cultural change for most prison officers.

There has been a fairly fixed prison officer culture which has in the past been hostile and obstructive to rehabilitation programmes in general. This is very slowly changing as improvements in training and changes in the management of prisoners are introduced. However, this culture change is not something that happens overnight, so that it is still the case that hostility and obstruction can make or break a D&A programme. In this sense D&A workers sometimes have to work as community development workers and spend a significant amount of time breaking down the barriers in attitude that some prison officers have. No one wants to be left standing at a gate for 15 minutes waiting to get through, while all the time knowing that this is eating into the only two hours of access time you have to inmates that day.

While this hostility among prison officers continues to exist in some areas, also existing is a great interest and willingness to do something different. In gaols where prison officers are keen, co-operative and very skilled in their interaction with inmates, the work of D&A staff is much easier, more interesting and most importantly of great benefit to inmates. If as a worker you can explain that an inmate is unstable because of changes in his or her methadone dosage, it makes a huge difference if the wing officer is concerned, willing to place that inmate in a one out cell and will take into consideration any strange or ratty behaviour.

This concern and willingness to assist inmates manage their D&A problems does exist with many prison officers, however there is still a long way to go. Part of the problem from the prison officers point of view is that they don't have enough knowledge and information about D&A issues in general and how they effect inmates in particular. A recently completed needs analysis of the D&A training needs of prison officers recommended much greater training in this area (Kevin & Calman, 1993). The Corrective Services Academy and D&A Services will be developing a training programme for prison officers on D&A issues.

One of the major problems prison officers mentioned in the needs analysis was their feeling that they were kept in the dark about what was happening to prisoners in D&A treatment. The issue of confidentiality is a difficult one in the prison system and is guaranteed to inflame the passions of ordinarily mild mannered people. It is true to say that there is considerable polarisation about confidentiality in the system. The two most extreme positions are that D&A Workers (and other non uniformed staff) should tell prison officers everything about the inmate including (or especially) any drug use

in prison; to D&A Workers should not tell prison officers anything about an inmate's D&A treatment, even whether or not he or she is attending treatment.

Somehow we must get to a middle ground so that information that is in the clients interests for appropriate people to know is actually conveyed to them. For example, it is vitally important that the prison officers who have day to day contact with a particular inmate is informed that that inmate may be suicidal. The problem for many non custodial staff is that they have been burnt in the past through passing on information in good faith which has rebounded unfairly on the inmate. Improvements in training and work roles will probably improve this situation but it is a slow process and while there continues to be distrust, information transmission is still fraught with difficulty.

People in prison are not there because they are innocent victims. Prisoners can be very difficult people as are most people when they are kept in a place they don't want to be in. As well, they have done something wrong - they have committed some kind of harm to the community and sometimes that harm may be associated with their use of alcohol and other drugs. This means that our client group is not only characterised by a lack of motivation to change (similar to other D&A client groups), but they can also be angry, resentful and violent to both themselves and others.

So what is the extent of the D&A problem in gaol? A large proportion of inmates in NSW prisons have drug and alcohol problems. The December 1992 **Drug and Alcohol Exit Survey** by Maria Kevin found that of a sample of 175 inmates about to be released, 67% reported being under the influence of a drug at the time of their most serious offence; 66% of the sample believed that there was a relationship between their drug use and subsequent imprisonment; 74% of the sample reported experiencing problems due to their use of drugs, and alcohol was cited as the main problem (36% of the total sample).

43% of the sample reported being under the influence of alcohol at the time of their most serious offence and of these 67% reported drinking very heavily at the time of their most serious offence (very heavily was defined in this report as more than 12 standard glasses of alcohol). The study identified alcohol as the most significant drug problem for male inmates. The sample size for female inmates was not high and it was therefore difficult to come to any conclusions about their drug use. Consequently, a separate study concerning the treatment needs of women in prison is currently being conducted and should be completed soon.

Against this background D&A Services provide a treatment and education programme to inmates in NSW prisons. D&A Services is part of Inmate Development Services which also consists of Psychological Services, Welfare Services, Education, AIDS Education Services and the Chaplains. The D&A Service has been in operation since 1986 and is funded through the cost shared NCADA programme. There is a full or

part time service in the 27 gaols across the State (not including Junee which is a privately run gaol). The broad aim of the programme is to provide inmates with support and skills to minimise the harm associated with their alcohol and other drug use both in gaol and upon release.

The Service was evaluated last year and at the same time an exit survey of inmates was conducted to determine the reach of the service to the prison population (Kevin, 1992; Keys Young, 1992). Both of these studies recommended broadly similar changes to the service - changes which had already been seen as needed in other areas of the system. Most basically it was recommended that a coherent programme be developed ensuring continuity of treatment objectives and options.

What these studies found was that each D&A Service in each gaol was operating independently and often with conflicting philosophies of treatment and consequently treatment options. While diversity of options is important, it was identified that there were real difficulties in providing continuity of treatment if there was no overall State plan. For example, it was possible for an inmate to be transferred from minimum security at Cessnock where he was doing a relapse prevention programme to minimum security at Silverwater where relapse prevention was not being run.

What was needed was a programme plan based on the needs of inmates at the differing points of their sentence. The evaluation report and the exit survey have provided us with valuable information about the model of service delivery needed.

At the beginning of an inmate's sentence it is important that an accurate screening and assessment is done to get basic information about presenting problems. As well, D&A Services has a role in the orientation and support of inmates at a time when they are frequently in crisis and can often be frightened and confused about how gaol works. This is particularly so for first offenders and young offenders. The screening and induction programme currently in operation at the Reception and Industrial Centre at Long Bay which is the major reception centre for the metropolitan area, operates a multi disciplinary screening programme and is the model for reception procedures for the rest of the State.

The D&A screening (along with the welfare screening) is placed on a case management file which travels with the inmate after he or she has been classified and placed in a gaol. This is a great breakthrough in the history of treatment of inmates. It means that really for the first time, when an inmate is classified and placed, the receiving gaol will have some baseline information about what his or her problems may be and can have a proactive response to the needs of the inmate. Rather than wait for inmates to self refer or hope that someone else may pick up the problem and refer, it is now possible for a Case Management Team to identify and respond to the needs of all inmates. This of course has staffing and resource implications which D&A and other staff are understandably nervous about. There is a perception that there is not enough staff to

cope with inmates who self refer and that the extra demands of case Management will make this more difficult. This may happen and staffing will need to be reviewed as a result.

If the inmate has a long sentence (a long sentence is 3-4 year or more), he or she will be placed in a maximum security gaol. At this point, the D&A Service needs to provide a good reliable assessment so that an agreed treatment plan can be devised. I should point out of course that the inmate has the same right as people in the community to refuse treatment.

In maximum security prisons the emphasis of the programme is to provide:

*assistance in clarifying plans and goals for the rest of the sentence

*basic harm minimisation information particularly with a gaol focus

*provide interventions to assist inmates to reduce stress and emotional volatility (we would like to present these interventions in conjunction with psychological services wherever possible)

*provide a peer support programme where selected inmates are trained as D&A peer supporters

*provide access to AA and NA services.

In gaols where there is a methadone service, interventions are to be co-ordinated with the Corrections Health Service which usually consists of counselling and where resources permit a specific group programme for methadone recipients. More work needs to be done between D&A Services and the Corrections Health Services in this area, but the relationship between the two services is getting better. There is flexibility here so that the D&A Worker can provide other interventions if there is a demonstrated need, however, these are the core interventions needed in a maximum security gaol where inmates are basically at the beginning of their sentence (although as I will discuss later it is not always that simple).

At medium security gaols the emphasis is on consolidation of the treatment plan as the inmate progresses through the security ratings. In some ways the inmates at this point are doing their time and getting on with work and possible education activities so an extensive D&A programme is not greatly needed. However, many inmates start their sentences in medium security gaols so as with maximum gaols a basic D&A education/harm minimisation programme needs to be made available. Peer support is an important part of the programme at this stage.

In minimum security gaols where inmates are soon to be released or are doing a short sentence, the programme needs to be more intensive and should focus on relapse prevention skills for when the inmate is back in the community.

The development of this structure of programme planning (Appendix 1) is linked closely to the introduction of Case Management in the system at the moment. While it seems a simple system and one wonders why it has not been introduced before, there was no real will to implement such a system as it does require that uniformed and non uniformed staff work together closely.

When inmates come into the system they usually have multiple problems including lack of work skills and lack of education as well as family problems and a possible D&A problem. Through Case Management procedures a Case Management plan is developed for each inmate and is adequately documented in the Case Management File, so that the plan can be continued with minimal interruption when the inmate is transferred to another gaol. Each inmate is allocated to a case officer and these officers will have a case load of between 15-25 inmates. The Case Officer will be responsible for monitoring the management plan of each inmate. Obviously Case Officers will need to have a greatly improved range of skills than has been required in the past and training at the Corrective Services Academy has changed and continues to change in response to these needs.

One of the benefits of the Case Management system is that it will allow us to identify high risk inmates for more intensive intervention. In the past it was very much the case that an inmate often underwent assessment after assessment depending on how many gaols he or she travelled to in the time of his or her sentence. Not only is this a waste of time and extremely irritating to the inmates, it indicates a lack of communication between centres and a lack of programme planning across the system. As well, staff members of the Inmate Development Services (IDS) did not work as a team and so it was possible for one inmate to be seeing the D&A Worker and the Psychologist and neither would communicate with each other about treatment. Case Management Teams and the Case Management file system will improve this greatly.

One of the recommendations of the evaluation report of D&A Services was the need for the development of specific programmes, rather than 5 different programmes about the same issue developed by 5 different people who all reinvent the wheel. We are in the process of contracting out to various people to develop and write these programmes. The D&A Peer Support Programme is completed and has just been trialled at the Reception Industrial Centre Long Bay. It should be available to all gaols by the New Year. The Drink Driver programme is near completion and has been written by the part time group worker who runs the programme at Emu Plains. An Alcohol Education programme is also being developed by the same person. A Relapse Prevention Programme is in the process of being developed and should be completed and ready to trial by January.

We have yet to develop a standardised D&A education/harm minimisation package although individual D&A Workers continue to write and present their own programmes. One of the benefits of standardised programmes is that new workers have something concrete they can present and work with rather than be more or less dumped in a gaol and told to get on with it. As well, if an inmate is transferred in the middle of a programme (although with adequate case management this should not happen) it is possible for him or her to link into a programme at the second gaol which should be broadly similar to the first gaol.

The problem of transfers is something that continues to bedevil any rehabilitation programme in NSW prisons. While efforts are being made by Classification Division to halt the high number of transfers in the system it is still a problem. It is very traumatic for both staff and inmates to have a counselling relationship terminated with no warning. Transfers have been used as a discipline measure in the system, but increasingly gaols will be required to manage their own problems particularly if they are relatively minor.

Transfers subvert the neat, linear programme that D&A Services attempt to put into place. Gaols are by their very nature volatile places. Some of the best laid plans fall to pieces because of the simplest of problems. For example, gaols are randomly searched, usually every month, especially in maximum security gaols. Of course it needs to be kept secret when a search is about to happen as the purpose is to locate contraband. However, if you as a D&A Worker have organised a whole group programme for this particular day, all your organisational efforts involving getting access to the inmates, possibly getting them released from work commitments, making sure you have booked a group room and organise community based workers to present at the group will be ruined as the gaol will be closed and inmates locked in their cells for the length of the search.

This has been a particular problem for D&A Services as we have relied on contracted group workers to deliver most of our group interventions. So it occasionally occurred that these group workers would arrive at the gaol unable to get in because of closures. As well, these workers are often erratic in their availability and variable in their skills as well a creating an enormous administrative work load with both D&A Workers and Head Office staff. We are in the process of converting the funds we spend on contracted group workers to full and part time D&A Workers. This means that the range of skills required for D&A Workers in the system will change, with more emphasis placed on adult education and group work skills rather than only counselling skills. More extensive training will be available to D&A Workers to update their skills in these areas.

As already mentioned, the programme seeks to assist inmates minimise the harm they may experience through their alcohol and other drug use, and a supportive skills based

programme is the basis of our work. More research and clinical trials are needed however, to see if this is useful and also to try and find out what kind of skills programme is needed. At the moment we are moving towards basing our work on what the literature suggests are useful interventions. NCADA monographs, the Quality Assurance Project and continued advice and contact with colleagues and experts in the field provide us with ideas about most useful interventions, as well as helping us to establish appropriate treatment and education standards. However, prisons are unique environments where power and control are the dominant features. Programmes need to be developed and implemented within this context.

As well, while many relapse prevention strategies are common sense, common sense is not always acted on. In some of my recent discussions with D&A Workers they said that many inmates know the principles of relapse prevention i.e. avoid high risk situations, have a plan etc. but they have every intention of going back to using harmfully when they get out, even if they don't want to. What these D&A Workers identify and I'm sure this is the situation in the community, is that these inmates don't feel they have a right to envisage a life for themselves that is different, and this is particularly so for women. They feel defeated from the beginning and have no confidence to put any of their knowledge or skill into practice. Something else needs to happen with these people and I believe it has a lot to do with adequate post release support. Increasing the personal skills of clients is important and useful, but there are large structural problems in the community (unemployment, discrimination etc) which make life difficult for all of us, but particularly for ex prisoners.

We in Corrective Services need to provide interventions that increase inmates sense of empowerment and self efficacy. These of course, are preconditions for freedom and liberty. If in our practice as Corrective Services workers, we could all envisage a future where our aim is to facilitate the ability of inmates to be responsibly free rather than facilitate their ability to cope with a lack of freedom, our success in this field would undoubtedly be higher.

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Appendix 1

ESSENTIAL ELEMENTS OF A CORRECTIONAL DRUG AND ALCOHOL PROGRAMME
DRUG AND ALCOHOL SERVICES NSW DEPARTMENT OF CORRECTIVE SERVICES

Inmate Type	*Goals*	*One to one intervention needed*	*Groups and other interventions needed*
Short term Remands	* *Identification of D&A problems in the inmate population* * *Contribute to crisis management of inmate population* * *Contribute to the orientation of inmates to the gaol environment*	*Immediate intervention* * *Individual crisis screening for self harm, drug withdrawal, and gaol environment problems in conjunction with other IDS and CHS staff. Orientation and explanation of gaol system. Utilisation of inmate support group and D&A Peer supporters if needed. Brief D&A screening. Referrals to other services if needed. Use screening instrument devised by D&A Services.* * *Screening should be placed on case management file.* *Next intervention* * *Motivational interview by D&A Worker including:* - *possibility of diversion to rehabs* - *organisation of community counselling* - *explanation of treatment options* - *planning for possible sentence* *-what D&A services are available in other gaols* - *HIV/AIDS (referral to AIDS Committee)*	* *Basic D&A education (including harm minimisation information eg how to use safely, drug interactions - will be developed as a core programme), may include Alcohol Education package and other specific issues such as Hep B and C.* * *Treatment options both inside and outside gaol (what are rehabs, etc, where to get help on the outside, how to contact other gaol based D&A workers, methadone). Use community resources and involve PMS re methadone.* * *AA/NA* * *Crisis Management - may include stress management interventions, peer support. Close liaison needed with other IDS Services.* * *Methadone Service - methadone gaols only (in conjunction with CHS)* * *D&A Peer Education programme* * *Up to date literature on D&A issues*

Inmate type	Goals	One to one intervention needed	Groups and other interventions
Newly sentenced inmates before classification (have not been on remand)	* Identification of D&A problems in the inmate population * Contribute to crisis management of inmate population * Contribute to the orientation of inmates to the gaol environment Time frame: 3 - 5 days	Immediate intervention * Individual crisis screening for self harm, drug withdrawal and gaol environment problems in conjunction with other IDS and CHS staff. Orientation and explanation of gaol system. Utilisation of inmate support group if needed. Brief D&A screening. Referrals to other services if needed. Use screening instrument devised by D&A. * If the brief screening indicates a D&A problem, further assessment is needed at gaol of classification. Screening should be placed on the case file.	* Inmate support group * D&A support group * Up to date literature
Maximum security - inmates at the beginning of their sentence	* Contribute to the development and commencement of inmates' management plan or programme pathway	Full assessment * D&A Worker to use a standardised, reliable, tested assessment instrument (to be devised by D&A Services) in a motivational interviewing format. It should include a D&A history, social history, skill level.	* Basic D&A Education - may include Alcohol Education Programme * D&A Peer education * Problem solving/self awareness (must have gaol focus) may include anger and conflict issues
Type of inmate	Goals	One to one intervention needed	Groups and other interventions

Maximum security continued...		* *Through case management procedures, a management plan or programme pathway should be devised and placed on the case management file.* *Counselling including:* - *goal setting* - *planning for sentence* - *contracting* - *issues that trigger relapse in gaol* - *encouragement to use other services (education etc)*	* *AA/NA* * *Stress Management* * *Methadone Service* *- in methadone gaols only (in conjunction with PMS)* * *Up to date literature on D&A issues*
Medium security - inmates in the middle of their sentence; beginning of sentence for some	* *Refine and continue management plan*	*Counselling including:* - *review of treatment goals* - *continue motivation and preparation to change*	* *D&A Peer Education* * *Basic D&A Education - may include Alcohol Education* * *Self awareness/ communication group* * *AA/NA* * *Methadone Service - in methadone gaols only (in conjunction with PMS)*

Type of inmate	*Goals*	*One to one intervention needed*	*Groups and other interventions*
Minimum security - C1	* *Provide intensive knowledge programme in preparation for day and works release* * *All inmates with D&A problems to have completed this part of the programme before they progress to C2 and C3*	*Issues to address in counselling* * *Planning - how to use the rest of sentence* * *Preparing for release - issues that may trigger relapse* * *How to plan for parole*	* *Relapse Prevention - (to be developed as a core programme package) with focus on concepts Includes:* - *Dealing with triggers* - *Relationship issues* - *Cravings* - *Peer pressure* - *Positive use of lapses* - *Dealing with depression and anger* * *Basic D&A Education (include harm minimisation practices, Alcohol Education, Drinker Driver programme* * *D&A Peer Education* * *Problem solving/self awareness/ communication skills (re-entry focus)* * *Methadone service - in methadone gaols only (in conjunction with PMS)* * *AA/NA* * *Up to date literature*

Type of inmate	*Goals*	*One to one interventions*	*Group and other interventions*
Minimum security - C2, C3 *Short sentence inmates*	* *Provide a skills programme to support inmates re-entry into the community* * *Provide knowledge and skills programme to inmates on short sentences* * *Provide a Drink Drivers programme specifically for drink driver offenders* * *Provide an interdisciplinary pre release programme (to be developed)*	* *Planning - what are you going to do when you get out:* - *the gate* - *on your first day* - *in the first week/month* * *Where to locate D&A resources and help on the outside* * *Relapse* - *Boredom* - *Leisure* - *Relationships* - *Sexuality* - *Employment/ Unemployment* - *Parenting* * *Link to appropriate methadone service in community in conjunction with PMS.* * *Parole issues* * *Contact with family, friends and employers - provide support and problem solving*	* *Relapse prevention - (to be developed as a core programme package) with focus on implementation Includes:* - *Dealing with triggers* - *Relationship issues* - *Cravings* - *Peer pressure* - *Positive use of lapses* - *Dealing with depression and anger* * *Basic D&A Education (include harm minimisation practices, Alcohol Education, Drink Driver programme)* * *D&A Peer Education - use peer supporters* * *Problem solving/self awareness/ communication skills (re entry focus)* * *Pre release programme* * *Methadone service - in methadone gaols only (in conjunction with PMS - bring in community clinic staff)* * *AA/NA* * *Up to date literature*

MEETING THE MULTICULTURAL CHALLENGE IN THE ALCOHOL AND OTHER DRUG FIELD

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Introduction

In 1988 the National Campaign Against Drug Abuse (NCADA) evaluation identified non-English speaking background (NESB) communities as a target for their campaign. The reason given for this was that a number of barriers to access were thought to exist which contributed to lower rates of service utilisation and the general marginalisation of NESB clients within the social system. It thus recommended that more effort should go into establishing the needs of NESB communities.

That same year, the National Health Conference identified drug and alcohol issues as a priority area with specific reference to NESB consumers. The conference outlined several broad factors which contributed to NESB communities not having the same level of access to health care as the English speaking population and experiencing premature drop out rates from treatment programs. These were:-

- An inability to speak English;
- the cultural predisposition (the values, attitudes and norms) of NESB people may differ markedly from the norms of service providers in the health service community;
- a general lack of awareness of the health care system on behalf of NESB citizens (this leads to over-utilisation of some services which are inappropriately equipped to deal with alcohol and other drug problems and the under-utilisation of those that are appropriate; and
- the slow response of the health care system to the ever changing needs of the varied population.

Other research has further suggested that generally NESB consumers have a low level of knowledge regarding some important alcohol and other drug issues such as an understanding of drugs, their short and long term effects; the levels and patterns that constitute hazardous levels of use; the role and value of counselling by professionals outside the family to solve problems.

To date, alcohol and other drug services have had limited success in their attempts to increase access and quality of care for NESB people. Their capacity to cater to these consumers has been impeded by a lack of cultural sensitivity and cultural knowledge, the inappropriateness of services (particularly treatment services in their lack of family involvement) and an apparent preference to refer rather than work with these consumers.

The multicultural challenge which Australia's multi racial community has afforded the health care system remains to be met appropriately, however the last decade has seen some major accomplishments and breakthroughs. This paper reviews these achievements in an attempt to provide a picture of the current state of affairs in this field.

Demographic profile

Based on the 1991 Census, NSW has a total population of over five million people, of which nearly fifteen per cent were born overseas in NESB countries, that is one in seven people. There are over one hundred and three different countries of birth and over eighty language groups represented in the NSW population, with over sixty having more than 1,000 members and sixteen having more than 10,000 (ABS, 1991). Please refer to Table 1 for further details.

This sector of the population is categorised as the NESB component. Despite being regarded as a “group”, in reality they are far from homogenous, with a great variety of subcategories, including country of birth; language spoken at home; religion; age composition; socio-economic status; and education levels. For example, in Lebanon, the culture of the muslim community is very different from that of the christian community. This diversity reflects a variety of drug and alcohol usage patterns, knowledge and needs and thus carries some important implications for the provision of services to these communities.

Table 1: Language spoken at Home of NESB communities with more than 10,000 members (1991 Census)

Language	Males	Females	Persons
Chinese º	60,513	59,065	119,578
Italian	56,730	54,241	110,971
Arabic *	54,922	51,505	106,427
Greek	47,911	47,057	94,968
Spanish	22,604	23,443	46,047
Vietnamese	20,834	18,579	39,413
German	16,913	17,660	34,573
Macedonian	12,854	11,836	24,690
Croatian/Serbian	17,484	16,579	34,013
Maltese	10,523	10,058	20,581
Polish	9,162	10,002	19,164
French	8,166	8,837	17,003
Turkish	7,806	7,307	15,113
Dutch	5,377	6,130	11,507
Other #	111,398	116,644	228,042
Total	**463,533**	**459,274**	**922,807**

º Comprises "Cantonese", "Mandarin", "Chinese as stated" and "Chinese languages n.e.i."
* Includes Lebanese
# Includes "Other languages but not stated"; "inadequately described" and "Yugoslavia n.e.i."

English language proficiency

English language proficiency is another important factor in the accessing of services. The lack of a common language between client and health professional can have serious implications for diagnostic accuracy and overall quality of care. It can inhibit describing symptoms effectively, asking questions and talking about fears and anxieties, leading to further distress and dissatisfaction with care.

Although the English proficiency of NESB people varies enormously both within and between NESB communities, an overall picture can be achieved by noting that the 1991

census showed that of those born in NESB countries and aged 5 years or over 150,000 did not speak English well and 32,000 did not speak it at all.

This figure underestimates the proportion whose proficiency in English is low since it excludes Australian-born whose English language fluency is poor. Additionally, many of those who view themselves as speaking English "well" or "very well" in general conversation may have difficulty in a treatment or counselling context.

The NESB community groups with the largest proportion lacking English fluency were Vietnamese (44.7%), Chinese (32.6%), Turkish (27.7%), Macedonian (23.3%) and Spanish (21.5%) with higher numbers of women than men in each group since women, like the aged and first generation migrants, have limited opportunities to develop fluency (National Health Strategy, 1993).

Research

As a result of the fact that the major health research funding bodies have failed to prioritise this issue, very few studies have addressed it. A literature review conducted at DAMEC in 1991 concluded that the existing research in this field of study has been limited, fragmented and of varying quality. As a result significant gaps regarding a number of important issues remain in the literature. See table 2 for details.

Table 2: Major remaining gaps in knowledge

_ Differential patterns of A&OD use and problems amongst NESB and the impact of cultural factors and migration experience on these patterns;
_ Attitudes to and knowledge of drug issues, such as how NESB define drugs and their effects;
_ How NESB access the health system, deal with drug use in their community and react to existing drug and alcohol services (ie. barriers to access);
_ NESB knowledge of services providing information and advice on drugs;
_ The commonalities and differences between and within NESB communities.

This has resulted in data which is difficult to generalise or compare for education, policy or prevention purposes.

The major problems with the existing research are as follows:-

- **Technical Problems -** It is difficult to compare studies due to variations in the sampling and measurement methods used;

- **A lack of Power in existing data sets -** Even in large scale data collections information about individual countries is rarely available;

- **Disagreements regarding some basic concepts -** Some studies compare NESB to ESB communities while others compare Australian to non-Australian born. In the latter, despite the fact that country of birth (COB) groupings are almost universally selected, problems arise since analysis is not always based on standardised ABS groupings of countries so that data for individual countries is difficult to obtain. Moreover, there is still debate about whether COB is the best variable to define ethnicity (ie. some regard language spoken at home or reported English fluency to be better indicators). When comparing NESB to ESB communities there is a problem of definition. Does NESB include NESB born? first generation? their children?.

- **High cost of specialised data collection -** The employment of bilingual interviewers or adding items to existing data collections

- **Some questions not addressed -** attempts to combine information on attitudes to and knowledge about drugs and the characteristics of users rarely address the issue of the impact of cultural factors and migration experience on drug use.

What do we know?

Current knowledge is sufficient to provide a broad description of the usage patterns, knowledge and service utilisation of NESB as a group and that of some specific NESB communities.

.... About usage patterns

While there are many small studies, there is no coherent research examining specific health issues for people of NESB. Moreover, data collections are ad hoc and unsystematic. The little that is available has concentrated on descriptive studies of the patterns of drug use with specific references to alcohol and tobacco.

Alcohol

To date, insufficient work has been done on the level of alcohol consumption or patterns of use to give a comprehensive picture of NESB communities compared with the general population. Nor have comprehensive patterns within communities in relation to period of residence in Australia and patterns of use in the home country been established. Only broad generalisations are possible.

In her survey of quantitative data relating to drug and alcohol use and abuse amongst ethnic communities, Alcorso (1989) concludes that despite the shortcomings of quantitative research, existing data shows that there are significant differences between birthplace in relation to levels of use and presentation to alcohol and other drug services. Eastern Europeans, particularly Soviet and Polish men, generally have a higher rate of alcohol problems than Australian-born, while Asian and Middle Eastern people have a lower rate. Alcorso argues that these findings support the hypothesis that cultural factors, in addition to other social factors, play a role in predicting the risks associated with alcohol and other drug abuse in Australia.

A study by Santamaria and Robinson (1980) found variations between ethnic (country of birth) groups in rates and types of problems on presentation. Patients from Central and Eastern European countries and Yugoslavia appeared over-represented compared to English speaking Australians. Italians and Greeks tended to present with a physical disease, the difference being that the Greeks seemed to have changed their drinking patterns since migration.

Central and Eastern Europeans were generally older on presentation than Yugoslavs but despite similarly heavy drinking patterns, did not show a high incidence of physical disease. Yugoslavs tended to be younger than the other two groups and suffered from severe family, social or work related disruption rather than physical disease. Their drinking patterns tended to be "explosive" in contrast to other groups and hence led to disruption at home and in society.

Given the dearth of research on alcohol use patterns of different NESB groups, policy makers have also relied on eliciting information from key informants such as health and welfare professionals. For instance, Hopkins (1989) used interviews with small groups of key informants to write a report to the Western Australian Department of Health on the needs of NESB people. He indicated that "Heavy alcohol use was noted among some Portuguese, Polish, Yugoslav, Chilean, Vietnamese and Italian born people".

Tobacco

In the general community, several factors have been linked to smoking status. These include employment, occupation and education. Numerous surveys show that

smoking levels tend to be higher among unemployed persons as opposed to employed; lower among white collar workers as opposed to blue collar workers; and higher among less well educated persons, so that as educational levels rise smoking prevalence generally decreases.

Research has shown that for the first generation of NESB people, the unemployment experience may be three to five times as high as the average employment level (Spathopoulos & Bertram, 1991). In terms of employment experience, first generation NESB immigrants suffer lower returns on their overseas schooling and employment experience and get jobs with a lower occupational status than comparable Australian born people.

A study by David Hill (1988) which analysed a representative sample at a national level and looked at birthplace, sex and age related to the proportion of those who had smoked, discovered that the occupational level of the household's main earner was clearly related to the smoking rates amongst women. Lower “blue collar” (36.1%) being more than double that of “upper white collar” (17.5%). The 20-29 age group amongst both men and women with a lower blue collar classification and lower educational classification (less than year 10 for men and years 10-11 for women) had the highest prevalence of smoking (60% and 58% respectively).

However, results of studies are not always consistent. For example, tables 3 and 4 provide two different pictures of tobacco use in a number of NESB groups. Table 3 shows that males born in Southern Europe or Asia have higher smoking rates than those men born in Australia. Women born in Northern Europe have higher smoking rates than women born in Australia.

Table 4 shows that among males all four NESB communities have higher daily use of tobacco than the general community. Among females, Lebanese smoked twice as much as females in the general community. Since the Greek and Italian communities are classified as part of Southern Europe they would have been included in the same category based on the divisions in Table 3.

Table 3: Smoking status based on country of birth (1993)

Country of birth	Males (%)	Females (%)
Australia	30.1	24.4
Northern Europe	34.2	30.6
Southern Europe	40.4	20.1
Asia	39.7	21.2
Other	30.0	23.2

Source: National Heart Foundation, Risk Factor Prevalence Study (1993)

Table 4: Daily tobacco use in four ethnic communities (1987)

Community	Males (%)	Females (%)
General	32.0	25.0
Greek	44.7	28.1
Italian	55.6	26.0
Lebanese	59.6	51.9
Vietnamese	56.4	27.3

Source: Trimboli and Ridoutt (1987) The drug use patterns of four ethnic communities: CEIDA.

Drug & Alcohol Multicultural Education Centre (DAMEC) studies

At DAMEC we are conducting a series of studies in an attempt to standardise data collection in this area and assess whether certain NESB communities are at a higher risk of drug-related harm than the general population and how communities manage or prevent such harm.

Specifically the studies aim to collect information about:

- patterns of use (tobacco, alcohol and other drugs);
- community attitudes to drugs and services; and
- community knowledge of drugs and services.

This is with the view of identifying problem areas and developing effective intervention strategies. The actual domains and variables of interest of these studies are described in table 5.

The selection of communities is based on size and lack of fluency in English. Studies have already been completed on the Vietnamese and the Spanish - speaking communities. Study of the Greek community is currently underway. We propose that this will be followed by the Chinese community.

The study has two components - targeting community members (15 to 65 years) and key informants (those who provide support and services to the community). The schedule for community members is based largely on existing items to allow available data from the general community to act as a benchmark for the NESB communities.

Table 5: Domains and Variables of Interest of DAMEC Studies

Domain	Variable
Prevalence of drug use -	Drugs used, characteristics of users
Definition of Drug problem -	Perceptions of a drug problem, risk of problem drug use
Drug knowledge -	Knowledge of drug types
Drug attitudes -	Drug image in context with other social problems, drug type
Management of harm -	Knowledge and use of services, knowledge of current programs being conducted, effect of mainstream efforts on the community
Identified needs -	Awareness of drug issues, deficits in knowledge, needs for prevention strategies, what should be done, who should be targeted, method of access
HIV/AIDS knowledge -	Knowledge about HIV/AIDS transmission, what are the sources of information
Intervention strategies -	What forms of intervention would be most appropriate for identified sub-groups in the community

.... About treatment services for NESB?

Another category of literature has set out to identify gaps in the services available to NESB people with an emphasis on barriers to access, attitudes to and knowledge of services. Of particular interest are informal resources within the community to deal with drug related problems.

Research suggests that some NESB community members are more likely to turn to doctors, clergy or informal support networks for help rather than accessing alcohol and other drug services. This in turn contributes to lower rates of service utilisation, premature dropout rates from treatment programs and a general marginalisation of NESB clients within the health system. A number of barriers have been described as producing or enforcing this marginalisation. Some of these barriers are as follows:-

1. Lack of English language proficiency

English language proficiency is an important factor in the accessing of services. The lack of a common language between client and health professional can have serious implications for diagnostic accuracy and overall quality of care. It can inhibit describing symptoms effectively, asking questions and talking about fears and anxieties, leading to further distress and dissatisfaction with care.

2. Migration experience

The migration experience can be very different from migrant to migrant. It can range from a migrant who came to Australia willingly, established himself and made his fortune; to a migrant who is unemployed, unable to have his qualifications recognised and working in a blue collar position or even a migrant who was removed from his home for reasons of war or political upheaval (refugee status). Despite this variation, feelings of separation, dislocation and confusion are experienced by all migrants (in varying degrees), and it is these feelings which can lead to heightened levels of stress and anxiety, which can predispose them to being at heightened risk of drug and alcohol abuse.

3. Over representation in high risk categories

The National Health Strategy (1993) states that many NESB workers are:-

> "Concentrated in the worse paid, hardest most monotonous, dangerous, and dirtiest jobs of the male and female segments of the labour market, particularly in the manufacturing sector. Consequently non-English speaking migrants have the lowest incomes, highest incidence of poverty and highest rate of unemployment in non-Aboriginal Australia".

It has been repeatedly reported that there is a tendency for risk behaviour to increase as the person's socio economic status decreases. People in manual, blue collar occupations and those who have experienced high levels of unemployment and social marginalisation tend to experience greater problems with tobacco, alcohol and other drugs.

For example, Moore et al (1989) showed that occupation and smoking prevalence are related. For both men and women, smoking was found to be higher amongst lower blue collar workers than upper white collar workers. Moreover, as education levels rise, smoking prevalence tends to generally decrease.

4. Lack of knowledge of A&OD issues

NESB's understanding of drugs, their short and long term effects and the levels and patterns that constitute hazardous use is limited and remains in a "vacuum" from the time they arrive in Australia. This is created by their isolation from mainstream information outlets due to their language and cultural barriers and the inappropriateness of this information for reaching this sub group of the population.

NESB gain their information through different outlets to those of the English speaking population. For example, DAMEC has found that NESB communities respond best to

communication through ethnic press, SBS (Special Broadcasting Service) and especially Ethnic Radio programs (2EA).

5. Different expectations from A&OD services

The NESB health consumer has a cultural predisposition (values, attitudes and norms) to certain expectations of A&OD services which differs markedly from the norms of service providers. Some examples are:-

- NESB's unfamiliarity with some services and concepts (ie. counselling);
- NESB expect the system to function like it does in their country of origin;
- Some NESB communities have a distrust of authority, making it difficult for them to utilise professional help.

In general, Specialist drug and alcohol services tend to be little known, poorly understood and underutilised by potential NESB clients.

6. Barriers from service providers

From the point of view of service providers, the basic problem is the absence of a clear marketing philosophy and flexibility within the organisational culture of services to meet the demands of a diverse customer pool. A recent review of mental health agencies (1992) found that:-

- services were poorly promoted in languages other than English
- services were not aware of how to access NESB clientele
- services were not found to be "user friendly" to NESB clientele

Additionally, other studies have found that service providers have a :-

- Lack of cultural knowledge and sensitivity
- Lack of cross cultural communication skills
- Dislike of using interpreters
- Preference for referral of NESB clients
- Regard NESB clients as “too hard”

Thus, the challenge of providing accessible and equitable services to all the members of our multicultural community is a double-edged challenge. We need to work with both NESB service users and mainstream service providers to narrow the service gap that exists (see table 6).

Table 6: Examples of the type of education needed by NESB service users and mainstream service providers

NESB clients need education about:-	**Service providers need skills based education about:-**
• how to use the interpreter service • cross cultural counselling skills • how to adapt their services to cater effectively to the needs of NESB (user friendliness)	• drugs and their effects • how the health system works • what particular services can and cannot do • how to access the interpreter service

Drug and Alcohol Directorate strategy

An attempt to address this challenge has been provided by the Drug and Alcohol Directorate in a recent strategy document (1993) titled "Providing Alcohol and Other Drug Services in a Multicultural Society". This document accentuates the need to consolidate work to date and begin to build ground rules from which future developments can emerge.

In particular it mentions the need for the establishment of a central co-ordinating and registration unit to: consolidate and review existing resources, projects, services and programs; provide assistance to services in the establishment of their operational plans and set the groundwork for future plans of extension. The strategy has four major outcomes in mind. These are:-

1• An increase in the number of culturally and linguistically appropriate multilingual information on A&OD issues (in particular regarding hazardous levels of consumption);

2• An increase in the level of knowledge and skills of A&OD service providers regarding NESB issues;

3• An increase in the rate of use of the interpreter service in the delivery of A&OD services;

4• An increase in the knowledge and use of existing A&OD services by NESB clients.

These outcomes are designed to be broad directional ideas from which specific strategies may be further developed by services as part of their strategic planning.

Some suggested strategies are given under each outcome and provide some guidelines for changes required over the next three years.

Conclusion

New South Wales has thus made some important advances towards meeting the multicultural challenge that it faces. The Directorate's strategy is major step towards consolidating our achievements to date in an attempt to provide better organised future advances in this area.

However, it is still the case that large gaps remain in a number of areas, including:-

- Our knowledge and understanding of some key concepts
- Knowledge of the needs of the target group
- Data collections, in particular of ethnicity data
- Possible frameworks for service delivery

We have only begun on the hard road ahead towards providing equal access and equitable services to all Australians.

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AN OVERVIEW OF ALCOHOL USE IN ABORIGINAL AUSTRALIA

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Introduction

The indigenous peoples of Australia (Aborigines and Torres Strait Islanders, hereafter, unless specified, referred to as "Aborigines") constitute approximately 2% of the nation's population. The need for special attention to this group in a description of alcohol in Australia stems from their unique status among minority groups (being the original occupants of this continent), their unparalleled levels of social disadvantage, and due to the particular history and impact of alcohol and the way in which this has informed perceptions of Aborigines current in the wider society. In this latter regard alcohol has been a central and recurring theme in the development of enduring stereotypes of Aborigines, which are reinforced by the high visibility of Aboriginal drinking and the behaviours associated with it. This situation has, perhaps unwittingly, been compounded by a longstanding research focus on remote Aboriginal Australia, an area where the consumption patterns among non-Aborigines are also extreme by the standards of metropolitan Australia.

Aboriginal disadvantage is both critical to this discussion and incapable of being briefly but comprehensively defined. The following brief overview is simply to suggest some of the parameters of social asymmetry by comparison to other Australians. While just under a quarter of the general population are fifteen years of age or less, among Aborigines (two thirds of whom now reside in urban centres or rural towns) this proportion is forty percent. Aboriginal youth are characterised by lower educational achievement, leading to substantially higher rates of unemployment throughout adulthood (three to four times greater) and thus widespread reliance on income derived from social security (approximately two-thirds to three-quarters of Aboriginal incomes nationally are derived from direct or indirect government transfers). Rates of police detention at the end of the 1980s were some twenty times the non-Aboriginal rates nationally (arrest for public drunkenness being a major contributor) with the proportion of Aborigines in prison being some fifteen times higher than for non-Aborigines.

In terms of health, Aboriginal life expectancy is some sixteen to twenty years less than in the wider population, with very high rates of infant mortality typical of earlier

decades (which remain two to three times greater than for the nation as a whole) replaced by excess mortality in middle adulthood from `lifestyle' diseases (in particular diseases of the circulatory system), and to a lesser but still significant extent, from non-natural causes. Alcohol has been incriminated as a direct cause in ten per cent of Aboriginal deaths, some three to four times the proportion for non-Aboriginal Australians.

Alcohol is invoked as both cause and consequence of many of these social and health problems and patterns of social disadvantage. The connection is surely more apparent than the direction of that relationship. Regardless, it is clear that in many ways alcohol impacts and structures Aboriginal life, particularly in remote Australia, and is a substantial contributor to premature mortality and excess morbidity. It is thus noteworthy by virtue of very real and important associations, but also by virtue of alcohol's potency as a symbol of the racist legislation of a colonial past and the legacies of discrimination and disadvantage that have persisted to the present.

History

Until recently there has been little academic disagreement with the widely held proposition that Aborigines had no experience of intoxicating substances prior to European settlement. This assertion is itself located among layers of expedient constructions that have, over the last two centuries, defined Aborigines in terms that are explicitly negative or suggest childlike helplessness and irresponsibility. In fact, various Aboriginal groups are known to have had access to and used psychoactive substances, and certain groups along Australia's far northern coastline were introduced to alcohol itself during seasonal contacts with Macassan seamen which spanned at least a century-and-a-half before settlement, with estimates of up to a thousand visitors annually involved in harvesting and preparing trepang.

Regardless, with European settlement in 1788 came unprecedented exposure to alcohol, indeed alcohol was both an inducement and reward used with the first contacted Aborigines at Sydney Cove. As the pastoral and mining frontiers relentlessly expanded from the penal settlements of the East coast, so did Aboriginal experiences of alcohol - and of its use by, and effects on, Europeans. At that harsh and bloody cultural interface, knowledge of alcohol and of behaviours associated with it, occurred in the context of other and more devastating consequences of contact as Aboriginal populations of the South and East were decimated by disease and violence, the survivors, more often than not, dispossessed and dislocated.

Indeed, Europeans were not tardy at introducing Aborigines to alcohol or in using it to their own ends. Those Aborigines seeking tenuous shelter on the fringes of European settlements, places of relative safety by comparison to the unpredictable and violent fringes of settlement, within a few generations had been incorporated into a new (European) landscape in which they were the outsiders, the `other' - diseased,

degraded, deceitful, and drunk. Drinking was soon central in a spectrum of reprehensible behaviours that raised moral hackles among the aspiring colonial `gentlefolk' - indolence, intoxication, gambling and miscegenation.

Moral outrage fuelled legislative action, and as the colony of New South Wales entered its second half-century the first law prohibiting Aboriginal access to alcohol was enacted (1838), followed in the next half-century by all mainland colonies. The issue in the island colony of Tasmania was somewhat less pressing, but only delayed, as a result of the systematic and almost total annihilation of the Tasmanian Aboriginal population. The States, which emerged from the various colonies following Federation in 1901, extended their legislative nets. They progressively restricted and controlled Aborigines, entwining prohibition in a framework of discriminatory laws that intruded into every domain of Aboriginal life which, despite pedantry and preoccupation with any degree of `colour' that purported to define some quanta of Aboriginality, was expanded so as to ensnare all Aborigines, regardless of lifestyle or of the oft invoked but functionally redundant category of descent.

During a half-century of quiet that extended past the middle of this century, which reflected the almost total subjugation of Aborigines to a labyrinthine system of institutional controls, escape from the draconian restrictions placed on `natives' was available to only a small group who had demonstrated sufficiently that they had extinguished any vestiges of Aboriginality. Such conditional `citizenship' brought with it tangible rewards, including the rights to education, ownership of land, free movement, hospital treatment, to retain income earned, to vote - and to drink. Public consumption of alcohol was, for many Aborigines and non-Aborigines, the immediate affirmation of equality with, and before, Europeans. By contrast, for the majority, who were unable or unwilling to make this chameleon-like cultural transformation, prohibition came to symbolise their excluded status as non-citizens. That is not to say that it prevented consumption. It surely did not.

What it did do was to structure the manner of consumption, reinforcing patterns of furtive and rapid drinking in town and fringe-camp settings, and consolidating its status and commodity value in remote settings where it was used both as a reward (as for workers in the cattle industry) and as a means of coercion (to obtain sexual access to Aboriginal women, a process that has continued to the present). The patterns of drinking were also structured by economic factors; Aborigines by and large had little in the way of monetary resources which were, when available usually seasonal. Their use of alcohol was thus informed by being classified as an Aboriginal legislatively (through prohibition) and by the social realities of being so classified (poverty and isolation). It was also informed by intra-cultural factors.

As an activity that was both secret (from European authority) and public (a shared activity among Aborigines), "grogging" developed its own codes and norms which reflected both traditional patterns of reciprocity and obligation, and the exigencies of

prohibition. While the act of drinking was, of necessity, hidden from (most) Europeans, that was not necessarily the case for drunken behaviour. Indeed, the state of intoxication provided an avenue for the confrontation of Europeans and their expectations of right and proper behaviour. Thus emboldened, Aboriginal drunken comportment was, and remains, a manifest marker of non-acquiescence, signalling the rejection of the imposed moralistic norms of the dominant culture, which were often articulated by missionaries who were frequently the de-facto executors of State power in remote Australia. At the same time as informing the symbolic meaning or value of alcohol, it also substantially increased its exchange value, providing a powerful profit enticement to Aborigines and non-Aborigines involved in the purchase, transport and supply of alcohol for Aboriginal clients - "sly grogging". However, regardless of the fleeting personal empowerment or economic incentives, drinking was, fundamentally, a social activity, as pleasurable for Aborigines as for those Europeans whose bibulous bonhomie was a public spectacle throughout urban and remote Australia.

Given the associations of prohibition and citizenship, it is not surprising that the right to drink became conflated with citizenship rights. In fact, the lifting of prohibition in the various states spanned fifteen years from 1957, during which time Aborigines were given the right to vote, included under certain workplace awards and provided limited access to social security benefits. In 1967 a national referendum which received a 90% yes vote, and which has, erroneously, come to be seen as synonymous with `rights', included Aborigines in the national census (they had previously not been so enumerated) and provided for the Commonwealth to legislate for Aborigines nationally. However, it was not until 1972 that prohibition was finally lifted in the last regions of remote Australia.

The conjunction of liquor and legislation in Aboriginal Australia did not end there. As noted earlier, Aborigines have since experienced extraordinary rates of incarceration, with more than half of the detentions in the late 1980s being as a result of drunkenness. This situation came under public scrutiny at that time due to a national inquiry, the Royal Commission into Aboriginal Deaths in Custody, in the investigations and deliberations of which Aboriginal alcohol use was a major consideration. Since that time all remaining states have decriminalised public drunkenness. Independently of this Royal Commission, through the 1980s a variety of other legislative measures were adopted in different jurisdictions in an attempt to control access to alcohol or its public consumption. The effects of these initiatives have been mixed; those appearing to have had substantial benefit for Aborigines themselves having been initiated and supported by Aboriginal communities, with statutory enforcement, this being the model which has resulted in the gazetting of `dry' communities in the remote Northern Territory.

Contemporary Alcohol Use

There are both similarities and clear differences in the patterns of alcohol consumption between Aborigines and other Australians. Not surprisingly, certain demographic

factors are associated with tendencies towards like use. Thus, for both groups, males are more likely to be drinkers and to consume more when drinking than females, youth also being associated with higher consumption. For Aborigines and others, urban residence and employment are predictive of more moderate use of alcohol, whereas, particularly for males, remote or rural residence is associated with heavier, though less frequent, drinking. Perhaps the most obvious, and often overlooked, commonality is that the use of alcohol is, in the first instance, an activity that gives pleasure and has substantial social functions.

Such similarities are not reflected in the continuing stereotypes of Aboriginal alcohol consumption which are prevalent in the wider society. According to such views, which emphasise difference by presenting extremes, drinking is almost universal among Aborigines, who are invariably heavy consumers. The studies which have attempted to quantify Aboriginal consumption have, in a sense, contributed to the stereotypes through their focus on remote populations in northern Australia. However, there is, at present, no reliable quantitative information on sizeable urban samples in the southern states. Thus, while it is likely that the information available on Aborigines residing in remote Australia does, in certain respects, apply to those living in urban and southern centres, as with the general Australian population, it is also probable that an urban-remote differential in consumption exists for Aborigines. As such, generalising from existing quantitative studies should be viewed with some caution. It should also be emphasised that there is substantial inter-group variation among populations in remote Australia.

Given those caveats, the quantitative information that is available provides a generally consistent picture. Contrary to the prevailing stereotypes noted earlier, the proportions of Aborigines identified as non-drinkers are consistently higher than for Australia as a whole. Compared with the general population, in which fifteen percent of adults do not drink, approximately one third of Aborigines are current abstainers; one-quarter of males and one half of females. Other than sex, age is the major determinant of drinking status. Thus, at all ages a greater proportion of males are current drinkers than females. For young adults, nearly all men and approximately two-thirds of females are drinkers, this proportion falling with age for both sexes, plateauing at about half of the male population for those in their fifth decade and older. For females the proportion of current drinkers falls steadily from around two-thirds of young adults, to some ten percent of elderly women. A significant difference between the sexes is that non-drinking males are far more likely to be ex-drinkers, whereas women who do not drink have more commonly been lifetime abstainers, indeed this group constitutes the majority of elderly women.

These proportions and differences are of note. Clearly, very few men, regardless of age, have been lifetime abstainers. For women that is not the case; past early adulthood, the proportion who have never consumed alcohol increases steadily with age. This suggests that for women who reached maturity before the ready availability

of alcohol to Aboriginal populations, but not for men, age seems to have been a factor supporting continued abstinence. While not all men started or at least tried drinking at that time, it appears that, ultimately, most did. That drinking is now normative for young adult males also suggests substantial peer pressures to drink and, conversely, the social burden that confronts those young men who attempt to abstain or give up. Indeed, as a unifying practice, drinking draws together young men for whom the contemporary political symbolism of alcohol use meshes with traditional social themes of relatedness. Consequently the construction of identity as drinkers has, for some, become conflated with Aboriginality itself which, in a sense, supports the stereotypes of the society for which extreme drinking behaviour is a symbolic rejection. This position, which has sought to `traditionalise' certain aspects of alcohol use (such as sharing and reciprocity) and its associated behaviour (at times including violence) has been loudly confronted as a rationalisation from within the Aboriginal community itself.

The clearest refutation of the stereotype of Aborigines as `hopeless drunks' is demonstrated by those Aborigines who have been able to give up alcohol which, among men, is approximately one third of those over forty years of age. With such a substantial group of abstainers, the social pressures to drink are correspondingly less than for young men, and there may be both support and encouragement by peers and family for the decision to stop drinking, particularly as by this age many of the complications and consequences of heavy alcohol use may be manifest. Although alcohol services to Aborigines have increased during the last decade, the vast majority of those who have ceased drinking over this period have done so without any formal intervention.

This capacity for self-motivated sobriety, often after many years of heavy drinking, is clear. The effects of alcohol on family life and health are the main inducements to cease drinking, factors which are likely to have a greater relevance and impact after young adulthood. Certain social organisations, notably Christian fundamentalist groups whose activities have been prominent in various places and at various times through remote Australia over the last two decades, have provided a structure that has supported abstinence, in a sense by providing an alternate and mutually exclusive identity referent. As a consequence, social bifurcations have emerged in some communities such that one is defined as a "drinker" or a "church man", although there may be movement between these two categories.

As a result, alcohol has produced or increased certain divisions within Aboriginal societies, and has been a contributory factor in developing tensions across generations. On the one hand, many older Aborigines who have successfully given up alcohol lament youths' wild ways and lack of interest in their traditions; on the other, younger Aborigines, often rebelling against the strictures of their elders and wider authority figures, frequently point out that it was older Aborigines who "taught" them about alcohol in the first place. Open dissent has also emerged in some areas between men,

who are more likely to be drinkers and supportive of its availability, and women, who are both more likely to be abstinent and yet to bear the social, economic and traumatic consequences.

While the proportion of Aborigines who are current drinkers is less, overall, than for the Australian population as a whole, the quantities consumed by those that do drink, are high. Indeed, most recent quantitative studies have reported that the majority of identified drinkers are consuming at harmful levels, generally being defined as more than sixty grams of alcohol per drinking day. As for drinking status per se, the major determinants of quantity consumed among drinkers are, again, sex and age; both younger age and male sex predict higher median quantities consumed on each drinking day. A large random sample survey from the remote Kimberley region of Western Australia revealed that the median consumption of alcohol, on those days during which drinking occurred, for teenage and young adult males was between 150 and 170 grams, and for similarly aged women was around 85 grams. This differential persisted throughout the lifespan with the median amount imbibed on a drinking day falling regularly to reach quantities half of those for youth and young adults, for both sexes, in old age.

Although age and sex are the major determinants of both drinking status and quantity consumed, the way in which alcohol is consumed largely reflects availability which, to different degrees, is limited by location, legal restrictions and resources. Obviously, where alcohol is not easily available, those who do drink are, necessarily, likely to drink episodically. By contrast, and given the quantities consumed by most who choose to drink, in urban, town and fringe-camp settings the major determinant of the pattern and quantity of alcohol consumed is the availability of resources. As Aborigines are, by and large, poor compared to the wider society and more frequently reliant on social security measures, most have less to spend, per capita, on alcohol. For those consuming alcohol in substantial quantity this thus requires the diversion of sustenance allowances to the purchase of alcohol or access to the sustenance allowances of others in the community. However, while there are no other limitations on access to alcohol for metropolitan and town dwelling Aborigines, and while this group is also more likely to have additional sources of income other than government transfers, it is in these settings that Aborigines who consume alcohol in moderation are most likely to be found, this group being better educated and more frequently employed.

While the majority of Aborigines now live in towns and cities, the proportion who live in remote Australia (in communities that were previously government or mission run settlements, or European pastoral leases) is far greater than for Australia as a whole. It is only within the last two decades that alcohol has been legally obtainable in most of these settings. With the lifting of prohibition, remote Aboriginal communities have not only gained the right to purchase and consume alcohol, they have also become a significant market. However, while Aborigines as consumers have been systematically

targeted by alcohol purveyors, they have largely been treated as consumers without rights. Thus the focus has been on volume sales with minimal consideration for providing either services or environments conducive to social drinking. Sheds and concrete "black bars" and "watering holes" remain typical of many remote towns and Aboriginal communities, with a growing emphasis on "take-away" sales in towns over the last decade in response to the intrusions of tourism into remote Australia.

Of course, one of the major attractions of remote Australia for tourists is that it is, in fact, Aboriginal Australia. As a consequence, Aboriginal arts and culture have been incorporated into the economic landscape and have become a major resource for remote towns. However, at the same time and in some of those very towns, particularly in Central Australia, economic and legislative initiatives have sought to remove from public view indigent drinking Aborigines who do not accord with the sanitised constructions of "outback Australia" favoured by the tourist industry. Laws have been enacted in certain jurisdictions with substantial Aboriginal populations prohibiting consumption of alcohol in public places. While not explicitly discriminatory, in intent and effect it is Aboriginal drinkers who are targeted, shifting the locus of consumption from the public to the domestic domain, in essence encouraging a return to earlier patterns of furtive and surreptitious drinking.

Away from towns, in the autonomous Aboriginal communities of remote Australia, a range of measures have been adopted to control the supply of alcohol. At the one extreme are communities that have themselves obtained liquor licenses as an economic enterprise, often taking over from hoteliers who had extracted considerable profits from local Aboriginal communities. At the other, as mentioned earlier, are communities that, with degrees of community and statutory support, have declared themselves "dry". Between these two are various arrangements, with most communities which do have canteens placing certain restrictions on beverages available (frequently only beer), the days and hours of operation, and in some communities limiting the availability of alcohol for consumption away from the canteen itself.

Regardless of the nature of these arrangements, alcohol has been a recurrent central issue in the politics of remote Australia. At the level of the Aboriginal communities themselves, individuals running for office may be judged largely on their position regarding alcohol. Aboriginal drinking also informs regional politics, both because of pressures from tourist oriented agencies and businesses to adopt measures to reduce the visibility of Aboriginal drinking, but also in response to the powerful economic investment of the alcohol industry and licensing bodies. Paradoxically, in Central Australia such apparently conflicting agendas are both vigorously pursued. Indeed, in Alice Springs, where it is illegal to have an open beverage container within two kilometres of a retailer licensed to sell alcohol (thus prohibiting public drinking in town areas), there are more licensed outlets per capita than anywhere else in the nation.

Elsewhere in the Northern Territory licenses have been granted which could not exist save for supplying remote Aboriginal communities.

Of course, the measures taken to stem the flow of alcohol to those remote communities that have attempted to enforce restrictions, have not stopped their members who chose to drink from doing so. For Aborigines living in communities where prohibition measures have been effective but who do wish to drink, this requires moving to live, or just to drink, in less restrictive, usually town, environments. In those communities where alcohol is available and where resultant problems have been substantial, there have also been population shifts, some people moving to towns where, whilst there is alcohol, the populations are larger and there are social resources that provide a greater measure of security. Others, particularly the elderly, have chosen to move to alcohol free `outstations' further remote from their communities. For some heavy drinkers who travel regularly between these settings, the remote communities and outstations function as effective brakes on their consumption, providing `time out' before resuming drinking.

As during the period of prohibition, contemporary restrictions on alcohol due to remoteness, legislation or community preference, have resulted in economic opportunities. Previously this good fortune fell largely to Europeans who were willing to act as intermediaries. The purchase, transport and sale of alcohol in remote communities now involves Aborigines and non-Aborigines who make rapid profits by supplying large quantities of alcohol around pay and pension days to those communities without a regular supply. Massively inflated prices result in periodic depletion of resources in those liminal economies, and frequently there are also significant increases in social disturbances associated with widespread binge drinking. Thus the periodicity of economic resources in remote Australia, both through block infusions of money derived from social security payments, but also from the relative affluence of those employed seasonally in the cattle industry, powerfully structures social life, in large measure through the intervening variable of alcohol.

Aboriginal drinking in urban centres frequently occurs in the hotels and clubs patronised by the wider society. However, even there, but more generally in remote settings, Aboriginal drinking usually takes place away from the point of sale. Around the towns of remote Australia, depending on circumstances, the site of consumption may be a usual or improvised gathering point. No matter which, drinking is characteristically a social event bringing together family, countrymen, and even groups who, in the past, may not have associated. Drinking circles contain women and men, children, though not participating in the drinking, being omnipresent. An atmosphere of amiability and communion typifies the early stages of "grogging" during which warmth of feeling and an emphasis on sharing is prominent. Tensions may dissipate in the conviviality of the moment and the bonhomie might persist, but may give way unpredictably to disputes and violence, old enmities and jealousies rekindled and new ones ignited.

As the focus of a social activity between Aborigines (as well as a communication to non-Aborigines) drinking has various functions in addition to its pleasurable effects. As mentioned earlier, alcohol structures communities along drinker/non-drinker lines, but in addition it is a significant factor in constructing and reconstructing social relationships between drinkers themselves. As a sought after commodity which is easily distributed, it is easily adapted to rituals of obligatory sharing and reciprocity which were characteristic of traditional resource utilisation. Having and giving alcohol stands as a marker of prestige and an affirmation of relatedness, providing a convenient mechanism for the negotiation of emotional and material credit.

To this end it may, in certain circumstances, be interchangeable with money. For instance, until the recent incorporation of Aborigines into the cash economy of the wider society, those who wished to gamble, and there were many despite the longstanding, widespread and hypocritical moral sermonising of missionaries and government agents, might regularly wager those few items of clothing or the like that were in their possession at the time. Alcohol, as an easily quantifiable exchange commodity, is, in many gambling circles, an even more convenient monetary substitute, just as rum functioned for Europeans in the early days of settlement. However, on the other hand, for Aborigines who take their gambling seriously, drinkers may often be excluded from the circle as drunken behaviour disrupts the important business at hand.

Regardless of age, sex, availability or function, the beverage of choice for Aboriginal drinkers is most frequently full-strength beer, low-alcohol beer constituting a relatively insignificant proportion of that consumed, and being generally disdained. Sweet white wine (Moselle) has emerged in the last decade as the main challenger to beer's supremacy, reflecting the aggressive marketing of two and four litre wine casks, which are portable, easily shared, relatively robust and, not insignificantly, cheap, as wine is given special taxation advantages over other beverages. Fortified wines (port and sherry) also remain relatively popular, spirits, due to cost and to a certain extent because of concerns about the relative toxicity of "hot stuff", are less so. Drinking methylated spirits is, by comparison, uncommon, but does occur in particular communities, usually when the supply of alcohol has somehow been compromised.

As with the general population, from whom it was learned in the first place, the behaviours associated with drinking and the comportment of intoxication have protean manifestations. However, the most socially significant difference to other Australians, of degree rather than type, is the propensity for personal violence which, while reflecting at a fundamental level intercultural forces, is largely confined to violence between Aborigines. Thus, in 1990-1991 the homicide rate for Aborigines nationally was nine times that for the general population. Aboriginal victims were more likely to be female and to be affected by alcohol than victims nationally. Offenders, who were usually male, were also more frequently affected by alcohol than offenders in the

general population, and twice as likely to have had previous convictions for assault. Such violence, a major contributor to the massive excess of Aborigines in the Australian prison population, is, by and large, impulsive and unpremeditated.

The conjunction of alcohol and violence, which often erupts around issues of jealousy, in some settings has become so frequent as to constitute an expected behaviour, particularly for young males. The social circumstances of poverty, the paucity of services in remote settings, the divisions between young adults and older Aborigines, the undermining of the latter's authority and of mechanisms for traditional conflict resolution, effectively lessen the means to contain such violence. This is compounded by cultural constraints that discourage confrontations that would challenge individual autonomy, the culturally legitimate right to do as one will with "my body, it's my life". Arrest for violence associated with alcohol is thus a normative experience for young adult males in some remote communities and in a sense has become an adolescent right of passage, as has drinking itself. Although the conflation of alcohol associated violence with traditional sanctions and punishments has been clearly rejected by Aboriginal groups, alcohol is still commonly invoked on an individual level as a means to explain violence and to absolve the perpetrator of responsibility, thus supporting the externalisation of blame - "it's the grog".

Alcohol has then, by and large, had a negative effect on family, community and traditional life in remote Aboriginal communities. This impact seems to be more substantial than in urban settings, and clearly for certain groups drinking alcohol is an unproblematic social activity. Regardless, as its consequences spread far beyond the limits of the drinking circle, nationwide there are initiatives by governments and Aboriginal organisations supporting sobriety or moderation. Despite these interventions, the overall patterns of consumption in Aboriginal Australia will probably continue into the near future, and are likely to change substantially only as the social and economic disadvantage of Aborigines is redressed.

However the situation is also in flux for other reasons. The first generation of Aborigines who could be legal drinkers as young adults two decades ago are now in late middle age. Given the alacrity with which most Aboriginal males became drinkers, many later giving up alcohol, the lifespan distribution has probably stabilised. That is not the case for women, and the major contemporary change in the prevalence of alcohol consumption is the slowly increasing proportion of young women who are drinkers.

As a consequence, family integrity and functioning are further compromised, with widespread reliance in some communities on older, non-drinking women, as the primary caretakers. Such alcohol associated family instability is normative for Aboriginal children in heavy-drinking environments, exposing them to and teaching them about alcohol and the behaviours expected or accepted that result from its use. `Learning' about drinking thus often begins in childhood and at home, the first direct

experience frequently during early to mid teens. Such experimentation may be facilitated by older teenagers and young adults and is generally not sanctioned by parents or older adults. However, while there may be sharp words of censure, punishment is uncommon and at times adolescent drinking may be overlooked or rationalised. For instance, in some remote areas petrol sniffing has become common among adolescents, contributing to further inter-generational tensions. Generally, reaching the age at which alcohol can be consumed is associated with an abandonment of sniffing in favour of drinking. Consequently, in such situations achieving that status may be welcomed by older Aborigines as an alternative to a behaviour considered a more serious problem and over which they often have little control.

Summary

Just two decades after the lifting of the last legislative controls on Aboriginal drinking, the legacy of prohibition and other racist legislation continues to inform the way in which alcohol is used by Australia's indigenous peoples. While Aborigines are less likely to be drinkers than other Australians, if drinking, they are more likely to do so excessively than those in the wider society, who are themselves, by international standards, heavy consumers. Alcohol is now part of Aboriginal life, as it was of the culture that introduced it. That is not to say that it is accepted as part of Aboriginal culture, a vigorously discussed issue on which hangs more than the semantics of culture versus tradition. Regardless, alcohol affects Aboriginal social life in most of the same positive and negative ways that it does other groups in the nation. At the same time, there are differences which are largely of degree. By far the most significant is the substantially greater levels of harmful consequences which, regardless of the smaller proportions of drinkers overall, affects the Aboriginal community more widely. This harmful potential exists largely by virtue of the culture of poverty that is the lot of most Aborigines and in which drinking occurs, a context in which pervasive and enduring social and economic adversity undermines resilience.

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MONITORING HIV INFECTION AND RISK BEHAVIOUR AMONG EX-PRISONERS IN NSW

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There is a potential for HIV to be transmitted in the prison system in New South Wales. First an overview of HIV infection and transmission in prisons around the world and in Australia will be presented. Then a study will be described in which ex-prisoners in NSW with a history of injecting drug use were interviewed. The study covered the risk behaviours such as injecting, syringe sharing and sexual activity of drug injectors when they were in and out of prison. Recommendations to prevent the spread of HIV within the prison system will be made.

Over ten years ago the first cases of AIDS among prisoners were identified with all seven inmates reporting a history of injecting drug use (Wormser et al, 1983). Since then high levels of HIV infection have been detected in some prisons, usually in cities with high levels of HIV infection among drug injectors.
Harding (1987) noted that the prevalence of HIV in prison will reflect the level of infection among drug users in the community and the proportion of drug users among the prison population.

One of the highest levels of HIV infection among prisoners was found in Spain where one in three male prisoners was infected (Martin et al, 1990). In New York State, 17% of male prisoners were infected (Truman et al, 1988) and in Brazil 18% of female prisoners were infected (Queiroz et al, 1988). In Stockholm 15% of the IDUs in prison populations were HIV positive (Olin & Kall, 1988). Lower levels of infection have been found among heterosexual male inmates in Houston (Williams, 1990) (see table 1).

In some states of the USA the prevalence of HIV among female prisoners has been found to be nearly double that of male prisoners. For example in the state of New York 64,000 prisoners were tested and 12% of the males and 20% of the females were found to be infected. In New York City the levels of infection for males and females were 16% and 26% respectively. Similar proportions of male and female prisoners were infected in Connecticut, Washington DC and Maryland (see table 2).

Table 1: HIV infection in prison

Location	Sample	%HIV+	Study
Spain	631 male	34	Martin
New York St	494 male	17	Truman
Houston	921 het men	8	Williams
Stockholm	IDUs	15	Olin
Brazil	284 female	18	Queiroz

Table 2: HIV levels among male and female inmates in the USA

State	Sample	% Male HIV+	% Female HIV+
New York State	64000	12	20
New York C	17000	16	26
Connecticut	12000	6	15
Washington DC	11000	20	25
Maryland	10000	8	18

A connection between imprisonment and HIV infection has been noted in Spain. A Spanish study of nearly 20,000 prisoners found a HIV prevalence of 30% and that the prevalence of HIV varied depending on the number of times offenders had been in prison. Of those who had been in prison four or more times, 48% were infected. Whereas of those who had been imprisoned less than four times, 21% were infected (Granados, Miranda & Martin, 1991).

A low level of HIV infection is known to exist in Australian prisons. During the calendar year of 1991 in Australia, there were over 34,000 (34,710) prison receptions and over 28,000 (28,756) HIV tests conducted on reception into prison. Of those tested only 71 cases of HIV infection were found, of which only 11 were previously unaware of their HIV status. This gives a national HIV prevalence of 0.25% in Australian prisons in 1991 (Macdonald, Fortuin & Kaldor, 1992). In 1992 the figure was 0.4% (MacDonald et al, 1993).

There have only been 21 documented cases of HIV being transmitted in prison worldwide. Most of these are poorly documented.
Study 1 Repeated testing of 542 inmates in an American military prison in 1985 did not detect any seroconversions (Kelley, Redfield, Ward, Burke & Miller, 1986).
Study 2 A study of 276 inmates in a French prison did not find any seroconversions had occurred during confinement (Espinoza, Balian & Bouchard, 1989).
Study 3 Of 360 inmates who had been in a Maryland prison for more than six years, 136 were tested in 1985. Two HIV positive inmates were detected. Both had been incarcerated since 1976 and 1975 and were therefore assumed to have acquired HIV in prison (Centers for Disease Control, 1986).
Study 4 Repeated testing of 393 prisoners in Maryland in 1987 found that two prisoners had seroconverted. They had been incarcerated for 69 and 146 days when they had last tested negative. However, inmates who refused to participate or were missed in the follow up were significantly more likely to have been committed for a drug offence, be black, or have a sentence of less than 5 years (Brewer et al, 1988).
Study 5 Repeated testing of 1,105 inmates in Nevada found three had seroconverted in prison. The time spent in prison before their last negative tests were 130 days, 20 days and 7 days. It was possible that two of these inmates were infected just prior to entering prison (Horsburgh, Jarvis, McArthur, Ignacio & Stock, 1990).
Study 6 In New York six infected inmates were found to have been incarcerated prior to prevalent infection in the surrounding community and they had been in the system 6 more years before the onset of symptoms (Gaunay & Gido, 1986).
Study 7 At baseline, 808 inmates in Illinois tested negative for HIV infection in 1988. Eight inmates had seroconverted one year later (Castro et al, 1991).

In England, Medley and colleagues used a mathematical model to estimate that 2% of drug injectors who shared syringes in prison would have become infected in 1990. This estimate is equal to 62 inmates contracting HIV annually. The model also showed that the rate of transmission could be reduced by reducing the length of time IDUs spend in prison, reducing the number of IDUs in prison or reducing the number of HIV positive prisoners (Medley, Dolan & Stimson 1992).

Cases of AIDS and HIV infection in Australia

As of June 1993 there had been 17,475 cases of HIV infection diagnosed and 4,258 cases of AIDS in Australia (National Centre in HIV Epidemiology and Clinical Research

[NCHECR], 1993). The total number of IDUs who have been diagnosed as HIV positive in Australia is 822, of whom 303 were homosexual or bisexual males, 379 heterosexual males and 119 females.

In a study in NSW prisons by Potter and Conolly from the Department of Corrective Services approximately half of the sample of 158 prisoners reported a history of injecting drug use (46% of males and 50% of females) and one third (31%) of males and almost half (44%) of the females reported injecting drugs in prison (Potter & Conolly, 1990). A census of the prison population is conducted every June and in 1993 there were 6,087 male and 305 female inmates in NSW (Eyland, 1993).

NSW Prison System

In August 1993, there were 29 HIV positive prisoners in NSW of whom 20 were IDUs (L. McGuiness, personal communication, January 1994). A methadone program operates in NSW prisons and in 1992 there were 463 inmates on the program at any time and 997 during the financial year (Drug and Alcohol Directorate, personal communication, September 1993). There is only one other prison methadone program in the world (excluding withdrawal) and it is in Rikers Island in New York. There has been a comprehensive program of peer education in NSW prisons where inmates are trained to educate other inmates about HIV. Also inmates are provided with bleach and educated about syringe cleaning. In 1990 there were over 400 needles and syringes found in prisons in NSW. Condoms are not provided to inmates in Australia except at the remand centre in the ACT.

AIM of the study

The aim was to recruit 30 HIV positive and 150 HIV negative IDUs who had been in prison in the last year and ask them about their risk behaviours in and out prison. Also blood samples from the respondents were collected to be tested for HIV, Hepatitis B and C.

Respondents were recruited from methadone units, hostels for ex-prisoners or drug injectors, probation offices, syringe exchange schemes, media advertisements, AIDS organisations and via street networking.

In agencies such as methadone clinics, where staff were likely to know the HIV status of clients, staff were asked to approach all those who were known to be HIV positive. Whenever a positive client agreed to take part, the next four clients through the door were also asked to take part. In agencies such as probation offices where staff were unlikely to know the HIV status of clients, an interviewer approached virtually every client who visited during the fieldwork period. Towards the end of the fieldwork period it became apparent that an insufficient number of HIV positive IDUs had been recruited and efforts were made to target them. Advertisements were placed in AIDS

organisations and newsletters that target HIV positive people. Efforts to recruit IDUs away from agencies were made by snowballing from IDUs recruited at agencies. All respondents were interviewed about their last time in prison. This was to increase the prospect of recall. This may result in under reporting as some respondents had injected in prison but not during their last incarceration.

Criteria for inclusion

Originally to be in the study respondents must have been in a NSW prison in the previous 12 months and injected drugs in the previous two years. However, this proved too difficult and the time periods were extended to having been in prison in the last five years (however, the median time since release was 26 weeks) and having injected in the last four years to enable a reasonable number of HIV positive respondents to be recruited.

Findings

Sample

Twenty five HIV positive (20 male and 5 female) and 160 HIV negative (135 male and 25 female) IDUs were recruited. The two groups were similar in terms of age (mean=32 yrs, 32 yrs), age at first injection (mean=19 yrs v's 18 yrs), age at which daily drug injecting commenced (mean=21 yrs v's 20 yrs), age at first sexual contact (mean=14 yrs v's 14 yrs) and age when first imprisoned (24 yrs v's 22 yrs) (see Table 3).

Table 3: Similarities between HIV positive and HIV negative IDUs

	HIV+ *n=25* (mean years)	**HIV-** *n=160* (mean years)
Current age	32	32
Age at 1st injection	19	18
Age when began injecting daily	21	20
Age when 1st sexually active	14	14

Age on 1st imprisonment	24	22

The groups differed in that HIV positive IDUs were significantly more likely to be Aboriginal (24% v's 8%) and to have been in prison less than four times (79% v's 51%). They were also more likely to nominate stimulants such as amphetamines or cocaine as the main drug injected outside prison (43% n=21 v's 28% n=144) and less likely to nominate heroin (57% n=21 v's 70% n=144). Among the males, HIV positive IDUs were significantly more likely to be homo/bisexual (70% v's 13%) (see Table 4).

Table 4: Differences between HIV+ and HIV- IDUs

	HIV+ *n=25* %	**HIV-** *n=160* %
Aboriginal	24	8*
In Prison < 4 times	79	51*
Main Drug Injected Outside Prison:	*(n=21)*	*(n=144)*
Stimulants	43	28
Heroin	57	70
	(n=21)	*(n=135)*
Homo/Bisexual (males)	70	13*

NB: * indicates p<0.01

HIV positive IDUs were more likely to have completed secondary education than HIV negative IDUs, but the difference was not significant (60% n=25 v's 45% n=160). Similar proportions of both groups had undergone previous treatment for drug use (80% n=25 v's 90% n=160), had been detained as youths (24% n=25 v's 38% n=157), had been remanded in custody rather being sentenced when last in prison (36% n=25 v's

29% n=160) and had been on a methadone program prior to imprisonment (36% n=25 v's 46% n=160) and when last in prison (40% n=25 v's 44% n=160).

HIV positive IDUs were imprisoned for shorter periods (mean=26 weeks, range: 1 to 156 weeks), than HIV negative IDUs (mean=43.3 weeks, range: 1 to 276 weeks). HIV positive IDUs had been released for a longer time than HIV negative IDUs when interviewed (mean=64 weeks, range: 1 to 260 weeks v's mean=35 weeks, range: 1 to 259 weeks).

Injecting and syringe sharing

The groups were similar in terms of injecting outside prison (84% n=25 vs 90% n=144) and injecting on a daily basis (67% n=21 vs 66% n=144). Figure 1 shows the proportion of HIV positive and negative IDUs who were injecting and sharing in and out of prison. In the two bars on the left equal proportions of both groups were injecting with less than one quarter sharing syringes outside prison. The two bars on the right show that in prison the proportions who continued to inject decreased but the level of sharing actually increased for HIV positive IDUs.

Figure 1: Injecting and sharing in and out of prison

Basically imprisonment stopped IDUs from injecting safely. Not only were more IDUs sharing in prison but they were sharing with a greater number of people.

Figure 2 shows that outside prison four HIV positive IDUs were sharing with four others, while 47 HIV negative IDUs shared with nearly 150 others within a three month period. In prison the number of others shared with increased dramatically for both groups. Eight HIV positive IDUs reported sharing with over 100 inmates while 50 HIV negative IDUs shared syringes with over 300 others.

Figure 2: Number of people shared with in and out of prison

Syringe cleaning in prison

Over half of the respondents said that bleach was easy to obtain in prison (55%). The efficacy of bleach as an HIV decontaminating agent has recently been seriously questioned (National Institute on Drug Abuse, 1993). For bleach to be an effective disinfectant, it must be full strength (5% sodium hypochlorite) and contaminated objects need to be exposed to bleach for a minimum of 30 seconds. A study has recently examined the how easy it is for inmates to obtain bleach in NSW prisons (Dolan, Hall & Wodak, 1994).

Sexual activity and unprotected sex

The males in the two groups were similar in terms of being sexually active outside prison (95% n=20 vs 88% n=135). HIV positive IDUs were more likely to always use condoms with their regular and casual partners than HIV negative IDUs. This is indicated by the dark section on top of the two bars on the left in Figure 3.

Figure 3: Sexual activity in and out of prison

In prison HIV positive IDUs were significantly more likely to be sexually active than HIV negative IDUs (60% n=20 vs 6% n=135). However as condoms were not available, some HIV positive IDUs engaged in non penetrative sex, but anal sex was the more common type of sex.

Sex partners

Respondents were asked how many sex partners they had outside prison. The HIV positive IDUs had 41 partners while HIV negative IDUs had nearly 400 partners. In prison both groups were less likely to engage in sex, with HIV positive IDUs having 20 partners and HIV negative IDUs having 31 partners (see Figure 4).

Figure 4: Sexual partners in and out of prison

HIV Transmission in prison

Six respondents reported that they had become infected with HIV while in prison. Investigation into one case has confirmed this report (Dolan, Hall, Wodak & Gaughwin, 1994). The other cases are still under investigation.

Comparison of study sample

The study sample was compared to the NSW Prison Census in 1993. The sample reflected the prison population on proportion Aboriginal (9%, 10%), proportion single (48%, 52%), and type of offence: assault (11%, 11%), break and enter (20%, 15%), drug offences (18%, 11%). However, in the sample proportionately more had been previously imprisoned (76%, 59%).

Summary

The potential for the transmission of HIV and other infections in prison in NSW is a major concern. Nearly half of the sample continued to inject when last in prison. Of those who injected in prison virtually all resorted to syringe sharing and with a large number of inmates. In terms of sexual activity there was a high level of unsafe sexual

activity outside prison especially by the HIV negative IDUs. Although few engaged in sex in prison, they did not have the option of using condoms in prison.

Recommendations

It is recommended that:
information is collected on risk behaviours, especially sexual behaviour among prisoners who do not inject drugs;
the prevalence of HIV in prison be measured at regular intervals rather than testing all inmates at an incredible expense;
a study be done to measure the incidence of HIV;
inmates are provided with condoms, over a dozen countries already do so without any problems;
a pilot syringe exchange scheme is introduced and
finally, that alternatives to custody are considered for drug injectors.

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"What's a nice girl like you doing in a place like this?" Meeting the treatment needs of women

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I chose the above title for this paper, not only to provide some competition for John Howard, but also to highlight the stigma that continues to surround women with alcohol and other drug problems and the ways in which these perceptions impact on treatment seeking. The paper will provide an overview of the relevant issues and research concerns in the area, and will use examples of comments made by women who were interviewed for a qualitative study of "self-managed change" or natural recovery to illustrate and contextualise some of the points.

Access and Equity Issues

The extent to which women with significant alcohol or other drug problems are under-represented in the treatment population is unclear. The Epidemiologic Catchment Area (ECA) Study in the United States (Robins, Helzer, Przybeck, & Regier, 1988) demonstrates that both men and women are under-represented in treatment in comparison to their numbers in the population. There are no Australian data on the prevalence of alcohol and drug dependence that are comparable to the ECA data. Instead, the nearest we have to population data is that on the prevalence of "high risk" levels of alcohol consumption derived from self-reported alcohol consumption among men and women in the community. The estimates of alcohol consumption have been derived in different ways in the two studies [by typical quantity frequency in the 1989 National Heart Foundation Risk Factor Prevalence Study (National Heart Foundation, 1989), and by last week of consumption in the 1989-1990 National Health Survey (Castles, 1991)]. High risk in each case was broadly defined in accordance with National Health and Medical Research Council guidelines (Pols & Hawks, 1992). Both surveys indicate that men are 3.2 to 3.7 times more likely than women to consume alcohol at high risk, however, when intermediate (average daily intake of 40g for women) and above levels of risk are considered the ratio drops to 1.6. Neither of these surveys were specifically designed to gather data on alcohol and other drug use or gender issues in health.

The most recent 1992 NCADA *Statistics on Drug Abuse in Australia* report that 6.5% of men and 4.1% of women drank at intermediate to high risk levels and that women's rates of drinking at this level are decreasing more slowly than are men's. The 1992 Census of Clients of Treatment Agencies (COTA) (Chen, Mattick, & Baillie, 1991) found an overall ratio of 4:1 of males to females in treatment as primary clients. This ratio has not improved since the previous survey in 1990. The women in the survey were found to be significantly younger than the men, they were more likely to be in non-residential treatment and were also more likely to have opiates or benzodiazepines as their primary problem drug than the men in the study.

The debate on the role of specialist women's services in an on-going one in this country. Currently women's treatment services receive less than 3% of National Campaign Against Drug Abuse (NCADA) cost-shared funding, which translates to men being excluded from 3.5% of treatment services (for those with such concerns). Many of the services, however, are only available to pregnant women or mothers. In reviewing the 1992 COTA Census, it was revealed that of the services receiving more than 97% of the funding, 38% of them did not treat a single woman on Census day. This may be because they are designated male only or because they failed to meet the needs of women with alcohol and other drug problems in their area.

Morbidity and Mortality

Women appear to be more susceptible to the physical effects of alcohol than are men, a fact reflected in the marked difference in recommended safe levels of alcohol consumption for men and women (Pols & Hawks, 1992). This increased susceptibility probably arises for a number of reasons. First, women have a smaller liver and substantially smaller blood volume than men so that concentration of alcohol in their vital organs is higher. Second, this effect is enhanced by the higher ratio of fat to lean tissue in women, as alcohol is relatively insoluble in lean tissue. Third, there are suggestions that women are especially sensitive to liver infection and inflammation, which is possibly due to the action of oestrogen (Krivanek, 1982). A further effect of oestrogen is to delay the metabolism of alcohol in women who are taking the oral contraceptive pill (Jones & Morgan-Jones, 1984). One consequence of these factors is that, for a given dose of alcohol, women achieve a higher blood alcohol level more quickly than men. Women have a more rapid rate of absorption, and the peak blood alcohol level that is achieved is consistently higher than in men. Even when weight differences are taken into account, women are more likely to become intoxicated at a given dose of alcohol than are men, and this is especially likely in the premenstrual phase (Jones & Jones, 1976).

Another consequence of the sex difference in alcohol absorption and metabolism is the greater vulnerability of women to many of the adverse health effects of alcohol. This is reflected in the overall mortality rate among dependent drinkers. While the death rate among male alcoholics has been reported to be two to three times greater than that of

men in the general population, the death rate reported for alcoholic women is 2.7 to 7 times that of women in the general population (Hill, 1983). Direct comparisons of alcoholic men and women matched on demographic characteristics suggest that excess mortality is more pronounced among alcohol dependent women (Hill, 1983).

Women who use illicit drugs, particularly injecting heroin users, enter an even more conspicuously male-dominated sub-culture. Just as women suffer the consequences of not being appropriately represented in wider society, female IDUs are considered doubly deviant and are doubly damned (Broom & Stevens, 1992). As males largely control access to illicit drugs and frequently inject their female partners, they use the injecting equipment first (Rosenbaum, 1981). A number of studies have now reported that female IDUs are significantly more likely to have a partner that injects drugs than are male IDUs (Rosenbaum & Murphy, 1990; Wells & Jackson, 1992). As a result of these and other factors, female IDUs are known to engage in higher levels of HIV risk-taking behaviours as they have less possibility for autonomy of decision making in how injecting behaviours will be conducted (Barnard, 1993; Darke, Swift, Hall & Ross, 1994).

A recent Italian study that examined a cohort of 4200 injecting drug users (IDUs) enrolled in methadone maintenance programs found that the mortality rate for the entire cohort was 10.1 but there was a significant gender difference of 9.3 for males and 18.1 for females. The large excess of mortality in both sexes was found for infectious, circulatory, respiratory, and digestive diseases as well as for violence, overdose and Acquired Immune Deficiency Syndrome (AIDS). There was an increased mortality among the women for pneumonia and septicaemia and for malignancies in males (Perucci, Davoli, Rapiti, Abeni & Forastiere, 1991). A later study on Scotland that retrospectively examined 1989 data on injecting drug use and mortality also found a significantly higher mortality for female IDUs (0.85% for women compared to 0.42% for men). This represents a relative mortality risk for female IDUs compared to female non-IDUs of 4 times higher but only 1.5 times higher for male IDUs compared to non IDUs (Frischer, Bloor, Goldberg, Clark, Green & McKeganey, 1993).

Concern about the consequences for physical health of alcohol and other drug use is one of the most frequently cited reasons that women give for seeking treatment (Brown, Gauvey, Meyers & Stark, 1971; Gomberg, 1986). In a study of three brief cognitive-behavioural treatment for problem drinkers, women who reported more physical symptoms at intake had superior treatment outcome than those reporting less physical consequences of heavy drinking (Sanchez-Craig, Spivak & Davila, 1991). In addition to the physical discomforts of nausea, diarrhoea and other gastrointestinal symptoms of alcohol misuse, women also suffer disturbances of endocrine function and an increased susceptibility to the development of certain malignancies.

A number of authors have suggested that various forms of addictive disorders co-exist. The most significant group of co-existing disorders among women are eating related.

Such co-morbidity may lessen the effectiveness of treatment, and may not be recognised by clinicians who specialise in one form of addiction (Goldbloom, Naranjo, Bremmer & Hicks, 1992; Higuchi, Suzuki, Yamada, Parrish & Kono, 1993; Peveler & Fairburn, 1990). In one study of 386 patients admitted for substance abuse 15% of 143 women had a lifetime diagnosis of anorexia or bulimia nervosa compared to only 1% of 243 men (Hudson, Weiss, Pope, McElroy & Mirin, 1992). Along with anorexia nervosa, women with alcohol and other drug related problems, and their families, are significantly more likely to have a co-existing problem with bulimia than are women who do not have substance misuse disorders (Bulik, 1987; Walfish, Stenmark, Sarco, Shealy & Krone, 1992; Lacey & Moureli, 1986). While the nature of the relationship between these types of disorders and psychoactive drug use is uncertain, it appears that women presenting with these disorders should be carefully screened for concomitant alcohol or other drug problems (and vice versa) because failure to treat disorders such as bulimia may precipitate a relapse to substance use (Katzman, Greenberg & Marcus, 1991).

The following quote is from R aged 22 who had been recovered from a severe alcohol and injecting speed dependence for 3 years: "*I was anorexic at 11 and again at 19. I got over it at 11 through drugs. At 19 I went on to become bulimic and the nightmare began. The obsession with food and weight and body image totally took over my life but the bulimia is what got me into the depths of despair and depression*"; and E also aged 22 who had been recovered from problems with the same drugs for 14 months: "*I gave up drugs and alcohol but picked up food and became bulimic..my bingeing and vomiting had become so bad that I had a big scab on my knuckle.*"

Psychiatric Co-morbidity

Dependence on alcohol and/or other drugs is also associated with a number of debilitating psychological disorders in women. The causal relationship between many of these disorders and substance misuse are extremely complex and remain unclear. A number of studies report the co-incidence of anxiety disorders (Roth, 1989), panic disorders (Otto, Pollack, Sachs & O'Neil, 1992; Pollard, Detrick, Flynn & Frank, 1990) and agoraphobia (George, Nutt, Dwyer & Linnoila, 1989) with alcohol and other drug dependence among women. Some of the many complicating factors in this nexus of anxiety related disorders and psychoactive substance dependence include the increased likelihood of women being inappropriately prescribed benzodiazepines and other sedatives for social rather than therapeutic reasons (Ettorre, 1992; Hancock & Sanson-Fisher, 1992; Wyndham, 1980). As withdrawal from both alcohol and benzodiazepines may precipitate and intensify anxiety and panic symptoms it can create an extremely complex clinical problem. Benzodiazepine use has been associated with a dependence syndrome and as contributing to morbidity and mortality from abuse, poisonings and attempted suicides among women (Lockwood & Berbatis, 1990). Among injecting drug users, benzodiazepine use has been identified as a predictor of

higher rates of injecting and engaging in more HIV risk-taking behaviours (Darke, Hall & Ross, 1992).

One of the other common co-existing disorders for women who have eating and/or substance dependence is depression. A deepening depression is frequently cited as the main reason that many alcohol and drug dependent women seek treatment (Gomberg, 1986). Alcohol dependent women are more likely to have attempted suicide than are alcohol dependent men or non-alcohol dependent women (Parker, Parker, Harford & Farnmer, 1987). It has been estimated that between one-quarter and two-thirds of alcohol dependent people experience symptoms of depression that are severe enough to interfere with daily functioning (Gomberg, 1989). Women are more likely to report such depressive symptoms than are men (Schuckit, 1986).

For the majority of alcohol dependent people the symptoms of depression are caused by the effects of alcohol use and withdrawal on the central nervous system, and occur only during, or shortly after, periods of heavy drinking (Turnbull & Gomberg, 1988). However, some symptoms of depression seem to be unrelated to consumption or withdrawal, and major depression that precedes alcohol dependence (primary depression) appears to cause more impairment than depression that occurs simultaneously with, or after alcohol problems (Rousaville, Dolinsky, Babor & Meyer, 1987). It has been reported that the structure of depression in alcoholic and non-alcoholic women does not differ significantly (Turnbull & Gomberg, 1990). Women generally appear to be more prone to suffer from primary depression than do men. However, alcohol dependent women with primary depression that is detected and treated are more likely to have an improved outcome than is the case for alcohol dependent men with primary depression (Rounsaville et al, 1987). In a recent Australian study of psychopathology among opioid users, measured by scores on the General Health Questionnaire (Goldberg & Hillier, 1979), found that women had significantly higher scores for anxiety, depression, somatic symptoms and social dysfunction than males in the sample (Darke, Wodak, Hall, Heather & Ward, 1992).

The self-esteem of alcohol dependent women has also been reported to be significantly lower than that of alcohol dependent men and non-alcohol dependent women (Beckman, 1978; Gossop, 1976). In the same studies it was found that the more alienated, socially isolated, depressed and anxious the alcohol dependent women felt, the lower was their self-esteem (Beckman, 1978; Regan, Leifer & Finnegan, 1984; Sanford & Donovan, 1985). The nature of the relationship between alcohol and other drug dependence and self-esteem is yet to be established. It may be that there is a causal relationship between self-esteem and alcohol dependence that operates in both directions: women with low self-esteem are more likely to misuse alcohol, and the misuse of alcohol, with its dysphoric effects and the increased guilt and social stigma, further decreases self-esteem. The effect of low self-esteem on the learning of new behaviours (such as abstinence or moderated drinking) is unknown, but it may be surmised that persons with low self-esteem believe that they are unable to learn new

skills or feel insufficiently at ease with themselves to be able to enjoy life without the altered perceptions induced by high levels of alcohol or other drug use. An Australian study of controlled drinking intervention found that self-rating on a problem drinking self-efficacy scale significantly predicted alcohol consumption at six-month follow-up (Sitharthan & Kavanagh, 1991). Clinicians working with alcohol dependent women have also reported that enhancing self-esteem is an effective treatment strategy (Bersak, 1990).

Women who are alcohol and drug dependent are more likely to engage in poly-drug use than are men (Blankfield, 1989). Alcohol dependent women, especially younger women, are more likely to have a problem with tranquillisers, hypnotics, analgesics and/or amphetamines but are less likely to use other illicit drugs than are alcohol dependent men (Blume, 1986). This is not related to the psychoactive properties of illicit drugs but because women are sensitive to the social and legal sanctions against illicit drug use (Berridge & Edwards, 1987). In the nineteenth century women, particularly upper class women who suffered from extreme boredom and the "cult of female invalidism", (Ehrenreich & English, 1973) were much more likely than men to use opiates. The historical patterns of substance use by women are testimony to the powerful influence of culture and social mores (patriarchy) on all aspects of women's lives.

Correlates of Dependence

A variety of evidence suggests that men and women differ in the ways in which they become dependent upon alcohol and other drugs. The notion of dependence is a complex and problematic one. A number of studies indicate that alcohol dependent women start both social and heavy drinking at a later age than alcohol dependent men (Broom & Stevens, 1992). In addition, women drink smaller amounts, and less often, for comparable levels of alcohol dependence. These data indicate a "telescoping" in the development of alcohol dependence in women, with a more rapid development of alcohol dependence problems in women than men (Piazza, Vrbka & Yeager, 1989).

The difference in the time course of developing dependence may reflect differences between men and women in the importance of genetic and environmental contributions to drug and alcohol dependence. The consequences of heavy drinking also differ between men and women. While women accumulate the same number of alcohol related problems as men in treatment, they do so in four less years (Ross, 1989). The types of problems alcohol and drug dependent women experience also differ. Women are more likely to experience family (Beckman & Amaro, 1986; Brennan, Moos & Kim, 1993; Klee, Schmidt & Ames, 1991; Robbins, 1989; Waller & Lorch, 1978) and psychological problems (Benishek, Bieschke, Stöffelmayr, Mavis & Humphreys, 1992; Darke, Wodak, Hall, Heather & Ward, 1992; Hesselbrock, 1991; Robbins, 1989). This may be because the drinking of alcohol dependent women is more often solitary than that of alcohol dependent men, with women favouring private drinking either alone or

with their partners at home rather than in public places where they may be vulnerable to physical attack and strong social disapproval (Kagle, 1987; Sokolow, Welte, Hynes & Lyons, 1980). Men more often drink in public places and with peers, and hence are more likely to experience conflicts with the public and legal sector as a result of their drunkenness (Argeriou & Paulino, 1976; Shore, McCoy,Toonen & Kuntz, 1988). Because more men than women are in paid employment they have higher rates of job loss for inebriety than do women.

Domestic violence

While alcohol dependent men display more violence when drinking than do women, it is women drinkers who are more likely to be the victims of violence (Campbell, Poland, Waller & Anger, 1992; Frieze & Schafer, 1984; Miller, 1990). Much of this violence occurs in a domestic context. While the aetiology of domestic violence is complex, one of the contributing factors for women with alcohol and other drug problems is that they are much more likely to have a partner with similar problems than are men. The following quote is from A, a 37 year old woman who was dependent on cocaine - "*by that time my marriage was not good and work was everything. I don't know if there is a connection but for me there was - the two went hand in hand - the cocaine kept me at work and it made me work longer - I wanted to work longer, I needed that - I needed to be totally self absorbed in what I did, I liked it and also I had nothing else. I don't know - maybe if I had had a happy marriage, if there had been a connection there..but I was married to a nut case..he was violent and emotionally abusive and I went from my family to boyfriend to husband like that ..and it was only once I realised there was a problem in several areas that I decided that I had to stop this.*" This quotation serves to highlight the impossibility of separating the complex interconnections of issues in peoples lives and to emphasise the need for highly trained therapists and long term interventions for this group of clients.

Dependent children

The majority of women with substance dependence problems are mothers (Eldred & Washington, 1975) and are more likely than men to remain responsible for their children (Gerstein, Judd & Rovner, 1979; Moise, Reed & Ryan, 1982). Concern about losing custody of their children often prevents these women from admitting that they have a problem with alcohol or other drugs. A significant proportion of women not only have concerns about government agencies removing their children, but are also unable to afford, or do not have access to, appropriate childcare while they seek treatment.

Childhood sexual assault

Women who have a history of sexual abuse in childhood and adult life appear to be over-represented among women seeking treatment for alcohol and drug dependence (Hurley, 1991; Wilsnack, 1984) and psychiatric disorders (Singer, Petchers & Hussey,

1989; Swett, Cohen, Surrey, Compaine & Chavez, 1991). As in community samples (Russell, 1983), women in substance dependence treatment also appear to be much more likely than men in treatment to report a history of sexual assault (Wallen, 1992). This may reflect the long-term consequences of unresolved sexual abuse, particularly in childhood, but it is difficult to be sure because the literature on the role of sexual abuse in the aetiology of substance dependence lacks clarity and consistency of definition, and there are few controlled studies that have used prospective designs. The sequelae of childhood sexual abuse has been likened to the symptoms of the post-traumatic stress syndrome, which include chronic fear, reliving the experience in a variety of ways, and feelings of anxiety, anger and depression (Van der Kolk & Herman, 1987). In accord with relapse prevention theory (Marlatt & Gordon, 1985) it has been suggested that an alcohol or drug dependent woman who has not had the opportunity to resolve these symptoms is more prone to relapse because she lacks the skills necessary to deal with flashbacks or nightmares (Young, 1990).

Women who have been sexually abused in childhood appear to have a strong need for a physically and emotionally safe treatment environment because their trust has been seriously violated in the past (Gelinas, 1983). Such women feel especially vulnerable in a residential mixed-sex treatment environment. In addition to lack of physical safety, these women are unlikely to discuss these experiences in a mixed-sex group, or with male therapists. Therefore, traditional mixed-sex treatment services are unlikely to appeal to women with a history of sexual assault. Many authors have discussed ways in which treatment environments can be made more suitable for women with histories of sexual assault (Chiavaroli, 1992; Russell & Wilsnack, 1991) and how this might impact on treatment outcome (D'Ercole & Struening, 1990).

The following quotation is from R, a 23 year old woman with poly drug dependence - *"I got assaulted in the park by a man when I was 12 and raped when I was 14...I was off my face at the time - I didn't tell anyone as I wasn't supposed to be out"*, and B, a 23 year old woman who had recovered from alcohol dependence for 2 years - *"..it was a stranger, he was an older boy who went to school, in year 12 and I was in sixth class ...one day he assaulted me in a children's playground and I got so scared. I didn't tell my parents until I was 16, because I felt that I had done it - that I was evil and bad and I'd caused it. When I finally told mum it was a relief - I'd been carrying that around for 5 years feeling that I'd made it happen...it was very damaging when you're that age - I thought I must have attracted it, I must have asked for it and I'll have to be careful not to send out those messages again but I didn't know what messages I was sending - I was playing in a playground"*. The question of women with a history of childhood sexual assault feeling safe in treatment is an important one as 25% of women in a current study we are undertaking report having experienced sexual harassment in a treatment setting.

Social stigma

When the role of women in society is equated with the stabilising functions of wife and mother, drunken women pose a special threat. While drunken behaviour by either sex is socially condemned, a drunken woman is doubly so. A number of researchers (Blankfield & Maritz, 1990; Gomberg, 1987, 1988) have reported that women with substance use problems believe that society in general views them as more `out of control' and morally degenerate than men with similar problems. One result of this greater social stigma attached to women with substance use problems is that they may be more reluctant to enter a treatment facility for drug and alcohol problems, where their diagnosis will be obvious. They may be even less likely to seek treatment in an agency that uses confrontational techniques, wherein women are forced to accept and identify with the stigmatising label of "addict" or "alcoholic". It is not surprising that women with substance use problems are more likely than are men to seek medical treatment for interpersonal or psychological problems (Beckman & Amaro, 1982), or to contact psychiatric services (Dahlgren & Myrhed, 1977; Weisner & Schmidt, 1992) without informing these professionals about their alcohol or other drug problems (Johnson, 1965).

The following quotation is from K, a 24 year old woman who had recovered from heroin dependence for one year - "*..looks down on women definitely, like in everything.....people find women pissed an insult and totally objectionable, where as with a man they think gee he must be having a really bad day..*"; and B - " *with the AA meeting and the psychiatrist I felt like I was labelled, and the first thing he said was .."oh you're a recovering alcoholic so were you promiscuous?" He obviously had a set opinion about how an alcoholic women would be. I'm sure they wouldn't ask a guy that...they would have patted him on the back and asked if he'd scored."*

As a result of these and other barriers to women seeking assistance for their alcohol and other drug problems in designated treatment services, it has been found that women attending general medical and mental health services have a greater relative risk of problem drinking than do men attending such services (Weisner & Schmidt, 1992).

Research Issues

The creation of specialist womens treatment services has been one suggested way for dealing with the insensitivity of existing drug and alcohol services to the special issues of women. Such services would provide treatment by women, for women. They aim to address the special issues facing drug and alcohol dependent women, such as sexual issues and sexual abuse, in a safe and secure environment that provides care for dependent children. The existence of such services also enables women practitioners to develop the necessary expertise to deal with drug and alcohol dependence in women, expertise that could be used to better meet the needs of women within traditional mixed-sex services.

The development and empirical validation of such specialist treatment services for women has been frustrated by the paucity of research in this specialist area. Despite the growing theoretical support for the provision of such specialist services, little empirical work has been conducted on them because so few services have been established, and even fewer have been extensively researched. As a consequence, the bulk of the published literature on these services consists of program descriptions (Marsh, 1982; Reed & Leibson, 1981) and a small number of uncontrolled treatment outcome studies that lack comparison groups (Cuskey, Richardson & Berger, 1978; Smith, 1985). The effect on treatment outcome of moving away from the prevailing male-dominated models of treatment for women has yet to be adequately tested. The prevailing treatment models are based upon services that catered primarily to men and have, as a consequence, been informed by the experiences of men.

The Randomised Control Trial

The sole exception is a study conducted by Dahlgren and Willander in Sweden (Dalhgren & Willander, 1989). This was a 2-year follow-up study of 200 women who were attracted into treatment at an early stage of alcohol dependence. Half were randomly allocated in a specialist women's service and half into a traditional mixed-sex treatment program. The median age of the women was 42 years, 90% were employed, and two-thirds lived with a male partner. None of the women had received previous treatment, had a history of psychosis or used narcotic drugs. The specialist treatment consisted of a medicated detoxification and a brief in-patient hospitalisation in a unit that employed only professional staff (physicians, nurses, psychologists and social workers). The residential treatment phase was followed by a one-year out-patient program that consisted of individually tailored programs. It included thorough medical care and psychological, social and welfare investigations, and was delivered in individual and group sessions.

At two year follow-up, 72% of the sample were contacted and the women who attended the specialist womens service had a more successful outcome in terms of alcohol consumption and social adjustment than the women who attended the traditional mixed-sex service for a comparable length of time. The social aspects of treatment outcome that reached statistical significance included job loss, (4% versus 17%), improved relationship with their children (35% versus 12%) and voluntary removal of their children (5% versus 25%). Outcomes measures related to mortality found that there was a statistically significant excess mortality for traditional mixed-sex clients but not the specialist women's service clients, and for requiring inpatient care for relapse (16% versus 31%) during the follow-up period.

An Australian Quasi-Experimental Study

This study by Copeland & Hall (1992) took advantage of the recent introduction of a specialist womens treatment service to evaluate its impact on drug and alcohol use in a

population of women who were more severely dependent on drugs and alcohol than those treated in the Dalhgren and Willander study.

Unfortunately a randomised controlled trial was not a practicable option as the research team had no control over the allocation of subjects to treatment; moreover, it is doubtful that this would have been acceptable to the staff in the programs that were evaluated. Consequently, the study design was a comparative outcome study which involved a six month study of changes in drug and alcohol use and associated problems in eighty women attending the specialist women's service and in a comparison group of eighty women attending two traditional mixed-sex treatment services. It was found that the specialist women's service attracted and retained in treatment significantly more women with dependent children, lesbian women, women with a history of childhood sexual assault and women with a maternal history of substance dependence. At six-month follow-up there were no statistically significant differences in treatment outcome due to low statistical power and the lack of difference in treatment content between the two types of services.

Gaps in the Research

There are a number of priority areas for on-going research in the women and drugs field. These include:

_prevention & treatment issues for "hidden populations" such as aboriginal women (particularly urban groups), lesbian women, young women and women from non-English speaking backgrounds;

_women and girls in custody as the social justice issues in the women and drugs field are highlighted in this area. This issue will be focussed on in the *1994 Women and Drugs Conference: Challenge, Consensus and Change*;

_brief/early interventions in non-health care settings;

_the natural history of substance use problems among women. This might take the form of a 20 year longitudinal study of the factors influencing the acceleration and amelioration of substance use among a representative sample of women;

_an examination of the implications of the disease model for women. This quotation from A, illustrates some of the relevant issues - *I'd heard of AA but I wouldn't be caught dead in one of those. I've never been to one but I wouldn't go to one. The christian ethos around it is not my scene. The Salvation Army did some brilliant things for alcoholics, but it doesn't suit everybody because of the shame that goes with it. You're intelligent enough to know what you're doing is destroying yourself but you're not going to stand up in front of 50 people and say that every day. You're already*

hitting yourself over the head every day for what you're doing you don't need anyone else to do it for you. What you need is self-esteem";

_the role of mutual support groups in relapse prevention among women. These study might explore the process of mutual support, an examination of which women benefit most from involvement in these groups and what the treatment community can learn from members of such groups in the management of relapse prevention; and

_the development of methodologies to explore the concept of "co-dependency" and related diagnoses of self-defeating personality disorder. These days it appears that to err is dysfunctional and to forgive co-dependent. Many feminists were initially attracted to the notion of co-dependence, which was a spin-off of the American treatment industry, because of mutual concerns about abuse and child welfare. Co-dependence was originally used to label spouses of alcoholics but now according to some authors in the field, 96% of the population suffer from this life long, fatal disease (Schaef, 1991). In practice, however, this diagnosis is primarily applied to women and what used to be bad habits and problems are now a full blown cult of victimhood. This pathologising of women's lives demonstrates the sad truth that women have to declare themselves sick and in recovery in order to find community with other women (Krestan & Bepko, 1991). This life long victim mentality also diverts individual women from constructive, empowering activity and dissipates the strength of the women's movement. While I don't wish to detract from individual's positive experiences with co-dependency, I do wish to call into question its clinical utility and contribution to social change that impacts upon the lives of all women.

Current NDARC Projects

A Study to Identify Alcohol & Other Drugs Treatment Issues for Women

This study is a two year project funded by the *Research into Drug Abuse Grants Program*, of the Commonwealth Department of Health, Housing, Local Government and Community Services which commenced in February this year. Ms. Wendy Swift is the Project Officer and we consult with a national reference group. The project involves interviewing 300 women in the following phases:

- interviewing women in drug and alcohol treatment services, including a wide variety of traditional, gender-sensitive & methadone maintenance programs around the country;

- interviewing 150 staff in treatment agencies for views of client needs and experiences;

- interviewing women in generalist health care settings such as women's health centres and general medical practitioners;

- interviewing women in a variety of self-help groups; and

- a qualitative study of self-managed change" - women who have recovered from problem use for more than one year without any formal treatment or self-help group attendance.

Study of the Relationship Between Childhood Sexual Assault (CSA) & Substance Misuse Problems Among Women

This study is a two year project funded by the *Research into Drug Abuse Grants Program*, of the Commonwealth Department of Health, Housing, Local Government and Community Services which commenced in May this year. Ms. Tracey Jarvis is the Project Officer. The project has a four group design, with fifty women in each group taking part in the quantitative aspect of the study and fifteen in each group going on to a qualitative interview. The four groups consist of women in substance dependence treatment with and without a history of childhood sexual assault and women in childhood sexual assault counselling with and without a history of alcohol and other drug problems.

The project has a number of hypotheses to explore including the predictors for the development of substance use problems among women with a history of CSA, the reasons for primary help-seeking and the relationship of unresolved CSA issues to relapse to substance misuse following treatment.

General Recommendations

_ **Principles of treatment should encompass a Social Model of Health and be consistent with the *1989 National Women's Health Policy Guidelines*. These include recognition of a women's right to be treated in an environment that provides for privacy, informed consent and confidentiality. She should be provided with interventions that are based on appropriate research.**

_At least one specialist women's service should be provided in each capital city.

_A non-threatening environment should be provided.

_Childcare should be available.

_Women should be able to make an <u>informed choice</u> of treatment goal.

_Individual counselling by professional staff should be available with the option of a female counsellor.

_Women-only groups to be provided frequently.

_Parenting issues should be addressed, including the possible intervention needs of the children.

_The question of sexual and other assault should be discussed. On-going counselling MUST be available and the decision of the client about the timing of therapy respected.

_Women should be offered referral to "mutual-help" groups where appropriate.

_As dictated by the Social Model of Health concerns about welfare, housing, educational and vocational issues should addressed in treatment and an appropriate network of suitable referrals developed;

and that

●**Women should continue to be a NCADA priority group for research and treatment provision funding**

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IRRELEVANT, UNAPPROACHABLE OR BORING: TREATMENT ISSUES FOR DRUG-USING YOUTH

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1. Introduction:

In attempting to make some cogent comments concerning issues related to the treatment of young people who are experiencing difficulties with alcohol or other drug use, it is useful to briefly review what is known of the levels, origins and development of such use.

1.1: Use of drugs by young people:

In New South Wales, and other states, regular attempts are made to sample high school students (Cooney, Dobbinson & Flaherty, 1993; Health and Community Services, Victoria, 1993) and TAFE students (Keys Young, 1993). There have been less regular surveys of various groups seen to be more `at risk', e.g. young offenders (Crundall, 1987; Howard & Zibert, 1990; Zibert, Hando & Howard, 1993), street youth (Hirst, 1989; Howard, 1992a; Porritt, 1991), those in treatment (Dunsmore House, 1993) and specific groups such as amphetamine users (Hando & Hall, 1993). General trends have also been reported by Oldenburg and Lemon (1992) and Tebbutt, Muir and Heather (1991). As most surveys rely on self-reports by young people, there is a need to be cautious in any interpretations of the data (Oldenburg & Lemon, 1992).

In general, the high school surveys showed a trend towards reduction of drug use from 1983 to 1989, but the 1992 survey showed some concerning changes. The trends for NSW high school students are quite similar to those for Victorian high school students as revealed in their 1992 survey (Health and Community Services, Victoria, 1993). Surveys of particular populations (young offenders, street youth and residents in adolescent detoxification facilities) show much higher levels of use (Crundall, 1987; Hirst, 1989; Howard, 1992a; Howard & Zibert, 1990; Zibert et al, 1993).

For example, a reduction in **regular use of alcohol** was reported [from 33% of boys and 32% of girls in the high school survey of 1983 to 20% boys and 16%

girls in 1992] (Cooney et al, 1993). This decline has continued a trend from 1983. However, 78.8% of detained young offenders (Zibert et al, 1993), and 75% of males and 73% of females in the street youth surveys (Howard, 1992a) used alcohol regularly. For TAFE students, 65 to 79% of males and 56 to 72% of females drank weekly, with 18 to 24% of males and 3 to 13% of females very often getting drunk (Keys Young, 1993). About 40% of male and 30% female high school students reported binge drinking.

Regular use of nicotine has increased since 1989 for high school students, after a decline from 1983 figures [from 13% of boys and 17% of girls in 1989 to 17% boys and 20% girls in 1992]. Between 28 and 36% of male and 23 to 31% of female TAFE students smoked daily. For detained young offenders, 90% were regular users, as were 90% of males and 93% of females in the street youth sample.

For **cannabis** there has been a significant increase in **experimental** use for the high school sample, which represents a return to 1983 levels (from around 25% of boys in 1983 to 30% in 1992, and for girls 22% in 1983 down to 15% in 1989 and up to 21% in 1992. Figures for **regular**/at least weekly use also increased: from 7 to 10% for boys and from 3 to 5% for girls. For TAFE students, between 16 and 29% of males and 9 to 17% of females reported weekly use. Of the detained young offenders 69% were regular users, as were 79% of the males and 76% of the females in the street youth survey.

For **opiates**, while less than 5% of the male high school students reported having tried them this was an increase on the 3% for 1989. Less than 1% reported **regular** use. Of the detained young offenders, 10% were regular users (18.6% had tried them), and 34% of male and 51% of female on the street youth were regular users (about 60% had tried them). Between 4 and 10% of male and 2 and 4% of female TAFE students have tried opiates, with about 1% being regular users.

For **stimulants:** 15% of male and 7% of female high school students aged 17 had tried them, whereas about 27% of the detained young offenders were **regular** users (53% had tried them) and 36% of the male and 55% of the female street youth sample were regular users (between 64 and 76% had tried them). Between 14 and 19% of male and 10 and 20% of female TAFE students have tried stimulants, with between 3 to 8% being regular users.

Inhalant use increased from 1989 to 1992 with 25 versus 32% of boys and 24 versus 30% of girls in the high school survey reporting that they had used these substances. There was also a rise in ever having tried **hallucinogens:** up from 6.4 to 8.7% for boys during 1989 to 1992 and from 3 to 5% for girls.

Less than 3% of all high school students reported **using a needle** to inject a drug in the 1992 survey (first time the question was asked). However, this mean

percentage includes 11% of males aged 17, of whom 7% reported frequent/at least weekly use of needles. In the Hando and Hall (1993) study of amphetamine users, over 69% reported use of needles, with at least one third sharing injection equipment. Over two thirds of a street sample had injected drugs, primarily amphetamines, with heroin being the next most commonly injected drug (Porritt, 1991).

Age of onset of illicit drug use appears to be earlier for the more `deviant' groups, and use increases with age. For young offenders, the approximate mean age of first use of illicit substances is 12, one year after mean age of first use of licit substances.

1.2: Initiation of Use:

It is generally accepted that the best predictor of experimentation with licit and illicit substances by young people is adolescence itself. Adolescence is a time of experimentation, exploration, curiosity and identity search and part of such a quest involves some risk taking behaviour. Within a milieu of social and peer influence and expectancies, together with easy drug availability, drug use becomes one aspect of this developmental process. When surveyed, young people often indicate that boredom, curiosity, wanting to have fun and to feel good are perceived as the main reasons for drug use (Howard, 1992b; Howard & Zibert, 1990; Zibert et al, 1993).

Most young people who initiate drug use do not develop significant problems; experimentation and a variable pattern of drug use onset and termination are common (Newcomb & Bentler, 1989; Tarter, 1990). Indeed, as Moore and Saunders (1991) have stressed "the use of drugs in some social settings is part of the social construction of meaning for individuals and groups" and that drug use is "almost always functional" (p.30). They continue: "in our view, drug use is rarely pathological, deviant or mindless, nor is it usually the result of estrangement from `agents of socialisation'. It is an activity which is almost universal across the globe, has many benefits, and is arguably part of normative adolescent development" (p.33).

The aetiologies of drug use initiation, occasional use, regular use and dependency may well be different (Hawkins, Lishner, Catalano & Howard, 1985; Robins & Przybeck, 1985). Nevertheless, some young people may be more likely to experiment, experiment earlier, and find such experimentation rewarding. While not espousing an "addictive personality" or the inevitable onset of drug use for young people with an accumulation of negative life experiences, and hopefully without falling too far into the `pathology paradigm' pit (Moore & Saunders, 1991), it is generally believed that those young people who maintain and escalate their use are more vulnerable to the presence of more problematic backgrounds, and lack of accessible internal and external resources. Earlier onset of use and continued use are strongly

associated with other "problem" behaviours such as: delinquency, precocious sexual behaviour, anti-social attitudes, and "failure" at and dropping out of education (Hawkins et al. 1985: Newcomb & Bentler, 1989). It is recognised that all of these behaviours, at some level, may be regarded as more or less functional attempts to cope with a wide variety of affects, circumstances and predicaments.

Those young people who reach the attention of alcohol and other drug agencies, the juvenile justice or welfare systems, are not typical of all young people who have ever used, or who do occasionally use, illicit drugs. Rather, the evidence "shows that in the main, young people who use drugs persistently or most destructively, do so largely to banish unpleasant sensations such as anxiety, depression and frustration. Those young people whose illicit drug use reaches the attention of the welfare or correctional system, often have experienced disrupted family backgrounds and are finding life intensely disagreeable in the present. Their use of illicit and other drugs as a source of relief holds compelling and - in the light of the adversities which many are obliged to face - quite understandable attractions for them" (Brown, 1991, p. 69).

1.3: Maintenance and Escalation of Use:

For those young people who continue or escalate their drug use, a variety of correlates have been explored:

Genetic: While there is some evidence for a genetic link, it is difficult to separate this from family influences, and the magnitude and mechanism of influence are not clear. The evidence is stronger for the transmission of male alcohol use (Bailey 1989; Hawkins et al., 1985; Newcomb & Bentler, 1989).

Family: Research findings generally relate to: parent-child relationships; the quality and consistency of family management; family structure; attachment; communication within the family; modelling of substance use; approval and tolerance of use; involvement; absence of closeness of parents; low educational aspirations for the children; lack of parental involvement in child's activities; weak parental control and discipline; death or absence of a parent; and emotional, physical and sexual abuse (Baumrind, 1985; Cavaiola & Schiff, 1988; Dembo et al., 1988; Dielman, Butchart, Shope & Miller, 1990-91; Hawkins et al., 1985; Farber, Kinast, McCoard & Faulker, 1984; Hoffmann, 1993; Janus, Burgess & McCormack, 1987; McCormack, Janus & Burgess, 1986; Murray & Perry, 1985; O'Connor, 1989; Rohsenow, Corbett & Devine, 1988; Stanton & Todd, 1982).

Personal: A variety of attitudes, beliefs, personality traits and behaviours have been linked to earlier onset and continued use of drugs. Generally a constellation of attitudes, beliefs and behaviours which indicate a `social bond' between the individual and conventional society tends to inhibit both delinquency and drug use.

Weak bonding has typically been related to the following individual traits, attitudes, beliefs and behaviours: poor attachment to parents; lack of commitment to school and education; non-regular involvement in church activities; alienation; rebelliousness; delinquency/crime; early aggressive behaviour; distractability; inability to tolerate frustration; sensation seeking; non-conformity; high tolerance to deviance; resistance to traditional authority; strong need for independence; low self control; need for excitement; risk taking; depression; anxiety; high levels of stress; poor coping strategies; low self esteem (perhaps better conceptualised as low efficacy); earlier onset of experimentation, particularly "gateway drugs" (nicotine, alcohol and cannabis); and gender (Bailey, 1989; Elliott, Huizinga & Ageton, 1985; Farrell, 1993; Fraser, 1987; Hawkins et al., 1985; Jessor & Jessor, 1977; Kandel & Yamaguchi, 1985; Rhodes & Jason, 1988; Teichman, Barnea, & Ravav, 1989; Towberman & McDonald, 1993).

However, many characteristics such as self-esteem, self-efficacy, locus of control, rebelliousness, risk taking and reactions to stress appear to be situation/context specific. That is, they do not appear to be traits which operate in a similar way across all settings, but ones which may vary according to the context within which the young person is participating at any given time.

School: While difficult to differentiate the independent influence of schooling variables from the interaction of what the child brings to school with him/her, the following have been cited as influential: school failure; truancy; early drop-out; low commitment to education and achievement; a rejecting school environment (Hawkins et al., 1985; Murray & Perry 1985; Newcomb & Bentler, 1989).

Peers: Association with drug using peers during adolescence is amongst the strongest predictors of adolescent drug use. Peer influence, approval and/or tolerance of drug use and modelling have been identified. Strong bonds to family and school usually decrease the influence of and reliance on antisocial peers (Dielman et al., 1990-91; Farrell, 1993; Elliott et al., 1985; Hawkins et al., 1985; Hoffmann, 1993; Jessor & Jessor, 1977; Kandel & Yamaguchi, 1985).

Other: Broader social economic and political forces also influence onset, maintenance and escalation of use, and may include: poverty; minority status; discrimination/harassment; high youth unemployment; lack of available, accessible and affordable recreational facilities; lack of access to alternative accommodation when the family home is inappropriate; lack of available, accessible and suitable mental health resources; a belief that the world may be destroyed through neglect or adult inability to negotiate peaceful solutions to conflict; ready availability of a huge range of legal and illegal substances that relieve distress (Burdekin, 1989; Elliott et al., 1985; Moore & Saunders, 1991; Newcomb & Bentler, 1989; Rhodes & Jason, 1988).

Methodological difficulties abound in studies on causation. In addition, recent research has stressed that there are multiple pathways to escalation of drug use and that the above variables act in neither a direct causal nor correlational manner (Farrell, 1993; Hoffmann, 1993). Most act in association with each other, increasing or decreasing the impact of each other. For example, the influence of drug using or approving peers appears to be highly significant in the development of problematic drug use by an individual; more so than family influence. However, family variables, such as low levels of involvement and attachment increase the likelihood of association with and influence by drug using peers. As Hoffmann (1993) has stated "Families can affect not only immediate drug use, but also the development of behaviors and associations conducive to drug use. Family relations have some impact on peer associations" (p. 548). Likewise, risk factors are reciprocal - they are both a potential `cause' and consequence of involvement in drug use (Farrell, 1993).

One way of **conceptualizing adolescent drug use** has been provided by Rhodes and Jason (1988, p. 12) as follows:

STRESS

RISK FOR

---> =

SUBSTANCE

(AB)USE

ATTACHMENTS + COPING SKILLS + RESOURCES

This conceptualization or model demonstrates that the impact of `high' stress (for example, any or all of a variety of social, economic, intra- and interpersonal variables) on an individual can be ameliorated by having positive attachments (say, to parents), good coping skills/strategies and access to resources. Likewise, lower levels of stress may lead to a heightened risk if there are corresponding low levels of attachment, coping skills and resources.

It should be clear then that the aetiology of problematic drug use during adolescence is multi-determined and that the individual, the environment and the drugs themselves cannot be considered in isolation (Dielman et al., 1990-91; Moncher, Holden & Schinke, 1991). However, excessive searching for `the causes', may divert attention from assisting youth survive more effectively in the present without recourse to becoming `comfortably numb'. Likewise, simplistic cause and effect models have not proved helpful and "Pathological explanations obfuscate our efforts to understand and respond to drug use by young people" (Moore & Saunders, 1991, p. 30).

1.4: Prevention and Treatment:

Given the above, preventive efforts may have many foci, however it would seem that targeting one influence, without recognition of the impact of others and the context(s) within which the adolescent is operating, may not be the most beneficial approach.

General prevention has traditionally involved broad-based education, particularly at school. Whilst efforts to promote health and living skills are useful and of benefit to individuals with `low risk levels', they are believed to have little impact on individuals regarded as `at risk' many of whom have left school before exposure to the educative effort or are frequently absent. Even socially bonded adolescents will come under some peer and other pressures to use drugs during adolescence, and enhanced strategies which enable them to deal with such influences should prevent or delay initiation for such young people. However, not so adolescents with weak bonds and high levels of intra-personal distress. Many will have no good reason to resist such urging and encouragement.

Other primary preventive interventions have included parent education, with particular emphasis on improving parenting skills (Silverman & Silverman, 1987), and community development.

Beyond general health education/living skills strategies, have been those which have focused specifically on the drugs themselves. School based programs such as "drug education", "I'm special", and"Just Say No" (refusal skills) are amongst these. The history of such endeavours has not been one of spectacular success (Bangert-Drowns, 1988; Wheeler, 1990), however, some programs targeting high risk young people in school have claimed a degree of efficacy (Mills, Dunham & Alpert, 1988).

In a recent critique, May (1993) has cautioned that "peer group pressure is an inadequate explanation of youthful alcohol use". He stressed that peer group pressure is not always negative or contaminating, but that it is "something that affects all social actors. The key point that must be made in respect to this is that it may equally act as a restraint on alcohol related behaviours by reflecting a wider set of values" (p. 162).

Reviews of programs have demonstrated mixed outcomes (Beschner, 1985; Tobler, 1986; Wheeler, 1990). In relation to the more `preventive' efforts, Wheeler (1990) cautioned that it may be a quantum leap to assume that the correlation between the aetiological variables and strategies listed above implies causation, and that the strengths of the correlations, where statistically significant, have been very weak. Wheeler adds: "This history of failure can be traced to the inability of earlier drug educators to comprehend why people take drugs" (p. 140).

In addition, it should be well recognised by now that **changes in knowledge, attitudes and beliefs do not necessarily lead to behavioural change**, and that social/living skills acquired in artificial settings do not necessarily generalize to the real world. Likewise, there may be an assumption behind teaching of skills that "with the aid of their newly-acquired decision-making skills, young people will automatically decide not to use drugs" (Moore & Saunders, 1991, p. 31). The above is not to imply that efforts be abandoned, merely that approaches be realistic.

More recent strategies have targeted personal and environmental variables for adolescents who have begun drug use and who also may come from dysfunctional families, oppressive physical environments, have poor/low educational achievement and be involved in criminal activity.

The complex and wide ranging mix of background factors and behavioural characteristics found in some youth (at times labelled `high risk') obviously lead to the need for a comprehensive range of approaches and responses. **Strategies arising** from this have included:

- street work targeting unattached/`at risk' youth.
- street based services for those resistant to or not yet ready for more traditional approaches.
- educational approaches targeting street youth and including the utilisation of the peer culture as part of the process.
- drop-in centres for youth which have an alcohol and other drug component, provide information, resource and referral services - direct access or via 'phone, `living skills' programs, including remedial education, assistance with preparation for employment and job search and advocacy.
- parent education.
- short term/crisis residential placements with ease of entry.
- medium and longer term residential placements (supported and independent).
- access to rental/housing stock.
- drink/drug driving programs.
- peer support programs (both for at school and for those who have left).
- wilderness experiences.
- detached family counsellors - with conflict resolution, family negotiation, family counselling being available.
- comprehensive services available within detention facilities for those unable to be included in community or non-custodial residential programs.
- community or area health services with an adolescent component which is `user friendly', and provide individual and/or group counselling with an emphasis on cognitive-behavioural approaches.
- detoxification facilities suitable for adolescents, when necessary.

- therapeutic communities (either adolescent specific or inclusive of adolescents) which cover a range of models, inclusive of twelve-step ones.

The above list is quite long, but most youth and workers wishing to find an appropriate service have difficulty locating many. In addition, most of the above services/strategies/interventions have been poorly evaluated, if at all. Of major concern is that despite the apparent variety and range, a major difficulty with many, if not most, services and programs which include a focus on drug use and related difficulties has been their **poor capacity to retain young people.**

2: Why young people do not use or get services as much as they might:

Youth can be a difficult group to work with and part of this difficulty may come from a combination of our own experience of adolescence, our training and experience, media stereotypes, and, if a current or ex-user at what age drug use came under control or was eliminated.

Most adolescents do not come for assistance voluntarily; they are usually sent/coerced/threatened by parents, probation officers, solicitors, school authorities, courts, refuge/hostel staff, and so on.

In addition, elaboration during the surveys of Howard and Kearney (1989) and Howard and Zibert (1990) suggested that interventions for drug related difficulties, whether drug-specific or generalist services, were perceived by those sampled as being unapproachable, irrelevant, frightening or at best minimally useful. Likewise, Levine & Singer (1988) found that young people most likely to use drugs are least likely to turn to formal agencies for help. Other recent Australian studies have found similarly (Brown, 1991; O'Halloran, 1990). Brown (1991) reported that the opinions of the young people reviewed reflected that "drug agencies...are perceived by many as useless, irrelevant, forbidding and distasteful" (p.38).

Consequently, several features of drug programs bear scrutiny. For example: ignorance of or minimisation of adolescence as a significant developmental stage, entry and assessment processes, adult program concepts and techniques forming the core of adolescent programs and services, staff issues, dual diagnoses, what to do with families, and the role of Alcoholics Anonymous (AA)/Narcotics Anonymous (NA).

2.1: Adolescence and its tasks:

Perhaps the major task of the adolescent period of development is the searching for an answer to the question **"Who am I?"** (Erikson, 1967). Curiosity, boredom and wanting to feel good are understandable and natural responses that result

from such a quest. Drug use during this stage of development can meet these responses, but retard the search for an answer, by helping to avoid it and its concomitant issues (Cavaiola & Kane-Cavaiola, 1989).

Many `at risk' adolescents, especially those with extensive drug use histories, have not reached the stage of **formal operational thinking** (e.g. a capacity to engage in role reversal, going beyond the "here and now" and understanding abstract concepts). They tend to be stuck at a stage of concrete operational thought; a "here and now", egocentric style of processing information and relating to the world. Also, there can be a lack of empathic communication, reflected by an inability to take the role of the other and fully appreciate their impact on significant others and the world at large (Howard, 1992b). This egocentrism can promote a consequent lack of acceptance of responsibility for behaviour: all others are to blame.

Such "stuckness" can be described as a type of **maturational or developmental lag:** development has been impeded (Greenberg, 1992). If such a lag exists, it has implications for programs, residential or community, where expectations of `age appropriate' behaviour are central; many adolescents **are** acting their age, but it is one far younger than expected. Greenberg (1992) points out "..staff must be sensitive to **immature acting out as a natural working through of the transition from child to adult.** This can be difficult for staff most familiar with adult therapy and limit setting...." (p. 104).

Drug programs which focus primarily on presenting information and alternatives, assuming then the adolescent's capacity to rationally choose from among what is offered, may be unrealistic if they do not take into account the **thinking and processing capacities of adolescents** "stuck" at an earlier maturational level. Likewise for interventions aimed at enabling young people to say "No" via assertiveness training and other techniques (e.g. refusal skills). The use of drugs by young persons is not necessarily a result of their inability to say "no"; rather, it is the complex issues of curiosity, boredom, and wanting to feel good which are most often perceived as focal by them. The reality may be that significant peer influences have been integral in the development of drug-related difficulties. Attempts to convince an adolescent of this early on may be counterproductive.

Greenberg (1992) from Walden House Therapeutic Community (TC) in San Francisco has stated "Adults in treatment may have come to realize their own limitations and the finiteness of their lives; they are aware of their own mortality. Conversely, adolescents may feel that they will live forever, and that any risks they take are without consequence. Teens frequently feel that if they sabotage their treatment programs there are unlimited opportunities for further treatment" (p.103). He goes on to stress that "these children, who although chronologically are teenagers, must be **coaxed into adolescence**. They may need time to play..."

Different concepts in relation to **time and a limited attention span** are also characteristics of adolescence and need to be taken into account in program development. Greenberg (1992) again, "Staff working with young people must be aware of the young person's relationship to time. Whether planning goals, giving consequences, or planning for the future, adolescents need immediate goals and consistent feedback" (p.105).

2.2: Motivation and Denial:

Youth often get labelled as "in denial", "not motivated", "not ready yet", and "not really an addict (yet?)" by some adults who run drug and alcohol programs and services, and by many adolescents and adults in the programs who have become addicted to the program language. An overemphasis on the identification, labelling, confronting and breaking down of **"denial"** can be counterproductive and may be serving purposes other than therapeutic (Brissett, 1988).

The **first point of contact** appears extremely important. Traditionally set up programs usually involve a formal assessment. Such assessments can often be extensive mental, emotional and historical excavations aimed at assessing "need", "problems", "denial", "motivation", and "readiness" ("rock bottomness") (Howard, 1992b). They can be unnecessary in the initial stages, when the primary "need" may be detoxification or a safe place to be, and counterproductive to the engagement process. Full assessment, when necessary can take place after initial engagement and a **`motivational interviewing'** style may assist in this process (Miller & Rollnick, 1991).

In addition, assessments often result in the adolescent being divided up into a series of problems (e.g. financial, drug, housing, legal, family, sexual) for which **referrals** are then made. Is it any wonder these referrals are often not taken up? The adolescent may come in feeling a bit `scattered', but not know how `scattered' they really are until after the assessment and referrals to X number of experts to deal with all the bits.

Moreover, expectations of "proper" motivation, readiness and so on, on admission to adolescent programs (community or residential) can be unrealistic, especially given the more or less involuntary nature of most adolescent referrals. **Ease of entry may be more important than "the right motivation".**

Motivation can grow via the engagement process, rather than be something to be assessed via some clever `motivmometer' on admission, with those registering high getting rewarded and those registering low getting confronted or discharged because they fail `the test'. Each exposure to a program/service can be positively re-inforcing and be part of a learning process in coming to

terms with one's difficulties with drug use or dependency, and assist in finding out what might help. **Recovery is a process, not an event.**

O'Halloran (1990) found that the young people surveyed in Canberra wanted services which did not put pressure on them via unreasonable expectations and conditions. They wanted to be able to leave and return to `treatment' as many times as they felt necessary. Condelli (1987) has found that a significant factor for retaining youths in therapeutic communities was their perception that staff wanted them to stay.

Low-key access is a crucial strategy for engagement of adolescents. Street-based services (e.g., street workers and the `AIDS BUS' servicing the Kings Cross area of Sydney) can provide accessible and easily accepted front line health and welfare information and materials (e.g., condoms, syringes), as well as harm reduction advice within the adolescent's currently chosen milieu. After engagement, these front line services can provide a link to more main-stream agencies as necessary.

The key features of street-based services appear to be accessibility, non-judgemental attitudes, non-intrusive assessments, support and advocacy. The **setting, style, appearance and location** of an agency are important factors in reducing the degree of alienation experienced. Such factors can give an adolescent the message that a program is adolescent user-friendly.

The issue of **doing something** for the adolescent in the early stages of engagement appears to be crucial. This does not mean unconditional smothering and becoming a pawn at the whim of the adolescent client, but realistic advocacy and demonstration of good faith so that trust may develop and consequently the therapist/worker may later `earn' the right to confront as appropriate.

The **use of court orders** and juvenile justice system involvement can both hinder and help. At times, being made an `offer too good to refuse' (i.e. rehabilitation instead of detention centre) can give a young person the opportunity to be exposed to positive possibilities and even an `excuse' for being there, thus saving face with peers (Howard, 1992b). Staff need to develop better capacities for dealing with reluctant or resistant clients, rather that waiting for the `properly motivated' to flock to their door.

2.3: Staff issues:

Howard and Kearney (1989) and Howard and Zibert (1994) undertook two surveys to explore first, what 70 youth workers regarded as important in working in peak services targeting difficult and marginal street youth (such as drop-in centres, refuges), and second, some aspects of the backgrounds and self

evaluation of competence of 106 juvenile justice centre youth workers in meeting the needs of incarcerated young offenders.

The study of **106 Youth Workers in the juvenile justice centres** (Howard & Zibert, 1994) found that knowledge was fair in relation to drugs, but HIV/AIDS and `street knowledge' were poor as was perceived capacity to be useful to those detainees drug affected on admission. There was a great degree of over- and under-estimation of levels of use. Their reasons for young people using drugs were not consistent with those of the reported by detainees, other than "wanting to feel good". "Boredom" and "curiosity" were seen by staff as having less significance than "wanting to be one of the group" and "seeing others use".

These youth workers felt that the detainees mainly **"denied"** having a drug problem and did not make use of the services available. This tended to reflect a lack of knowledge of how few services actually exist, a tendency to blame, and ignoring or minimising the impact of program staff variables on admission and retention. As Kleber (1989) has stated: "...rarely is it considered that it may be the particular treatment (which is) at least partly at fault" (p.81).

About **32% of the workers reported coming from a family with at least one member with a drug and/or alcohol problem, and 30% admitted to having had a drug and/or alcohol problem themselves.** These figures are close to those found for the young people in their charge (Howard & Zibert, 1990, 1994). Obviously their own treatment experiences will influence their perceptions as to causation and appropriate treatment.

These beliefs, attitudes and personal experience all have a significant impact on the style and form of program provision.

The responses to inquiries from the **70 youth workers** employed in services for youth out of home, but not in detention (Howard and Kearney, 1989) about what behaviours/qualities were seen as most important in **engaging difficult youth in helpful relationships** were in order: 1. Humour; 2. Relating at the level of the youth; 3. Employing non-threatening behaviours; 4. Developing a trusting relationship, maintaining consistent limits, being honest; 5. Sharing common interests, being `friendly', being a good listener, being able to `play', being involved actively, `knowing' what might be needed (being in tune); 6. Having access to resources.

The main behaviours/qualities of workers seen as most important in the **maintenance** of such youth in helpful relationships were: 1. Being reliable, demonstrating care, providing support; 2. Provision of a `safe' environment, providing a `sense of belonging'; 3. On-going contact; 4. Maintaining trust; 5. Being honest, allowing freedom for the youth to make choices.

The above cover such aspects as: humour, sensitivity, being consistent, active and non-threatening, and being able to give something tangible (of oneself and of resources). Overall, the worker characteristics for these samples imply that education/training and `skills/techniques' are not necessarily the most essential attributes. It appears to be more personal qualities which may be enhanced by education/training that are seen as crucial. Likewise, some apparently relevant life experiences may get in the way if not recognised and resolved. This has implications for both employment and training as it is personality and a demonstrated capacity to relate to adolescents, particularly difficult ones, that should form the major criteria for **job selection**, not merely academic attainments.

In addition, Connie (personal communication, 1993) is currently investigating what `experts' and clients perceive to be the crucial competencies of staff and programs providing residential services to young problematic drug users. To date, areas being explored to establish performance criteria include: the ability to create a safe milieu, demonstrating an understanding of the developmental stage of adolescence, ability to communicate with and involve young people in activities, an ability to complete ongoing assessments and develop case plans, an ability to respect boundaries, a capacity work as part of a team, and an ability to foster self reliance.

2.4: Other staff issues:

It is likely that the **"style" of approach** adopted in many adult programs may be unsuitable for adolescents. For example, and in addition to the above, **some designated adolescent drug programs are run, and the ideology dictated by those who came to recovery in their mid to late twenties, or later.** A philosophy of what worked and at what age for such people may dictate the model, and there may be consequent little faith in the possibility of rehabilitating adolescent drug users. In addition, many of the adult programs were set up in the 1970s and 80s to work with problematic heroin users. Drug use patterns have changed since then. (Measham, Newcombe and Parker, 1993).

Greenberg (1992) has stated "I believe that many adolescents fail in the TC (therapeutic community) because staff have expectations that are beyond the capacity of the young client. Staff who are trained in the TC model, with its emphasis on self help, need to understand the difficulty that underprivileged and severely disturbed youth may have. While adults may be committed to their own growth, change, or program of therapy, **young people may have no immediate investment in their lives"** (p.105).

In particular, staff should be at all times aware of their role, boundaries, the purpose of the treatment being offered and the maximum length of stay possible in the program. For example, it can be counterproductive and even a negative experience for an adolescent to be encouraged to `spill all' (**especially**

sexual victimisation experiences) in a short term program such as a detoxification facility. The role there may be to assist the adolescent through any detoxification that may be necessary, get some stability and control back, assist in the development of strategies to **`hold'** emergent issues, make informed choices about any suitable program/treatment for themselves and prepare for this. An alternative is to engage in `deep and meaningfuls' which may addict the adolescent to the detox unit and its staff, and entertain significant issues which are mostly beyond the capacity of a short-term program to deal with effectively.

Recent writings on "Recovery" (e.g. Gorski, 1991) locate dealing with **`family of origin issues'** as the central theme of the fifth stage (Late Recovery) in their Developmental Model of Recovery; recognition of dependency and recuperation are the central themes of their first two stages (i.e. Transition and Stabilization). Clinical experience over the years indicates that many of those who complete/graduate from programs may not have fully resolved a number of issues related to their families of origin, especially experiences of child sexual assault. Some of them identify this and seek assistance but some others, who may remain in programs as staff, can, as a result of such non-resolution, overtly or covertly conspire to not have these issues more thoroughly dealt with.

3: Residential placement:

While drug use-specific residential placement is infrequently necessary for adolescents, a period of residential `detoxification' sometimes is. Detoxification for adolescents is not usually one requiring medical intervention, as levels of drug use are mostly not as high as those of adults. However, adequate medical back-up is essential.

The `detoxification' is normally from peers, the streets, toxic families, or other relationships. It provides a short time away from chemicals, in a safe place, where consideration of the impact of use, some education and increasing awareness of alternatives can occur. There are only two such units in New South Wales for those under 18: "Dunsmore House" at Rooty Hill, and "Errol Flynn", a facility of the Ted Noffs Foundation at Darlinghurst. These periodically come under threat of closure. Longer term programs are more rare: "TRACA" (Ted Noffs Foundation) at Hazelbrook. Otherwise, adolescents requiring longer term treatment go to the Odyssey House adolescent program in Melbourne. Some adult programs will take a limited number of adolescents, but not usually as a priority.

The outcome of studies on the effectiveness of **therapeutic communities** is not unequivocal. While supporters see much merit in the approach, others seem less enthusiastic (e.g.Brown, 1991; Heather and Tebbutt, 1989). High `split rates' and the degree of structure and commitment required are noted. However, for youth whose life and drug-related difficulties are longstanding and substantial,

community located, outclient approaches may not provide enough. The therapeutic community approach has only recently, but not very widely been applied to adolescents (Greenberg, 1992). Little research, other than anecdotal and descriptive, has been produced, and such programs can be fairly costly.

It is important to recognise, however, that therapeutic communities have come a long way since their beginnings, are not as heavily confrontational and brutal as some were in the early days, and are quite dissimilar to their caricatures in current urban myths and stereotypes. Many now: involve the family of the adolescent; adopt a relapse prevention focus; provide aftercare and outclient services; pay attention to the special needs of minority youth, culture and gender issues; recruit from a broader range of professionals than only program graduates; and recognise the special difficulties of dual diagnosis clients (Muller, Arbiter & Gilder, 1992). Some programs worthy of more attention in the United States are "Walden House" in San Francisco (Greenberg, 1992), "Amity" in Tucson, Arizona (Mullen, Arbiter & Gilder, 1992), and the "Odyssey House" adolescent programs in Utah, Melbourne, Auckland and Christchurch.

A difficult decision to make is whether to keep the adolescent within the drug-use specific range of services, or to use mainstream ones. It is important to recognise that `normalisation' where possible should be a guiding principle, otherwise young people may become locked into careers as `drug users', defining all their difficulties as drug-related. In reality many issues may be those typical of adolescence as a time and should not be treated as indicative of pathology or drug use.

4: Some Other Treatment Issues:

Various reviews of treatment effectiveness have been undertaken recently (e.g. Ali, Miller & Cormack, 1992; Heather & Tebbutt, 1989; Mattick & Baillie, 1992; Mattick & Hall, 1993; Mattick & Jarvis, 1993; Tarter, 1990). While many of the interventions reviewed have not been systematically evaluated for adolescents, and as Tarter (1990) has concluded "There is a paucity of empirical evidence demonstrating the superiority of one treatment over another..." (p35), some conclusions are worth highlighting, as are some other issues.

After **appropriate assessment**, especially if motivational interviewing is utilised in the initial stages, the **matching** of the intervention to the particular needs of individual clients is stressed to reduce drop-out rates. These needs might be shaped by the client personality, the strength and level of drug dependency, the degree of motivation to change, the stage of change of the client (e.g. precontemplation, contemplation, action, maintenance, relapse), the drug(s) used, and other variables. Engaging youth around current and `real' (i.e. to them) issues may also lead to more preparedness for change.

A well developed **relapse prevention model** is recommended as an appropriate framework within which to operate (e.g. Brownell, Marlatt, Lichenstein & Wilson, 1986). Such models provide for a focussed way of working, yet can easily accommodate changes. Working on variables which maintain use (such as cues, internal emotional states and interpersonal relationships), and which could stimulate a return to use (i.e. any use after abstinence or to a level of use higher than chosen) is regarded as a logical beginning.

Clarity of program and client goals, the setting and regular review of treatment plans, and the recognition of the importance of **boundaries** are other issues of significance. **Cognitive-behavioural** approaches tend to be favoured, as are the acquisition of skills which are able to be generalised to a range of settings (Heather & Tebbutt, 1989). Where there is significant psychopathology, longer-term treatment, possibly residential initially, may be more appropriate.

Gender differences in the pathways to use, and how these differences influence maintenance, escalation and cessation of use have largely been ignored until recently. Previously it appears to have been widely assumed that drug use by women differed from that of men only in degree. Some significant Australian work has now begun on assessing the impact of gender. Baily, Saunders, Phillips and Allsop (1991) have found that in relation to alcohol use, "the predictors of a return to inimical drinking are, for women, in direct contradiction to the existing, male dominated, literature. Indeed some protective factors for males are predictors of relapse for women" (p. vii). "Clinicians need to be aware of the greater importance of intrapersonal factors (bad moods or bad memories) triggering relapses in women and for interpersonal factors (social situations, remembering the good times) being cues for men" (p. ix). While there is a need for replication of this study, and testing the findings over a broader range of drugs and ages, they have important implications for theory and practice development, and for interventions for young women. The same may be true for young people from different **cultural and religious** backgrounds.

Most youth oriented programs recognise the importance of **nutrition and exercise** as crucial elements (Chrisjohn, 1992; Mullen, Arbiter & Gilder, 1992). Brown (1991) has suggested that effective agencies "which attract significant numbers of young people with drug related problems are those which provide a range of services, including physical amenities such as accommodation, meals, clothing and other material assistance, while also furnishing social and emotional support, recreational outlets and educational and vocational activities." (p 70).

Likewise, the role of **peer supports** (Dayton, 1987) **and social networks** are viewed as significant. "Strategies of teenage social network restructuring, utilization of high-quality social supports in the therapeutic process, and exploration of the ways in which abstinent supports can be useful in potential

relapse situations are all likely to enhance treatment success" (Richter, Brown & Mott, 1991, p384). Post treatment variables have been identified as significant in return to problematic use of drugs by young people (Shoemaker & Sherry, 1991).

5: Dual Diagnosis:

The existence of what are called `dual diagnosis' clients has come to be more clearly recognised in the adult literature of late. As yet little has been produced in relation to adolescents. In the adult literature, several models have been proposed to explain the now frequently recognised comorbidity of substance dependency and disorders, such as schizophrenia. For example, the vulnerability models hypothesises that drug dependency may cause schizophrenia or increase the likelihood of its expression in an already vulnerable individual. Another model suggests that use of drugs by persons with schizophrenia is a form of self-medication of their symptoms. A third model postulates that drug dependent persons with schizophrenia self-medicate uncomfortable neuroleptic induced extrapyramidal symptoms (Dixon, Haas, Weiden, Sweeney & Frances, 1991; El-Guebaly, 1990).

In the adolescent literature, Friedman, Utada, Glickman and Morrissey (1987) have reported that "..it appears likely that there is an additive or cumulative interaction effect in which having psychiatric symptoms (psychopathology) contributes to the tendency to use drugs, and using drugs adds to the tendency to have psychiatric symptoms" (p. 242). Greenbaum, Prange, Friedman & Silver (1991) suggested that "Substance abuse may mimic, precipitate, exacerbate, be an effect of, or be independent of nonsubstance use disorders." (p. 575), and Tarter (1990) that "The comorbid psychiatric disturbance may precede the onset, emerge concurrently with, or appear after the development of substance abuse. Furthermore, psychiatric disturbance may be causally related to drug use behaviour. For instance, drug use may be an attempt to self-medicate a negative affective state such as dysphoria or anxiety" (p.39).

However, methodological issues hamper much of the research. For example, the timing of the diagnostic interview may affect the reliability and validity of responses, as can differences in interview techniques and diagnostic criteria, and the period of abstinence required before a clear diagnosis can be made. (Weiss, Mirin and Griffin, 1992).

Often dual diagnosis clients `fall between the cracks' and receive less than adequate responses from both mental health services and those designed for drug dependants. Several reasons for this have been put forward. For example, the use of neuroleptics can conflict with an all drugs free milieu, some behaviour of mentally disordered clients can interfere with some rehabilitation settings, mentally disordered clients may respond poorly to confrontive techniques, and the complicated management of such clients may be beyond the expertise of agencies with little or no mental health professional back-up.

In addition, drug using clients are often regarded and treated very negatively in mental health settings; frequently described as manipulative, difficult, likely to abuse any medications given, dangerous and noncompliant (Salloum, Moss &

Daley, 1991). Likewise, many clinicians work in rather rigid models and apply the same approach to all clients (Zweben & Clark, 1990-91).

As adolescence is a time where some serious mental disorders may initially present (for example, schizophrenia and bipolar mood disorder) accurate diagnosis is crucial (Burke, Burke, Regier & Rae, 1990; Christie et al., 1988).

One of the major issues in working with clients who may have dual diagnoses is what to do first. El-Guebaly (1990) has written: "Some say treating a psychiatric problem first is like `treating a bleeding ulcer with psychotherapy alone!' Even if the primary disorder is determined, is the sequential or concurrent treatment of both disorders best? Traditionally, for assessment in an inpatient setting, a temporal sequence is recommended, i.e. observation of the patient while off all drugs for two to four weeks and treatment only if symptoms persist. Once long term management is initiated, a concurrent approach tackling both disorders is recommended" (p. 264).

6: The Family:

Family issues should not be ignored as many young people can return home if both they and the family learn better adaptive and coping skills. Others need to separate adequately and be able to leave the family behind rather than explode out of it, carrying the residue of such conflicts with them.

Even though it would appear that by their offending behaviour, drug use, possible homelessness and street lifestyles, some adolescents may be unconcerned with parents or view them negatively, surveys have highlighted the significance of parents as, at times, helpful and concerned (e.g. Howard & Zibert, 1990; Zibert, Hando & Howard, 1993). Thus, family work components need to be included to teach parents more effective and appropriate parenting skills and more realistic expectations of their son or daughter. Even if no discernible family 'pathology' exists, parents need support and information to better understand their son or daughter's predicament, and so support treatment.

In particular, many therapeutic communities emphasise the need for early engagement of the family of the adolescent, to either assist in retaining the adolescent in a program and/or to neutralise the potentially negative impact of a `toxic' family (Kalajian, 1992; Obermeier & Henry, 1989; Schroeder, 1989).

In more recent approaches the therapist is actively involved in the engagement of the family, rather that waiting for them all to come to the therapist. This approach has been developed and found effective with the families of adolescents with drug difficulties. It blends strategic, structural and systemic approaches and is based on concepts of `joining' and `restructuring' of brief strategic family therapy. The therapist joins the family in a way that does not

challenge the family structure, and restructures only those interactions that prevent the family from getting into therapy (Szapocznik, Perez-Vidal, Brickman et al., 1988).

Whether it be family therapy or low level family involvement, it has an impact on treatment outcome. A recent study by Howard (1993) found that a perception of family support predicted retention of adult males in residential drug treatment. Shoemaker and Sherry (1991) have stated "... the number of family sessions was an important predictor of virtually all the outcome measures. Family involvement in the treatment process was the single most frequent predictor of outcome" (p 103).

7: Alcoholics Anonymous/Narcotics Anonymous:

Some programs have incorporated **Alcoholics Anonymous (A.A.) and Narcotics Anonymous (N.A.)** approaches. A useful model is presented by Cohen (1989) which incorporates basic A.A. and N.A. principles with family support/work and after care. Gifford (1989) maintains that the N.A. model is the most appropriate one for adolescents. Discussions with respondents in Howard and Kearney's (1989) study supported such a view as there was a clear preference for N.A. over A.A. due mainly to the age difference in participants. It is recognised that some self-help groups specifically target and/or are facilitated by young people.

However, a too ready adoption of programs based on disease model concepts must be avoided. Adolescents have problems identifying with older, formerly dysfunctional adults who suggest that they were like them when young (O'Halloran, 1990). Or, they may pick up a different message: "this person says drugs ruined his life, yet here he is alive and coping and recovering... hell, I have about 15-20 more years of drugging to do before I need to get serious... it's not as bad as they say if he's alive to tell me about it....". Or, "... who in the hell wants to live beyond 21 anyway and end up out the front talking to a bunch of losers.." Nor do some young people with significant or emergent mental health difficulties need to be told that all their symptoms are explained by their drug use and will remit when such use ceases. With appropriate diagnoses and prudent use of medication, some serious psychiatric conditions can be treated effectively. A.A. and N.A. can assist greatly in such situations, but are not the only alternatives. They can and should form part of the range of services available. In a study by Alford, Koehler and Leonard (1991) self-help groups used in conjunction with individual and group work showed promise.

There appears to be no need to posit drug dependency or other drug-related problems as equal to, or indicative of, a `disease' to suggest abstinence and self-help group attendance as goals for some adolescents. What adolescent-friendly self-help groups can provide is of prime importance to some young people. For example: structure, support from a sponsor who takes an

interest in them, and realistic models for contemplating and dealing with one's predicament.

8: A Final Issue ?:

Language: All `professions' have their own particular languages which may get in the way of effective outcomes at times. Throughout this paper various terms and labels peculiar to the alcohol and other drug area have been used. Programs themselves utilise yet more terms. For example: recovery, awarenesses, contracted, disease, sharing, addict, substance abuse, step groups, attitude, levels, picking up, rehab., detox., coey and coda (co-dependent), head miles, busting, dry re-entry, control junkie, and so on.

The use of this language deserves attention itself if an aim is to provide programs in environments which are as `normal' as possible, for the shortest period of time necessary, and which avoid the creation of `addict careers'. Many young people only suffer from an attack of `acute adolescence' and do not need to be `pathologised' and referred to services which have been re-labelled by the `alcohol and other drug industry'. For example, a refuge or hostel re-labelled as a `rehab.', an overly interested parent as `coda'.

9: Conclusion:

To increase program effectiveness and to maximise retention in treatment, staff and program developers may need to take the following into account:

- The peculiar characteristics of adolescence as a time and adolescents themselves.

- The recognition that not all young people who use drugs have problems with their use, are `precontemplators', or, if `contemplators', wish any assistance at this time.

- That motivation can be enhanced and grow, that it should not be `measured' on intake, and that `recovery is a process not an event'.

- That programs should have clear aims, boundaries, and be clearly structured.

- The recognition that program and staff biases exist, and attempts made to minimise these.

- That service delivery should be non-stigmatising, non-pathologising and as `normal' as possible in structure, style and setting and take into account significant cultural issues.

- That ease of entry should be a priority.

- That on-going work should be based on adequate non-toxic, and,where appropriate, staged assessment.

- That treatment plans should be set and regularly reviewed.

- That attempts should be made to match clients to treatment.

- That `dual diagnoses' clients exist and may require special arrangements.

- That material assistance and advocacy is provided where necessary.

- That socialisation experiences are important.

- That the family is of major significance and should be involved to the degree deemed appropriate.

- That a focus on realistic and generalisable skills development and maintenance is essential.

- That some young people require individual (psycho)therapy, and that cognitive-behavioural approaches may be more effective.

- That group work should be a major therapeutic approach.

- The provision of education (including remedial and further) and vocational experiences is essential.

- Adequate referral and follow-up procedures, including `after-care'.

- That specific programs are not the ONLY means of or approach to treatment.

- The recognition that many adolescents will need to enter with confused motivation and may need to re-enter many times or be referred to a more appropriate service/program/agency.

The lack of use of available services by youth is of concern. That some which attempt to provide a highly professional and monitored service are under threat is also of concern. The paucity of appropriate programs and the existence of those which actively or covertly exclude young people, place so-called high risk youth and society in a difficult situation. This may leave young people with few choices but to return to the damaging environments from which many have tried to escape. Honest self-evaluation, a desire to thoughtfully experiment, and an openness to submit programs to external review and evaluation may go

part of the way to realistically assess the requirements of young people who have exhibited alcohol or other drug associated difficulties, and provide responses which engage such young people in effective programs for as long as necessary.

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