Assessment of the Need for Perth-Based Aboriginal Substance Misuse Services

National Drug Research Institute
Curtin University of Technology

Assessment of the Need for Perth-Based Aboriginal Substance Misuse Services: A Report Prepared for Noongar Alcohol and Substance Abuse Service

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1. Introduction

This project was initiated by Noongar Alcohol and Substance Abuse Service (NASAS). The aim of the project is to provide NASAS with information to enable it to plan services that better meet the needs of Aboriginal people in Perth with substance misuse problems.

In 1988, 40 Aboriginal people met to discuss their concerns that existing organisations in Perth, dealing with substance misuse in the Aboriginal community, were having limited success. At the meeting decision was made to establish an Aboriginal-specific service—Noongar Alcohol and Substance Abuse Service (NASAS). Since NASAS was incorporated in 1989 it has developed a range of services to address substance misuse by Aboriginal people in Perth.[1] Among other things, the services provided by NASAS aim to respond to recommendations 80 and 287 of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) which state:

> Recommendation 80:
> That the abolition of the offence of drunkenness should be accompanied by adequately funded programs to establish and maintain non-custodial facilities for the care and treatment of intoxicated persons.
>
> Recommendation 287:
> That the Commonwealth, States and Territories give higher priority to the provision of alcohol and other drug prevention, intervention and treatment programs for Aboriginal people which are functionally accessible to potential clients and staffed by suitably trained workers, particularly Aboriginal Workers.[2]

In 1998—in accordance with recommendation 80 and in response to the observations and experiences of its own committee and staff members—NASAS began investigating the need for a Perth-based safe house (more commonly known as a sobering-up shelter) and detoxification centre for Aboriginal people. Several meetings were held between staff, committee members, funding agency representatives and private consultants to discuss the possible establishment of these services. Following this initial planning process, NASAS contracted Revelations Training & Organisational Development to prepare a business plan for the development and operation of a sobering-up, detoxification and aftercare program.[3] The business plan was comprehensive, detailing the proposed program's aims, objectives, strategies, target group, staffing requirements, data collection procedures, and estimated budget.

Approximately two years after the business plan was prepared, a meeting was held between representatives from NASAS, relevant funding agencies, and consultants from the ARUP Group and MPS Architects to discuss the next stage of the program development. During the meeting, it was recommended that Dennis Gray, from the National Drug Research Institute (NDRI), Curtin University of Technology be involved

in the management of the planning activities. This led to a number of meetings between representatives from NDRI and NASAS to discuss the role NDRI would play in the development of a safe house and detoxification centre.

It was tentatively agreed that NDRI's main role in the project would be to undertake an assessment of the needs of Aboriginal people living in Perth in relation to alcohol and drug intervention services, and in particular, to determine whether an Aboriginal specific safe house and detoxification centre is required. Both the resources and the timeframe allocated for the project limited the scope.

The project is being undertaken in two stages. The first is the needs assessment that is the subject of this report. This will be followed by a review of the existing business plan in which the recommendations arising from the needs assessment will be considered and any necessary changes to the plan will be made. NDRI is responsible for managing and conducting Stage 1 of the project, and although NASAS is responsible for undertaking Stage 2, NDRI will provide assistance and support during this review process.

1.1 Objectives

Bob Coote from the ARUP Group first proposed the objectives of the needs assessment; the NASAS Reference Group later refined them with the assistance of NDRI. To better reflect the purpose of the project the objectives, as agreed to by NASAS and NDRI, were as follows. To:

- identify the extent of alcohol and other substance misuse amongst the Aboriginal population of Perth;
- identify the main groups within the local Aboriginal population who misuse substances and establish what, if any, are their alcohol and other drug intervention service needs;
- identify the number of services available to address substance misuse amongst Aboriginal people in the Perth area, and to what extent these services are meeting the needs of Aboriginal people;
- identify gaps in current Aboriginal alcohol and other drug intervention services in the Perth metropolitan area; and,
- make recommendations on direction of NASAS, with particular reference to a safe house and residential detoxification centre, and the extent to which it can address the service needs of Aboriginal people living in Perth and surrounding suburbs.

2.0 Methods

The data collection methods were developed in consultation with the NASAS Reference Group. They primarily involved a review of existing documentary and statistical sources and a limited number of interviews with staff of service provision and funding agencies. Data was obtained from the following sources.

- The Western Australian Department of Health and the Australian Bureau of Statistics (ABS) provided statistical data on: rates of alcohol and other drug use; associated harm; and the Indigenous population in Western Australia.
- The Drug and Alcohol Office (DAO)—formerly known as the Western Australian Drug Abuse Strategy Office (WADASO)—provided statistical data on the rates of admissions to the only Perth-based sobering-up shelter and the East Perth Police Lock-up.
- Other Perth-based alcohol and drug intervention services, provided their annual reports and statistical usage data, to enable us to estimate the extent to which Aboriginal people are using their services and the extent to which they are meeting the needs of local Aboriginal people
- NASAS made available documentary and statistical data on the operation and outcomes of its projects, on the clients for whom it provides services, on the administration and management of NASAS, and on the policies regarding the operation of NASAS services.
- Interviews with NASAS clinical and outreach team staff members were conducted to obtain data on proposed services and to identify unmet community service needs.
- Interviews were conducted with the staff of other Perth-based alcohol and other drug intervention services to determine to what extent they are meeting the needs of local Aboriginal people, and to identify the unmet service needs of Aboriginal people. In particular, there views were sought regarding the need (or otherwise) for the services of a sobering-up shelter and/or detoxification centre.

2.1 Ethical Issues

The project was conducted within the framework of the National Health and Medical Research Council's *Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health Research*.[4] NASAS initiated the project, and the research methods used were finalised in conjunction with NASAS. The Office of Aboriginal Health (WA), the Office of Aboriginal and Torres Strait Islander Health (OATSIH) and the Western Australian Drug and Alcohol Office have jointly covered all financial costs pertaining to the project through funding grants to NASAS. Ethics committee approval for the project was given by the Curtin University of Technology Human Research Ethics Committee (HR 44/2002).

Organisational representatives who were interviewed are not identified in this report, unless they specifically asked to be named. All those interviewed, as part of the project were informed:

- of the purpose of the project and the data collection procedures;
- of their right to decline to participate in the project;
- that unless they specifically wanted to be identified individually, all responses would be confidential; and
- that they could withdraw all or part of their statements at any time during the project.

Operational data reports from various alcohol and drug intervention services in Perth were requested in writing. The provision of this data was voluntary and was used for the specific purpose of determining the extent to which Aboriginal people used these services and to identify unmet needs of the Perth Aboriginal population. Operational data from NASAS was also obtained for similar purposes. These project data did not name or identify individual clients.

3. Patterns Of Drug Use In Perth

3.1 The Perth Aboriginal Population

In 1996, the population of Western Australia totalled 1,726,095 persons of whom 50,793 (2.94%) were of Aboriginal and/or Torres Strait Islander descent. Of the 50,573 Indigenous people, 17,198 (8,269 males, and 8,929 females) or 33.9 per cent resided in the Perth Statistical Division—where they comprised 1.4 per cent of the population of 1,244,320. Another 6,922 Indigenous people (13.6% of the Indigenous population of WA) reside in the south-west of the state (in the Midlands, South-West, Upper Great Southern and Lower Great Southern Statistical Divisions).[5]

The Indigenous Australian population in Western Australia is relatively young with 40.8 per cent of Indigenous people being aged between 0–14 years, compared to 22.3 per cent of the non-Indigenous population in this age group. People aged 65 years or older comprise just 2.9 per cent of the Indigenous Australian population, while comprising 10.4 per cent of the non-Indigenous population.[5]

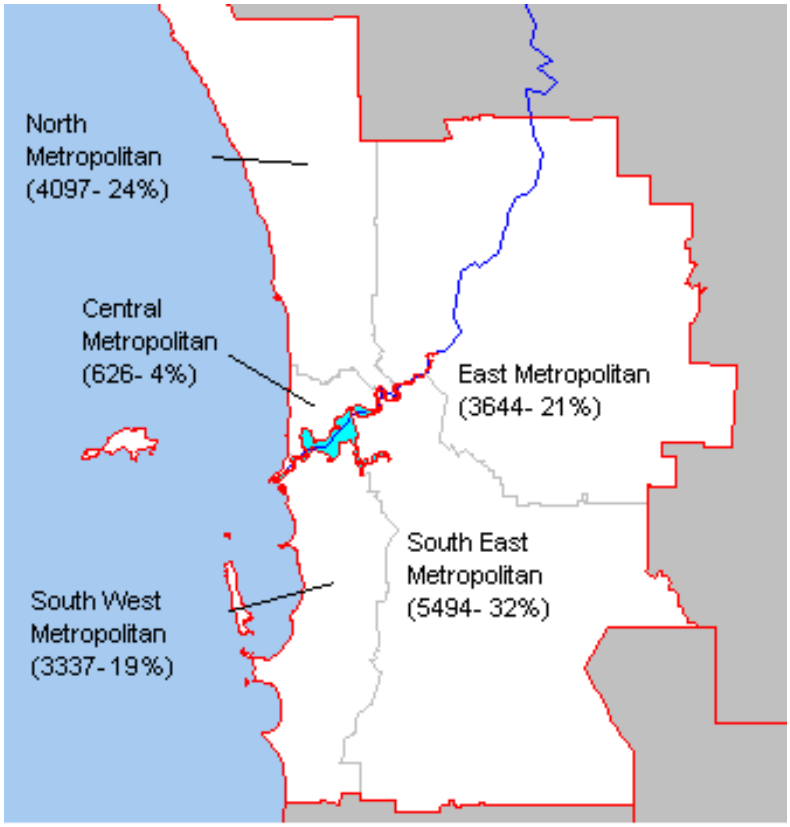

Figure 3.1: Number and percentage of resident Indigenous persons by Subdivisions within the Perth Statistical Division, with the Indigenous population, 1996[5]

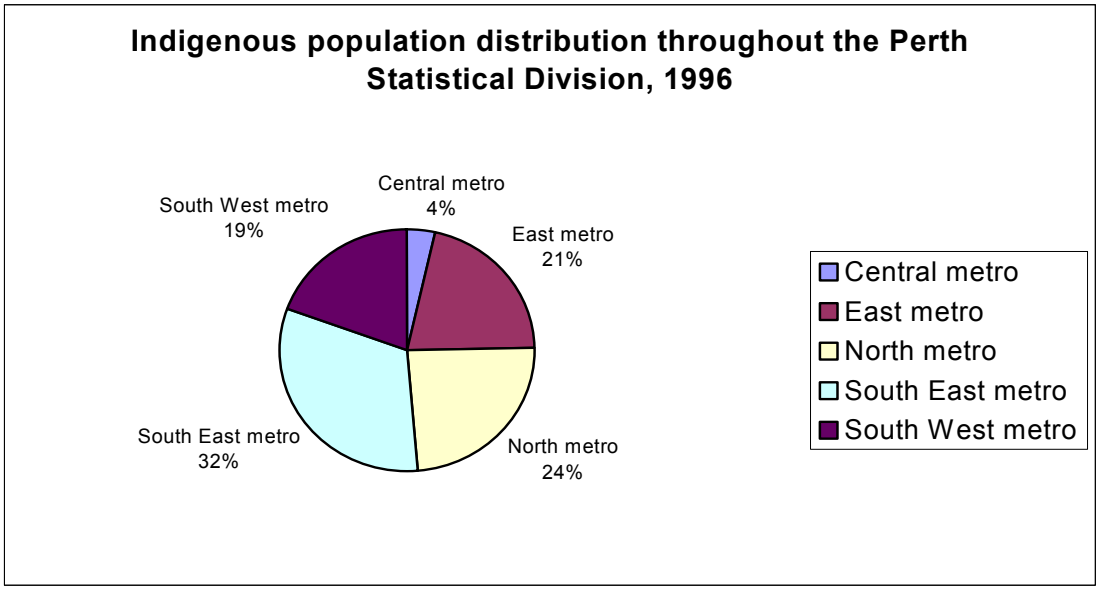

Figure 3.2: Indigenous population distribution throughout the Perth statistical division, 1996[5]

Figures 3.1 and 3.2 show the Subdivisions within the Perth Statistical Division and the percentage of the Indigenous population within each at the time of the 1996 Census.[5] This population is not distributed evenly through the metropolitan area. Thirty-two per cent live in the South-East Metropolitan Statistical Subdivision including local government council areas such as Armadale, Belmont, Canning, Gosnells, Serpentine-Jarrahdale, South Perth, and Victoria Park. The Indigenous population makes up just two per cent of the resident population of that Subdivision.

The Subdivision with the least number of Indigenous Australian residents is the Central Metropolitan Statistical Subdivision. This Subdivision includes the local government councils of Cambridge, Claremont, Cottesloe, Mosman Park, Nedlands, Peppermint Grove, Perth, Subiaco, and Vincent. Indigenous people comprise just 0.51 per cent of the resident population in this Subdivision, and Indigenous people living in this area comprise only 3.6 per cent of Perth's resident Indigenous population.

3.2 Estimates of the prevalence of drug use in Perth

Documentation of the prevalence of alcohol and drug use within the Indigenous Australian population has been limited, and focused mainly on alcohol as the primary drug of concern. In 1994, on behalf of the National Drug Strategy (NDS), AGB McNair conducted a national survey among 2993 Indigenous people in urban areas—population clusters of ▫1000 people in which about 67 per cent of Indigenous people reside.[6] No national survey of substance use among Indigenous people has been

undertaken since that time, nor has there been a comprehensive study of the prevalence of drug use in Perth.

Table 3.1: Drugs ever tried and currently used, Aboriginal and Torres Strait Islanders and the general population, Australia, 1994 and 1993

	Drugs ever tried (for non-medical purposes)		Drugs currently used (for non-medical purposes)	
	Aboriginal and Torres Strait Islander survey 1994	General population survey 1993	Aboriginal and Torres Strait Islander survey 1994	General population survey 1993
Tobacco	77%	74%	54%	29%
Alcohol	84%	82%	62%	72%
Marijuana	48%	36%	22%	13%
Sleeping tablets	4%	35%	0.9%	0.9%
Pain killers	4%	3%	2%	2%
Petrol sniffing	4%	Not asked in 1993	0.3%	Not asked in 1993
Glue, other sniffing	5%	Not asked in 1993	0.7%	Not asked in 1993
Inhalants generally	7%	4%	0.8%	0.7%
Speed	6%	6%	1.7%	1.4%
Cocaine	2%	3%	0.5%	0.5%
Heroin	3%	2%	0.4%	0.2%
Hallucinogens	7%	8%	2%	1.4%
Designer drugs	1.4%	3%	0.6%	1.5%
Injected illegal drugs	3%	2%	2%	0.5%
None of the above	*9%*	*8%*	*22%*	*21%*
None of the illicits	*46%*	*58%*	*71%*	*82%*
Marijuana the only illicit	*32%*	*22%*	*18%*	*10%*
At least one other illicit	*19%*	*16%*	*6%*	*5%*
At least one other hard	*12%*	*12%*	*4%*	*3%*
Don't know	*3%*	*5%*	*6%*	*3%*

Source: Commonwealth Department of Human Services and Health 1996:24.[6]

The Social Science Data Archives at the Australian National University provided copies of the 1994 survey data files to NDRI. However, it was not possible to analyse separately the data from Perth because of the small number of positive responses to questions about the use of particular drugs. Thus, although there are some limitations in the results of the 1994 NDS Survey, the national data presented in

Table 3.1 provides the best baseline estimate of alcohol and other drug use among Aboriginal people in urban areas such as Perth.

Among the key findings of the 1994 NDS Survey were that:

- the percentage of Indigenous people (54%) that currently smoked tobacco was about twice that among non-Indigenous people (29%);
- although the percentage of Indigenous people (62%) who currently drank alcohol was less than in the non-Indigenous population (72%), more of those Indigenous people who drank regularly did so at harmful levels compared to non-Indigenous people (79% compared to 12%);
- the percentage of Indigenous people (13%) that currently used marijuana (cannabis) was almost three times that among non-Indigenous people (36%);
- there was a slightly higher percentage of people that currently used other illicit drugs among Indigenous people (6%) than there was among non-Indigenous people (5%); and,
- among Indigenous people the percentage who reported currently injecting drugs (2%) was considerably higher than that among non-Indigenous people (0.5%).[6]

The 1994 NDS Survey found that more Aboriginal men than women were regular drinkers. However, a study conducted in Albany in Western Australia found that among young Aboriginal people aged 8 to 17 years, there was no statistically significant difference in the proportion of males and females who drank.[7] These results were similar to those of a survey of secondary school children in New South Wales.[8] These studies suggest that in the future in Perth, there is likely to be an increase in the proportion of Aboriginal women who drink and that some of these will consume alcohol in a harmful manner.

In 2001, Gray and his colleagues conducted research into the extent of injecting drug use and associated harms in Western Australia.[9] On the basis of increases in hospital admissions for drug related problems, hepatitis C notifications, and arrests for drug-related offences, they estimated that injecting drug use had increased by between 50 and 100 per cent since the time of the 1994 NDS survey. This means that the percentage of the Aboriginal population aged 14 years or over that had ever injected drugs is probably between 4.5 and 6.0 per cent and that the percentage that were currently injecting drugs was between 3.0 and 4.0 per cent. On this basis they estimated that there were between 360 and 485 Aboriginal people in the Perth region who were currently injecting drugs. Given this increase in injecting it is likely that there has been an associated increase in the use of various illicit drugs.

In the 1994 NDS Survey, the term 'poly-drug use' was used to describe the use of more than one *illicit* drug. However, as that survey shows, there were correlations

between heavy tobacco smoking and heavy alcohol consumption.[6] As there were considerably more people using these drugs in combination than there were using combinations of illicit drugs, at a population level this is likely to have more adverse health consequences. However, among Aboriginal people in Albany aged 15 to 17 years, 48 per cent were frequent users of some combination of tobacco, alcohol and cannabis, as well as occasional users of other substances.[7] Also, a non-random sample of 74 Aboriginal Western Australians who inject drugs (most of whom were from Perth) reported high levels of cannabis and alcohol use in addition to their use of illicit drugs such as amphetamines.[9]

High frequencies of poly-drug use among Aboriginal people have also been found in studies from non-urban areas of the Northern Territory[10, 11] and among injecting drug users in South Australia.[12] Together with the Western Australian data, the results of these studies suggest that those Aboriginal people in Perth who have substance misuse problems are likely to be misusing more than one drug.

The issue of the emerging problem of poly-drug use was also addressed by the Western Australian Community Drug Summit.

> There is evidence of increasing illicit drug use among Indigenous Western Australians, with poly-drug use being common. While there are regional variations in the levels of drug use, with the types of drugs used, and with the harm and impact associated with that use, there are some common themes emerging across the state (including)…there is a need to address the underlying causes of substance misuse, such as housing, employment and mental well-being, and for existing services both within and outside of the alcohol and other drug field to respond to those causes.[13]

Another source that provides an indication of problematic drug use in the Perth Aboriginal community is data from NASAS on the drugs (and related problems) for which clients primarily sought treatment (see Table 3.2). The data do not give an indication of the prevalence, or levels, of substance use, but they do provide an indication of the relative importance of each. These data provide a conservative picture, as they do not include the secondary drug problems with which many clients present—and which reflect a pattern of poly-drug use.

For Aboriginal people using NASAS during the period 1997–2001, alcohol was the major drug for which treatment was sought—being identified by between 56 and 69 per cent of clients, depending upon the year. Alcohol was followed in importance by cannabis with between 11 and 16 per cent of clients seeking treatment for problems related to this substance. During the same period, volatile substances remained the primary drug of concern for between eight and ten per cent of clients. There was a steady increase in the number of clients seeking assistance for amphetamine-related problems. The percentage of clients presenting with amphetamine-related problems

increased 2.75 times from four per cent in 1997 to 11 per cent in 2001, and it rose from being the fourth to the third most common reason for presentation.

Table 3.2: Principle presenting drug problems of clients by sex, NASAS, 1997 – 2001

		1997	1998	1999	2000	2001	Total
Alcohol							
	Female	182	122	154	91	80	629
	Male	469	339	405	267	257	1737
	Total	651	461	559	358	337	2366
Amphetamines							
	Female	7	6	15	20	20	68
	Male	27	20	29	32	46	154
	Total	34	26	44	52	66	222
Barbiturates							
	Female	2	1	1	1	1	6
	Male						
	Total	2	1	1	1	1	6
Benzodiazepines							
	Female			1	3		4
	Male	4	1	1	2	2	10
	Total	4	1	2	5	2	14
Cannabis							
	Female	27	13	34	19	19	112
	Male	80	64	89	79	70	382
	Total	107	77	123	98	89	494
Heroin							
	Female	3	2	7	9	6	27
	Male	4	8	22	12	7	53
	Total	7	10	29	21	13	80
Other (includes Ecstasy, Hallucinogens & LSD)							
	Female	8	8	9	9	3	37
	Male	7	11	10	6	5	38
	Total	15	19	19	15	8	75
Significant Others Alcohol & other drugs use							
	Female	14	6	5	5	5	35
	Male	4	1	1	1	1	8
	Total	18	7	6	6	6	43
Tobacco							
	Female						
	Male			1	1		2
	Total			1	1		2
Volatile Substances/ inhalants							
	Female	58	36	45	27	30	196
	Male	47	26	44	24	23	164
	Total	105	62	89	51	53	360
Total							
	Female	302	195	272	188	181	1138
	Male	642	470	602	425	417	2556
	Total	944	665	874	613	598	3694

4. Alcohol And Other Drug-Related Harms

Substance use becomes a problem when it results in harms to individual users, members of their families, or the wider community—manifesting itself in a broad range of health, economic, social and cultural problems. Alcohol and drug-related deaths, hospitalisations, and arrest rates provide *indicators* of the harms caused by substance misuse. These rates can also provide indications of the prevalence of substance misuse both within the community as a whole and within different segments of it—with high rates among one segment reflecting high levels of substance misuse.

4.1 Health-related harms

The Western Australian Health Department provided us with data on the estimated number of deaths and hospitalisations caused by alcohol, tobacco, and other drugs. The numbers of these deaths and hospitalisations have been calculated using the aetiological fraction method.[14] This estimates the proportion of deaths in each disease category caused by the particular drug under consideration. Hence, the estimated number of deaths does not necessarily equal a whole number.

Mortality

Between 1996 and 2000, it is estimated that there was a total of 38.8 alcohol-caused deaths among Aboriginal people in the Metropolitan and South-West regions (Table 4.1). Alcoholic liver cirrhosis was the most common category with 15 deaths (39%). This was followed by 6.2 deaths (16%) from road injuries and 5.0 deaths (13%) from 'alcoholism' (alcohol dependence syndrome). Alcohol-caused road injuries were more common among males than females.

Tobacco is estimated to have caused 56.6 per cent of all drug-related Aboriginal deaths in the Perth Metropolitan and South–West regions of Western Australia, in the period 1996–2000. The estimated number of these deaths (63.3) by disease category by year is shown in Table 4.2. The major categories of tobacco caused deaths were heart disease and lung cancer. Lung cancer accounted for 29 deaths (46%) and lung cancer for 12.9 deaths (10%).

Table 4.1: Estimated number of Aboriginal alcohol-caused deaths, Metropolitan and South-West Regions, Western Australia, 1996–2000

	1996	1997	1998	1999	2000	Total	% of total
Alcoholic liver cirrhosis	2.0	3.0	2.0	2.0	6.0	15.0	39%
Alcoholism	1.0	1.0	1.0	1.0	1.0	5.0	13%
Assaults	0.5	0.5	0.0	1.5	0.5	3.0	8%
Cancer	0.2	0.0	0.3	0.1	0.1	0.7	2%
Falls	0.3	0.6	0.0	0.0	0.0	0.9	2%
Other alcohol-related diseases	0.1	0.3	0.2	1.1	0.0	1.7	4%
Other alcohol-related injuries	0.0	0.0	0.0	1.1	1.5	2.6	7%
Road injuries	2.1	1.1	2.3	0.7	0.0	6.2	16%
Stroke	0.1	0.4	0.3	0.0	1.1	1.9	5%
Suicide	0.3	0.1	0.4	0.5	0.5	1.8	5%
Total	6.6	7.0	6.5	8.0	10.7	38.8	100%

Source: Western Australian Department of Health

Table 4.2: Estimated number of Aboriginal tobacco-caused deaths, Metropolitan and South-West Regions, Western Australia, 1996–2000

	1996	1997	1998	1999	2000	Total	% of total
Atherosclerosis	0.0	0.7	0.0	0.4	0.0	1.1	2%
Chronic bronchitis	1.5	0.0	1.4	1.2	2.4	6.5	10%
Complications of pregnancy/infancy	1.2	0.9	0.6	0.3	0.5	3.5	6%
Heart disease	7.6	5.2	5.8	5.0	5.4	29.0	46%
Lung cancer	3.8	1.5	3.1	3.0	1.5	12.9	20%
Mouth & throat cancer	1.2	0.0	0.4	0.5	0.4	2.5	4%
Other cancers	0.1	0.1	0.3	0.5	0.2	1.2	2%
Other conditions	0.4	0.9	0.5	0.0	0.2	2.0	3%
Stroke	0.2	1.2	1.3	0.0	1.9	4.6	7%
Total	16.0	10.5	13.4	10.9	12.5	63.3	100%

Source: Western Australian Department of Health

Table 4.3: Estimated number of Aboriginal deaths caused by drugs other than tobacco and alcohol, Metropolitan and South-West Regions, Western Australia, 1996–2000

	1996	1997	1998	1999	2000	Total	% of Total
IDU conditions	0.3	0	0	0	0	0.3	3%
Opiates	1	2	1	1	0	5	49%
Psycho-stimulants	0	0	0	1	2	3	29%
Unclassified drugs	0	0	0	0	0	0	0%
Complications of pregnancy/infancy	0	0	0	0	0	0	0%
Drug psychoses	0	0	1	0	0	1	10%
Sedatives & barbiturates	0	0	0	1	0	1	10%
Total	1.3	2	2	3	2	10.3	100%

Source: Western Australian Department of Health

The number of deaths caused by drugs other than tobacco and alcohol among Aboriginal people in the Metropolitan and South-West regions was estimated to be 10.3 (Table 4.3). Opiates were responsible for 5.0 (49%) of these deaths and psycho-stimulants for 3.0 (29%). Approximately seven of these deaths were among males.

Although alcohol was the most widely used drug, tobacco was the major cause of drug-related deaths in the Perth Metropolitan and South–West Regions, in the period 1996–2000. It is estimated to have caused a total of 63.3 deaths (56%); compared to 38.8 deaths (35%) due to alcohol, and 10.3 deaths (9%) due to other drugs. Overall, males accounted for 64 per cent of these deaths and females 36 per cent.

Table 4.4: Aboriginal to non-Aboriginal mortality rate ratios, Metropolitan and South-West Regions, Western Australia, 1996–2000

Drug	Sex	Rate ratio	95% confidence interval
Alcohol	Male	5.43	3.02 – 9.79
	Female	4.74	2.61 – 8.68
Tobacco	Male	3.20	2.01 – 5.07
	Female	3.01	2.00 – 4.52
Other drugs	Male	1.64	0.78 – 3.41
	Female	2.03	0.81 – 5.01

Source: Western Australian Department of Health

As the data in Table 4.4 illustrate, the rates of death caused by alcohol and tobacco among both Aboriginal males and females are at least twice those among non-Aboriginal people. In addition rate of death caused by other drugs is possibly 50 per cent greater among Aboriginal males and twice as great among Aboriginal females as among their non-Aboriginal counterparts.

Hospitalisation

The estimated numbers of hospitalisations for alcohol-caused conditions in the Metropolitan and South-West Regions in the period 1996–2000 are presented in Table 4.5. Alcoholism (alcohol dependence syndrome) accounted for 42 per cent of all these hospitalisations. The next most common conditions were other alcohol-related diseases, accounting for 24 per cent, while 12 per cent of hospitalisations were the result of alcohol-related falls.

Table 4.5: Estimated number of Aboriginal alcohol-caused hospitalisations, Metropolitan and South-West Regions, Western Australia, 1996–2000.

	1996	1997	1998	1999	2000	Total	% of Total
Alcoholic liver cirrhosis	11.0	10.0	19.0	6.0	18.0	64.0	4%
Alcoholism	113.0	110.0	120.0	142.0	131.0	616.0	42%
Assaults	61.0	0.0	0.0	0.0	0.0	61.0	4%
Cancers	1.0	1.1	1.1	0.3	1.4	4.9	0%
Falls	35.9	36.8	37.5	36.1	29.4	175.7	12%
Other alcohol-related diseases	73.2	78.3	69.7	68.3	62.7	352.2	24%
Other alcohol-related injuries	10.2	8.1	9.5	7.9	7.5	43.2	3%
Road injuries	20.4	15.0	16.9	13.5	16.6	82.4	6%
Stroke	2.1	4.5	3.5	3.3	3.9	17.3	1%
Suicide	10.6	7.0	9.4	5.2	7.3	39.5	3%
Total	338.4	270.8	286.6	282.6	277.8	1456.2	100%

Source: Western Australian Department of Health

In the period 1996–2000, it is estimated that approximately 775 Aboriginal people were hospitalised in the Perth metropolitan and South-West regions for tobacco-caused health problems (Table 4.6). The most common of these admissions were for ischaemic heart disease (257.7 or 33%), chronic bronchitis (128.3 or 17%) and other heart diseases (119.7 or 15%).

Table 4.6: Estimated number of Aboriginal tobacco-caused hospitalisations, Metropolitan and South-West Regions, Western Australia, 1996–2000.

	1996	1997	1998	1999	2000	Total	% of total
Atherosclerosis	2.2	2.0	3.1	3.4	4.2	14.9	2%
Chronic bronchitis	21.1	26.6	16.9	26.7	37.0	128.3	17%
Complications of pregnancy/infancy	21.7	15.1	19.8	22.3	23.8	102.7	13%
Ischaemic heart disease	47.8	51.9	51.7	59.2	47.1	257.7	33%
Lung cancer	3.8	2.9	1.6	3.8	4.4	16.5	2%
Mouth & throat cancer	2.3	3.4	2.9	1.2	6.1	15.9	2%
Other cancers	2.5	3.4	1.7	1.6	4.2	13.4	2%
Other conditions	21.8	21.7	22.1	15.7	16.8	98.1	13%
Other heart diseases	22.5	27.0	29.8	25.1	15.3	119.7	15%
Stroke	5.1	4.0	8.3	9.1	7.8	8.3	1%
Total	150.8	158.0	157.9	168.1	166.7	775.5	100%

Source: Western Australian Department of Health

Table 4.7: Estimated number of Aboriginal hospitalisations caused by drugs other than alcohol and tobacco, Metropolitan and South-West Regions, Western Australia, 1996–2000

	1996	1997	1998	1999	2000	Total	% of total
Anti-depressants	0.0	2.0	0.0	7.0	9.0	18.0	3%
Complications of pregnancy/infancy	3.8	5.6	5.0	3.2	0.7	18.3	3%
Drug psychoses	6.0	10.0	13.0	22.0	48.0	99.0	14%
Hallucinogens & cannabis	3.0	3.0	2.0	4.0	3.0	15.0	2%
IDU conditions	2.9	0.4	0.0	2.6	2.9	8.8	1%
Opiates	22.0	24.0	19.0	34.0	19.0	118.0	17%
Other/ combination psychotropic agents	2.0	4.0	4.0	8.0	7.0	25.0	4%
Psycho stimulants	2.0	2.0	7.0	6.0	11.0	28.0	4%
Sedatives & barbiturates	3.0	3.0	2.0	5.0	3.0	16.0	2%
Tranquillisers	6.0	9.0	5.0	15.0	19.0	54.0	8%
Unclassified drugs	73.0	32.0	57.0	39.0	23.0	224.0	32%
Volatile substances	17.0	14.0	7.3	14.2	15.1	67.6	10%
Total	140.7	109.0	121.3	160.0	160.7	691.7	100%

Source: Western Australian Department of Health

Between 1996 and 2000, there were an estimated 691.7 hospitalisations of Aboriginal people for other drug-caused health problems in the Metropolitan and South-West Regions (Table 4.7). These accounted for 23 per cent of all alcohol and other drug-caused hospital admissions of Aboriginal people. The largest category of admissions was for unclassified problems (224 or 32%). The largest identified category was opiate-caused conditions (118 or 17%) followed by drug psychoses (99 or 14%).

In Table 4.8, a comparison is made of hospital admission rates per 1000 person years for drug-caused conditions among Aboriginal and non-Aboriginal residents of the Metropolitan and South-West regions of Western Australia in the five-year period 1996–2000. The table shows that both Aboriginal males and females are more likely to be hospitalised for all drug related conditions and that, in the case of alcohol, the rate of hospitalisation among Aboriginal men and women is *at least* three times greater than among non-Aboriginal people.

Table 4.8: Hospitalisation rates by Aboriginality, Metropolitan and South West Regions, 1996–2000

	Condition	Aboriginal		Non-Aboriginal		Rate	95%
		ASR	95% CI	ASR	95% CI	ratio	CI
Males	Alcohol	40.8	37.7–43.9	4.7	4.7–4.8	8.7	3.9–19.2
	Tobacco	25.8	22.5–29.0	9.8	9.7–9.9	2.7	0.7–10.3
	Other drugs	6.0	5.3–6.6	2.0	1.9–2.0	3.0	1.0–9.1
Females	Alcohol	20.8	19.4–22.3	3.1	3.0–3.1	6.7	3.3–14.0
	Tobacco	16.5	14.8–18.2	4.1	4.1–4.2	4.0	1.4–11.6
	Other drugs	6.8	6.1–7.5	2.2	2.2–2.3	3.1	1.1–8.7

Hepatitis C notifications

A consequence of the increase in injecting drug use, and a major public health concern, is the increase of blood borne viruses. Gray and his colleagues reported that the number of hepatitis C notifications among Aboriginal people in Western Australia increased by an annual average of 34.8 per cent from 21 in 1993 to 99 in 1999.[9] In that period Aboriginal notifications increased from 1.8 to 8.4 per cent of all notifications. Furthermore the age of Aboriginal people at notification was considerably younger than that in the non-Aboriginal population—with a median in the 30–34 year age group compared to 40–44 years in the non-Aboriginal population.

4.2 Crime-related harms

The Crime Research Centre at the University of Western Australia provided data on Western Australian Police arrests, in the Perth Metropolitan region between 1994 and 2000, for offences that are commonly alcohol- or other drug-related. It is not possible to separate the offences by drug type, although some particular offences do provide an indication of this. The data presented below have been separated by offence (Table 4.9) and Aboriginality (Table 4.10) of the offender, for each year.

Table 4.9: Alcohol and other drug-related arrests, by Aboriginality and year, Metropolitan region, 1994–2000.

Year	Aboriginal	% of year	Non-Aboriginal	% of year	Unknown	% of year	Total
1994	7 340	15.8%	38 732	83.2%	466	1.0%	46 538
1995	7 999	17.2%	38 076	81.9%	430	0.9%	46 505
1996	7 780	15.9%	40 716	83.2%	429	0.9%	48 925
1997	9 421	17.9%	42 703	81.1%	514	1.0%	52 638
1998	8 997	18.6%	39 032	80.6%	421	0.9%	48 450
1999	7 960	17.0%	37 463	80.1%	1 347	2.9%	46 770
2000	8 330	16.6%	39 368	78.2%	2 627	5.2%	50 325
Total	57 827	17.0%	276 090	81.2%	6 234	1.8%	340 151

Source: Crime Research Centre, University of Western Australia

Table 4.10: Arrests by offence and Aboriginality of offender, Metropolitan region, 1994–2000

	Aboriginal	% of offence	Non-Aboriginal	% of offence	Unknown	% of Offence	Total
Against Person	6 330	22%	22 814	78%	208	1%	29 352
Burglary	4 231	25%	12 261	74%	126	1%	16 618
Drugs	2 621	6%	38 866	93%	222	1%	41 709
DUI	3 170	7%	40 220	89%	1 662	4%	45 052
Liquor Licensing	642	29%	1 488	67%	107	5%	2237
Other	18 780	19%	76 065	78%	2 881	3%	97 726
Other Theft	9 276	16%	46 832	83%	467	1%	56 575
Property Damage	2 118	20%	8 516	79%	89	1%	10 723
Street Order	10 659	27%	29 028	72%	472	1%	40 159
Total	57 827	17%	276 090	81%	6 234	2%	340 151

Source: Crime Research Centre, University of Western Australia

The alcohol and drug-related police arrests are: those against the person; burglary; other theft; property damage; street order—that includes resist/hinder police, trespassing and vagrancy, drunkenness, other good order offences—but mostly disorderly conduct offences; drugs; driving under the influence; liquor licensing (which includes street drinking); and other. While Aboriginal people made up only 1.4 per cent of the population of the Perth Statistical Division at the 1999 Census, they accounted for 17 per cent (57 827) of all the 340 151 drug and alcohol-related arrests between 1994 and 2000.

The largest number of offences amongst both Aboriginal and non-Aboriginal people were classified as 'other', and it is not possible from the data provided to ascertain any other particulars about them. Apart from these offences, among Aboriginal people, the largest single category of offences was 'street order' offences—these include resisting or hindering police, trespassing and vagrancy, drunkenness, but most were disorderly conduct offences. There was a total of 10 659 arrests of Aboriginal people for 'street order' offences and they accounted for 27 per cent of all offences in this category.

Together, there was a total of 14 507 arrests of Aboriginal people for 'burglary' (4231) and 'other theft' (9276). The next most common category of offence for which Aboriginal people were arrested was 'assault'. Over the 10 year period there was a total of 6330 Aboriginal arrests for assault and Aboriginal people made up 22 per cent of all arrests in this category.

Although the number of arrests was low (642 Aboriginal and 107 non-Aboriginal) for 'liquor licensing offences'—such as street and park drinking—this was the category of offences in which Aboriginal people made the largest proportion of arrests (29%). The percentages of Aboriginal people arrested for 'driving under the influence' (7%) and 'drug' offences (6%) were lower than for other categories of offence, but they were still considerably higher than the percentage of Aboriginal people in the population.

4.3 Summary

The data presented in Chapter 3 indicate that the most commonly used drugs among Aboriginal people are alcohol, tobacco and cannabis. The percentage of Aboriginal people using other illicit drugs is smaller but data on the likely increase in injecting drug use indicates that illicit drug use is increasing. The percentages of Aboriginal people currently using most categories of drugs are higher than those in the non-Aboriginal population. The data presented in this chapter reflect this and provide an indication of both the health and social problems caused by the misuse of alcohol and

other drugs. Tobacco is responsible for most drug-caused deaths and alcohol for most drug-caused hospitalisations. However, the deaths and hospitalisations due to other drugs are rising. Aboriginal people are arrested for alcohol and other drug-related offences in proportions much greater than their proportion of the population of the Perth metropolitan area. In the next chapter, we look at the services that are available in Perth to help Aboriginal people deal with excessive use of alcohol and other drugs and the harms associated with such misuse.

5. Substance Misuse Services

There are a number of mainstream government and non-government agencies providing substance misuse services in the Perth metropolitan area to which Aboriginal people have access. In addition, there are various projects and services—conducted by both mainstream and Aboriginal community controlled organisations—that specifically target Aboriginal people with alcohol and/or other drug problems. These are documented in the *Directory of Programs and Services* maintained by the Western Australian Drug Abuse Strategy Offices (WADASO—now the Drug and Alcohol Office), in NDRI's *Indigenous Australian Alcohol and Other Drugs Database*, and in the report *Indigenous Drug and Alcohol Projects: 1999–2000*.[15–17] These are outlined below.

5.1 Mainstream Services

Salvation Army

The Salvation Army manages the Perth-based Bridge Program, which incorporates Bridge House and Harry Hunter Rehabilitation Centre. The Bridge Program is a multi-strategic intervention, which—although it accommodates Aboriginal clients—is not a specifically Aboriginal alcohol and drug program.

Bridge House

The Salvation Army's Bridge House commenced operation in the suburb of Highgate in 1963. Since that time, it has expanded its service and now currently operates a three-phase program for individuals affected by alcohol and other drug use. It includes a sobering-up service, non-medical detoxification, and assessment and facilities for 40 people.

In 1989, the Salvation Army was selected to manage the first sobering up centre to be established in Western Australia. In May 1990, an interim service was commenced using temporary premises in West Perth before moving to purpose built premises in December 1990.[15] The Bridge House Sobering-up Centre remains the only facility of its kind in Perth. The Centre's prime purpose is to provide a safe, care-oriented environment in which persons found drunk in public may sober up, thus diverting them from police lock ups. People can be referred 24 hours a day, seven days a week, but acceptance is reliant on availability of beds.[15, 16]

Harry Hunter Rehabilitation Centre

The Harry Hunter Adult Rehabilitation Centre is the location for a medium term residential alcohol and drug recovery program. Up to 42 substance dependent people can be accommodated (including up to six women) fulfilling the second phase of the Salvation Army's treatment program. The aim is to reduce the harm associated with drug and alcohol use to enable participants to function independently in the community.[15]

Next Step Specialist Drug and Alcohol Service—East Perth (Formerly The Central Drug Unit)

Next Step—East Perth offers a range of services for people with problem substance dependency. These services include pharmacotherapies, inpatient medical-based detoxification and treatment, and outpatient services. The clinic is open from 8.30 am to 4.30 pm Monday to Friday. The service has a priority admission policy for Aboriginal clients who present at the outpatients' clinic, and wish to enter the detoxification program.[15]

Serenity Lodge

Serenity Lodge was established in 1977 and is based on the 'Minnesota treatment model'. It is an abstinence-based program that includes: AA/12 Steps philosophy, personal development, and the improvement of life skills. It provides a nine-week residential rehabilitation program for people dependent on alcohol and other drugs, and can accommodate eight females and 30 males. Non-residential dependent and co-dependent programmes are also offered. Referrals can be initiated 24 hours a day, seven days a week.[15]

Holyoake

The Australian Institute on Alcohol and Addictions, which goes that goes under the name of 'Holyoake', commenced operations in 1975. It provides a range of non-residential, family-focused services to people of all ages for a fee. Services include: initial assessment; education and skills-based programs; individual counselling; and, community education and training.[15]

Mission Australia—Yirra

Yirra is a mainstream service established in 1992. It provides short-term accommodation, treatment and rehabilitation for 13 to 17 year-old males and females and their families, experiencing problems related to substance use. The program

offers a range of interventions including, motivational assessments, counselling and advice, family support, a therapeutic day programme and linked residential placement. The residential program provides: individual and group counselling; recreational activities; life skills; and education and training activities with 24-hour support and supervision.[15]

Palmerston Association

Palmerston was established in 1980 as a rehabilitation service for illicit drug users, their parents, and friends. It has a non-residential centre in Northbridge and a residential therapeutic community at Wellard for people over 17 years of age who require medium-term treatment and rehabilitation in a secure drug-free environment. Palmerston auspices two Community Drug Service Teams located at Fremantle and Albany. It also has shared involvement in a third team, operating in conjunction with Cyrenian House in Perth. The philosophy of the program is to encourage self-responsibility and lifestyle change to empower problem users of illicit drugs and their families to take control of their situations by providing a range of treatment services.

The Team's services include: early intervention and family support; outreach counselling for youth; attention to specific local problems; support for Local Drug Action Groups; and support and consultation to other education and health service providers. Residential and non-residential treatment services for adolescents and adults include: assessment; individual counselling; group work; and, recreational activities.[15]

Community Drug Service Teams

Funded by the Drug and Alcohol Office (DAO), there are 12 Community Drug Service Teams (CDST) operating throughout the state within 12 defined regions (referred to as CDST Zones). CDSTs are located in both metropolitan and country areas, including smaller communities and towns. Their aim is to maximise the community's access to their services and provide support to local communities, particularly through Local Drug Action Groups (LDAGs). There are five CDSTs in the metropolitan area: North Metropolitan, North East Metropolitan, Perth Metropolitan, South Metropolitan, and South East Metropolitan. Each team provides a number of services, including: general substance dependency counselling; support to the local community to help prevent alcohol and other drug misuse problems; and support to other health and welfare providers in the management of treatment of alcohol and other drug problems among their clients.[15]

Cyrenian House

Cyrenian House was established in 1981 to assist in a broader range of drugs and drug use issues for individuals and families. Cyrenian House has facilities in Northbridge and Wangara. It provides both residential and day programs, and its services include: assessment; non-medical detoxification; individual counselling; educational and therapeutic groups; social and recreational activities; and community education activities. Cyrenian House draws on a wide range of approaches including cognitive behavioural therapy, social learning theory, family systems theory, 12 steps and psychotherapeutic models. Cyrenian house also shares the operation of a CDST with the Palmerston Association.[15]

Saranna

In June 1998, Cyrenian House relocated its residential program to Saranna, a purpose built facility on 12.9 hectares of land at Gnangara. Saranna is designed specifically for women (with pre-school aged children) who have substance misuse problems. It provides them with a long-term residential treatment program that includes parenting skills training. Accommodation is in self-contained cottages, with the children accommodated with their mothers in family units. This programme is the only women's residential treatment program in Western Australia and it receives funding from the National Illicit Drugs Strategy to provide a number of beds for Aboriginal women.[15, 16]

Cyrenian House Residential Programme

Cyrenian House Residential Programme is an abstinence-based eight-week residential program for both men and women who are voluntarily seeking to change their drug/alcohol using patterns. Cyrenian House Residential Programme is a safe and supportive environment providing individual counselling, educational and therapeutic groups, recreational activities, good nutrition and attendance at 12 Step meetings. Clients may negotiate a further 8-12 weeks to explore identified issues at greater depth.[15]

Hearth

Hearth is a service for families affected by substance misuse problems. Hearth, located in Mount Lawley, offers a home visiting service for parents who themselves have an alcohol and/or other drug problem and who have children under the age of eighteen. Hearth also offers office based counselling for parents or caregivers to children under the age of eighteen, who are affected by someone else's substance misuse. The service is reliant on family self-referrals. In the year 2001, of their 144 clients (33 males, 111 females) 4.9 per cent were identified as Aboriginal people.[15]

5.2 Aboriginal services in Perth

In 2001, NDRI was commissioned by the Australian National Council on Drugs (ANCD) to identify all alcohol and other drug intervention projects that directly targeted Indigenous Australians that were operating during the 1999–2000 financial year. The report identified 277 intervention projects, and mapped them and per capita expenditure on them by ATSIC region.[17] In Western Australia there was a total of 74 projects, conducted by 58 organisations—of which 55 projects were conducted by 40 Aboriginal community-controlled organisations. In the Perth Noongar region, there were 13 projects conducted by 11 organisations. These included: four treatment projects; five prevention projects; three acute intervention projects (two patrols and a youth outreach program); and a needs assessment project. Six of these projects were carried out by four Aboriginal community-controlled organisations.[17]

In the State as a whole, there are currently 17 projects providing treatment targeted at Aboriginal people. Of these, four are located in the Perth Noongar ATSIC Region. Two provide non-residential counselling services (conducted by NASAS and Derbarl Yerrigan Aboriginal Health Service), and one provides a lunch service (also conducted by NASAS). The fourth provides residential treatment. However, the latter is not conducted by an Aboriginal community-controlled organisation and the facility is not specifically for Aboriginal people. Perth-based Cyrenian House runs the Saranna women's treatment program, which provides long-term residential treatment services to clients and their small children. It received a grant to reserve a number of beds for Aboriginal women wishing to be part of the Saranna program.

Noongar Alcohol and Substance Abuse Service (NASAS)

As indicated previously, NASAS is an Aboriginal community controlled organisation located in East Perth. A multi-strategic approach is used by NASAS to address alcohol and other drug related issues within the Perth Aboriginal community. The main services provided by NASAS are non-residential clinical counselling, training workshops, education programs, and outreach service. The outreach team provides support to the Aboriginal community in Perth through a number of programs, including: transport; a lunch program; community liaison; education; counselling; and discos. The NASAS outreach team also assists a number of homeless people in the East Perth area, with transport by the patrol, and through its lunch program.

In September 2001 NASAS established, and now operates, the first Aboriginal-operated and staffed women's refuge in Perth. The refuge provides beds for five Aboriginal women and their children. In addition, NASAS will open the Eveline Sobering-up Centre in Midland at the end of May 2002, providing a second sobering-up facility in Perth to service the Eastern metropolitan area.

NASAS is continuing to further expand its multi-strategic approach, with the planned establishment of an after-care facility in Muchea, for Aboriginal people affected by alcohol and other drug use.

Nyoongar Patrol System

The Nyoongar Patrol System is an Aboriginal specific program that commenced operation in 1998 under the administration of the Aboriginal Advancement Council. In 2001, the Patrol became incorporated and is now an independent body that also manages the Swan Patrol in Midland. The Nyoongar Patrol is a community-based project that deals with social and welfare issues in the Perth central business district, Northbridge, Cultural Centre, Forrest Chase and the Town of Vincent. It operates a day patrol on Monday to Thursday from 11:00 am to 7:00 pm, and on Friday from 4:00 pm to 10:00 pm. It also operates a night patrol on Thursday from 4:00 pm to 12:00 am, and on Friday and Saturday from 6:00 pm to 2:00 am. The main purpose of the service is to detect and provide early intervention for Aboriginal people who are at risk of substance abuse, self-harm, family violence, homelessness, and entering the criminal justice system.[16]

Nyoongar Patrol activities include foot patrols, attending to crisis incidents, minimising and preventing conflict through mediation, making appropriate referrals, improving public relations with the business sector, liaising with business people regarding specific issues, and providing transport for Aboriginal youth at risk.[16]

The Swan Patrol has functions and operational procedures similar to those of the Nyoongar Patrol. The Swan Patrol is a community-controlled service, which is based on the philosophy of Aboriginal self-determination and ownership. It aims to identify and provide early intervention to Aboriginal people that are at risk. It operates Monday to Friday from 1:00 pm to 9:00 pm.[16, 18]

Derbarl Yerrigan Health Service

Derbarl Yerrigan Health Service—formally known as Perth Aboriginal Medical Service (PAMS) — has its main branch located in East Perth. The Service has been in operation since 1973, providing a free medical clinic for Aboriginal people in the Perth metropolitan area. The Service also has a branch in the North-east metropolitan suburb of Midland, which provides a similar service to that of the main branch. Both branches have a holistic care approach to health and employ a range of providers including doctors, nurses, and welfare officers who provide community-based

assistance according to the needs of the community.[19] Derbarl Yerrigan does not currently conduct any specific alcohol or other drug programs. However, it provides primary health care for Aboriginal people and their families experiencing the effects of drug and alcohol use on their health. The Mental Health Unit, operated by Derbarl Yerrigan, also receives funding to treat Aboriginal people with both mental health and substance misuse problems.[17]

5.3 Service Utilisation

In this section of the report, attempts are made to assess the extent to which Aboriginal people use the existing Perth-based Aboriginal and mainstream services. The data collected however, are somewhat limited to the periods the services have been operating or using their current reporting facilities, or by the formats in which the data were provided. It is also important to note that the number of Aboriginal clients using each service is dependent upon the services provided and the groups targeted. However, despite these limitations the data give an indication of the extent to which Aboriginal people in Perth use various services.

Data on the use of services by Aboriginal people were provided by the Salvation Army (Bridge House Sobering-up Shelter, Bridge House Detoxification, Bridge House Counselling), Hearth, Midland Holyoake, Perth CDST, and South East Metro CDST. Usage of these services is summarised in Table 5.1. The percentage of Aboriginal clients, using the services ranged from two per cent (Perth CDST) to 20 per cent (Midland Holyoake, North East Metro CDST). Although Aboriginal people used other services, the way in which the organisations were able to provide data precluded the identification of the numbers or percentages of Aboriginal people accessing particular programs within these services.

The only sobering-up shelter in the Perth metropolitan region area is operated by the Salvation Army, and is part of the wider Bridge House program, which also includes a detoxification and counselling program. According to its admissions data, the sobering-up shelter has a large proportion of Aboriginal clients. Table 5.2 shows client admissions for each year by Aboriginality and gender. The service caters for both Aboriginal and non-Aboriginal people, but recognises a need for more services:

> There are not significant gaps…rather more capacity is required…If we had about 50 per cent more capacity, than we have now, we could start to catch up with the drug problem in Perth.

Table 5.1: Aboriginality of substance misuse service clients by gender, Perth Metropolitan Region, 1997–2001

Organisation	Female	Male	Total
NASAS			
Indigenous	1123	2527	3650
Non-Indigenous	15	28	43
Not stated	0	1	1
Total	1138	2556	3694
Bridge House Sobering-up shelter			
Indigenous	1972	5060	7032
Non-Indigenous	989	5482	6471
Not stated			
Total	2961	10542	13503
Bridge House Detoxification			
Indigenous	259	611	870
Non-Indigenous	955	3878	4835
Not stated	37	75	112
Total	1251	4564	5817
Bridge House Counselling			
Indigenous	14	21	35
Non-Indigenous	283	349	632
Not stated	7	3	10
Total	304	373	677
Hearth			
Indigenous	6	1	7
Non-Indigenous	87	25	112
Not stated	18	7	25
Total	111	33	144
Midland Holyoake—include North-East Metro CDST			
Indigenous	29	336	365
Non-Indigenous	530	783	1313
Not stated	85	93	178
Total	644	1212	1856
Perth CDST			
Indigenous	2	5	7
Non-Indigenous	86	185	271
Not stated	3	5	8
Total	91	195	286
South-East Metro CDST			
Indigenous	69	121	190
Non-Indigenous	548	1252	1800
Not stated	84	204	288
Total	701	1577	2278
Total of all Services			
Indigenous	3474	8682	12156
Non-Indigenous	3493	11982	15475
Not stated	234	388	622
Total	7201	21052	28253

Table 5.2: Bridge House Sobering-up Shelter admissions by Aboriginality, and sex by year 1997–2001

		1997	1998	1999	2000	2001	Total
Aboriginal	Males	1028	1196	1047	919	869	5059
	Females	359	467	379	346	421	1972
	Total						7031
Non-Aboriginal	Males	1248	1073	1112	1080	969	5482
	Females	185	165	238	205	196	989
	Total						6471
Total		2820	2901	2776	2551	2455	13503

Aboriginal people accounted for 52 per cent of all clientele in the Bridge House sobering-up shelter, between 1997 and 2001. There is no distinct pattern of usage in this service—but the percentage of non-Aboriginal males is higher than that of Aboriginal males. Aboriginal women lifted the total percentage of Aboriginal clients to higher than that for non-Aboriginal clients. Of the 52 per cent of clients who were Aboriginal, 28 per cent of Aboriginal people were females—accounting for 14.6 per cent of the total admissions for the period, while non-Aboriginal females represented half the proportion of all female admissions for that same period, accounting for 7.3 per cent.

Between 1997 and 2001, 15 per cent of the detoxification service clients were Aboriginal (four per cent females, 11 per cent males). Seventy-eight per cent of all clients were male; but of the Aboriginal clients, females were represented to a greater extent, accounting for 30 per cent, compared to 20 per cent for non-Aboriginal female clients. Between 1997 and 2001, the Bridge House counselling program had 35 Aboriginal client contacts out of a total of 677 (5%). Forty per cent of their Aboriginal clients were women; compared to the non-Aboriginal clients among whom 45 per cent were female. Interestingly 92 per cent of the total counselling program's clients were seen between 1999 and 2001; the reason for this increase is unknown, but the number of Indigenous people using the service was small.

Next Step Specialist Drug and Alcohol Services provided data to NDRI staff on contact with Aboriginal clients in 1998–2000 for their study of *The Harm Reduction Needs of Aboriginal People Who Inject Drugs*.[9] This data is reproduced in Table 5.3. Although there was an increase in the small number of Aboriginal clients seen, this percentage

was well below the percentage of Aboriginal people in the Perth population. As noted in that report

> Many of those attending Next Step are referrals from the legal system and only reflect first attendance, not participation in a particular program or whether the first appointment was followed up.
>
> Staff of the organisation had a clear impression that they saw very few Aboriginal clients and that the increase in the number attending in the last two years may be related almost entirely to an increase in referrals from the justice system (p 23).[9]

It is important to note that the numbers in Table 5.3 are of contacts not clients. We were advised by Next Step Specialist Drug and Alcohol Service that during 1997–2001 a total of 314 contacts was made by 108 clients—an average of 2.9 attendances per client.

Table 5.3: Admissions to Next Step Specialist Drug and Alcohol Services by Aboriginality, 1998–2000 [9]

	1998		1999		2000	
	n	%	n	%	n	%
Aboriginal	19	0.4	61	1.2	124	2.5
Non-Aboriginal	3875	99.6	4920	98.8	4856	97.5
Total	3894	100.0	4981	100.0	4980	100.0

Table 5.4: East Perth Police Lockup Detentions by Aboriginality and gender, 1997–2001

	Number	Percentage (%)
Aboriginal		
Males	321	48%
Females	65	10 %
Unknown sex	24	4 %
Total Aboriginal	410	62 %
Non-Aboriginal		
Males	229	34 %
Females	27	4 %
Unknown sex	4	1 %
Total non-Aboriginal	260	39 %
Total	670	100 %

Table 5.4 shows the total number of detentions at the East Perth lockup, by Aboriginality and gender from 1997 to 2001, while figure 5.1 graphs the number of detentions in each year. Although the numbers are much smaller than for the sobering-up shelter, Aboriginal people figure disproportionately in the total number of alcohol and drug-related detentions (n = 670) — with Aboriginal people accounting for 62 per cent and non-Aboriginal people accounting for 38 per cent detentions. The ratio of non-Aboriginal females to Aboriginal females, detained in the lock-up, is 1:2.4; however the ratio of non-Aboriginal males to Aboriginal males is lower 1:1.4.

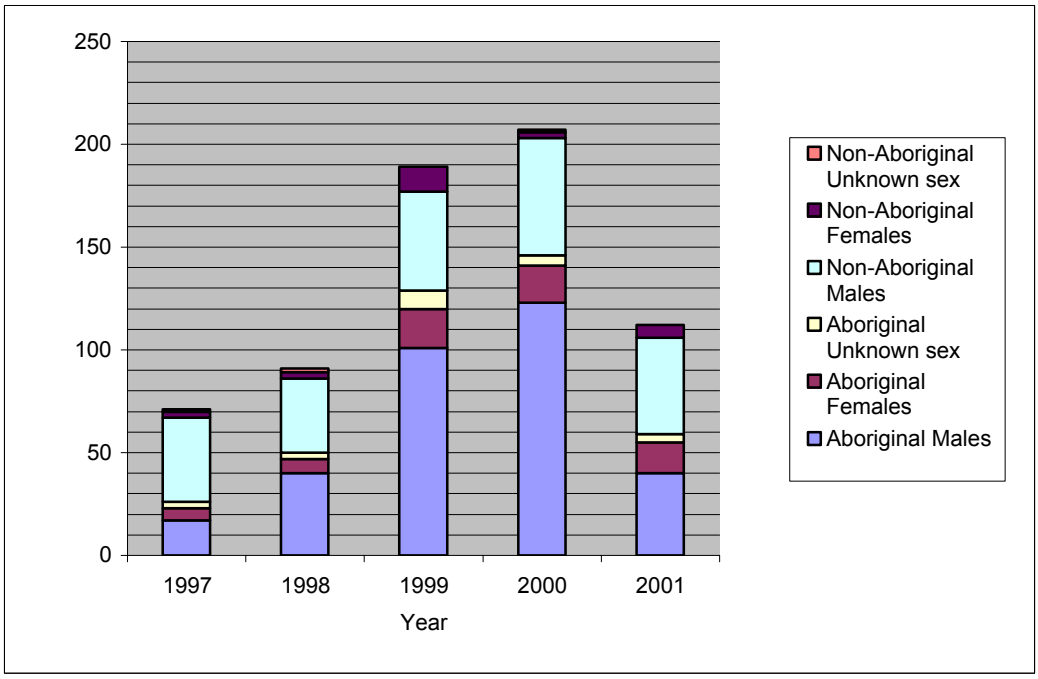

Figure 5.1: East Perth Police Lockup Detentions by year, 1997–2001

5.4 Service Limitations in Perth

In total, the 74 Indigenous alcohol and other drugs intervention projects conducted in Western Australia received $7,497,138 in the 1999–2000 financial year. The largest amounts expended in Western Australia were in the Wunan (Kununurra) and Kullarri (Broome) ATSIC regions. Perth Noongar Region—which has 35 per cent of the State's resident Aboriginal population—was third, receiving a total of $1,230,941 (16.4% of funds). The regions with the largest per capita expenditure were Kullarri ($343.74) and Wunan ($336.74). The Perth Noongar region was ranked seventh, out of nine regions, receiving $62.28 per capita.[17]

All alcohol and drug intervention services have limitations that impact on service delivery in Perth. These are particularly evident in the examination of services from an Aboriginal perspective. Few of the significant non-Aboriginal services in Perth employed Aboriginal staff, and all identified an increase in Aboriginal staff as being a factor that would make their services significantly more accessible to Aboriginal clients. Some of the most common service limitations identified were common across the service agencies in Perth. These included: the current limited capacity of services; finding Aboriginal staff; cultural differences between service providers and clients; and internal agency procedures that exacerbated this problem.

Representatives of some of the non-Aboriginal services in Perth were asked whether they were aware of any possible problems experienced by Aboriginal people using their services. Each of the service representatives admitted that Aboriginal people faced obstacles in accessing or using their services.

> There is a need for a different approach with Indigenous people … and realising that it is a different culture and it will take a lifetime of training to understand it all.

> We have deficit amongst our staff and health care professionals—of Aboriginal people. I wonder about the kind of drug use that happens in the Aboriginal community—the patterns of drugs; how they use and what they use—and whether that causes some difficulties in accessing our service.

Other organisations identified their inability to find qualified Aboriginal staff as a major hindrance to providing a culturally appropriate service. Most respondents recognised the importance of having Aboriginal staff members working with their Aboriginal clients.

> We have not been very successful in recruiting Aboriginal workers, not for lack of trying. However, we have taken steps through training and various other things to try to be sensitive to Aboriginal culture. I think there is a whole package of cultural issues that makes it difficult for us to deliver good service to Aboriginal people.

> I'd imagine because we don't have—in the past we've tried to employ Aboriginal workers in recognition that most of the people who work here are non-Aboriginal people—and that maybe our culture and who we are is quite different, and that it might be more difficult to engage Aboriginal people. The way we operate and our belief systems are different. That might have some impact as to the why it is that Aboriginal people decide not to come here.

> (I)f Aboriginal people had the choice of going to an Aboriginal run service or a non-Aboriginal service they'd go for the Aboriginal one—but at the moment they don't have that choice. This is only if they are intoxicated, if they aren't then there is nowhere for them to go.

> More Aboriginal staff in these services; there is a respect of Aboriginal people (for Aboriginal people), they'd feel more comfortable talking to other blackfellas because they are more culturally aware and it's easier to relate their problems to someone of the same culture.

The issue of finding qualified staff was raised in the Community Drug Summit, and this and the limited amount of funds allocated to staff training have been highlighted in various alcohol intervention evaluations and a review of funding for Indigenous alcohol and other drug services.[13, 16, 20] However, some respondents also stated that

employing Aboriginal staff in non-Aboriginal services is not always appropriate, because while employing Aboriginal staff they do not always amend their policies and services to assist Aboriginal people in using their services. This is also very much an issue of self-determination: 'Aboriginal run for Aboriginal people … and the power to control the services.'

Many staff from these organisations were aware that operational requirements make it difficult for all drug users to access their service in times of crisis. Many services operate between nine and five weekdays—restricting accessibility to many people who require their services when they in crisis. This was an issue raised in the Community Issues Paper for the Community Drug Summit,[13] and by one of the respondents:

> In both regional and urban areas, few service providers operate outside of standard working hours. However, this is the time when most acute problems arise and when crisis care is most needed. Concern about this is also linked to inadequate levels of emergency housing for people who use illicit drugs, their partners, and their families.

> I think that they do and there are a number of reasons for that (difficulties of Aboriginal accessing the service). The fact that we are a middle-class mainstream agency plays a part; also. … I know that we have a 24-hour detoxification unit, but the outpatient services work nine to five, Monday to Friday.

Further testimony to the cultural differences evident in current services was highlighted in a discussion about completion and sobriety rates of existing detoxification and treatment services. One respondent highlighted the priority and importance of family obligations to Aboriginal people, and how their sobriety can be affected:

> (C)ultural difficulties experienced by Aboriginal people relate to the commitment to family and the commitment to be in certain places for certain family events, where there is a lot of alcohol. So that does create significant problems, which people from European cultures can have a greater capacity to cut themselves off, even from family links, that many Indigenous people can't do.

> (C)apacity is needed, if there's an agency that can do it more culturally relevant than we can do it. I'm convinced it's important to have a range of options in the alcohol and other drugs services in Perth. Because if the Salvation Army turns them away then there's somewhere else for them go to—and vice versa—if NASAS turns them away then there's elsewhere for them to go. If they have problems with a worker in either agency they have an alternative. If there are families in conflict (feuding) we have alternatives and the capacity for others.

Family obligations also influence the time individuals spend in detoxification and treatment services and the ability of some to remain in them. Many often have to leave due to family obligations and due to the regulations they are not always allowed back in. The nature of these family relationships means that others are affected by the alcohol or drug misuse, and have far reaching implications for the individual's recovery.

5.5 Unmet Needs

As a consequence of investigating the achievements of, and limitations experienced by, the existing services, a number of unmet service needs among the Aboriginal population in the Perth metropolitan area were identified. The recent Western Australian Community Drug Summit and staff representatives from alcohol and drug intervention services in Perth have recognised these unmet needs, or gaps in services.

One of the representatives identified the need simply for more capacity in the current services, as a service providers are not able to adequately deal with the existing problems in Perth. The lack of adequate services for Indigenous people was also highlighted by the Community Drug Summit in Perth (2001):

> Among the most important of the gaps in services is the scarcity of appropriate intervention services. Many Indigenous people with substance misuse problems are reluctant to leave family and 'country' for treatment. Thus, as a consequence of the absence of appropriate residential detoxification and rehabilitation programs in many areas of the state, many Indigenous programs in many with problems go untreated. In many areas, there is also a lack of choice for individuals seeking treatment. In Perth, for example, there is one residential treatment project for Indigenous women conducted by a non-Indigenous organisation, but no Indigenous organisation is funded to provide a comprehensive intervention program.[13]

Difficulties in accessing services were also highlighted in the Western Australian Community Drug Summit:

> Many parents of illicit drug users feel isolated, frustrated by their inability to access services for their children; depressed because of the impact of their children's use on other family members, and are filled with self-blame and shame. In such circumstances, they usually try to deal with their problems within the family unit and only seek outside help when their efforts fail. However, once that decision has been made, there is confusion about which services to approach for help, and barriers to accessing services. There is nowhere people can drop in for an informal non-judgmental chat and obtain information, and it is extremely difficult to get counselling or other support to help them cope with the drug use of family members.[13]

The need for another detoxification service and sobering-up facility, in the metropolitan area, was highlighted in a majority of service provider interviews. When asked if they support the proposed sobering-up shelter and detoxification service, all respondents from both Indigenous and mainstream service agencies were in favour. Most stated simply that such culturally appropriate services were lacking in Perth.

> (T)o have a detoxification centre in the city. It would address issues of people in the park who are intoxicated, cover the C.B.D. (central business district). When driving at night you can see people outside the train station because they have no place to go. There are many people in Northbridge who are intoxicated or affected by drugs; there are people who are homeless as well. These people are affected by substances and they go into a detoxification centre. The current services can't address the need as they have their rules. The services can't be temporary accommodation for these people as they're taking beds off others.

> (I)f people are trying to get placed into a fee-paying (service), and don't have that money, it's difficult for people to access these services, especially since we don't have money set aside for this purpose.

> One of the problems we've seen here with Aboriginal clients is they often don't stay to complete their detoxification. They want a safe place to be and a safe environment to be in while they are in crisis or going through withdrawal. Often after they've got a little bit of a plan together, or they've had a day or two here, they decide they want to go back out into the community and continue their use. … They don't necessarily want to do a treatment program; they just want a safe environment to get their needs met in. A sobering-up shelter would be good—if they want to leave and continue to use they can do so—because the whole philosophy of a sobering-up shelter is that there isn't a premise that they'll go on to complete a detoxification, and then go on to have further follow-up.

> We try to provide a more holistic approach—most of those Aboriginal clients who come here are looking primarily for some sort of residential treatment, very few of our Aboriginal clients actual engage in follow-up options. They usually present in crisis, need some accommodation to detox, then more often than not they drop out of treatment before completion.

One respondent raised the need for an appropriate place for people to stay as many homeless people in the city are also affected by alcohol or drugs, and are restricted in options by the regulations of the current services. Similar concern was expressed by a representative of another organisation who said that many of their clients were presenting because they required accommodation. One respondent put it simply: 'They need a safe place to go to. (They) need a lot of support, as do their families.'

Among non-Aboriginal people, community-based detoxification has been shown to be cheaper than detoxification in special facilities and there is some anecdotal evidence suggesting that detoxification has been achieved successfully in remote, 'dry' Aboriginal communities. Despite this, it is not the best approach for Aboriginal people living in urban areas. As one respondent pointed out:

> Home detoxification is not practical as too many Aboriginal clients are homeless or living in temporary accommodation arrangements or are changing their residency all the time.

However, community-based detoxification is not just a problem for the homeless. In their study of Aboriginal people who inject drugs, Gray and his colleagues highlighted the difficulty individuals face when they lived—as many Aboriginal people do—in overcrowded conditions where other household members continue to make heavy use of alcohol and other drugs.[9]

6. Discussion

There has been limited research on Aboriginal substance misuse issues in Perth and this needs assessment was restricted by the funds allocated and time allowed for a comprehensive needs assessment of services for Aboriginal people in Perth. The aims of this assessment were:

- to identify the number of services available to address substance misuse amongst Aboriginal people in the Perth metropolitan area;
- to identify the main groups within the local Aboriginal population who misuse substances and establish what, if any, are their alcohol and other drug intervention service needs;
- to determine the extent to which these services are meeting the needs of Aboriginal people; and,
- to identify the gaps in current Aboriginal alcohol and other drug intervention services in the Perth metropolitan area.

In order to meet these objectives, project statistical data and annual reports were obtained from NASAS and various drug and alcohol intervention services in Perth. An Aboriginal population profile of Perth was developed from population data obtained from the ABS. Alcohol and drug-related harms were identified through health-related alcohol, tobacco, and other drug data, provided by the Health Information Centre at the HDWA. The Crime Research Centre at UWA provided alcohol and drug-related arrest data for the identification of crime-related harms.

Community and service provider perceptions were gauged from interviews with 12 representatives from the Drug and Alcohol Office (DAO) and a number of Perth community intervention services used by Aboriginal people, including: Noongar Alcohol and Substance Abuse Service (NASAS); Next Step Detoxification Services; Nyoongar Patrol; and the Salvation Army's Bridge House Program. The finding based on these data are presented below.

Drug use

Despite being dated, the 1994 NDS Survey[6] provides best baseline estimates of substance use within the Indigenous population in Australia. The survey shows that the level of substance use is higher among Aboriginal people than among non-Aboriginal people. When more recent research is viewed, the limited evidence suggests that substance misuse in the Aboriginal population is increasing. While the 1994 survey shows us that substance misuse is higher among Aboriginal males than

Aboriginal females, research in Albany has suggested that among Aboriginal young people there is no statistically significant difference in prevalence of alcohol consumption between males and females.

Recent research also shows that between 1996 and 2000, hospital admissions caused by opioids, psycho-stimulants, drug psychoses and intravenous drug use increased more rapidly among Aboriginal people, highlighting the cause for concern. There has been an increase in the number of people presenting at NASAS for illicit drug-related problems, which is further cause for concern.

Harms

The health consequences of substance misuse in the metropolitan area are much greater among Aboriginal than non-Aboriginal people. According to both NASAS and HDWA data, in spite of the prevalence and impact of tobacco on health within the Aboriginal population, alcohol clearly remains the drug of most concern to the Aboriginal population. Despite a smaller number of Aboriginal people consuming alcohol, those that are consuming alcohol are consuming it in more harmful amounts.[21] In 2001, NASAS data shows that after cannabis, the next drug of concern is amphetamines, having increased in prevalence above volatile substance use in 1999.

The rates of death caused by alcohol and tobacco among both Aboriginal males and females are at least twice those among non-Aboriginal people. In addition the rate of deaths caused by other drugs is possibly 50 per cent greater among Aboriginal males, and twice as great among Aboriginal females, as among their non-Aboriginal counterparts. Both Aboriginal males and females are more likely to be hospitalised for all drug related conditions and that, in the case of alcohol, the rate of hospitalisation among Aboriginal men and women are at least three times greater than among non-Aboriginal people.

Research has found that between 1993 and 1999 the number of Aboriginal notifications of hepatitis C increased from 1.8 to 8.4 per cent of all notifications.[9] In this same period there was an annual average increase of 34.8 per cent in the number of Aboriginal hepatitis C notifications.

While Aboriginal people made up only 1.4 per cent of the population of the Perth Statistical Division at the 1999 Census, they accounted for 17 per cent of all drug and alcohol-related arrests between 1994 and 2000. The proportion of Aboriginal people arrested for alcohol and drug-related offences shows an over-representation of Aboriginal people in the justice system because of alcohol and drug use. Many of

these offences could have been minimised with the availability of an alternative sobering-up shelter. The ability to meet the demand is currently restricted by their capacity and regulations.

Existing services

There is a range of mainstream services but, generally, they are not appropriate and not accessed by Aboriginal people. Although the current services are addressing some of the needs of Aboriginal people—with all the services reported having Aboriginal clientele—it was found that Aboriginal people are more inclined to use Aboriginal-specific services, such as NASAS, where 99 per cent of the clients are Aboriginal. Excluding the sobering-up shelter, where 52 per cent of clients are Aboriginal, the average proportion of Aboriginal clients using these mainstream services is 13 per cent, ranging between two to 20 per cent. Although these percentages are greater than the percentage of Aboriginal people in the population, limitations in the size of existing services and barriers to use of them means that the need for services for Aboriginal people is not being met.

The number of Aboriginal services is limited. Perth Noongar Region has 35 per cent of the State's resident Aboriginal population, but in 1999–2000 services in the region received only 16.4 per cent of funds for Indigenous-specific intervention projects. The current expenditure on Aboriginal alcohol and other drug interventions within Western Australia is disproportionately allocated, with per capita spending in the Perth Noongar ($62.28), and Kaata-Wangkinyiny ($19.06) ATSIC regions being less than 20 per cent that in the region receiving the highest level of per capita funding ($336.74). This indicates a need for more resources to be allocated to the Perth Noongar region, as there is clearly a demand for services that is not being adequately met.[17]

In the Perth metropolitan region there is a limited number of services available for Aboriginal people. For the Perth Noongar ATSIC region there is one residential treatment service that caters for Aboriginal people, but this service is operated by a non-Aboriginal organisation, and it is just part of a wider treatment program specifically for women with young children. Aboriginal people requiring residential treatment services, and wishing to stay within their region, must use the mainstream services, which presents other obstacles.

Respondents from mainstream services indicated that Aboriginal people still encountered difficulties using their services, despite efforts to accommodate their needs. One of the reasons given for this was the inability of mainstream organisations

to find Aboriginal staff. However, the problems associated with Aboriginal people accessing mainstream services goes far beyond the issue of staffing. The bureaucratic nature and policies of these organisations restricts users' access to their services in times of crisis and are not flexible enough to allow for Aboriginal people to meet their cultural and family obligations. The sheer demand for these services, in particular those offered by the sobering-up shelter and treatment programs, makes it difficult to meet the needs of the entire population, let alone the needs of Aboriginal people.

What is needed?

There is a need for the services for Aboriginal people to be run by Aboriginal people. In a submission to House of Representatives—Standing Committee On Family And Community Affairs—the National Aboriginal Community Controlled Health Organisation (NACCHO) highlighted the need for Aboriginal community control of health services 'first(ly), because of a lack of access to appropriate services within a mainstream context, and secondly in order to put self-determination into practice at the local level.[22] That is not the only reason; in regard to the substance misuse needs of Aboriginal people, the mainstream services need to cater for all Australians, but the ground rules are different.

> Mainstream rehabilitation and other services, while often well intentioned, are usually inappropriate for Aboriginal people. While it is true that mainstream services must meet their obligations to all Australians, including Aboriginal peoples, NACCHO's experience is that mainstream programs cannot provide culturally appropriate services for Aboriginal people.[22]

Other research reinforces this view, for instance, Robyn Williams states that:

> Culturally appropriate programs/approaches are crucial in enhancing personal empowerment and as a result, promote more effective service delivery for Aboriginal people. The most able or equipped to provide a culturally safe atmosphere are people from the same culture. [23]

Given the increases in substance misuse, the harms associated with such use can be expected to also escalate within the Aboriginal community in Perth. Although alcohol is likely to remain the primary drug of focus, interventions strategies should also be put in place to accommodate clients who present with volatile substance, cannabis, amphetamine and other illicit drug use problems. Illicit drug users currently make up a small percentage of clients seeking treatment at NASAS; however, recent trends suggest that illicit drug use—in particular injecting drug use—is on the rise. This could indicate that in the future an increasing number of clients who seek sobering-up and detoxification services may do so primarily for the use of cannabis, amphetamines, volatile substances, or other illicit drugs. Therefore, a review of any possible 'special' needs of clients presenting for illicit drug detoxification should be carried out and strategies to address these needs should be developed. Illicit drug detoxification may require a different approach to that of alcohol detoxification, and it

also may present greater risks such as blood borne viruses to both patient and staff that may impact on NASAS' Duty Of Care Policy.

There is also evidence to suggest that there is a need for the proposed non-medical residential detoxification aimed at achieving a supervised transition to a drug-free state without significant medication use. Both community-based and residential detoxification options were investigated, and it was found that while a community based detoxification service offers financial benefits, it appears that a residential service is more appropriate to the lifestyles and needs of many of the potential Aboriginal clients. Many of the clients accessing the services of NASAS and the Nyoongar Patrol Systems are transient or come from an inadequate home environment in which there is insufficient support or overcrowding, making community-based detoxification almost impossible, and inappropriate to achieve the desired outcomes.

'Because of the complexities of the pharmacology involved in poly-drug use and abuse it is unwise to contemplate withdrawal except in an inpatient environment.'[23] Residential detoxification provides a supportive and controlled atmosphere, away from the individual's usual residence and other factors, for withdrawal; this is especially relevant to issues of poly-drug use and multiple drugs of treatment. Residential detoxification should be considered if one or more of the following factors are present: a risk of severe withdrawal symptoms, such as epileptic fits or extreme agitation; inadequate home environment, such as inadequate support or overcrowding; homelessness or the person is currently living in a crisis shelter; the influence of other drug users or access to the substance(s); poly-drug use, thus poly-drug detoxification is not advisable unless in an inpatient facility.[24, 25]

The location of any residential detoxification centre needs to be central and easily accessible from all metropolitan areas by car and public transport. This is why the proposed site in East Perth is ideal to establish such a facility. The site is also located close to both bus and train stations and is in an area that NASAS is already servicing through its outreach service—which will also be operating from the proposed facilities. Members of the resident population are not the only ones requiring access to these services. According to interview respondents, the transient population or 'park people' comprise the main group using the acute interventions operating in Perth. The services will be located close to existing health and alcohol and other drug services: Derbarl Yerrigan Health Service; Next Step Detoxification Service; Noongar Alcohol and Substance Abuse Service (existing services); and Salvation Army's Bridge House about two kilometres away. The close proximity of the services will promote effective

referral processes, allow for the services to support each other, and provide the clients with a choice of which services simplify the referral process.

This and other research suggests that the best approach to tackling substance misuse among Aboriginal people is to implement a multi-strategic model involving a range of projects and services.[20, 26] Perth could possibly be on its way to having such a network, but there are some obvious gaps in the services currently available. A major gap is the lack of an Aboriginal residential treatment program in Perth, or in the immediate surrounding ATSIC region. For those living in Perth, the closest residential service specifically designed for Aboriginal people is located approximately 780 kilometres away in the Goldfields region. Nor is there a detoxification service in Perth that meets the special needs of Aboriginal people.

A range of intervention strategies is needed to competently address Aboriginal drug and alcohol use and associated problems, and a holistic approach is the key to successful drug intervention. This suggests that the establishment of a residential treatment facility, sobering-up shelter, and detoxification unit would complement the current efforts being made by NASAS and other Aboriginal and mainstream drug services to provide a range of prevention projects, acute interventions and counselling services.

7. Recommendations

Based on the results of our assessment of service needs for Aboriginal people in Perth, I make the following recommendations as a means of strengthening the services in available to Aboriginal people in Perth, and surrounding regions.

1. Since there is no Aboriginal-specific residential service in the Perth Noongar or Kaata-Wangkinyiny ASTIC regions, and because of the limitations associated with detoxification services currently available in the Perth metropolitan region—an Aboriginal specific residential treatment facility be established in East Perth.

2. Due to the limitations of the sobering-up service currently available in the Perth metropolitan region, and the number of Aboriginal clients accessing this service—an Aboriginal specific sobering-up shelter (safe house) be established in East Perth.

3. In accord with the identified needs of Aboriginal alcohol and drug users in Perth—the proposed service, along with the other alcohol and drug intervention services in Perth, provide a comprehensive and multi-strategic approach to Aboriginal alcohol and other drug intervention, detoxification, and treatment.

4. In light of the percentage of tobacco-related deaths among Aboriginal people—there be programs specifically concentrating on reducing tobacco-related harms within the Aboriginal community.

5. In light of the evidence of poly-drug use among Aboriginal people—that the services do not concentrate on the treatment of one drug, but rather take a comprehensive approach to substance misuse—including provision for detoxification from a variety of drugs

6. In light of the service needs and target population highlighted by the respondents—there be an Aboriginal community controlled residential service located in the Perth Noongar ATSIC region.

7. Given the increase in the numbers of Aboriginal females using alcohol and other drugs—services provide programs specifically for female and male substance users.

8. Due to the high concentration of Aboriginal people in the Perth Noongar and Noongar country (Kaata-Wangkinyiny) ATSIC regions—Aboriginal-specific services be available in areas of high Aboriginal concentration.

9. The proposed services be flexible in their provision of services to clients, having in place culturally appropriate procedures, such as those that will allow clients to meet family and cultural obligations.

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