

1 Introduction

1.1 Purpose of the project

The Australian Institute of Health and Welfare (AIHW) was commissioned by the Australian Government Department of Health and Ageing (DoHA), on behalf of the Ministerial Council on Drug Strategy (MCDS) to identify and report on the current state of data collections relating to substance use issues for Aboriginal and Torres Strait Islander peoples in Australia, and set out options for improving these data. The stated objectives of the project were to:

- identify data needs
- examine existing data sources that may be accessed to provide a picture of Indigenous substance use and resultant impacts across the nation
- inform the best way forward, in terms of the improvement of Indigenous data collections
- explore the feasibility of development of an ongoing Indigenous (drug-specific) survey supplement to existing surveys and
- identify options for new, policy-relevant analyses of existing data sets.

This report thus identifies and reviews relevant data sources, highlights inconsistencies between them, identifies data gaps and makes recommendations about how to improve the availability and usefulness of data on this subject. While options are identified for new analyses of existing data sources, this project does not involve carrying out these analyses.

This report was presented to the MCDS in May 2006. The report findings are expected to feed into a broader National Drug Strategy Data Analysis Project, which aims to identify and analyse the information needed to inform the implementation and measurement of initiatives developed under the National Drug Strategy.

1.2 Project methodology, analytical framework and report structure

The first step in the project methodology was an extensive search of information, including literature, policy statements and information about programs and initiatives (see Chapter 2 for a summary and Appendix 1 for the full literature review). This search provided the contextual background to this report and assisted in identifying a set of preliminary information needs.

These preliminary information needs were subsequently refined into a series of key questions following a stakeholder workshop, held in November 2005. The purpose of the workshop was to highlight key information needs, outline the extent and state of existing data sources, and develop preliminary options for improving data availability and analysis (see Chapter 3 for a summary and Appendix 2 for a more detailed presentation of the discussion). Material from the literature review and the stakeholder workshop were used to outline the key information needs (Chapter 4), against which information sources were assessed (Chapter 5).

The project team assessed a broad range of data sources relating to Aboriginal and Torres Strait Islander peoples' substance use and their associated harms. While most of these data sources come from the health and welfare areas, relevant data sources from areas such as criminal justice, policing and homelessness are also explored where they provide additional information to describe this population and their substance use patterns. Analysis focuses on national collections (both population based and administrative data) that are in the public domain. However, this focus is not exclusive. For example, jurisdiction or local level data sources have been included if they provide relevant and good quality information, or if they provide a good model for collecting data. Information from published research literature and from Indigenous communities was also sought.

Three main steps were undertaken to assess the extent to which key data sources inform the needs of stakeholders:

1. Key data sources were analysed individually in terms of a standard template. This template was designed to gather information on the purpose, scope, content, definitions and methodology of each collection and thereby the extent to which it can address the information needs of stakeholders. The template (Table 5.2) was also designed to identify information in relation to all areas of the five domain framework (Table 1.1).
2. Key data sources were compared and contrasted in terms of their characteristics, as specified in the template in Table 5.2 (for example, their comparability in terms of counting rules and frequency of collection, the consistency with which they define key variables such as Aboriginal and Torres Strait Islander status and substance use).
3. Key data sources were analysed as a set of data sources in terms of their ability to inform key questions and information needs of stakeholders.

An analytical framework is used throughout the report to organise the presentation of contextual information relating to Indigenous substance use, the information needs of stakeholders (that is, key questions), the review of data collections, and the development of future options for improving information in this area. The five-domain framework (Table 1.1) was developed following the literature review and refined following discussions with stakeholders. The framework reflects the key questions identified through these processes.

The five domains of the framework are intended to capture:

- contemporary patterns and trends in the use of tobacco, alcohol and other drugs
- the contextual factors associated with substance use *and* non-use, including exposure to preventive initiatives
- recognised harms associated with tobacco, alcohol and other drug use
- intervention and treatment services currently operating to assist Aboriginal and Torres Strait Islander peoples with substance abuse problems
- estimated expenditure on preventive, intervention and treatment programs and associated services, including health and long-term care.

Throughout this report, the term 'substance use' is used to refer to the use of tobacco, alcohol or other drugs.

Analytical frameworks such as those used in *National Comorbidity Initiative: a review of data collections relating to people with coexisting substance use and mental health disorders* (AIHW 2005e), *A guide to Australian alcohol data* (AIHW 2004a), the conceptual framework for *Australia's health* (AIHW 2004b), the National Health Performance Framework (NHPC 2001), the National Aboriginal and Torres Strait Islander Health Performance Framework (NATSIC 2004a, 2004b) and the *Overcoming Indigenous Disadvantage* framework (SCRGSP 2005), informed the structure of this report and its underlying analysis. The report and framework are also consistent with, and inform, the National Drug Strategy (2004–2009) and the Aboriginal and Torres Strait Islander Peoples Complementary Action Plan (2003–2006).

Chapter 5 presents a detailed comparative analysis of the key information sources identified. Chapter 6 outlines the extent to which these data sources address information needs and identifies information gaps. Chapter 7 presents options of closing these information gaps.

The findings of the report are summarised under four related headings:

1. What are the priority information areas?
2. What information is available?
3. To what extent can existing information answer the key questions?
4. What are the information gaps and how do we fill them?

Table 1.1: Framework for information relevant to the description and understanding of Aboriginal and Torres Strait Islander peoples' substance use

| Tobacco, alcohol and other drug use and associated risk behaviours | Context and influences | Associated harms and health status | Intervention and treatment services | Resources |
|---|--|--|--|---|
| Prevalence of use (including lifetime, current and most recent use) and trends in use | Demographics (e.g. age, sex, Indigenous status, geographic location) | Mortality | Options (per substance type, per geographic location, per intervention/treatment type) | Expenditure (direct): preventive programs, intervention and treatment programs and facilities |
| Type of substance(s) used (including traditional drugs) and multiple drug use | Social context (e.g. living arrangements, residential setting, household composition, income and primary income source) | Comorbidity—actual and associated health conditions, including mental health, and acute morbid states such as overdose | Uptake | Expenditure (indirect) (e.g. health care, long-term care, incarceration) |
| Age when substance(s) first used | Social participation (e.g. education, employment, recreation) | Disability (e.g. acquired brain injury, paralysis) | Affordability | |
| Frequency of use | Family and personal context and influences (e.g. influence of, and exposure to, family functioning and resilience, family stressors (e.g. grief) and social disruption (e.g. crime and violence); indicators of emotional and spiritual wellbeing, including connection to land and people; experience of discrimination) | Pregnancy and the unborn child | Accessibility | |
| Amount used | | Economic impact on individual and community | Appropriateness and cultural acceptability | |
| Drug paraphernalia/tools | | Suicide | Outcomes of interventions and treatment (evaluation) | |
| Geographic and seasonal variation (in substance use) | | Homelessness | | |
| Monetary expenditure on substances | Substance use context and influences (e.g. influence of, and exposure to, substance use by family, peer group, community; cultural acceptance of specific substances; availability and opportunity to use substances, patterns of supply and demand, prevention strategies (e.g. community regulations (dry communities, licensing laws), education) | Violence | | |
| Risk behaviours (e.g. sharing needles) | | Crime (as perpetrator and victim; crime as a result of use (e.g. violent assault) or undertaken to continue use (e.g. petrol siphoning, theft) | | |
| | | Detention and imprisonment | | |

2 Background: summary of literature review

There is consensus that a significant substance abuse problem exists among Aboriginal and Torres Strait Islander peoples. The use, and misuse, of alcohol, tobacco and other drugs is influenced by a wide range of socioeconomic and cultural factors, and the effectiveness of methods for preventing or treating this use are sometimes weakened by a series of problems as to where, how and by whom prevention, intervention and treatment strategies are provided.

The literature on this topic is somewhat fragmented, with little or no published material in some important areas (for example, mental health). Most of the reviewed literature is based on studies of particular communities, geographical places or time periods, so findings may not necessarily be applicable to the wider Aboriginal and Torres Strait Islander population.

This chapter presents a brief overview of the available published literature with reference to the framework in Table 1.1; a more comprehensive literature review is presented in Appendix 1.

2.1 Tobacco, alcohol and other drug use

A variety of licit and illicit substances are used by Aboriginal and Torres Strait Islander peoples, but most research has focussed on the problem areas of risky drinking, and the use of cannabis, heroin, amphetamines and sniffing of inhalants and solvents, particularly petrol. Recent data from the 2004–05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) indicates that over half (50–57%) of Aboriginal and Torres Strait Islander peoples aged between 18 and 54 years are current smokers, compared with 29% or fewer of other Australians (ABS 2006). While a number of population surveys indicate that Indigenous peoples are less likely than non-Indigenous people to have consumed alcohol in the last 12 months (71% compared to 82%; AIHW 2005a), there is conflicting evidence about the relative levels of risky or high risk drinking among these population groups. Illicit substance use appears to be somewhat higher for Indigenous Australians. The 2002 NATSISS and the 2004 NDSHS both indicate that approximately one quarter of Indigenous peoples used illicit substances in the last 12 months (AIHW 2005a). The comparable figure for non-Indigenous Australians was 15%, based on the 2004 NDSHS.

Many Indigenous Australians who become involved in drug use start using drugs from a young age, usually in their early to mid-teens, and generally at a younger age than other Australians (AIHW 2005a; Burns et al. 1995a; Clough et al. 2004; Gray et al. 1997; Larson 1996; Shoobridge et al. 1998). Substance use tends to vary with geographic location, with heroin and amphetamines, for example, more commonly used among urban living Indigenous Australians (Larson 1996; Larson et al. 1999; Shoobridge et al. 1998) and petrol sniffing among individuals living in regional areas, especially remote communities (Brady 1988; Burns et al. 1995a; d'Abbs & MacLean 2000). However, contemporary changes in drug use behaviour have seen a move towards an increased use of illicit drugs (for example, heroin: Shand & Mattick 2002), and the rapid uptake of certain drugs in areas where that drug had previously been unknown, such as the introduction and subsequent widespread use of cannabis in East Arnhem Land (Clough et al. 2002a, 2002b). Multiple drug use has also become problematic and, for those using large quantities of a drug or more than one substance, expenditure can be costly. The most detailed examination of expenditure comes from Clough et al. (2002b, 2004) who estimated that residents of two communities in East

Arnhem Land had a weekly outlay of between 31 and 62% of individual median weekly income, and 6–10% of the community monetary resources, on cannabis purchases.

2.2 Associated harms

The potential harms associated with substance use are large, and are exacerbated by the risky behaviours (for example, needle sharing) that often accompany illicit drug use. Aboriginal and Torres Strait Islander peoples who consume alcohol at risky levels, or who smoke, suffer considerable premature mortality (Hicks 1985, cited in Gray 1990; Measey et al. 1998; Unwin et al. 1995); life expectancy among Indigenous Western Australians was estimated by Arnold-Reed and colleagues (1998) to have the potential to rise 5.9 years (for males) and 3.4 years (for females) if tobacco smoking and unsafe alcohol use were eliminated together. Little, however, is known about mortality resulting from other drug use, despite sporadic reports of deaths attributable to petrol sniffing (Brady & Torzillo 1994; Goodheart & Dunne 1994; South Australian Coroners Court 2002) and a known association between suicidal ideation and substance use among Indigenous Australians (heroin: Shoobridge et al. 1998; alcohol: Hunter 1991; cannabis: Clough et al. 2006, Tatz 1990). More information is available on comorbidities, particularly the chronic conditions arising from heavy alcohol and tobacco use, HIV, HBV and HCV infection rates among intravenous drug users (Holly 2001; Larson 1996; Roberts & Croft 2000; Shoobridge et al. 1998), and cognitive and mobility impairments experienced by chronic petrol sniffers (Cairney et al. 2002, 2004, 2005). Permanent disability is also a very real consequence for long-term substance users, but very little is known about the proportion of Aboriginal and Torres Strait Islander peoples who are so affected, although there are some reports emanating from the Northern Territory and the Anangu Pitjantjatjara Lands in South Australia that suggest a considerable number of long-term petrol sniffers have been severely disabled as a result (Mosey 1997, cited in d'Abbs & MacLean 2000; Roper 1998, cited in d'Abbs and MacLean 2000; Select Committee on Substance Abuse in the Community 2004; South Australian Coroners Court 2002).

Criminal and violent behaviour, and subsequent incarceration, are similarly potential harms associated with substance use. Aboriginal and Torres Strait Islander peoples are incarcerated at a highly disproportionate rate compared with the rest of the Australian population (ABS 2005), and evidence suggests that drug-influenced criminal behaviour is a frequent pathway to incarceration. Stealing, break and entry, vandalism, gambling, drug dealing, sex work and violent crime (for example, assault) are regular consequences of intoxication (Brady 1985; Burns et al. 1995a; d'Abbs et al. 1994; Larson 1996), with violent crime and property damage being the main offences committed by Indigenous male prisoners and detainees (2004 DUCO and DUMA collections: Putt et al. 2005). Around 60% of both male and female Indigenous prisoners acknowledged that they had been under the influence of some form of substance at the time of their offence (Johnson 2004; Putt et al. 2005), although few male Indigenous prisoners attributed committing the crime to their intoxication.

2.3 Context and influences

The reasons behind current patterns of substance use among Aboriginal and Torres Strait Islander peoples are undoubtedly many and complex, and 'everyone has an "opinion" on the causes' (Brady & Torzillo 1994). Alcohol and drug use is often cited as a consequence of the effects of colonisation and dispossession, and the subsequent separation from culturally meaningful practices, but there is an increasing focus on the influence of contemporary realities of poor living standards, unemployment, 'welfare dependence', family conflict and

resolution, lack of facilities and boredom that are characteristic of many Indigenous communities. Being able to 'structur(e) time in a day to day sense...consistent with more productive activity, satisfaction, and cultural support and growth' (ANCD 2002) is considered crucial to guarding against immersion in sustained substance use, but often the opportunities to maintain that structure are missing. Education is important for opening up such opportunities, but, while apparent school retention rates among Indigenous Australians have improved (ABS & AIHW 2005), many children, particularly those in remote communities and who have started using drugs, are failing to stay at school (Burns et al. 1995a; Butt 2004; Clough et al. 2004; Gray et al. 1997; Holly & Shoobridge 2003). Employment is another potential casualty of substance use: either because the substance user loses the ability or desire to seek or maintain employment, or because the absence of employment opportunities encourages and sustains substance use. Little has been published on the employment status of known Indigenous substance users, but studies of alcohol users in Perth and Carnarvon (Blignault & Ryder 1997) and intravenous drug users in Brisbane, Adelaide and Murray Bridge (Holly & Shoobridge 2003; Larson 1996; Shoobridge et al. 1998) suggest a history of unemployment or underemployment.

The influence of the familial environment is another critical factor in influencing substance use or abstinence, particularly for Indigenous Australians where connections to the immediate and extended family are strong and culturally expected. In communities where risky alcohol use and drug taking is problematic, or for individuals who are regular users, family instability is often commonplace, characterised by frequent conflict and episodes of domestic and other violence, parental absenteeism and home-based alcohol and drug use (ANCD 2002; d'Abbs et al. 1994; Hunter 1991; Kelly & Kowalyszyn 2003). The peer group is also greatly influential, as acknowledged by young Indigenous Australians involved in petrol sniffing (Brady & Torzillo 1994; Burns et al. 1995a) and intravenous drug use (Shoobridge et al. 1998). While the sway of the peer group is not unique to Aboriginal and Torres Strait Islander peoples, it may be more attractive for those whose home life and family circumstances are stressful.

Exposure to substances, their use by community members and the opportunity to use these substances influences use, but the effect of supply and demand is an area of research requiring more attention. The Illicit Drug Reporting System uses 'key experts' to estimate the prevalence of drug use in Australian capital cities, and, by extrapolation, the supply of specific drugs. But, in non-urban settings, the collection of such information is more difficult, particularly for illegal or stigmatised drugs (see, for example, Clough et al. 2002b). Investigation by Clough and colleagues in the supply of kava and cannabis in East Arnhem Land provides a microcosm study of how supply and demand can greatly influence substance use behaviour (Clough & Jones 2004; Clough et al. 2002a, 2002b).

2.4 Intervention and treatment services

Efforts to prevent and reduce substance use among Aboriginal and Torres Strait Islander peoples cover a wide range of interventional approaches that target prevention (primary interventions), addressing the needs of the user and their community (secondary intervention) and treatment and long-term care (tertiary intervention). While formal evaluations of these interventions has generally been able to focus only on specific case studies, and for those that have been evaluated the results are generally favourable, there is still concern that interventions need considerable improvement. One notable flaw is the common assumption that Aboriginal and Torres Strait Islander peoples are a homogenous population, with interventions shaped accordingly (Gray et al. 1995). Better approaches

would acknowledge the diversity of the population, as well as ensuring cultural appropriateness, encouraging staff training and expertise, and offering a broader range of intervention approaches (particularly for treatment), which include support for families.

Preventive approaches (or primary interventions) have traditionally relied on education, but there is an increasing movement to supplement education with recreational programs, which act to alleviate boredom and focus interest and energies on sport and related activities (see, for example, Butt 2004; Stojanovski 1999, cited in d'Abbs & MacLean 2000). Temporary relocation to outstations or 'homeland centres' is another way of redirecting attention, where persons at risk of developing a drug problem, and those who are already using drugs, may spend time away from the community and become involved in cultural and other meaningful activities (d'Abbs & MacLean 2000). Diverting or halting the supply of alcohol and other drugs is a complementary approach to prevention, typified in Australia by the implementation of 'dry communities' and other forms of alcohol restriction, and the introduction of 'non-sniffable' Avgas and Opal fuels into communities where petrol sniffing is rife.

Secondary interventions have generally been described in the literature with respect to problem alcohol users and petrol sniffers and tend to occur in more regional and remote areas. The most well-known and commonly implemented of these interventions are night patrols and sobering-up shelters (see Blagg & Valuri 2003; Brady et al. 2006; d'Abbs & MacLean 2000; Gray et al. 2000). Night patrols and sobering-up shelters may work in concert. Night patrols are instrumental in maintaining safety and resolving conflict by diverting intoxicated people away from custodial care to designated safe place. Sobering-up shelters providing a safe environment in which persons can 'sleep it off' and be referred to appropriate services, if available.

Treatment, rehabilitation and counselling are the main tertiary interventions offered to Aboriginal and Torres Strait Islander peoples (Gray et al. 2002; OATSIH 2005). The success of these treatment options are, however, questioned in the literature as many Indigenous drug users shun these services because of cultural inappropriateness, confidentiality concerns or feelings of shame (intravenous drug users: Lane 1993; Larson 1996; Shoobridge et al. 1998), lack of knowledge about treatment services (Larson et al. 1999) or because such services are not available or too distantly located – a particular problem for people living in remote communities.

2.5 Resources

Information on national expenditure related to Indigenous drug use focuses primarily on funding of intervention programs. In the period 2003–04, Aboriginal and Torres Strait Islander substance use specific services, which included treatment/rehabilitation, counselling, education and sobering-up shelters, received \$27.5 million in recurrent funding from (primarily) the Office for Aboriginal and Torres Strait Islander Health (OATSIH) and other sources (OATSIH 2005). A review of all alcohol and other drug intervention programs operating in Australia in the period 1999–2000 found that a third of the money distributed to alcohol and other drug intervention programs for Indigenous Australians was for residential treatment programs, around 27% for acute intervention programs (for example, night patrols, sobering-up shelters) and approximately 13% for treatment services (Gray et al. 2002).

Relevant information on expenditure for other, related services, such as health services, is mostly missing.

2.6 National drug strategies

The National Drug Strategy, formally known as the National Campaign Against Drug Abuse, is a cooperative venture between the Australian Government, state and territory governments and non-government organisations to deal with drug use, and its associated harms, in Australia. One of the priority areas under the National Drug Strategy is the implementation of the National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan (2003–2006) (MCDS 2004). The Action Plan is based on the concept of harm minimisation – the overriding focus of the National Drug Strategy – and recognises the social, economic, environmental and physical health inequalities experienced by Indigenous Australians.

Six 'key result areas' shape the action plan:

- building individual, family and community capacity to address current and future issues in the use of alcohol, tobacco and other drugs, and promote their own health and wellbeing
- actively promoting a whole-of-government commitment, alongside collaboration with community-controlled services and non-governmental organisations, in reducing drug-related harm
- improving access to the appropriate range of health and wellbeing services that play a role in addressing alcohol, tobacco and other drugs issues
- recognising the role of holistic approaches, from prevention through to treatment, and continuing care that is locally available and accessible
- introducing and improving workforce initiatives to enhance capacity of community-controlled and mainstream organisations to provide quality services
- increasing ownership and sustainable partnerships for research, monitoring, evaluation and dissemination of information (MCDS 2004).

Most states and territories have developed their own drug strategies that either target drug use among Aboriginal and Torres Strait Islander peoples, or deal with drug use among the general population, but include reference to the special needs of Indigenous Australians. These strategies have similar objectives of harm minimisation, reducing supply and demand, and improving interventions. See Appendix Table A1.2 for more detail.

3 Stakeholder workshop

3.1 Workshop background

A workshop was held on 24 November 2005 in Canberra to consider and discuss the information needs and data sources relating to drug use among Aboriginal and Torres Strait Islander peoples. Participants invited to the workshop included community leaders and members, service providers, policy makers and researchers, as well as people with expertise in relation to data capture and analysis (see Attachment 1 to Appendix 2 for a list of participants and invitees).

The workshop was structured around three key questions:

1. What are our priority information areas?
2. What information is already out there?
3. How can the information be improved?

Opening discussions focused on the need for high-quality data to provide a basis for action, noting that current data are sufficient to start some interventions, but to understand and describe the availability and impact of such interventions requires more accurate and relevant data. Early discussion also focused on the need for consistent identification of Aboriginal and Torres Strait Islander peoples across data sources, and the need for information that is useful at individual, community, regional, jurisdiction and national levels. However, there was also a strong view that concerns about accuracy of data should not prevent us moving forward with interventions.

3.2 Workshop discussion and proposals

What are the priority information areas?

Workshop participants were asked to consider the sorts of information critical to understanding the current pattern of substance use among Aboriginal and Torres Strait Islander peoples, the associated harms and the most appropriate methods to avoid and treat substance abuse. That is, what are the key questions or priority information areas?

Areas of information considered by workshop participants to be of greatest importance are those that focus on patterns of substance use, the factors driving or influencing use, identifying the harms associated with use, and the interventions available and/or successful in halting substance abuse. These may be summarised as:

- What is the level of the problem?
- What are the broader social indicators influential in usage patterns?
- What are the harms experienced by the individual and the community?
- What interventions exist and do they work?

Within these broader-level questions more specific inquiries were raised as being of similar importance. Specific interest was expressed in information that:

- recognises the diversity of substance use among Aboriginal and Torres Strait Islander peoples, including diversity in substance types used and geographic and seasonal variation in the use of particular substances
- assists in identifying the factors associated with ‘communities at risk’ as well as ‘strong communities’
- is collected or analysed at the community level or regional level, recognising the potential difficulties in agreeing on appropriate definitions of communities or regions
- improves understanding of the social determinants of substance use, including unemployment, poverty, means and patterns of supply, involvement of the criminal community and legal settings in place
- enables identification and evaluation of interventions proposed or already in place, including:
 - which interventions work for particular problems?
 - why interventions are working?
 - how much of what should be happening is actually happening?
 - which interventions do not work, why not and what alternatives can be offered?
- is linked to the development of a systematic set or ‘dashboard’ of key indications
- uses strategic qualitative analysis to assist in interpreting and reporting information
- ‘hears the voices of those involved’, namely, listens to the experiences of Indigenous people who currently use or have used substances (for example, as in Dance et al 2004).

What information is already out there?

Workshop participants were invited to examine a preliminary list of existing data sources prepared by the project team and identify additional relevant data sources for the list, as well as identifying irrelevant data sources that should be removed from the list.

Although the general consensus among participants was that there is a wide range of data available on drug use among Indigenous peoples, it was also noted that there are information gaps in the areas of patterns of use and supply, harms, interventions, accessibility and expenditure. In addition, existing data sets seem to focus on illicit drugs while excluding alcohol, which has the most wide-ranging associated harms. Furthermore, the causes of substance use are likely to be different in each community, as are the data needed to capture this diversity.

Participants noted that some of the data currently collected are not accessible because of ethical and confidentiality issues.

It was also noted that there is some potential for improving the analysis and reporting of some of the data currently collected in the field. For example, Aboriginal and Torres Strait Islander primary health care and substance use services collect a wide range of information about their clients through patient information systems, a small subset of which is reported as part of the Service Activity Report (SAR) and the Drug and Alcohol Service Report (DASR). It was agreed that the information Aboriginal and Torres Strait Islander primary health care and substance use services collect needs further exploration.

How can the information be improved?

Participants were asked to consider how information about substance use among Aboriginal and Torres Strait Islander peoples can be improved. It was acknowledged by participants that there is a plethora of data that can help inform the issue, but to get value out of the data they must be analysed and interpreted in a meaningful way, taking into consideration the varying audiences. Participants expressed the desire to have a 'helicopter view' of what is happening across sectors in relation to substance use among Aboriginal and Torres Strait Islander peoples – that is, an analysis of all available data relevant to the issue.

Options for disseminating such an analysis were discussed, including the need for timely dissemination of results to government bodies, communities and researchers – especially true for reporting emerging issues and monitoring trends.

Two specific options for improving the dissemination of information were raised, namely:

1. the inclusion of a dedicated chapter on substance use in the next report of *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples*
2. production of a more regular report, specific to Indigenous substance use and associated harms, which would slice into and incorporate data from a broader range of data sources.

It was noted that such collations would give, for example, the National Indigenous Drug and Alcohol Committee (NIDAC) and other committees 'something to work with'.

In relation to improving information (either in terms of presenting analysis or in any future data development or data collection arrangements) the following issues were raised by participants:

- the need for timely and relevant analysis
- the need to be able to present analysis disaggregated to regional or community levels
- the importance of focussing on the balance between individual and community factors
- enabling greater access to existing data sources, and to a wider analytical audience
- exploring the possibility of data linkage of existing data sources
- promoting comparability between data sources
- improving the current gaps identified in data sets, such as information on interventions or causal factors
- the appropriate methods for identifying emerging issues
- the need to get the most amount of information out of current survey data.

Critical to improving information on substance use among Aboriginal and Torres Strait Islander peoples is the need to improve identification of Indigenous status, particularly in existing administrative collections. Current, recurring problems with collecting Indigenous status data compromises accurate estimates of the number of Aboriginal and Torres Strait Islander peoples utilising services and programs.

Several options for improving and obtaining more information about substance use among Aboriginal and Torres Strait Islander peoples and its associated harms were presented to workshop participants to generate discussion.

Module/set of questions for inclusion in Indigenous population surveys

The inclusion of a drug-specific data module in Indigenous population surveys, including information about substance use and social determinants or contextual factors, was supported in theory. However, a number of points were made in relation to the practicality of this option. Firstly, a standard module incorporated within a population survey would need to take into consideration cultural heterogeneity across Aboriginal and Torres Strait Islander communities. Secondly, development of a drug-specific data module would need to include a review of the existing substance use module in the NATSIHS and the NATSISS to see if they can be improved and to determine the amount of overlap between the modules in each survey. Greater overlap between these and any other relevant surveys (for example, the National Drug Strategy Household Survey) would increase the analytical abilities of the data. The Australian Bureau of Statistics (ABS) noted that a trade-off with other priority subject areas may need to occur if the existing substance use module were to expand. Development for the 2008 NATSIHS will begin in 2007.

Focus of discussion moved from the ABS population surveys to the National Drug Strategy Household Survey (NDSHS), which provides a broader range of substance-related data. In 1994, an urban Indigenous supplement to the 1993 NDSHS was run, but the quality of data collected was poor. It was suggested that over-sampling for Aboriginal and Torres Strait Islander peoples in future National Drug Strategy Household Surveys may improve population substance use data. The next NDSHS is scheduled for 2007.

There was discussion around the fact that a boost in sample size or questionnaire length inevitably imposes a burden on more respondents. However, as representatives from the NIDAC noted, if respondents were informed appropriately of the purposes of the survey, and how the information collected has potential to improve the quality of life for Indigenous people, then they would be happy to participate as it would be 'making Aboriginal and Torres Strait Islander peoples partners in the move'.

Module/set of questions for inclusion in Aboriginal and Torres Strait Islander primary health care and substance use services data collections or a snapshot survey of clients accessing these services

The Aboriginal and Torres Strait Islander primary health care and substance use services currently provide data to OATSIH as part of their funding agreements in one of two ways, either as part of the SAR (for Aboriginal and Torres Strait Islander primary health care services) or the DASR (for Aboriginal and Torres Strait Islander substance use services). Currently, data from the SAR and DASR collections are reported at the establishment level; however, OATSIH noted that these collections have been under review and may evolve over time.

The Aboriginal and Torres Strait Islander primary health care and substance use services provide services to specific geographic regions and collect a lot of client-level data that is not reported under the SAR and DASR collections. Participants suggested that there may be alternative options for interrogating data held by Aboriginal and Torres Strait Islander primary health care and substance use services independent of the SAR and DASR collections. One such option may be to mine existing data holdings within these organisations to see how they can inform the issue of substance use among Aboriginal and Torres Strait Islander peoples. Another option may be to survey clients of these services to find out their perception of, for example, treatment and intervention efficacy. Such approaches would need to deal with confidentiality issues, and other legal and ethical considerations, and be developed in close consultation with communities.

Module/set of questions for inclusion in administrative data sets including people who identify as Aboriginal or Torres Strait Islander peoples

The inclusion of a drug-specific data module or a set of questions in administrative data sets covering mainstream programs was generally supported. It was thought that a common set of items included within collections such as the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS), the Juvenile Justice National Minimum Data Set and the Supported Accommodation Assistance Program National Data Collection (SAAP-NDC), would enable core information to be collected across sectors to provide a fuller picture of drug use among Aboriginal and Torres Strait Islander peoples and their use of treatment and other health and community services. The main concern relating to this option is the quality of Indigenous identification in administrative collections.

Monitoring emerging issues

Possible methods for monitoring emerging issues (for example, increased use of methamphetamines) or monitoring drug use among people who do not seek treatment for substance use and/or who are not currently included in population surveys conducted by the ABS were explored. The NIDAC has identified a range of emerging issues that they would like to understand better, such as youth and misuse of inhalants, Indigenous youth drug use in cities and the increase in injecting drug use and related traumatic experiences.

One method for identifying emerging issues could be through an environmental scan – systematically drawing on the knowledge of people (such as community leaders/elders, health workers, local police, youth workers) about emerging issues or areas of concern. An environmental scan also has the capacity to provide information relevant at smaller geographic or community levels (including risks, harms and social factors relevant to the community). It was suggested that information obtained through an environmental scan could be used in conjunction with administrative data to shed more light on substance use issues within communities and around Australia. (The Illicit Drug Reporting System is an example of such a monitoring system currently employed in urban areas of Australia.)

There was also interest in monitoring the structure of the illicit drug markets and routes of supply. The emergence of cannabis in the Top End, is an example of a drug that, once introduced, quickly became widely used.

Monitoring prisoner treatment and health was also flagged as an area where more information is needed. Four states (New South Wales, Queensland, Western Australia and Tasmania) recently conducted a survey of prison entrants, which was adapted from the Australian Needle and Syringe Program (NSP) survey. A significant proportion of those surveyed were Indigenous (17%) and they provided information on their recent drug use and other risk behaviours. It is hoped that this survey will be repeated every 2 years across all correctional jurisdictions.

The Prisoner Health National Minimum Data Set, currently under development, will also include information relating to alcohol and other drug use. It will be important to ensure that the data collected in this NMDS is consistent with other collections.

Adding extra data items to existing collections

The option of adding items – such as substance use and/or Indigenous status – to existing data collections was supported. A recent example of this is the recommended introduction of a data item on smoking during pregnancy in the National Perinatal Data Collection (NPDC).

Replicating the Western Australian Aboriginal Child Health Survey

The Western Australian Aboriginal Child Health Survey (WAACHS) was a large scale epidemiological survey of the health and well-being of Western Australian Aboriginal and Torres Strait Islander children undertaken in 2000–02. The option of replicating the survey in other jurisdictions was discussed. Participants were advised that a project is currently being undertaken, whereby synthetic estimates for other states and territories are being calculated using the data obtained from Western Australia. It was agreed that replicating the survey in other jurisdictions would be very costly.

Adding data items to the Longitudinal Study of Indigenous Children

The Longitudinal Survey of Indigenous Children (LSIC), managed by the Australian Government Department of Family and Community Services and Indigenous Affairs (FACSI), is currently under development. It is planned to collect data on the following areas: culture, health, childcare, education, families and community; with draft content at this stage including items on smoking and alcohol consumption by parents and smoking and alcohol use by mothers during pregnancy.

4 What are the priority information areas?

4.1 What are the key questions?

The work on the literature review (Chapter 2 and Appendix 1) and discussions at the workshop (Chapter 3 and Appendix 2) revealed consistent themes in the types of information required about Indigenous substance use and its associated harms. Drawing on both of these sources, the key questions for the field appear to be about:

- the nature or patterns of substance use among Indigenous substance users (for example, prevalence of substance use, type of substance used, frequency of use, age at first use, geographic variation, risk behaviours)
- the characteristics of Indigenous substance users and their context, including their social context, social participation, influence of, and exposure to, family functioning and resilience, family stressors and disruption, and exposure to substance use in the community
- mortality, morbidity and disability among Indigenous substance users
- other associated harms, such as violence, crime, detention, imprisonment and homelessness
- what is known about the affordability, accessibility and appropriateness of current approaches for intervention and to treat substance use in Indigenous persons
- what is working well, in terms of intervention, treatment and prevention, why is it working and what extra measures or initiatives could make a difference
- expenditure relating to treatment and other interventions.

Thus, there appears to be a great deal of interest in information which supports all elements of the five-domain framework presented in Chapter 1 (Table 1.1). Running across the entire framework and the key questions, are some important information needs. There appears to be a need for:

- information that is available both at an individual level and community level. This is particularly important for Indigenous communities as it is recognised that patterns of substance use and contextual factors vary widely across geographical locations and communities. For example, knowing what treatment services are accessed by an individual is an important part of the picture, but is not sufficient without also knowing what services are available within a community. Information about the patterns of substance use of individuals (for example, substance type, age of first use) is useful, but may be more powerful when analysed at a community level and combined with information about, for example, supply of drugs in this particular area.
- information that enables a picture to be developed of the linkages across the domains of the framework, for example, between contextual factors, patterns of substance use, associated harms and the availability of interventions. This is particularly so in the case of promoting the availability of 'whole of government' information.
- timely information about emerging issues to assist in developing appropriate policy and program responses as early as possible.

The remaining chapters of this report will therefore focus on what information existing key data sources currently contain (Chapter 5), how we can make better use of the information already available to answer the above questions (Chapter 6) and how we might best fill identified gaps to answer questions that can not yet be adequately answered (Chapter 7).

5 What information is already available?

This chapter describes all data sources key to the discussion of substance use among Aboriginal and Torres Strait Islander peoples (Section 5.1). Using the template in Section 5.2, the data sources are compared in terms of their methodology, scope, coverage and timing, as well as comparability across data items (Sections 5.3 and 5.4).

5.1 Key data sources

Initially, 73 data sources were identified as relevant to the understanding of substance use among Aboriginal and Torres Strait Islander peoples. A subset of 44 data sources were then selected as ‘key’ data sources (Table 5.1) and are further examined in this chapter. Data sources were considered ‘key’ to this project if they were capable of informing more than one element of the five-domain framework, and if they contained an Indigenous identifier and some information relating to substance use. A list of data sources excluded from further analysis follows Table 5.1.

Table 5.1: List of data sources key to substance use among Aboriginal and Torres Strait Islander people and its associated harms

| No. | Collection name | Abbreviation |
|--|--|--------------|
| <i>Alcohol- and drug-related data sources</i> | | |
| 1 | National Drug Strategy Household Survey | NDSHS |
| 2 | Australian Schools Students Alcohol and other Drugs Survey | ASSAD |
| 3 | Illicit Drug Reporting System—Injecting Drug Users | IDRS–IDU |
| 4 | Illicit Drug Reporting System—Party Drug Initiative | IDRS–PDI |
| 5 | Indigenous drug injectors study (South Australia) | IDIS |
| 6 | Australian Needle and Syringe Program Survey | NSP |
| 7 | Youth Alcohol Consumption Research | YACR |
| 8 | Alcohol and Other Drug Treatment Services National Minimum Data Set ^(a) | AODTS–NMDS |
| 9 | Drug and Alcohol Service Report | DASR |
| 10 | Brief Treatment Outcome Measure—Concise | BTOM–C |
| 11 | Central Australian Youth Link-Up Service Inhalant Substance Misuse Database | CAYLUS |
| <i>General health- or welfare-related data sources</i> | | |
| 12 | Australian Bureau of Statistics (ABS) National Aboriginal and Torres Strait Islander Health Survey 2004–05 | NATSIHS |
| 13 | ABS National Aboriginal and Torres Strait Islander Social Survey 2002 | NATSISS |
| 14 | ABS 2001 National Health Survey | NHS |
| 15 | Western Australia Aboriginal Child Health Survey | WAACHS |
| 16 | Footprints in Time: the Longitudinal Study of Indigenous Children* | LSIC |
| 17 | Australian Longitudinal Study on Women’s Health | ALSWH |

(a) States and Territories may collect additional data items that are not part of the AODTS–NMDS and therefore not available nationally. For example, the NSW Minimum Data Set for Drug and Alcohol Treatment Services (NSW MDS–DATS) currently collects information on principal source of income, living arrangements and usual accommodation. The NSW MDS–DATS is also collected from opioid maintenance pharmacotherapy services in NSW, as part of the Brief Treatment Outcome Measure–Concise (BTOM–C).

(continued)

Table 5.1 (continued): List of data sources key to drug use among Aboriginal and Torres Strait Islander people and its associated harms

| No. | Collection name | Abbreviation |
|---|---|---------------------|
| 18 | Bettering the Evaluation and Care of Health | BEACH |
| 19 | Service Activity Reporting | SAR |
| 20 | National Hospital Morbidity Database | NHMD |
| 21 | AIHW National Mortality Database | NMD |
| 22 | National Coroners Information System | NCIS |
| 23 | National AIDS/HIV Registry | |
| 24 | National Perinatal Data Collection | NPDC |
| 25 | Kids Help Line Statistics | KHLS |
| 26 | Lifeline Statistics (Call Database–Client Service Management Information System) | |
| 27 | National Non-admitted Patient Emergency Department Care Database | NAPEDCD |
| 28 | New South Wales Population Health Survey | NSW–PHS |
| <i>Mental health-related data sources</i> | | |
| 29 | National Survey of Mental Health and Wellbeing (Child and Adolescent Component) 1998 | NSMHW (C & A) |
| 30 | National Survey of Mental Health and Wellbeing—Low Prevalence (Psychotic) Disorders 1997–98 | NSMHW (psychotic) |
| 31 | National Community Mental Health Care Database—based on the National Minimum Data Set | NCMHCD |
| 32 | National Residential Mental Health Care Database | NRMHCD |
| <i>Housing-related data source</i> | | |
| 33 | Supported Accommodation Assistance Program National Data Collection | SAAP–NDC |
| <i>Criminal justice-, corrections-, policing- and child protection-related data sources</i> | | |
| 34 | ABS National Prisoner Census | NPC |
| 35 | National Prison Entrants' Bloodborne Virus Survey 2004 | NPEBVS |
| 36 | National Police Custody Survey | NPCS |
| 37 | Drug Use Careers of Offenders | DUCO |
| 38 | Drug Use Monitoring in Australia | DUMA |
| 39 | 2001 New South Wales Inmate Health Survey | NSW–IHS |
| 40 | 2002 Queensland Women Prisoners' Health Survey | QLD–WPHS |
| 41 | 2002 Victorian Prisoner Health Study | VIC–PHS |
| 42 | NSW Young People in Custody Health Survey 2003 | YPiCHS |
| 43 | NT Police Drug Seizure Data Base | NT PDSDB |
| 44 | Illicit Drug Data Report collection | IDDR |

The project team initially identified and reviewed a very broad range of data sources that covered all domains of the framework (Table 1.1). This process included reviewing information sources relating to, for example, government-funded housing programs, labour force participation, income support and education. Of the 73 data sources initially reviewed, 29 data sources were excluded from further analysis. While many of these 29 data sources have the capacity to provide information about particular issues (for example, comparative

information about the Australian population overall from the ABS Australian Census of Population and Housing or contextual information about income support from the FACSIA General Customer Survey), they were excluded for the following reasons:

- National Tobacco Survey – because it does not collect information about Indigenous status.
- Council of Australian Governments Illicit Drug Diversion Initiative National Minimum Data Set – because the collection is incomplete and information is not readily available.
- National Opioid Pharmacotherapy Statistics Annual Data collection (NOPSAD) – because it does not collect information about Indigenous status and because the collection currently only reports on limited service level data.
- Growing up in Australia: the Longitudinal Study of Australian Children (LSAC) – because more relevant information will be collected in the LSIC collection currently under development.
- ABS 1997 National Survey of Mental Health and Wellbeing (adult) – because it does not collect information about Indigenous status. A second adult National Survey of Mental Health and Wellbeing is planned for 2007.
- Mental Health National Outcomes and Casemix Collection – because it is not currently possible to link outcomes information to client information, including Indigenous status and other demographic information. This collection, however, provides a model for collecting outcome information.
- ABS Survey of Disability, Ageing and Carers – because it does not collect information about substance use or Indigenous status (since 1993).
- ABS General Social Survey and ABS Labour Force Characteristics of Aboriginal and Torres Strait Islander peoples – because they contain no substance use information and minimal relevant information compared to other ABS surveys selected for further analysis.
- ABS Census of Population and Housing – because, while containing essential information to estimate the numbers of Aboriginal and Torres Strait Islander people in Australia, it does not contain information about substance use and minimal relevant information compared to other population surveys selected for further analysis.
- Commonwealth-State/Territory Disability Agreement National Minimum Data Set – because it does not contain substance use information.
- National Notifiable Disease Surveillance System Data Collection – because it does not contain reliable information about Indigenous status nor information on substance use.
- Pharmaceutical Benefits Scheme and Medicare Benefits Scheme data – because, while the PBS captures some information about substance use through script information, it is difficult to translate this into an estimate of the number of people with substance use problems. The MBS data do not enable estimates of substance use among people attending Medicare-funded services.
- ABS Australian Housing Survey and the Community Housing and Infrastructure Needs Study – because they do not contain information about substance use.
- Commonwealth-State Housing Agreement five data sets as they are based on households, rather than people, and they do not contain appropriately detailed information about the substance use patterns of individuals receiving this form of support.

- General Customer Survey (GCS) and the Longitudinal Data Set (LDS) 1% Sample – because they do not collect information about substance use, and Indigenous status is not a mandatory data item in the LDS.
- Household, Income and Labour Dynamics in Australia survey – because the sample of respondents of Aboriginal and Torres Strait Islander origin is too small to make inferences about the wider Aboriginal and Torres Strait Islander population.
- ABS Crime and Safety Survey – because it does not contain information about substance use and there are more appropriate data sources for this review.
- Juvenile Justice National Minimum Data Set and the Child Protection and Support Services National Minimum Data Set – because they do not contain information about substance use.
- Prisoner Health National Minimum Data Set – because it is currently in the early stages of its development. It is envisaged that the Prisoner Health NMDS will include data items relating to Indigenous status and substance use, and will become an important data source relating to drug use among Aboriginal and Torres Strait Islander people.
- Ministerial Council of Employment, Education, Training and Youth Affairs collection – because it contains no information on substance use.

5.2 Describing key data sources

All of the key data sources listed in Table 5.1 were described in terms of the following template (Table 5.2). The completed templates/collection summaries for all key data sources are available on the AIHW website at <www.aihw.gov.au/drugs/>, as related material to the online version of this report.

Table 5.2: Template for describing relevant data sources in the area of Aboriginal and Torres Strait Islander substance use and its associated harms

| Data collection details | |
|--|---|
| Data source (title) | Full name of the survey of data collection. |
| Brief description | Brief outline of the data source. |
| Purpose(s) | Main stated purpose or purposes of the data source. |
| Collection methodology | Key features of the collection methodology, such as whether it is an administrative data collection or survey, the method of data collection (e.g. computer-assisted telephone interview (CATI), self-completion, administrative by product data) and sampling methodology (e.g. multi-stage, stratified area design sample of households). |
| Scope/target population | Theoretical or intended coverage of the relevant population and, if possible, proportion of total (a) Indigenous and (b) Australian populations. |
| Coverage (actual) | Actual coverage of the theoretical or intended population including, wherever possible, information about response rates. |
| Geographic coverage | The Australian state and territory or other geographic area covered by the data source. |
| Frequency/timing | The year(s) in which data have been collected for the data source and the period over which data were collected (e.g. 1990, 2001, 2003, each financial year from 1997–98). |
| Basic collection count | The basic counting unit for the data source (e.g. treatment episode, separation, client). |
| Data content (list of all data items) | List of all data items. |
| Definitions—how are the following data items addressed and/or defined? | |
| Substance use and associated risk behaviours | |
| Patterns of substance use | For example, types of substance(s) used by the individual including traditional drugs and multiple drug use, prevalence of substance use (including current and lifetime use), frequency and quantity used, age drug(s) first used and drug paraphernalia or tools used for drug use/method of use. |
| Cost of substance(s) | Whether and how information about the cost of substances to the individual is recorded in the data (e.g. knowledge of price, individual expenditure on substances). |
| Risk behaviours | Whether and how information about risky behaviours associated with substance use are recorded in the data (e.g. sharing needles, drink driving). |
| Context and influences | |
| Indigenous status | Whether and how information about Indigenous status is recorded in the data source (e.g. Aboriginal, Torres Strait Islander, both Aboriginal and Torres Strait Islander, neither Aboriginal nor Torres Strait Islander). |
| Age | Whether and how age details are recorded in the data source (e.g. date of birth, age or age groups). |
| Sex | Whether and how sex is recorded in the data source. |
| Cultural and linguistic diversity | Whether and how information about cultural and linguistic diversity is recorded in the data sources (e.g. preferred spoken language, country of birth, English proficiency) |
| Geographic location of respondent | Whether and how information about a respondent's geographic location is recorded in the data source (e.g. postcode or Statistical Local Area (SLA) of an individual's usual residence). |
| Geographic location of agency or other relevant unit | Whether and how information about an agency's (or other relevant unit's) geographic location is recorded in the data source (e.g. postcode or SLA of an agency's central office or service delivery outlet). |
| Indicators of social context | Whether and how information that provides indicators of an individual's social context is recorded in the data source (e.g. living arrangements, residential setting, marital status, household composition, income source). |

(continued)

Table 5.2 (continued): Template for describing relevant data sources in the area of Aboriginal and Torres Strait Islander substance use and its associated harms

| | |
|---|--|
| Indicators of social participation | Whether and how information that provides indicators of an individual's social participation is recorded in the data source (e.g. labour force status, education status, recreation). |
| Family and personal context and influences | Whether and how the data source records information about an individual's family and personal context and influences (e.g. influence of and exposure to family functioning and resilience versus family stressors such as grief, crime and violence; indicators of emotional and spiritual wellbeing including connection to land and people, and experience of discrimination). |
| Substance use context and influences | Whether and how the data source records information about an individual's context and influences in relation to substance use (e.g. influence of, and exposure to, substance use by family, peer group, community; cultural acceptance of specific substances); availability and opportunity to use substances; patterns of supply and demand; preventive strategies (e.g. dry communities, licensing laws, education). |
| Associated harms/health status | |
| Comorbidity/health conditions | Whether and how information about the morbidity or health conditions of the individual are recorded, (e.g. health conditions, such as Hepatitis C, HIV AIDS, cirrhosis of the liver; mental health conditions, such as schizophrenia and psychosis, overdose). |
| Disability | Whether and how information about disabling conditions associated with substance use are recorded in the data (e.g. acquired brain injury). |
| Pregnancy and the unborn child | Whether and how information is recorded in the data source about health-related exposures during pregnancy (e.g. to smoking, alcohol and other drugs). |
| Suicide | Whether and how information about suicide is recorded in the data source (e.g. suicidal thoughts and attempts). |
| Crime and justice | Whether and how information about crime (where the individual is either the victim of crime or the perpetrator of crime) is recorded in the data source (e.g. victim of domestic violence, theft) or interaction with justice system (e.g. detention and imprisonment). |
| Treatment and intervention services | |
| Options included in collection | Whether and how information about treatments and/or interventions are recorded in the data source (e.g. treatment type, programs or services accessed or received). |
| Uptake | Whether and how information about the uptake of services is recorded in the data source (e.g. reasons for not attending a service even though service needed). |
| Affordability | Whether and how information about the affordability of services is recorded in the data source (e.g. whether information about individual income and cost of services can be used as an indicator of affordability, or individual's assessment of the affordability of available services is recorded). |
| Accessibility | Whether and how information about the accessibility of services is recorded in the data source (e.g. whether information about the location of an individual versus the location of services can be used as an indicator of accessibility, or individual's assessment of the accessibility of available services is recorded). |
| Appropriateness | Whether and how information about the appropriateness of services is recorded in the data source (e.g. whether information about the cultural staffing profile of a service is recorded, or individual's assessment of the appropriateness of available services is recorded). |
| Treatment/intervention outcomes | Whether the data source includes any information relating to outcomes of treatment/intervention provided. |
| Resources | |
| Expenditure on services (direct and indirect) | Whether and how data sources record information on the expenditure on services. This relates to direct expenditure on substance use intervention and treatment programs and facilities and indirect expenditure on broader health care, long-term care and incarceration associated with substance use). This item relates to expenditure by government on health programs, treatments, interventions, justice, housing etc, not expenditure on services per individual. |

(continued)

Table 5.2 (continued): Template for describing relevant data sources in the area of Aboriginal and Torres Strait Islander substance use and its associated harms

| Administrative details of data source | |
|--|---|
| Collection management agency | The name of the organisation that manages or is responsible for the data source. |
| Title/name of contact | Contact details for the agency that manages the data collection. |
| Address | Contact details for the agency that manages the data collection. |
| Email | Contact details for the agency that manages the data collection. |
| Internet | Contact details for the agency that manages the data collection. |
| Phone/fax | Contact details for the agency that manages the data collection. |
| Data custodian/access | Contact details for the person who should be contacted in relation to accessing information from the data source |
| Funding agency | The agency (or agencies) responsible for funding the data collection. |
| Output (e.g. of latest report based on data) | Links to, or examples of, recent publications or data products (e.g. data cubes) relating to the data source. |
| References (for preparing this template) | Publications or information sources used in preparing this template. |
| When will data from this reference period/survey be available? | Expected release of the data for the most recent collection year (i.e. data relating to the definitions, scope, methodology and so on, in the remainder of the template). |
| Other comments | Additional information not covered elsewhere, including significant variations over time such as the inclusion of Indigenous components. |

5.3 Comparability of key data sources in terms of methodology: scope, coverage, timing and collection counts

The focus of the comparative analysis in this section is on how comparable the key data sources are in terms of their basic methodological characteristics, such as counts, scope, coverage and timing.

Methodology

Of the 44 key data sources reviewed:

- Eight are population surveys – four of which are conducted by the ABS
- 20 are other surveys, for example one-off surveys or occasional surveys of particular populations such as people accessing a service sector such as corrections and
- 16 are administrative collections, including national minimum data sets (Table A3.1).

Of the 16 administrative data collections, 13 are considered unit record collections on the basis that one record is recorded and stored for each unit of the collection count (whether this was a client, closed treatment episode, episode of care, separation, phone call and so on). The remaining 3 administrative collections involve the collation and reporting of aggregate data, for example, where state/territory government departments forward a set of specified tables to a central agency for national collation.

Each of the key data sources reviewed provide valuable information about substance use among Aboriginal and Torres Strait Islander peoples and its associated harms. However, there are some limitations to the data sources based on their methodology. For example, one advantage of population surveys is that they use large representative samples from which prevalence estimates can be derived for a selected population. On the other hand, because of their large sample size and associated high costs, population surveys are generally conducted relatively infrequently. Table 5.3 highlights some advantages and disadvantages of population surveys, other surveys and administrative collections.

Table 5.3: Advantages and disadvantages of key data sources

| | Advantages | Disadvantages |
|---|--|--|
| Population surveys e.g. NDSHS, NATSISS, NATSIHS and NHS | <p>Large, representative samples which provide only source of prevalence over selected population</p> <p>Can be related to other data to explore associations and contexts</p> <p>Can be used to explore trends over points in time</p> <p>Two relevant population surveys specific to Indigenous people (NATSISS and NATSIHS) are likely to have good Indigenous identification</p> | <p>Data collected via population surveys can rarely be disaggregated to a community level (i.e. small area estimates generally not possible)</p> <p>Indigenous samples may be too small for meaningful analysis</p> <p>Methodology for collecting substance information is problematic (e.g. self-reporting in presence of family members in NATSISS and NATSIHS; particularly problematic in remote areas)</p> <p>Response rates can be low (e.g. NDSHS)</p> <p>Information is collected at periodic intervals (e.g. NATSIHS and NATSISS each have a 6-yearly cycle meaning new data are available every 3 years)</p> <p>Population surveys collect information at an individual rather than community level</p> <p>Samples include only people living in households (i.e. there are problems around defining Indigenous households, omission of homeless population)</p> <p>Information is self-reported</p> |

(continued)

Table 5.3 (continued): Advantages and disadvantages of key data sources

| | Advantages | Disadvantages |
|--|--|---|
| Other surveys—child focus e.g. NPDC, WAACHS, LSIC and ASSAD | Surveys generally have a specific focus and collect in-depth information about this area of focus (e.g. WAACHS) May be longitudinal (e.g. LSIC) May provide early warning of emerging problems by targeting young populations (e.g. ASSAD) and mothers (e.g. NPDC) | Sample often limited to specific geographic areas (e.g. WAACHS) Indigenous sample may be too small in surveys not designed to collect information from Indigenous populations (e.g. ASSAD) Relatively infrequent (e.g. ASSAD triennial since 1984) or one-off (e.g. WAACHS) Disaggregation to small areas or community level not generally possible Information is generally self-reported |
| Other surveys and studies—drug focus e.g. IDIS, NSP, IDRS–IDU and IDRS–PDI | Provide information about people who are already drug users and who may or may not be accessing treatment Provide information about people who are homeless or not in households (e.g. IDRS–IDU) Enables monitoring of emerging trends in patterns of supply and use of drugs (e.g. IDRS–IDU and IDRS–PDI) Enables monitoring of adoption of treatment services (e.g. overall numbers accessing needle and syringe programs, numbers of IDUs reporting using treatment services) | Generally include limited information about contextual factors May have low response rates (e.g. NSP) Not representative of all geographical areas (e.g. IDRS–IDU and IDRS–PDI covers only capital cities) and sampling is not systematic Information is self-reported |
| Other surveys—corrections e.g. DUMA, DUCO, NSW-IHS and QLD–WPHS | Provide relevant information about people in the corrections system Provide information about drug use and its relationship with crime (e.g. DUMA/DUCO) and health (e.g. NSW IHS) Sometimes ongoing (e.g. DUMA quarterly since 1999) | Not representative of all geographic areas (e.g. DUMA is not national) May be one-off (e.g. Queensland WPHS) Information is self-reported |
| Administrative collections—drug focus e.g. DASR, AODTS–NMDS and CAYLUS | Easier than population or other surveys to disaggregate to finer geographical areas Some collections provide community-level information (e.g. DASR) May include qualitative information on success stories at local level (e.g. DASR) Do not rely solely on self-reported information (e.g. AODTS–NMDS) Provide information about people with drug problems who are accessing treatment (e.g. AODTS–NMDS) Some provide information on substance use issues of particular relevance to Indigenous communities (e.g. CAYLUS) | Treatment outcome data are not available Limited contextual information is collected Some collections are not based on unit or individual records (e.g. DASR) Only includes service users Key drug treatment collections are not comparable in terms of collection count (e.g. AODTS–NMDS which covers mainstream treatment services, and the DASR which covers Indigenous specific drug treatment services) There are scope limitations in some collections (e.g. AODTS–NMDS only includes government-funded services and does not include sobering up shelters or prisons) |

Scope, coverage and timing

The data sources reviewed have widely varied methodologies and purposes, which are reflected in their scope, coverage and timing (Table A3.2). For example, among population surveys, the scope may vary according to the age groups surveyed (for example, all people, adults only, children only), or could be specific to a sub-group of the population, such as Aboriginal and Torres Strait Islander peoples, which is the case for the NATSISS and the NATSIHS. Among other surveys, the scope ranges from prisoners, detainees and remandees in correctional facilities to secondary school students, women and injecting drug users.

Administrative collections generally define their scope in terms of program boundaries and associated funding arrangements (for example, the AODTS–NMDS collects information from all publicly funded alcohol and other drug treatment agencies). The IDRS–IDU and IDRS–PDI collections cover a sample of injecting drug users and ecstasy users as well as key informants, and triangulate this information with data from a range of other sources, including national morbidity data, population data and treatment services data.

Most data sources include all states and territories in Australia in their geographic coverage (Table A3.2). A small number of data sources are surveys specific to a particular state or territory, for example the QLD-WPHS (Queensland), NSW-IHS and the YPiCHS (New South Wales) and the NT PDSDB (Northern Territory). Other data sources that are not national, or unique to one state or territory, include the NSMHW (psychotic) (metropolitan areas of the Australian Capital Territory, Queensland, Victoria and Western Australia only), DUCO (various jurisdictions over time), DUMA (Queensland, Western Australia, New South Wales and South Australia) and CAYLUS (remote and central Australia, Northern Territory).

There are widely differing timing arrangements for the reviewed data collections. Of the population surveys reviewed, the most recent in the series had generally been conducted between 2001 and 2004 (Table A3.2). The most notable exception is the NSMHW, which has been conducted only once (in 1997 for the adult component, 1998 for the child and adolescent component and 1997–98 for the psychotic component). The second adult component of the NSMHW is scheduled to be conducted in 2007. Among administrative data collections, most are conducted on a financial year basis, with the most recent data generally available for 2004–05. For data sources such as Lifeline Statistics, data are collected on an ongoing basis, but can be collated on a financial year basis.

Collection counts

The basic collection count—or unit of measure—varied widely across the reviewed collections, from population estimates of people or households (generated by surveys) to client counts or number of phone calls (generated by administrative collections) (Table A3.2). Among administrative data collections reviewed, the basic counting unit varied substantially. For example:

- ‘closed treatment episodes’ in the AODTS–NMDS
- ‘inhalant users’ in CAYLUS
- ‘deaths’ in NMD
- ‘separations’ in NHMD
- service level estimates of ‘client numbers’ and ‘episodes of care’ in the SAR and DASR
- ‘clients’, ‘closed support periods’ and ‘ongoing support periods’ in the SAAP–NDC

- 'phone calls received' in Lifeline Statistics and Kids Help Line Statistics (KHLS)
- 'seizures' in NT PDSDB
- 'notifications' in NPDC
- 'arrests' and 'seizures' in IDDR

Variation also occurs in the way the terms listed above are defined, meaning that analysts should be cautious when comparing counts across collections. While varying definitions of 'clients' are generally broadly comparable, definitions relating to episodes of care have detailed definitions that relate mostly to the way commencement and cessation dates are specified, and rules for when and why an episode should be closed. Thus, the broad concept of an episode of care is not generally directly comparable across collections.

A number of data sources also include a counting unit for the number of agencies or establishments that provide services or assistance to clients. For example:

- 'number of treatment agencies' in the AODTS-NMDS
- 'number of establishments' in the NCMHCD
- 'number of agencies' in the DASR and SAR
- 'number of SAAP-funded agencies' in the SAAP-NDC

For more detail on the information presented in this section, see Table A3.2.

5.4 Comparability of key data sources in terms of data items

This section outlines the comparability of key data sources in terms of data items that inform the understanding of substance use among Aboriginal and Torres Strait Islander people in Australia (for example, basic demographic details, such as age, sex, geographic location; indicators of social context such as living arrangements; indicators of social participation, such as labour force status; and influences and exposures such as crime and family violence.). The section commences by examining the key data sources in terms of how they define two of the most critical variables to this discussion, namely Aboriginal and Torres Strait Islander status (Indigenous status) and substance use.

Indigenous status

The national standard for collecting information about a person's Indigenous status is detailed in the national data dictionaries for health, community services and housing and the AIHW's online metadata registry METeOR. An extract of the agreed national standard for Indigenous status is set out in Box 5.1. The national standard for collecting Indigenous status produces data that can be analysed separately for people of Aboriginal origin; Torres Strait Islander origin; Aboriginal and Torres Strait Islander origin; and neither Aboriginal nor Torres Strait Islander origin.

Box 5.1: The standard *National health data dictionary* question and classification for Indigenous status

The National health data dictionary (NHDD) recommends that the following standard question be used to elicit information about Indigenous status. The question is based on the ABS standard for Indigenous status:

[Are you] [Is the person] [Is (name)] of Aboriginal or Torres Strait Islander origin?

The response categories are as follows:

(For people of both Aboriginal and Torres Strait Islander origin, mark both 'Yes' boxes.)

- No*
- Yes, Aboriginal*
- Yes, Torres Strait Islander*

The dictionary recommends the following output classification for Indigenous status:

Aboriginal, but not Torres Strait Islander, origin

Torres Strait Islander, but not Aboriginal, origin

Both Aboriginal and Torres Strait Islander origin

Neither Aboriginal nor Torres Strait Islander origin

Not stated/inadequately described

The classification includes a broader grouping of the detailed categories, as follows:

Indigenous: that is, Aboriginal, but not Torres Strait Islander, origin; Torres Strait Islander, but not Aboriginal, origin; and both Aboriginal and Torres Strait Islander origin

Non-Indigenous: that is, neither Aboriginal nor Torres Strait Islander origin

Not stated/inadequately described

Source: AIHW 2005c.

Of the 44 key data sources reviewed, 22 collect information about Indigenous status according to the national standard, and in such a way that it is possible to say that respondents were of Aboriginal and/or Torres Strait Islander origin/descent or not (Table 5.4). An additional 16 data sources ask the relevant question about Indigenous status in a way that identified Indigenous status in very broad groupings: Indigenous, non-Indigenous or not stated. The Northern Territory Police Seizure Data Base (NT PDSDB) identifies the Indigenous status of a person through a question relating to 'ethnic background', where Aboriginal is one coding option. The SAR and DASR collections include service level estimates of Indigenous status; this is done by the service allocating Indigenous status to the client numbers and episodes of care. SAR and DASR services also provide estimates of Indigenous status for staff.

Only one of the key data sources reviewed does not include information about the Indigenous status of respondents (the IDDR). This collection was retained for further analysis and comparison as it provides information relating to the supply of illicit drugs in Australia.

As stated in Section 5.3 and detailed in Table 5.4, the target population of the data sources reviewed vary considerably. Eight of the key data sources have target populations specific to Aboriginal and/or Torres Strait Islander people or services. Some of these data sources, for

example, the CAYLUS and the WAACHS, use an Indigenous identifier to screen people for inclusion in the survey. Where Aboriginal and/or Torres Strait Islander people are not the specified target population, the proportion of Indigenous people participating in the survey or data collection varies.

Of those data sources that record information about service usage, the proportion of Indigenous clients varies, for example:

- of closed treatment episodes in the in the 2003–04 AODTS–NMDS collection, 10% involved clients identified as Aboriginal and/or Torres Strait Islander peoples (AIHW 2005b) and
- of SAAP clients in the 2004–05, 16% identified as Aboriginal and/or Torres Strait Islander peoples (AIHW 2006).

The proportion of Aboriginal and Torres Strait Islander people participating in surveys also varies. However, this variability is often a result of the locality and purpose of the survey, for example:

- ten per cent of injecting drug users interviewed for the 2004 IDRS–IDU identified as Indigenous Australians (Stafford et. al. 2005a)
- four per cent of regular ecstasy users interviewed for the 2004 IDRS–PDI identified as Indigenous Australians (Stafford et. al. 2005b)
- eight per cent of respondents to the 2004 NSP survey, interviewed at a sample of NSP sites across Australia, identified as Indigenous Australians (National Centre in HIV Epidemiology and Clinical Research 2005).

Table 5.4: Indigenous identification^(a) and target population group of key data sources

| No. | Collection name | Abbreviation | Target group | Indigenous question |
|-----|---|--------------|--|--|
| 1 | National Drug Strategy Household Survey | NDSHS | General—population aged 12 and over | Indigenous status, as per national standard (five-option output classification) |
| 2 | Australian Schools Students Alcohol and other Drugs Survey | ASSAD | General—school students | Indigenous status, as per national standard (five-option output classification) |
| 3 | Illicit Drug Reporting System—Injecting Drug Users | IDRS-IDU | General—injecting drug users | Indigenous status (three-option broader grouping) |
| 4 | Illicit Drug Reporting System—Party Drug Initiative | IDRS-PDI | General—regular ecstasy users | Indigenous status (three-option broader grouping) |
| 5 | Indigenous Drug Injectors Study (South Australia) | IDIS | Indigenous injectors | Indigenous status, as per national standard (five-option output classification) |
| 6 | Australian Needle and Syringe Program Survey | NSP | General—injecting drug users from a sample of NSP sites across Australia | Indigenous status (three-option broader grouping) |
| 7 | Youth Alcohol Consumption Research | YACR | General—teenagers aged 15–17 years | Indigenous status (three-option broader grouping) |
| 8 | Alcohol and Other Drug Treatment Services National Minimum Data Set | AODTS-NMDS | General—AODTS service users | Indigenous status, as per national standard (five-option output classification) |
| 9 | Drug and Alcohol Service Report | DASR | Indigenous-specific—substance use services | The service is asked to allocate Indigenous status to the client numbers and episodes of care (Indigenous, non-Indigenous). Services are asked whether staff is of Aboriginal and/or Torres Strait Islander origin. |
| 10 | Brief Treatment Outcome Measure-Concise | BTOM-C | General—publicly prescribed pharmacotherapy clients | Indigenous status, as per national standard (five-option output classification) |
| 11 | Central Australian Youth Link-Up Service Inhalant Substance Misuse Database | CAYLUS | Indigenous-specific—petrol sniffers | Indigenous status is used to screen collection population |

(a) The classification of Indigenous status as summarised in this table relates to either 'five-option output classification' (i.e. Aboriginal, but not Torres Strait Islander; Torres Strait Islander, but not Aboriginal; both Aboriginal and Torres Strait Islander; neither; not stated) or 'three-option broader grouping' (i.e. Indigenous, non-Indigenous, not stated)

(continued)

Table 5.4 (continued): Indigenous identification^(a) and target population group of key data sources

| No. | Collection name | Abbreviation | Target group | Indigenous question |
|-----|--|--------------|--|--|
| 12 | Australian Bureau of Statistics (ABS) National Aboriginal and Torres Strait Islander Health Survey 2004–05 | NATS/HS | Indigenous-specific | Indigenous status, as per national standard (five-option output classification) |
| 13 | ABS National Aboriginal and Torres Strait Islander Social Survey | NATSISS | Indigenous-specific | Indigenous status, as per national standard (five-option output classification) |
| 14 | ABS 2001 National Health Survey | NHS | General | Indigenous status, as per national standard (five-option output classification) |
| 15 | Western Australia Aboriginal Child Health Survey | WAACHS | Indigenous-specific—Indigenous children | Indigenous status is used to screen collection population |
| 16 | Footprints in Time: the Longitudinal Study of Indigenous Children | LSIC | Indigenous-specific—Indigenous children | Indigenous status, as per national standard (five-option output classification) |
| 17 | Australian Longitudinal Study on Women's Health | ALSWH | General—women | Indigenous status, as per national standard (five-option output classification) |
| 18 | Bettering the Evaluation and Care of Health | BEACH | General—GP consultations | Indigenous status (three-option broader grouping) |
| 19 | Service Activity Reporting | SAR | Indigenous-specific—primary health care services | Collected as service level estimates in relation to client numbers (i.e. service are asked to report the number of clients over the reporting period that are Aboriginal and Torres Strait Islander clients, non-Indigenous clients or not stated Indigenous status. A separate question is asked about the proportion of total clients who are Torres Strait Islanders. |
| 20 | National Hospital Morbidity Database | NHMD | General | Indigenous status, as per national standard (five-option output classification) |
| 21 | AIHW National Mortality Database | NMD | General | Indigenous status, as per national standard (five-option output classification) |
| 22 | National Coroners Information System | NCIS | General | Indigenous status, as per national standard (five-option output classification with additional categories 'still enquiring' and 'unlikely to be known') |
| 23 | National AIDS/HIV Registry | | General—AIDS/HIV reported cases | Indigenous status (three-option broader grouping) |

(a) The classification of Indigenous status as summarised in this table relates to either 'five-option output classification' (i.e. Aboriginal, but not Torres Strait Islander, but not Aboriginal; both Aboriginal and Torres Strait Islander; neither, not stated) or 'three-option broader grouping' (i.e. Indigenous, Non-Indigenous, not stated)

(continued)

Table 5.4 (continued): Indigenous identification^(a) and target population group of key data sources

| No. | Collection name | Abbreviation | Target group | Indigenous question |
|-----|---|-------------------|-------------------|---|
| 24 | National Perinatal Data Collection | NPDC | General | Indigenous status of mother, as per national standard (five-option output classification) |
| 25 | Kids Help Line Statistics | KHLS | General—children | Indigenous status (three-option broader grouping) |
| 26 | Lifeline Statistics (Call Database—Client Service Management Information System) | | General—adults | Indigenous status, as per national standard (five-option output classification) |
| 27 | National Non-admitted Patient Emergency Department Care Database | NAPEDCD | General | Indigenous status, as per national standard (five-option output classification) |
| 28 | New South Wales Population Health Survey | NSW-PHS | General | Indigenous status, as per national standard (five-option output classification) |
| 29 | Child and Adolescent Component of the National Survey of Mental Health and Wellbeing, 1998 | NSMHW (C & A) | General—children | Indigenous status (three-option broader grouping) |
| 30 | National Survey of Mental Health and Wellbeing—Low Prevalence (Psychotic) Disorders 1997–98 | NSMHW (psychotic) | General | Indigenous status (three-option broader grouping) |
| 31 | National Community Mental Health Care Database—based on the National Minimum Data Set | NCMHCD | General | Indigenous status, as per national standard (five-option output classification) |
| 32 | National Residential Mental Health Care Database | NRMHCD | General | Indigenous status, as per national standard (five-option output classification) |
| 33 | Supported Accommodation Assistance Program National Data Collection | SAAP-NDC | General | Indigenous status, as per national standard (five-option output classification) |
| 34 | ABS National Prisoner Census | NPC | General—prisoners | Indigenous status (three-option broader grouping) |
| 35 | National Prison Entrants' Bloodborne Virus Survey 2004 | NPEBVS | General | Indigenous status, as per national standard (five-option output classification) |

(a) The classification of Indigenous status as summarised in this table relates to either 'five-option output classification' (i.e. Aboriginal, but not Torres Strait Islander, Torres Strait Islander, but not Aboriginal; both Aboriginal and Torres Strait Islander; neither; not stated) or 'three-option broader grouping' (i.e. Indigenous, Non-Indigenous, not stated)

(continued)

Table 5.4 (continued): Indigenous identification^(a) and target population group of key data sources

| No. | Collection name | Abbreviation | Target group | Indigenous question |
|-----|--|--------------|--|---|
| 36 | National Police Custody Survey | NPCS | General | Indigenous status (three-option broader grouping) |
| 37 | Drug Use Careers of Offenders | DUCO | General | Indigenous status (three-option broader grouping) |
| 38 | Drug Use Monitoring in Australia | DUMA | General | Indigenous status (three-option broader grouping) |
| 39 | 2001 New South Wales Inmate Health Survey | NSW-IHS | General—prisoners | Indigenous status, as per national standard (five-option output classification) |
| 40 | 2002 Queensland Women Prisoners' Health Survey | QLD-WPHS | General—female prisoners | Indigenous status (three-option broader grouping) |
| 41 | 2003 Victorian Prisoner Health Study | VIC-PHS | General—prisoners | Indigenous status (three-option broader grouping) |
| 42 | NSW Young People in Custody Health Survey 2003 | YPICHS | General—juvenile | Indigenous status (three-option broader grouping) |
| 43 | NT Police Drug Seizure Data Base | NT PDSDB | General—people involved in drug seizures | Ethnic background: Aboriginal, other |
| 44 | Illicit Drug Data Report collection | IDDR | General | Indigenous status not collected |

(a) The classification of Indigenous status as summarised in this table relates to either 'five-option output classification' (i.e. Aboriginal, but not Torres Strait Islander, Torres Strait Islander, but not Aboriginal; both Aboriginal and Torres Strait Islander; neither, not stated) or 'three-option broader grouping' (i.e. Indigenous, Non-Indigenous, not stated)

As with any data item, there are issues with collecting quality data relating to the Indigenous status of respondents. With the support of national data committees and the National Advisory Group on Aboriginal and Torres Strait Islander Health Data (NAGATSIHD), considerable effort has been put into improving Indigenous identification in data sources. A recent example of this has been in relation to hospital separation data. In 2005, the AIHW undertook a project to monitor and improve the completeness of Indigenous identification in hospital records over time. The project provided:

- a description of the extent to which the Indigenous origin of Indigenous patients is under-identified in separations data
- an outline of methods that jurisdictions use to improve Indigenous identification data – including examples of best practice and of methods that have not worked
- development of guidelines to support consistent and appropriate analysis of Indigenous status information in hospital separations data.

A series of recommendations about policies and processes needed to improve the quality of Indigenous identification in separations data were then made, and endorsed by the Statistical Information Management Committee (AIHW 2005d). Similar work was undertaken by the AIHW in 2004 on the quality of Indigenous identification in seven community services data collections (AIHW 2004c) and the AIHW is currently producing a report on the extent to which quality issues have subsequently been addressed.

Substance use

For the purposes of this report, a broad concept of substance use has been explored, including the use of three broad groups of drugs: tobacco, alcohol and other drugs (licit and illicit) for non-medical purposes. However, the operational definition of ‘substance use’ will vary depending on the research question. For example, depending on the data source and the research purpose, analysts might define ‘substance use’ in terms of whether a person has: ever used tobacco; currently uses illicit drugs; uses alcohol at levels which are considered harmful in the short-term or long-term; or uses drugs and also has related behaviours that cause distress to the individual or other person. In this section, we review the key data sources in terms of the information they contain about substance use.

Of the 44 key data sources reviewed:

- 26 include questions or data items relating to tobacco, alcohol and other drugs
- seven include questions or data items about other drugs only
- four include information about tobacco and alcohol only
- four include information about alcohol and other drugs but not tobacco
- one includes information about tobacco only
- two do not currently include any substantial information about substance use of any kind (Table A3.3).

Of the 26 collections including information on all substances:

- 14 collections include questions specifically about the individual’s patterns of use of tobacco, alcohol and other drugs, thus enabling estimates to be developed of the number of *people* within specified populations (for example, Australian households in the case of the NDSHS, NSW prisoners in the case of the NSW-IHS) who have ever used or are currently using substances.

Within this group of data sources:

- all include information about whether a person has 'ever used' drugs and some indication of 'current' or 'recent' use, such as whether they have used drugs in the last: week, month, 3, 6 or 12 months (NDSHS, ASSAD, IDRS-IDU, IDRS-PDI, YACR, NATSISS, WAACHS, ALSWH, NSW-PHS, NSMHW (C&A), NSMHW (psychotic), NSW-IHS, QLD-WPHS, YPiCHS)
 - all also include information about the frequency of use of tobacco, alcohol and/or other drugs
 - 12 include information about the quantity of tobacco, alcohol and/or other drugs used and
 - eight include information about the age at which the person commenced using and tobacco, alcohol and/or other drugs.
- one (AODTS-NMDS) provides information about the principal and other drugs of concern for people attending alcohol and other drug treatment services
 - two (SAR and DASR) provide service-level estimates of the different types of drugs for which services are provided in the reporting period (including tobacco, alcohol and other drugs)
 - one provides an estimate of the number of people using GP services for drug-related problems (BEACH)
 - three provide estimates of the number of hospital separations, community mental health service contacts or residential mental health care episodes involving a drug-related diagnosis (NHMD, NCMHCD and NRMHCD, respectively)
 - one provides an estimate of the number of episodes in emergency departments where the presenting problem or diagnosis was drug-related (NAPEDCD)
 - two provide estimates of the number of deaths related to drugs (NMD and NCIS) and
 - two provide estimates of the number of calls to telephone helplines where the main problem raised is drug-related (KHLS and Lifeline).

Of the seven collections which include information on other drugs only, all have a focus on illicit drugs:

- two provide estimates of the number of people presenting to specific programs (NSP and CAYLUS) as well as some limited information about frequency of use among people attending Needle and Syringe Programs and the CAYLUS service, and some information on the frequency of use of injected drugs (NSP)
- one provides an estimate of the number of people on the HIV/AIDS registry who inject drugs
- one provides an estimate of the number of people entering prison who inject drugs
- one provides an estimate of the number of people arrested for possession of illicit drugs
- two provide estimates of the number of people in prison or juvenile remand establishments (DUCO) or detained in custody (DUMA), including information on those who have 'ever used', 'current use' and, in the case of DUCO, some information on patterns of drug use.

Of the four collections including information about tobacco and alcohol only:

- the NATSIHS and NHS provides estimates of the number of people who have ‘ever used’ drugs, a measure of ‘current use’ (last year and last week in NATSIHS, last week in NHS) as well as information about frequency of use and quantity used
- the LSIC will provide an estimate of the number of people who have ‘ever used’ tobacco and alcohol and their frequency of use
- the NSW-PHS provides an estimate of the number of people who have ‘ever used’ or are ‘currently using’ tobacco and alcohol and their frequency of use.

Of the four collections including information about alcohol and other drugs, but not tobacco:

- one (IDIS) includes information from a sample of injecting drug users about whether they have ‘ever used’ alcohol or other drugs and information about their ‘current use’ including information about frequency of use, quantity used and age first injected
- one (SAAP-NDC) provides an estimate of the number of clients presenting for SAAP services where the presenting problem or support provided are drug-related
- one (NPCS) provides an estimate of the number of occasions in which a person is in police custody for drug-related reasons and
- one (VIC-PHS) provides an estimate of the number of people incarcerated in Victoria who ever used alcohol and/or illicit drugs and their frequency of use.

Specific information about injecting practices is collected in 17 key data sources including the IDRS-IDU, IDRS-PDI, IDIS, ALSWH, NSW-IHS and DUCO.

Exposure to tobacco smoke is also collected in a number of surveys, usually by asking how many regular smokers there are in the household (for example, ABS NHS and NATSIHS, WAACHS).

The remainder of this section summarises the way in which the key data sources include information relating to each of the five domains of the framework in Table 1.1.

Alcohol, tobacco and other drug use and associated risk behaviours

This section further explores the 44 key data sources in relation to the information they collect about prevalence of substance use, frequency and quantity of substance(s) used, monetary expenditure on substances and risk behaviours associated with substance use.

Prevalence of substance use

Information that can be used to estimate the prevalence of substance use in a selected population is collected in 41 of the key data sources. For example:

- ‘ever used and current use’ is collected in 18 data sources. The majority of these data sources delineate ‘use’ further by asking whether the substance has ever been used, for example, over the last 12 months, month, week, 48 hours and/or day
- ‘ever used’ is collected in the NSP, LSIC, VIC-PHS and IDDR
- ‘current use’ is collected in the YACR and BTOM-C. In the NMD and NCIS, current use is implied where a drug-related death has been recorded
- ‘estimates of use’ are recorded for 12 data sources. Examples of these estimates include: estimate of petrol and glue sniffers in the CAYLUS, estimate of hospital separations where a drug-related diagnosis has been made in the NHMD, and estimate of people accessing SAAP services where alcohol and drugs in recorded as the presenting reason in the SAAP-NDC.

Frequency and quantity used

Frequency of substance use is collected in 23 data sources. The data items used to collect this information vary depending on the type of substance frequency is being recorded against. For example:

- the YACR includes a data item on 'frequency of smoking', coded as daily, weekly but not daily, less than weekly
- the NSMHW (C & A) includes a data item on the 'frequency of marijuana use over the past 30 days', coded as none, 1 or 2 times, 3 to 9 times, 10 to 19 times, 20 to 39 times 40 or more times
- the DUCO includes a data item on 'frequency of illicit drug use', coded as less than monthly, one to several times a month, one to several times a week, once a day, several times a day.

The amount (quantity) of substances used is collected in 19 data sources. As for frequency of use, the data items used to collect information on quantity vary depending on the type of substance. For example:

- the IDRS-PDI asks for the amount of ecstasy used in a typical use episode
- the YACR asks for the amount of alcohol consumed, coded as under 10 drinks, over 10 drinks or just a few sips
- the CAYLUS asks how much petrol a person had sniffed on a particular day
- the NPDC asks for the average number of cigarettes smoked per day during the second half of pregnancy.

A number of data sources, including the NSW-IHS and QLD-WPHS, collect consumption of alcohol information using the Alcohol Use Disorders Identification Test (AUDIT).

Age first used drugs and method of use

'Age first used (substance)' is collected in 11 data sources including:

- the NDSHS, which asks about 'age first used' in relation to alcohol, tobacco and a range of illicit substances
- the NATSIHS, which asks about 'age commenced daily smoking'
- the ALSWH, which asks about 'age first started smoking'
- the DUCO collection, which asks respondents to indicate the age at which they first used drugs and the age at which they first used them regularly.

'Method of use' is collected in the NDSHS, IDRS-PDI, AODTS-NMDS and BTOM-C.

Monetary expenditure on substances

Little information is collected on the monetary expenditure on substances from the data sources reviewed. Five data sources collect information on the amount spent on particular drugs, for example:

- the IDRS-PDI collects information on the 'amount of money spent on ecstasy in the last 6 months'
- the IDIS asks about the 'amount spent on heroin in the past week' and the 'cost of a hit of heroin'
- DUCO collects information on the 'weekly expenditure on drugs'.

Risk behaviours

A variety of data items are used to identify risk behaviours:

- 'sharing needles (and other injecting equipment)' is collected in 11 data sources
- 'injecting drug behaviour' is collected in eight data sources, and is often accompanied by further data items relating to the type of drug injected, frequency of injecting and so on
- 'risky behaviours while under the influence (of a substance)' is collected in seven data sources: types of risky behaviours include drink or drug driving, stealing, abuse of a person and so on
- 'drinking at a risk of harm' is collected in four data sources
- 'overdose' is collected in six data sources
- 'presence of tattoos and piercings' or 'obtaining tattoos and piercings while under the influence' is collected in five data sources
- 'safe sex practices' or 'risky sexual behaviour' is collected in 10 data sources
- '(engaged in) sex work' is collected in the IDRS-IDU and DUMA
- 'perceived risk' is collected in the IDRS-PDI in relation to ecstasy and IDIS in relation to bloodborne viruses.

Context and influences

Table A3.4 outlines whether basic demographic data items are included in each of the 44 key data sources reviewed. Most key data sources enable a basic profile of individuals to be developed in relation to sex, age, cultural and linguistic diversity and geographic location.

Sex

Nearly all of the data sources reviewed collect information about the sex of respondents. There is minimal variation in the way the data items are defined and the information collected.

Indicators of age

Almost all data sources include information about the age of respondent, with SAR being the most notable exception.

Of the remaining key data sources reviewed:

- respondent's 'date of birth' is collected in 23 data sources
- 'age in years', 'age at last birthday' or 'age at collection' is collected in 13 data sources
- 'age group' is collected in five data sources, not necessarily in comparable formats
- 'age at death' is collected in the NCIS and NMD.

Cultural and linguistic diversity

Within the key data sources reviewed, a variety of data items are used to obtain information about the cultural and linguistic diversity of respondents. Often, more than one data item relating to cultural and linguistic diversity is collected in each data source.

Of the data sources reviewed, data items relating to the respondents' birth places included:

- 'country of birth' – collected in 25 data sources
- 'place of birth' collected in the VIC-PHS and 'region of birth' in the YPiCHS

- ‘country of birth [of the respondents’] parents’ – collected in the YACR and VIC-PHS.

Data elements relating to cultural diversity include:

- ‘year of arrival to Australia’ – collected in three data sources; the NCIS collects the number of ‘years the individual has been in Australia’
- ‘parental culture and religion’ – collected in the LSIC
- ‘ethnic background’ – collected in the KHLS and the NT PDSDB (the latter also collecting ‘nationality’).

Data elements relating to linguistic diversity include:

- ‘main language spoken at home’ – collected in 12 data sources; ‘main and other language spoken at home’ are collected in the NDSHS and ‘main language spoken by parents’ is collected in the NSP and NPEBVS
- ‘preferred language spoken’ – collected in the AODTS-NMDS
- ‘English proficiency’ – collected in the NHS and ‘difficulty communicating in English’ in the NATSISS
- ‘Indigenous language(s) spoken’ – collected in the NATSISS and WAACHS; the WAACHS also collects ‘Indigenous language(s) understood’.

Of the key data sources reviewed, eight do not collect any information on cultural and linguistic diversity.

Geographic indicators

Data sources were reviewed to determine whether they contained indicators of the geographic location of individuals and of agencies.

In most of the data sources reviewed the location of the respondent was defined as the physical location of their residential setting. A number of different data items are used within data sources to obtain this information, with data sources often collecting one or more of these. The most common data items used to indicate the geographic location of respondents are:

- ‘postcode’ – collected in 15; also enabling state and territory, Rural, Remote and Metropolitan Areas Classification (RRMA) and Accessibility/Remoteness Index of Australia (ARIA) to be identified or generated
- ‘residential address’ or ‘household address’ – collected in five
- ‘suburb/town of residence’ – collected in five
- ‘Australian Standard Geographical Classification (ASGC) remoteness area of residence’ – collected in three; this is a five-digit code which is derived using a state/territory identifier and the SLA of residence
- ‘Statistical Local Area (SLA)’ – collected in three
- ‘metro/rural/remote classification’ – collected in three.

Because the majority of key data sources were population or other surveys, the location of a relevant agency (for example, treatment service) was not applicable and therefore not collected (for example, NDSHS, NATSISS, NATSIHS). Of the 27 collections that did include a geographic indicator for a relevant agency, the most common ways of collecting geographical information about the agency are:

- state/territory – collected for eight collections (for example, state of prison in NPEBVS, state of needle and syringe program in NSP)
- postcode – collected in two collections (for example, postcode of general practice in BEACH, postcode of school in ASSAD)
- full street address of the relevant agency – collected in seven collections (for example, the address of the Indigenous-specific substance use service in DASR).

The NT PDSDB contains information about the ‘full address of the seizure’ and an indicator of whether the ‘seizure [was in an] Aboriginal community’.

Indicators of social context

The way in which key data sources include information that describes the more complex aspects of individual’s lives, such as their social context and social participation, varies widely. The most common indicators of social context found in the reviewed collections related to accommodation, family relationships and income.

The data sources that address indicators of social context most comprehensively are the NDSHS, NATSIHS, WAACHS and LSIC (Table A3.5). Of the key data sources reviewed, 11 do not contain any data items relating to indicators of social context, including the AODTS-NMDS, DASR, SAR, NPCS, and QLD-WPHS.

Accommodation

The most common data items providing an indication of an individual’s accommodation arrangements are:

- ‘household composition’ – collected in 11 data sources. This data items also relates to ‘family relationship’ indicators.
- ‘accommodation type’ – collected in 12 data sources (referred to variously as ‘accommodation type’ (for example, IDRS-PDI), ‘household type’ (for example, NDSHS), ‘residential setting’ (for example, ALSWH) and ‘type of housing’ (for example, DUCO and DUMA)
- ‘living arrangements’, ‘living situation’ or ‘living environment’ – collected in eight collections
- ‘number of bedrooms’ – collected in two sources.

Family relationships

The most common data items about individuals’ relationships are:

- ‘marital status’ – collected in 15 data sources
- ‘parental status’ – collected in three data sources
- ‘number of siblings’ – collected in the NSMHW (C&A).

Other data items relating to family relationships that are collected in at least one data source include ‘relationship status’, ‘number of dependent children in household’, ‘birth order’ and ‘caregiver relationships’.

Income

The most common data item about individuals’ income is ‘income source’ which is collected in eight key data sources, including one data source which also collects ‘main income source’.

Other less common data items relating to income include 'average gross income', 'level of income', 'disposable income', 'assets' and 'source of retirement funding'.

Indicators of social participation

As with the indicators of social context, a variety of data items are used to obtain information about social participation (Table A3.5). Again, most data sources use more than one data item to collect this information. These data items are outlined under the following headings: employment, education and other indicators of social participation. Fifteen of the key data sources reviewed did not collect information relating to social participation.

Employment

A number of different data items are used within data sources to obtain information relating to employment, with data sources often collecting one of these. The most common data items used to indicate respondents' employment were:

- 'employment status' or 'labour force status' – collected in 18 data sources; in the NSW-IHS and QLD-WPHS collections, the labour force status of the respondent prior to imprisonment is collected
- '(current) occupation (type)' – collected in 10 data sources; the data item for the NDSHS asks for the 'type of work undertaken'; the NSW-IHS and QLD-WPHS collect the occupation of the respondent prior to imprisonment
- 'hours worked' – collected in the NATSIHS and NSMHW (C&A)
- 'employment history' – collected in the YPiCHS; the VIC-PHS collects the work history of an individual prior to and post entering prison.

Other employment related data items collected include 'voluntary work', 'industry last employed in', 'main job held' and 'shift work' (Table A3.5).

Education

Information collected about education includes:

- 'educational attainment' – collected in 16 data sources
- 'current education status' or 'year currently enrolled in at school' – collected in three data sources
- 'accessibility to education' – planned for collection in the LSIC (which may also collect 'accessibility and experience in playgrounds, preschool, primary, secondary and tertiary education').

Other less common data items relating to education include 'school absenteeism', 'educational experience', 'school leaving age' and 'place of education'.

Other indicators of social participation

- 'attendance at day care' and 'participation in social and recreational activities' are collected in the WAACHS
- 'use of or access to childcare' is collected in four data sources, including the NSW-IHS and LSIC
- 'participation in selected activities' is collected in the ALSWH.

Family and personal context and influences

Twenty-one of the key data sources collect information that provides an indication of the family and personal context of individuals and the related influences to which they are exposed. Most collections use more than one data item to collect this type of information and the set of data items varies widely across data collections. For example:

- ‘forced removal from natural family’ is collected in seven data sources, including the NATSISS, WAACHS, SAR, NSW-IHS and VIC-PHS
- ‘experience of racism or discrimination’ is collected in the NATSIHS and WAACHS
- ‘parenting practices’ (for example, parental engagement or discipline practices) is collected in the WAACHS
- [exposure to] ‘violence’ (family or other), ‘abuse’ or ‘neglect’ is collected in nine data sources, including the NATSISS, Lifeline statistics, DUCO and YPiCHS.

Substance use context and influences

Information that could potentially be used to describe the substance use context and influences of individuals was included in 19 of the key data sources, with little commonality across collections. For example:

- the NDSHS, which collects the most comprehensive information in this area, asks individuals about: their opportunity to use drugs and the availability of drugs; peer pressure to take drugs; knowledge of regulations relating to drug use; awareness of preventive strategies; cultural acceptance of specific drugs
- the IDRS-IDU collects information about respondents’ knowledge of purity and availability of injectable drugs and whether they have been a victim of drug-related crime
- the IDRS-PDI asks respondents about their knowledge of purity and availability of drugs, source of drug, location drugs were obtained (scored) and occupational/social/financial/legal problems they attribute to their drug use
- the YACR asks young people about peer group problems relating to alcohol and tobacco, alcohol advertising campaigns, parental rules on drinking alcohol and about their perceptions of substance use
- the NATSIH and NATSISS ask questions about life stressors, where possible responses include the use of substances by self or other
- the WAACHS asks about parent/caregiver use of alcohol and tobacco, perceptions of community problems and experience of substance use among school peers.

The IDDR and NT Police Drug Seizure Data Base both include information about drug-related offences including type of drug seized, location of seizure, drug purity and basic demographics of the offender. Indigenous status of the offender is included in the NT PDSDB but not the national IDDR.

Associated harms/health status

Table A3.6 outlines whether data items relating to associated harms and health status are included in each of the key data sources. Most key data sources enable a basic profile of individuals to be developed in relation to at least one aspect of substance-related associated harms or health status. This section will focus on comorbidity/health conditions, disability, pregnancy, suicide, and crime and justice.

Comorbidity/health conditions

Information about health problems, status or conditions, in conjunction with information about whether or not a person is a substance user, can be used to explore comorbidity of substance use and other health conditions. Most (35) of the key data sources contain some information relating to individuals' health status, with information generally being collected by a number of data items in each source. The most common ways of collecting information about health status are:

- self-reported health status – collected in 16 sources with varying methodology and level of detail (for example, the ABS Short Form-1 (SF-1), which asks respondents to rate their general health according to a scale, is used in the NDSHS; SF-12 in YPiCHS; SF-36 in QLD-WPHS; and the Lifeline and KHLS record 'health' as a main call issue)
- self-assessed health conditions – collected in four sources, all by asking the respondent about any long-term health conditions they have (NDSHS, NATSIHS, NHS, HILDA)
- mental health status – specific information relating to mental health (in addition to other indicators of mental health that would be detected through diagnosis) is collected in 15 sources, in various ways (for example, IDRS-IDU and IDIS ask if an individual has any mental health problems; NDSHS, NHS, NSW-PHS, DUCO and DUMA use the Kessler 10 instrument, Lifeline and KHLS record 'mental health' as main call issue)
- specific questions about blood borne infections and/or sexually transmitted infections – collected in eight sources (IDRS-PDI, NSP, National AIDS/HIV Registry, NPEBVS, NSW-IHS, QLD-WPHS, VIC-PHS, NSW YPiCHS)
- diagnosis (by medical professional) – collected in four sources (NHMD, NCMHCD, NRMHCD, MHNOC)
- severity of dependence – collected in IDRS-PDI and IDIS using the Severity of Dependence Scale.

Disability

The International Classification of Functioning, Disability and Health (ICF) defines disability as a multidimensional concept, relating to the body functions and structures of people, the activities they do, the life areas in which they participate and the factors in their environment that affect these experiences (WHO 2001). Each of these components is described in the context of a health condition. Information about health conditions and environmental factors (for example, social context and social participation) is reviewed elsewhere in Chapter 5. In this discussion we are really focussing on what we know about the extent to which substance use is associated with activity limitation (for example, difficulty learning or solving problems) or participation restriction (for example, difficulty in acquiring and keeping employment).

Of the key data sources, 12 include some information relating to disability. For example, the ABS surveys (NHS, NATISHS and NATSISS) generally collect information using Short Forms (for example, SF-12, SF-36) which contain information about health conditions and the effects of health conditions on functioning and wellbeing. Such information could be used to indicate the level of functioning and therefore disability among substance users. Examples of the data items that relate to disability in the key collections are:

- disability as a 'stressor – NATSIHS
- disability status (based on ABS concept of disability) – NATSISS, WAACHS
- disability/disability type – NSW-IHS, VIC-PHS (intellectual), YPiCHS (status)

- functional impairment – NSMHW(psychotic)
- parental condition – LSIC
- disability impacts – LSIC
- help needed because of disability – ALSWH
- call issue – Lifeline
- long-term illness/disability – QLD-WPHS.

Pregnancy and the unborn child

Information about substance use behaviour among pregnant women is an important predictor of exposure to health risks for both the mother and child (for example, low birth weight, dependence). The key data sources contain the following information about substance use and pregnancy:

- ‘drug intake while pregnant’ is collected in the NDSHS, WAACHS and LSIC
- the NMD collects information about ‘maternal alcohol addiction’ and ‘maternal drug addiction’
- ‘tobacco smoking status during pregnancy’ and ‘average number of cigarettes smoked per day during the second half of pregnancy’ are collected in the NPDC in some jurisdictions
- ‘quitting smoking because of pregnancy’ and ‘(receiving) smoking advice while pregnant’ are both collected in the NDSHS.

General data items relating to pregnancy include:

- for all births, the NPDC collects the demographic and pregnancy characteristics of mothers, and the characteristics and outcomes of their babies
- ‘ever had children’ and ‘breastfeeding history’ are both collected in the NATSIHS and National AIDS/HIV registry; ‘use of contraception’ is also collected in the NATSIHS
- ‘pregnancy history’ and ‘use of hormone replacement therapy’ are both collected in the ALSWH
- ‘reproductive health’ is collected in the NSW-IHS and information about ‘fertility’ is collected in the QLD-WPHS
- ‘transmission of HIV to child’ is collected in the National AIDS/HIV registry.

Suicide

A variety of data items are used within the data sources to provide information relating to suicide, including:

- ‘attempted suicide’ – collected in eight data sources including the CAYLUS, WAACHS, NMD and YPiCHS
- ‘suicidal thoughts’ – collected in six data sources and ‘suicidal ideation’ is collected in a further 5 data sources
- an indicator of ‘self harm’, which is collected in five data sources including the ALSWH, NSW-IHS, QLD-WPHS, VIC-PHS and YPiCHS; the YPiCHS also collects information relating to ‘methods of self harm’
- the DASR collection, which provides a service level indicator of self-harm or suicide.

Other less common data items relating to suicide include 'deliberate overdose' (IDIS), 'suicide call issue' (KHLS, Lifeline Statistics), 'diagnosis of intentional poisoning' (NRMHCD) and 'intent' (NCIS).

Crime and justice

Information about crime and justice is collected in 28 of the key data sources reviewed and is an important indicator of associated harms that may result from substance use. Common data items include:

- 'prison history' – collected in five data sources and 'criminal history' in a further two data sources
- 'most serious offence' – collected in five data sources; in the DUCO this data item relates to the 'most serious charge' and 'most serious regular charge'
- 'ever been in prison/detention' – collected in the IDIS, NSP and WAACHS; in the WAACHS this data item relates to 'overnight stay at juvenile detention centre or police station'
- 'physical violence or fighting' – collected in the WAACHS and NMD
- 'contact with police' – collected in the NATSISS and WAACHS and 'contact with the criminal justice system' in the DUMA
- 'self reported criminal activity' – collected in the IDRS-IDU and IDRS-PDI
- 'experience of abuse' – collected in the NDSHS and the WAACHS.

The NT PDSDB and IDDR both collect comprehensive information about people who have been arrested as part of a drug seizure.

Other data items relating to crime and justice that are collected in at least one data source include 'prisoner status', 'length of imprisonment', 'victim of violence', 'reason for committing an offence' and 'number of arrests/charges in the past 12 months'.

Intervention and treatment services

Intervention and treatment service options and uptake

The scope of the key data sources reviewed for this study covers a broad range of treatment and intervention services, including those within the health and welfare sector and more broadly in sectors such as income support and corrections. Among the key data sources information is collected directly (either as by-product administrative data or through survey) about uptake of services from agencies providing the following treatment and/or intervention service types:

- mainstream drug and alcohol treatment services (AODTS-NMDS) and opioid pharmacotherapy services (BTOM-C)
- specialist Indigenous-specific substance use services (DASR)
- services provided by general practitioners (BEACH)
- needle and syringe programs (NSP)
- youth services (CAYLUS)
- Aboriginal and Torres Strait Islander primary health care services (SAR)
- hospital services (NHMD) and emergency department services (NAPEDCD)

- specialist mental health care in the community (NCMHCD) and in residential settings (NRMHCD) and in both settings (MHNOCC)
- telephone support services (Lifeline and KHLS)
- crisis accommodation support (SAAP) services and
- corrections (NPEBVS, NPCS, DUCO, DUMA, NSW-IHS, QLD-WPHS, VIC-PHS, YPiCHS).

The above sources can be used to make inferences about the uptake of services by people with substance use issues, but only where information about substance use is also available (see Chapter 6 for further discussion).

Many of the remaining key data sources also provide information about the uptake of treatment and intervention services because they ask respondents questions about their recent efforts to access health services (Table A3.7). For example:

- the IDRS-IDU and IDRS-PDI ask drug users whether they are currently accessing drug treatment and about drug treatment they have accessed in the last 6 months
- the IDIS asks about the use of treatment services generally
- the NAC ask respondents about awareness of health promotion campaigns relating to alcohol and tobacco
- the NATSISS, NATSIHS, NHS, WAACHS and ALSHW collect information (in various formats) about the use of health services such as hospitals, general practitioners and dental services (the LSIC also plans to collect such information).

Affordability, accessibility and appropriateness of interventions and treatment services

Information about affordability, accessibility and appropriateness of intervention and treatment services is limited. For example, information which could relate to affordability is collected in five key collections:

- NATSIHS and LSIC – cost may be indicated as the reason a person did not attend services
- DASR – collects some information about how much services cost for clients
- BEACH and ALSWH – collect ‘cost’ of GP services.

Information relating to accessibility is collected in 15 key data sources. For example:

- the NATSIHS, IDIS, WAACHS, LSIC, NSW-PHS, NSMHW(C&A), NSMHW(psychotic) ask respondents about their reasons for not attending health services or barriers to health services or similar
- some collections include data items that could potentially be used to infer something about accessibility to services (for example, Lifeline and KHLS could possibly use location of callers, number of phone calls received, number of phone calls answered, response to rural and remote calls, NAPEDCD could potentially use waiting times to service delivery for particular triage categories).

Information about the appropriateness of services or interventions is collected in 14 key data sources, in various ways. For example, the following data items could potentially be used as rough indicators of appropriateness:

- IDIS collects information about ways of improving the service and the advantages and disadvantages of treatment

- DASR and SAR includes information about the Indigenous status of staff, as well as information about their training and qualifications
- Responses to the question on why services were not used can include 'service not culturally appropriate' (NATSIHS and LSIC)
- Satisfaction with service is collected in the ALSWH, NSW-PHS, YPiCHS
- Access to Aboriginal health services within prisons is collected in NSW-IHS, QLD-WPHS and the VIC-PHS.

Outcomes of interventions and treatment services

Information about the outcomes of treatment or interventions is available from eight key data sources, for example:

- BTOM-C provides a measure of treatment outcomes for clients of methadone or buprenorphine treatment programs in New South Wales
- DASR and SAR ask services to provide information about particular achievements or success stories in the past year
- SAAP-NDC can report on the extent to which the goals of a client's case management plan were achieved by the end of a support period (for clients with an agreed case management plan)
- DUCO asks about the perceived effectiveness/usefulness of drug use services.

While no information is collected on outcomes for clients of alcohol and other drug treatment services at a national level (under the AODTS-NMDS), outcomes information is collected in a number of jurisdictions, for example, the Significant Treatment Goal Achievements in Victoria.

It is possible that indicators of outcomes (at the service level or client level) may exist or could be developed using the information from some of the remaining collections.

Resources

Key data sources were searched for information about expenditure by governments on substance use interventions. Such information is not readily available for drug treatment programs from the sources reviewed. However, as noted in Chapter 2, a detailed study of alcohol and other drug intervention programs funded by government was undertaken by the Australian National Council on Drugs in relation to the 1999–2000 financial year (Gray et al. 2002). Such expenditure data cannot be broken down in terms of amounts directed specifically to programs targeting Aboriginal and Torres Strait Islander peoples.

Of the key data sources, only two included routine questions relating to expenditure on services. The DASR asks Indigenous-specific substance use services to state the service's income for substance use (excluding client payments) in the reporting period and also asks services to comment on funding issues arising during the reporting period.