"It will kill us faster than the white invasion"

Views on alcohol and other drug problems and HIV/AIDS risk in the Canberra/Queanbeyan Aboriginal community and on the suitability of a 'heroin trial' for Aboriginal heroin users

Glenda Humes, Michele Moloney,
Francesca Baas Becking and Gabriele Bammer

Working Paper Number 6

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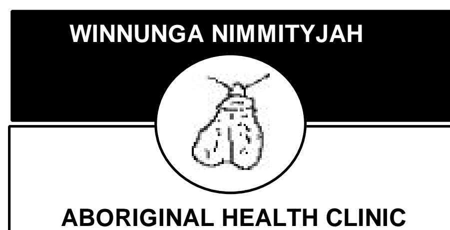

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The late Olive Brown was also a key player in the early development of this proposal. The two reports are a testimonial to her commitment to enabling the community to know and own information about itself and be involved in planning and decision making.

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Foreword

Health care needs to be re–introduced as a process in Aboriginal people's lifestyles. We not only need to have access to Aboriginal services, but we also need to be involved in identifying the issues and developing the processes which will ensure wellness and holistic health.

This is a component of Aboriginal people's rights to self reliance and self determination at community, family and individual levels.

This study not only fits in with the spirit and concept of community controlled health; it has developed a process which allows for community involvement and control.

The findings of the Royal Commission into Aboriginal Deaths in Custody have reinforced the concerns of Aboriginal people about the negative impact of alien processes. These processes have forced Aboriginal people to adopt lifestyles which have brought with them new sets of problems.

The approach taken in this study allows people to investigate some of these problems from a local perspective and to use the information to develop their own processes to resolve them. This is important for the development of Aboriginal people. For too long we have been forced to accept what 'others' have thought to be of benefit. Aboriginal people need to be empowered in regard to their lives.

I recommend careful reading of the two reports which arise from these studies. They show how the Aboriginal community is different from the non–Aboriginal community. They also report Aboriginal people's views on their lives and the importance that we place on dignity and relationships in the delivery of services.

Kaye Mundine
Chairperson
Winnunga Nimmityjah

Executive Summary

From the point of view of the Feasibility Research into the Controlled Availability of Opioids, the aim of this study was to look carefully at the possible impact of a trial on local Aboriginal heroin users and the local Aboriginal community generally. The questions relating to the feasibility study were subsumed under a broader consideration of unmet needs, particularly regarding service provision for people with problems with alcohol and other drug use and for people at risk of HIV/AIDS.

Nineteen Aboriginal community leaders and 28 service providers were interviewed. Among the community leaders 53 percent thought a 'heroin trial' was appropriate for Aboriginal heroin users, 42 percent did not and 5 percent did not know. Of the service providers 53 percent thought a trial was appropriate, 25 percent did not, 4 percent thought 'maybe' and 18 percent did not know. Three of the service providers were Aboriginal and all thought that a trial was appropriate. In general, both the advantages and disadvantages of the trial proposal were seen to apply equally to Aboriginal and non–Aboriginal users. Thus the question of whether or not a trial is appropriate for Aboriginal heroin users is subsumed under the broader question of whether or not a trial should proceed at all.

Both the community leaders and the service providers thought that alcohol and other drug use was an issue for the Aboriginal community. The community leaders saw alcohol and yandi (cannabis) as the drugs of most concern. Non–Aboriginal services generally have few Aboriginal clients and are not well known in the community. The reasons for this need to be carefully explored. The Aboriginal community leaders also made a number of suggestions for ways in which services could be improved. A number of possibilities for increasing Aboriginal involvement and awareness of Aboriginal culture and issues were suggested. Raising awareness among young people and establishing an Aboriginal community centre were suggested as prevention strategies. Initiatives in this area require serious and long–term commitment, need to be under Aboriginal control and must be adequately resourced.

Both community leaders and service providers see the Aboriginal community to be at risk from HIV/AIDS and there was a perception that the risks are similar in the Aboriginal and non–Aboriginal communities. Many community leaders reported fears that HIV/AIDS could have a significant negative impact on the community. The risks of spread through unsafe sexual practices, especially among young people, were a particular worry. Intoxication was seen to play an important role in increasing these dangers. There was a feeling among Aboriginal community leaders that they had no solutions for adequately dealing with this issue. This is an important area that needs to be urgently addressed.

INTRODUCTION

One of the aims of the Feasibility Research into the Controlled Availability of Opioids is to look carefully at the possible impact of a trial on all relevant populations. The potential impact on local Aboriginal heroin users and the local Aboriginal community generally is therefore an important area of study.

We also recognise that in relation to the gamut of unmet needs for service provision associated with problems arising from alcohol and other drug use and with HIV/AIDS risk in the local Aboriginal community, the need for a 'heroin trial' is probably only a minor consideration. Questions relating to the feasibility study were therefore subsumed under a broader consideration of unmet needs, particularly regarding service provision for alcohol and other drug users and for people at risk of HIV/AIDS.

There were two studies – one of community leaders and one of service providers. We had also planned to do a third study of Aboriginal heroin users. Two interviews were conducted before we realised that, to be done properly, such a study would need more resources than we had at our disposal. Our experience showed that it is not appropriate to focus on users of just one drug. It is important, and possible given adequate resources, to conduct a study of illicit drug users (rather than just heroin users) and this needs to be given some priority in future research in this area.

As far as the feasibility study was concerned, the aim of the study of local Aboriginal community leaders was to determine if they thought a heroin trial was appropriate for local Aboriginal heroin users. We were also interested to see how problems associated with heroin use rated in importance compared with problems associated with alcohol and other drug use generally. Given that a prime driving force behind the proposal for a heroin trial is to curb the spread of HIV, we were also interested in the perceptions of community leaders about HIV risk in the community. We put all of this in the context of how the leaders saw the community as a whole and what they saw to be the primary issues for the community.

The second study was of service providers, both Aboriginal and non–Aboriginal, whose services had some relevance to alcohol and other drug users and/or to the prevention of HIV/AIDS, although this might not be their primary focus. The main aim of this study was to examine how adequate these services are for Aboriginal people. The service providers were also asked their views about the appropriateness of a heroin trial for local Aboriginal heroin users. In addition, the results were used to assess the need for a heroin trial in relation to other needs.

This report covers responses about the proposal for a 'heroin trial'; views on alcohol and other drug use; and views on HIV/AIDS. This report should be read in conjunction with "Finding Out for Ourselves. An analysis of the needs of Canberra/Queanbeyan Aboriginal people, especially with regard to alcohol and other drug problems and HIV/AIDS risk". The companion report puts the feasibility study considerations into broader context.

While we have used the word 'local' to define our study populations, the research was in fact confined to Canberra and Queanbeyan and did not encompass the whole Bogong region[1]. We believed that it was artificial to study Canberra alone, but resource and time constraints prevented us from studying the whole area. It is also important to note here that the results showed that it is inappropriate to think of the local community as a single entity; instead it is composed of a number of interacting groups.

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[1] The Bogong region is one of 60 current ATSIC Regional Council areas. As well as Canberra and Queanbeyan, the Bogong Region encompasses Goulburn, Yass and the Snowy Mountains. The shires covered extend from Boorowa, Crookwell and Mulwaree in the North to Snowy River and Bombala in the South. These ATSIC areas were determined through consultation with the Aboriginal communities. The Aboriginal and Torres Strait Islander population of the ACT numbers 1,775 in a total population of just over 280,000 (Castles, 1993).

Methods

Twenty–six Aboriginal community leaders in Canberra/Queanbeyan were identified. The selection criteria were that they had a high profile in the community and that they were involved in Aboriginal organisations. We also selected people to cover a range of government, community and voluntary organisations. Seven could not be interviewed in the time available, so the study group consisted of 19 people.

The interviews with community leaders were conducted by Glenda Humes and Michele Moloney. They were interviewed in a variety of locations– their homes; their workplaces; and in coffee shops. The interviews took between 1.5 and 3 hours. A semi–structured format was used (Appendix B). There were some differences between interviewers in how questions were asked and these are highlighted in the appropriate section of the results.

Francesca Baas Becking analysed the quantitative data using SPSS. She and Glenda Humes analysed the qualitative data using conventional methods, including content analysis and the identification of common themes, views and characteristics.

The interviews with service providers were conducted by Michele Moloney, who also took primary responsibility for the analysis of the data. This was done manually. We aimed to interview providers covering a range of services for alcohol and other drug users, and all of the primary services were covered. Further details are presented in the results section.

Twenty–eight service providers were interviewed using a semi–structured format (Appendix C). Interviews were generally conducted in the providers' work place and took between 1.5 and 4 hours.

All four authors were involved in writing the report, but primary responsibility for the writing was taken by Gabriele Bammer.

The study is covered under the ACT Epidemiological Studies (Confidentiality) Act 1992.

RESULTS

COMMUNITY LEADERS

The Sample

Of the 19 community leaders interviewed, 10 were women and 9 were men. (Of the seven who could not be interviewed in the time available, 4 were women and 3 men.) Eleven were born in New South Wales, one in the ACT and seven elsewhere in Australia. Ten were employed by the government and nine in community organisations (this includes those who worked in a voluntary capacity). Twelve worked for Aboriginal organisations and seven were identified Aboriginal workers in Aboriginal or non–Aboriginal organisations.

Thirteen were involved in a range of cultural activities; 10 were involved or employed in education, either in policy making capacities or other work, including the Aboriginal Educational Consultative Group; and 9 had an association with the Bogong Warriors Aboriginal Rugby League. Eight of the community leaders selected had an association with the Bogong Aboriginal Corporation; 8 were involved in health in various capacities; and 6 had a specific interest and involvement in alcohol and other drug activities. Five of the 19 were members of the ACT Advisory Committee and two were ATSIC Regional Councillors. (Any one person could be involved in more than one activity.)

The Heroin Trial

Sixty–eight percent had heard of the proposal for a 'heroin trial'; 32 percent had not (Figure 1). None gave much detail about what they thought a trial would entail. One thought the aim was:

> *"to eventually get them off and on to methadone";*

one that

> *"you can go and get free heroin";*

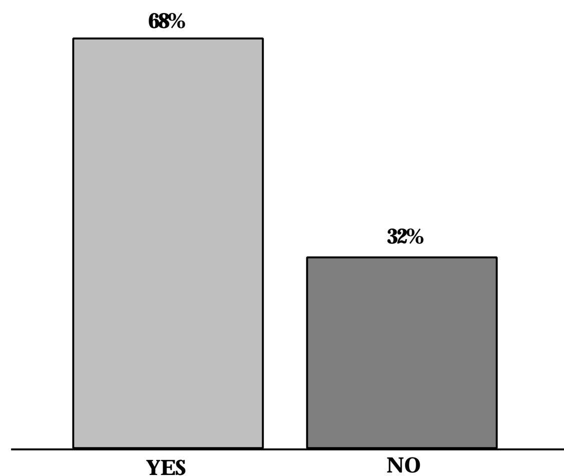
and one that

> *"they are considering putting it [heroin] on the market".*

One respondent simply said

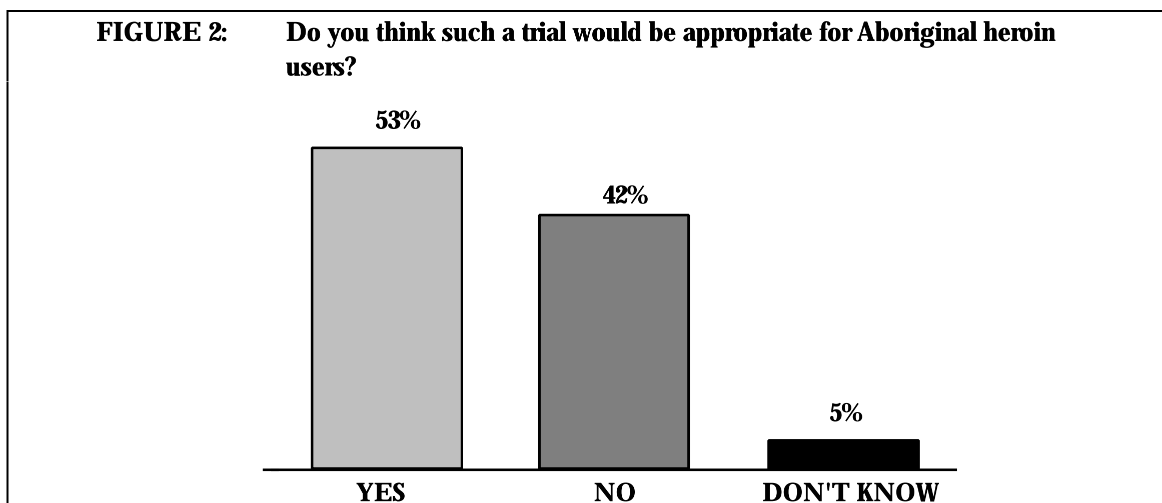
> *"It's the brainwave of a so–called politician."*

FIGURE 1: Have you ever heard about the proposal for a "heroin trial" in the ACT?



Fifty–three percent thought it was appropriate for Aboriginal heroin users; 42 percent did not and 5 percent did not know (Figure 2).

FIGURE 2: Do you think such a trial would be appropriate for Aboriginal heroin users?



The community leaders identified a range of positive and negative effects that could arise from such a trial. The positive effects could be grouped into two categories– first, that a trial might decrease criminal behaviour; and second, that there were advantages in having medically regulated and supervised heroin available. Regarding decreased criminal behaviour, it was suggested that users would not have to steal so it might reduce the high rate of drug–related burglaries in Canberra; and that it would cut down on drug trafficking. There were seen to be advantages to providing heroin in a medical setting, namely that the risks of overdose would be reduced, that it would provide an opportunity for monitoring and education and that there could be more control over the disposal of needles. One person said they would want to know the results of other trials; if they were successful in getting people off heroin, a trial should be supported. One participant favoured legalisation.

Some participants reported that they could see no positive effects at all and thought the idea was "*stupid*". In addition, a broad range of reasons against a trial was given. Some felt that trial drugs would only be used as a "*top up*" and that use of illegal drugs would not be reduced. Some thought that what was needed was "*programs to get them off rather than keep them on it*". One thought that a trial would lead to an influx of users into the ACT and another that it could produce an "*explosion*" of heroin users. An influx of users into the ACT could bring a range of health problems and one person thought that a trial would not lead to improvements in health. Two thought that it would lead to an increase rather than a decrease in criminal behaviour. There was also a concern that it might put more stress on the Aboriginal community.

A number of other comments were made which did not necessarily relate to positive or negative effects of a trial. These were that users needed but would not ask for help, because using was a "*shame job*". There was a concern that people would abuse a trial. There might be problems with differences in state laws, so that what was legal in the ACT might not be legal elsewhere. There was also a fear that there might be exploitation of Aboriginal heroin users, but this was not elaborated on.

Six respondents (32 percent) made comments to the effect that Aboriginal heroin users should be treated the same as non–Aboriginal users. They were evenly divided between those in favour of and those opposed to a trial. One thought that a trial should have Aboriginal workers. Two commented that they would prefer alternatives; one was in favour of "*proper treatment*" and the other said

> *"Why should we try to trial them when we can educate them off? If our population is dwindling why should the ACT government help in accelerating the decline in our numbers with this program?"*

Another participant thought that Aboriginal heroin users were

> *"doubly at risk because society considers them deviants"*

and that a way needed to be found to run a trial

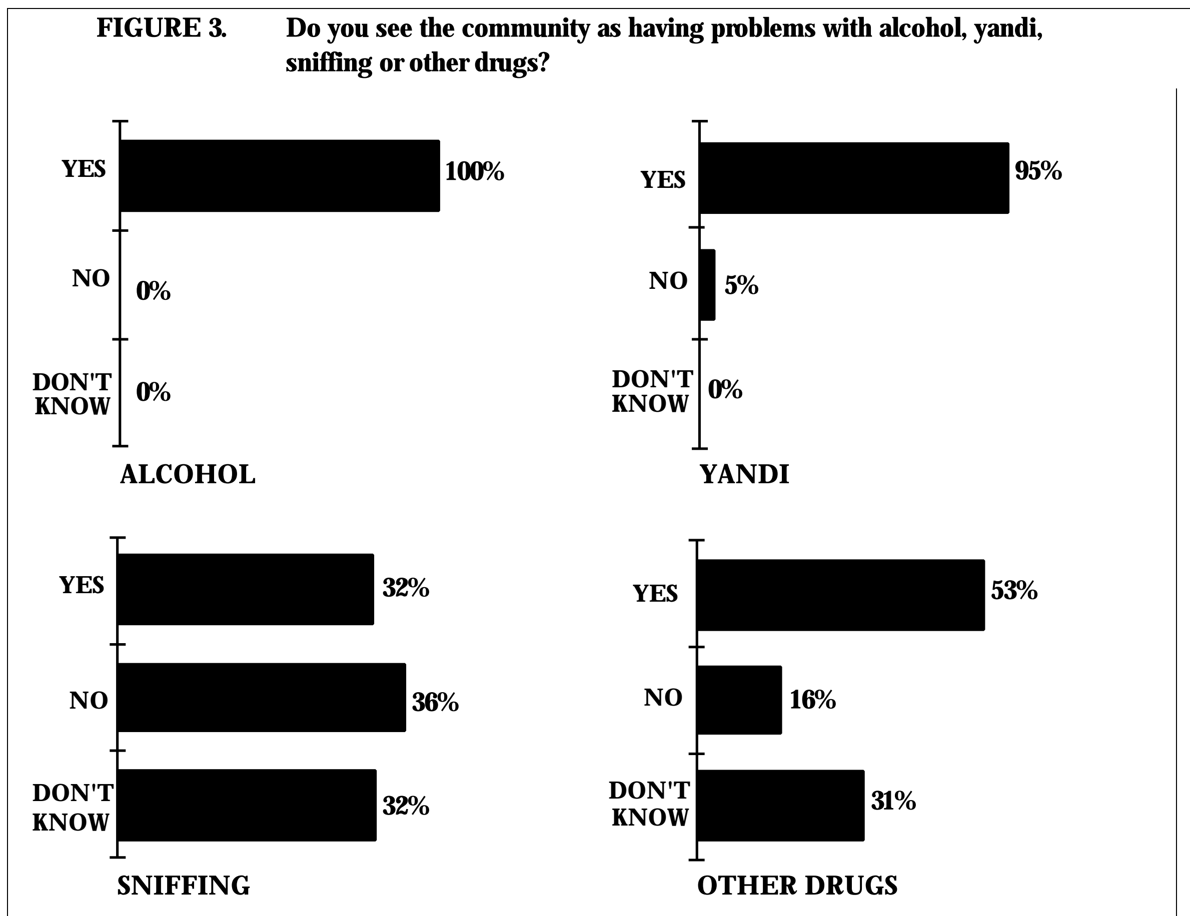
> *"without having them branded in the community".*

Alcohol and other drug use generally

a. Perceptions of problems

The community leaders were asked if they saw the community as having problems with alcohol, yandi (cannabis), sniffing, or other drugs. The results are shown in Figure 3. Alcohol and yandi were seen as the most important problems, with many respondents naming both when asked which was most important.

FIGURE 3. Do you see the community as having problems with alcohol, yandi, sniffing or other drugs?



In response to the question "Can you give details of the drug and/or alcohol problem?", alcohol "abuse" was seen as a major problem within the Aboriginal community. The view was that alcohol and other drug use is mainly associated with older Aboriginal people and with those in their mid–twenties and early–thirties. People in responsible positions were seen to be using alcohol too much and this was thought to reflect badly on the community. Alcohol was seen as being readily available, easy to carry and cheaper than other drugs to get high on. It was seen as a bonding agent— especially with males. The use of alcohol is socially acceptable in the community and this then makes the control of alcohol much more difficult. Heavy alcohol use in the community is seen to cause family violence and involvement with the police, where normally people live fairly quiet lives. There was recognition from one respondent that a good cross–section of the community will use alcohol and some other drugs for whatever purpose they need them. This did not necessarily mean that these people are "abusers" of alcohol and other drugs. One other talked about moderation and how important this is as opposed to "abuse".

The use of yandi amongst young people was of grave concern to many of the respondents, as it was seen to be culturally and spiritually unacceptable. They pointed out that yandi is prevalent in the gaols (outside the ACT) and schools and is available on the streets to Aboriginal children. The lack of parental control and guidance for youth on the issue of yandi was the concern of one respondent who said that

> *"the kids are seeing their parents doing it and if they can we can..."*

Most of the respondents appreciated the pressure society places on young people and how difficult it can be for them to fit in. There was also recognition of peer pressure, the problems of self esteem and the difficulties for the young in having the capabilities to break away from destructive forces.

For Aboriginal women heavy use of prescription drugs, especially sedatives, was the main drug problem, and this was thought to be becoming more common. Prescription drugs were said to be available on the black market and it was believed that Aboriginal people were using this source to purchase drugs.

Heroin was mentioned by two respondents who suggested that there were many heroin users who were hidden and that the community was not aware that they are users. The comment was also made that experimental use and dependence were usually mutually exclusive.

The community leaders were also asked to comment on the general effect of alcohol and other drugs on the Aboriginal community. Prompts for this question included image, cultural strength and identity, survival, disempowerment and equity (whites can use without being judged). The responses were varied and covered many issues.

The major effect that was identified by the respondents was the impact of alcohol and other drugs on how the community perceived itself and the negative and destructive social and cultural impact of alcohol in particular.

"[Alcohol] destroys people and robs the community of valuable people".

One respondent talked about how the community was

"lacking in cohesiveness and dignity"

and that the family unit is also strongly affected by the use of alcohol at home and in public.

"Losing our social identities – into white lightening"

and

"It just buggers them up – they are completely different people"

are comments that show the perceived effects of alcohol and other drug use on individuals.

Another respondent felt that whenever alcohol was involved, racism raised its head. It was felt that non–Aboriginal people would not attract the same sort of attention that is given to Aboriginal people in the same circumstances. In the wider context, other respondents also indicated that this was an example of the need for community members to take responsibility for themselves and be seen to be doing the right thing.

"The wider community tar us with the one brush. Community leaders should be mindful they are role models."

b. Service provision

Community leaders were asked “Do you personally know which services in Canberra help with drug and alcohol problems?”. No prompts were provided. The results (Figures 4a and 4b) reflect that, apart from those with a background in alcohol and other drug issues, the majority of the community leaders interviewed did not have an extensive knowledge of available services. It is particularly noteworthy that many government services were not mentioned.

FIGURE 4a. Services known to help with drug and alcohol problems

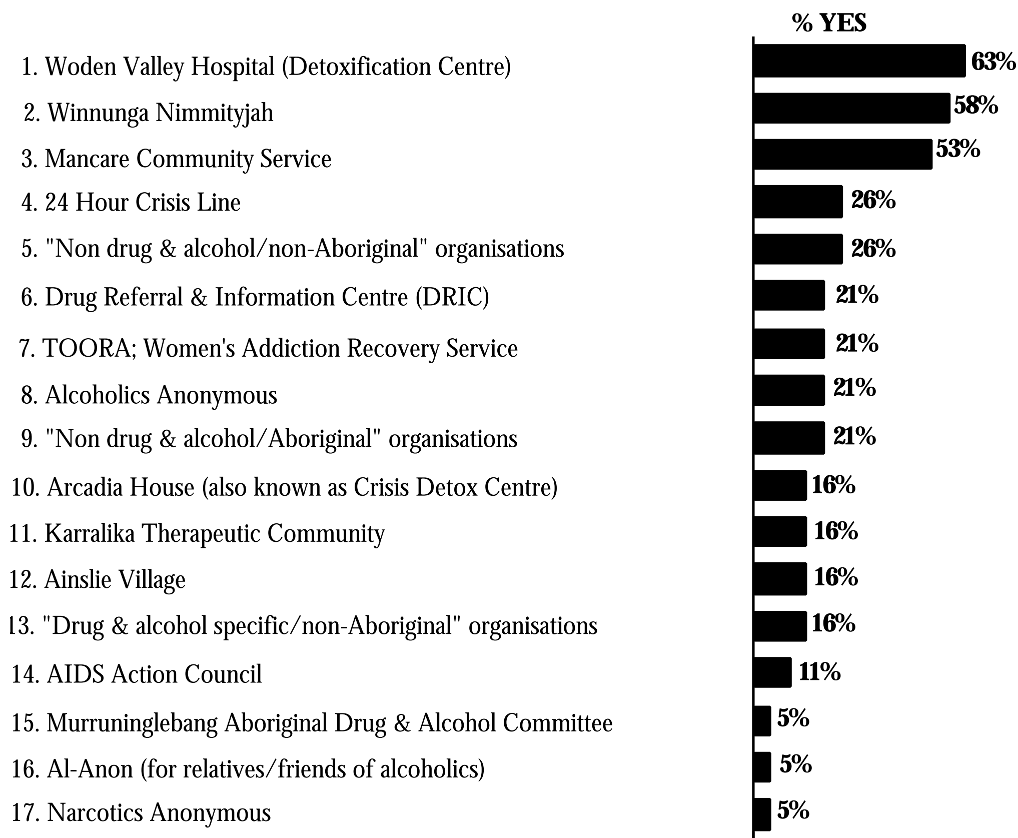
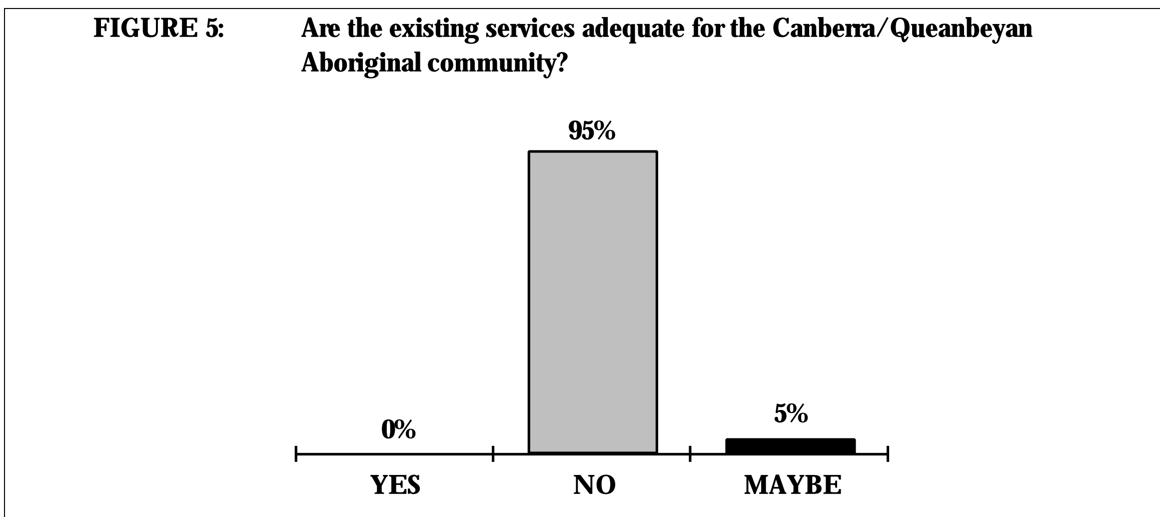


FIGURE 4b: Alcohol and other drug services not mentioned by community leaders

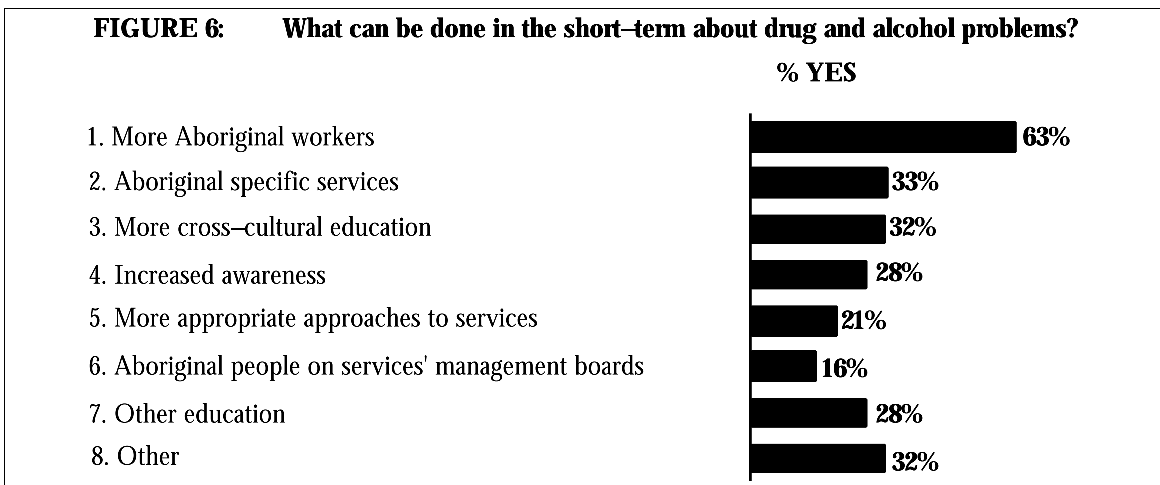
1	Alcohol and Drug Services (Government)
2.	Woden Valley Hospital Unit (methadone)
3.	Woden Valley Hospital Unit (counselling)
4.	Civic Community Unit (counselling)
5.	Civic Treatment Referral Unit
6.	ADD Inc
7.	Needle Exchange Program
8.	Rennie St Halfway House
9.	ACTIV League
10.	ADFACT
11.	Halfway House
12.	Drink Driving Prevention Program
13.	General practitioners
14.	Sharps Hotline
15.	Drugs in the Family

Apart from Winnunga Nimmityjah, services mentioned which were not on our list (see question 13 in Appendix B) were grouped into three categories. The category "Non drug and alcohol/non–Aboriginal" includes refuges, the police, and the government service Home and Community Care. The category "Non drug and alcohol/Aboriginal" includes the Aboriginal Legal Services and community organisations such as the Bogong Aboriginal Rugby League. "Drug and alcohol specific/non–Aboriginal" refers to organisations such as the Alcohol and Drug Foundation of Australia (ADFA, now called the Alcohol and Other Drugs Council of Australia) and Kenmore Psychiatric Hospital.

None of the respondents thought that existing services were adequate for local Aboriginal people (Figure 5).



The views of community leaders on short–term solutions to alcohol and other drug problems are shown in Figure 6. It can be seen that more Aboriginal involvement rated highly. This could be achieved by employing more Aboriginal workers, establishing Aboriginal–specific services and having Aboriginal members on the Boards of Management of services. Regarding Aboriginal–specific services, two specific suggestions were made. One was for a shop–front counselling area which would be open after 11 pm. The second was to establish a service where Aboriginal people would work with police with the aim of keeping Aboriginal people out of jail.



A need to educate workers in services about Aboriginal culture and other Aboriginal issues was also seen to be important. There was also seen to be a need to increase awareness of problems among the community. Specific suggestions were made regarding increasing awareness among children. Scare tactics, pointing out problems associated with alcohol and other drug use were suggested as well as a trip to jail. 'Other' educational issues included more education in schools and

taking children "*out to the scrub*". Two respondents also pointed out that there needed to be recognition that not much could be done in the short–term through education, but that it needed to be a long–term process.

'Other' issues raised were the need for support groups; that there needed to be role models from the community; and that non–Aboriginal people wanting to address these problems

"need to come to us Koories[2], not us to them".

Similar responses were given when community leaders were asked about the strengths and weaknesses of the existing services. The prompts provided for this question, namely location, structure, staff, programs and accessibility were all identified as important by one or more of the respondents.

In general, respondents commented that services such as Mancare, the police and the AIDS bus were "*trying to make linkages*" and "*wouldn't turn the blacks away*". Women's services were also seen as "*trying to respond*" to the needs of the community. Government services were seen to be available and accessible, but they

"must ... tailor their services for Aboriginal use".

The location of the services was not seen as a problem for one respondent because

"Canberra is not a big place, and buses are fine."

However, the response to a more general question on service provision indicated that other people saw transport and accessibility as a problem.

Two topics were raised in response to a more general question about solutions to alcohol and other drug problems.

One was the identification of Aboriginal positions within existing services and Aboriginal–controlled alcohol and other drug services. Indeed, the issue of "*Koorie specific services*" was a major area of concern.

The second was detoxification centres, which were specifically criticised because they do not employ Aboriginal workers.

"We should have our own detox; for blacks, by blacks".

c. Other solutions

In response to a more general question about solutions to alcohol and other drug problems, the community leaders raised service provision issues, discussed above, and wider issues which are discussed here.

The provision of an Aboriginal community place or community centre was seen as very important by the majority of respondents. They saw a centre as a way of increasing community support networks within the Aboriginal community, as well as providing a good meeting place and a location to get information to the community. This opinion was supported by various comments such as

"We have to be careful that we don't just address the drug and alcohol problem – we have to look at the community structure."

Another said

"The community have to have a say and some control over it."

Another commented that we need

"the generation of a real sense of a Koorie community."

Thirteen respondents raised the issue of educational and awareness programs to target children and youth as well as adults. Within this context they also mentioned the key problem of funding, not only for these programs, but also for programs aimed at prevention, intervention and treatment of alcohol and other drug problems in Aboriginal people.

HIV/AIDS

Community leaders were first asked "What is your understanding of the AIDS issue for Aboriginal people?". Fear and uncertainty about HIV/AIDS were expressed by a number of respondents. For example

"Hear the word AIDS and you panic."

"If you get it, you die."

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[2] the authors do not all agree with this spelling of the word Koorie, but for the purposes of this report have chosen this spelling.

"AIDS will kill us same as everyone else and they will get it."

Related to this, some respondents thought that the only way to educate the community about HIV/AIDS was to make it dramatic,

"give them hard–hitting facts",

and to be explicit about the disease itself.

Education and awareness were identified by 13 respondents as the key factors in ensuring that Aboriginal people are made aware of the significance of the impact of HIV/AIDS.

"Education is absolutely essential."

Respondents felt that the community is not educated enough; that HIV/AIDS awareness is not broadcast enough; that we need

"more education, protection and screening",

and that

"people need to understand".

As part of the educational and awareness concerns, respondents also identified a range of specific issues which need addressing. These include the fact that many in the community perceive HIV/AIDS to be a homosexual disease

"AIDS is seen as a white gay disease – community needs to be told it is heterosexual too."

Cultural factors, sexual behaviour (safer sex practices and "promiscuity") and the mobility of the community were also seen to be important.

One respondent said that HIV/AIDS was not seen to be a part of Aboriginal lifestyle or culture, but that traditional communities were just as much at risk as urban and rural communities. It is important to be able to recognise differences between communities and that *"shame"* concerning sexual matters and asking for help plays a major role in how individual communities approach the HIV/AIDS issue.

Young people were seen to be a specific risk group in that they moved from one community to another and that they were "*irresponsible*" in their sexual practices. Homosexual men were also said to move away from their home community to find sexual partners elsewhere and they were thought to not necessarily practise safer sex.

Community leaders were then asked if they saw the Canberra/Queanbeyan community as being at risk of AIDS. The results show that the majority of respondents saw the community as being at risk (Figure 7). Three respondents thought the risk of contracting AIDS was low because they did not know anyone in the community who had the AIDS virus.

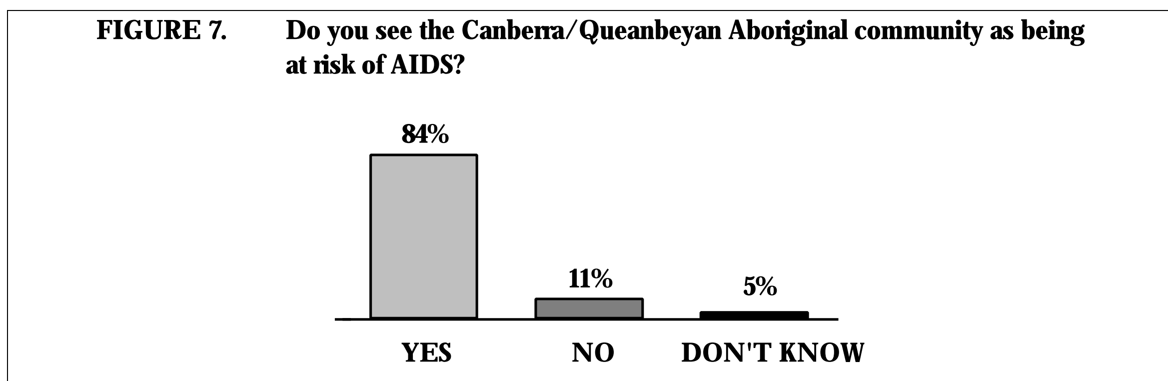


FIGURE 7. Do you see the Canberra/Queanbeyan Aboriginal community as being at risk of AIDS?

The respondents were asked to give reasons why they thought the Canberra/Queanbeyan community was or was not at risk. Again, the issue of the lack of education and awareness was raised and young people were again identified as the group at most risk. This is reflected in comments such as

"Young ones – [it's just] one big party"

and

"Young ones looking for a partner for one night."

Some members of the community thought that by living in Canberra AIDS would not touch them. However, the more general view was that not only was the Canberra/Queanbeyan community at risk, but so was the wider community–right across Australia. In other words, Canberra/Queanbeyan was seen as

"... no different to any other area"

and 5 respondents stated that AIDS is of

".. national concern, which is a problem right across society – no exceptions."

"Promiscuity" and not taking the necessary precautions for safer sexual behaviour were seen as important elements by seven respondents. They thought this pointed to a general unwillingness by people in the community to take responsibility for their actions. As one respondent said

"One person contracted AIDS ... and travels extensively – does [s/he] care?"

Another expressed a concern that

"When you promote a promiscuous society, of course we are at risk."

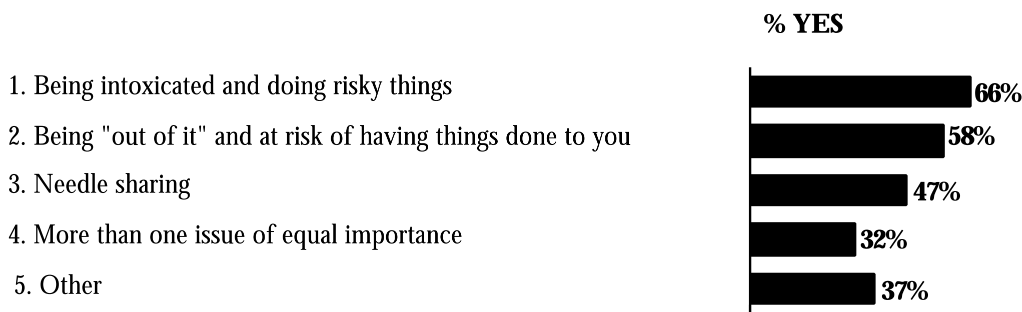
and another

"Sexually they take risks."

A strong link was perceived between alcohol and other drug use and HIV/AIDS risk (Figure 8). The question on this aspect was asked differently by the two interviewers: one did not prompt for risky behaviours; the other did; and hence the absolute percentages need to be interpreted with some caution. If both had prompted, the percentages would probably have been higher. If neither had prompted, they would probably have been lower. Nevertheless, intoxication was seen to be associated with risky behaviour. When people are "out of it" through using alcohol or other drugs they are perceived to engage in risky behaviours such as "promiscuity", unsafe sex and needle–sharing. 'Other' factors perceived to be important were peer pressure, ignorance, lack of sex education at school and that people "*play around*" in their home communities. The comment was made that

"It's a communal lifestyle; anything communicable rages".

FIGURE 8. What connection do you see between drug and/or alcohol use and AIDS risk in the Canberra/ Queanbeyan Aboriginal community?



The effect of HIV/AIDS on the Canberra/Queanbeyan community was discussed with the community leaders and concerns about major social and community impacts were raised. These are reflected in comments such as

"People with natural talent are being lost"

"[It] does affect the whole community – it shouldn't but it does"

and

"People get shunned."

The spread of HIV/AIDS was seen as having a potentially disastrous effect on how the community would function. However, some respondents were uncertain about how the spread of HIV/AIDS in one community could affect another community. Eight respondents saw that HIV/AIDS could make the community dysfunctional. The general feeling among community leaders was that they had no solutions for addressing this issue.

There was also concern that people in the Canberra/Queanbeyan community did not want to talk about or face the issue that Aboriginal people in the local community have HIV/AIDS*. One respondent made a very strong point that we have to get past community denial if we are to do anything to combat the disease at the community level. Although one respondent saw that there were more deaths related to alcohol than HIV/AIDS, others saw AIDS as a disease that could wipe out communities

"[it] will kill [us] faster than the white invasion."

SERVICE PROVIDERS

The Sample

Twenty–eight service providers from 15 agencies were interviewed. Two of the services were Aboriginal and three of the service providers interviewed were Aboriginal. ACT and NSW (Queanbeyan) government agencies were included and there were also 13 non–government agencies in the sample. Twelve of the service providers interviewed worked for government agencies and 16 for non–government agencies. Five of the agencies (18 of the service providers) dealt only with alcohol and other drug problems; for 3 agencies (3 service providers) this was a major part of their work and for 7 agencies (7 service providers) dealing with alcohol and other drug problems was not their major function.

TABLE 1. Agencies and service providers

Number of agencies contacted = 15
Number of service providers interviewed = 28 (23 women, 5 men)

AGENCIES			SERVICE PROVIDERS		
Aboriginal	**Non–Aboriginal**		**Aboriginal**	**Non–Aboriginal**	
2	13		3	25	
TYPE OF AGENCY			**TYPE OF AGENCY WORKED FOR**		
Government	**Non–Government**		**Government**	**Non–Government**	
2	13		12	16	
ALCOHOL & OTHER DRUG PROBLEMS			**DEAL WITH ALCOHOL & OTHER DRUG PROBLEMS**		
Only	**Major**	**Peripheral**	**Only**	**Major**	**Peripheral**
5	3	7	18	3	7
CATER FOR			**CATER FOR**		
Men & women	**Women only**	**Men only**	**Men & women**	**Women only**	**Men only**
12	3	0	25	3	0

Ten of the service providers were involved in agencies providing rehabilitation; nine with policy, planning and education; eight with professional counselling; four with providing refuge or emergency accommodation; four with providing needle and syringe exchange; four with medical services; three with the provision of methadone and two with detoxification. (Agencies could provide more than one service and therefore be counted more than once.)

The Heroin Trial

Eighty–nine percent of the service providers had heard about the proposal for a heroin trial; 11 percent had not (Figure 9). Two of the three Aboriginal service providers had not heard about the trial proposal. More than half of the service providers had some previous involvement in research or discussions for the feasibility study and referred to this when asked

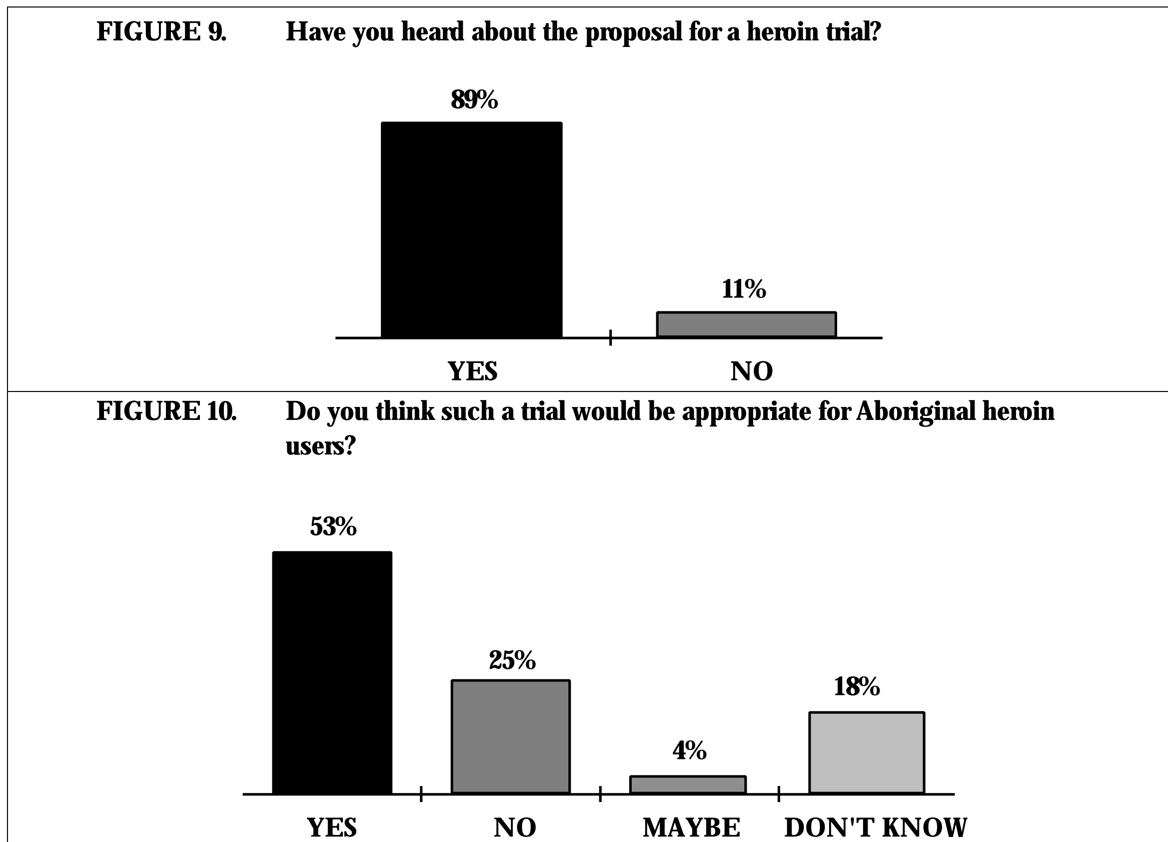
*There are a small number of known HIV–positive Aboriginal people in Canberra/Queanbeyan.

what they knew about the trial proposal. One other participant thought that a trial would run along the lines of a program in England and another thought it was a proposal for legalisation (erroneously).

Figure 10 shows the responses for whether or not a trial was thought to be appropriate for Aboriginal heroin users. Just over half thought that it would be and one–quarter thought not. All the Aboriginal service providers thought that a trial would be appropriate.

FIGURE 9. Have you heard about the proposal for a heroin trial?

FIGURE 10. Do you think such a trial would be appropriate for Aboriginal heroin users?



A number of people, both in favour and against, said that it should be the same for Aboriginal as for non–Aboriginal people. However, two people who answered "no" to this question made the following comments: one that they were opposed because, in the view of the respondent, Aboriginal people were genetically more susceptible to drugs and one because "*we* [presumably non–Aboriginal Australians] *have done enough damage*".

A range of possible positive and negative consequences was given. The positive factors included that three service providers mentioned that a trial might lead to reduction in criminal behaviour and three said that if the heroin was given under controlled conditions many risks could be cut down. Each of the following factors was mentioned by two service providers: "*decriminalising*" (their words) would make it possible to get a better sense of how many people were using; improved understanding would dispel some of the myths and prejudices; and a trial could take people off methadone. Other factors mentioned were: that it would be "*an enormous crack in the door*"; that it would enable users to put more energy into the rest of their lives; that it would improve health; that it would mean giving clean drugs in a controlled environment; that it would not be so expensive; that it is a means of getting people to stop using; and that it has fewer risks environmentally.

The negatives included: that more people might move to Canberra; that a trial would cost a lot of money; that it might be difficult to establish a secure administration site; that it could not be (or would have to be) properly monitored; that a trial would not be workable in part because the effects of heroin only last for a few hours; that it might lead to an increased number of users; and that it was not working overseas. Each of these was mentioned by two service providers. Other factors were: that it was an improper use of a drug that should be used in palliative care; that it could lead to invasion of privacy for those on a trial; that the people on a trial would develop bad veins from the many injections; that it would lead to a new black market; and that the idea of providing an injectable drug was problematic.

Alcohol and other drug use generally

All the service providers thought that the Aboriginal community was at risk from alcohol and other drug use (Figure 11).

Sixty–one percent of the service providers said all of their clients (both Aboriginal and non–Aboriginal) were alcohol and other drug affected; 29 percent said more than 50 percent were; and 11 percent said less than 50 percent were (Figure 12). This needs to be viewed in light of the results in Table 1, where the functions of the agencies regarding alcohol and other drug use are described.

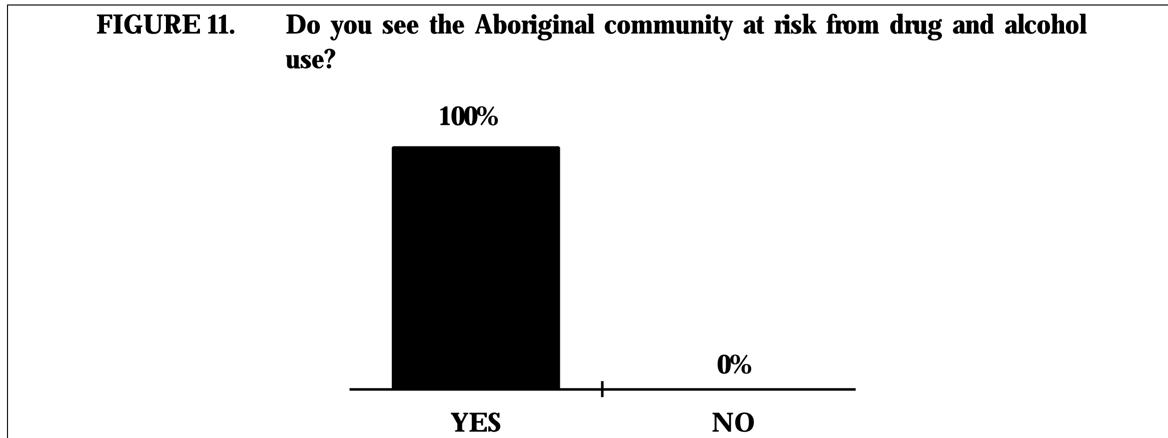


FIGURE 11. Do you see the Aboriginal community at risk from drug and alcohol use?

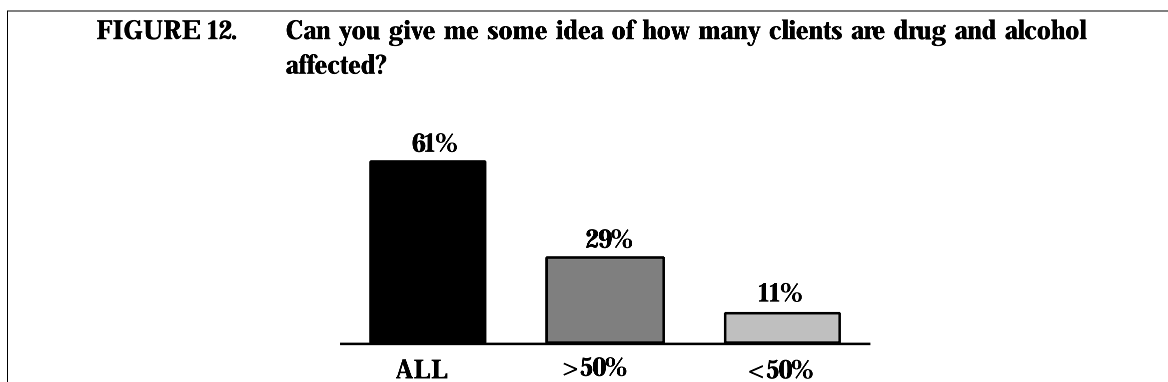
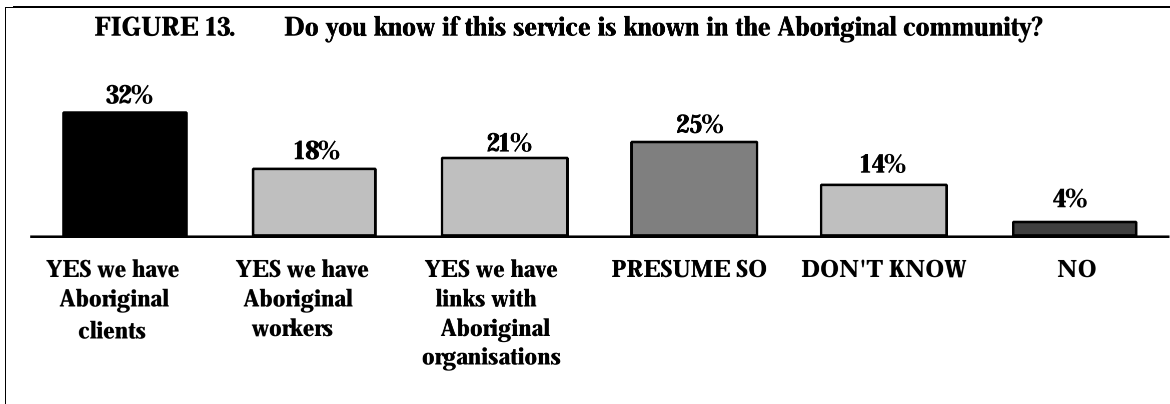


FIGURE 12. Can you give me some idea of how many clients are drug and alcohol affected?

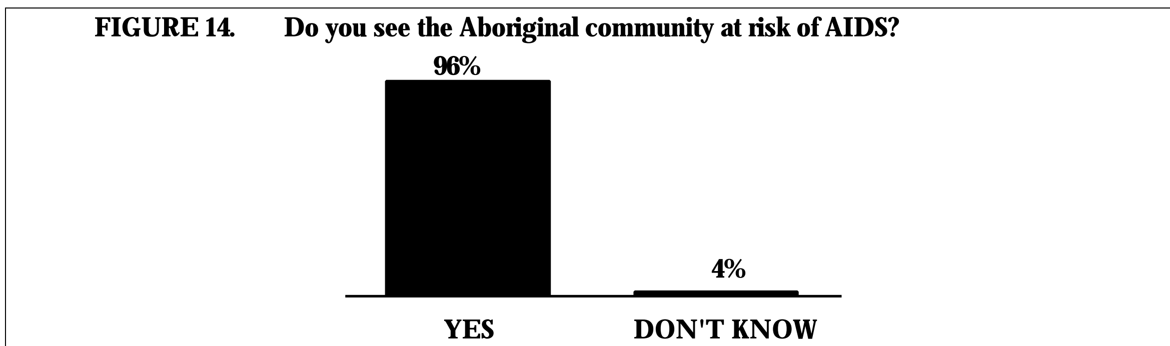
When asked about the ratio of Aboriginal to non–Aboriginal clients, there was a marked difference between agencies that employed Aboriginal workers and those that did not. The two service providers from Aboriginal agencies reported that 95 percent of the clients were Aboriginal. The service provider from the non–Aboriginal agency that employed Aboriginal workers reported that 70 percent of clients were Aboriginal. For the remaining non–Aboriginal agencies: one service provider did not know; three said they had no Aboriginal clients; most reported that they had one or two Aboriginal clients; two reported up to 5 percent; and one reported that 33 percent of clients were Aboriginal (because of the nature of the service the majority were children).

Figure 13 shows the responses to the question “Do you know if this service is known in the Aboriginal community?”. Most service providers thought that their agency was known, either because they have Aboriginal clients (32 percent; 2 of these were from Aboriginal services), have links with Aboriginal organisations (21 percent), or have Aboriginal workers (18 percent; 2 of these were from Aboriginal services) (more than one response could be given). Twenty–five percent presumed their service was known, but had no evidence; 14 percent did not know and 4 percent said “no”.



HIV/AIDS

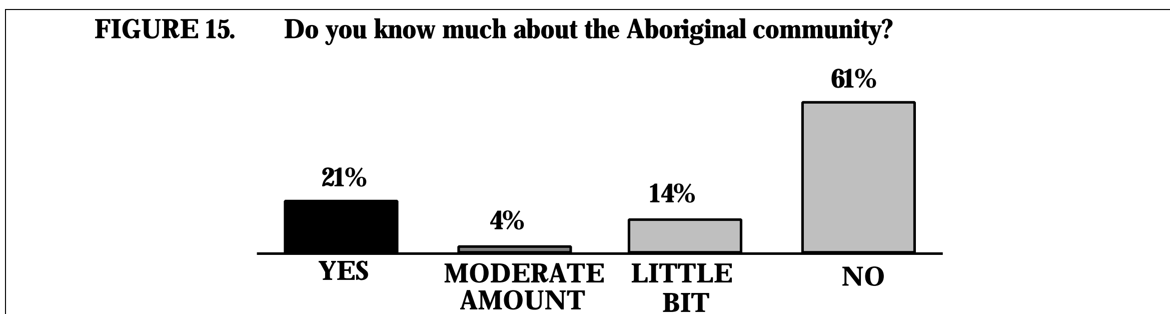
All the service providers were aware of AIDS as an issue and 96 percent thought the Aboriginal community was at risk for HIV/AIDS (Figure 14). One service provider said that they did not know. The majority said that the risk for the Aboriginal community was the same as for everyone else.



One service provider from an Aboriginal organisation who commented that "*AIDS will wipe us all out*" reported that the agency's workers were not educated about HIV/AIDS.

Knowledge about the Aboriginal community

In response to the question "Do you know much about the Aboriginal community?", 21 percent of service providers said "yes", 4 percent said "a moderate amount", 14 percent said "a little bit" and 61 percent said "no". Of the 21 percent who said "yes", half were Aboriginal workers. The results are shown in Figure 15.



Discussion and Conclusions

The heroin trial

While there is no clear picture of the extent of heroin use in the Aboriginal population or about the characteristics of Aboriginal heroin users, an argument can be made that if a 'heroin trial' proceeds, it should be available to Aboriginal heroin users. Both the community leaders and the service providers were marginally in support of a trial for Aboriginal heroin users. More importantly, the advantages and disadvantages of the trial proposal were seen to apply equally to Aboriginal and non–Aboriginal users. Only a few respondents thought that Aboriginal heroin users should somehow be seen as different; they were all opposed to a trial.

Thus the question of whether or not a trial is appropriate for Aboriginal heroin users is subsumed under the broader question of whether or not a trial should proceed at all. This is the concern of the whole feasibility study and will therefore not be discussed further here.

Alcohol and other drug use

Both the community leaders and the service providers thought that alcohol and other drug use was an issue for the Aboriginal community. The community leaders saw alcohol and yandi (cannabis) as the drugs of most concern.

Regarding service provision, there seems to be a mismatch between the perceptions of community leaders and of service providers. While many service providers thought that their services were known in the Aboriginal community, none or very few of the community leaders knew about the majority of services. To protect confidentiality, we have not reported here on matching between individual services, but the picture holds if this is done. There are clearly two well–known non–Aboriginal services: the detoxification centre at Woden Valley Hospital and Mancare.

It is also important to note that only services which had Aboriginal workers reported a high proportion of Aboriginal clients. The vast majority of services had very few Aboriginal clients. This is despite the agreement between community leaders and service providers that alcohol and other drug use is a problem for local Aboriginal people. Further work needs to be conducted on the needs for services from the point of view of those with alcohol and other drug problems.

The Aboriginal community leaders thought that existing services were inadequate and suggested more Aboriginal involvement in services to improve the situation. Strategies for achieving this which were supported included employing more Aboriginal workers, establishing Aboriginal specific services and having Aboriginal members on Boards of Management of services. Specific mention was made of the need for an Aboriginal detoxification centre. A need to educate workers in services about Aboriginal culture and other Aboriginal issues was also seen to be important. This last point ties in well with the responses of the service providers, which show that those who are non–Aboriginal know little about the Aboriginal community.

There is scope for a range of interventions here, but some notes of caution need to be injected.

One possible area for intervention would be to employ more Aboriginal workers in existing services. However, Aboriginal workers employed in non–Aboriginal organisations cannot be expected to work successfully in isolation. They need to be given the opportunity to network extensively with other Aboriginal workers and to have a base in the local Aboriginal community. Furthermore, they need to be employed at a high enough level in the organisation to be able to influence policies and services.

Another possible area for intervention is to improve knowledge among service providers and policy makers about Aboriginal issues. However, education about Aboriginal culture and other issues is not something that can be learnt in a one–off lecture. On the other hand, talks by Aboriginal people have some value, though too often Aboriginal people are expected to provide this service without compensation.

A third possible area for intervention is to strengthen existing, or to establish new, Aboriginal–specific services. Again such initiatives need to be adequately resourced.

Community leaders also identified the need for an Aboriginal community place or community centre. This was seen to be a way of facilitating community building and as an education outlet. Education and awareness programs, particularly targeting youth were also seen to be important.

It is clear that improvement in Aboriginal health in relation to problems caused by alcohol and other drugs requires serious and long–term commitment– not tokenistic gestures. Initiatives need to be under Aboriginal control and must be adequately resourced.

HIV/AIDS

Similar considerations apply in the area of HIV/AIDS. Again both community leaders and service providers see the Aboriginal community to be at risk from HIV/AIDS and there was a perception that the risks are similar in the Aboriginal and non–Aboriginal communities. The community leaders see education of the community as an important prevention strategy. The results from the service providers study indicate that there also seems to be a need to increase the level of HIV/AIDS education among alcohol and other drug workers and particularly among Aboriginal workers.

It is interesting that in relation to other community issues such as education, unemployment, housing, family violence, racism, alcohol and yandi, HIV/AIDS did not rate as a major issue of concern for Aboriginal community leaders (see the companion report by Moloney et al., 1993). While between 60 percent and 85 percent of community leaders rated these other issues as being of major concern, only 5 percent rated AIDS in this way.

Nevertheless, when they were asked specifically about HIV/AIDS, many community leaders reported fears that it could have a significant negative impact on the community. The risks of spread through unsafe sexual practices, especially among young people, were a particular worry. Intoxication was seen to play an important role in increasing these dangers.

It is important to note that there was a feeling among Aboriginal community leaders that they had no solutions for adequately dealing with this issue. This is an important area which needs to be urgently addressed.

REFERENCES

Castles, I. (1993) *Australia's Aboriginal and Torres Strait Islander Population*, Census of Population and Housing, 6 August 1991. Canberra: Australian Bureau of Statistics, Catalogue No. 2740.0.

Moloney, M; Humes, G; Baas Becking, F. and Bammer, G. (1993) *"Finding out for ourselves". An analysis of the needs of Canberra/Queanbeyan Aboriginal people, especially with regard to alcohol and other drug problems and HIV/AIDS risk.* Canberra: Winnunga Nimmityjah, National Centre for Epidemiology and Population Health and Australian Institute of Criminology.

Dear

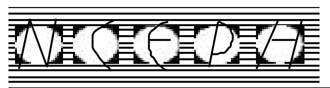
WHAT IS THE HIV RISK FOR ABORIGINAL HEROIN USERS IN THE ACT?

Winnunga Nimmityjah (Aboriginal Health Service), The National Centre for Epidemiology and Population Health (NCEPH) and the Australian Institute of Criminology (AIC) have developed a research project to find out if Aboriginal heroin users in the ACT are at risk of HIV. The project aims are to:

- establish the nature, importance and extent of drug related problems, particularly HIV risk, in the ACT Aboriginal community;
- establish the number, characteristics and behaviours of Aboriginal heroin users in the ACT;
- assess the appropriateness of current alcohol and other drug services in the ACT for Aboriginal people; and
- assess, from an Aboriginal perspective, the feasibility and acceptability of a trial to provide heroin to dependent heroin users in a controlled manner.

The project will be divided into three sections. These will be interviews with three different groups of people: Aboriginal heroin users; identified Aboriginal community leaders; Aboriginal and non–Aboriginal service providers. It is the intention of the project that community leaders and service providers will be asked to identify problems and strategies for meeting the needs of Aboriginal heroin users.

NATIONAL CENTRE FOR EPIDEMIOLOGY AND POPULATION HEALTH
THE AUSTRALIAN NATIONAL UNIVERSITY, GPO BOX 4, CANBERRA ACT AUSTRALIA 2601
TELEPHONE 06 249 2378 FAX 06 249 0740



NATIONAL CENTRE FOR EPIDEMIOLOGY AND POPULATION HEALTH

AUSTRALIAN INSTITUTE OF CRIMINOLOGY

CONSENT FORM

The results of the research will be available for agencies to consider in terms of improving services to Aboriginal people. Winnunga Nimmityjah will use the results to develop programs to address these problems and to advise other agencies on how their services for Aboriginal people could be improved.

NCEPH and the AIC will use the results to produce a working paper in the series "Feasibility Research into the Controlled Availability of Opioids Stage 2 Working Papers" and it is also planned that they will write up the results for publication in academic journals. However, this will not be done without the approval of Winnunga Nimmityjah.

The project team will consist of Aboriginal and non–Aboriginal team members who are involved in all stages of the project.

It is extremely important that prominent Aboriginal people and organisations who provide services to heroin users are interviewed to assist in identifying issues within the community which impact on Aboriginal heroin users and on the provision of services to Aboriginal heroin users.

The project commenced in late January 1993 and will conclude in late June 1993.

It is planned that the interview will be in the form of a questionnaire which has been developed by the research team. The questions will cover areas such as client services, service provision and unmet needs.

Your input into the research would be greatly appreciated and useful. A project team member will be in contact with you in the next week to arrange a time which is mutually agreeable to interview you.

I... understand that this study is for the purpose of research into "What is the HIV risk for Aboriginal heroin users in the ACT?". It is conducted by Winnunga Nimmityjah, the National Centre for Epidemiology and Population Health (NCEPH) at the National University and the Australian Institute of Criminology (AIC).

I understand that I will be asked questions about the Aboriginal community in Canberra/Queanbeyan in regards to issues of concern to the community, service delivery to Aboriginal people and issues of alcohol and drug use in the community.

I understand that all possible precautions have been taken to protect my identity and the security of the information I provide.

I understand the results of this study will be made available in a public document but it will be done in a way that no information identifying me will be published.

I understand I can ask any questions during the interview at any time as long as these do not involve a breach of another's confidentiality.

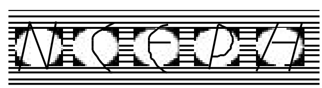
I understand that I have the right to decline to answer any question during the interview and that I can terminate the interview at any time.

I understand that this interview will take about 90 minutes to complete.

Signed..

dated..

NATIONAL CENTRE FOR EPIDEMIOLOGY AND POPULATION HEALTH
THE AUSTRALIAN NATIONAL UNIVERSITY, GPO BOX 4, CANBERRA ACT AUSTRALIA 2601
TELEPHONE 06 249 2378 FAX 06 249 0740



NATIONAL CENTRE FOR EPIDEMIOLOGY AND POPULATION HEALTH

AUSTRALIAN INSTITUTE OF CRIMINOLOGY

APPENDIX B.

COMMUNITY LEADERS QUESTIONAIRE

12 March, 1993

ABORIGINAL **C**OMMUNITY **A**IDS **P**ROJECT

NAME ______________________________

DATE ______________________________

1. How would you identify the Aboriginal community of Canberra and Queanbeyan?

....
....
....
....

2. What makes this community work? [What are the good things]

....
....
....
....

3. Why doesn't the community work? [What aren't so good]

....
....
....
....

4. Are there any particular things we should know about the Canberra/Queanbeyan Aboriginal community?

....
....
....
....

5. What are the major issues of concern to the Canberra/Queanbeyan Aboriginal community? [Do not go through list or prompt – just circle all that are mentioned, and write down any comments]

[Then ask interviewee to pick most important out of those mentioned] ☐

1*Alcohol issues
2* Yandy (marijuana) issues
3* Other drug issues
4* AIDS
5* Lack of support for the community
6* Unemployment
7* Youth have no direction
8* No adequate services
9* Housing
10* Health
11* Lack of family support
12 * Education
13* Racism
14*Police relations
15* Gambling
16* Sexual lifestyles
17* Family violence (adult)
18* Child abuse (physical, psychological, sexual)
19* Sexual assault (adult)
20* Other ....

....
....
....

....
....
....
....

[Note for interviewer — If not already mentioned, ask specifically about :
* Unemployment
* Education
* Racism
* Police relations
* Family violence (adult)]

6. Do people in the Aboriginal community identify as part of the wider Canberra/Queanbeyan community?

yes ☐

no ☐

7. To what extent do people in the Canberra/Queanbeyan Aboriginal community use services elsewhere?

....
....
....
....
....

If they do, what are these services?

....
....
....
....
....

8. How mobile is the community?

....
....
....
....
....

Can you give percentages for the following groups? :

1* stay here all the time ☐

2* stay here most of the time but sometimes go away for a few weeks ☐ (not annual leave)

3* stay here some of the time and go away for a few months ☐

9. [Note for interviewer – Ask question if not previously mentioned; OR
If previously mentioned in Q5, ask for more specific information]
Do you see the community as having problems with alcohol, yandy, sniffing or other drugs?

[Circle YES, NO or DON'T KNOW, then ask interviewee to pick most important]

1* Alcohol	YES / NO / DON'T KNOW
2* Yandy	YES / NO / DON'T KNOW
3* Sniffing	YES / NO / DON'T KNOW
4* Other drugs	YES / NO / DON'T KNOW

10. Can you give details of the drug and/or alcohol problem?
[**prompts** - particular part of the community (eg young people)
- particular drugs]

....
....
....
....
....

11. As a community, what do you see that needs to be done in relation to drug and alcohol problems?

....
....
....
....

12. What can be done in the short-term about drug and alcohol problems?
[Do not prompt - circle all that are mentioned, then ask interviewee to pick most important]

1* more aboriginal workers
2* aboriginal people on services management boards
3* more cross-cultural education
4* more appropriate approaches to services
5* other (specify)..

....
....
....
....
....

13. Do you personally know which services in Canberra help with drug and alcohol problems?
[Do not prompt – circle all those that are mentioned]

1* <u>Alcohol and Drug Services (Government)</u>
    2* Woden Valley Hospital unit (Methadone)
    3* Woden Valley Hospital unit (Counselling)
    4* Woden Valley Hospital unit (Detoxification centre)
    5* Civic Community Unit (Counselling)
    6* Civic Treatment Referral Unit
    7* 24 Hour Crisis Line
8* <u>ADD Inc.</u>
    9* Crisis Detox Centre (CDC) / Arcadia House

10* Drug Referral and Information Centre (DRIC)
11* Needle Exchange Program
12* Halfway House/ Renee
13* ACTIV League; Jude Byrne
14* 24 Hour Crisis Line
15* ADFACT
16* Karralika Therapeutic Community / Isabella Plains
17* Halfway House
18* Drink Driving Prevention Program
19* TOORA ; Womens Addiction Recovery Service
20* Mancare Community Service; Wayne Cunningham
21* Ainslie Village; Noreen
22* AIDS Action Council ; Jan Glass
23* Murruninglebang Aboriginal Drug and Alcohol Committee
24* G.P.: Dr Peter Rowland
25* ANU Campus AIDS Worker; Jane Kearney
26* Sharps Hotline
27* Alcoholics Anonymous
28* Al-Anon (for relatives/friends of alcoholics)
29* Drugs in the Family (Recorded message for parent support)
30* Narcotics Anonymous
31* Other ____

....
....
....
....
....
....
....

14. Are the existing services adequate for the Canberra/Queanbeyan Aboriginal community?

1*yes
2*no
3*maybe
4*don't know

Can you tell us more about your answer?

....
....
....
....

15. What would you say are the strengths and weaknesses of the existing services?

prompts:
- location
- structure
- staff
- programs
- accessibility

....
....

....

....

16. What is your understanding of the AIDS issue for Aboriginal people?

prompts:
- in general
- specific for Canberra/Queanbeyan
- what about AIDS education for Aboriginal people

....

....

....

....

....

17. Do you see the Canberra/Queanbeyan Aboriginal community as being at risk of AIDS?

1* yes
2* no
3* maybe
4* don't know

18. Why is/ why isn't the Canberra/Queanbeyan community at risk of AIDS?

....

....

....

....

....

19. Have you heard about the proposal for a "heroin trial" in the ACT?

1* yes
2* no
3* maybe
4* don't know

If **Yes** - What have you heard?

....

....

....

....

....

....

Note for interviewer – If No, explain that the 'herion trial 'is a trial where heroin would be provided to dependent users in a controlled manner.

20. What positive or negative effects would you see as coming from such a trial?

prompts:
- criminal activity reduction
- improved health
- more users
- people moving to Canberra/Queanbeyan

....

………

………

………

………

………

21. Do you think such a trial would be appropriate for Aboriginal heroin users?

1* yes
2* no
3* maybe
4* don't know
Why is/ why isn't such a trial appropriate for Aboriginal herion users?

....
....
....
....
....

22. What connection do you see between drug and/or alcohol use and AIDS risk in the Canberra/Queanbeyan Aboriginal community?
Do not prompt – circle all that are mentioned, then ask interviewee to pick most important.

1* needle sharing
2* being "out of it" and at risk of having things done to you
3* being intoxicated and doing risky things
4* other ....

....
....
....
....

23. Drugs and alcohol have a major effect on the Canberra/Queanbeyan Aboriginal community. Can you comment?

prompts
- image
- cultural strength and identity
- survival
- disempowerment
- equity (whites can use without being judged)

....
....
....
....
....

24. What about [the effect of] AIDS and the Canberra/Queanbeyan Aboriginal community? Can you comment?

prompts
- image
- cultural strength and identity
- survival
- dis-empowerment
- equity (whites can use without being judged)

....
....
....

………

………

25. What is your understanding of the hepatitis issue for Aboriginal people?

Note for interviewer Be sure to talk about both Hepatitis B and Hepatitis C
prompts: - in general
- specific for Canberra Queanbeyan community

………

………

………

………

………

26. Do you see the Canberra/Queanbeyan Aboriginal community as being at risk to Hepatitis?

Note for interviewer Be sure to talk about both Hepatitis B and Hepatitis C

1* yes
2* no
3* maybe
4* don't know

27. Why is/ why isn't the Canberra/Queanbeyan Aboriginal community at risk of Hepatitis?

Note for interviewer Be sure to talk about both Hepatitis B and Hepatitis C

………

………

………

………

………

APPENDIX C.

QUESTIONNAIRE FOR SERVICE PROVIDERS

ABORIGINAL COMMUNITY AIDS PROJECT

29 MARCH 1993

NAME ______________________________

DATE ______________________________

1. Can you talk about what this service does?
   * function
   * Is this an Aboriginal specific service
   * what do you specifically provide?
   * other

2. Can you tell me about your staff?
   * number of staff ....
   * what do they do
   * gender breakdowns % FEMALE_________ MALE_________
   * age breakdowns % 15-19_____ 20-24_____ 25-29_____ 30-34_____
     35-39_____ 40-44_____ 45-49_____ 50-54_____
     55-60+____
   * full time/ part time % full time_______ part time_______
   * Aboriginal workers [home community]
   * ethnic workers - specify ethnicity
   * qualifications and experience of workers
   * training in working with Aboriginal clients % trained _____ untrained _____

3. Can you tell me about the day to day operation of your service?
   * by phone - in person
   * hours of operation
   * emergency / after hours
   * outreach
   * residential
   * other

4. How do people come to use your service?
   * court order
   * word of mouth
   * referral - by whom
   * publicity

   Can you give me some idea of percentages?

Other

5. Do you know if this service is known in the Aboriginal community?
    * how do you know
    * what restriction do you see to it being known

6. What is your management structure?
    * Aboriginal involvement at board or director level

7. Do they work specifically with Aboriginal people or the wider community?
    * if indicated that an Aboriginal worker is employed follow Q2.
    * funding for the worker - Is this identified by the service or the funding body

8. What do you mean by the word client?
    * person who contacts the service by phone
        for self
        for others
    * person who comes in to service

9. Do you keep formal records of the client numbers?

10. Can you give me a breakdown of your total client numbers and give some idea of the ratio of
    * Aboriginal clients
    * ages
    * male / female

11. How is a person identified as an Aboriginal?

12. What is your estimate of the number of clients who come in over a 12 mth. period and how often?

13. Why would a person need to come to your service more than once?
    * ongoing help with the same problem
    * to see another worker in the service
    * new or different problems
    * all of the above or none

14. Do many clients ring up for advice only?
    * do you keep numbers
    * do many follow up
    * are many referred to other agencies
    * how many would you know don't follow up / How
    * could you suggest any reason why clients wouldn't follow up

15. Can you give me some idea of how many clients are drug and alcohol (D/A) affected?

16. Do drug/alcohol/AIDS clients come into contact with your service?
    * how
    * direct
    * ring for advice

17. What are the positives about your service?

18. What are the negatives/ restrictions?

19. Who funds the service?

20. Is the funding adequate?

21. Can clients always be accommodated or do you find sometimes you have to make referrals to other agencies?

22. What would be some idea of the number of referrals?

23. What would be some of the other agencies to which you refer clients ?

24. Are there always other agencies available to meet the needs of the client?

If not ,why not?

What then happens to these clients?

25. Are there specific projects that you have applied for to be funded in the last 3yrs?

What would be some of them?

How many would have been knocked back?

Are you always given an explanation for the approval / disapproval?

26. What would you like to see happen with your service?

27. Do you consider D / A an issue in relationship to problems your agency deals with?

    Why/why not?

28. Do you see the Aboriginal community at risk to D / A in the Canberra/ Queanbeyan community?

    Why/why not?

29. Do you see the Aboriginal community at risk to AIDS in the Canberra/Queanbeyan community?

    Why/why not?

30. Are you aware of AIDS as an issue?

31. Are you and other staff AIDS educated?

Why/ why not?

Who facilitated the AIDS education?

32. Are new members of staff AIDS educated?

Why/ why not?

33. What do you see that needs to be done by

1* your service
2* other agencies
In relationship to drugs
alcohol
AIDS
other

34. Do you know much about the Aboriginal community?

35. Have you heard about the proposal for a "heroin trial" in the ACT?

1* yes
2* no
3* maybe
4* don't know

If **yes** - What have you heard?

36 What positive or negative effects would you see as coming from such a trial?

prompts: - criminal activity reduction
- improved health
- more users
- people moving to Canberra/Queanbeyan

37. Do you think such a trial would be appropriate for Aboriginal heroin users?

1* yes
2* no
3* maybe
4* don't know

Why is/ why isn't such a trial appropriate for Aboriginal heroin users?

38 Is there anything you would like to see taken up with this study or future studies?

FEASIBILITY RESEARCH INTO THE CONTROLLED AVAILABILITY OF OPIOIDS

The Feasibility Research into the Controlled Availability of Opioids arose from a request to the National Centre for Epidemiology and Population Health (NCEPH) from the Select Committee on HIV, Illegal Drugs and Prostitution established by the Australian Capital Territory (ACT) Legislative Assembly.

A first stage of research, conducted in collaboration with the Australian Institute of Criminology (AIC), found that a trial to provide opioids, including heroin, to dependent users was feasible in principle. It was recommended that a second stage of feasibility investigations to examine logistic issues be conducted.

The first stage investigations examined illegal drug use in the ACT, the arguments for and against the controlled availability of opioids as reviewed in the literature, the current Australian political context for a trial, the role of interest groups in social controversies, legal issues, possible options for a trial, ethical issues, attitudes to a trial in the general community and among key interest groups (police, service providers, and illegal drug users and ex–users), and evaluation by a randomised controlled trial.

In addition, a proposal for a trial was developed as the starting point for the Stage 2 investigations.

The research which needs to be conducted to determine Stage 2 logistic feasibility can be divided into five areas:

- core information (for example, estimating numbers of users, determining relevant characteristics of ACT–based users, documenting the known information about the psychopharmacological and toxicological effects of opioids);
- information relevant to trial design and evaluation;
- information relevant to service provision;
- information about relevant legal, law enforcement and criminological matters;
- community and key stakeholder acceptability of a specific trial proposal.

The Stage 2 research is also governed by the following principles:

- the research should have intrinsic value so that, regardless of whether or not a trial goes ahead, the research should be of value to treatment services or to drug policy generally;
- research should be conducted in all relevant disciplines and the disciplinary findings should be integrated to address the central problem;
- the process should involve to the greatest extent possible the key interest groups– illicit drug users, ex–users, service providers, police, policy makers and the community.

Stage 2 of the feasibility research into the controlled availability of opioids has many components. As significant advances are made in each particular substudy, we publish the results as a working paper, so that the information is available for discussion in the public arena.

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NEWSLETTERS

Newsletters reporting project results are also published from time to time.

These publications are available free from:
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