

6 To what extent can existing data sources answer key questions?

6.1 Introduction

This chapter assesses the key questions and information needs detailed in Chapter 4 against the information from the data sources presented in Chapter 5. This chapter thus tackles the question: to what extent can the available information be used and analysed in a way that will better answer and shed light on the priority information areas?

The data sources are examined against the key questions, as identified in Chapter 4, relating to the five-domain framework. To recap, the key questions relate to:

- nature of Indigenous substance use (domain 1 – tobacco, alcohol and other drug use and associated risk behaviours)
- characteristics and context of Indigenous substance users (domain 2 – context and influences)
- associated harms, such as mortality (domain 3 – associated harms and health status)
- other associated harms, such as homelessness and crime (domain 3 – associated harms and health status)
- affordability, accessibility and appropriateness of interventions (domain 4 – intervention and treatment services)
- effectiveness of interventions (domain 4 – intervention and treatment services)
- expenditure on treatment and interventions (domain 5 – resources).

Sections 6.2 to 6.6 identify the extent to which of the reviewed data sources can inform each of the key questions, summarised under each of the 5 domains.

Three cross-cutting questions

Three main information needs were identified through the November workshop, that run across the key questions. These three information needs are for:

- community-level and individual information
- whole-of-government and cross-sectoral information
- timely information on emerging trends and patterns.

Broadly speaking, with a few exceptions, existing data sources do not easily lend themselves to supporting these three information needs. For example:

- very few data sources collect information at the community level. However, with sufficiently large sample sizes and agreed definitions of ‘communities’, information collected at the individual level could potentially be aggregated up to community-level data (for example, NATSISS). The feasibility of this type of analysis requires further exploration with the ABS.
- much of the information collected across different sectors is not directly comparable (particularly in terms of collection counts, but also in terms of data items and definitions).

- timely information about emerging trends is collected only in a very small number of sources, relating to specific population sub-groups (for example, IDRS-IDU, IDRS-PDI, IDIS).

These gaps overlay much of the following discussion and are discussed further in Chapter 7.

Examination of the data sources

The following discussion takes into consideration the comparability of data sources in terms of methodology, collection count, data items and so on (as described in Chapter 5). However, the discussion does not extend to highlighting all of the possible specific analytical issues the collections might present. For example, potential analysts might need to consider the limitations of particular sample sizes (for example, it is possible that reliable population estimates might not be generated, particularly for specific geographic areas). Potential analysts may also need to develop their own definitions for what constitutes 'substance use' among the given population (for example, any use of tobacco, alcohol or other drugs, problematic use of licit or illicit drugs for non-medical purposes). Finally, analysts may need to account for the likelihood that Indigenous substance use information is under-reported due to, for example:

- the sensitivities around and disincentives to accurately reporting substance use information
- the likely under-reporting of Indigenous status in many collections due to the level of 'not stated' responses that occur in most data collections for this data item.

A full assessment of each key data source in terms of its quality (for example, representativeness of the selected sample, extent of 'not stated' responses for variables other than Indigenous status) was beyond the scope of this project.

The majority of discussion in this chapter relates to the 44 key data sources identified in Chapter 5. While there are various possible ways of summarising the extent to which these key data sources can answer the key questions, we have chosen to group them in terms of the broad population groups to which they relate. The 44 key data sources are useful in terms of describing the characteristics of substance use within the following broad population sub-groups (there is overlap between these groups):

- the Australian population overall (the NDSHS, NATSISS, NATSIHS, NHS, NSMHW(C&A), NSMHW(psychotic), NSW-PHS)
- children and adolescents (ASSAD, WAACHS, KHLS, LSIC)
- women (NPDC, ALSWH)
- substance users (IDRS-IDU, IDRS-PDI, IDIS, CAYLUS) and substance users who access specialist treatment (AODTS-NMDS, DASR, BTOM-C)
- people accessing health interventions (BEACH, SAR, NHMD, NAPEDCD, NCMHCD, NRMHCD, YACR, National AIDS/HIV Registry, NSP, Lifeline Statistics)
- people accessing crisis accommodation support programs (SAAP-NDC)
- people in custody (NPC, NPEBVS, NPCS, DUCO, DUMA, NSW-IHS, QLD-WPHS, VIC-PHS, YPiCHS) or coming into contact with the police system in relation to a drug-related arrests and seizure (NT PDSDB and IDDR)
- people who have died (NMD, NCIS).

6.2 Tobacco, alcohol and other drug use and associated risk behaviours

Key questions in this domain of the framework relate to the nature or patterns of substance use among Indigenous substance users, including:

- What is known about the prevalence of substance use?
- What is known about the type(s) of substances used?
- What is known about the quantity and frequency of substance use?
- What is known about the age at which substances were first used?
- What is known about expenditure on substances?
- What is known about risk behaviours associated with substance use?

The capacity of existing data sources to answer these questions is now examined. The main identified data gaps, in relation to each element of the five-domain framework, are summarised in Table 6.1.

Prevalence of substance use

As a set, the 44 key data sources reviewed for this project could be analysed to generate estimates of the prevalence of substance use for both Indigenous and non-Indigenous people in various population sub-groups. In some cases, the estimates would be based on the self-reported responses to a series of direct questions about substance use behaviour (for example, NDSHS) while in most data sources analysts would need to develop proxy measures for substance use based on the information available in the data source (for example, all hospital separations with a drug-related primary diagnosis for the NHMD). Unless specifically stated, the following prevalence estimates could be developed for both Indigenous and non-Indigenous populations within each collection's scope.

Prevalence among the population

The prevalence of substance use among the overall Australian population can be estimated using the NDSHS, which covers tobacco, alcohol and other drugs. In 2004, 463 people responding to the survey reported that they were Aboriginal and/or Torres Strait Islander people (AIHW 2005b). The size of this sample means that national prevalence estimates can be generated for tobacco, alcohol and selected other drugs, but further analysis of, for example, prevalence rates among different age groups or in different states and territories, is not possible. While the NDSHS has a relatively large sample size overall, and is the only population survey that asks alcohol and other drugs questions of people under 18 years of age, the overall response rate to the survey was 46% in 2004, leading to some concerns over potential response bias and coverage (AIHW 2005f).

The NATSIHS and NATSISS were specifically designed to collect information about the health and social characteristics of Indigenous people. These collections include information about tobacco, alcohol and other drugs although, as would be expected, this information is not as detailed as for the NDSHS. Both the NATSIHS and the NATSISS produce national estimates of the prevalence of smoking and alcohol use. However, due to methodological issues encountered in the rural/remote element of the survey, prevalence estimates for the use of 'other drugs' by Indigenous people in rural/remote locations are not published. The NHS, particularly in conjunction with its Indigenous supplement, also provides information about smoking and alcohol use among Aboriginal and Torres Strait Islander peoples.

There have been concerns raised regarding the methods employed and the results indicated by the 2002 NATSISS for Indigenous alcohol consumption (for example, Chikritzhs & Brady 2005). Specifically, the 2002 NATSISS generated lower estimates of risky and high risk drinking for Indigenous people, than comparable surveys (for example, the 2001 NHS). The 2002 NATSISS results are also difficult to reconcile with the relatively high Indigenous death and morbidity rates for alcohol-attributable disease and injury (Chikritzhs & Brady 2006).

The scope of population surveys means that they explicitly exclude people from various locations. For example, the NDSHS sample excludes the homeless, institutions, correctional facilities, aged care facilities, military bases, schools or places of business. The number of people who might be defined as substance users who are currently present in some of these locations can be estimated using some of the data sources described below. However, information about the prevalence of substance use among Indigenous people who are homeless and not presenting for any services or treatment is not presently available.

Prevalence among children and adolescents

The ASSAD enables prevalence estimates to be generated for use of tobacco, alcohol and illicit drugs (ever and current use) among secondary school students in Australia (aged 12–17 years), although the capacity of this survey to provide reliable estimates among Indigenous students is likely to be limited. Broadly comparable prevalence estimates for the use of tobacco, alcohol and illicit drugs for an Indigenous-specific sample of young people (also aged 12–17 years) could be generated from the WAACHS. The WAACHS also collects information about the prevalence of use of substances by parents.

The LSIC, currently under development, proposes to include items on smoking and alcohol use by parents. If these data items are comparable with the WAACHS, it is possible that prevalence estimates about exposure to alcohol and tobacco use by Indigenous children could be available across Australia and over time.

Prevalence among women

The two key data sources touching on substance use among women are the NPDC and the Australian Longitudinal Study on Women's Health (ALSWH). While the ALSWH includes Aboriginal and Torres Strait Islander women as participants, it was not designed as, and should not be used as, a source of data about the health of Aboriginal and Torres Strait Islander women. The NPDC enables estimates to be generated of the number of women who smoke during pregnancy, although this information is not available for all states and territories.

Prevalence among people accessing treatment for substance use

There is fragmentation in the way information is collected about people receiving substance use treatment in Australia. For example:

- the AODTS-NMDS collects information from all publicly funded (at state, territory and/or Australian government level) government and non-government agencies that provide specialist alcohol and/or other drug treatment services
- the DASR collects information at the service level about clients attending Indigenous-specific substance use services
- the NOPSAD collection is a collation of information on the numbers of people attending opioid pharmacotherapy treatment.

It may be possible to generate an estimate of the number of substance users (Indigenous and non-Indigenous) who access treatment using the AODTS-NMDS. However, this collection is based on 'closed treatment episodes', rather than clients, and does not contain a facility such as a statistical linkage key to assist in reducing double counting of people.

The DASR currently provides service-level estimates of the number of Indigenous people receiving treatment from Indigenous-specific substance use services.

Another population of interest are those people accessing opioid pharmacotherapy programs. The national collection that currently describes this population (NOPSAD) does not include basic demographic information such as sex or Indigenous status (and was therefore not reviewed in depth for this report). Data development is currently underway to enhance the NOPSAD (led by the AIHW and funded by DoHA).

A number of jurisdictions already collect more information than is available nationally, and their experiences in developing and implementing such collections are of potential national interest. For example, the NSW Minimum Data Set for Alcohol and Other Drug Treatment (NSW MDS-AODTS, now known as the NSW MDS for Drug and Alcohol Treatment Services (NSW MDS-DATS) currently collects information about 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) (see further discussion in the section on treatment outcomes).

There are currently no national data available about agencies with a main function of providing accommodation or overnight stays such as 'halfway houses' and 'sobering up shelters' (unless funded under the SAAP Program and therefore reporting under the SAAP-NDC) or about clients of private agencies that do not receive government funding.

Ongoing information is not currently available about drug treatment services based in prisons or other correctional institutions, although work on a National Prisoner Health Minimum Data Set has commenced.

Prevalence among substance users not necessarily accessing treatment for substance use

CAYLUS currently provides estimates of the number of petrol and glue sniffers in remote and central Australia. While relating to a limited geographic area, this collection is of particular significance as it reports on a substance use problem that is known to be more prevalent amongst Indigenous populations.

Prevalence among people accessing general health interventions

Most of the reviewed collections relating to health interventions could be used to generate estimates of the prevalence of substance use among their clients. However, such estimates are generally high-level, not comparable across data sources and usually based on proxy indicators of substance use. For example:

- the prevalence of substance use among Indigenous people attending GP services could be indicated using the BEACH survey, based on responses to the data item 'reason for encounter/problem managed'.
- the prevalence of substance use among people attending Aboriginal primary health care services could be estimated using service-level estimates from the SAR collection, based on which substance use issues the service provided treatment/assistance for in the reporting period (tick box for alcohol, tobacco/nicotine, cannabis/marijuana, petrol and so on).

- the number of hospital separations with a drug-related diagnosis (NHMD) may provide an indication of prevalence in this group, but, among other issues, double counting may be an issue difficult to deal with.

Prevalence among people accessing crisis accommodation support

The SAAP-NDC can be used to generate an estimate of the prevalence of substance use among Indigenous people presenting for crisis accommodation support. The proxy measure for 'substance use' would be based on broad data items such as main presenting reason ('problematic drug/alcohol/substance abuse') or the type of support provided to the client ('drug/alcohol support or intervention') and is thus likely to underestimate the prevalence of substance use among this service population.

Prevalence among people in custody

Both the DUCO and DUMA provide estimates of the prevalence of past and present illicit drug use among people sentenced or detained in prison or other correctional facilities. The NSW-IHS and QLD-WPHS provide estimates of past and present substance use for tobacco, alcohol and other drugs among adult prisoners and the YPiCHS also collects this information in relation to young detainees in NSW. The VIC-PHS provides estimates of whether Victorian inmates have ever used alcohol or illicit drugs.

Prevalence among people who have died

Both the NMD and the NCIS are capable of generating estimates of drug-related deaths, which is a rough proxy for the prevalence of substance use among Indigenous people who have died.

The prevalence of substance use among Indigenous people who have died is likely to be underestimated using these sources as, to be recorded, drugs need to be considered as the primary cause of death or as directly contributing to the death. Long-term substance use often contributes to other chronic health conditions, which are then more likely to be included as the cause of death.

Prevalence among people accessing income support

Among the initial data sources explored for this project was the Longitudinal Data Set 1% sample, which contains extracts from the operational databases held by Centrelink, including customers' characteristics and payment details. The data custodian for this collection is FACSIA. While the LDS includes a non-mandatory data item on Indigenous status, it does not include information about substance use.

In addition to estimating the prevalence of substance use, there is interest in further detail about the patterns of substance use. The usefulness of information about types of such patterns (for example, substances used, quantity and frequency of substance use and age at which drugs first used) is affected by the limitations in generating accurate prevalence data outlined above. For instance, the extent to which any further information can be obtained about types of substances used by Indigenous people, is limited by the extent to which Indigenous people are identified in administrative data sources or included in sufficient numbers in population survey samples.

Type(s) of substances used

As detailed in Chapter 5 (and summarised in Table A3.3), a range of reviewed data sources provides information about the types of substances used by Indigenous and non-Indigenous people. Most collections provide information about whether tobacco, alcohol or other drugs are used. However, not all collections report on all of these substances. For example, while the NATSIHS collects information about tobacco, alcohol and 'other drugs', DUCO only collects information on the use of illicit drugs. Further, the level of detail available about the types of 'other drugs' used varies.

CAYLUS is the only reviewed collection that focuses on a substance type with particular relevance to Indigenous populations (in this case petrol and glue sniffing).

As a set, the reviewed key data sources provide considerable information about the types of substances used by Indigenous and non-Indigenous people. However, this information is not always comparable, and the extent to which it is able to meet the needs of analysts depends to some extent on their precise information needs. For example, an analyst focussing on the use of amphetamines among Indigenous people would have greater difficulty in locating comparable information than an analyst focusing on the use of alcohol.

Quantity and frequency of substance use

Information about both the quantity and frequency of substance use is important in terms of defining the level of risk or harm associated with substance use. For example, national guidelines defining the 'short-term' and 'long-term' risk of harm in relation to alcohol consumption relate to the quantity of drinks consumed over specified periods of time (see Appendix 1). As noted in Chapter 5, there is considerable variation in the way information about quantity and frequency of substance use is collected across the reviewed collections. Thus, while there is a reasonable amount of information about quantity and frequency of use for the various substances (tobacco, alcohol and other drugs), its lack of comparability may limit its ability to answer certain questions. As with information about substance types, the extent to which analysts' needs can be met depends to some extent on the specific questions people want to answer.

Age at which substances first used

The age at which people first use substances is an important predictor of lifetime use of substances and provides information about past and current patterns of uptake, and thus important information for people developing appropriately targeted prevention and intervention strategies. As noted in Chapter 5, information about age at which substances were first used is collected in 11 of the reviewed data sources, three of which ask only about age at which injected drugs or ecstasy were first used (IDRS-PDI, IDRS-IDU and IDIS) and two of which ask only about age at which tobacco use commenced (NATSIHS and ALSWH). The most relevant sources of information about age at uptake for a range of substances (at the population level) are the NDSHS and WAACHS. Relevant information is also available about age at which substance use commenced for people in custody (for example, the DUCO, NSW-IHS and YPiCHS).

Expenditure on substances

There is generally very limited information about expenditure on substances by Indigenous and non-Indigenous people. Information about expenditure on substances, particularly in

relation to income, is an important predictor of financial stress and, potentially, other associated harms such as criminal activity. As noted in Chapter 5, only five collections include information on expenditure (for example, the IDRS-PDI collects information about expenditure on ecstasy, IDIS on heroin and DUCO on all substances).

Risk behaviours associated with substance use

Information about risk behaviours associated with substance use provide an indication of the likely intensity of substance use and are predictors of related possible harms (for example, death or injury associated with drink driving, contracting sexually transmitted diseases from unsafe sex practices, contracting HIV/AIDS or other blood borne viruses through sharing needles).

In Chapter 5 we outlined the types of information collected about risk behaviours associated with substance use (for example, method of drug use particularly sharing needles, drink/drug driving, stealing, tattoos and piercing, safe sex practices, sex work). For example, the NDSHS collects information about risk taking behaviours while under the influence of alcohol or illicit drugs in last 12 months (for example, working, swimming, driving a boat or car, operating hazardous machinery, creating a public disturbance, causing damage to property, stealing money, goods or property, or abusing someone verbally or physically) as well as information about tattoos and body piercing and injecting behaviour. The data sources focusing on injecting drug users (IDRS-IDU, IDIS and NSP) also collect information about risk behaviours, with a focus on injecting behaviour and sexual practices. The WAACHS collects extensive information about risk behaviours or symptoms for Indigenous children, including information about whether they feel isolated from others or lonely, whether they are wagging school or running away from home, deliberate self harm and sexual behaviour.

In contrast, data sources relating to people accessing drug treatment services (for example, AODTS-NMDS, DASR) and health interventions (for example, BEACH, SAR) collect minimal information about risk factors (for example, AODTS-NMDS collects information on whether clients' injecting practices). The Indigenous-specific population surveys (that is, NATSISS and NATSIHS) do not directly collect information about risk behaviours associated with an individual's substance use, although they do collect extensive information about the context or environment in which the individual lives that could potentially infer levels of risk (for example, information about the extent of cultural identification, family stressors).

Thus, depending on the specific area of interest, the data sources reviewed could be analysed to inform understanding of the types of risk behaviours associated with drug taking among Indigenous and non-Indigenous people (for example, comparing needle sharing behaviour as reported in the IDRS-IDU for Indigenous and non-Indigenous intravenous drug users with that reported in the IDIS sample of Indigenous intravenous drug users). However, there is limited information in about risk behaviours associated with substance use in Indigenous-specific population surveys or relevant drug treatment collections.

6.3 Context and influences

This section explores the extent to which existing data sources are able to describe the characteristics of Indigenous substance users and associated contextual and other influential factors. To properly delineate how such characteristics and contextual factors relate to problematic substance use among Indigenous peoples, it is desirable that descriptors (for

example, demographics, social context, exposure to substance use in the community) are available in relation to both Indigenous substance users and non-users as well as non-Indigenous substance users and non-users.

Demographics of substance users

Sex, age and cultural and linguistic diversity

The majority of key data sources reviewed provide comprehensive, and broadly comparable, information about the demographic profile of substance users, and non-users, in a range of settings and population subgroups. Most of these data sources are able to describe the characteristics of substance users, generally in relation to sex, age, and cultural and linguistic diversity. Where the information is not directly comparable across data sources, there may be a need for analysts to use less detailed information (for example, aggregating 'age in years' in the VIC-PHS to the 'age groups' used to collect age related information in the NSW-IHS).

Geographic location of substance users and services they access

Knowing where substance users reside and access services is important for planning appropriate interventions and treatment services. Patterns in relation to substance types, and the variation in substance use problems across, for example, metropolitan areas and more regional and remote areas, should be understood in order to plan appropriately targeted and timely interventions.

Geographic indicators among the population

Broad information on the geographical location of substance users can be examined using population surveys. The NATSISS, NATSIHS and NHS collect information relating to the state/territory of residence of the respondent as well as the ASGC remoteness area of residence. The NDSHS collects the census collection district of the respondents household, which can be translated using concordance files to the same ASGC remoteness areas as reported in the other population surveys. As already noted above, prevalence estimates for 'other drug' use among Indigenous people living in rural and remote locations are not published from the NATSISS and NATSIHS.

Geographic indicators among substance users accessing drug treatment

The AODTS-NMDS and DASR collections each record information about the geographical location of outlets providing services. Although geographic information is collected differently in each of these collections (that is, SLA of agency is reported in the AODTS-NMDS and postal address of service is reported in the DASR) it is still possible to analyse these data using the same classification (for example, using concordance files to allocate ASGC remoteness area classifications using postcode and SLA data). A recent research paper on mapping national drug treatment capacity examined the locality of drug treatment services using this type of information (ANCD 2005).

Analysis focussing on the geographic location of people being treated is currently not possible using the key drug treatment data sources, namely AODTS-NMDS and DASR.

Geographic indicators among substance users not necessarily accessing drug treatment

The IDRS-IDU and IDRS-PDI surveys collect information pertaining to the geographical location of the respondent's residential address (that is, state/territory of residence and

suburb/town of residence); however, options for translating this information into other classification types is limited (for example, suburb/town can not easily be coded to ASGC remoteness areas without a postcode). Analysis of geographic data from the IDRS-IDU and IDRS-PDI can be used to monitor patterns of substance use and associated behaviours at a high level (that is, for the capital city in which they were collected).

The scope of the IDIS (South Australia only) and CAYLUS (central Australia only) limits the amount of geographical analysis that can be undertaken.

Geographic indicators among children and adolescents

Each of the key data sources relating to children and adolescents includes a geographic indicator for the respondent, and therefore may support some analysis of substance use by location. The WAACHS and LSIC collect full residential address of the respondent, and therefore may be able to support analyses of geographic information at various levels, including local area estimates and ASGC remoteness areas. Similarly, the ASSAD collects residential postcode of the respondent, which could also potentially be analysed at various geographic levels. The KHLS only records the state/territory where the phone call was made, meaning that only very broad state-based estimates could be derived.

Geographic indicators among women

The NPDC could potentially be used to explore the geographical location of Indigenous women who use tobacco during pregnancy (in the limited number of jurisdictions for which this information is currently available).

Geographic indicators among people accessing health interventions

With the exception of the YACR, all reviewed data sources relating to health interventions include information about the geographic location of the relevant health intervention (for example, BEACH collects postcode of the general practitioner's major practice address, SAR collects full address details of the Aboriginal and Torres Strait Islander primary health care service). While there is variation in the way geographic information is collected, data from many of these collections could be described according to a single classification (for example, using concordance files to allocate ASGC remoteness categories).

Most reviewed collections relating to health interventions contain information about the geographic location at which respondents usually live (with the exception of the SAR and NSP). Such information is collected in various formats. For example, the National AIDS/HIV Registry records the respondent's current residential postcode, postcode of residence at time of blood donation as well as the state/territory of bloodborne infection diagnosis; the YACR only captures information relating to the suburb or town where the respondent lives; and other data sources, including the NAPEDCD, NCMHCD and NRMHCD, capture information about 'area of usual residence'. As with the service-level data, it is likely that information about respondents (including substance use prevalence and patterns where available) could be analysed and compared according to a single classification, such as the ASGC remoteness classification. However, the wide variation in the way such geographic information is collected would make this a complex technical and analytical task.

Geographic indicators among people accessing crisis accommodation support

The SAAP-NDC could be used to generate estimates of substance use for people presenting at crisis accommodation services using a geographic indicator for the service outlet. The SLA of the SAAP agency is collected, and could be translated, through concordance, to ASGC

remoteness areas or state/territory estimates. Because of the nature of SAAP services, the current residential location of the SAAP client is often the service centre. The extent to which estimates of substance use could be generated by geographic location would be limited to the proxy measure used to identify substance use in this data source.

Geographic indicators among people in contact with the corrections system

Various geographic indicators are used in the data sources relating to people in custody. In most cases, as the respondents are either incarcerated or detained, the geographic identifier of the respondent is the same as the geographic identifier of the watch house, police station, prison or juvenile detention centre. The type of identifier used within these data sources vary. For example, the NPCCS, DUCO and DUMA all collect 'postcode' of watch house or police station, the NSW-IHS, QLD-WPHS and VIC-PHS all collect 'location of prison', and the YPiCHS collects 'address of juvenile detention centre'. Although different data items are used to collect geographic information within these data sources, it is likely that, through concordance a common indicator of geographical location could be used.

The NT PDSDB collects the residential address of people apprehended with drugs, as well as the address of where the drug seizure took place. These data could be analysed at a local level to provide a profile of drug seizures within the territory. Similar information is obtained at a national level through the IDDR collection.

A geographic indicator of respondents' residential address prior to incarceration or detainment is not collected in most data sources.

Geographic indicators among people who have died

Both the NMD and NCIS collect geographic indicators of where people have died, and in the case of the NCIS residential address of the deceased is also recorded. Calculating estimates of substance-related deaths in relation to geographic location is possible insofar as deaths are identified as being a 'drug related death'.

Social context of substance users

Information relating to the social context of an individual is important, as it can provide an indication of the predispositions to substance use and related harms. The types of indicators of social context identified in the population data sources tended to relate to accommodation (for example, accommodation type), family relationships (for example, household composition, marital status, parental status) and income (for example, main source of income, disposable income). Generally, most of the key data sources reviewed can provide some information about the social context of substance users.

Of the key data sources reviewed, those relating to substance users accessing the health system tend to contain the least amount of information about the social context of respondents. Most notably, the key treatment data sources at a national level – AODTS–NMDS and DASR – do not contain any data items relating to social context, although such contextual information is collected by some states and territories participating in the AODTS–NMDS and by many Indigenous-specific drug treatment services that contribute to the DASR. Similarly, a number of health intervention related data sources contain no (for example, NAPEDCD) or very little (for example, NCMHCD and NRMHCD) information on social context.

Social participation

The extent to which people are participating in social or community activities is an important indicator of their sense of connectedness to those around them and society as a whole. The types of indicators of social participation that were found in the key data sources tended to relate to employment and education status, with a small number of sources also collecting information about participation in social or recreational pursuits.

The WAACHS and NATSISS ask the most comprehensive range of questions relating to social participation. In relation to Indigenous children, the WAACHS includes questions on day care and learning, educational attainment, current educational status, social and recreational activities, parent/caregiver employment and availability and use of public transport. In relation to Indigenous people aged 15 years or more, the NATSISS includes questions about voluntary work, educational attainment, current study, educational experience, employment status and barriers to employment. These sources provide a great depth of information about social participation of Indigenous people. As previously noted, however, this information is not available in relation to Indigenous people using 'other drugs' in rural and remote areas.

The remaining population data sources tend to include information about employment and education status only (for example, NDSHS, ALSWH, ASSAD).

The two national substance use treatment collections (AODTS-NMDS and DASR) and the CAYLUS collection (Central Australia only) do not include information about the social participation of clients in terms of employment, education or other social and recreational activities, although indicators of social participation at the community level are available in the DASR. The IDRS-IDU, IDRS-PDI and IDIS include information about education and employment status for their more narrowly focused sample (that is, injecting drug users for IDRS-IDU and IDIS and users of ecstasy and related drugs for IDRS-PDI).

Very little or no information is collected about social participation in relation to people attending other health interventions such as general practitioners (BEACH), Aboriginal and Torres Strait Islander primary health services (SAR), emergency departments (NAPEDCD) or hospitals (NHMD).

Family and personal context and influences

In relation to this element of the information framework, the project team searched data sources for information about:

- the extent to which people have been exposed to or influenced by, for example, positive family functioning and resilience, family stressors, such as grief, and social disruption such as crime and violence
- people's social and emotional wellbeing, including whether they feel a connection to their land and people, and their experience of discrimination.

This element of the information framework relates very closely to 'indicators of social context', with more of a focus on family and individual interactions and feelings.

Between them, the NATSIHS and the NATSISS pick up on many of the above themes in relation to Indigenous people aged 15 and over (for example, cultural identity, family and individual stressors, removal from family, discrimination, neighbourhood/community problems, support in time of crisis, victim of physical or threatened violence). The WAACHS picks up a similarly broad range of family and personal contextual information in relation to Indigenous children (for example, parental engagement, parental discipline, forced

separation from family, partner/spouse relationship, social and religious supports, family life stress events, positive family interactions, experience of racism).

Comparable contextual information is not generally available for the non-Indigenous population through the data sources reviewed for this project.

Information about family and personal context and influences of individuals is not available for substance users attending mainstream drug treatment services (AODTS–NMDS) or Indigenous-specific drug treatment services (DASR). However, the DASR (and SAR) provide indicators of the community environment in which the service operates (for example, the drug problems that most affect the service) and the CAYLUS collection specifically records information about the history of the community in which its clients live. The DASR, SAR and CAYLUS are rare examples of data sources that collect information at the community level.

There is a reasonable amount of information about family and personal context in data sources relating to people in custody. The most common types of information collected are history of sexual or physical abuse (DUCO, QLD-WPHS, YPiCHS) and Indigenous removal from family (NSW-IHS, QLD-WPHS, VIC-PHS).

Substance use context and influences

Data sources were reviewed to see if they held information about:

- the extent to which individuals are exposed to substance use by family, friends, peers and others in the community and perceptions of substance use (for example, cultural acceptance of specific drugs, availability and opportunity to use specific drugs)
- the substance use context at a community level (for example, patterns of supply; patterns of demand; prevention strategies already in place such as dry communities, licensing laws and education campaigns or programs).

The NDSHS has by far the most comprehensive information about perceptions of, and attitudes towards, specific drugs, as well as information about opportunity to use specific drugs and awareness of preventive strategies. However, as noted previously, the NDSHS does not include a fully representative Indigenous sample.

Similarly, ASSAD includes information about secondary school students' exposure to substance use education programs and the YACR collects information about exposure to health promotion programs relating to alcohol. The capacity of these data sources to be analysed reliably in terms of Indigenous people is limited by their relatively small Indigenous samples.

The NATSISS and NATSIHS may provide some contextual information about substance use context and influences for Indigenous adults via their data items on stressors (that is, respondents can report substance use issues are a major stressor). The WAACHS includes relevant information for Indigenous children (for example, parental/caregiver use of alcohol and tobacco; perceptions of community problems can include substance use problems; experience of substance use by school peers).

The IDRS-IDU and IDRS-PDI provide information about patterns of demand such as where specific drugs are scored from but these sources are limited in terms of their geographic coverage (that is, capital cities only) and Indigenous sample sizes.

Information about patterns of supply of illicit drugs could be informed by the NT PDSDB and IDDR collections, which include information about drug-related arrests and drug seizures by geographic location.

Information about patterns of supply for tobacco and alcohol are not available in the sources reviewed, although it is known that sales data are collected in some states and territories. National data is available from the ABS, which produces information on the apparent per person consumption of alcohol by persons aged 15 years and over, based on alcohol sales data (ABS 2005c).

No collated information about the location of dry communities was found among the sources examined.

6.4 Associated harms and health status

The information framework for this study (Table 1.1) includes a number of elements relating to the harms and health status that may be associated with substance use, or non-use. The key data sources were reviewed to establish the extent to which they inform discussion about the association between substance use and:

- mortality
- comorbidity/health conditions
- disability
- sexual health and pregnancy
- economic impact on individual and community
- suicide
- homelessness
- crime and justice including violence, detention and imprisonment.

Mortality

The main sources of information about death due to substance-related causes are the NCIS and NMD. For example, the NCIS defines drug-related deaths as those where there has been a positive toxicology reported, or no or negative toxicology, but a known history of drug/poison/alcohol abuse. In relation to the NMD, cause of death is coded according to the ICD-10 and information about contributing factors such as substance use may not be consistently identified. Due to the coding practices for mortality-related collections, it is likely that drug-related deaths are underestimated.

Suicide

Information about suicide or harm (for example, attempted, ideation) is available to some extent in the mortality-related collections (NMD and NCIS). Information about suicide attempts and suicidal ideation is most often collected in the corrections-based collections.

Comorbidity/health conditions

Data sources operationalise the concepts of 'substance use' and 'health conditions' or 'health status' in various ways and there is therefore great variation in the ways in which comorbidities (of substance use problems/disorders and other health conditions) appear in the data sources (see AIHW 2005e for a discussion of the various ways of measuring health conditions).

Briefly, many of the reviewed data sources that contained information about substance use also contained information about physical and mental health issues. As noted in Chapter 5, across the data sources, information was most likely to be collected about health status/mental health status, rather than about health conditions (for example, diagnosis) per se. While not directly comparable, it may therefore be possible to analyse selected data sources in terms of the health and mental health status of Indigenous and non-Indigenous substance users (and non-substance users) in various settings.

For example, the NDSHS, NATSISS, NATSIHS and WAACHS in combination should enable high-level indicators of the relative health status of Indigenous substance users (as well as Indigenous non-substance users and non-Indigenous substance users and non-users). Such information is also available about people appearing in corrections-based collection such as the NSW-IHS, QLD-WPHS and VIC-PHS.

The IDRS-IDU, IDRS-PDI and IDIS contain physical and mental health information relevant to their target group (for example, information about injection related health problems).

Detailed information about health conditions is available in a number of health intervention collections, such as the NHMD and NAPEDCD, while BEACH collects information about problems managed and reason for encounter. While it is possible that such detailed information could potentially be compared to broader indicators of health status, overall, there is little comparability between health intervention collections and others reviewed for this study.

Analysts would need to be aware of the limitations of using diagnostic information to establish a health indicator, as most collections reviewed (with the exception of hospital-based service collections and BEACH for example) rely on self-reporting.

Information about health status or health condition is not available from the main national drug treatment collections (AODTS-NMDS and DASR).

Disability

Information about disability is collected in various ways across the reviewed collections. Broadly speaking, information about disability is available at the population level via, for example, the NATSISS and WAACHS; and for corrections-based collections via the VIC-PHS, NSW-IHS and YPiCHS. There is limited comparability in the way information is collected about disability in these data sources. Other health intervention services and drug treatment services do not generally collect information about disability.

Pregnancy and the unborn child

Only very few data sources collect information about substance use while pregnant (for example, NDSHS, WAACHS, LSIC and NPDC). For example, the NDSHS asks respondents about the use of any substances while pregnant or breastfeeding and the WAACHS asks about smoking or use of other drugs during pregnancy. Information currently available about substance use during pregnancy in the NPDC is limited to tobacco and is only collected by five states and territories. Because the NPDC is an ongoing collection and covers all pregnant women in Australia, it appears to be a potential vehicle for improving information in this area.

Economic impact on individual and community

Information about the economic impact of substance use on individuals or at a community level could potentially be obtained by directly asking individuals or communities (for example, by survey or via community leaders) about the perceived economic consequences of substance use. The IDRS-IDU was the only reviewed data source that specifically asked individuals about the financial impact of their drug use. There were no collections that specifically sought such information at the community level.

Alternatively, at least in the case of economic impact on individuals, it is conceivable that proxy measures of economic impact could be derived using available data about, for example, disposable income and expenditure on drug use. However, as none of the data sources included information on both of these variables, this approach is not currently feasible.

Homelessness

The SAAP-NDC collects information about all people attending agencies funded under the Supported Accommodation and Assistance Program to assist people who are homeless or at risk of becoming homeless.

Homelessness can sometimes be detected in other collections through items on 'residential setting'. The main data sources relating to drug treatment services (AODTS-NMDS and DASR) do not include information about residential setting (although this information is routinely collected in some jurisdictions such as NSW where the NSW MDS-DATS includes data items on usual accommodation and living arrangements).

Population surveys, such as the NATSISS, NATSIHS and NDSHS, are typically household surveys and only include people who are currently residing in households.

Crime and justice including violence, detention and imprisonment

The most comprehensive information about this element of the information framework is found in the corrections-based collections, which generally include a wide range of contextual information and substance use information. Relevant information is also available from population data sources such as the NATSIHS and NATSISS (for example, whether a victim of crime or violence).

The NT PDSDB and IDDR collections record information about drug-related arrests and drug seizures, which are other key indicators of criminal behaviour relating to substance use. However, national reporting of the IDDR does not include Indigenous status of the offender.

6.5 Intervention and treatment services

The data sources reviewed for this project were evaluated to see if they assist in describing the uptake, affordability, accessibility and appropriateness of treatment and intervention services by people with substance use issues. The project team initially explored data sources relating to a very broad range of intervention services, including health and welfare services generally (including prevention services), specialist alcohol and drug treatment services, specialist mental health services, specialist disability services, hospitals, housing support and income support, assistance through the Pharmaceutical Benefits Scheme and Medicare Benefits Scheme, telephone help lines, the criminal justice and child protection systems, and

the education and training systems. Data sources were also reviewed to establish whether it is possible to detect the involvement of substance use in mortality and coronial data.

While it is possible that the full range of these services are being delivered to people with substance use issues, only 43 data sources were identified in which it is possible to detect this target group (that is, all key data sources excluding the IDDR).

Among these key data sources, the main national substance use treatment data sources are the AODTS–NMDS and DASR. The clients of other health intervention and treatments services are described in, for example, SAR (Aboriginal and Torres Strait Islander primary health care services), BEACH (general practitioners), NSP (Needle and Syringe Program Survey), CAYLUS (youth services), NHMD/NAPEDCD (hospital and emergency department services), NCMHCD/NRMCHD (specialist mental health care in the community and residential settings) and Lifeline/KHLS (telephone counselling services). Some information is also collected about the reach of health promotion campaigns via the YACR.

However, as previously noted, the collection counts for all of these sources vary widely. For instance, the AODTS–NMDS reports on closed treatment episodes, the DASR reports at the service level, and the NHMD/NAPEDCD are based on ‘hospital separations’. This means that it is both difficult to estimate the number of people attending specific intervention service types and to compare numbers across service types.

Information about the uptake, accessibility, affordability and appropriateness of health interventions is not generally collected and is limited to a number of relevant questions about access to health services in the NATSIHS and LSIC (under development). For example, the NATSIHS asks respondents for the reasons they did not attend health services in the last 12 months even though health services were needed.

There is currently no information available about the outcome of intervention services, including specialist drug treatment services, with two notable exceptions. In New South Wales, government-funded opioid pharmacotherapy services collect information about clients using the BTOM-C. This tool collects a range of information including the frequency and quantity of substance use and dependence, at various points in the treatment cycle (for example, baseline, 12 months). The tool, developed initially by the National Drug and Alcohol Research Centre, is being trialled for use in relation to other treatment types and substances. In Victoria, all publicly funded alcohol and other drug treatment services report client outcomes according to the Significant Treatment Goal Attainment tool. The AODTS–NMDS Working Group has improvement of information about clients’ drug treatment outcomes as a high priority on its work plan and conducted a small workshop on this topic in early 2006 (see Chapter 7 for further discussion).

Information about interventions to reduce the supply of substances, particularly at the community or local level, is not readily available.

6.6 Resources

The key data sources were reviewed in terms of the information they contain about expenditure (by government or others) on services relating to Indigenous substance use. Such information was not available from the reviewed data sources, which is not entirely unexpected. Possible methods for estimating the level of government expenditure on treatment/interventions relating to Indigenous substance use could involve, for example, analysis of selected financial data from state/territory government annual reports and

inferences based on the proportions of service users of specific service types who identified as Aboriginal and Torres Strait Islander peoples.

6.7 Summary

Table 6.1 presents a summary of the gaps identified in the key data sources throughout Chapter 6. The extent to which it is desirable, feasible and realistic to address these gaps is discussed in Chapter 7.

Table 6.1: Main information gaps according to framework domain

Domain 1: Tobacco, alcohol and other drug use and associated risk behaviours	
Prevalence among the population	<p>Some minor improvements could be made to the comparability of the NDSHS, NATSIHS, NATSISS and NHS in the way they collect information about tobacco, alcohol and other drugs.</p> <p>It is not currently possible to accurately estimate the prevalence of 'other drug' use by Indigenous people in rural and remote areas.</p> <p>It is not currently possible to estimate the prevalence of substance use among the homeless (Indigenous and non-Indigenous) population who do not present for services.</p>
Prevalence among children and adolescents	<p>Information about the prevalence of substance use among children younger than 12 years of age (Indigenous and non-Indigenous) is not presently available (although it may be possible to make inferences based on information collected about the age at which substances are first used).</p>
Prevalence among women	<p>Information about the use of tobacco by women (Indigenous and non-Indigenous) during pregnancy is currently only available for five states and territories. Information about the use of alcohol and other drugs by Indigenous women during pregnancy is not available.</p> <p>Longitudinal information about Australian women's health is not available separately for Indigenous women.</p>
Prevalence among people accessing treatment for substance use	<p>There is currently difficulty in estimating the number of people (Indigenous and non-Indigenous) accessing mainstream substance use treatment services (reporting under the AODTS–NMDS) and opioid pharmacotherapy treatment services (reporting under the NOPSAD). These collections could be strengthened by the inclusion of, for example, a statistical linkage key in relation to the AODTS–NMDS, and the inclusion of a data item on Indigenous status in the NOPSAD.</p> <p>Should prevalence estimates be developed for the mainstream services covered by AODTS–NMDS and NOPSAD, these would not be comparable with the service-level estimates generated from the Indigenous-specific substance use services covered by the DASR, because of their different counting rules.</p> <p>Further work could be done to close remaining gaps in information available about drug treatment services overall (for example, in relation to clients of private treatment agencies, sobering up shelters).</p>
Prevalence among substance users not necessarily accessing treatment for substance use	<p>Prevalence information relating to petrol sniffing is available only from a limited geographic area.</p>
Prevalence among people accessing general health interventions	<p>The types of estimates available for the prevalence of substance use among Indigenous people attending various types of health service are not comparable and are generally high-level (i.e. are based on varied collection counts and do not provide information about past use or about the use of tobacco, alcohol and other drugs separately).</p>

(continued)

Table 6.1 (continued): Main information gaps according to framework domain

Prevalence among people accessing crisis accommodation support	Estimates of the prevalence of substance use among Indigenous people accessing crisis accommodation support are likely to be under-estimates and it is not possible to delineate prevalence separately for tobacco, alcohol and other drugs.
Prevalence among people in custody	Prevalence information about substance use among detained or sentenced populations is not available for all states and territories. Among the states and territories for which information is available, there is variation in the way the information is collected, including the substances for which prevalence estimates could be generated (that is, illicit drugs only in DUCO and DUMA, alcohol and other drugs in VIC-PHS, all drugs in remaining collections).
Prevalence among people who have died	The prevalence of substance use among Indigenous people who have died is likely to be underestimated using existing sources as, to be recorded, drugs need to be considered as the primary cause of death or as directly contributing to the death.
Prevalence among people accessing income support	It is not currently possible to estimate the prevalence of substance use among income support recipients.
Type(s) of substances used	Information about type(s) of substance(s) used lacks comparability across data sources.
Quantity and frequency of substance use	Information about quantity and frequency of substance use lacks comparability across data sources.
Age at which substances first used	There is quite limited information about age at which substance use commences.
Expenditure on substance use	There is limited information about expenditure on substances.
Risk behaviours associated with substance use	There is limited information about risk behaviours associated with substance use for Indigenous people at the population level. There is limited information about risk behaviours for (Indigenous and non-Indigenous) people accessing drug treatment.
Domain 2: Context and influences	
Geographic indicators among the population	Population data about the prevalence of substance use among Indigenous people living in rural and remote locations are not currently available. Sample sizes for the key population surveys relating to Indigenous substance use mean it is difficult to disaggregate data to a community level or develop other types of small area estimates of substance use.
Geographic indicator among substance users accessing drug treatment	The key drug treatment data collections do not collect information relating to respondents' geographical location.
Geographic indicators among substance users not necessarily accessing drug treatment	The IDRS-IDU and IDRS-PDI are only collected in capital cities and therefore caution must be taken if interpreting these data at a state/territory level.
Geographic indicators among people accessing health interventions	There is a lack of comparability in the geographic information collected about people (Indigenous and non-Indigenous) accessing health interventions and no indicator of the respondent's geographic location in some key data sources relating to health interventions (for example, NSP, SAR).
Geographic indicators among people in contact with the corrections system	A geographic indicator of respondents' residential address prior to incarceration or detention is not collected in most data sources.
Information about social context among people accessing treatment	There is little or no information to indicate social context among substance users (Indigenous and non-Indigenous) attending drug treatment services or other health interventions.
Information about social participation among substance users	There is little or no information to indicate the level of social participation among substance users (Indigenous and non-Indigenous) attending drug treatment services or other health interventions.

(continued)

Table 6.1 (continued): Main information gaps according to framework domain

Family and personal context and influences	<p>There is a lack of comparability in the type of information collected about family and personal context and influences across population sub-groups and collections.</p> <p>Information about family and personal context and influences is generally not available, for comparison purposes, for non-Indigenous substance users.</p> <p>Information about family and personal context and influences is not collected in relation to people (Indigenous and non-Indigenous) accessing substance use treatment or more general health interventions.</p>
Substance use context and influences	<p>Information relating to substance use context and influences is relatively limited.</p> <p>Information about the supply and sale of licit drugs (alcohol and tobacco) is limited.</p>
Domain 3: Associated harms and health status	
Mortality relating to substance use	Owing to the coding practices for mortality-related collections, it is likely that drug-related deaths are underestimated.
Suicide	Information about suicide is not routinely available in the reviewed data sources, with the exception of the NMD and NCIS.
Comorbidity of substance use and health conditions	<p>The main national drug treatment data collections do not include information about the general health status or related health conditions of people accessing treatment.</p> <p>There is limited comparability between the data sources that do record substance use and health information in terms of how this information is requested and/or recorded (for example, 'health status' or 'health conditions').</p>
Disability	<p>There is limited comparability across data sources containing disability information in the way such information is collected.</p> <p>There is no information about substance use-related disability among people attending drug-treatment or other health-related services.</p>
Substance use and pregnancy	Currently information about substance use during pregnancy (collected in the National Perinatal Data Collection) is limited to tobacco and is collected by only five states and territories.
Economic impact of substance use on individual and community	There is very little information available about the economic impact of substance use at either the individual or community level.
Homelessness	<p>There is very limited information about substance use among homeless people.</p> <p>National drug treatment data sources (AODTS–NMDS and DASR) do not include information about the residential circumstances of individuals.</p>
Crime and justice	Indigenous status is not nationally available for drug-related arrests.
Domain 4: Intervention and treatment services	
Intervention and treatment services	<p>Information about uptake, accessibility, affordability and appropriateness of health intervention services is very limited.</p> <p>Information about interventions to reduce the supply of substances is not readily available.</p> <p>Outcomes of intervention services, including drug treatment services, are not currently available nationally.</p>
Domain 5: Resources	
Information about resources	Information about resources applied to substance use services is extremely limited and essentially restricted to information about staff numbers collected in DASR.

7 What are the information gaps and how do we fill them?

7.1 Introduction

The last decade has seen considerable improvements in the availability of information about substance use (particularly illegal drug use) among Aboriginal and Torres Strait Islander peoples. Over this period considerable research has been undertaken, and published, providing a better picture of the scale of the problem, the consequences of substance use, and interventional approaches proposed and used to prevent and treat substance abuse among Aboriginal and Torres Strait Islander peoples. There have also been ongoing efforts, by national, state/territory and local groups with responsibility for Indigenous health, Indigenous information and data development, and drug and alcohol issues for Aboriginal and Torres Strait Islander peoples, to improve the quality and availability of relevant information.

However, as we have highlighted in the preceding chapters of this report, the picture remains incomplete in many important respects (see Table 6.1).

It is known that there are patterns of substance use which are of particular concern among Aboriginal and Torres Strait Islander peoples (for example, higher prevalence of inhalant use, increasing prevalence in use of injectable drugs such as heroin, and use of amphetamines). A picture is also emerging of the higher rates of adverse effects from substance use among Aboriginal and Torres Strait Islander peoples, including the significant mortality and years of life lost due to substance use (see Chapter 2 and Appendix 1). For example, Arnold-Reed and colleagues (1998), using Western Australian mortality data from 1991 to 1995, estimated that, with a combined elimination of tobacco smoking and unsafe alcohol use, Indigenous life expectancy would increase 5.9 years for males and 3.4 years for females to 64.4 and 68.7 years respectively.

Improvements in the interventions (at the primary, secondary and tertiary levels) used to prevent, treat and combat substance use have the capacity to reduce the prevalence of substance use and ameliorate these adverse effects, and have a significant effect on life expectancy. High-quality information about the nature of the problem and the effectiveness of various interventions would greatly assist in planning, implementing, monitoring and evaluating such interventions and the associated improvements in the health and circumstances of Aboriginal and Torres Strait Islander peoples.

Similarly, a better understanding of the contextual factors impinging on the prevalence and patterns of substance use including, for example, living arrangements, employment opportunities, family stressors and the supply of drugs, would assist in better understanding the success or otherwise of interventions to reduce the supply of, and demand for, substances and the harms associated with substance use.

Chapter 7 is the conclusion to this report, in which we draw together the information gathered from the literature review, stakeholder workshop and analysis of data sources. Section 7.2 summarises the priority information needs and main information gaps in relation to substance use by Aboriginal and Torres Strait Islander peoples and Section 7.3 presents a series of options for improving the availability of information in this area and making better

use of the information that already exists. These options are also presented in numbered format in the report summary.

7.2 Priority information needs and the main information gaps

Sorting priorities

From the literature review and the discussion in the workshop, it is clear that the broad, five-domain framework of Table 1.1 developed for the project (see Chapter 1) is a useful depiction of the information needed to understand and develop policies for substance use among Aboriginal and Torres Strait Islander peoples. Besides substance use and immediately related harms and interventions, personal, social and community factors are all also relevant to the issue.

The key questions and information needs for the field, as detailed in Section 4.1, are broad, spanning all domains from the framework, and the task of prioritising them is a difficult one. While all the information needs appear to be important, reflecting the diverse range of interests relating to this topic, there is some information that is fundamental to understanding the nature of substance use among Indigenous people. This is information that enables substance use and Indigenous status to be consistently recorded, and thus basic prevalence estimates of various types of substance use across locations and population groups to be developed. Limitations in this highest priority information reduce the usefulness of the remaining information about, for example, patterns of substance use, contextual factors and access to services.

Within the broad framework (Table 1.1) and the related key questions, it is possible to identify priority areas for action. This chapter attempts to narrow down information needs, gaps and recommendations to those that are:

- essential, in the sense that without them progress cannot be made
- practical, in the sense that implementation is feasible
- least burdensome to data providers, including survey participants and
- most likely to ‘make a difference’; while the November workshop participants wished to see improvements in information, they wanted a focus on those that would support action.

Main information gaps or deficits

Based on the above criteria, the main information gaps or deficits are outlined below. We first outline the main information gaps in relation to the key questions, before presenting a set of broader information gaps. It should be noted that the limitations applying to prevalence data follow through to the capacity of information sources to answer all other questions. For instance, without high-quality identification of Indigenous substance users across data sources, it is not possible to accurately describe the related contextual factors and associated harms.

Gaps relating to the key questions

What is known about the nature or patterns of substance use among Indigenous peoples?

Some improvements in population survey data are needed. Population survey data provide prevalence rates for selected populations (and associated contextual information to varying

degrees) and allow changes in these prevalence rates to be monitored over time. Australia has a number of relevant population surveys (in particular the NDSHS, NATSISS and NATSIHS), which together provide information about substance use and related personal, contextual and community factors. However, while reliable national estimates of alcohol and tobacco use among Aboriginal and Torres Strait Islander peoples are available, such estimates are not available for the use of other drugs. Specifically, the usefulness of prevalence information at the population level is currently limited in the following ways:

- There is room for some improvement in the comparability between population surveys relating to Indigenous substance use (NATSISS, NATSIHS, NHS) and substance use generally (NDSHS).
- The Indigenous sample size in the key population survey on drugs (NDSHS) does not support disaggregated analysis in relation to Indigenous people (for example, by age, characteristics, state/territory).
- The NATSIHS and NATSISS can not generate reliable estimates of the prevalence of 'other drug' use for Indigenous people living in rural and remote areas.

Prevalence information from other data sources also has limitations:

- There is incomplete information about substance use during pregnancy (for Indigenous and non-Indigenous women).
- Information about the number of *people* (Indigenous and non-Indigenous) in substance-use treatment and health interventions is generally not available.
- Prevalence information about substance use among people (Indigenous and non-Indigenous) in custody is well developed but could be improved in terms of completeness and comparability across data sources.

Information about patterns of substance use among Indigenous people (for example, types of substances used, quantity and frequency used, age first used, expenditure, associated risk behaviours) is limited and lacks comparability across data sources (including population and other data sources, such as surveys and administrative data collections). In particular, information about substance types of particular interest to Indigenous people (for example, petrol and glue sniffing, chewing tobacco, kava) is limited.

What is known about the characteristics of Indigenous substance users and their contextual factors?

There is a lack of comparability in the contextual information available about substance users in the Australian population overall (NDSHS) and the Indigenous population (NATSISS, NATSIHS). This lack of comparability in information about contextual factors also exists across the broader set of data sources reviewed (that is, relating to drug treatment services, health services and corrections).

Information about contextual factors is not available nationally for people accessing drug treatment services or other health interventions.

Information on supply of licit drugs – local, regional and national patterns – is another gap and is important for identifying existing and, particularly, changing and emerging patterns of drug use. Data on the sale of licit drugs (alcohol and tobacco) is collected in some states and territories but a national collection is not currently available (for example, data on alcohol sales, once collected on a national basis, is now restricted to Queensland, Western Australia and Northern Territory). Information on the supply of illicit drugs may span a broad spectrum of sources, from drug seizures data collected at the State/Territory (for example, NT PDSDB), national level (for example, IDDR) to local level knowledge provided

by key experts (for example, IDRS-IDU). Such information is not currently collected systematically in relation to supply issues affecting Aboriginal communities (see emerging issues below).

What is known about the harms associated with substance use by Indigenous peoples?

There is limited reliable information about substance-related deaths among Indigenous and non-Indigenous people.

Information about comorbidities associated with substance use or general health status of substance users is not available for people (Indigenous and non-Indigenous) attending drug treatment services.

Information about individual expenditure on substance use is not generally available, making it difficult to explore the financial impact on individuals or at the community level.

Information about substance use among Aboriginal and Torres Strait Islander peoples in custody could be strengthened in terms of its coverage and comparability.

What is known about the affordability, accessibility and appropriateness of current approaches for intervention and treatment of substance use in Indigenous persons?

Information about the uptake, accessibility, affordability and appropriateness of substance use treatment services and other health interventions is very limited (for Indigenous and non-Indigenous people).

In terms of treatment, prevention and intervention, what is working well and why is it working? What extra measures/initiatives could make a difference?

Information on treatment services and other interventions – availability, location and (in particular) the effectiveness of treatment services and other interventions – are important gaps. ‘Interventions’ may include education/information, health promotion programs and activities, and communication. Knowing ‘what works’ and why, and alternatively ‘what doesn’t work’ and why not, is a pre-requisite to selecting, planning and locating appropriate interventions.

There is no national information about the outcomes of intervention services, including substance use treatment services (for Indigenous or non-Indigenous people). There have been efforts at the state and territory level to measure outcomes (for example, New South Wales has implemented the BTOM-C for public prescribers under its opioid pharmacotherapy program and Victoria has implemented the Significant Treatment Goal Attainments process across all mainstream substance use treatment services), but these measures are not currently developed or agreed for the broader range of service and substance types and/or not likely to be suitable for national adoption and reporting.

Information about interventions to reduce the supply of drugs, particularly at a community or local area level, is not readily available.

What is known about expenditure relating to treatment and other interventions?

Information about government or individual expenditure on treatment or other interventions is not readily available (for Indigenous and non-Indigenous substance use-related interventions).

General or overarching gaps

Emerging issues are not well identified by most data collection vehicles, the exception being the IDRS which uses ‘key experts’ to identify emerging trends in illicit drug markets. There

are many key figures in Aboriginal communities who are aware of critical information about emerging trends—for instance, changes in the local drug market or supply chain, changes in drug availability or new drug use patterns or escalation of risk (for example, sharing becomes riskier when injecting rather than inhaling is the method of use). Capturing this information in a systematic and timely way would enable prevention or intervention programs and responses to be much more rapidly and effectively mounted.

Cross-cutting information is scarce. The broad nature of the framework (Table 1.1) reflects that drug use is just one aspect of personal and community health and is related to many others. There is a great need for information and data that ‘talks across’ policy and service sectors—for instance about substance use and housing, homelessness, corrections, drug education and school programs and interventions. Such information would support a whole-of-government approach to drug use and related matters. Privacy issues would need to be considered if the methods to address this gap had such implications.

There is interest in community-level information. Much of the information needed to inform this topic is needed not only at an individual level but also at a community level (that is, where the ‘unit of analysis’ is the community rather than the individual). Profiles of communities—in terms of economic and geographic descriptors, risk factors and community resources—could contribute to understanding drug use trends and risks, and in identifying areas where intervention is most needed and lessons that could be learnt.

Administrative data sources are diverse. Some administrative data sources have the capacity to produce richer data (for example, Aboriginal and Torres Strait Islander primary health care and substance use services). Others contain limited information about substances, include information about substances, but limited information about contextual factors, and/or use data items that do not correspond to those in other collections or national data standards.

Information dissemination in different formats, to suit different users, is needed. For instance, information provided back to communities might assist them to answer *their* key questions.

Data quality, in particular Indigenous identification in relevant surveys and administrative data collections, remains a high priority. Without improvement, the potential value of many data sets is jeopardised or lost. While efforts to improve data quality can seem a difficult and longer-term option, the improvement of Indigenous identification in key collections is critical to the useability of many existing data sets.

At the workshop, indicators were seen as an area where there was a great deal of activity but perhaps not yet agreement on key high-level indicators of ‘problem’ and ‘outcome’. There was agreement, however, that further work on such key indicators could be more effectively done via the existing national structures (for example, work under way by SCATSIH and OATSIH on Aboriginal and Torres Strait Islander health indicators).

7.3 Options for improvement and better use of existing sources

Options for improving and making better use of existing data sources are detailed below. These options are further summarised in the report summary.

Prevalence and related issues—population surveys

Indigenous population surveys

The Australian Bureau of Statistics' NATSIHS and NATSISS are good vehicles to accommodate future population data requirements. These are multidimensional surveys that are not specifically designed as substance use surveys and cover a wide range of topics. They are national surveys based on more representative samples than the other sources considered in this report. The two surveys have only minor inconsistencies in the way they collect information about substance use (in relation to the alcohol measures) and provide complementary information on contextual factors (for example, the NATSISS collects information on involvement in social or recreational activities and perceptions of neighbourhood or community problems; the NATSIHS collects information on health status, access to health services and health risk factors; both surveys collect a range of other contextual information, including information about cultural identification and forced removal from natural family). The surveys are each conducted every 6 years, meaning that new information is available from one or the other on a 3-yearly cycle.

Further effort is needed to improve the prevalence estimates of 'other drug' use among Indigenous people living in rural and remote areas. There are difficulties associated with collecting accurate data on drug and alcohol use because of sensitivity issues, and these become even more complex in remote areas. The ABS approaches these complexities through the use of facilitators and translators for interviewing in surveys of Indigenous people and has developed strategies for communication within communities. The experience of a number of researchers who have carried out epidemiological studies in remote communities may further inform the development of improved methods of studying and surveying remote communities in future (see for example, Clough et al. 2002a on trafficking of cannabis in Arnhem Land). Continued efforts are also needed to balance the need to allow for diversity within Indigenous populations against the need to produce prevalence estimates based on nationally consistent concepts.

In relation to all population surveys, there is a need to continue and expand on the considerable efforts already made to: more appropriately define the concept of 'household' in a way that accommodates cultural differences; improve methods of obtaining information in culturally acceptable ways; improve information about substance use patterns among Indigenous people living in rural and remote locations; and improve the comparability of information across population surveys (for example, NATSISS, NATSIHS, NHS and NDSHS). To support such developments, existing advisory and consultative processes should be maintained and, if necessary, enhanced.

A useful first step towards improving comparability between the NDSHS, NATSIHS and NATSISS may be to review the existing alcohol and drug modules in the surveys in the light of the identified information needs and the gaps highlighted in this report in existing sources. This would be the first step towards developing a drug-specific survey supplement ('drug-specific data module') for Aboriginal and Torres Strait Islander peoples responding to population surveys. This work would need to complement work already underway by the ABS on alcohol consumption and tobacco smoking as part of its Review of Strategic Statistical Issues for Future National Health Surveys (ABS 2005b). Efforts to improve comparability would also need to take into account concerns raised by some academics regarding the estimates of Indigenous alcohol consumption generated from the 2002 NATSISS (see Chikritzhs & Brady 2005).

Development for the 2008 NATSISS starts in 2007, while the next NATSIHS is scheduled for 2010–11. It will be desirable to have planned, or begun the specific developmental work on, substance use data requirements before the overall processes commence for these surveys, to ensure it fits into the ABS timetable and can be considered for inclusion in future surveys.

Other population surveys

The NDSHS provides detailed information about substance use in the Australian community. The NDSHS is currently the most comprehensive survey on Australian substance use issues, with respondent numbers increasing to 30,000 for the 2004 survey. However, the number of Indigenous people included in the survey is low, with 463 people in the 2004 survey identifying as Aboriginal and/or Torres Strait Islander people (AIHW 2005b). The size of this sample means that national prevalence estimates can be generated for tobacco, alcohol and selected other drugs, but further analysis of, for example, prevalence rates among different age groups or in different states and territories, is not possible. As noted in Chapter 6, results from the NDSHS are subject to potential response bias and coverage issues due to its response rate (46% in 2004) (AIHW 2005f).

One option for improving data in this survey is to investigate improvements to the methodology of the survey, to allow better estimates of prevalence of Indigenous substance use and related factors. As the next NDSHS is scheduled for 2007, pursuit of this option would need to commence rapidly.

Population survey drug use module

There is considerable merit in developing a drug-specific data module for use in population surveys (a drug-specific survey supplement to existing surveys). Such a module would need to pick up the sorts of information collected in the NDSHS, ensuring comparability between the NDSHS, NATSISS and NATSIHS. The structure of the module should, however, be flexible enough for use in other population surveys, such as the National Health Survey (NHS) and National Survey of Mental Health and Wellbeing. For example, a drug-specific data module could be developed in such a way that data items could be adopted at varying levels of detail, depending on the purpose or constraints of the collectors or respondents.

Most importantly, any drug-specific data module developed for use in Indigenous population surveys would need to suit the needs of Indigenous people, including focusing on substances of particular significance to Indigenous people and, if appropriate, ensuring that relevant contextual factors (for example, forced removal from natural family) are included.

A draft drug-specific data module could be rapidly developed, based on the work done for this report.

Contextual factors

There is interest and value in collecting information about the contextual factors associated with Indigenous and non-Indigenous substance use (and non-use). Development of a brief module outlining the priority contextual factors (as per Table 1.1) for collection could be used to increase consistency across population surveys and other data sources. For example, many of the data items typically used to indicate social context (for example, living arrangements, residential setting, marital status) and social participation (for example, labour force status, education status) are already collected in most population surveys and many other surveys and administrative data sources, but not necessarily according to

available nationally defined data standards. Data items for collecting such contextual information could be included in a drug-specific data module.

Administrative and services data

Administrative data from Indigenous-specific services

Participants at the November 2005 workshop considered that there was a wealth of information collected in the course of delivering services such as the Aboriginal and Torres Strait Islander primary health care and substance use services, and that these data are under-utilised. Some data are extracted, at establishment level, and transmitted to DoHA for the SAR and DASR collections. These collections have been under review.

There is potential, however, to mine the client-level data to analyse patterns of client profiles, related service provision and, potentially, outcomes. Consideration of options for such analysis would require attention to privacy and confidentiality issues, for both the services' and clients' data. Alternatively, client-level data could be used in consolidating collation and analysis, perhaps involving the development of a Minimum Data Set. Principles for Indigenous research and data collection (specified, for example, in the National Health and Medical Research Council's 'Criteria for Health and Medical Research of Indigenous Australians') would guide any resulting proposal. Similarly, any proposed changes to administrative data collections would need to be implemented in accordance with agreed protocols such as the 'National Aboriginal and Torres Strait Islander Health Protocols for the Routine Collection of Standardised Data on Aboriginal and Torres Strait Islander Health' (1997).

More generally, the experience of the Aboriginal and Torres Strait Islander primary health care and substance use services could guide the development of the proposed drug-specific data modules for surveys and other collections. The reverse is also true: that the development of drug-specific data modules could guide any proposed analysis of data from Aboriginal and Torres Strait Islander primary health care and substance use services.

Administrative data from mainstream alcohol and other drug treatment services

It is not possible to accurately quantify the number of people receiving treatment across the spectrum of specialist alcohol and other drug treatment services. The difficulty in obtaining this information relates largely to the scope (for example, exclusion of pharmacotherapy services from the AODTS-NMDS), methodology (particularly counting rules), and quality of Indigenous identification in the key national collections in this area (DASR, AODTS-NMDS and NOPSAD). For example, mainstream alcohol and other drug treatment services (reporting under the AODTS-NMDS) report in terms of closed treatment episodes and Indigenous-specific substance use services (reporting under the DASR) provide service-level estimates of client numbers. Information about people receiving opioid pharmacotherapy treatment is reported separately, in aggregate form, via the NOPSAD collection.

Currently, information about the basic demographic characteristics of people accessing mainstream alcohol and drug treatment services (reporting under the AODTS-NMDS) is available, but there is no further information on contextual factors at a national level. Very little information is available about the characteristics or contextual factors of people accessing opioid pharmacotherapy programs (reporting under the NOPSAD data collection).

One option for improving information on the numbers of people accessing mainstream drug and alcohol treatment services is to introduce a statistical linkage key into the existing AODTS-NMDS to estimate the number of people attending treatment services. A statistical

linkage key would also enable estimation of the numbers and types of treatment episodes per person.

An option for improving contextual information about people attending AODTS–NMDS programs is to introduce additional nationally defined data items, such as living arrangements, income source and employment status (as per the existing New South Wales Minimum Data Set for Drug and Alcohol Treatment Services), or select priority data items from a drug-specific data module, if developed.

It should be noted that improvements to the AODTS–NMDS may not significantly improve the availability of information about Aboriginal and Torres Strait Islander peoples in treatment as most Indigenous substance users attend Indigenous-specific substance use services (reporting under the DASR).

Clearly any changes to existing data sources, such as the AODTS–NMDS, have resource implications, including the need to promote changes and train staff in the collection of new data items. In addition, introducing new data items, particularly a statistical linkage key, requires special attention in terms of promoting the security of its collection in relation to privacy legislation and issues.

Corrections

Information about substance use and contextual factors is relatively well developed in relation to people in custody (for example, DUCO, DUMA, NSW-IHS, VIC-PHS, QLD-WPHS). Given that this population is clearly one at high risk of substance use and further associated harms, and given the relatively high feasibility of improving data in this area, this seems an ideal area to pursue a greater level of comparability across data sources (for example, in the collection of information about substance use and contextual factors). This area could also benefit from the development of data modules for substance use and contextual factors suggested above.

Environmental scan of emerging issues

As previously noted, emerging issues are not well identified, in a timely way, by existing data collection vehicles. A method is needed to capture critical information about emerging trends, of which many key figures in Indigenous communities are aware. Designing a suitable methodology would, of course, entail reaching agreement on who those ‘key figures’ are. Gathering and collating this information in a systematic, ethically appropriate and timely way would enable prevention or intervention programs and responses to be much more rapidly and effectively mounted.

Community leaders would need to be involved in developing an appropriate method, along with key researchers who have pioneered ethical and effective research methods acceptable to Aboriginal communities. Existing relevant committees, such as the NIDAC, would also play a key role in the development of an acceptable and effective proposal.

Lessons could be also learned from the ‘mainstream’ drug field. The Illicit Drug Reporting System attempts to act as an early warning system for illicit drugs, by identifying emerging trends in illicit drug markets, locally and internationally.

This proposal received strong support from workshop participants who considered that it had the potential to significantly improve communities’ and policy makers’ ability to respond in a more timely way in this sometimes rapidly changing field.

Understanding outcomes

One of the most significant data gaps identified in the literature and at the workshop resonates with a significant gap in the drug field more generally – routine information on the outcomes of interventions. Developing and defining outcome measures is a complex, yet valuable, undertaking. It requires careful consideration of the most appropriate way to evaluate the success of treatment options, as well as cultural interpretations of that success and inherent differences between individuals and their likelihood of responding to treatment. Defining outcomes for primary interventions, such as the establishment of recreational programs for young people, and primary/secondary interventions, such as the establishment of out-stations (for petrol sniffers in particular), is also of interest (see Chapter 2 and Appendix 1).

The IGCD Alcohol and Other Drug Treatment Services NMDS Working Group set aside a day to workshop alcohol and other drug treatment outcome measures in early 2006. The workshop highlighted the complexity in developing outcome measures that are relevant for different substance types, service types and service settings, as well as for particular population groups, such as Aboriginal and Torres Strait Islander peoples, women and youth. There are currently widely varied practices in each of the states and territories, ranging from no available information on treatment outcomes (most) to the collection of data according to a multidimensional clinical tool (BTOM-C) in publicly provided pharmacotherapy services in New South Wales. An attendee at the outcomes workshop, also an invitee from the November workshop on this project, made an important point about developing outcomes in relation to substance use among Aboriginal and Torres Strait Islander peoples. He noted the need to explore ‘what wellness looks like to Aboriginal and Torres Strait Islander peoples’ and ensure that this concept of wellness or idea of ‘what life should be like’, is reflected in specified outcomes at the community level and therefore reflected in what measures should be used to indicate progress towards these outcomes.

The outcomes workshop identified a range of options for furthering work in the area of drug treatment outcomes for people accessing AODTS-NMDS. It is planned that this area of work will be progressed through discussions between the IGCD AODTS-NMDS Working Group, the DoHA (which funds the AIHW to coordinate the collation, analysis and publication of national data under the AODTS-NMDS) and the IGCD.

Mortality data

The coding of data about deaths (NMD, NCIS) is likely to underestimate the involvement of substance use in Indigenous and non-Indigenous deaths. However, efforts to alter coding practices are unlikely to achieve as much success as other methods for improving information in this area. Rather, there is scope to increase the availability of information based on attributable fractions and related methodology (whereby the number of deaths or years of life lost due to specific risk factors or diseases is estimated) (see, for example, Arnold-Reed et al. 1998 study referred to above and in Chapter 2). The AIHW is currently in the process of estimating the number of deaths, and burden of disease, attributable to alcohol, tobacco and other drugs for all Australians and future work is planned to determine estimates for the Indigenous population (see Appendix 1).

‘Modules’ and promoting ‘cross-cutting’ whole-of-government information

‘Whole-of-government’ information requires a commitment to a reasonable degree of consistency across related administrative data collections, population and other surveys.

Modules, for use in administrative data sets and surveys, represent a key way of making better use of existing data collections and ensuring consistency. Workshop participants particularly supported the inclusion of a drug-specific data module or set of questions in administrative data sets covering mainstream programs.

Drug-specific data modules could be developed in parallel for mainstream drug-specific collections (for example, the AODTS–NMDS, data collected and reported through Aboriginal and Torres Strait Islander primary health care and substance use services, and for more generic collections, such as the Juvenile Justice National Minimum Data Set, National Prisoner Health Minimum Data Set and the SAAP–NDC. Such a module or modules would enable specific, core information to be collected across sectors, and hence provide a more detailed picture of the use of health and community services by Aboriginal and Torres Strait Islander peoples (and non-Indigenous people) who have used, or currently use, substances. Importantly, any data module should be designed so that it can be used at various levels of detail, depending on the environment.

Accurate Indigenous identification within these collections is a pre-requisite to their efficacy. Modules and other efforts to improve comparability among collections will not yield useable information unless Indigenous clients are accurately identified (see also below).

It would be important that modules incorporated into collections are asked of all relevant clients or respondents and not only Aboriginal and Torres Strait Islander peoples.

Data quality and Indigenous identification

Without accurate and complete reporting of Indigenous status, the value of many data sets and their relevance to Indigenous people is lost. Considerable effort has been made in the health and community services sectors to improve data quality in this regard, but much remains to be done. In particular, there needs to be examination of the methods that best capture data on Aboriginal and Torres Strait Islander peoples. Similarly, continued efforts are needed to eliminate the use of methods that are not good practice for collecting Indigenous status, such as using a default of ‘non Indigenous’ where Indigenous status has either not been requested or not provided.

One of the prime objectives of the NAGATSIHD is to improve Indigenous identification among all health-related data sources. Further efforts could be made to support this NAGATSIHD process, for instance, via regular reporting of identification rates and seeking the Group’s advice on how to improve these rates and other aspects of data quality. It should be noted, however, that the ultimate responsibility for improving the rates of Indigenous identification rests with data providers and data custodians.

Community-level information

Community-level information can be assembled in a number of ways – by aggregating upwards from individual information (for instance to describe unemployment in a region); by describing features of geography (for example, distances from major towns or employers); by using aggregate regional indicators (for example, of transport or of economic activity in a region); or by recording features of the administrative structure (for example, council policies, initiatives and powers, role in alcohol control or distribution). Better use may also be made of existing smaller-community and regional-level collections such as the Queensland Alcohol Management Program data and the recently commenced project on ‘Reducing alcohol-related harm in rural communities’ (Shakeshaft et al. forthcoming).

The purpose of assembling such information would be to identify communities at risk and also 'strong communities'. It may, for instance, give insights into community attributes associated with better health status of people living in a given area. The challenges would include the variability in the relevant factors across Australia and the need to balance local relevance with design costs, and the need for some level of comparability.

Further work is required to consider the scope of community-level indicators that would be both informative and feasible to collect, and to consider issues such as privacy and sensitivity around the presentation of information from small communities.

Dissemination

Dissemination of information can be in many formats, transmitted in a number of mediums and designed for a number of audiences. There was a suggestion from the workshop that dissemination is uneven, in terms of being designed more for central policy makers and researchers. Formats and media suitable for local policy makers were considered to need more emphasis, as was the process by which information is disseminated back to the community, including its content and timeliness. This would represent another important way in which better use could be made of existing information, so that the information can be used by the communities.

Synthesis of information already available

There are a large number of sources of data that include information, or touch upon, substance use among Aboriginal and Torres Strait Islander peoples. The value of synthesising available data was recognised as high priority by workshop participants, who wanted to ensure value for effort (in terms of the effort already expended on these data sources) and the possibility of promoting earlier action (given the lead-time for some of the development required to 'fill gaps'). A synthesising analysis could use the framework of this study (Table 1.1), and provide further discussion of key questions and information gaps, and the information about data sources. Any approach would require a considered methodology to ensure meaningful interpretation of different data sources is achieved.

Two options for presenting such analyses were highlighted at the November workshop:

- Explore the feasibility of including a special chapter on Indigenous substance use in the next publication of *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples* report (ABS & AIHW 2005). This report is a biennial report, jointly prepared by the ABS and AIHW.
- Develop a stand-alone report involving a more detailed synthesis of available information, based on the framework for this study and drawing on the literature and data sources described throughout the study. Such a project could involve exploring substance use and non-use among Indigenous and non Indigenous people, using available information.

Considerable work would be involved in implementing either of these options, at least in part due to the information gaps and effort required to synthesise information from data sources with, for example, varied methodology, scope, frequency and counting rules.

Such a report outline would need to be developed in consultation with peak advisory bodies such as NAGATSIHID, NACCHO, SCATSIH and NIDAC to ensure that the report informed, wherever possible, priority questions of interest and was presented and disseminated in a way that maximised its usefulness to Indigenous people.