Prison-based treatment for alcohol and other drug use for Aboriginal and non-Aboriginal men

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Prison-based treatment for alcohol and other drug use for Aboriginal and non-Aboriginal men

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Three-quarters of people in prison have a history of hazardous use of alcohol and other drugs (AoD), yet there is a paucity of research into AoD use and prison-based treatment. This lack of prison-based AoD research exists despite the enormous body of research conducted over many decades into problematic AoD use generally in Australia. This research project adds to the limited evidence base for prison-based AoD treatment within Australia. It may also be of international relevance: given its focus on Australia's Indigenous (Aboriginal and/or Torres Strait Islander[1]) peoples, the knowledge gained here could be useful in informing approaches to these issues for Indigenous/First Nations peoples in other countries.

Theoretically, under the principle of equivalence of care (1), people in prison should receive health care to the same standard as they could access in the community. As Australia has a universal health care system, the full spectrum of health services should be available, including those for AoD use problems. However, this is not the case. The principal aim of this research is to inform better provision of AoD treatment services for people in prison in Australia. The research has a focus on Aboriginal people because, as is made clear within the thesis, this group is vastly over-represented in Australian prisons.

While both quantitative and qualitative research methods have been utilised in this project, the primary methodology used for data collection and analysis is qualitative. Chapter One provides an overview of the research and its significance and potential benefits. Chapter Two examines the Australian and international published research into prison-based AoD treatment. Chapter Three describes the extent of AoD use and harms among prisoners in the state of New South Wales (NSW), which highlights the need for the availability of effective AoD treatment programs. Chapter Four describes the qualitative methodology used and the characteristics of the participants in the research. Chapters Five, Six and Seven then outline the histories and AoD treatment experiences of participants, and the resultant findings. In Chapter Eight, the research questions are revisited, and conclusions are drawn.

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[1] Aboriginal and/or Torres Strait Islander is used interchangeably with Indigenous.

ORIGINALITY STATEMENT

'I hereby declare that this submission is my own work and to the best of my knowledge it contains no materials previously published or written by another person, or substantial proportions of material which have been accepted for the award of any other degree or diploma at UNSW or any other educational institution, except where due acknowledgement is made in the thesis. Any contribution made to the research by others, with whom I have worked at UNSW or elsewhere, is explicitly acknowledged in the thesis. I also declare that the intellectual content of this thesis is the product of my own work, except to the extent that assistance from others in the project's design and conception or in style, presentation and linguistic expression is acknowledged.'

Signed

Date

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Abstract

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List of Acronyms

AA	Alcoholics Anonymous
AIHW	Australian Institute of Health and Welfare
AoD	Alcohol and other drugs
AUDIT	Alcohol Use Disorders Identification Test
CBT	Cognitive behaviour therapy
CCT	Clinical controlled trial
CSNSW	Corrective Services New South Wales
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th edition
IDATP	Intensive Drug & Alcohol Treatment Program
IPDE	International Personality Disorders Examination
JMCC	John Morony Correctional Centre
K10	Kessler Psychological Distress Scale
LSI-R	Level of Service Inventory – Revised
NA	Narcotics Anonymous
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NDARC	National Drug and Alcohol Research Centre
NDSHS	National Drug Strategy Household Survey
NHMRC	National Health and Medical Research Council
NIDAC	National Indigenous Drug and Alcohol Council
NSW	New South Wales
OMMCC	Outer Metropolitan Multi-Purpose Correctional Centre
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
RCT	Randomised controlled trial
TBI	Traumatic brain injury
TC	Therapeutic community
UNSW	University of New South Wales

Chapter One: Introduction and Background

1.1 Introduction

Treatment for alcohol and other drug (AoD) use is available in Australian prisons, but there has been limited published research into such prison-based treatment in Australia (2, 3). Contact with the justice system, including imprisonment, presents an opportunity to deliver AoD treatment to a group that may otherwise be difficult to reach who are in need of such treatment. This is the premise upon which this research was based, and the research presents a way forward to help address problematic AoD use within this population.

Research over the past decade has found that 75% of all those entering prison in Australia had used alcohol and other drugs at hazardous levels, with similar numbers of Indigenous and non-Indigenous people having done so (4, 5). Hazardous AoD use is more pronounced among Indigenous Australians within the general population, with drug and alcohol use identified as a leading contributing factor in Indigenous imprisonment (6). Consequently, there is a focus in this research on Indigenous people because this group is vastly over-represented in Australian prisons compared to other Australians, with an incarceration rate of 2,038.6 per 100,000 compared to 162.8 per 100,000 population in 2016 (7).

1.2 Background

1.2.1 Policy framework for alcohol and drug use in Australia

The overuse of alcohol and other drugs contributes significantly to poor health as well as social dysfunction. To address the health and social harms from illicit drug use Australia adopted a Harm Reduction Strategy which has three principles: 1) to reduce the demand for illicit drugs; 2) to reduce the supply of illicit drugs; and 3) to minimise the harm caused when using illicit drugs (8). The Harm Reduction Strategy broadly applies also to harms from alcohol.

1.2.2 Alcohol and other drug use in Australia

The National Drug Strategy Household Survey (NDSHS), which has been conducted every two to three years since 1985, is a confidential survey of the self-reported alcohol and drug use of Australians 14 years of age and older. It is possibly the most commonly used and cited source of information when trying to develop an understanding of AoD use nationally (9). The 2016 NDSHS reported that, for alcohol use, 31% of Indigenous Australians and 23% of non-Indigenous Australians had not consumed alcohol in the previous 12 months. However, a comparison of those Indigenous and non-Indigenous people who did consume alcohol showed that 35% to 23% (respectively) had done so at levels that placed them at risk of alcohol–related harms (9).

The 2016 NDSHS further reported that 10.4% of Australians had used cannabis in the previous 12 months, with Indigenous Australians being 1.9 times more likely to have used cannabis. While 1.4% of survey respondents reported recent use of meth/amphetamines, Indigenous Australians where 2.2 times more likely to use meth/amphetamines than were non-Indigenous Australians. The NDSHS also reported that 0.2% of respondents had used heroin recently, however, there was no comparison provided between Indigenous and non-Indigenous Australians (9).

A limitation of the NDSHS is the small sample size of Indigenous Australians. The 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) draws on a much larger sample size and estimates harmful alcohol consumption in each age group and by sex (10).

Table 1.1: NATSISS 2008 Chronic risky/high risk alcohol consumption 15 years and over by sex (page 142)

Age group (years)	Male	Female
15–24	18.6	14.3
25–34	20.6	17.1
35–44	27.1	17.6
45–54	20.9	13.1
55 and over	13.5	6.5

NATSISS 2008, reported that overall 27% of Indigenous Australians had not consumed alcohol in the previous 12 months and that 73% had consumed alcohol (10). With 17% of Indigenous persons aged over 15 years had an alcohol consumption patterns that was risky/high-risk during the previous 12 months. The NATAISS reported that 15.5% of Indigenous people had used cannabis in the past 12 months and that 3.6% had used amphetamine/speed in the last 12 months. There was again no figure provided for heroin use (10).

These findings, together with those from the NDSHS, indicate that while there are more Indigenous than non-Indigenous Australians abstaining from alcohol use, a greater proportion of those who do consume alcohol do so at risky/harmful levels than non-Indigenous Australians. This has been a consistent finding over many decades. The other consistent finding is that a larger proportion of Indigenous Australians use cannabis than do non-Indigenous Australians. While the proportion of Indigenous that use meth/amphetamines is small, it also seems likely that more Indigenous than non-Indigenous Australians do so.

1.2.3 Alcohol and other drug use history of prison inmates

A history of hazardous AoD use is common among men and women in prison, with many inmates reporting they had been under the influence of alcohol and/or other drugs at the time of their offence (5, 11, 12). A 2010 study found that an estimated 85% of the inmate population in the United States of America (USA) either met the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) criteria for a substance abuse disorder or their offence was substance use related (20%) (12, 13). Similarly, in 2012, more than half the European Union prisoner population reported illicit drug use prior to prison, highlighting the strong relationship between illicit drug use and crime (11).

In Australia, the 2009 NSW Inmate Health Survey reported that 62.6% of men had consumed alcohol at harmful levels (as defined by the Alcohol Use Disorders Identification Test (AUDIT, Appendix 1), and 42.1% of men had used illicit drugs daily or almost daily prior to prison, with significant numbers also reporting polysubstance use (5). Daily/almost daily illicit drug use (including injecting drug use) in the year before prison was more common among Indigenous men (51%) compared to non-Indigenous men (38%), with cannabis being the most commonly used illicit drug for both groups (5). Despite the over-representation of illicit drug use among prisoners, relative to the general population, the most commonly used substance among inmates is nicotine, with 83% of Indigenous and 71% of non-Indigenous men reporting being a current tobacco smoker on entry to prison (5).

1.2.4 Alcohol and other drug use risk and harms

The National Health and Medical Research Council of Australia (NHMRC) has developed guidelines to reduce the risk of alcohol-related harm (14) wherein a standard drink is defined as 10g of alcohol or equivalent 12.5mL of pure alcohol (14). The guidelines for reducing harm over a lifetime for healthy men and women advise drinking no more than two standard drinks on any one day. Guidelines to reduce alcohol-related harm from any single occasion advise healthy men and women to drink no more than four standard drinks (14). It appears that no use of any illicit drug is considered safe, with the effects of a drug dependent upon the height, weight, age and sex as well as the general health of a person.

Harms can result from a single episode of AoD use in the short-term, as well as chronic harms arising from long-term use. The Australian Institute of Health and Welfare (AIHW) publication, *Impact of alcohol and illicit drug use on the burden of disease and injury in Australia 2011*, provided insight into the costs of AoD use for the health system (15). It was estimated there that alcohol and illicit drug use was responsible for 4.5% of deaths and 6.7% of the total burden of disease injuries in Australia in 2011 (15), with alcohol alone

responsible for 4.6%, and illicit drugs for 2.3%, of all disease and injury (15). For Indigenous Australians, another 2011 report from the AIHW showed that 19% suffered from mental health and substance use disorders (16). The types of harms to health arising from an individual's AoD use are many, and can differ dependent upon the substance/s used.
The sale of alcohol is regulated in Australia. I and it is illegal to sell alcohol without a licence. Home brewing for personal consumption is legal, though this form of alcohol accounts for an extremely small proportion of alcohol use in Australia. Short-term harms from alcohol use can include but are not limited to: low self-esteem, self-harm, accidental poisoning (both fatal and non-fatal), road transport accidents, assault, and serious assault resulting in death (17). Long-term chronic harms include but are not limited to: liver cirrhosis or other liver complications including failure, organ damage or failure, self-harm, accidental injury to self, low self-esteem, accidental poisoning (both fatal and non-fatal), assault, and serious assault resulting in death (17, 18).

Heroin, which is illegal in Australia, is an opioid and is derived from the poppy plant. Most of the heroin in Australia is smuggled into the country. Heroin is usually smoked or injected intravenously, with the act of injecting carrying its own risk of blood-borne virus transmission (19). Short-term health effects can include lethargy, drowsiness, disorientation, reduced sensitivity to pain, and depressed breathing (18, 20, 21). An overdose can result in a person stopping breathing, leading to death. Chronic harms from long-term use can include fertility problems, low sex drive, depression, damaged organs including heart, lungs, liver and brain, and death (17, 20, 21).

Amphetamine and methamphetamine are made synthetically from chemicals (20, 21). Methamphetamine is illegal, but some forms of amphetamine are manufactured for health use with this form made for ingestion (20, 21). Amphetamine and methamphetamine can be smoked or injected intravenously, with the act of injecting carrying its own risk of blood borne virus transmission (19). Acute harms from short-term use of amphetamine include increased heart and respiratory rate, anxiety and paranoia, depression, inability to sleep, and social dysfunction. Chronic harms from long-term use can include increased risk of stroke, heart and kidney problems, and difficulty breathing (20, 21). Overdose can occur on any occasion of use, and can result in highly elevated heart rate and possible heart attack, fitting, loss of consciousness, stroke, and death (19-21).

Although it can also be ingested, cannabis is usually smoked, where the effect is more immediate and potent. Cannabis laws in Australia differ between jurisdictions, but its use remains illegal in almost all jurisdictions (21). Short-term harms can include feeling anxious

and paranoid, feeling drowsy, increased appetite, decreased awareness of surroundings, lack of concentration, slower reactions, and an increased heart rate (20-22). Chronic harms from long-term use can include an increased risk of respiratory infection and disease, decreased libido, depression, low self-esteem, decreased concentration and memory, lung cancer, and death (20, 21).

Further, social dysfunction caused by AoD use can include but is not limited to: violence in the home and in public, emotional abuse of family members, neglect of people in the care of the AoD user, unemployment, housing instability, and financial stress from diverting resources to AoD use (15, 16, 22, 23). In Australia, the possession and use of illicit drugs is an offence (21), which can lead to legal issues and incarceration. The lowering of inhibitions from AoD use can also contribute to offences such as break and enter, theft, assault, and driving offences such as driving unlicensed or in an unregistered vehicle, and driving a motor vehicle while under the influence of alcohol or drugs (20, 21).

1.2.5 Treatment of alcohol and drugs

There are multiple factors that contribute to AoD dependence, which are both physiological and psychological. There are multiple different screening tools used to help identify and diagnose alcohol and drug dependence, including the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) (13), the Alcohol Use Disorders Identification Test (AUDIT) (appendix 1) and the Drug Abuse Screening test (24). Each of these identify substance use on a regular basis, and if there are related personal problems from the individual's regular substance use. While screening tools can be used by any number of health professionals including by public health researchers, only a medical practitioner can diagnose alcohol and/or drug dependence (13, 24).

Psychologically people can be and feel dependent upon AoD to function normally, either at home or in public (17, 25). Some people may have learnt to socialise while using alcohol or other drugs and feel uncomfortable socialising if they are not under the influence (17, 25). Physiological dependence is when a person becomes used to daily or almost daily use of alcohol or drugs, and the body becomes used to the substance being present. When the substance becomes depleted various physical reactions can occur, in a process known as withdrawal (17, 25). The severity of withdrawal symptoms can vary depending on what the substance is, how long the person had used and the way in which they had used, as well as physical attributes such as height, weight, and sex (14, 25). Severe alcohol, heroin, and amphetamine withdrawal can be life-threatening and should occur under medical supervision.

Alcohol withdrawal

Alcohol withdrawal can take between seven and 10 days. Symptoms from withdrawal can be mild or severe and can include but are not limited to: craving alcohol, trembling, anxiety, insomnia, sweating and fever, and in the worst cases, fitting (17).

Drug withdrawal

Heroin withdrawal can take up to 10 days, with symptoms commencing within the first 24 hours after the last use (17, 25). There can be mild or severe symptoms from withdrawal that can include but are not limited to: craving for heroin, insomnia, anxiety, hypertension, rapid heart rate, respiratory problems, and depression (17, 25).

Amphetamine and methamphetamine is broken down in the body within several hours of use and the term 'comedown' in often used with these drugs (26, 27). Comedown can last a few days and during this time people can experience dehydration, muscle pain, anxiety, insomnia, fatigue, anger or aggression, and depression (17, 25).

Cannabis withdrawal can take 14 days or longer as the drug is not quickly metabolised and residual amounts may remain (17, 25). Symptoms from withdrawal can include but are not limited to: craving for cannabis, sweating, anxiety, anger or aggression, insomnia, decreased appetite, and depression (3, 4).

The physiological and psychological effects of AoD withdrawal working together make it extremely difficult for people to stop using and then to remain free from AoD use (28, 29). Most people who have had alcohol or drug dependence are unable to use AoD at modest levels (21). It is well documented that alcohol and other drug dependence is a chronically reoccurring condition for which ongoing maintenance is recommended (17, 25).

1.2.6 Alcohol and Other Drug use and Offending

Research has shown that property and other crime can be linked to illicit drug use and alcohol consumption. Drug use can require significant resources and illegal income generation activities are sometimes undertaken to support continued use (30-32). These income generating activities can include stealing money, stealing goods that can be sold for money, robbery of an individual, robbery of a business, as well as the selling of drugs to support one's own drug use (30-32). Alcohol use has been associated with interpersonal violence and assault (33-35). The use of AoD increases the risk of imprisonment and many people in prison have a history of AoD use prior to their incarceration (6, 36).

The link between AoD use and criminal offending is well documented, with approximately 64% of men in prison in NSW self-reporting having been under the influence of alcohol and/or other drugs at the time of their current offence (5). More specifically, 22% of Indigenous men and 20% of non-Indigenous men reported being intoxicated with alcohol at the time of their offence, 21% of Indigenous and 22% of non-Indigenous men reported being under the influence of illicit drugs, and 29% of Indigenous and 16% of non-Indigenous men reported being under the influence of both alcohol and illicit drugs (5). Over half (52%) of the men who had been under the influence of alcohol or other drugs at the time of their offence believed that their current sentence was in some way related to their drug use. Further, 23% of men who reported AoD use at the time of their offence said that they had committed the offence in order to buy alcohol and/or drugs (5). This link between AoD use and criminal offending suggests there is an opportunity to reduce the potential for future criminal offending on release from prison through the provision of prison-based AoD treatment.

1.2.7 Alcohol and other drug treatment in prison

A large proportion of the people entering prison have a history of AoD use and may need clinical support for withdrawal. Whilst in prison, these people should have the opportunity to have behavioural change treatment that may assist them in not relapsing back into AoD use. The provision of prison-based AoD treatment is essential for two reasons. The first is the potential to reduce the likelihood of recidivism and hence to reduce imprisonment rates. The second reason relates to the long established principle of equivalence of care in prison medicine, which asserts that health care in prison should be equivalent to that available in the general community and commensurate with the level of need (37). To this end, prisons should have comprehensive treatment services available to address the extensive AoD use problems that are prevalent among this population group.

Alcohol and other drug treatment programs *are* available in all Australian state and territory prisons but there is limited aggregated information about treatment coverage. The only national source is *The Health of Australia's Prisoners Report* produced by the AIHW (38). The indication in this 2015 report is that the vast majority of those in prison who need AoD treatment do not receive such treatment, with just 8% of people leaving prison ('dischargees') reporting having received alcohol treatment (38). There is no corresponding figure in the AIHW report for people leaving prison who had received drug use treatment (38).

1.2.8 Alcohol and other Drug use Treatment Programs in Prison

There are many different alcohol and/or other drug treatment programs in Australian prisons. While some of these programs focus on illicit drug use, most tend to be inclusive of both alcohol and other drug use, given that the majority of inmates have misused both alcohol and drugs. Few programs are solely focused on treating alcohol abuse (2, 3). There have been few peer-reviewed published evaluations of such prison-based AoD programs (see Chapter Two), and whilst there are likely to be internal government department evaluation reports, this literature is not readily accessible to the public.

Alcohol and other drug treatment programs offered in Australian prisons are based on either cognitive behavioural or psychoeducational principles. Psychoeducational programs are more akin to information sessions and do not involve engagement with individual level behaviours. These programs aim to impart knowledge about the problem that the individual can use in the future, including information about services they can access after their release (2, 3, 39).

Cognitive behavioural treatment (CBT) is a common form of prison-based AoD treatment in Australia and worldwide. There are many variations of CBT but, broadly, it aims to assist the individual to re-evaluate their problem behaviour, in this case alcohol and/or other drug use, and to review how this has affected their own life and the lives of others around them (39-41). As part of this re-evaluation, individuals learn about the contributing factors to the behaviour, including the possible triggers associated with use. The CBT approach then assists the individual to formulate strategies for how to avoid or better deal with problem behaviours to assist them to either not use or minimise AoD use going forward (39-41). The final stages of CBT - and AoD programs generally - involve providing individuals with information about services they can access for assistance in the future.

Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) 12-Step programs are also available in prisons but the level of coverage is unknown. These programs are generally provided through external volunteers who go to the prison to run a group, although inmates can also run their own 12-Step programs (42). However, not all prisons have 12-Step programs available. The 12-Step program of AA is the basis of all 12-Step programs, and has a chronic disease model of care to encourage and support abstinence from alcohol. Alcoholism is attributed as being a physical, mental and spiritual disease by AA that is beyond the control of the individual and hence it is suggested that the individual follows a program of recovery which includes prayer and meditation on a daily basis, and developing trust in a higher power – that is to say, a personal God or other power of some kind greater

than themselves - so that they may be relieved of the desire to drink. It is suggested that people who attend AA identify as being an alcoholic, regularly attend meetings, pray, practice meditation, and share their experience of recovering from addiction with others who have similar issues. The AA program recommends abstinence as the only option for people who have not been able to stop or reduce their level of alcohol use (42).

Limited published or publicly available research into the effectiveness of prison-based AoD programs in Australia is available. The systematic review undertaken for this research identified only one paper reporting on AoD treatment outcomes for prison inmates published in the peer-reviewed literature since 1997. Furthermore, the peer-reviewed literature for treatment in this population for Indigenous peoples, including Australia's Aboriginal and/or Torres Strait Islander people, is negligible (see Chapter Two). As a result, the availability, uptake and efficacy of prison-based programs for alcohol and/or other drug disorders is unclear.

1.2.9 Modes of AoD Treatment Delivery

Alcohol and other drug treatment in prison is either delivered on a one-on-one basis between the inmate and therapeutic staff, or as a therapeutic group program. Therapeutic groups of inmates range in size from approximately four to 20 people, depending on the treatment type and the available resources. Alcohol and other drug treatment is delivered using different models, which can be grouped into the four categories discussed below.

1) Therapeutic Community (TC)

Inmates in the therapeutic community (TC) setting live in a separated area from the rest of the prison population. A prison-based TC is essentially the same as a community-based TC, where people reside in a community and participate in the daily therapeutic activities, as well as being responsible for self-care and taking part in the running of the community. A TC can utilise any one or a combination of therapeutic treatment approaches, including CBT, psychoeducational and 12-Step models.

2) Residential Program

Inmates in the residential AoD program also live in a separate area from the rest of the prisoner population but they do not necessarily take part in the day-to-day running of their area of the prison. Inmates attend daily therapeutic activities that are usually scheduled from Monday to Friday, though this can vary. A residential program can use any one therapeutic approach, or a combination of therapeutic treatment approaches including CBT, psychoeducational and 12-Step models.

3) Therapeutic Treatment Prison

A therapeutic treatment prison is a correctional facility which is wholly dedicated to therapeutic treatment. Treatment can be exclusively focused on alcohol and other drugs, or in combination with treatment for mental health issues. A therapeutic treatment prison can use any one or a combination of therapeutic treatment approaches including CBT, psychoeducational and 12-Step models.

4) Day Attendance Group Program

Day attendance programs are group treatment programs whereby inmates are housed in the general prison population, but attend the AoD treatment program. Program attendance varies depending upon the program, where the individual could possibly be attending group treatment each day from Monday to Friday, or just once per-week. Day attendance group programs can use any one or a combination of therapeutic treatment approaches including CBT, psychoeducational and 12-Step programs.

1.2.10 Placement into Treatment

There is a demand for alcohol and other drug services from prison inmates, with half of the men with a history of AoD use in NSW having sought alcohol and/or drug treatment prior to prison, and 61% of this group stating they wanted help for their alcohol use problem (5). Prison inmates who require AoD treatment are usually waitlisted following screening on entry to prison. The length of wait is dependent upon the availability of treatment programs and the level of demand for positions in the program.

The assessment of AoD treatment needs is usually judged by a validated assessment tool, such as the Level of Service Inventory Revised (LSI-R) which is used in New South Wales. Another commonly used tool is the World Health Organization's (WHO) Alcohol Use Disorders Identification Test (AUDIT) which examines alcohol use in the previous 12 months (24, 43). One-third of people entering prison are released within 12 months and over half are released after serving 24 months (7). This window of opportunity suggests that effective screening for AoD problems on entry to prison is appropriate, both to enable treatment and for referral pathways to community-based programs to be initiated during the incarceration period. Completion of an appropriate AoD treatment program can also assist the inmate in their parole application for early release.

1.2.11 AoD Treatment Program Literature

Given the relative lack of Australian peer-reviewed publications on prison-based AoD treatment in Australia, programs are largely informed by the international literature. In an

Australian context, it is unclear what AoD treatment programs work best for prison inmates. A meta-analysis by an American research team of prison-based AoD treatment research published between 1968 and 1996 (44), and a systematic review, also by an American research team, of treatment research published between 1980 and 2004 (45), reached similar conclusions: that the therapeutic community model of care was associated with statistically significant reductions in the primary outcome of reduced substance abuse, and that treatment for substance abuse can reduce the incidence of reoffending when released. Neither of these studies, however, critiqued the methodological quality of the research papers that were included in their reviews (see Chapter Two). This means that the accuracy of the findings of the papers that were included in these reviews was not determined and as such means the results need to be interpreted with some caution.

1.2.12 Aboriginal and Torres Strait Islander People

Australia's Indigenous people are the Aboriginal and the Torres Strait Islander people. Aboriginal people originate from mainland Australia and the state of Tasmania, while Torres Strait Islander people originate from the islands in the Torres Strait, the body of water between Australia and Papua New Guinea. Nationally, the term 'Aboriginal and/or Torres Strait Islander' is used as some people have either or both Aboriginal and Torres Strait Islander heritage. In New South Wales the term Aboriginal is most often used because the Torres Strait Islands are not part of that state. For the purposes of this work, the terms Aboriginal or Indigenous are predominately used; however, Aboriginal and/or Torres Strait Islander has been used where appropriate.

1.2.13 Over-Representation of Indigenous Australians in Prison

The disproportionate level of Indigenous imprisonment in Australia was first highlighted in 1991 when the findings from the *Royal Commission into Aboriginal Deaths in Custody* report were released (46). The Royal Commission concluded that the reason so many Aboriginal people had died in custody was because of their over-representation in prison (46). Over the intervening decades, there have been numerous initiatives directed at stemming the increasing numbers of Aboriginal people entering prison, but the statistics collected over that time clearly demonstrate that the increase has continued unabated.

At the time of the Royal Commission in 1991 the crude[2] rate of Aboriginal imprisonment nationally was 1,738.6 per 100,000. This rate dropped significantly the following year to a

[2] Only the crude rate was available in the Australian Bureau of Statistics' Prisoners in Australia 2000: 4517.0 report.

crude rate of 1,497.8 per 100,000 (47). However, over the following 24 years the rate has surpassed both the 1991 and 1992 levels (7, 47). Figure 1.1 below shows the increasing rate of Indigenous imprisonment for the years 2007 to 2017 (7, 47).

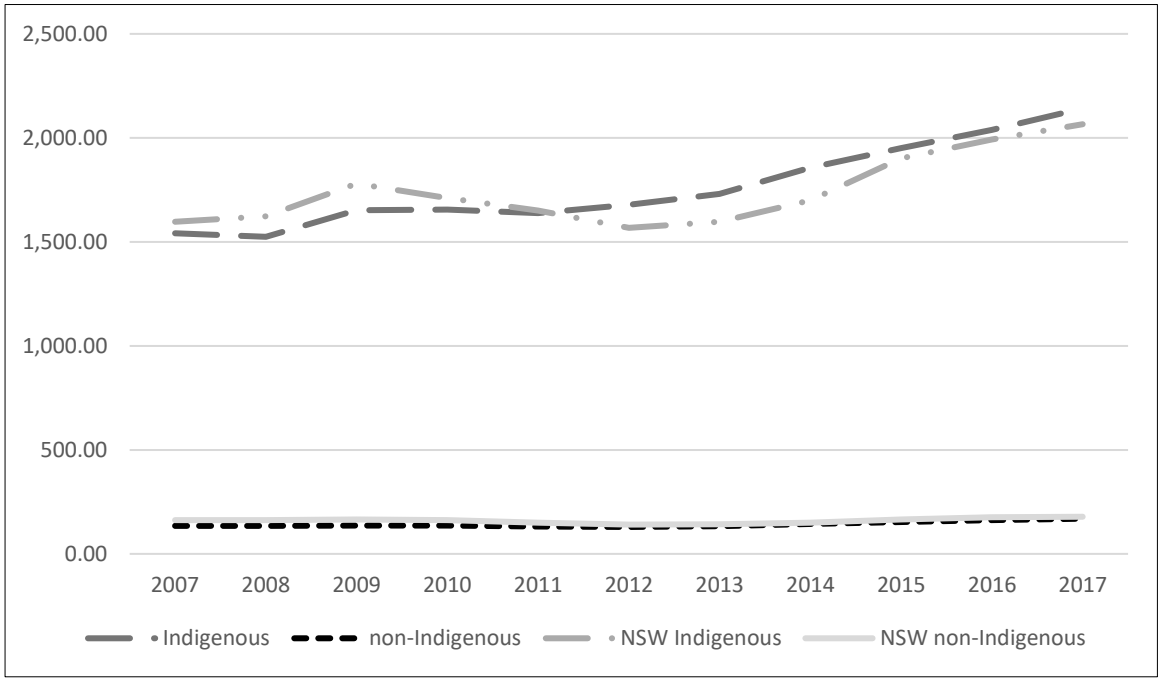


Figure 1.1: Australian Indigenous and non-Indigenous Imprisonment Rates per 100,000 Population 2007 to 2017

Indigenous Australians comprise just 2.8% of the Australian population, but nationally they comprise 27.4% of the Australian prisoner population, and 24.3% of inmates in the prison system in New South Wales. As well as the national rates of imprisonment, the figure above also shows imprisonment rates for NSW, since the qualitative section of this PhD was based in Sydney, NSW.

New South Wales has the largest total Indigenous inmate population in the country, with 3,197 (28.3%) of the 11,307 Indigenous prisoners held in Australia's prisons in 2017 (48). There has been a steady increase in the crude rate of Indigenous imprisonment over the decade of 2007-17, the national rate increasing from 1,540.6 per 100,000 in 2007, to 2,141.6 per 100,000 in 2017. Comparatively, non-Indigenous imprisonment increased from 135.4 per 100,000 in 2007, to 169.2 per 100,000 in 2017 (48). This is an increase of 601.0 per 100,000 for Indigenous and 33.8 per 100,000 for non-Indigenous Australians from 2007 to 2017 (48).

Alcohol and drug use has been identified as a leading contributing factor to the over-representation of Aboriginal people in prison by the National Indigenous Drug and Alcohol

Committee (NIDAC), the advisory body to the Australian government which was disbanded in 2015. The *Bridges and Barriers Report* produced by NIDAC in 2013 proposed that if harmful AoD use was more effectively addressed then Indigenous imprisonment could be significantly reduced, particularly if Indigenous people were diverted away from prison by the courts into residential rehabilitation services (6). While diversion, or the expansion of diversion programs, seems to merit further consideration, the number of Indigenous people in prison who had already been to diversion programs prior to incarceration is unknown. That being so, diversion and treatment programs are complementary rather than mutually exclusive. Further research into prison-based AoD treatment could help improve treatment programs in Australian prisons, in turn leading to a reduced likelihood of a return to prison for Indigenous people.

As identified in Chapter Three, clearly both Indigenous and non-Indigenous men entering prison in NSW have a high level of AoD use, with 26% requiring treatment for illicit drug use, 21% for alcohol and drug treatment, and 32% for alcohol-focused treatment. Prison-based AoD treatment could be particularly beneficial for Aboriginal people, who are more likely to return to prison than non-Aboriginal people: 77.1% and 49.8% respectively (7). There is limited published research into the provision of prison-based AoD treatment to Indigenous people in Australia, however, and internationally only two papers with a focus on Indigenous-specific AoD treatment program evaluations were identified in the systematic review undertaken for this project (see Chapter Two).

1.3 Research Questions and Methods

There were three interrelated research question for this study:

1) What is the international evidence for the effectiveness of prison-based alcohol and other drug treatment for men?
2) What is the level of need for such treatment programs in New South Wales?
3) How can prison-based AoD treatment for men be further developed, and how can it be further developed specifically to meet the needs of Aboriginal men in prison?

Differing research methods were employed to answer the three research questions, which are fully described in chapters two, three and four respectively. In brief, the first question was answered by conducting a systematic review of the existing literature using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) method, in conjunction with the Quality Assessment Tool for Quantitative Studies, and the Evaluation Tool to Assess the Quality of Qualitative Research Studies (49-51). The second question was answered by conducting an analysis using standard quantitative methods with an

existing data set. The third question was answered using a grounded theory method for qualitative research (52, 53), applied to the collection of primary data from 31 men who were scheduled to commence the Intensive Drug and Alcohol Treatment Program (IDATP) in NSW prisons.

The IDATP is described in section 1.5 below. The initial research plan was to interview 30 men who had been accepted into the IDATP, but who had not yet started the program (baseline interviews), and to then conduct follow-up interviews with the same men eight to nine months later in prison before release. While both baseline and follow-up interviews were completed, only the baseline data are reported in this thesis given they yielded a considerable volume of high quality and rich data, which were directly related to the specific aims of this thesis. The analysis and writing of the results of the follow-up interviews would have extended the PhD project by several months, as such this data is being analysed as a post-doctoral project.

1.4 Intensive Drug and Alcohol Treatment Program

The primary qualitative data collection for this research study took place with men who were about to commence the Intensive Drug and Alcohol Treatment Program (IDAPT), which was established in February 2012, approximately 12 months prior to the commencement of this PhD. The program was established by the NSW Government as part of a response to the large numbers of people entering prison who have a history of problematic alcohol and drug use related to their offending. At its commencement, the IDATP had a capacity of 62 beds and was due to be expanded to 250 beds over successive years.

The IDATP for men initially operated at the medium security John Morony Correctional Centre (JMCC) in Western Sydney, and was moved in 2015 to the minimum security Outer Metropolitan Multi-Purpose Correctional Centre (OMMCC), also in Western Sydney and on the same campus as the JMCC. The move to the OMMCC was intended to make the IDATP available to low security inmates who would otherwise have to be placed in a medium security prison to attend the program. The move to minimum security was also to provide a more conducive environment for therapeutic purposes, as it affords the inmates greater autonomy and personal self-care responsibilities and assists in the transition to release from prison. A similar program for women was established in 2014 at Dillwynia Correctional Centre, which is located on the same campus as the other two correctional centres in the outer Western Sydney suburb of Windsor.

Regular drug testing using urinalysis is stipulated in the admission application and contract the inmate signs as a condition of entry to the program. Cases of inmates found to be using illicit drugs and/or who are disruptive and not responding to treatment are reviewed by therapeutic staff, who can implement disciplinary action and, if necessary, expel the inmate from the IDATP.

1.5 Ethics Approval and Project Reference Group

Each aspect of this research underwent ethics committee review and received clearance, and was conducted in accordance with NHMRC guidelines (54, 55). Ethics approval was required for the primary data collection, which was the qualitative component of this research. The research proposal for this component was approved by the Research and Ethics Committee and Commissioner of Corrective Services NSW (Appendix 2). A separate ethics approval was obtained from the Aboriginal Health and Medical Research Council Human Research Ethics Committee (AH&MRC HREC), which is registered with the NHMRC, in May 2014 (approval number 1013/14, Appendix 3). UNSW ratified the AH&MRC approval and did not require a separate ethics application.

Feedback from the AH&MRC HREC required that a Reference Group be formed to guide the qualitative component of the research and to demonstrate Aboriginal community input and guidance to the research. The Reference Group was shared with another UNSW PhD candidate whose thesis explored the social capital of men in prison undertaking Hepatitis C treatment. The purpose of the Reference Group was to advise on and guide the PhD programs for both candidates, and hence Terms of Reference were jointly developed. Representatives from the following organisations were included in the Reference Group:

- Aboriginal Health and Medical Research Council of NSW
- Aboriginal Medical Service Western Sydney (prior to its defunding in 2015)
- Babana Aboriginal Corporation (Aboriginal men's group)
- Corrective Services NSW
- Hepatitis NSW
- Justice Health and Forensic Mental Health Network NSW
- Kirby Institute, UNSW Australia
- National Centre for Epidemiology and Population Health, Australian National University
- National Drug and Alcohol Research Centre, UNSW Australia
- Sydney Medical School, Drug Health Services, the University of Sydney.

These organisations were invited to participate because of their expertise in Aboriginal health, prison/offender health, and drug and alcohol treatment. The Reference Group primarily advised on the data collection processes, including the use of the data collection interview guides and methods to recruit participants, and on how to work appropriately with Aboriginal men in prison. Five meetings were held over three years, with minutes recorded.

1.6 Aboriginal Health Lens

Whilst this study encompasses all male populations and their AoD treatment issues, it has an Aboriginal health framework because the researcher is Aboriginal and, as such, an Aboriginal lens has influence on all aspects of the research, including data collection, interpretation, and reportage. This Aboriginal-led research is at the nexus of public health and criminal justice, informed by Aboriginal concepts and experiences, including the Aboriginal definition of health whereby the wellbeing of an individual is connected to the wellbeing of the community as a whole across spiritual, mental, and social domains (National Aboriginal Health Strategy Working Party, 1989)(56). The Aboriginal lens acknowledges that all Aboriginal and Torres Strait Islander people have experienced disadvantage perpetuated since colonisation, and that the Aboriginal and Torres Strait Islander people involved in the primary data collection for this research have experienced the disproportionately high rates of poor socio-economic status, health literacy and empowerment that are strongly correlated with criminality.

The Aboriginal lens acknowledges that all Aboriginal and Torres Strait Islander peoples have experienced disadvantage perpetuated since colonisation. Within this context, it should be recognised that the Department for Corrective Services NSW is possibly the oldest government department in Australia given that New South Wales began as a penal colony on the 26th of January 1788. Potentially then, no NSW government department has had a longer relationship with Aboriginal people, and while in 1788 none of the penal colony's original inmates were Aboriginal, in 2017, 24.3% of prison inmates in the state are Aboriginal (48). It is likely that almost every Aboriginal and/or Torres Strait Islander person is in some way affected by the over-imprisonment of those within their communities.

With the removal from their lands, Aboriginal peoples lost the means by which they had supported themselves for tens of thousands of years. Aboriginal people are now dependent upon the industrialised economy from which they are at the same time largely excluded (57). Aboriginal people have lower levels of employment and of those who are employed a larger proportion are employed in labouring type work than are other Australians (57).

Aboriginal people were forced in the past to not speak their own languages and the majority of Aboriginal people today speak English. The consequent loss of languages is a tremendous deprivation that means the old ways of passing down knowledge and cultural heritage between the generations are interrupted, and there has been a significant loss of this knowledge over the past 230 years (58). Educational levels, by mainstream Australian standards, are much lower for Aboriginal people than for non-Aboriginals (59). Tertiary education levels are much lower, particularly for completed university degrees, with more Aboriginals having been to prison than to university (60). With just 0.8% of students that complete a degree by higher research being Aboriginal and/or Torres Strait Islander, the author of this thesis is one of the few to have completed a doctoral level degree (61). While there have been significant gains made to redress the educational disadvantage, there is more needing to be done into the future (59).

Aboriginal and Torres Strait Islander people have faced, and continue to face, social disadvantage though racism and discrimination. There is a growing body of research that outlines the impact of racism on the physical and mental health of Aboriginal people (62). There are multiple indicators outlining the poor health of Aboriginal people, perhaps the most poignant being the differential life expectancies which are, for men 10.6 years. and for women 9.5 years. less than those for non-Aboriginal Australians (63). The bluntest and possibly most distressing indication of the poor mental health of young Aboriginal people is that the suicide rate is 3.7 times higher than that for non-Aboriginal people between 15 and 24 years of age (64).

As will be discussed in various parts of the thesis, the Aboriginal men involved in the primary data collection for this research each have intergenerational experience of material, economic, and social disadvantage. Going forward from these histories of disadvantage and incarceration, most do not have a secure career pathway, and many have few role models of other Aboriginal men who live functional, happy lives in the broader community. For cultural reasons, as an Aboriginal man I decided that my work in the area should focus on working with men, particularly as it would not be acceptable for me to interview Aboriginal women one-to-one about their alcohol and drug use.

1.7 The Researcher

In qualitative research, it is recognised that the researcher is the data collection instrument and, as such, it is appropriate to describe myself and my interest in this field (65). I am a

Bardi man from the remote Djarindjin Aboriginal Community located in the Kimberley region of Western Australia (WA).

In 1997 I worked in the community general store and had had no substantial career plans at that time. Responding to an advertisement at the community office, I enrolled in the Aboriginal Health Worker Certificate IV at the Kimberley Aboriginal Medical Services Council (KAMSC) School of Health Studies located 200km away in Broome, WA. This was the commencement of my career in Aboriginal health. I went on to work as an Aboriginal health worker and project officer in various roles in Aboriginal health, predominantly in the Aboriginal community controlled health sector in urban, regional and remote settings. In 2008, after 10 or more years working in these various roles, I commenced working in AoD research at Curtin University's National Drug Research Institute (NDRI). Four years later I moved to The Kirby Institute, UNSW Australia, where I began this PhD in 2013.

A major factor in my moving into a research career in 2008 was my motivation to undertake and complete university study. I completed a Graduate Diploma of Indigenous Health Promotion at The University of Sydney in 2009. In 2013, I was the first Aboriginal person to graduate with a Master of Public Health from The University of Western Australia.

Having witnessed first-hand the destructive effects of harmful AoD use on my extended family and community, I was interested in researching in the area to develop ways in which to combat this problem. I had myself been involved in the harmful use of alcohol, but became abstinent from alcohol and all illicit drugs and other psychoactive substances before 2008. At the time of writing, I am an active member of Alcoholics Anonymous and have been so for over 10 years. A subjective analysis approach was used in considering AA, as well as all other AoD treatment/support programs in this PhD, and my involvement in AA was disclosed to my supervisors prior to, or soon after, commencement in my Doctoral studies.

In sum, I chose to conduct research in this subject area because I have a personal interest, having observed the dysfunction and harm to health caused by hazardous alcohol use within the Aboriginal community from an early age. Furthermore, as an Aboriginal man, I have been aware of the increased likelihood of going to prison since I was an adolescent. It was not until I started working as an Aboriginal health worker, and later as a researcher in the drug and alcohol field, that I understood the relationship between AoD use and the high-level of Aboriginal imprisonment, and the need for more research in this area.

1.8 Significance and Benefits

This research is significant as it adds to what is currently a very limited knowledge base on prison-based AoD treatment in Australia, and internationally. The benefit is the potential for enhancing AoD treatment services for Australia's prison population as a result of this research.

There has been limited research reviewing the provision of AoD treatment in prison in Australia and internationally, and perhaps none at all by and with Aboriginal Australian men. In particular, there has been limited *qualitative* research into prison-based AoD treatment. Between 1995 and 2015, just one qualitative paper was identified in the systematic review for this dissertation, and that paper was judged to be of poor methodological quality. Additionally, there were no Australian qualitative papers and just two international quantitative papers identified that were published between 1995 and 2015 which had a focus on Indigenous peoples, and both these papers were also of poor methodological quality.

There is potential benefit for the Australian community, and perhaps particular benefit for Indigenous Australians as an outcome of this research, because the findings could help improve the delivery and resourcing of AoD treatment in prison, which could lead to reduced AoD use upon return to the community, and a reduction in reoffending. This would benefit people being released from prison, their families and the community.

1.9 Thesis Outline

There are six data chapters, each of which address the three research questions, followed by a Discussion and Conclusions chapter. Chapters Two to Seven each begins with an introduction and aim/s, followed by methods, results, discussion and then the conclusion. Chapters Four, Five, Six, and Seven use the same data, with the methods fully detailed in Chapter Four and brief methods section in the three following chapters.

Chapter Two, *A systematic review of prison-based substance abuse treatment for men*: *determining best evidence practice,* relates to the first research question: *What is the international evidence for the effectiveness of prison-based AoD treatment for men?* The aim of the systematic review was to develop an understanding of the extent of the research literature, the quality of the research and, importantly, identify the most effective form of prison-based AoD treatment. This chapter is a systematic review of Australian and International peer-reviewed literature reporting on prison-based AoD treatment research published between 1995 and 2015, with 25 papers found suitable for inclusion (27, 29, 66-

88). At the time of submission of this thesis, Chapter Two has been submitted to a peer-reviewed journal for publication.

Chapter Three, *Alcohol and other drug use among Aboriginal and non-Aboriginal men entering prison in NSW* relates to the second research question: *What is the level of need for such treatment programs in New South Wales?* This chapter compares the prior AoD use of Indigenous and non-Indigenous prison entrants and identifies the implications of this for AoD treatment provision within NSW prisons. This chapter reports on secondary analysis of an existing data set, and was published in 2015 in *Health & Justice* journal (Appendix 4)(4).

Chapter Four, *Qualitative methods and the participants,* presents the qualitative methods used in Chapters Five, Six and Seven. This chapter also provides an individual summary of each of the 31 participants that make up the sample for the grounded theory qualitative research presented in the three subsequent chapters.

Chapter Five, *Drug and alcohol use histories and treatment experiences of men in a prison-based treatment program,* answers the first part of the third research question: *How can prison-based AoD treatment for men be further developed?* This chapter reports on findings of how prison-based AoD treatment for men can be further developed to better meet their needs, and was informed by the interviews with all 31 participants.

Chapter Six, *The experiences of Aboriginal men of alcohol and other drug use, related issues and prison-based treatment,* answers the second part of the third research question: *how can [prison-based AoD treatment] be further developed to meet the needs of Aboriginal men in prison*? This chapter reports on findings addressing how prison-based AoD treatment for men can be further developed to specifically meet the needs of Aboriginal men.

Chapter Seven, *Alcohol and drug use in the cycle of Aboriginal re-imprisonment,* extends the discussion of the findings reported in Chapter Six by examining the entire cycle of imprisonment of Aboriginal men, and proposing some strategies on how hazardous AoD use and imprisonment may be avoided for future generations of Aboriginal men.

Chapter Eight: *Discussion and conclusion*. This chapter summarises the findings from each of the previous chapters. Drawing from the conclusions of these data chapters, the thesis puts forward some evidence-based recommendations for how prison-based alcohol and other drug treatment programs in Australia may be improved, to the benefit of both the inmates and society at large.

Chapter Two: A Systematic Review of Prison-Based Alcohol and other Drug use Treatment for Men: Determining the Best Evidence for Practice

2.1 Introduction and Aims

The majority of people in prison in NSW have a history of AoD use, with 61% reporting that they had been under the influence of AoD at the time they committed their offence (5). Although this represents a compelling argument for the provision of substance abuse treatment services in prisons, the effectiveness of such programs in an Australian context is unknown as there has been limited published research and no systematic review or meta-analysis of programs in Australia. Two international reviews were identified in this chapter: a meta-analysis of studies published between 1968 and 1996 by Pearson et al. (44), and a systematic review of studies published between 1980 and 2004 by Mitchell et al. (45, 89). Both concluded that a therapeutic community model of care was associated most often with statistically significant reductions in the primary outcome of substance abuse. However, neither specifically focused on the methodological quality of existing evaluations and both studies are over a decade old. This means that the effectiveness of current prison-based behavioural treatment programs remains unclear, essentially because the accuracy of the findings from the studies included in these reviews is unknown.

This chapter presents a systematic review of published papers that report on the effectiveness of prison-based AoD treatment. It answers the first research question for this thesis: *What is the international evidence for the effectiveness of prison-based alcohol and other drug treatment for men?* Specifically, this chapter has two aims: First, to determine the methodological quality of prison-based substance abuse treatment evaluation studies published in the peer-reviewed literature between 1995 and 2015 (inclusive), and second, to identify which treatment model is most effective in treating AoD use problems in this population. This chapter was submitted for publication to a peer-reviewed journal in February 2018, prior to submission of this thesis, authored by Michael F Doyle (lead author), Anthony P Shakeshaft, Mieke Snijder, Jill Guthrie and Tony G Butler.

2.2 Methods

2.2.1 Search Strategy

A Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) compliant literature search was undertaken for peer-reviewed research papers of prison-based substance abuse treatment, published over a 21-year period (1995 to 2015 inclusive) (49). The search strategy, including the identification of relevant databases, search strings, and selection criteria was developed in consultation with librarians at the University of New South Wales. Word strings developed to search these databases had four domains: 1)

identification of the research participant group or setting; 2) substance abuse disorders; 3) provision of treatment or care; and 4) identifying the paper as being either research or evaluation. The resultant search strings were:

1) Prison OR gaol OR jail OR detain* OR arrest* OR justice or (justice system) OR crim* OR (criminal justice) OR offend* OR parol* OR probation OR correction* or (correctional centre) or (correctional center) or (correctional facility) or (correctional institution) or (correctional service).

AND

2) Alcohol* OR amphetamine OR (crystal methamphetamine) OR methamphetamine OR speed OR ice OR cannabis OR hemp OR marijuana OR heroin OR illicit OR (illicit drug) OR cocaine OR (substance abuse) OR (substance dependence) OR (drug abuse) OR (drug depend*) OR (drug addict*) OR addiction

AND

3) Counsel* OR diversion OR education OR (health promotion) OR intervention OR maintenance OR (peer-education) OR pharmacotherapy OR prevention OR promotion OR rehabilitate OR rehabilitation OR relapse OR (relapse prevention) OR therapeutic OR (therapeutic community) OR therapy OR treatment

AND

4) Research OR evaluation OR indicator OR outcomes OR program OR (program evaluation) OR treatment OR (treatment completion) OR (treatment outcomes) OR qualitative OR quantitative OR statistic OR completion.

Forty-five databases were searched from seven bibliographic platforms with records/references for possible eligible papers retrieved: Informit (3,201 records); OVID & Cochrane Library (2,027 records); Campbell Library (21 records); Web of Science (1,950 records); CINAHL (2,412 records); Scopus (2,824 records); and the Project Cork database (612 records). The Endnote program was used to store and manage records/references.

2.2.2 Inclusion and Exclusion Criteria

The inclusion criteria were: 1) prison-based substance abuse treatment; 2) treatment participants are prison inmates; 3) research participants be men only, or men and women prisoners; 4) published between 1 January 1995 and 31 December 2015; and 5) available in English.

The exclusion criteria were: 1) papers that related to previously published data; 2) pharmacotherapy-based substance abuse treatment; 3) mental health and substance abuse

comorbidity treatments; 4) women-only studies, and 5) grey literature. Pharmacotherapy programs were excluded because the focus was on behavioural treatment programs. Co-morbidity treatments were excluded to maintain a focus on substance abuse programs. Women-only studies were excluded because the substance use treatment needs for women are different from those for men; for example, many women in prison with substance use issues have also been sexually assaulted. The grey literature was excluded because it represents a substantial body of literature with a very low probability that methodologically rigorous evaluations would be published there and not in the peer-reviewed literature.

2.2.3 Categorising of Prison-based Alcohol and other Drug Treatment

To enable better comparison of substance misuse treatments, grouping categories were developed according to treatment location: Residential Treatment, where a separate section of the prison is used for the substance abuse treatment; Therapeutic Prison, where the whole facility is for the provision of rehabilitative treatment/s; and prison-based Therapeutic Community, and Group Treatment, where inmates are housed in the general population, but attend substance abuse treatment. This categorisation approach is consistent with the two aforementioned reviews (44, 45). As well, for comparability between treatment duration, months were converted to days: that is, one month to 30 days, six months to 182 days, and nine months to 274 days. As part of the quality control, a random sample of 20% of papers identified as prison-based substance abuse research identified in the search by the lead author Michael Doyle (MD) were independently reviewed by co-author Mieke Snijder (MS).

2.2.4 Critical Appraisal of Methodology

Assessment of Quantitative Papers:

The methodological quality of quantitative papers was appraised using two methods: the Dictionary for the Effective Public Health Practice Project Quality Assessment Tool for Quantitative Studies (QATQS, Appendix 5 & 6) (50, 90), and a global rating. The QATQS has eight criteria: 1) selection bias; 2) study design; 3) confounders; 4) blinding of participants and research staff; 5) data collection methods; 6) withdrawal and dropout of participants; 7) treatment integrity; and 8) data analysis. Each criterion is graded as strong, moderate or weak. Due to the difficulty in blinding substance abuse treatment in prisons, criterion four was excluded.

We developed a global rating which built on the QATQS rating, where evaluations with two or more weak QATQS ratings were classified as ‘weak’; those with one weak QATSQ criteria were classified as ‘moderate’; and those with no weak QATQS ratings were classified as ‘strong’ (50).

A random sample of 52% of the resulting 24 quantitative papers (n=13) was reviewed. Initially there was 80% agreement between MD and MS on the global rating. Differences were discussed and resolved, reflecting the original rating assigned by MD (50).

Assessment of Qualitative Papers:
As distinct from the reviews by Pearson et al. and Mitchell et al. mentioned above (44, 45), qualitative research was included, using Long and Godfrey's evaluation tool, which has four areas for critique: 1) phenomenon studied and context; 2) ethics; 3) data collection, analysis and potential research bias; and 4) policy and practical implications. The tool facilitates an assessment of the methodological quality of a study when these critiqued areas are summarised (51).

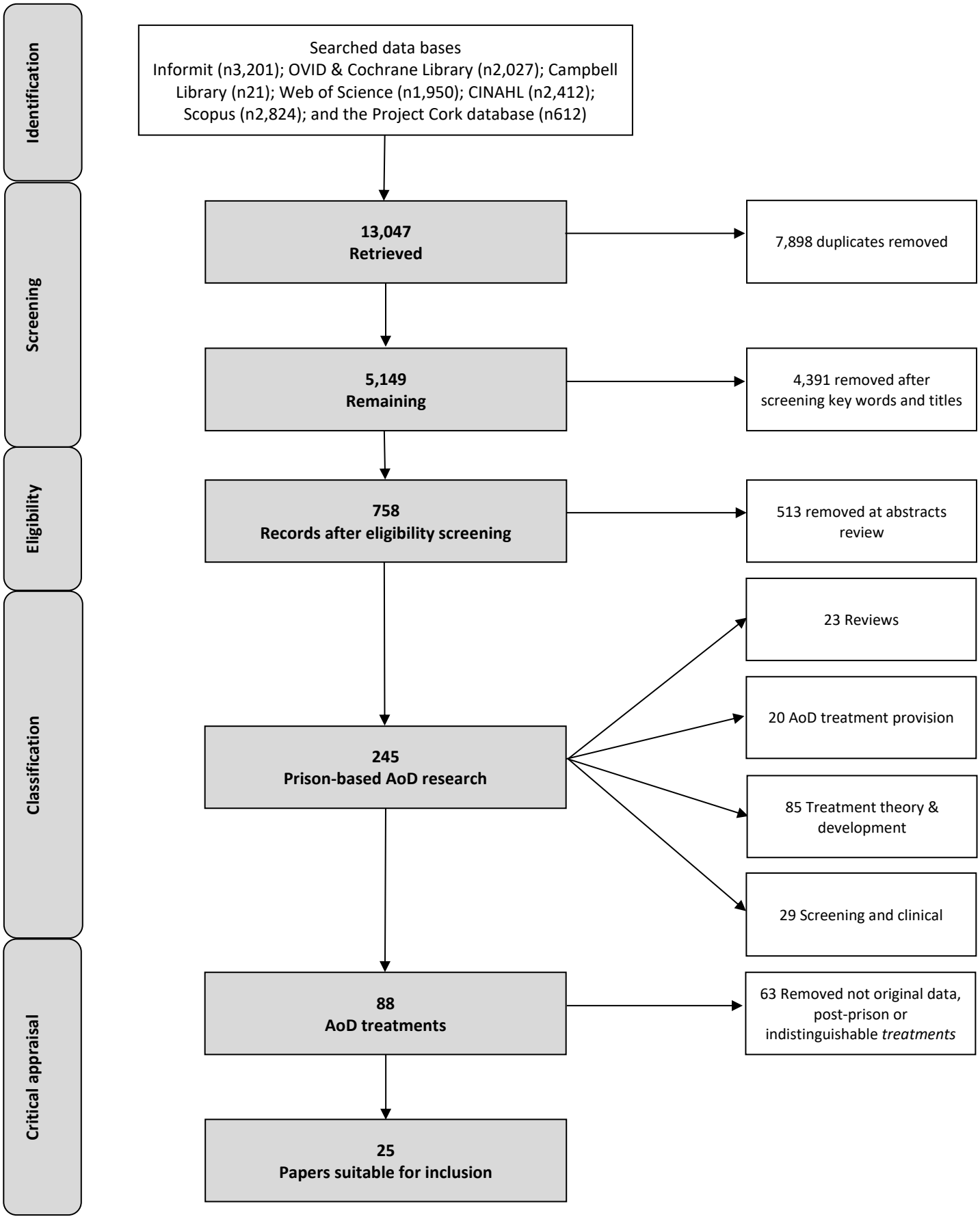
2.3 Results

2.3.1 Identification AoD Treatment of Evaluations

In total 13,047 records/references were retrieved from the search, with 7,898 duplicates removed leaving 5,149 records/references. A manual search of titles and keywords was conducted, which resulted in the elimination of a further 4,391 records/references which did not meet the inclusion criteria. The abstracts of the remaining 758 records/references were then reviewed, resulting in 513 further records/references being removed because this more detailed review revealed they did not meet the selection criteria.

Of the remaining 245 references, 88 were identified as being evaluations of substance abuse treatments. Of these, 63 were removed because they reported data from an earlier study paper already included in the review, reported on a post-prison treatment, or reviewed multiple treatments without a comparative framework to enable analysis of those different treatments. This resulted in 25 papers included in this review, comprised of 24 quantitative studies and one qualitative study. The search process is presented in Figure 2.1 below.

Figure 2.1: Search Flowchart Peer-reviewed Prison-based AoD Treatment Papers



2.3.2 Substance Abuse Treatment Evaluations

Of the 25 papers, seven evaluated residential treatment (66-71, 88); three, therapeutic prison (72-74); eight, therapeutic community (29, 75-81); and seven, group treatment (27, 82-87). Twenty-one evaluated ongoing treatment **programs** (66, 69-71, 73-81, 83-86, 88, 91, 92) and four were **studies** set up to evaluate a specific substance abuse treatment for this population (27, 72, 82, 87). Twenty-four used quantitative methods and one qualitative (91). Over half were from the United States (n=15) (27, 29, 69, 71, 72, 75-77, 79-81, 83, 88, 91), two each from Canada (66, 85) and Taiwan (70, 87), and one each from Australia (84), Croatia (70), Japan (73), Poland (86), the United Kingdom (Wales) (82), and South Korea (78). Eight included samples both of men *and* women (29, 70-72, 75, 83, 88, 91). Twelve were published from 1995 to 2005 (27, 29, 69-71, 74, 75, 77, 79, 84, 88, 91) and 13 from 2005 to 2015 (66, 72, 73, 76, 78, 80-83, 85-87, 91).

A total of seven treatment approaches were described across the 25 papers. Eight used cognitive behavioural therapy (CBT) or similar, such as cognitive social therapy (CST) (66, 71, 73, 79, 82, 85, 87, 88); six used or adapted the Alcoholics Anonymous 12-Step program (69, 74, 79, 86, 91); six were psychoeducational (66, 70, 74, 76, 84, 91); nine used a therapeutic community approach (29, 75-81); two used the MATRIX model[3] (73, 76); two used a meditational approach (72, 87), and one was a computerised educational program (83). Three of the therapeutic community treatments and one residential treatment had post-prison care (29, 69, 75, 77), and a therapeutic prison had 12-Step program attendance as a condition for release, however, post-prison attendance was not monitored (74).

Entry into treatment was predominately voluntary, with three exceptions: Linhorst et al. described court-mandated attendance if parole was revoked (91); and Vaughn et al. described entry as being court-ordered entry if men meet certain criteria, and the men in this program had to repeat the treatment until they passed or their prison term expired (70). Vukadin et al. also described court-ordered treatment, with psychologists in the custodial system also able to order placement (74).

[3] Matrix is an intensive daily program, working on all aspects of the individual's addiction; the model uses a combination of CBT, motivational interviewing and 12-Step approaches.

Table 2.1: Alcohol and other Drug Treatment Characteristics (n=25)

Author	Country	Aim/approach	Eligibility & exclusion criteria	Treatment duration & group size;	
Arseneault (2015)	Canada	Psychoeducational program, with a harm reduction, motivational & CBT approach, incorporated academic.	Minimum security & 42 days prior to release; moderate to severe alcohol/drug use, motivated to receive help; literate, able to function in group. Inmates with mental a disorder not controlled by medication were excluded from the program.	42 days; group size=1	Residential
Linhorst (2012)	United States	Psychoeducational program incorporating 12-Step & recovery model of Alcoholics, Narcotics or Cocaine Anonymous.	Entry by Court order if community option have failed or are not appropriate, participant must agree to placement. Court can order placement in cases of parole revocation. Exclusion criteria not specified.	90 days; group sizes, 30 in men's & 15 per women's group	
Pelissier (2001)	United States	CBT based group programs covering lifestyle choices & drug use, relapse prevention & anger management.	Program entry and exclusion criteria to moderate (mod) & high intensity programs not specified.	Mod 274 days; group size not stated - High 365 days; group size not stated	
Raney (2005)	United States	CBT day attendance treatment program covering choices & drug use, relapse prevention	Program entry and exclusion criteria not specified other than being minimum security for entry	274 days; group size 30	
Staton (2000)	United States	*Program* based on AA 12-Step program and *'additional focus on linking cognition with behaviour'*	Program is for inmates with self-admitted AoD problems & offences related to AoD. None violent and 'other less criminal charges'	182 days; group size not stated	
Turley (2004)	United States	Based on AA 12-Step. Later sessions in program focus on staying sober. Post-prison component	Non-violent inmates with history of AoD use are eligible to volunteer for program. Exclusion criteria not stated.	60 to 90 days; group size not stated	
Vaughn (2003)	Taiwan	Psychoeducational program with education classes, taught in lecture format with limited interaction.	If assessed as requiring AoD treatment inmates are mandated to complete program. Assessment inclusion, exclusion criteria not specified.	90 days; group size not stated	
Bowen (2006)	United States	Vipassana mindfulness meditation study, teaching mindfulness & detachment from emotional situations	Study located in an AoD treatment facility with all inmates eligible to volunteer for control or treatment groups.	10 days; group size not stated	Drug treatment prison
Matsumoto (2014)	Japan	CBT approach program using day attendance model & classes with self-learning workbook based on MATRIX program.	Staff can place inmates in program if the reason for imprisonment is drug abuse or if drug abuse may impede social adjustment. No exclusion criteria specified.	Book 32 days; group size 30 - day attendance 90 days; group size 10; drug treatment prison	
Vukadin (2004)	Croatia	AoD treatment prison with 2 x programs described as modified TC's with 12-Step program incorporated. Additional psychoeducational component covering alcohol education. Post-prison AA & NA encouraged.	Court ordered or if sentence is ≥182 days phycologists can order placement. No entry or exclusion criteria specified.	Days not stated; group size not stated	

Author	Country	Aim/approach	Eligibility & exclusion criteria	Treatment duration & group size;
Inciardi (1997)	United States	3 stage TC program (incarceration, work release, parole): approach to treating the whole person not just the drug use, with aim to enhance prosocial behaviours & to change behaviour, negative thinking and feelings that pre-dispose to drug use. Post-prison component	Eligibility & exclusion criteria for program were not specified	Key & WCI village 365 days, Crest duration not stated; grp sizes not stated
Joe (2010)	United States	3 treatment program modalities: 2 x TC using Matrix Model. Methamphetamine TC graduates involved in peer teaching. 1 x psychoeducational group program	All inmates screened on entry to prison & those in need of AoD treatment offered placement in a program. No other detail provided on entry or exclusion criteria	TC's 182 to 274 days, Group program not clear ≥98 days; group sizes not stated
Knight (1997)	United States	TC program addressing AoD relapse, reasons for drug use, preparation for release, work release component & post-prison care component.	Inmates screened for drug use history on prison entry. When inmates have 270 to 300 days left to serve the Treatment Referral Committee make recommendations to Parole Board . Inmates excluded if offences are violence or sexual related	TC & CTC 274 days, TC group size 25 to 50, CTC grp size not stated
Lee (2014)	South Korea	TC program, adapted form United States but specific model not described	Voluntary program participation for men sentenced to 182 to 365 days with convictions of criminal activities related to substance abuse. No program exclusion criteria specified	TC's 182 days, group size not stated
Stohr (2002)	United States	2 x TC programs with social learning theory applied using a CBT model. AA & NA 12-step components included	Verified AoD abuse (definition not specified) with program 1 being parole violators & 2 regular 'termers'. No program exclusion criteria specified.	274 to 365 days; group size not stated
Welsh (2007)	United States	TC program, addressing criminal thinking and AoD use behaviour and develop skills for relapse prevention	Triage approach but entry and exclusion criteria not specified	274 to 504 days; group size not stated TC
Welsh (2010)	United States	TC program, addressing criminal thinking and AoD use behaviour and develop skills for relapse prevention	540 to 1020 days to serve, documented history of AoD (minimum score 3 on TCU Drug Screen 2), medium to low security, no serious mental health problems	365 days; group size not stated
Wexler (1999)	United States	TC program. Addressing criminal thinking and AoD use behaviour and develop skills for relapse prevention. Post-prison care component	Voluntary entry for inmates with drug problem (no case definition), minimum 270 to 420 days to serve. Inmates convicted of arson or sexual crimes are excluded	182 to 274 days; group size not stated

Author	Country	Aim/approach	Eligibility & exclusion criteria	Treatment duration & group size;	
Bowes (2012)	Wales	CBT approach study covering problem solving, coping with high risk situations & managing anger & stress	History of alcohol related violence during 2 years prior to prison, medium to high risk of re-offending. Excludes acute mental illness/impairment, interment life sentence, inmates convicted of sexual offences.	30 days; group size = 8 to 10;	
Chaple (2014)	United States	Interactive computerised AoD education program	Diagnosed moderate to low level substance use disorder, not currently receiving treatment, parole review or release 120 to 180 days. No exclusion criteria stated	90 days; group size not stated	
Crundall (1997)	Australia	Psychoeducational program using social learning model with specific adaptations for Aboriginal Australians	No program entry or exclusion criteria specially stated.	Duration not stated; group size not stated	
Davis (2014)	Canada	Programs using social-cognitive theory and incorporates relapse prevention therapy and CBT. High intensity includes managing dependency & countering addictive beliefs	Offenders were eligible for program and study, if AoD were implicated in their offense & if they had moderate to severe substance use problems. No exclusion criteria stated for program	42 (mod) & 140 days (high); group size not stated	Group treatment
Gossage (2003)	United States	Study into the use of traditional Native American healing methods involving song and prayer in a sweat lodge setting to enhance or re-establish belief systems and practises that increase resilience. Alcohol education incorporated	Voluntary participation in study, with the exception of maximum security being excluded	Duration not stated; group size not stated	
Lee K-H (2011)	Taiwan	Study using mindfulness meditation classes incorporating stress reduction, CBT & relapse prevention	Study inmates must have ≥1 year sentence due to drug possession or sale. Have past illicit drug use & had been abstinent in the past 182 days. Illiterate inmates & those with acute mental illness were excluded	70 days; group size not stated	
Slaski (2006)	Poland	Program is an adapted from AA 12-Step. Enhancement in self-awareness, acceptance of inability to control psychoactive substance use	Admitted to program if alcoholic or alcohol dependent (no case definition provided), no exclusion criteria specified.	90 days; group size not stated	

There was wide variation in treatment duration: Residential ranged from 42 to 365 days, therapeutic communities from 182 to 532 days, therapeutic prison from 10 to 30 days, and group treatments from 30 to 140 days. Two treatments operated for 30 days or less (72, 82), eight for 30 to 90 days (66, 69, 70, 83, 85-87, 91), four between 90 to 182 days (29, 73, 78, 91), six for 182 to 364 days (71, 76, 77, 79, 80, 88), and two for 365 days or more (75, 81). Treatment duration was not specified in three papers (27, 74, 84). The only pattern that could be observed was that psychoeducational treatment tended to be for 90 days or less (66, 70, 83, 91) and therapeutic community treatment tended to be for 182 to 365 days (29, 75-81).

2.3.3 Appraisal of Quantitative Papers

For the quantitative papers (n=24) included in the systematic review, screening for substance abuse history routinely occurred at prison entry, resulting in clinical referral which was the most common route to behavioural substance abuse treatment and thus research participation (n= 18).

Six papers had a strong study design with five being clinical controlled trials (29, 66, 78, 83, 87) and one a randomised controlled trial (82). Thirteen study designs rated as moderate, and six as weak. Allocation of participants into treatment or control groups occurred after recruitment in four papers (78, 82, 83, 87). The other papers had treatment group participants that had been allocated to treatment through clinical referral processes; controls in these papers were specifically recruited by researchers, or were identified retrospectively from data files. Seventeen papers had moderate selection bias, six weak (27, 72, 78, 86, 87), and one paper rated as strong with no apparent bias (82).

Data collection was rated as strong for 12 papers (29, 66, 72, 73, 76-78, 80-82, 85, 87), and moderate for one (86), all 13 using validated survey tools. Fourteen papers used routinely collected prison department data (29, 66, 69, 72, 73, 75-77, 80, 81, 84, 85, 88, 91). One paper supplemented self-reported data on social behaviour with third party data (84). Nine papers rated as strong with study dropout or withdrawal reported (29, 66, 73, 75, 77, 78, 82, 83, 87), seven papers rated as moderate, reporting limited information on dropout or withdrawal, and nine as weak (27, 69, 70, 76, 80, 81, 88). In total there were 53 different data collection tools catalogued.

The results of the appraisal of quantitative papers for both QATQS and global ratings are reported in Table 2.2 (n=24) below. Appendix 7 is a list of the validated survey tools utilised in the studies reported in these papers.

Table 2.2: Appraisal of Quantitative Papers (n = 24)

Author	Sample	Selection bias	Study Design	Confounders controlled	Data collection methods	Withdrawal & drop-out	Intervention integrity	Global rating	
Arseneault (2015)	**Men** N=150 Intervention: n=80 Controls: n=70	**Moderate** Clinical-referral	**Moderate** Controlled clinical trial Randomisation: No	**Strong**	**Strong** Routine data: Yes Self-report: Yes Validated tools: Yes (1-13)	**Strong**	96% of intervention group completed treatment. Treatment had curriculum. Attendance to other treatments not reported.	**Strong**	Residential treatment
Linhorst (2012)	**Men & women** N=1,151	**Moderate** Clinical-referral or mandated	**Moderate** Cohort analytic Randomisation: No	**Weak**	**Weak** Routine data: Yes Self-report: Yes Validated tools: No	**Weak**	Only graduates included in analysis. Treatment had curriculum. Attendance to other treatments not reported.	**Weak**	
Pelissier (2001)	**Men & women** N=1,569 Intervention: n=760 Controls: n=809	**Moderate** Clinical-referral	**Moderate** Cohort analytic Randomisation: No	**Moderate**	**Weak** Routine data: Yes Self-report: Yes Validated tools: No	**Moderate**	Only graduates included in analysis. 75% men and 59% of women in intervention group completed treatment. Treatments had curriculum. Attendance to other treatments not reported.	**Moderate**	
Raney (2005)	**Men & women** N=87	**Moderate** Clinical-referral	**Weak** Cohort Randomisation: No	**Strong**	**Weak** Routine data: No Self-report: Yes Validated tools: No	**Weak**	Treatment attendance not reported. Treatment had curriculum. No other treatment attended.	**Weak**	
Turley (2004)	**Men** N=411	**Moderate** Clinical-referral	**Moderate** Times series analysis Randomisation: No	**Weak**	**Weak** Routine data: Yes Self-report: Yes Validated tools: No	**Moderate**	Only graduates included in analysis. Treatment had curriculum. No other treatment attended.	**Weak**	
Vaughn (2003)	**Men & women** N=698 Intervention: n=304 controls: n=394	**Moderate** Clinical-referral/ mandated	**Moderate** Cohort analytical Randomisation: No	**Weak**	**Weak** Routine data: No Self-report: Yes Validated tools: No	**Moderate**	Intervention group completed treatment. Treatment had curriculum. No other treatment attended.	**Weak**	
Bowen (2006)	**Men & women** N=173 Intervention: n=57 Controls: n=116	**Weak** Self-referral	**Moderate** Cohort analytic Randomisation: No	**Moderate**	**Strong** Routine data: Yes Self-reported data: Yes Validated tools: Yes (14-19)	**Weak**	Only graduates included in analysis. Treatment had curriculum. Intervention group able to attend other AoD treatments (no data recorded).	**Weak**	Drug treatment prison
Matsumoto (2014)	**Men** N=251	**Moderate** Clinical-referral	**Weak** Cohort Randomisation: No	**Weak**	**Strong** Routine data: Yes Self-report: Yes Validated tools: Yes (20, 21)	**Strong**	Intervention group completed treatment. Treatment had curriculum. No other treatment attended.	**Weak**	
Vukadin (2004)	**Men** N=108 Intervention: A n= 63 Intervention B n=46	**Moderate** Clinical-referral & mandated	**Weak** Cohort Randomisation: No	**Weak**	**Weak** Routine data: No Self-report: Yes Validated tools: No	**Not applicable**	Treatment attendance not reported. Treatment has curriculum. No other treatment attended.	**Weak**	

Author	Sample	Selection bias	Study Design	Confounders controlled	Data collection methods	Withdrawal & drop-out	Intervention integrity	Global rating	
Inciardi (1997)	**Men & women** N=448	**Moderate** Clinical-referral	**Moderate** Cohort analytical Randomisation: No	**Strong**	**Weak** Routine data: Yes Self-report: Yes Validated tools: No	**Strong**	Treatment attendance not reported. Treatments had curriculum. Attendance to other treatments not reported.	**Moderate**	Therapeutic Communities
Joe (2010)	**Men** N=2,026	**Moderate** Clinical-referral	**Moderate** Cohort analytical Randomisation: No	**Strong**	**Strong** Routine data: Yes Self-report: Yes Validated tools: Yes (22-26)	**Moderate**	Only graduates included in analysis. Treatments had curriculum. Attendance to other treatments not reported.	**Moderate**	
Knight (1997)	**Men** N=414 Intervention: n=293 Controls: n=121	**Moderate** Clinical-referral	**Moderate** Cohort analytical Randomisation: No	**Strong**	**Strong** Routine data: Yes Self-report: Yes Validated tools: Yes (27-33)	**Strong**	Only graduates included in analysis. Treatment had curriculum. Attendance to other treatments not reported.	**Strong**	
Lee H (2014)	**Men** N=48 Intervention: n=24 Controls: n=24	**Weak** Self-referral	**Strong** Controlled Clinical trial Randomisation: Yes, not described	**Strong**	**Strong** Routine data: No Self-report: Yes Validated tools: Yes (34)	**Strong**	Intervention group completed treatment. Treatment had curriculum. Contamination present with 75% of controls also received one to one counselling.	**Moderate**	
Stohr (2002)	**Men** N=82	**Moderate** Clinical-referral or mandated	**Weak** Cohort Randomisation: No	**Strong**	**Weak** Routine data: No Self-report: Yes Validated tools: No	**Weak**	Treatment attendance not reported. Treatment had curriculum. No other treatment attended.	**Weak**	
Welsh (2007)	**Men** N=708 Intervention: n=217 controls: n=491	**Moderate** Clinical-referral	**Moderate** Cohort analytical Randomisation: No	**Strong**	**Strong** Routine data: Yes Self-report: Yes Validated tools: Yes (35, 36)	**Moderate**	Intervention group completed treatment. 5 different TC interventions, authors state high consistence between treatments. Treatment has curriculum. Attendance to other treatments not reported.	**Strong**	
Welsh (2010)	**Men** N=347	**Moderate** Clinical-referral	**Weak** Cohort Randomisation: No	**Moderate**	**Strong** Routine data: Yes Self-report: Yes Validated tools: Yes, (32, 33)	**Moderate**	All participants completed treatment. Treatment has curriculum. Attendance to other treatments not reported.	**Moderate**	
Wexler (1999)	**Men & women** N=715 Intervention: n=42 Controls: n=290	**Moderate** Clinical-referral	**Strong** Controlled clinical trial Randomisation: Yes. Not described	**Strong**	**Strong** Routine data: Yes Self-report: Yes Validated tools: Yes, (30, 37-42)	**Strong**	Intervention group completed treatment. Treatment has curriculum. No other treatment attended.	**Strong**	
Bowes (2012)	**Men** N=115 Intervention: n=56 Controls: n=59	**Strong** Clinical-referral	**Strong** Randomised control trial Randomisation: Yes, & described	**Moderate**	**Strong** Routine data: No Self-report: Yes Validated tools: Yes (43-47)	**Strong**	68% of intervention group completed treatment. Treatment had curriculum. 64% of intervention & 34% of controls attended individual drug counselling.	**Strong**	Group Treatment
Chaple (2014)	**Men & women** N=494 Intervention: n=249 Controls n=245	**Moderate** Clinical-referral	**Strong** Controlled clinical trial Randomisation: Yes, not described	**Strong**	**Weak** Routine data: No Self-report: Yes Validated tools: No	**Strong**	50% of intervention group completed treatment (recorded at only one site). Computerised curriculum. Attendance to other treatments not reported.	**Moderate**	

Author	Sample	Selection bias	Study Design	Confounders controlled	Data collection methods	Withdrawal & drop-out	Intervention integrity	Global rating
Crundall (1997)	**Men** N=58 Intervention: n=45 Controls: n=13	**Moderate** Clinical & Self-referral	**Moderate** Cohort analytic (Randomisation: No)	**Weak**	**Weak** Routine data: Yes Self-report: Yes & 3rd party Validated tools: No	**Weak**	Treatment attendance not reported. Treatment had curriculum. Attendance to other treatments not reported.	**Weak**
Davis (2014)	**Men** N=1,747 Intervention A n=1,431 Intervention B n=316	**Moderate** Clinical-referral	**Moderate** Cohort analytical Randomisation: No	**Weak**	**Strong** Routine data: Yes Self-report: Yes Validated tools: Yes (16, 20, 28, 48-53)	**Weak**	Only graduates included in analysis. Treatments had curriculum. Attendance to other treatments not reported.	**Weak**
Gossage (2003)	**Men** N=190	**Weak** Self-referral	**Weak** Cohort Randomisation: No	**Moderate**	**Weak** Routine data: No Self-report: Yes Validated tools: No	**Moderate**	Treatment attendance not reported. No mention of treatment curriculum. Attendance to other treatments not reported.	**Weak**
Lee K-H (2011)	**Men** N=24	**Weak** Self-referral	**Strong** Controlled Clinical trial Randomisation: Yes, not described	**Moderate**	**Strong** Routine data: No Self-report: Yes Validated tools: Yes (30, 50, 54)	**Strong**	Intervention group completed treatment. Treatment had curriculum. Attendance to other treatments not reported.	**Moderate**
Slaski (2006)	**Men** N=57 Intervention: n=3 Controls: n=26	**Weak** Ambiguous	**Moderate** Cohort analytic Randomisation: No	**Moderate**	**Moderate** Routine data: No Self-report: Yes Validated tools: Yes (55)	**Weak**	Treatment attendance not reported. Treatment had curriculum. Attendance to other treatments not reported.	**Weak**

Group Treatment

The Intervention Integrity column of Table 2.2 above reports treatment exposure level, the integrity (or consistency), and unintended exposure to similar treatment/s. The exposure level was specifically reported in four papers (66, 82, 83, 88), and 13 described the treatment group participants as completed or graduated (29, 69, 70, 72, 73, 76-78, 80, 81, 85, 87, 91). Only two reported specifically on integrity (80, 83); however, most of the treatment regimens reported having a curriculum. There was no mention of a curriculum for one paper (27). An unintended dose of a similar treatment or treatments was reported in three papers (72, 78, 82), with seven describing environments that precluded attendance to other treatments (29, 69-71, 73, 74, 79). It is unlikely that the participants in the residential treatment or therapeutic community treatment would attend another treatment, but this could not be concluded from the available data.

2.3.4 Aims of the Papers

The aims of the evaluation papers could be categorised into four main groups: process, impact, outcome, or a combination of these. Three papers evaluated substance abuse treatment process whereby they reported participants' experiences of the process while in, or shortly after, treatment (71, 74, 79), and seven evaluated impact whereby they tested participant knowledge both before and after treatment (73, 76, 78, 82, 85, 87). Eleven papers evaluated the post-prison outcomes of treatment through analysis of post-prison data (27, 69, 70, 72, 75, 77, 80, 84, 86, 88, 91). Four papers overlapped between these three categories, with two evaluating impact and outcome (29, 66) and two evaluating impact and process (81, 83).

Eighteen papers compared treatment and control groups. Of these, twelve compared a single treatment group and a control group (29, 66, 70, 72, 77, 78, 80, 82-84, 86, 88), five compared differences between separate groups undertaking two different treatments (no control group) (74, 76, 85, 87, 91), and one had multiple treatment groups and one control group (75). The analysis was limited to a single cohort in five papers (27, 71, 73, 79, 81), and was limited to one treatment but different treatment cohorts in the time series analysis paper (69). These six papers focused their analysis on pre- and post-treatment measures for the cohort group.

Table 2.3: Aims and Outcome of Evaluations (n = 25)

Author	Aim of evaluation	Analysis	Outcome	
Arseneault (2015)	Evaluate the impact and outcome post-prison of the six-week long pre-release addiction treatment	Data from pre- & post-treatment and control group. Treatment completion or prior to release (controls); 42 days and 182 days post-release (or in prison). *Some inmates not released as anticipated*. Measures: AoD use, social and psychological functioning, arrest, re-imprisonment Statistical analysis: Chi-square, t-tests, latent growth curve analyses Intention to treat analysis: Yes	No significant difference in AoD use between groups at follow-up.	
Bowes (2012)	Evaluate the impact of new treatment compared to standard.	Data from (new) treatment group and control group pre- and post-treatment. Prison-based data only Measures: Likelihood of alcohol use and violence Statistical tests: ANOVA, t-tests Intention to treat analysis: Yes	Significant reduction in likelihood of violence and alcohol use. Results are theoretical as participants still in prison	
Knight (1997)	Evaluate outcomes of new TC, with post-prison care compared to control group.	Data from treatment and control groups 60 days before treatment completion/release; 182 and 365 days after release. 30% of follow-up group agreed to drug testing. Focused on re-imprisonment not drug use. Measures: Drug use, arrests, re-imprisonment, Statistical tests: Chi-square Intention to treat analysis: No	Significant difference with TC graduates less likely to use drugs and re-imprisonment, the effect was larger for participants who entered the post-prison care treatment	Strong
Welsh (2007)	Compare outcomes from participants with and without post-prison care after TC treatment.	Data from participants with and without mandatory post-prison care at TC completion; post-release at 90 and 365 days. Measures: AoD use (urinalysis for drug use), arrest, re-imprisonment Statistical tests: ANOVA, chi-square, logistic regression Intention to treat analysis: No	No significant difference between groups for AoD use. Post-prison care group less likely to be re-imprisoned, particularly if employed or older	
Wexler (1999)	Compare impact of and outcomes from TC participants with and without post-prison care, to control group.	Data from TC and control groups while in prison, and during post-prison care and at 365 days post-release. The analysis focused on re-imprisonment. Only interviewed the post-prison care participants with other follow-up data from departmental files. Measures: Drug use, arrest, re-imprisonment, social functioning Statistical tests: Chi-square, univariate Intention to treat analysis: Yes	Significant result with TC graduates less like to be re-imprisoned with those who in post-prison care having the best results.	
Chaple (2014)	Assess impact and compare inmate experience of the process of new computerised AoD and standard educational classes	Data from pre- and post-treatment for new computerised treatment and control groups and 120 to 180 days post-release. AoD use data not collected at follow-up. Measures: Satisfaction, perception of treatment, previous AoD use, harm reduction, arrest, re-imprisonment Statistical tests: Chi-square, t-tests, generalised linear modelling Intention to treat analysis: Yes	. No significant difference between levels of knowledge acquired by each group. Higher level of treatment satisfaction among treatment group	Moderate

Inciardi (1997)	Compare outcome from TC only, TC + post-prison care, no TC but with post-prison care, and control	Data from prior to leaving prison, 180 and 540 days post-release. Measures: AoD use, arrest, re-imprisonment Statistical tests: Descriptive, logistic and least squares regression Intention to treat analysis: Yes	Significant results with lower AoD use at 180 & 540 days for TC + post-prison (best results), & the post-prison care only groups	
Joe (2010)	Compare impact of methamphetamine treatment of 2 x TC, a group treatment & control group	Data from pre- and post-treatment for 2 x TC, 1 x group treatment, & prison intake for control group & 120 days later for controls. Prison-based data only. Measures: Self-efficacy drug use harm reduction, criminal behaviour and social functioning Statistical tests: t-tests, linear models, multivariate Intention to treat analysis: No	Significant improvement across psychological functioning areas for all 3 treatment groups. Best result from the 2 x TC.	
Lee H (2014)	Assess impact of TC on, self-efficacy for drug use avoidance, & increase problem-solving skills compared to control group	Data from pre- and post-treatment. Self-referral to research with random allocation to treatment or control group. Prison-based data only. Measures: Self-efficacy for drug use harm reduction, problem solving skills Statistical tests: Chi-square, Wilcox rank sum tests, t-tests Intention to treat analysis: Yes	Small sample, results not statistically significant	
Lee K-H (2011)	Assess impact of mindfulness treatment compared to standard treatment	Data from pre-, during, and post-treatment. Analysis measuring change within each group, with no direct comparison between groups. Prison-based data only. Measures: Depression levels and self-efficacy for drug use harm reduction Statistical tests: MANOVA, ANOVA Intention to treat analysis: Yes	Significant difference in treatment group pre- and post-tests. No significant difference in control pre- and post-tests.	Moderate
Pelissier (2001)	Compare arrest and AoD use outcomes among moderate and high intensity federal prison treatment program and controls	File data used, with result from treatment groups combined. High and moderate treatment groups interviewed 42 days after commencement and within 14 days of treatment completion, 2/3 of these groups placed in prison-based 'half-house' with others receiving in prison transitional care. Participant file data including for controls reviewed 182 days post-release. Measures: AoD use, arrest, re-imprisonment Statistical tests: Survival analysis, correlation, logistic regression, multivariate Intention to treat analysis: No	Data for treatment groups reported together. Significant difference with decreased AoD use and lower rearrests among treatment groups.	
Welsh (2010)	Assess impact of TC on treatment group.	Baseline date from treatment intake; 30 days after commencement; 182 days; and at treatment completion 365 days. Prison-based data only. Measures: Self-efficacy drug use harm reduction, antisocial personality characteristic changes Statistical tests: Linear modelling, GLM repeated measures, multivariate, ANOVA, F-tests Intention to treat analysis: Not applicable	Significant results for decreased depression but not for AoD self-efficacy. Significant relationship with 3 factors time x risk x motivation all associated with decreased anxiety.	
Bowen (2006)	Evaluate outcomes of mindfulness meditation and standard AoD treatment	Data collection from treatment and control groups at treatment completion or prior to release (controls); and at 120 and 180 days post-release. Missing data estimated using maximum likelihood calculation Measures: AoD use and problem-solving skills Statistical tests: Univariate, chi-square Intention to treat analysis: No	Significant decreased in AoD use post-prison for meditation group.	Weak
Crundall (1997)	Compare outcomes of treatment group and control	Data collected on average 112 days post-release; third parties (e.g. probation officer) used to supplement missing data. Measures: Alcohol use and socialisation with people who drink Statistical tests: Chi-square and univariate	No significant difference between groups for alcohol consumption post-prison	

		Intention to treat analysis: Unclear		
Davis (2014)	Compare impact of moderate and high intensity treatments.	Data from prison entry and 42 to 140 days at treatment completion. Prison-based data only. Measures: AoD use harm reduction, psychological functioning, problem solving skills Statistical tests: Univariate, multivariate Intention to treat analysis: No	Significant outcome, participants in both treatments with increased social desirability had the largest change in attitudes and beliefs about AoD use	
Gossage (2003)	Evaluate outcomes from Traditional Sweat Lodge treatment among Native American men	Data collected pre- or at treatment commencement, data included AoD use prior to prison; and 90 to 270 days post-release. Results compared self-reported AoD use before and after prison. Measures include: AoD use, cultural practises and understanding Statistical tests: Chi-square, univariate Intention to treat analysis: Not applicable	No significant results including no reduction in alcohol use.	
Linhorst (2012)	Compare treatment outcomes Court ordered to parole revocation groups	File data from treatment intake; completion 90 to 120 days later and 365 days after re-lease. AoD use data not collected at follow-up, analysis focused re-imprisonment Measures: AoD use, arrest and probation failure, Statistical tests: Chi-square, t tests, univariate, logistic regression Intention to treat analysis: No	Significant result with Court ordered group less likely to be re-imprisoned.	
Matsumoto (2014)	Evaluate the impact of treatment moderate and high methamphetamine use treatment groups	Data from treatment enrolment, commencement of self-teaching work-book, after completion of self-teaching workbook, and after completion of day attendance treatment. Prison-based data only. Measures: Self-efficacy for drug use harm reduction, psychological functioning Statistical tests: Wilcoxon signed-rank test, t-tests Intention to treat analysis: Not applicable	Significant increase in self-efficacy for the moderate and high methamphetamine use groups. No significant change in the low dependency group	Weak
Raney (2005)	Investigate impact of an early release incentive on AoD treatment and perceptions of treatment helpfulness	Data collected from 3 groups at different stages of the same treatment. Within group responses from participants who were offered early release incentive and those who were not are compared. Qualitative data also used in analysis, this was not verbatim there were notes by interviewer. Interviews concurrently, group 1 at 1 month after commencement, 60 to 90 days and 90 to 180 days. Prison-based data only. Measures: Knowledge acquisition of drug use harm reduction, satisfaction, perception of treatment Statistical tests: t-tests, univariate Intention to treat analysis: Not applicable	Some p-vales provided in-text but without further details validity of results cannot be determined. Authors claim results show incentive of early release is effective in helping inmates focus on treatment gaols.	
Slaski (2006)	Assess outcome difference between prison and community-based alcohol treatments	Data collected 7 days after treatment commencement for both groups, 90 days later for prison and 240 days for community group. Prison group data from prison only. Measures: Behavioural characteristics including reflective practises, defensiveness Statistical tests: Univariate, ANOVA Intention to treat analysis: Unclear	Significant result with increase in reflective behaviour of the prison group.	
Stohr (2002)	Investigate process experiences of different TC 1 and TC 2 treatment groups	Single survey with no specific treatment stage time frame stated. Prison-based data only. Measures: Satisfaction and perception of treatment Statistical tests: ANOVA Intention to treat analysis: Not applicable	Significant differences with participants at TC 1 listing NA and AA meetings as the 'biggest strength'. TC 2 participants listed cognitive change program	

Turley (2004)	Assess outcomes of AoD treatment over several years 1995, 1998 and 2000 compared to controls Evaluation: Outcome	File data from treatment intake, and 180 days post-release compared to control groups. AoD use data not collected at follow-up. Measures: Arrest, re-imprisonment Statistical tests: Chi-square Intention to treat analysis: No	Significant reduction for arrests among treatment compared to control groups.	
Vaughn (2003)	Assess outcomes from first prison AoD treatment in Taiwan Evaluation: Outcome	Data from treatment and controls pre-release and 365 days post-release. Measures: AoD use, social functioning, employment, housing and arrest, re-imprisonment Statistical tests: Chi-square Intention to treat analysis: Yes	Significant results with adverse treatment effect with treatment participants more likely to engage in AoD use than the controls.	Weak
Vukadin (2004)	Investigate process experiences 2 addiction treatments in a maximum security prison Evaluation: Process	Single data collection from inmates in an alcohol or narcotic treatments. Prison-based data only. Measures: Satisfaction and perception of treatment Statistical tests: Chi-square Intention to treat analysis: Not applicable	No p-values reported. Authors claim positive perceptions of treatments. Narcotic treatment group, less favourable toward treatment than the alcohol group	

Substance use was measured in 12 papers (27, 29, 66, 70, 72, 75, 77, 80, 84, 86, 88, 91). There was no comparison group in one of these (27), while the 11 others each had comparison group/s: residential treatment, four (66, 70, 88, 91); therapeutic prison, one (72); therapeutic community, four (29, 75, 77, 80), and group treatment, two (84, 86). Four of the 11 reported a positive impact for reduced substance use among the treatment group: residential treatment, one (88), therapeutic prison, one (72), and therapeutic community, two (75, 77). Substance use harm-reduction self-efficacy was measured in eight papers (71, 73, 76, 78, 81, 83, 85, 87), and drug use harm-reduction in six (71, 73, 76, 78, 81, 87). Satisfaction and perception of treatment were measured in four (71, 74, 79, 83), with other measures including but not limited to social functioning in four (29, 66, 71, 76), problem solving in three (72, 78, 85), and psychological functioning, including depression, in four (66, 73, 78, 85).

Of the twelve studies that rated as strong or moderate, six used prison-based data only (76, 78, 81-83, 87) and six had post-prison data (29, 66, 75, 77, 80, 88). Of the six with post-prison data, four reported reduced likelihood of imprisonment (29, 77, 80, 88). Three reported reduced substance use, were all treatments that lasted between 274 days (9 months) and 365 days (12 months), and used forms of CBT (75, 77, 88).

QATSQ Global Ratings

Five studies were ranked globally on the QATSQ as strong (29, 66, 77, 80, 82), seven as moderate (75, 76, 78, 81, 83, 87, 88), and 12 as weak (27, 69-74, 79, 84-86, 91). These ratings are used to group the papers for Table 2.3 above, which reports the aims, analysis and statistical tests, as well as the outcomes of the research.

2.3.5 Appraisal of the Qualitative Paper

Key findings for the only qualitative paper, by Straton et al. were not stated concisely. The article was a general summary of a residential treatment program with inmate and staff participants. The methodological framework was vague, with no description of the participant group and no detail about the context of the interviews - for example, whether data were collected via audio recording or by written notes, or whether results were for the inmate or staff participants. The authors reported the program as successful in changing the behaviour so that participants were less likely to abuse substances upon release, however post-release data were not presented (91).

2.4 Discussion

Of the 25 studies evaluating behavioural substance abuse treatment in prison, the number published in the period 1995 to 2005 (n=12) is comparable to those published in the period 2006 to 2015 (n=13). The methodological quality of the evaluations has improved over time, however: just three of the 12 evaluations published from 1995 to 2005 were methodologically sound (moderate 2, strong 1), compared to nine of 13 in the most recent decade (moderate 5, strong 4). Of the 12 quantitative evaluations rated globally as either strong (n=5) or moderate (n=7), eight were from the United States (29, 75-77, 80, 81, 83, 88), with one each from Canada (66), Taiwan (87), South Korea (78), and the United Kingdom (Wales) (82). Seven of the 12 methodologically sound studies evaluated therapeutic communities (29, 75-78, 80, 81), three, group treatments (82, 83, 87), and two, residential treatments (66, 88). The methodological quality of evaluations of the therapeutic community treatments was clearly higher than for the other treatment approaches, with seven of the eight (88%) rated as methodologically sound, compared to 43% of group treatment and 30% of residential treatment approaches.

Of the twelve methodologically strong or moderate studies, eight had statistically significant results (29, 75-77, 82, 83, 87, 88). Of these eight, three reported a statistically significant reduction of AoD use post-prison: Pelissier et al 2001, reported on treatment that was in a residential setting (88), while Inciardi et al 1997, and Knight et al 1997, both reported on treatment in TC settings (75, 77). All three reported on treatments that used a form of CBT treatment. Measures for drug use post-prison were urinalysis results, with Pelissier et al also including refusals to undertake urinalysis as a positive test for drugs. Alcohol use measures were self-reported, either directly by participant or from file information. There were no medical tests for alcohol use.

It is not possible to report on the AoD use of people who are lost to follow-up, and the three methodologically sound studies reporting statistically significant reduction in AoD use post-prison (75, 77, 88) had significantly less participants at follow-up than were initially eligible to be in the study. Inciardi et al, reported a total of 1,002 eligible participants with 448 (44.7%) participants interviewed at follow-up; Pelissier et al, identified 3,112 eligible participants, reporting on 1,569 (50.4%) participants at follow-up, and Knight et al, had a total of 603 eligible participants, with 414 (68.7%) at follow-up.

There are multiple reasons for the loss to follow-up that were reported in the eight studies with post-prison data. Research participants may not want to be associated with the criminal justice system once they are released and they may have higher day-to-day priorities than

taking part in research. Additionally, people in this population may not wish to admit to the use of illicit drugs, which is an illegal activity. Nonetheless, while the results at follow-up indicated a statistically significant reduction in AoD use, these results should be interpreted with caution. The only methodologically sound papers which reported reduced AoD use were Pelissier et al, Knight et al and Inciardi et al. All were TC or residential treatment programs, used forms of CBT, and had durations of 274 days (9 months) to 365 days (12 months). All three had aftercare.

Four methodologically sound papers reported reduced likelihood of re-imprisonment (29, 77, 80, 88). Imprisonment data can be accessed from police, courts and prison databases in most developed countries, though this can be a time-consuming process. Reporting accurately on re-imprisonment has its challenges, including participants moving outside of the legal jurisdiction where the research is taking place - for example, in the United States participants could move to any one of the other 50 states. The four papers, Pelissier et al (2001), Knight et al (1997), Welsh (2007) and Wexler et al (1999), all had varying approaches when measuring re-imprisonment.

Welsh (2007), had a sample of 2,809 eligible participants (inmates). Through a list-wise deletion, a process whereby cases are deleted if they do not have 100% of the data reported correctly, Welsh had a final sample of n=708: the treatment group of n=217 and a control group of n=491 participants, equating to 25.2% of the eligible sample. Wexler et al (1999), had n=715 participants, with n=425 in the treatment groups and n=290 in the control group. Wexler et al. categorised the treatment and controls into five sub-groups: A) controls (n=425); B) dropped out of treatment in prison (n=98); C) completed treatment in prison but did not attend aftercare (n=194); D) completed prison treatment but dropped out of aftercare (n=36), and E) completed both prison-based TC and post-prison care (n=97). All 715 participants were interviewed at 12-month follow-up. This either gives 100% follow-up, or it is possible there were more participants but only those with whom they had follow-up interviews were included in the analysis. Nonetheless, Wexler et al, conducted an intention-to-treat analysis of the participants, with TC and aftercare dropouts included in the analysis, and was the only one to do so. Pelissier et al, identified n=3,112 eligible participants, but reported on n=1,569 (50.4%) participants at follow-up, with an single intervention group of n=760 and n=809 controls. Knight et al, had a total of n=603 eligible participants with n=414 (68.7%) at follow-up with an intervention group of n=293 and n=121 controls.

While these results indicate that prison-based residential or therapeutic community AoD treatment does reduce the likelihood of re-imprisonment, further work needs to be

undertaken to understand the true effect. A report by the NSW Bureau of Crime Statistics and Research in Australia (2016) published after the inclusions criteria for this review (1995-2015) undertook such an analysis for prison-based AoD treatment programs and found no statistically significant reduction in re-imprisonment (93). There was, however, a trend that indicated reduced likelihood of re-imprisonment in the Bureau of Crime Statistics report and it is possible that with a larger sample size the trend could become statistically significant. It should also be considered here that this review was focused on AoD treatment and we cannot make a firm finding about reduced likelihood of re-imprisonment based on it alone, because non-AoD treatment programs that focus on areas including interpersonal violence and anger management should also be considered in relation to reduced re-imprisonment. Future intention-to-treat analysis as well as a survival analysis would also yield more accurate results for reporting on reduction of re-imprisonment.

Prison is a challenging environment in which to conduct research, with multiple ethical and methodological challenges. Six of the total 25 papers had a strong research design with one being a randomised controlled trial (RCT) (82) and the others clinical controlled trials (CCT) (29, 66, 78, 83, 87). The RCT by Bowes et.al (2012) enrolled participants voluntarily and then randomly assigned them to the treatment or control groups, with those in the control group receiving standard behavioural substance use treatment so as not to deprive them of behavioural substance use treatment (82). This method is possibly the most viable way to conduct a randomised controlled trial in a prison environment. However, Bowes et al. did not have post-prison follow-up. A future RCT with a similar design that has post-prison follow-up could make a significant contribution to the understanding of the effectiveness of prison-based substance abuse treatment.

Despite minority populations (for example, African-Americans and Indigenous Peoples) being over-represented in prison populations, this study found that only two treatment evaluations focused on these minority groups: a US study related to First Nations peoples (27); and an Australian study in which 87% of the intervention group and 100% of the control group were Indigenous (84). Although the authors of both papers discussed likely positive effects, neither rated globally as being methodologically sound, meaning their results remain inconclusive. Furthermore, no US papers specifically focused on African-Americans, despite their over-representation in the prison system (12). In Australia, Aboriginal and/or Torres Strait Islanders (Indigenous Australians) comprise 27% of the prisoner population but just under 3% of the Australian population (94, 95). In New Zealand, 15% of the population are Māori but Māori people are 50% of prison inmates; and Indigenous Canadians represent 3.8% of the population but 16.6% of that country’s federal prison population (96).

Considering these large populations of Indigenous Peoples in prison and their culturally unique needs, quality research is needed to help determine the most effective form of prison-based behavioural substance abuse treatment for them.

2.5 Conclusion

The methodological quality of published evaluations of prison-based behavioural substance use programs has improved in the last decade. Therapeutic communities received the strongest evaluations, producing the most positive findings. All therapeutic communities included a version of cognitive behavioural treatment.

There is still an urgent need for methodologically sound evaluations of treatment programs for Indigenous Peoples, given their over-representation in prisons globally and their relatively poor health status compared to non-Indigenous populations (97).

For prison-based behavioural substance abuse treatment programs for men, current best evidence supports the provision of cognitive behavioural treatment delivered in a therapeutic community or residential format. Post-prison treatment appears to be a promising addition to in-prison treatment. The next chapter considers the extent to which there is scope to tailor best-evidence, prison-based AoD treatment programs to the specific needs of Indigenous, compared to non-Indigenous, prisoners.

Chapter Three: Alcohol and other Drug use among Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander Men entering Prison in New South Wales

Published in Health and Justice 2015

3.1 Introduction and Aims

It is well understood, both in Australia and internationally, that a history of alcohol and other drug use is relatively common among people in prison (5, 11, 12). It is therefore appropriate that prison-based alcohol and other drug (AoD) use treatment is available in all Australian states and territories. What is not well understood, however, is, the extent to which the prison-based AoD treatment needs of Indigenous and non-Indigenous men differ. This knowledge gap gives rise to the second research question for this thesis: *What is the level of need for such treatment programs in New South Wales?* The specific aims of this chapter are twofold: to compare prior AoD use among Indigenous and non-Indigenous prison entrants, and to identify the implications for AoD treatment provision for Indigenous and non-Indigenous inmates within NSW prisons.

The findings in this chapter identify the differences and similarities in AoD use between Indigenous and non-Indigenous men entering prison in NSW. The chapter focuses on men and on the state of NSW because the primary data collection for this thesis - as reported in the following chapters - was undertaken with men in prison in that state. This chapter was published in *Health & Justice* journal in 2015, authored by Michael F Doyle (lead author), Tony G Butler, Anthony Shakeshaft, Jill Guthrie, Jo Reekie and Peter W Schofield. The published version can be found at Appendix 4.

3.2 Methods

This chapter reports on secondary analysis of an existing data set. The lead researcher, Doyle, was provided the data set by PhD supervisor Butler. The researcher did not participate in data collection nor in the original analysis of the data. However, his new contribution was to design and implement the re-analysis of the data, and the writing of this chapter and the associated published paper.

3.2.1 Participants

The sample comprised 200 men received into the criminal justice system in the Hunter Region of New South Wales between September 2003 and June 2004. The data were collected as part of a study examining reported past Traumatic Brain Injury (TBI), and full details of the study are published elsewhere (98, 99). Participants were randomly recruited and their TBI status was only determined after they had been recruited. The participants were recruited after being received into a police cell complex or a reception prison and included both those on remand for sentencing by the courts and those recently sentenced. The project officer was primarily responsible for recruitment and, due to resourcing,

recruitment usually occurred one day per week. The project officer, or a nurse within the prison reception unit, administered the 11-page survey, with results being self-reported by participants. The project officer recruited 57% of participants and nurses recruited 43%, with only 3% of those approached declining to take part. No refusal data was recorded by reception unit recruiters. The cross-checking of data showed similar participant responses between those interviewed by the project officer and by other recruitment staff.

Recruitment was sequential; however, on days when resources did not permit sequential recruitment due to high volume of inmates entering custody, potential participants were identified by the last digit of their unique Corrective Services NSW assigned identification (ID) code in order from highest digit (nine) to lowest. In over 95% of cases the participant had been given this number when previously incarcerated or arrested. Consequently, there was little likelihood of any association between the last digit of the number and the temporal sequence in which they had been received into custody for the current offence (100, 101).

3.2.2 Measures

Alcohol use was measured using the 10-item World Health Organization's (WHO) Alcohol Use Disorders Identification Test (AUDIT) (24). Drug use questions are asked about any, and daily, drug use in the past four weeks (nicotine, cannabis, heroin, amphetamines, prescribed medications). Any illicit drug use was defined as having used any of: anaesthetics, anabolic steroids, non-prescribed methadone or opioid other than heroin, heroin, cocaine, amphetamine (and other related stimulants), cannabis, hallucinogens, volatile solvents and volatile inhalants daily in the past four weeks.

Mental health status was assessed using the 10-item Kessler Psychological Distress Scale (K10) to measure levels of psychological distress, and the International Personality Disorders Examination (IPDE) to measure impulsive personality (102, 103). The IPDE is a screening tool used to detect mental health disorders, and together with the K10, is widely used in epidemiological studies of mental health (104). Other data reported are those recorded by the health staff when assessing inmate risk upon entry to prison, such as previous episodes of mental health treatment, and self-harm episodes including previous suicide attempts. Details of previous TBI were reported, as this was the main outcome measure of the original study (98, 99). For this analysis TBI was defined as any injury ever to the head that caused a feeling of being 'dazed or confused' and or 'loss of consciousness/blackout'. It was established that answers from these inmates were quite accurate as some results were cross-checked using medical records (105).

3.2.3 Ethics

The original study received ethics approval both from the NSW Justice Health & Forensic Mental Health Network (JH&FMHN) Human Research Ethics Committee, and the Hunter New England Human Research Ethics Committee. Informed consent was required for participation.

3.2.4 Statistical Analysis

Participants were described by Indigenous status (yes/no), age (18-24 years, 25-39 years and 40+ years), marital status (married/de facto or single/separated), country of birth (Australia or other) and educational attainment (did not complete year 10, completed year 10, and completed year 12 or post school qualifications). For offending history, respondents were asked if they had been to juvenile detention or not. The primary offence for which they were in custody was categorised as being violent or non-violent, with a violent offence being one whereby harm was inflicted on another person.

Individual items on AUDIT are scored 0-4 and aggregated to a total from 0-40. Respondents' scores were categorised using the standard WHO categories (24): 0 (no alcohol consumption); 1-7 (low-risk alcohol consumption); 8-19 (harmful/hazardous risk to health from alcohol consumption); and ≥20 (high-risk of harm from alcohol consumption and/or possibly alcohol dependent). Since WHO recommends an alcohol intervention for people who score ≥8, respondents' AUDIT scores were then also categorised as either <8 (no treatment) and ≥8 (treatment recommended). Other drug use was categorised as yes, no or missing for daily use in the past four weeks.

For mental health status, each item on the IPDE was scored as positive or negative, with three or more positives in a single domain being an indication of that particular personality disorder (103). The K10 is scored numerically with a score of ≤19 indicating a minimal level of distress, 20 to 29 indicating an elevated level of distress, and ≥30 indicating a severe level of distress(102). Only the most severe distress level category was used for analysis because entry to prison can be in itself a cause of distress. Answers to items for previous mental health treatment, suicide attempts, family member attempted suicide, and self-harm episodes were categorised as yes, no or missing.

Data were analysed using IBM software Statistical Package for the Social Sciences (SPSS) version 22. The characteristics of Indigenous and non-Indigenous participants were compared: Chi-square tests were used to compare categorical variables and Mann Whitney U tests for continuous variables. Logistic regression analysis was used to investigate factors

associated with an AUDIT score of ≥8 (treatment recommended group). Variables with p<0.1 level significance in univariate analysis were included in the multivariate model, as well as Indigenous status and age.

3.3 Results

3.3.1 Inmate Characteristics

Over half of the sample was aged between 25 and 39 years, 72% were single, and 95% were born in Australia. One fifth (20%) identified as being Indigenous, which reflects the Indigenous composition of the male prisoner population in NSW at the time of the study (12). Educational attainment levels were similar between Indigenous and non-Indigenous inmates. For their current term of imprisonment, more Indigenous offenders (64%) than non-Indigenous offenders (50%) had committed offences categorised as violent. A similar number of Indigenous (80%) and non-Indigenous (77%) inmates scored 30 or over on the K10, indicating 'severe' distress. Just over two-fifths (42%) of non-Indigenous inmates and over half (53%) of Indigenous inmates screened positive for impulsive personality (IPDE). There was a high prevalence of brain injury for both Indigenous and non-Indigenous participants, but there was not a statistically significant difference between the groups. Overall, none of the differences between Indigenous and non-Indigenous respondents were statistically significant. There being no significant difference in inmate characteristics it is possible to infer that these men had similar backgrounds and life experiences, which is interesting given the differences in other finding below.

Table 3.1: Demographic, Offending History and Mental Health Characteristics by Indigenous Status

Characteristic	Indigenous (n = 40)	Non-Indigenous (n = 160)	Total	P-value
Age (years)	Median 28.7 IQR 23 to 35	Median 30.0 IQR 24 to 37		0.20[1]
Age category (years)				
18-24	14 (35.0%)	43 (26.9%)	57 (28.5%)	0.36[2]
25-39	22 (55.0%)	88 (55.0%)	110 (55.0%)	
40+	4 (10.0%)	29 (18.1%)	33 (16.5%)	
Marital status				
Married/de facto	10 (25.0%)	40 (25.0%)	50 (25.0%)	0.86[2]
Single/separated	27 (67.5%)	116 (72.5%)	143 (71.5%)	
Missing	3 (7.5%)	4 (2.5%)	7 (3.5%)	
Country of birth				
Australia	38 (95.0%)	151 (94.4%)	189 (94.5%)	0.89[2]
Other	2 (5.0%)	9 (5.6%)	11 (5.5%)	
Educational attainment				
Did not complete year 10	17 (42.5%)	51 (31.9%)	68 (34.0%)	0.42[2]
Completed year 10	13 (32.5%)	57 (35.6%)	70 (35.0%)	
HSC/Certificate/Degree	10 (25.0%)	52 (32.5%)	62 (31.0%)	
Juvenile detention				
Yes	16 (40.0%)	53 (33.1%)	69 (34.5%)	0.43[2]
No	24 (60.0%)	106 (66.3%)	130 (65.0%)	
Missing	-	1 (0.6%)	1 (0.5%)	
Offence type				
Violent	25 (62.5%)	80 (50.0%)	105 (52.5%)	0.10[2]
Non-violent	12 (30.0%)	75 (46.9%)	87 (43.5%)	
Missing	3 (7.5%)	5 (3.1%)	8 (4.0%)	
Number of arrests, Mean and median	Median 15.0 IQR 1.0 to 7.5	Median 10.0 IQR 1.0 to 11.0		0.06[1]
Kessler psychological distress scale (K10)				
No distress: 10-19	3 (7.5%)	12 (7.5%)	15 (7.5%)	0.84[2]
Mild to moderate: 20-29	5 (12.5%)	26 (16.2%)	31 (15.5%)	
Severe distress: 30+	32 (80.0%)	122 (76.3%)	154 (77.0%)	
Impulsive personality (IPDE)				
Positive	21 (52.5%)	67 (41.9%)	88 (44.0%)	0.23[2]
Negative	19 (47.5%)	93 (58.1%)	112 (56.0%)	
Ever treated for a mental health problem				
Yes	13 (32.5%)	48 (30.0%)	61 (30.5%)	0.76[2]
No	26 (65.0%)	108 (67.5%)	134 (67.0%)	
Missing	1 (2.5%)	4 (2.5%)	5 (2.5%)	
Have previously attempted suicide				
Yes	8 (20.0%)	25 (15.6%)	33 (16.5%)	0.52[2]
No	31 (77.5%)	130 (81.3%)	161 (80.5%)	
Missing	1 (2.5%)	5 (3.1%)	6 (3.0%)	
Family member attempted suicide				
Yes	5 (12.5%)	28 (17.6%)	33 (16.5%)	0.46[2]
No	33 (82.5%)	126 (78.7%)	159 (79.5%)	
Missing	2 (5.0%)	6 (3.7%)	8 (4.0%)	
Have previously self-harmed				
Yes	4 (10.0%)	10 (6.2%)	14 (7.0%)	0.42[2]
No	35 (87.5%)	144 (90.0%)	179 (89.5%)	
Missing	1 (2.5%)	6 (3.8%)	7 (3.5%)	
Traumatic brain injury				
Yes	33 (82.5%)	131 (81.9%)	164 (82.0%)	0.57[2]
No	7 (7.5%)	29 (18.1%)	36 (18.0%)	

[1] Mann Whitney U Test
[2] Chi-square Test

One quarter of non-Indigenous inmates reported that they did not consume alcohol in the 12 months prior to prison as indicated by an AUDIT score of 0 (Table 3.2). Over half of all Indigenous (55%) and non-Indigenous (53%) inmates scored ≥8 on the AUDIT, indicating a need for an alcohol intervention. Possible alcohol dependence was indicated among 22.5% of both Indigenous and non-Indigenous respondents (scored ≥20 on AUDIT). Inmate characteristics are presented in Table 3.1 below.

Cannabis was the most common illicit drug used on a daily basis in the past 4 weeks, with statistically significantly greater use among Indigenous (46%) than non-Indigenous (37%) inmates (p=0.05). Overall, compared with cannabis, considerably fewer inmates, both Indigenous and non-Indigenous, reported having used either amphetamine (14%) or heroin (13%). However, a statistically significant smaller proportion of Indigenous than non-Indigenous inmates had used amphetamine on a daily basis in the past four weeks (3% vs 17%, p=0.03). There were no statistically significant differences in the use of heroin or prescribed methadone/buprenorphine/naltrexone by Indigenous status.

Table 3.2: Indigenous and non-Indigenous Alcohol and Daily Illicit and Licit Drug use in the past 4 weeks

Alcohol and daily illicit and licit drug use		Indigenous (N = 40)	non-Indigenous (N = 160)	Chi-square p-value
No consumption	AUDIT 0	7 (17.5%)	40 (25.0%)	0.76
Low-risk	AUDIT 1-7	11 (27.5%)	36 (22.5%)	
Harmful/hazardous	AUDIT 8-19	13 (32.5%)	48 (30.0%)	
High-risk/dependent	AUDIT 20+	9 (22.5%)	36 (22.5%)	
Nicotine daily (drug) use past 4 weeks	Yes	33 (91.7%)	117 (77.5%)	0.06
	No	3 (8.3%)	34 (22.5%)	
	Missing	*4*	*9*	
Cannabis daily (drug) use past 4 weeks	Yes	17 (45.9%)	55 (36.7%)	0.05
	No	20 (54.1%)	95 (63.3%)	
	Missing	*3*	*10*	
Heroin daily (drug) use past 4 weeks	Yes	5 (13.2%)	18 (12.3%)	0.89
	No	33 (86.8%)	128 (87.7%)	
	Missing	*2*	*14*	
Amphetamine daily (drug) use past 4 weeks	Yes	1 (2.8%)	24 (16.8%)	0.03
	No	35 (97.2%)	119 (83.2%)	
	Missing	4	7	
Prescribed methadone/ buprenorphine/ naltrexone daily (drug) use past 4 weeks	Yes	3 (8.1%)	11 (7.4%)	0.88
	No	34 (91.9%)	138 (92.7%)	
	Missing	3	11	

3.3.2 AoD use and Mental Health Status

Although 24% of respondents were alcohol abstinent, two-thirds (64%) of alcohol abstainers had consumed illicit drugs on a daily basis (Table 3.3 below). Most of the inmates had not been treated previously for a mental health problem, even though there were high levels of severe distress reported in the K10 across all AUDIT categories. Three-quarters of inmates reported daily nicotine use, with high prevalence across all AUDIT categories.

Table 3.3: Alcohol, Nicotine and Illicit Drug use, and Mental Health status by AUDIT Category

Alcohol use	Daily nicotine use in past 4 weeks	Daily illicit [3] drug use in past 4 weeks	K10[4] ('severe' distress)	Previously treated for mental health problem	Total
No consumption AUDIT = 0	32 (21.3%)[1] (68.1%)[2]	30 (31.9%) (63.8%)	36 (23.4%) (76.6%)	16 (26.2%) (34.0%)	47 (23.5%)
Low-risk AUDIT = 1 to 7	35 (23.3%) (74.5%)	22 (23.4%) (46.8%)	41 (26.7%) (87.2%)	13 (21.3%) (27.7%)	47 (23.5%)
Harmful /hazardous AUDIT = 8 to 19	50 (33.3%) (82.0%)	23 (24.5%) (37.7%)	47 (30.5%) (77.0%)	15 (24.6%) (24.6%)	61 (25%)
High-risk/ dependent AUDIT = 20+	33 (22.0%) (73.3%)	19 (20.2%) (42.2%)	30 (19.5%) (66.7%)	17 (27.9%) (37.8%)	45 (22.5%)
Subtotal	150 (75%)	94 (47.0%)	154 (77%)	61 (30.5%)	200 (100%)
Indicated no use	37	97	46[5]	144	-
Missing	13	9	-	5	-
Total	200	200	200	200	200

[1] Percentage within column
[2] Percentage within row
[3] Includes: Anaesthetics, anabolic steroids, non-prescribed methadone or opioids other than heroin, heroin, cocaine, amphetamine (and other related stimulants), cannabis, hallucinogens, volatile solvents and volatile inhalants
[4] Only severe distress was reported as entry to prison can be a distressing event.
[5] Refers to a K10 score that did not indicate 'severe distress level'

The univariate analysis showed that the odds of daily heroin use in the past four weeks were reduced (OR=0.33, p=0.02) among the alcohol treatment recommended group. There was no significant difference between the treatment recommended and no treatment groups in their reported use of nicotine, cannabis and amphetamine in the past four weeks. The odds of the alcohol treatment recommended group using any illicit drug daily in the past four weeks were statistically significantly lower than the no treatment group (OR=0.48, p=0.01). However, when daily heroin use was excluded from the 'any illicit drug use' category, the odds of reduced use by the alcohol treatment recommended group, compared to the no treatment group, were no longer significantly different (OR=0.66, p=0.15).

The multivariate analysis showed that the odds of heroin use by those in the alcohol treatment recommended group remained significantly lower (OR=0.37, p=0.04) among those who had used heroin daily when Indigenous status, age and any illicit drug use (excluding heroin) are factored into the model. There was no statistically significant association between the treatment recommended group and Indigenous status, age, TBI or drug use (excluding heroin). These data are presented in Table 3.4 below.

Table 3.4: Alcohol Intervention and non-Intervention groups by Demographics/Health Issue

Demographic/Health issue[4]		AUDIT < 8 (no treatment) (n = 94)	AUDIT ≥8 (treatment recommended) (n = 106)	Univariate O.R. (95%CI)	P-value	Multivariate O.R. (95%CI)	P-value
Indigenous status	Indigenous	18 (19.1%)	22(20.8%)	1.0		1.0	
	Non-Indigenous	76 (80.9%)	84 (79.2%)	0.90 (0.45-1.81)	0.78	0.79 (0.37-1.66)	0.53
Age in years	18-24	25 (25.6%)	32 (30.2%)	1.0	0.78	1.0	
	25-39	52 (55.3%)	58 (54.7%)	0.87 (0.46-1.66)	0.68	0.93 (0.47-1.87)	0.84
	40+	17 (18.1%)	16 (15.1%)	0.75 (0.31-1.74)	0.48	0.67 (0.27-1.67)	0.39
Traumatic brain injury	Yes	74 (78.7%)	90 (84.9%)	1.0			
	No	20 (21.3%)	16 (15.1%)	0.66 (0.32-1.22)	0.26		
	missing	0	0				
Daily nicotine use in past 4 weeks	Yes	67 (77.9%)	83 (82.2%)	1.0			
	No	19 (22.1%)	18 (17.8%)	0.76 (0.37-1.57)	0.47		
	Missing	8	5				
Daily cannabis use in past 4 weeks	Yes	38 (44.7%)	37 (36.3%)	1.0			
	No	47 (55.3%)	65 (63.7%)	0.70 (0.39-1.27)	0.24		
	Missing	9	4				
Daily heroin use in past 4 weeks	Yes	16 (18.8%)	7 (7.1%)	1.0		1.0	
	No	69 (81.2%)	92 (92.3%)	0.33 (0.13-0.84)	0.02	0.37 (0.14–0.96)	0.04
	Missing	9	7				
Daily amphetamine use in past 4 weeks	Yes	14 (17.3%)	11 (11.2%)	1.0			
	No	67 (82.7%)	87 (88.8%)	0.60 (0.26-0.26)	0.25		
	Missing	13	8				
Daily prescribed methadone/ buprenorphine/ naltrexone in past 4 weeks	Yes	5 (5.7%)	5 (4.9%)	1.0			
	No	82 (94.3%)	98 (95.1%)	0.44 (0.14-1.37)	0.16		
	Missing	7	3				
Any illicit drug use daily (excl. heroin)	Yes	45 (51.1%)	42 (40.8%)	1.0		1.0	
	No	43 (48.9%)	61 (59.2%)	0.66 (0.37-1.17)	0.15	0.64 (0.35-1.18)	0.15
	Missing	6	3				
Any illicit drug use daily	Yes	52 (59.1%)	42 (40.8%)	1.0			
	No	36 (40.1%)	61 (59.2%)	0.48 (0.27-0.80)	0.01		
	Missing	6	3				

3.4 Discussion

Based on the AUDIT scores, over half (106) of the sample met the criteria for requiring an alcohol intervention and 45/106 (43%) of that group warranted further investigation for possible alcohol dependence. We found no significant differences between Indigenous and

[4] No statistically significant differences between the AUDIT identified no treatment and treatment recommended groups by demographic characteristics of marital status, country of birth, educational attainment, juvenile detention, offence type, K10, impulsive personality, ever been treated for a mental health problem, have previously attempted suicide, family member attempted suicide, and have previously self-harmed. Data not shown.

non-Indigenous inmates with regard to alcohol use, suggesting that problematic alcohol use is equally spread between these two groups. These results would imply that about 50% of prison entrants could benefit from an alcohol intervention, and that supervised withdrawal from alcohol may be required for between 20% and 25% of prison entrants. The extent to which case management occurs for alcohol use disorders in Australian prisons is unknown.

Illicit drug use was common among inmates, with almost half reporting daily use. Inmates who reported using heroin on a daily basis either consumed less alcohol or no alcohol. The major differences by Indigenous status were that Indigenous inmates were more likely to use cannabis (p=0.05), but less likely to use amphetamine on a daily basis than were non-Indigenous inmates (p=0.03). Tobacco use was high among both Indigenous and non-Indigenous inmates with 150/200 (75%) smoking on a daily basis, implying a role for smoking cessation interventions. Of the 200 study participants, based on our screening measures, only 42 (21%) did not merit any AoD behavioural treatment, 64/200 (32%) warranted an alcohol (but not illicit drug) intervention; 52/200 (26%) required help for illicit drug use (but not alcohol) and 42/200 (21%) required assistance for both alcohol and illicit drug use. Despite these differences, it is likely that if these inmates were to receive a prison-based AoD intervention program, that program would be focused on illicit drug use only, or on alcohol and illicit drug use, but not on alcohol specifically, as discussed further below.

The IPDE scores indicated that 44% of inmates potentially had impulsive personalities and the K10 results showed that 77% (n =154) had severe psychological distress. The K10 result should be interpreted with caution, since entry to prison can itself be a distressing event; nonetheless, the findings here are broadly consistent with the well-established high levels of poor mental health among people in prison (26, 27). Both the IPDE and the K10 are screening tests, with further assessment required before a diagnosis can be made, but it is highly likely that a significant proportion of the participants in this study would benefit from support for their mental health.

Alcohol and other drug treatment needs for Indigenous and non-Indigenous prison entrants may be different. The results indicate that there is some scope for recommending a focus on cannabis among Indigenous inmates as more Indigenous than non-Indigenous men reported daily use (46% versus 37%, p= 0.05). Other data support a focus on cannabis use for Indigenous Australians not just in prison but in the general population. The 2011 *National Drug Household Survey* reported cannabis use among Indigenous respondents was 19% as against 10% for non-Indigenous respondents (age of ≥14) (106), and the *National Aboriginal and Torres Strait Islander Health Survey* released the same year reported that nearly one in

five (19%) of Indigenous respondents (aged ≥15) had used cannabis in the previous 12 months (no comparable figure for non-Indigenous use) (89). Within Australian prisons there appear to be no cannabis-specific programs either for Indigenous or for non-Indigenous inmates (2, 3), even though it is the most commonly used illicit drug among prison inmates (107).

It is possible that the alcohol and other drug treatment needs of the prison entrants in this study are different from those of other inmates. Within this study, data were collected in 2003-04, and there was some difference in AoD use relative to the findings of the 2009 *NSW Inmate Health Survey* (5), which had data collected in 2008-09[5]*.* For example, based on AUDIT scores, an intervention for alcohol use would have been indicated for 53% in this sample but for 63% of respondents in the Inmate Health Survey. There could be a number of factors as to why such a difference occurred, including the three-year difference between the dates of data collection. Another notable difference is that the participants for this sample are all prison entrants from one site, while the *Inmate Health Survey* represents a cross-section of the whole prisoner population in NSW, with many of those inmates having been in prison for 12 months or more. Another possibility is a difference in recall, which is a strength of this study as participants in this survey were asked to recall recent use of AoD, rather than recalling AoD use that occurred several months or even years earlier.

With this group of participants some caution is needed when interpreting results, since prison entrants could be reluctant to answer questions that relate to criminal activity (for example, consuming illicit drugs). However, inmate responses in this study had a high degree of consistency with the notes recorded in their medical records, and as such can be thought to be fairly accurate with their responses (100). Compared to the 2009 *NSW Inmate Health Survey*, however, the smaller numbers in this study, particularly of Indigenous participants, limit its statistical power.

Court-based and mandated referral pathways into drug treatment occur regularly. Drug courts operate in every Australian jurisdiction, but the national response to the most commonly-used substance, alcohol, has been much less coordinated (108). The results from this study demonstrate that more than half of the sample may benefit from an alcohol intervention and that non-Indigenous men are in equal need of an alcohol related intervention. Alcohol has been included as an extension of the drug court in some, but not

[5] The difference between data collection dates means the comparison between the two surveys should be done with caution.

all, Australian jurisdictions (108). This extension is used predominantly in those areas with a higher proportion of Indigenous Australians as residents, however, which are generally away from the large state capital cities and major population centres (108).

There is limited aggregated data on the provision of AoD treatment within prison, yet there are prison-based AoD programs operating in every Australian jurisdiction (2, 3). It is not known how many inmates commence and complete these programs, nor is it known how long is the average wait time from prison entry and assessment to commencement of an AoD treatment program. There appears to be no published research into the long-term outcomes of those who complete the AoD programs, and neither is it known if people who undertake these programs are any less likely to return to prison. With such sparse research into prison-based AoD treatment it is not known whether Indigenous inmates have different outcomes to non-Indigenous inmates; what is clear is that there are few jurisdictions that have Indigenous-specific programs. Further research in this area is essential, particularly with the view to improving services for Indigenous Australians who are vastly over-represented in the nation's prisons.

Alcohol and other drug treatment in prison can be effective, but such treatment should be specific to the individual's needs or it can be harmful (39, 109). Inmates are assessed by staff and are referred to or placed into the AoD treatment programs (11, 18). There are different AoD programs which focus on differing aspects of drug use or treatment, but generally program classes consist of around 12 and up to 20 inmates attending a one- to two-hour class two to three times a week for around 12 weeks (11, 18). Limited aggregated data are available on the numbers of inmates who undertake and complete AoD treatment programs, and it is not known how long a wait there is between entry to prison and commencement of an AoD program (11, 18). What is quite clear, however, is that few of these programs are specifically alcohol focused - most are for alcohol and other drug use - and few AoD programs are specifically for Indigenous people (11, 18).

3.5 Limitations

The major limitation of this Chapter is that the data set was collected between September 2003 and June 2004 and, as such, it was 11 years old when this Chapter was published as a paper. The data set was provided to the researcher by primary PhD supervisor Professor Tony Butler as it was available and was relevant to the research field of interest.

3.6 Conclusion

In summary, there was a diversity of educational levels, employment history and history of imprisonment among the group as a whole, but there was no statistically significant difference on these demographics between Aboriginal and non-Aboriginal participants. The findings from the analyses in this chapter demonstrate that a majority (79%) of study participants would most likely benefit from some form of AoD treatment on entry into the prison system. Both Indigenous and non-Indigenous inmates had similar rates of prior use of alcohol and tobacco, but there were some distinct differences in the use of certain illicit drugs. While AoD treatment is offered to prison inmates in all Australian jurisdictions, there is only limited data available to assess accessibility, participation, benefits, and short and long-term outcomes. The clear implication is that more research is required into each of these aspects of prison-based AoD treatment.

This research further indicates that while both Indigenous and non-Indigenous prison entrants would most likely benefit from AoD treatment, it may be that the benefits for each group would be greater if their differing needs were considered in the design and conduct of the programs. The next chapter in this thesis, which describes the characteristics of the 31 men who took part in the qualitative part of this research, aims to contribute to a deeper understanding of why this is desirable and how it may be achieved.

Chapter Four: Qualitative Methods and the Participants

4.1 Introduction and Aims

In this chapter the qualitative methods and the participants involved in the primary data collection are described. This chapter provides the foundation for Chapters Five, Six and Seven, which all arise out of the methods used and results from the interviews with the 31 participants who are described here. The aims in this chapter are first, to outline the rationale for the use of grounded theory for this research; second, to outline the methods used; and third, to give the reader an understanding of the men who participated, including insight into their personal circumstances. A summary of participants follows the methods section. A table is also provided, outlining some of the basic demographics of the men who participated in this research.

4.2 Research Setting

Participants were recruited via their engagement in the Intensive Drug and Alcohol Treatment Program (IDATP). Baseline interviews occurred prior to commencement of IDATP, with the follow-up interviews planned for eight to nine months later, allowing enough time for participants to have completed the IDATP program. Given the baseline data alone yielded a considerable volume of high quality and rich data, which were directly related to the specific aims of this thesis, those data are the focus of Chapters Four to Seven.

The IDATP was established in February 2012 by the New South Wales Government as part of the response to the large numbers of people entering prison who had a history of hazardous AoD use related to their offending behaviour (110). The IDATP is a residential program, which initially operated at the medium-security John Morony Correctional Centre, but was later expanded to the Outer Metropolitan Multipurpose Correctional Centre, the minimum-security prison located on the same campus. Both facilities are situated in the Sydney suburb of Windsor, NSW, Australia (110).

At commencement, the IDATP had a capacity of 62 beds and it was the intention that it be expanded to 250 beds over successive years. Full operational capacity had not been achieved at the time this research was conducted. The IDATP is a six-month program, with inmates required to participate in work or educational classes while in IDATP (110). The central therapeutic treatment component of IDATP is the *Criminal Conduct and Substance Abuse Treatment* program, known as *Pathways*, which is usually delivered three times per week in 2-hour sessions over 21 weeks for a total of 126 hours. *Pathways* works on a cognitive behavioural change model (111). The program was developed in the United States and is used for prison-based AoD treatment in most Australian states and territories (2, 3).

4.3 Ethics

As noted in Chapter One, ethics approval was provided by the Aboriginal Health and Medical Research Council of NSW Human Research Ethics Committee and CSNSW Research Ethics Committee. All work was conducted in accordance with NHMRC guidelines, including those for research with Aboriginal and Torres Strait Islander people. These guidelines stipulate that such research must encourage the survival and protection of Aboriginal culture, respect multiple knowledges and cultural diversity, build capacity of Aboriginal people, and have real benefit for Aboriginal communities (54, 112).

4.4 Methods

A grounded theory method, as described by Strauss and Corbin, was used (53). Grounded theory was selected as the most appropriate qualitative method because there were no existing theories from qualitative research reporting on the AoD treatment experiences of men in prison that could be used as a guide for this work (52, 53). This was also the case for published qualitative work into prison-based AoD treatment for Aboriginal men, since the systematic review discussed in Chapter Two did not identify any relevant and methodologically robust published qualitative papers (44, 45).

The advantage of grounded theory within this context is that new theory is developed through in-depth interviewing and systematically analysing the data of a theoretical sample of people who have experienced the phenomenon being researched (52, 53). As such a systematic process was used for gathering and drawing meaning out of the data, to generate an original analysis and theory (52, 53, 113).

The findings in the next three chapters are at times reported with numbers of participants to provide some within-sample comparisons, and some findings are presented in table format in order to provide an overall description (114). The following chapter, Chapter Five, an analysis of the Aboriginal men's experiences, was separately undertaken to draw out meaning specific to these men and to develop an understanding of the specific needs of this group in relation to AoD treatment programs in Australian prisons.

4.4.1 Question guide

Strauss and Corbin (1992) proposed that grounded theory needs to have a research procedure that is consistent and maintains an objective but sensitive view of the data, but is also flexible (53). The procedure developed for this work was to use the same question guide for each participant, but to use the question guide with some flexibility and not to have

a linear flow of questions. Objectivity was maintained while remaining sensitive to the research topic and the responses of the participants, with the same questions being asked but the language used to express them being adapted through the course of the 31 interviews (53). There was also a practical consideration with the development of the question guide, as the researcher was advised by the CSNSW ethics secretariat officer (in 2014) to have a complete question guide prior to the ethics application. This was because the ethics committee would be unlikely to approve a research project if they did not know what questions would be asked of inmates.

The semi-structured question guide was designed to generate in-depth insights into the experiences of the men in the IDATP. It was developed in consultation with professional people (both Aboriginal and non-Aboriginal), working in the Aboriginal sector, drug and alcohol professionals, academics, and Corrective Services NSW staff. The question guide was developed before the first meeting of the project Reference Group, because it was deemed necessary to commence ethics processes as soon as possible and the question guide was required by the ethics committees. Many of the people consulted in the design of the question guide later became Reference Group members.

The development process included reviewing several therapeutic community questionnaires/question guides and evaluations and tools (115-117). This was undertaken to develop an understanding of the types of questions that should be covered and the domains (or groups) these questions should be placed into. The researcher drafted the questions and consulted supervisors (Butler, Guthrie and Shakeshaft) until the final question guide was developed. This resulted in open-ended questions being developed within seven domains:

1) **Demographic information:** Background information to contextualise the interviews from each of the participants. This included discussion on family backgrounds.
2) **Imprisonment and offending history:** An enquiry into how often the participant had been in prison and when they first came into contact with the criminal justice system, in order to understand the context of their involvement in offending and history in prison.
3) **Education and employment:** To contextualise the education and work experience these men had had and to explore if this had an impact upon their AoD use and offending. This also contextualised and explored their future prospects post-prison.
4) **Alcohol and other drug use:** To understand the extent of the AoD use, when they commenced use, the social circumstances, what they had used most frequently and what was their preferred drug, as well as how often they had used.

5) **Alcohol and other drug use treatment:** Directly related to the research question, 'How can prison-based AoD treatment for men be further developed, and how can it be further developed specifically to meet the needs of Aboriginal men in prison?' but framed in the past tense to reflect back on what had happened in the past.
6) **IDATP and current term of prison:** Directly related to the research question, 'How can prison-based AoD treatment for men be further developed, and how can it be further developed specifically to meet the needs of Aboriginal men in prison?' but framed in the current tense.
7) **Post-prison plans:** This question was asked to understand what the men thought was needed to be in place for them to change their lives so as to be happier in the future.

The questions were chosen because they were thought to be the most likely to open up the conversation around the different aspects of enquiry.

The functionality of the question guide was more as a checklist for areas covered during the interview, as the conversation was free flowing. There were occasions when, on reviewing the question guide at the end of the interview, it was realised that specific question/areas had not been covered, and these then were put as direct questions. The question guide was trialled by conducting several mock interviews with colleagues and was refined before use in the field.

4.4.2 Participant Sample

The participant sample size had to be nominated to CSNSW Human Research Ethics Committee well before the research could commence inside a NSW prison. Predetermining a sample size in qualitative research is undesirable, and there are no papers or books that can accurately guide a researcher on how many interviews are needed to answer a research question (117, 118). The standard practice in qualitative research is to continue recruiting and interviewing of participants until data saturation point has been reached (52, 117, 118). At saturation point the interview data from new participants begins to be similar and repetitive to the data from previous interviews, and there is no, or limited new information being collected. In grounded theory, saturation is reached when all aspects of the research topic are adequately covered in enough depth to be able to develop theory (118).

The approximated figure devised by the research team for the sample, which would result in enough data to cover all aspects of the subject in sufficient detail, was 30 participants. Within this sample of 30, there was to be minimum of 10 Aboriginal men, but with ideally even numbers of 15 non-Aboriginal and 15 Aboriginal men interviewed. There were also two

major practical aspects to consider in this research project. The first was consideration of what might be a practical number of interviews to be undertaken by a student in the field alone in what could be a challenging environment (prison). The second was to consider the practicality of the size of the data set during analysis, as too large a data set could be overwhelming for the student. The research application to CSNSW Human Research Ethics Committee nominated that 30 participants be interviewed.

A total of 31 participants were interviewed, which was one more than nominated. This was because when the researcher had interviewed 29 participants a further two Aboriginal men wanted to participate and were interviewed. Interviews took place between June and August 2014, with 14 participants self-identifying as Aboriginal and none identified as Torres Strait Islander.

4.4.3 Participant Criteria

Potential study participants for the theoretical sample were all inmates accepted into, but who had not commenced, IDAPT. The IDATP entry criteria are that the person should:

1) be sentenced with no further court matters outstanding;
2) be at least 12 months from their earliest possible release date;
3) be assessed as medium-high or high-risk of re-offending on the Level of Service Inventory - Revised (LSI-R) with an alcohol and other drug domain score of 7 suggesting medium to high risk of re-offending (10);
4) be of a suitable security classification (with maximum security inmates ineligible);
5) not be convicted of a child sexual offence;
6) not be seriously cognitively impaired;
7) not be in an acute phase of mental illness; and
8) not be involved in a serious incident/s of misconduct in prison in the previous two months.

Entry into IDATP was voluntary with inmates having to apply for the program. The study-specific selection criteria for participation in this research were, first, willingness to be interviewed, and second, a capacity to provide informed consent.

The selection criteria meant that 100% of the potential participant pool had a moderate AoD problem for which they had voluntarily enrolled into treatment. This is somewhat different from the general prison population where, as outlined in the previous chapter, 80% could benefit from some form of AoD treatment; there were no child sexual offenders in the

recruitment pool; only medium and minimum security inmates where eligible; and none of the eligible men had a low-risk of re-offending.

4.4.4 Recruitment

A basic information flyer was posted on notice boards in various places around the prison which advised inmates of the study and that they may be invited to participate. CSNSW staff provided to the researcher a paper waiting list of inmates accepted into but waiting to commence IDATP. This list was kept onsite at John Morony Correctional Centre. Using this list, in consecutive order from earliest arrival to the IDATP to most recent, the potential participants were called to the administration building of the prison. The researcher spoke to each potential participant about the study and asked if they were interested in participating. Only seven people refused to participant and, as provided by ethics processes and approvals, refusals were accepted and the participants were not asked to provide a reason for their refusal.

Participants were informed that their interview data would be kept confidential, except where they disclosed any illegal activity that had not been dealt with by the courts, or if they threatened harm to another person or themselves. In these cases, such information would have to be reported to CSNSW or the NSW Police. Participants were also informed they would not be identifiable in the resulting thesis and publications, and to this end pseudonyms have been used in place of participants' names. Lastly, unique information that could identify the participant has been withheld or altered so as to keep the meaning of the story, but to maintain the confidentiality of the individual.

Interviews lasted approximately 30 to 60 minutes and were audio recorded using a voice recording data device. As per ethics guidelines, invited individuals were able to choose not to participate in the research without having to provide a reason (54, 55). Furthermore, those who chose to participate were later able to withdraw from participating, without having to provide a reason (54, 112). Thirty-six potential participants were invited to voluntarily take part in a confidential face-to-face interaction, with five declining the invitation.

4.4.5 Interview Dates and Setting

The interviews were conducted one-on-one in either an office designed to conduct individual interviews, or in a small meeting room. Both interview environments were in the administration building at John Morony Correctional Centre, and neither room had a window other than in the door/s, which is a standard security measure in prisons to enable staff to see who is in the room. Consequently, there was no natural light in either room. Both rooms

were private in the sense that there was no security or other staff stationed outside while the interviews took place.

The interviews took place in batches between June and September 2014. It was necessary to have a long recruitment period, as recruitment was dependent upon inmate turnover at the IDATP with approximately between 10 and 15 inmates entering IDATP each month. As discussed below, following the first seven interviews in June the interviewing process was paused to take stock of the quality of the data being collected.

Nine men were interviewed in June. The majority of the interviews then took place in August, with 17 men interviewed that month giving a total of 29 men interviewed by the end of the month. As the list of potential Aboriginal men to participate was then exhausted, a two-week break was necessary as this would allow for turnover of inmates at IDATP, and the final two interviews were then conducted in mid-September 2014. There were 17 on-site data collection days and 35 interviews conducted, with an average of two interviews per day.

4.4.6 Field Notes

Written and audio field notes were taken that recorded the non-verbal communication, such as facial expressions and gestures as well as the general tone of the interaction from the moment of meeting the participant. Also recorded in field notes were the environmental factors within the interview room, such as lighting and activity in the prison on the interview day. The researcher also made note of possible connections between concepts that needed to be considered during data analysis. The field notes were used to ensure the data was contextualised so as not to drift from what the participants had said during the interviews (52).

4.4.7 Quality Control

After the first two weeks of interviews in June, which resulted in seven interviews being conducted, the data collection was paused for a quality control review. An independent and highly skilled senior researcher with extensive experience in prison-based qualitative research (Dr Lorraine Yap) reviewed the collected data and the methods used while in the field with the researcher. This resulted in the augmentation of the interview technique to ensure all relevant areas of questioning were covered in sufficient detail to be able to draw out meaning during the data analysis. This process also resulted in four of the men who had been interviewed in June being re-interviewed in July, which accounts for there being 35 interviews with 31 participants.

4.4.8 Data Coding, Analysis and Management

The NVivo 11 software package (QSR International, 2012) was used to manage the data for the analysis process. All interviews were transcribed by an external service, with transcripts checked by the researcher for accuracy upon return. The data (transcripts) were assigned individual identification numbers, which were comprised of the letters from the name and year and day of birth of the participant. Pseudonyms were assigned and have been used in reporting of the data to protect the identity of the men. Identifying information in the data has been slightly changed or removed to further ensure participants cannot be identified.

Data coding and analysis was a three-step process: 1) open coding, 2) axial coding, and 3) focused (refined) recoding.

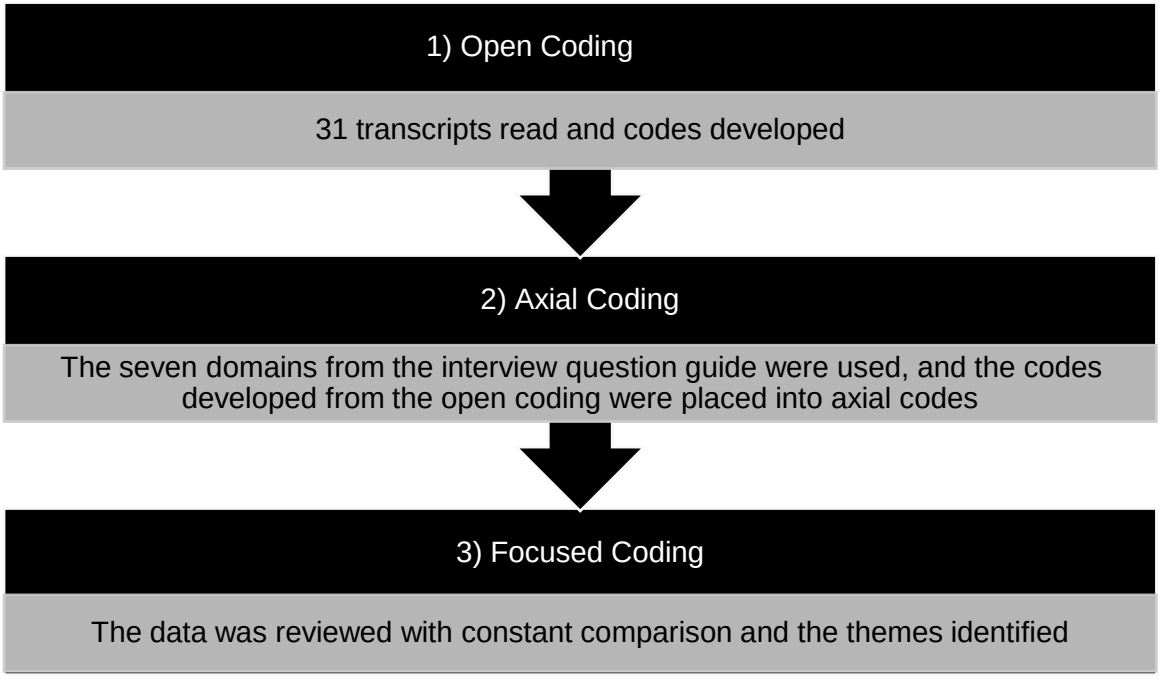


Figure 4.1 Steps Taken for Data Coding and Analysis

The participants were each interviewed using the same question guide, which had questions that related to each domain of enquiry, though follow-up questions and discussion varied greatly with each participant. This process ensured that all aspects of enquiry were covered in each interview as is required for data collection in grounded theory (42, 52, 113, 118). The analysis of the data commenced after the data were collected, in accordance with Strauss and Corbin's approach to grounded theory (53).

The first stage of analysis was: three transcripts were read, notes taken, and the first codes developed for the open coding process (52, 65). Next, all transcripts were read and coded,

including the three previously read. Axial coding that grouped the open codes into broader ones followed the open coding; the axial codes identified were very similar to the seven domains of questions (52, 65). Following the axial coding, focused coding was undertaken, which involved re-reading and recoding the data within the axial codes. The focused coding saw the evolving of separate but interrelated codes that were much more specific in nature (52, 65).

There was constant comparison of data both within and between the focused codes and the characteristics of the focused codes were noted so as to ensure data consistency within each code (52, 65, 113). This process led to the identification of the themes, concepts, and theory. The themes were further developed by cross-checking with the extensive field notes that were taken in both written and audio formats. These themes are presented in the following three chapters, and is how the findings have been grounded in the data (52, 65, 113).

4.4.9 Data Coding, Analysis and Management (Chapter Six and Seven)

Commencing at step two within the open codes the data from the Aboriginal participants was isolated for analysis by screening out the non-Aboriginal participants' data. For step three, the focused coding was undertaken with only the Aboriginal data. This entailed the data in each of the codes being reviewed and recoded accordingly. This lead to the identification of the themes and concepts relating to Aboriginal men's stories and experiences which are reported in Chapters Five and Six.

4.5 Cultural Identification

The 14 Aboriginal men were made known to the researcher for the purpose of this study via a list provided by CSNSW. All participants were also asked if they were Aboriginal and/or Torres Strait Islander, and all self-identified as Aboriginal. None identified as being Torres Strait Islander.

The researcher informed all participants that he is Aboriginal. The Aboriginal men further enquired about the researcher's Aboriginality, and the researcher accordingly disclosed his language group, home community, and insights into his motivation for undertaking the research. Information about the researcher and his motivation to undertake this work is detailed earlier in the thesis.

Some men were from small minorities and their unique cultural background could lead to their identification; for this reason, these men are reported as being Aboriginal or non-Aboriginal.

4.6 Introduction to the Participants

As outlined above, 31 men voluntarily participated in this research, with 14 self-identifying as Aboriginal. Table 4.1 outlines the demographic backgrounds as well as preferred and most commonly used drugs and/or alcohol of the participants. The table is a reference point to contextualise the main characteristics of the individual men and to provide an understanding of their backgrounds when reading their quotes as reported in the succeeding chapters.

To help protect the identities of the men, two very general terms were used to describe their line of work. The term blue-collar work is used to describe all labouring type work on building sites, farming or other similar roles, and white-collar is used to describe office-based work roles. The table also provides an overall summary of the men to allow for a comparison between individuals and to understand their similarities and differences.

Table 4.1: List of Participants by Aboriginal status, Age and other Demographic detail

Name	Aboriginality	Last Address	Age	Education	Work in Community	Imprisonment	Preferred AoD	Most used AoD
Adam	No	Sydney	21	Year 9	Blue Collar (sporadic)	Second term	Amphetamine	Amphetamine
Dean	No	Regional City	22	Year 9	No	Fifth term	Heroin	Heroin, cannabis
Alex	No	Interstate City	26	Year 10	White collar, before age 18	Third term	Cocaine, alcohol	Alcohol
Ben	No	Sydney	27	Year 6	Blue Collar (sporadic)	Second term	Cannabis	Cannabis
Jay	No	Sydney	27	Year 7	Blue Collar	Third term	Amphetamine	Amphetamine
Kent	No	Regional City	29	Year 10	Blue Collar (sporadic)	First term	Amphetamine	Amphetamine, alcohol
Joe	No	Sydney	29	Year 12	Blue Collar	Second term	Amphetamine	Amphetamine 1
Sam	No	Regional City	29	Year 9	Blue Collar	Fourth term	Heroin	Heroin
Luke	No	Sydney	30	Year 10	Blue Collar (sporadic)	Second term	Cocaine	Cocaine
Jack	No	Sydney	31	Year 8	White collar	Second term	Alcohol 6	Alcohol 26
Max	No	Sydney	31	No-schooling	No	Fourth term	Heroin	Heroin
Owen	No	Sydney	37	Year 9	Blue Collar (sporadic)	Third term	Heroin	Heroin
Dan	No	Sydney	39	Year 10	Blue Collar	Second term	Alcohol	Alcohol

[6] Alcohol consumption or drug use often occurred while using poker machines

Name	Aboriginality	Last Address	Age	Education	Work in Community	Imprisonment	Preferred AoD	Most used AoD
John	No	Sydney	39	Y ear10	Blue Collar (sporadic)	Several terms	Heroin	Heroin
Lee	No	Sydney	41	Year 9	Blue Collar (sporadic)	Eighth term	Amphetamine	Amphetamine
Cole	No	Sydney	42	Year 10	Blue Collar	Third term	Alcohol, cocaine	Alcohol
Kurt	No	Interstate City	47	Year 9	Blue Collar (sporadic)	Fifth term	Amphetamine, cannabis	Amphetamine, cannabis
Bill	Aboriginal	Sydney	20	Year 8	Before age 18 (Blue Collar)	Third term	Alcohol	Alcohol
Ray	Aboriginal	Regional Town	20	Year 8	Blue Collar (sporadic)	First term	Alcohol	Alcohol, buprenorphine
Mark	Aboriginal	Regional City	21	Year 10	Blue Collar (sporadic)	First time	Cannabis, amphetamine	Cannabis, amphetamine
Carl	Aboriginal	Sydney	26	Year 10	Before age 18 (Blue Collar)	Third term	Heroin	Heroin
Gary	Aboriginal	Sydney	27	Year 9	Blue Collar (sporadic)	Fifth term	Heroin	Heroin
Jess	Aboriginal	Regional Town	27	Year 10	Blue Collar	Third term	Alcohol, cannabis	Alcohol, cannabis
Rob	Aboriginal	Regional City	28	Year 10	No	Fifth term	Amphetamine	Amphetamine, buprenorphine
Neil	Aboriginal	Sydney	29	Year 8	White Collar (sporadic)	Second term	Heroin	Heroin
Ian	Aboriginal	Regional Town	32	Year 5	No	Fourth term	Heroin	Heroin

Name	Aboriginality	Last Address	Age	Education	Work in Community	Imprisonment	Preferred AoD	Most used AoD
Ed	Aboriginal	Sydney	35	Year 10	White Collar (sporadic)	Second term	Heroin	Cannabis
Ryan	Aboriginal	Regional City	39	Year 10	Before age 18 (Blue Collar)	Fifth term	Heroin	Heroin
Toby	Aboriginal	Regional Town	39	Year 10	Blue Collar (sporadic)	Third term	Amphetamine, ecstasy	Amphetamine, alcohol
Tom	Aboriginal	Regional Town	39	Year 10	No (has disability)	Second term	Heroin	Heroin
Jim	Aboriginal	Sydney	42	Year 9	Blue Collar (sporadic)	Fifth term	Cocaine	Heroin

The information presented in Table 4.1 shows that this group of research participants overwhelmingly experienced very low levels of formal education, high unemployment, employment in manual labour type roles, have had several terms of imprisonment, and that poly drug use was common. The individual summaries that follow were written from reading and re-reading the full interview transcripts. Specific material was chosen to be included in the summary, about the men's backgrounds, family life, future aspirations and lived experiences of prison-based AoD treatment. The purpose of this information is to understand the personal context for their AoD use, and to tell the story that these men had planned and hoped when they were younger for a different future than the one they currently have in prison.

These summaries help bring the researcher and reader closer to the material covered in subsequent chapters which discuss concepts, which is important in developing theories about what the interviewees are experiencing (52). The summaries show socio-demographic details which are not able to be covered in the contents and themes of later chapters. Importantly, they show the progression among many of the participants in their drug using, and often extensive use, and paint an important backdrop for the concepts explored subsequently.

4.6.1 Non-Aboriginal Participants

Adam

At 21 years of age Adam was the youngest non-Aboriginal man interviewed. This was his second term in prison as an adult, and he had been in prison several times as a juvenile. Adam was friendly but not particularly talkative, giving brief answers to most questions. Adam had lived with his parents in Sydney before entering prison. He did not have any children, though he had a girlfriend who he said lived with her parents.

Adam dropped out of school of his own volition in year nine, not as a planned or forced event, and his education from that point on took place only through attending school in juvenile detention. He had blue-collar labouring type jobs sporadically but said his ability to hold down a job for a long period of time was compromised by his amphetamine use.

His drug of choice was amphetamine and it was also his most commonly used drug. His first drug used was cannabis at age 12, with him having consumed alcohol around the same time. While he would like to change his amphetamine use, he indicated that his cannabis and alcohol use were not really a problem. In terms of AoD treatment, Adam reported wanting to serve his current sentence at Park Lea which has a drug treatment centre, but

this did not occur and instead he entered IDATP. He did not receive AoD treatment in juvenile detention, having only previously received AoD treatment in adult prison prior to IDATP.

When asked about future plans, as well as wanting to get out and stay out of prison, Adam's other goals were to live with his girlfriend. When asked about work or study he said he *'wouldn't mind going to TAFE'*.

Dean

A non-Aboriginal man, Dean was one of the younger men to be interviewed at 22 years of age. He had lived in a regional NSW city with his girlfriend and their children, but seemed reluctant to discuss his family. He had not spent much time in the community because he had been involved in the criminal justice system continuously since he was in his early teens. This was his fifth term in prison as an adult, and he had been to juvenile detention multiple times.

Dean grew up in a single parent home with his mother. He started spending time away from home staying at friends' places in his teens and, as he put it, being on the *'street running amuck'*. He left school in the community at around 14 years old, with his education from that point on through attending school in juvenile detention. He has never held a job. From around 14 years old he said he was always hanging out with older boys, and that was how he got introduced to cannabis and other drugs including heroin and amphetamines.

Dean's primary drug of choice and most commonly used was heroin, though if it was not available he would use cannabis. By the time of interview Dean clearly would have known his drug use was causing problems as he had been in drug court. It would have been made clear to him at drug court that if he continued to use drugs and to commit offences to support that drug use he would be imprisoned. Nonetheless, he had committed a break and enter while on the drug court program, which had resulted in his first term in an adult prison.

Future aspirations were quite straightforward for Dean; all he really could say was, *'When I get out, I wanna just, yeah, stay out of trouble, get a job or something, you know. Get a job, yeah'*. He was grateful to be on methadone as a result of being in prison, and he believed that if he was no longer having to support his drug use through crime then he would not re-offend. He had no plans other than being at home with his girlfriend and helping her look after their children.

Alex

Alex had been living with his mother in another state capital city, but his offence took place while in NSW. He was a fit and slightly muscular 26-year-old who put quite a bit of effort into his health and fitness while in prison, and he was quite talkative on that subject. He had a young son who lived with his ex-partner interstate. Alex had not been in trouble as a juvenile, with his only substantial contact with police and courts being as an adult when he was 18. This is Alex's third term in prison.

Alex finished year 10 then tried TAFE, but did not finish any courses. He had worked in a café for a short time after TAFE. These events were before he started spending much of his time socialising with his friends or, as he put it, *'kicking back with the boys'*. He spoke very fondly of his friends, the boys, and indicated that he would do anything to help them out and they would do the same for him. It was with this group of friends he began using drugs.

Alex described his drug use as social, using cocaine, some *'pills'* occasionally, and alcohol. This use was regular but not on a daily basis. He spoke of these events as often occurring when he would be staying at a hotel and going out to parties, though how this was financed for a man who was not working is unclear. His motivation to attend IDATP was not cohesive, since early in the interview he said the program might help prepare him for life when he is released, but it later became clear he didn't believe he had a drug problem, and it appeared his main interest was in being released on parole as soon as possible.

Alex's future aspirations were not around using less drugs as he did not think his drug use was a problem to start with. He said, *'Yeah, I wanna [yeah] work and still live, like I'm still gonna be with the boys but more smarter'*. Exactly what he meant by being *'more smarter'* was not clear, but one possible meaning is avoiding the police and courts. Career-wise he did not have a clear direction other than perhaps going to TAFE to get qualified as a personal trainer, so he could work in a gym. His main personal aspiration was to spend time with his son and have him back in his life on an ongoing basis.

Ben

A non-Aboriginal man of 27 years of age, Ben lived in Sydney with his partner and their children prior to his second term of imprisonment. Two of the three children were stepchildren and the other was his biological child, however, Ben made it clear that he does not distinguish between them, treating them equally. Ben was one of the most talkative men interviewed; he had a friendly disposition and was quite interested in the research outcome being one that could improve AoD treatment for people in prison. He had had about a three

to four-year break between sentences and he said he was finding it difficult to be in prison this time, as he was older and because he had a family now. He said, *'It hurts now that I've got my family and that. It kills me to be in here'*.

Ben's mother left him and his siblings with his father when he was quite young. His mother apparently received a crime compensation payout for $70,000 several year ago, which would have been equivalent to $114,235 in 2014 dollars, and she left the family as soon as she got the money. Ben spoke highly of his father but also was judgmental towards him for working so hard in a labouring job that did not pay much money. Ben had worked with his Dad briefly, but was able to make much more money from break and enter offences, and now regretted having committed these offences and wished he had taken a different life course. Ben had also briefly worked in other jobs, which were all labouring type roles. His education was quite limited, having only completed primary school and attended high school briefly, about which he said *'I was too involved in drugs and making money. Yeah. So I didn't have much time for school'*. Ben felt he had enough reading and writing skills to get by in life.

Ben identified cannabis as his primary drug of choice, with his AoD use almost exclusively cannabis use. He did not believe he had a drug use issue, but was committed to the IDATP program nonetheless as he wanted to learn more about the harms of drug use. Ben's current offence did not appear to be directly related to drug use – he had assaulted his partner's ex-boyfriend who had apparently been threatening him (Ben) and his partner. Ben had an interesting take on drugs being involved in his offence as he felt it was still drug-related because the man he had assaulted was involved in the illicit drug use trade. Another motivation for Ben to undertake IDATP was to gain parole faster and get back to his family. Ben was to be eligible for parole in the next 12 months.

Ben's future aspirations were to get home to his family and help care for his children, as well as possibly find some work. His main pastime both in and out of prison was music and he had recorded a number of music clips before he came to prison which he had posted online. Ben shared the web-link to his clips with the researcher. Ben's music genre was rap, and he sang/rhymed about overcoming unfair hardships including the economic and social system in Australia, and getting off the drugs and living a fulfilling life. One of Ben's goals was to record more music in the future. As mentioned, he was one of the most talkative men interviewed and had a very friendly disposition.

Jay

Jay was a 27-year-old non-Aboriginal man who had lived most of his adult life in Sydney. Before being imprisoned, he had been living with his partner and their four children, three of whom are stepchildren. Jay was quite friendly, though he seemed to get quite tired after about 30 minutes albeit happy to persevere. This was his third term in prison and he had been in trouble with the law as a juvenile but had never been to juvenile detention. He believed that being in gaol this time had made him realise *'spending money on drugs ain't worth it'*.

Jay was brought up by his father and stepmother. While his father and stepmother had separated, Jay had a closer relationship with his stepmother than he did with his father. He was expelled from school in his first year of high school and when told by his father that he either go back to school or get a job, he chose the latter. He has been working in the mechanical trade ever since then, but has not completed formal vocational training. He had been working prior to his current term of imprisonment.

Jay thought his amphetamine use was a problem and he wanted to stop using. His motivation was to be able to provide for his family and that money spent of drugs was wasted money. He made very assertive statements about not going back to drug use throughout the interview, and these were predominately related to the financial impact of drug use on his family. He felt that being in jail meant he was unable to work and provide for them and that life was quite tough for the family without him there to support them financially.

Kent

Kent was a 29-year-old non-Aboriginal man who had lived in a regional city in NSW with his mother before entering prison. He was born overseas, and his mother brought him and his siblings to Australia when he was about four years old. He was raised by his mother and stepfather, with Kent referring to his stepfather – who his mother met in Australia - as Dad. Kent had brown skin pigmentation and identified with his cultural heritage strongly. He had not seen his biological father since he was quite young, but he does have some contact with his father's family though they live in another country. Kent has two children who live with their mother who he calls his 'missus' though he did not live with her. Kent had been living with another woman he referred to as his girlfriend before he entered prison.

Kent left school at 15 years old because he said he did not *'get along with the teachers'* and because *'just hate someone, people telling me what to do. [Yeah] Yeah'*. His Dad used to take him to rugby league football games on the weekend and to training during the week. His

Dad was apparently quite involved in the local football club. Kent had worked from time to time in blue-collar labouring roles, but he appears to have largely been unemployed and his main pastime was drug use and alcohol.

Kent had predominantly used amphetamine, which was his preferred drug, before his current sentence in prison. He had in his teen years experimented with other drugs, including cannabis. When he was unable to obtain amphetamine he would consume alcohol, particularly when he was coming off amphetamines after several days use. His offence was for breaching a restraining order which he had had placed on him, apparently by police, to keep him away from his girlfriend. Kent was very happy that the mother of his children, his 'missus', had moved closer to the prison to be able to visit him with the children more frequently and to possibly rekindle their relationship.

Kent was looking forward to being released from prison. However, he did not have any substantial plans other than getting an outdoor job somewhere and spending time with his kids. He also spoke of helping his mother out as she was apparently the carer for Kent's brother's children who had been placed in her care by the state government department responsible for child welfare. He had no plans to undertake any training or anything to that effect, and he was vague about any future goals or direction other than not taking drugs and only having an occasional drink.

Joe

Joe was 29 years of age and had migrated to Australia with his parents when he was about three. He had been living in Sydney with his wife and they did not have any children. This was his second term of imprisonment, though it related to the same charge as his first term. He had been held on remand in prison to be sentenced for assaulting a police officer and had eventually received a suspended sentence, which he had then breached by reoffending and was placed in prison. His new offence was for stealing money from a female dancer at a men's club. He virulently denied having done so, but was imprisoned for breaching his suspended sentence and attracted a minor charge for the alleged stealing offence. As a juvenile, Joe had also assaulted a police officer and was sentenced to juvenile detention. It appeared that while Joe had been using drugs for a long period of his life, he had otherwise been functional, with him running his own small business.

Joe completed year 12 of high school in juvenile detention, and was released shortly after his final exams. He had not attended university and had no formal vocational training. He described himself as being very good at several manual labouring jobs in the construction

field and operated his own business as a sub-contractor. His parents and siblings apparently had a strong work ethic, with his parents - who are still together- having both worked in labouring type roles since they immigrated to Australia.

Joe identified that he had a drug use issue and had been using amphetamine for several years, but he had maintained a functional work life though he had financial difficulty. Joe further identified as having had a gambling problem, with him having been to pubs or clubs to play the poker machines after work. This left him in a situation of having worked long hours, being paid well, but having limited to no financial benefit from the effort. He had discussed his drug use with his family and had had some counselling, but not for gambling. When asked why he had not tried to find help for his gambling, he said, *'I was too embarrassed. I didn't think. I was in denial that I had a bad habit. 'Cause I say well I, I wasn't doing harm to anyone'*.

Joe's main goal was to stop using drugs and be able to lead a better life in the community without gambling again. He was distressed about being in prison but was adamant that he would get back to running his own business as he still had good contacts.

Sam

Sam was a well-spoken, articulate and friendly 29-year-old non-Aboriginal man who had been living with his partner and their son in a regional NSW city. Of all the men interviewed, Sam used the least profanities and had the most extensive vocabulary. Sam spent most of his spare time in prison reading and studying, with the conversation with him at times more akin to having a discussion with colleagues at a university. This was his third sentence but, as he put it, this was his only *'big sentence'* having been in prison for short periods previously. Sam's answers to the questions were insightful, which may indicate he had reflected on his AoD use, treatment experiences, and his offences before the interview, or perhaps he had at least discussed these previously and composed his thoughts. The other possibility with Sam is that with a greater command of the English language he was able to articulate his experiences more concisely.

Sam's father had committed suicide when Sam was 13 and his mother committed suicide six years later when Sam was 19. These events had a profound effect upon him and his life course, with his mother falling into depression after the death of his father and the family becoming dysfunctional. Sam's school marks had been good up until that point and then he dropped out of school. He started working in labouring type jobs and his life had stabilised for a few years until his mother died.

Sam had consumed alcohol and cannabis after his father died and had tried amphetamine, which helped him get through his long work hours. He first used heroin after his mother died, and he held a stable job for many years while using heroin. It was the interpersonal networks from using heroin that caused issues for him and which were the driving factor for his offending. Sam was not happy to have ended up in prison, but was relieved to be able to get assistance for his drug use problem.

Sam was making the most he could out of being in prison, having completed several educational courses, and he looked forward to further study when released. Sam had a strong focus on self-improvement, saying *'Five and a half years out of your life is a lot of time to waste to, and, if, if I go out the same person that I come in, then it was all a waste, wasn't it?'*. His goal was to continue not using drugs, finish his study, and to start working in his field of study. Most importantly though he wanted to be reunited with his partner and son.

Luke

Luke was a 30-year-old man from Sydney who had been living with his parents prior to entering prison about five-and-a-half years ago. A noticeable feature with Luke compared to other inmates was that he had expensive gym shoes, which apparently his mother had bought him. He had not had a partner nor any family responsibilities. Luke's mother apparently deposited money into his prison account and visited him every weekend. This was Luke's second term in prison, however, both terms in prison related to the same offence. He had not been in trouble with the law as a juvenile. He was one of the less talkative men and appeared to have a short attention span.

Luke left high-school at 15 years old to start a trade apprenticeship which he did not complete. He indicated he was not interested in undertaking any further training because he thought he was too old, despite the fact that 30 years old would generally be considered still relatively young to undertake retraining.

Luke had first used alcohol and cannabis around the age of 17 years, and his preferred drug was cocaine though he had not used that or any drugs on a daily basis. The offence he was in prison for was what must have been a serious assault but, as he said, *'It was a misunderstanding between him and a mate, and they were both mutual friends, so I was left to sort it out in-between but then one person got out of hand and I ended up … so yeah, sorted him out'*.

Luke had been released after serving time for the assault and was on parole, but re-offended by driving while under suspension and he also apparently tested positive to a drug, which was cocaine. His only response when asked about what was happening at that time in his life was that he needed to get around town and he had not harmed anyone.

Luke's future plans were fairly straightforward; he was planning on going home to live with his parents and get a job and not get into trouble again.

Jack

Jack was a 31-year-old non-Aboriginal man serving his second term in prison. He had had limited formal education having left school after year eight, though enjoyed reading books while in prison. At first, he was cautious about taking part in the interview, however, as the interview progressed he became more relaxed and quite talkative. Jack had dark skin pigmentation and had been subjected to discrimination while growing up. His white Australian mother had raised him and his younger brothers alone in suburban Sydney, his father - who was born overseas - having separated from his mother when he was young. Jack had been to juvenile detention and this was his second term in prison. His offence related to alcohol use and a serious assault.

Being dark skinned had had a significant impact upon Jack's life with him first experiencing discrimination when he started going to school. He described his early life as challenging, and spoke about wanting to write a book about how he had overcome these difficulties, though he did not specify the difficulties but just indicated that you learn to get on with life. Jack was concerned about his mother and brother who lived with her, and how they were getting by financially in Sydney. His father did not live in Australia and he had had limited contact with him throughout his life.

Jack first tried alcohol around the age of 15. He had had alcohol, drug, and gambling problems in the 12 months before prison. It became apparent that gambling either on poker machines or at the casino had consumed tremendous monetary resources and time. For Jack it was as important to undertake the gambling treatment programs in prison as the AoD treatment programs. While he was unhappy about being in prison, he also took the view that he may as well make the most of the situation. Jack had previously worked but his gambling and AoD issues made it difficult for him to maintain his employment. At one stage before he started gambling he had saved $5,000 over several months. Once he started gambling the $5,000 disappeared in just a few days, which devastated him and sent him into a spiral that culminated with his first term of imprisonment as an adult.

Towards the end of the interview he was curious about the research and about how one becomes a researcher. Jack was articulate in his speech and he had been working towards improving his reading and speech *'I wanna improve my reading and writing skills. You know, I feel that my speech, the way that I speak isn't at a level that I'd like it to be, you know. I wanna improve my vocabulary as well'*. Jack went on to say that when in prison he had to *'dumb down'* and speak like other inmates because it is not good for people to know you are smart when in prison. His aspirations for the future were to take care of his mother and brother and get a well-paid job. He did not really care what type of work it was so long as he was well paid.

Max

Max was a 31-year-old non-Aboriginal man who had been living in Sydney for the short periods of time between being in prison. He was serving his fourth term in prison. Born overseas, he immigrated to Australia at the age of 11 years with his family. He had brown skin pigmentation and was a healthy looking and fit man. Max had had five children from four different women. He had not had contact with any of his children for several years, with some children living with their mothers and some having been removed from their mothers and placed in state care.

Since he was 14 years of age he had been in and out of juvenile detention and spent a limited amount of time in the community. His parents, sibling and extended family had apparently disowned him, and it was difficult for him to find someone who was willing to have him paroled to their address. Max had never been to school and said he cannot read or write very well. He would like to learn how to read and write but said he had been waiting for over six months to be able to get into a prison-based education program and was furious at the delay.

When it came to drug use he had used 'pretty much everything', starting with cannabis when 12/13 years old, and moving onto amphetamine, heroin, cocaine, and ecstasy over the next couple of years. His preferred drug was heroin and he said he had never liked alcohol. He also said that before entering IDATP he had always either been on drugs, coming off drugs or trying to get on to drugs.

Max expressed that he would like to get out of prison and stay out and possibly buy a house one day. But as he said, he liked easy money which he can make from committing crimes. As he put it*: 'Like I make like easy money too. It's a bit hard - you know what I mean? -*

where like when I'm out there I can make like thousands of dollars in a couple of hours [Yeah] than working a whole week for a thousand bucks or 800 bucks. It's a bit hard, you know'.

Owen

Owen was a 37-year-old non-Aboriginal man who had lived in Sydney throughout his adult life and was a long-term heroin user. He had been living on and off with mates in a state supported housing unit, but had also been homeless. Despite being a long-term heroin user he had had limited contact with police, with this being his third prison term. This was apparently his longest term in prison as he had previously been in for six months and once for seven months. Both previous offences were stealing, but this time he was in for robbery and armed robbery. He had not been in trouble as a juvenile.

Owen had grown up in a regional NSW city with his mother and two siblings. He regretted doing the same to his children as his father had done by being absent and having not seen them for five years, although this was because their mother cut all contact between him and the children. He left school in year nine and had worked on and off in labouring roles for many years, but had not done so in the past eight years. He had held one job working with an electrical company for two to three years.

Owen first tried alcohol when he was 12 years old and cannabis when he was 14 years old, but neither of these were used in excess. He had not stopped using heroin ever since he first tried it at 18 years of age. He had been on methadone at times and was quite stable during these times, but it was when he has not been on methadone that he has had to support his heroin use through offending.

Owen had met the researcher's twin brother, who at the time worked in a needle and syringe program in Sydney. Owen said he was quite friendly with the researcher's brother and this seemed to put Owen at ease when talking to the researcher. Owen had been working as the cleaner in the administration building in the prison office which is normally only a job given to the most trusted inmates. Owen planned to give the 12-Step program of Narcotics Anonymous another try when out of prison and was hoping one day to stop needing to be on methadone. His highest priority though was to try and have contact with his children. He said *'I wanna, I wanna write a letter to my kids and try and at least … that first step … to mending that relationship'*.

Dan

Dan was a 39-year-old non-Aboriginal man who had been living in Sydney before going to prison. Dan lived alone and had no family responsibilities, though he had two young children who live with their mother. Dan had apparently been to court to gain access and the court case was still in progress. He also had a 17-year-old son who lived in Queensland with his mother, and who apparently had not wanted Dan to have contact with him. Dan hoped to develop a relationship with this son at some point in the future. Dan is currently serving his second term in an adult prison. His previous term was approximately 20 years ago when he was 18 years of age, and prior to that he had also been in juvenile detention.

Dan had been expelled in year 11 of high school for fighting. Dan's father was apparently a strict man and Dan felt he wanted to rebel against him and began misbehaving when young. Dan said he was a good student until about year eight, and his grades started deteriorating when he started hanging around with the 'wrong crew'. These were other young men whom he had known for some time. He commenced experimenting with drug and alcohol use in his teens. Later in life his preferred substance was alcohol, though he had used amphetamine occasionally, but only after consuming alcohol.

Dan has a history of offending by driving while under the influence of alcohol. He felt strongly that he needed to drive because he was self-employed and worked on housing renovations. His current term in prison came about because he had a suspended sentence for driving while under the influence, and breached this suspended sentence by driving again while under the influence of alcohol.

The main aims Dan had were to gain access to his two younger children and to develop a relationship with his older son. The first objective he had was to get his licence back when released because he believed he needed it to work. It appeared that Dan thought he could manage his alcohol use and not drink drive. With regard to this, he suggested, *'Give me a breathalyser on my ute so I can go to work. [Yeah] I don't drink every day. I'm not driving every day drunk'.* Dan was very much of the opinion that getting his licence back would make a huge difference in his life.

John

John was a 39-year-old non-Aboriginal man from Sydney who had been living with his Aboriginal partner and their children. John identified his three children as being Koori (Aboriginal). He was very supportive of his partner and their children being involved in their Aboriginal cultural heritage, and attended Aboriginal events. John had been interviewed by

researchers may times before while in prison, but he had not met an Aboriginal researcher and was very willing to take part in the research. He said he had been coming to prison regularly since 1992 and could not remember how many times he had been to prison, but estimated he had spent a combined total of about 17-and-a-half years in prison. He went to juvenile detention at age 17. His offences as an adult were break and enter.

John grew up in the eastern beach suburbs of Sydney and his family of origin was and still is wealthy. He first consumed alcohol and cannabis around the age of 13, and during these early teen years he would miss school to hang around the beaches with his friends and drink. He continued to go to school but sporadically, eventually dropping out in year 10. He said this period of his life was *'a blur'* as he had started to consume large amounts of alcohol regularly, and recalled going to class in high school while intoxicated. He also got into brawls at school.

John's drug of choice was heroin, which he started using when he was 20 years old, and he has almost exclusively used only heroin since that time. He was on methadone at the time of the interview and had been on methadone previously. He had stopped taking methadone when he got work, and said he was not dependent upon methadone and could stop taking it without a problem. He had worked sporadically but can make a lot more money from break and enter offences. He once went to a residential rehabilitation service located in a rural area several hours drive away from Sydney with his family. It was an Aboriginal service and he and the family enjoyed being there for many reasons, including his children socialising with the other Aboriginal children and attending local school. John said, *'It was fantastic going to, taking my kids to a country school. They loved the school up there. It was a country school'*. John spoke about spending quality time with his family walking on the beach together. Once they got back to Sydney though, all the same problems awaited them, with people they know turning up at their home and wanting to involve John in their activities. He commented, *'Came back to Sydney. Back to Mt Druitt there and I reoffended like within the same week of leaving rehab'*.

John had apparently not been in prison for a few years and then, as a result of DNA testing on evidence from an old break and enter, the offence was matched to him, he was charged, found guilty, and imprisoned. His goal, when he gets out of prison, is to move the family to another suburb because people he used drugs with just drop around to his home and harass him. Interestingly, he commented that in prison everything is organised, and it works well, but it gets harder and harder to do time the older one gets, and he really did not want to go back to prison again.

Lee

Lee was a 41-year-old non-Aboriginal man from Sydney. He had been living with his partner, their two children, his mother and his niece in the one house before going to prison. He was a friendly man, with a large muscular build and brown skin pigmentation. Lee was a religious man, frequently referring to the 'Lord' during the interview, and it appeared that his whole family was quite religious. Lee was born overseas and had three children, with one living overseas with her mother in his county of birth. He had had limited contact with this child. He had been in and out of prison for all of his adult life and estimated he had been in prison eight times. His first offence was driving without a licence when he was 16 years of age for which he got a fine. He did not go to juvenile detention at all. His current offence was an extremely serious assault in which he said he nearly killed his drug dealer. This offence occurred while he was under the influence of amphetamine.

Lee left school part way through what would be equivalent to year 10 and moved to Australia, but did not continue any education. He had no qualifications and had worked in labouring roles, holding jobs for several months but not for longer than a year. He believed he had an addictive nature and always got addicted to different substances. He started smoking cigarettes at 10 years of age, and had started drinking alcohol around age 12 and had liked alcohol so drank more whenever he could.

Lee started using amphetamine in the 1990's but did not know exactly when. However, since he started he cannot remember a period of time when he had not been using amphetamine. His amphetamine use pattern varied over the years, sometimes using daily and other times once every few days. He had been to a number of AoD treatment programs over the years, but continued to use amphetamine.

The only goal Lee had was to get out and stay out of prison, so he can be with his children. He believed that when someone had had enough of AoD then it is up to them to stop using, and that support does not really work because it has to be a decision the individual makes to stop using. His main goal was to get back to his children and to provide for his family, as he said *'I've gotta feed my kids. I mean they're struggling at the moment bro. The sooner I get back out there and put money on the table, the better'*.

Cole

Cole was a non-Aboriginal 42-year-old man born overseas and had been living with his mother and sister in Sydney. He has two adult children: a son of 18 years of age who lived in Sydney and whom he sees regularly, and a 23-year-old daughter that he has had very

limited contact with since she was born. This was his third term in prison and he had not ever been in juvenile detention. His first offence was a serious assault, which apparently meant he had been classified as a violent offender. Cole had a tall and muscular build and very dark skin pigmentation. His physical appearance was striking as he would be much larger than the average man. He was a friendly, thoughtful and considerate person. Later in the interview as he became more relaxed, Cole spoke openly about racism in Australia and what he has endured over his lifetime.

Cole moved to Australia at age 14, and said he finished year 10 but did not go to year 11, instead going to work in a supermarket. Cole believed that in most situations where decisions could go for or against him that he had often not had the benefit of the doubt or been given a second chance. He said he had once told his parole officer that he had used cannabis after having been drinking after work with colleagues, and that he was sorry for doing that and if she could please not order a urinalysis until the following day. According to Cole the parole officer ordered an immediate urinalysis and he tested positive for cannabis. As a result, and despite him apparently having been doing very well on parole, he was sent back to prison.

Cole's first AoD use was alcohol at the age of 13 years. He said he had been drinking with his uncles back in his country of birth, and that it was fairly normal for the younger men to drink with the older men in the family. He learnt how to fight when drinking with the older men, because the young men sparred with each other while the older ones coached and watched on. Cole *said 'I give my cousin, you know, give my cousin a glass too, and we, like we'll have a few glasses and that. And, after that, we'll, my uncle would get us to start fighting, start fighting my cousins, you know'*. Cole's preferred drugs were cocaine and alcohol, but the most commonly used drug was alcohol.

Cole's only goal when he gets out of prison was to find his adult daughter and develop a relationship with her. When prompted he did say he wanted to stay out of prison and not use drugs or drink alcohol excessively again.

Kurt

Kurt was a non-Aboriginal man and at 47 years of age the oldest interview participant. He had lived alone in another state capital but was in NSW when he committed his new offences. These also breached the conditions of parole in his home state and so when he finishes his NSW sentence he will be transferred interstate to another prison. He had been in and out of prison his whole life and had been to juvenile detention. His offence history had

been stealing type offences and for his latest offence he described having to pay back his drug dealer and that was why he committed the offence. When asked about his offending he pivoted the conversation away to his religious belief in Jesus Christ and that he had turned his life over to the Lord.

Kurt grew up in a rural area on the outskirts of a state capital. At school, he was apparently disruptive, and his teacher had placed a desk outside the classroom for him to sit at. He left school when he was 14 years of age and not long after he met a pastor and became a practising Christian. He has a certificate to be able to perform a manual labouring job but had no plans for undertaking any more study or training. He had held down one job for about 18 months but otherwise his time in the workforce had been sporadic.

He first used alcohol and cannabis at about the same time when he was 15 years of age. He then first used methamphetamine at 18 or 19 years of age. When in the community he had used cannabis and methamphetamine on a daily or close to daily basis, but he chose not to use drugs in prison. He believed that his drug use issues could be resolved by turning his life over to Jesus Christ, but when asked why this approach had not worked in the past he said only that it would work now because he had learnt his lesson and now fully believed in the Lord.

Kurt's only goal was to become a pastor one day. As he said, *'I don't know what about work, what I'm gonna do. I eventually, I believe that I'm gonna go into full-time ministry … but how that all pans out that'll be a stepping stone'*. Kurt's religious practices are stronger when he is in prison than when in the community. It is clear that when in the community Kurt is involved in illicit drug use on a daily basis and criminal offending by way of stealing, neither of which activities would likely be acceptable in any religious congregation. Kurt implied that when he talks about Jesus the other inmates leave him alone.

4.6.2 Aboriginal Participants

Bill

Bill was a 20-year-old Aboriginal man who had been living in Sydney with his parents, his brother and his brother's two children. Bill did not have children himself, nor did he have a partner. Bill described his parents as drinkers and said he had grown up with drinkers all around as well as there being plenty of drug use in his neighbourhood. This was his second or third time in prison and he had been to juvenile detention 'heaps'. His first offences were stealing when around 13 or 14 years of age. His current offence cannot be disclosed for confidentiality reasons as it was quite a high-profile offence. Bill had a small physical build.

He seemed to have a short attention span and at times during the interview he appeared to be thinking about other matters and was quite distant.

He grew up in Sydney with his parents and he had a large extended family. Bill was expelled from school in year 9 for fighting, stealing, and generally being difficult. He completed year 10 of school in juvenile detention. He said he had worked but was vague on the details. His first cannabis and alcohol use occurred around the same age as his first offence, which was at 13 or 14 years of age.

Bill reports having tried every drug he can get access to, though his preferred substance is alcohol. He binge drank most weekends and would often drink for several days in a row. Bill is the third generation of his family to be primarily a drinker, with his grandfather, his father and all his siblings being drinkers. He would seem to have had no shortage of drinking partners within his family. He said he has lost family due to alcohol and drug use.

In terms of future plans Bill said, *'I don't know. … I don't have a clue at the moment, you know'.* He had commenced a course at TAFE to become a personal trainer for the gym, and he said he had done well at that, but it is not offered in prison. However, he thought that he might look into finishing that course at some stage. He said he was going to stop drinking but had no plan to formulate how that might be done, which he may need returning to a family with so many alcohol drinkers. His only clear goal was to get a driver's licence because, he said, *'I got, I got my own car. I've got all that. I've got my car, I've got a bike and that, but I haven't got my licence. That's what I've gotta get when I get out'*.

Ray

Ray was a 20-year-old Aboriginal man from regional NSW. His accommodation had been unstable, sometimes staying with his family and sometimes with mates. He had also been living on and off with his girlfriend. He has no children of his own but views himself as being responsible for his current girlfriend's two children and his ex-girlfriend's one child. His current offence related to assaulting a police officer after attempting to run away from the police. Ray's mother had called the police because Ray had had a fight with her partner after her partner had beaten her up. Ray said, *'her boyfriend ended up coming into my room and choking her, putting her up against the cupboard. So, I punched him in the mouth, threw him outside and said, I said to him, "Wait there! I'm getting your shit. You're out of here!" And my mum turned around and said to me, "No, you're leaving." I said, "Whatever." Went in and packed my shit, and left. She rung the coppers'*. This was Ray's first term of imprisonment and he had not been to juvenile detention.

Ray and his three siblings were removed by a government department from his mother's care when primary school age and placed in care with their extended family. At one stage he and his brother were placed with his father for a short time, until an altercation occurred between his grandfather and his brother and they were kicked out by his father. He and his brother and sisters were then placed with his uncle, but his uncle did not treat him or his siblings well, and he physically abused them. Ray was kicked out of his uncle's house after he fought back against him.

He left school in year eight as he did not like being told what to do. He had tried alcohol and cannabis before he was old enough for high school when he was around the age of 11 or 12 years. By the age of 16 he was consuming these drugs daily and an attempt at this time to withdraw from AoD use was unsuccessful. He eventually got help when he arrived in prison. Ray has completed a number of certificates, which certify him to perform manual labouring jobs. He would like to be a diesel mechanic or something similar, and work on the mines. He wanted to no longer use cannabis and not consume alcohol again as it is a waste of money. He also wanted to move away with his girlfriend from the area he lived in because, he said, *'As soon as you get out, you hang around with the same people, you're gonna do the same shit. … That's why I'm gonna move away'.*

Mark

Mark was a 21-year-old man who had been living with his father in a regional NSW city. His mother is Aboriginal, and her side of the family are from a region in NSW several hundred kilometres away from where he had been living. Mark said he had no children and no family responsibilities. He committed his first offence at the age of 13 years when he broke into a car to steal money. His current offence was a break and enter. He was serving his first term in prison, however, most of his juvenile years had been spent in detention and he estimated that the longest he had been out of prison/detention was for six months since the age of 11 years.

Mark's mother was apparently *'always'* at the pub and did not take care of him or his two siblings so they were removed by a government department and placed separately into different foster families, but Mark kept on running away from the foster families. Eventually he was sent to live with his maternal grandmother in a regional area of NSW. He had lived with her until he was 11, which was when he first got in trouble with the law and she sent him to live with his father. He went to juvenile detention for the first time not long after these events. Mark competed year 10 high school in juvenile detention, and has also undertaken a number of TAFE certificates while in juvenile detention.

Mark first drank alcohol around 9 years of age and smoked cannabis at around the same age. He had access because his mother smoked cannabis and drank alcohol, and would leave cannabis in a bowl on the table at home. His main drugs as an adult were amphetamine and cannabis, though he used whatever drug he could get a hold of, including buprenorphine. He could not remember a time when he was in the community and had not been on some type of drug. The only time he remembers not using drugs was when in juvenile detention. In relation to this, he said:

Mark: … oh no, not, I can't say while I'm in gaol but when I was in juvie. …Gaol's different, you know.

MD: So, when you were in juvie, you weren't on anything?

Mark: I wasn't on nothing, no.

MD: How did you feel during that time?

Mark: I felt good. I felt fit. I felt I had a lot more energy. I felt good, you know. I got out, got out looking, looking healthy, you know. [Yeah] Then in the community the ice just shrivels ya.

Mark said he wanted to get out of prison and to stay out, but it was clear he did not have a plan of any kind. He believed that if he got a job then he would not use drugs. He also though he would like to finish a TAFE course he had commenced.

Carl

Carl was a 26-year-old Aboriginal man who had lived in Sydney with his partner and their two children. At 26 years of age, he had a 15-year history of offending, having first spent a night in a police cell at the age of 11. This was his third time in prison as an adult. His offences related to stealing, though he was reluctant to elaborate on his offending much further.

He grew up in Sydney with his mother and brothers. He was warned by his mother and uncles about where his life was heading and the likelihood of going to gaol, but he continued to use drugs and misbehave as he did not take well to advice. There was a lot of alcohol use by adults in his family, including by his mother. He was removed from his family and placed in care into a boys' home. He was expelled from school in year 10 for fighting and missing class. Carl had some training in prison around using computers, and was also thinking about doing something around fitness as he had a keen interest in that area, but they apparently do not offer this type of course.

Carl's first drug use was cannabis at around 11 years of age. He said he did not like alcohol and did not drink. His drug of choice was heroin and he had tried heroin for the first time shortly after he was expelled from school at around age 15 years. Soon after his first use of heroin he felt he had to be on some type of drug all the time because he did not like being *'straight'*.

His goals were to not use drugs and not go back to prison. He was quite thoughtful with his comments on this subject*: 'If you address your drug, drug issues and your criminal thinking, your, your criminal pattern and your drug issue, I don't see no reason of you coming back to gaol. You know what I mean? If you're, if, if you're not getting into trouble, if you're not using drugs, you know what I mean? you're not coming back to gaol'.*
Carl was hoping to gain some form of work and did not care what it was so long as it paid the bills. He thought he might explore the possibilities of working in the fitness industry.

Gary
Gary was a 27-year-old Aboriginal man who had been living in Sydney with his mother. This was his third term in prison and he had been in juvenile detention. He estimated he had only been in the community for 18 months since he turned 18 years of age, having spent most of his adult life in prison. Gary was friendly and became more and more talkative as the interview progressed. One area he was quiet about was his children. All he said about his children was that they lived with their mother.

Gary grew up with his maternal grandmother in a rough regional centre where there was much crime, including interpersonal violence and stealing, and within a community awash with alcohol and drugs:

> ***MD: So, you grew up in a, in a sort of violent neighbourhood?***
> *Gary: Yeah. [Yeah] Real violent, you know. [So] Lot of drugs and grog, yeah. [Yeah, yep]*
> ***MD: And, yeah, so then you started, you got in trouble with the cops?***
> *Gary: Yeah. [Yeah] Just cars, you know, stealing cars and shit. Yeah.*

He lived with his grandmother because, as he put it, *'mum was an alcoholic and drug addict'* and she had apparently continued to drink and drug throughout her life. Gary had no plans for reuniting with his mother. His father did not want to have much to do with him, and although Gary talks to his paternal grandfather and his uncles, overall, he has had little to do with his father's side of the family. He stopped going to school when he was 14 or 15 as he

said, *'couldn't bother going'*, and had no qualifications nor any plans to do anything towards getting qualifications.

The commonly used drugs where he grew up were cannabis and amphetamine as well as alcohol. When Gary left school he started using amphetamine, having already started to use cannabis at the age of 12. His reasons for having used both of these drugs were the same, and put simply it was because everyone else was using those drugs. He did not want to drink alcohol because he had seen the dysfunction resulting from excessive alcohol use. He was apparently still using drugs while in IDATP as he said he had had some dirty urinalysis results, but he thought that should be overlooked because he is in IDATP to learn how not to use drugs.

Gary wanted to get out and stay out of prison and to get a house somewhere, but his plans were clearly not well-formulated as he could not elaborate on any particular aspects. He was a pleasant and talkative young man, but he seemed to be almost drifting in life.

Jess

Jess was a 27-year-old Aboriginal man from a regional farming area of NSW. He had been living with his partner and two children and had been self-employed in his own rural business before going to prison. He was not a talkative man, and was abrupt and seemed somewhat ambivalent at times. This was his third prison sentence and he had not been to juvenile detention. When asked about why he was in prison he avoided the question and said he was with a friend at a party, they had been using drugs and drinking and things got out of hand.

Jess grew up with his mother and siblings in the same rural area where he lived with his partner and children. He said he had done well in primary school but struggled in high school. He eventually left home and moved to a regional centre where he went to TAFE, and it was here that he tried alcohol or cannabis for the first time. It appears he worked when not in prison and that he had completed a number of TAFE certificates while in prisons that accredit him to use particular manual work equipment.

Jess's drugs of choice were alcohol and cannabis, though he did not believe he had a problem with these drugs as he used them out of boredom mainly. He thought he should do the IDATP course as it could help with parole. He said he had been a model inmate by not using drugs and evidenced this by saying he has never had a dirty urinalysis.

Jess's main gaol was to get back to his partner and children. He also wanted to get his

driver's licence back because it was hard getting around his home locality without having a licence, and this would make it easier for his sole-trader business. In relation to his goals, Jess said: *'Nothing. I just wanna get out. … Get me family together again… me kids. Get me licence. Just pull me head in an behave meself.'*

Rob

Rob was a 28-year-old Aboriginal man with no fixed address. He was arrested and returned to prison from a regional city where he had been staying at a relative's home and it was for this reason he was listed as being from a regional city. At that time, he was on the run having been paroled to attend a residential rehabilitation service. He did not have any children and saw this as a good thing because he did not have to concern himself with having to care for children. Rob was the most talkative participant of all, with it being difficult to keep up with him during the conversation so as to ensure the major areas were covered. Rob was very proud of his cultural identity and discussed this in quite some detail. This was his fifth term in prison and he had spent much of his younger years in juvenile detention. As he put it, he has *'barely been out of prison'*. His first offences were breaking into cars to steal money, so he could buy food for himself and his siblings, and his offences as an adult also related to break and enter and stealing.

Rob said he was good at school, having attended high school in juvenile detention.
He grew up with his mother who he said was an alcoholic and a gambler, and he and his siblings were removed from her care. After he was removed from his mother, he spent most of his time in juvenile detention or in boys' homes. His family seemed to be a dichotomy of complete dysfunction or religious church-going people. He first tried alcohol and cannabis when he was about 11 years of age, though he was not quite sure if it might have been earlier. He started smoking cannabis regularly between 12 to 14 years of age. He thought he had been good because he had not smoked tobacco.

Rob first used heroin at age 16 and not long after he tried amphetamine. When he was 24, he injected amphetamine for the first time and life deteriorated, his drug use increased exponentially, and his offending increased to match. When last out of prison he had been paroled to attend a residential drug rehabilitation service, but he had absconded. He claimed he wanted to stop using drugs but had continued to use while in prison, with buprenorphine being his main drug. Rob said he wanted to stop using drugs as he felt better when off the drugs even if just for a short time: *'I was thinking, "Fuck. If you don't touch drugs and your mind's more clearer, … your life will be better." … You understand what I'm saying? … I thought, "Fuck." So I tried it for two days … and, yeah, drugs fuck you up man'.*

Rob, like all of the men interviewed, wanted to get out and stay out of prison. He wanted to get a job on the mines as he had heard of these opportunities from an Aboriginal career advisor at a previous prison. He had also thought about undertaking some training and perhaps becoming a diesel mechanic.

Neil

Neil was a well-mannered and well-spoken 29-year-old Aboriginal man from Sydney. He had no children and did not have a partner. He had been living with the eldest of his two older sisters and her children in what has been the family home for generations. His father was Aboriginal, and he worked as a cultural educator. Neil did not speak much about his mother who was, he said, *'white'* Australian. Neil and both his sisters and their children identified as being Aboriginal. This was his second term in prison and he had spent most of his adult life in prison as the previous sentence was for seven years. His current offence was apparently a serious assault, which occurred while he was intoxicated. He had been to juvenile detention for a short period, with his first offence occurring around 14 years of age.

Neil grew up in Sydney with his family and has a large extended family in Sydney and other parts of NSW. The family travel regularly to visit their relatives. He said his family is predominantly women, and he felt he needed to step-up and be responsible for the family, which made him feel sad about being in prison. He stopped going to school in year 10 after he got suspended for fighting, and he was told they did not want him to come back to school so he did not. Neil's father had issues with alcohol and so did his grandfather. This intergenerational alcohol use extended to Neil.

Neil tried alcohol for the first time at around age 10 and went on to try cannabis at 11 or 12 years of age. By the time Neil was about 14 years old he was drinking alcohol regularly, including binge drinking, and he was also using cannabis regularly. He did not use any other illicit drugs until he went to prison, where he was introduced to heroin for the first time. Neil had never known anyone to use heroin or amphetamines in his family as they only drank alcohol or used cannabis. He developed a drug habit in prison which he took back to the community.

Neil managed to get a 'great' trainee job when last in the community but he lost the job because his drug use made his life unmanageable. Neil was a thoughtful man, and when asked about his gaols he gave the following answer: *'My plans, my goals, you know, for the future. You know, have another look at them. [Yeah] See if they're, you know, realistic or not. You know, just, yeah, just, I think I just need a big refreshment, you know'.* He did not want

to discuss his plans in detail, but it was clear he had put some thought into his future. He also was interested in getting support post-prison for AoD issues, but felt ultimately it was up to him to not use drugs and to learn new skills in this regard. For example, Neil believed he needed to learn ways to deal with stress and not drink or use drugs.

Ian

Ian was a 32-year-old Aboriginal man from a regional town in NSW where he had lived with his mother. He had a partner and son that lived a short distance away from his mother's home. Ian had strong views on the need for Aboriginal men to unite and be strong together, which was probably an influence from his father who had passed away. As Ian said: *'Noongar, Murray, Koori side of things. We're all brothers. [Yeah] If we were back in the days - you know what I mean? - instead of dividing tribes, this, this and that, if we were all connected on, maybe things would have been different. You know what I mean?'.*
Ian's father had worked on Aboriginal rights and had helped set up the Aboriginal Land Council in his area. Ian was very proud of his cultural heritage and that both he and his son had learnt some of their cultural dance heritage. This was Ian's third term in prison, having spent most of his life in prison and in juvenile detention. About this, he said: *'Pretty much I'll be straight with you brother, I'm institutionalised'.* He had a history of robbery and assault type offences.

Ian and his five brothers were raised by their mother, as his mother and father frequently broke up and got back together again. He went to two weeks of high school before he was expelled for fighting, he attended high school in juvenile detention from that point. Ian had no qualifications and no interest in training or education. He apparently put on a bad boy persona to impress the girls when in his teens and first tried cannabis around age 10 and alcohol around 11 years of age.

Ian started using cannabis and alcohol regularly by age 13 years. He tried amphetamine at 15 and liked the effect, and then gave heroin a try at 16 years of age and he enjoyed the effect of heroin more than any other drug as it relived all stress. He started using amphetamine for crime and heroin to relax and de-stress. He has never worked as he has been in prison most of his life.

When it came to his future perspectives, he was well intended. He wanted to work with youth to encourage them not to take the path in life he had and to make better choices. He also wanted to play football again. The biggest gaol he had was to become more involved in Aboriginal cultural activities and to paint again, as well as perhaps work for the local

Aboriginal Land Council. Importantly for his drug use, he planned on being on methadone in the community as that would relieve his need to offend to support a drug habit.

Ed

Ed was a 35-year-old Aboriginal man who grew up in a regional area of NSW and had been living in Sydney with his ex-partner and three children. Ed was well spoken and was one of the few men that read all of the participant information independently, as most of the men had the sheet read to them. This was his second term in prison, but it related to his first term as he had been paroled and that parole was rescinded due to non-compliance with a transfer to a residential rehabilitation service. His offence was armed robbery of a bank, which he said he had been under peer pressure to commit with his co-offenders. Ed had not been to juvenile detention and had not been in trouble with the law until he was an adult.

Ed grew up in the care of his father's parents as his father was in prison during his childhood for robbery and his mother had died of a drug overdose when he was 10 years of age. He had two biological sisters and a stepsister and stepbrother. One of his biological sisters and his stepbrother were both in prison. Ed's schooling apparently went quite well with him attaining good grades and being quite friendly with teachers, and having formed a particular friendship with the physical education teacher. Ed left school to start working and earn money. For a period of time he worked for an Aboriginal corporation where he undertook work such as mowing lawns, as well as attending TAFE where he completed several certificates for manual labouring work. He first used alcohol and cannabis around 16 years of age and very shortly after began daily use of these two substances.

Ed drank alcohol and used cannabis regularly from 16 years of age and went on to try heroin and amphetamine when he was around 18 years old. At that time, Ed was living with his partner and both he and his partner worked. Ed tried to conceal his amphetamine and heroin use from her, though his drinking was openly a problem and his father in-law encouraged him to do something about it, so he got a naltrexone implant. Ed said only amphetamine and cocaine worked while he had the implant. Ed's drug use continued and his broke up with his partner, and at that point his drug use went out of control. He particularly enjoyed using heroin as it took away the emotional pain.

Ed wanted to undertake the IDATP program because of his drug use and the need to get it under control and stop using drugs. He was planning on attending a maintenance program when he gets released. Ed also had had mental health issues in the past and the management of his mental health would help reduce the possibility of him returning to

prison. As Ed said: *'That's my biggest downfall. [Yeah] Yeah. If I take drugs, then, you know, I start losing weight, I don't eat. … You know, I stay up all night. I, that's when I, that's when the schizophrenia kicks in. … I'm not taking my medication. …And I'm out stealing, you know. And I need to, that's my problem that I need to address, … my, my, my addiction to drugs. [Yeah] It's hard'.*

Ryan

Ryan was a 39-year-old Aboriginal man from a regional city in NSW. For the brief periods he had been in the community, Ryan had lived with his partner and seven children. Ryan had not been to juvenile detention though he had predominantly been in prison since serving his first sentence in 1992. When asked the exact number of times he had been to prison he was not sure but thought it was his fifth term. His offences related to armed robbery and stealing or break and enter, and the offences were all to support his drug use.

Ryan grew up with his parents and had a stable home life. He said that he was the '*white sheep of the family',* that the rest of his brothers and sister do not have a drug or alcohol problem and they all work. He left school after year 10 and started hanging around with other young Aboriginal men in his area. When asked about drugs or alcohol he only really focused on one drug, that being heroin. He said he did not drink alcohol.

Ryan said he was 'hooked' the moment he first used heroin. When asked why he was hooked he joked to the researcher*, 'Try it! You'll find out'*. Heroin apparently relaxed him and made all of his problems go away. The drug heroin had an instantaneous and profound effect on Ryan, he wanted more and more and more, and he has never willingly stopped using heroin since he started. He spoke of himself as being a selfish drug user and he clearly felt bad at not being around for his children.

Ryan had no plans for the future, and when asked: '*What sort of things do you think could be put in place to help you?'* Ryan said: *'Haven't had, don't know yet. [You don't] If I knew that, we wouldn't be having this conversation'*. Ryan had no aspiration of further education or training or any idea of future work.

Toby

Toby was a 39-year-old Aboriginal man from a regional city in NSW. He had been living with his ex-partner and their three children until they broke-up and he breached a violence restraining order she had against him. He first got into trouble with police when 16 or 17 years old, but he did not go to juvenile detention. This was his third term in prison. The two

previous terms in prison were for driving-related offences including driving while under the influence of alcohol.

Toby grew up in a regional town with his parents. His father was, as he put it, a *'bad man in those days'*, but has apparently stopped drinking alcohol. Toby did okay at school and got along well, and he left about halfway though year 11 as he got a traineeship in retail management. Toby seems to have either genuinely achieved well in his employment endeavours or described his work in overly positive terms, since in every job he had, he had worked his way up to management level.

Toby first used alcohol and cannabis at about the same time, at 12 years of age. Toby did not think he had a drug or alcohol problem and was doing the IDATP to get parole faster. He said his ex-partner had a drug problem (cannabis) and he had been trying to get her off the drugs for years. He minimised his offence and expressed a view that he had not really done anything wrong and that she should not have had a restraining order on him as he was trying to help her. Toby said: *'The magistrate gave me a suspended sentence and an AVO saying that I couldn't go within the house even though it was my house, that I lived there with my two kids. So, I was forced, because of this hole in the wall, I was forced to live with the, the in-laws for, I don't know, what was it? 18 months it was - 12 months, right - which is a bit hard when you're trying to run a family. Yeah. Went away for work. Came back. Went over there to get some more clothes. Bang! There I breached me suspended sentence. Got into another argument'.* Toby did not appear to take responsibility for his actions in regard to his partner.

Toby's future aspirations were to get out of prison and stay out. As he did not have an alcohol or drug problem to begin with he did not need any help in that area and finding a job was allegedly fairly easy for him.

Tom

Tom was a 39-year-old Aboriginal man from a regional town in NSW. He had been living between his mother's and his partner's homes. He had one child who lived with his partner. He was a friendly man to talk to. Tom's current offence was related to stealing and this was his second term in prison, with the first term related to driving offences. Tom first started getting into trouble with the law when he was 13 years old, and had been to juvenile detention several times. Tom enjoyed making money from offending, particularly when he was young: '*I just, yeah, like, like thieving. I don't know why. I just get an adrenalin rush off it.* [Yeah?] *Yeah. I've always, always been that way as a kid before I started using and that,*

you know. I just … always in the wrong place at the wrong time I guess, you know. In with the wrong crowd. [Yep] Just love money too'.

Tom grew up with his mother, older brother and two younger brothers and sister. He first tried cannabis and alcohol around age 14 years and his use quickly escalated to daily or almost daily. He left school in year 9 because he went to juvenile detention and continued school while inside. He has completed a few TAFE courses for manual labouring type roles. Tom was unable to work and had been on disability benefits due to a serious car accident that left him physically impaired.

Tom's town was apparently replete with alcohol and drug use and it seemed quite normal to him to do these things, particularly as his older brother was drinking alcohol and using cannabis. Tom's main plan for the future was to not use drugs as it leads to criminal thinking and he believed he needed to move away from the town he lived in because he would likely go straight back into the same old behaviour with the same people around.

Jim

Jim was a 42-year-old Aboriginal man from Sydney. He had been living at his mother's home with his current partner who was pregnant at the time and had since had the baby. Jim had several other children with different partners. He had not long been with his current partner before offending and going into prison after having spent 10 years in the community since his last sentence. He had been to juvenile detention several times on remand but had only been sentenced once to a term in juvenile detention. His new offence was armed robbery. He said he had committed the offence to raise money to be able to pay for rent for a new place for him and his partner.

Jim was expelled from school in year 10 following a fight that apparently arose out of a football match during lunch. He said he liked school but did not engage much with teachers. Jim had no qualifications and had worked in labouring type roles. He apparently enjoyed working as it gave him a sense of higher self-esteem, but his reasons for not working were not cohesive. He blamed the reporting regime of being on parole for why he could not hold down a job, but it is almost certain that he would not have been on parole for the whole 10-year period between his current and previous term in prison.

He first used cannabis at 14 years and alcohol at 15 years of age. He began regular use of both at 17 years, and said he was trying to numb himself. He did not want to say what he was trying to numb, he just said he did not want to think about anything back then. He

progressed to heroin use shortly after turning 17, and though his favourite drug was cocaine his most commonly used drug was heroin.

He wanted not to use drugs again and to be able to have a beer at the pub, but he realised that when he drinks he is more likely to use drugs. He spoke about having triggers for drug use and that he needed to deal with these better and hoped to learn how to do that at IDATP. He thought support services were okay, but that ultimately it is up to the individual to stop using drugs. Jim expressed the view that drug testing while on parole kept people in line and that it was extremely helpful.

4.7 Conclusion

This chapter described the methods used for the collection of the data that are analysed and presented in Chapters Five, Six and Seven. It also presented an overview of the interview participants in the qualitative section of this research study, to provide the reader with some context for the more detailed examination of these data in the following chapters.

As the brief personal summaries show, the men who took part in these interviews had some individual differences, but there were also some striking within-group similarities. In particular, the Aboriginal men appeared to have had more similar backgrounds than did the non-Aboriginal men. This is possibly explained by the fact that the Aboriginal men were the only major cultural grouping in the study, whereas the other men were from more diverse cultural backgrounds. It also became evident that, in general, the Aboriginal men spoke more about their families and family background. This is consistent with Aboriginal kinship and the values of having an extended family; however, to precisely state this as a finding from the research would require further analysis.

Similarly, while many of the Aboriginal men had engaged in paid work, the non-Aboriginal men had a stronger work history, and it appeared that social/work connections were driving some of the employment opportunities available to them. This was not the case for the Aboriginal men, who did not appear to have as many connections to people in the workforce. Again, a separate analysis would need to be conducted to interrogate this trend, but it would be consistent with the broader literature that has identified Aboriginal people as having higher rates of unemployment and being largely excluded from the mainstream economy (26, 28).

During the process of writing up the biographical summaries of each of the men, one clear commonality did emerge which was shared across both groups. For most of the men, educational levels were quite low, with many of the men not having completed year 10 of high school. Several of the men, chiefly Aboriginal men, had attended high school in juvenile detention.

Chapter Five will expand on these preliminary insights through a more detailed examination of the drug use histories and treatment experiences of each of the men who took part in interviews for this study.

Chapter Five: Drug and Alcohol Use Histories and Treatment Experiences of Men in a Prison-based Treatment Program

5.1 Introduction and Aims

Chapters Five, Six and Seven address different aspects of the third research question for this thesis: *How can prison-based AoD treatment for men be further developed?* This chapter specifically reports on how prison-based AoD treatment for men can be further developed to better meet their needs, using the data from interviews with each of the 31 men who participated in this research.

The data and discussion in this chapter are intended to add to the limited published research into prison-based AoD treatment and, in particular, to the paucity of qualitative work, both in Australia and internationally, in this field (as identified in Chapter Two).

In all, there were seven domains of questions covered during the interviews and these became the axial codes:

1) Demographic information.
2) Imprisonment and offending history.
3) Education and employment.
4) Alcohol and other drug use.
5) Alcohol and other drug use treatment.
6) IDATP and current term of prison.
7) Post-prison plans.

The findings reported in this chapter predominately relate to axial codes 4 and 5: that is, alcohol and other drug use, and alcohol and other drug use treatment. The chapter begins with a more extensive consideration of the participants' histories of AoD use, as well as of their first involvement in the criminal justice system than was provided in Chapter 4. This data is drawn from a theme in axial code 2, imprisonment and offending history. This discussion then leads into the drug and alcohol treatment experiences of the 31 men from which theory has been developed as to how such treatment can be augmented and improved in the future. None of the data presented related directly to the participant's experiences of the IDATP program, since these interviews took place before the men had commenced the IDATP.

5.2 Methods

The methods are reported in detail in Chapter Four but, in brief, this chapter uses the grounded theory method as described by Strauss and Corbin (53). All inmates participated in in-depth interviews, using the same interview guide (Appendix 8) by the same researcher (MD). The data from all 31 interviews were analysed together using the NVivo software

package. Through an iterative process of constant comparison and reviewing, the data were coded and the theory which is presented below, was developed.

5.3 Findings

5.3.1 Demographics

The majority of the 17 non-Aboriginal men were from Sydney (n=12), with three being from regional cities in NSW, two from interstate capitals, and none from a regional town in NSW. The 14 Aboriginal men were more evenly distributed, with six from Sydney, three from regional NSW cities, and five from regional NSW towns. There were no Aboriginal men from an interstate capital. The distribution of the two groups broadly reflects the broader Australian population data, which reports 35% of Aboriginal and 71% of non-Aboriginal people living in in a capital city, and 44% of Aboriginal and 21% of non-Aboriginal people living in a regional area (95). There were no Aboriginal or non-Aboriginal participants from remote locations. The age distributions of Aboriginal and non-Aboriginal men in the sample were three Aboriginal and two non-Aboriginal men between the ages of 18 to 24, six Aboriginal and nine non-Aboriginal men aged between 25 and 34, and five Aboriginal and six non-Aboriginal men aged 35 and older.

In relation to educational level, one Aboriginal and one non-Aboriginal man left school in primary school, five Aboriginal men and eight non-Aboriginal men left before commencing year 10, and eight of the Aboriginal men and six non-Aboriginal men left school in year 10. One non-Aboriginal man had left school in year 12, though before completion, and another non-Aboriginal man had never attended school.

In relation to having been in the workforce, five of the non-Aboriginal men and one Aboriginal man had worked in blue-collar labouring type jobs, one non-Aboriginal man and two Aboriginal men had worked, though sporadically, in white-collar type jobs, and eight non-Aboriginal men and five Aboriginal men had worked sporadically in blue-collar labouring type jobs. One non-Aboriginal and three Aboriginal men had worked only when younger (before the age of 18 years), two non-Aboriginal and two Aboriginal men had not worked, and one was unable to work due to disability.

As part of this qualitative study, this participant summary was not intended to be a quantification but rather a general overview of the participant group.

5.3.2 Alcohol and other Drug use History

All of the 31 participants had a long history of AoD use, which for most men began during childhood and continued on into the present, with all of the men having used AoD the last time they were in the community. This AoD use often started with alcohol and then cannabis, in that order. This was described by Owen:

> *Owen: Marijuana it would have been. [Yeah?] Pot, yeah, cannabis.*
> ***MD: Cannabis?** [Yeah] **And how old were you then?***
> *Owen: I'd say 14. [14? Yeah] Yeah, 14. [Yeah] Yeah. [Oh okay]*
> ***MD: And when was the first time you tried alcohol?***
> *Owen: Oh fuck … let's say 11 or 12, yeah. [Oh okay] Yeah, younger, yeah. [Yep] But I wasn't drinking all the time, you know. Just [Yeah] … yeah.*

John had consumed alcohol and used cannabis in his adolescence, but as was the case with many of the men, the use of other illicit drugs occurred at a later age:

> *John: About 15 I used to drink. Yeah. [Yeah] About 15. When I was young, we grew up on the beach out at Bondi, you know. We'd go travel from Bondi to Coogee and Maroubra. We just used to drink a lot. [Yep] And then I started smoking pot about 16. And then, yeah, I didn't touch heroin or anything until I was 20. I came to gaol. I went to the juvenile at 17. Went, started gaol at 18.*

When it came to age of first AoD use, several participants had consumed alcohol and/or used cannabis at the age of 10 or 11 years, although first use was more common around 13 to 15 years of age. One participant, Luke, was older than 15 years, saying that his first drug use (including alcohol) was at age 17. The reasons given for their first use were vague or non-specific, with many of the men appearing to find this difficult to answer. The most common answer was along the lines of *'don't know'* or, as Sam put it:

> *Sam: 'No reason in particular. I was just young and … all mates around, and we'd get on the drink and smoke a bit of pot or something like that.'*

It was clear that cannabis and alcohol were readily available for most participants within their family and domestic social environments during childhood and adolescence, and to some extent within their social environments in high school. Many of the men often observed when younger the use of cannabis or heavy consumption of alcohol by parents and other family members at home, such as was the case for Carl, aged 26 years, who had been in prison

three times. It appeared that Carl had seen his mother use cannabis for as long as he could remember, with him first trying cannabis himself at 12 years of age and then going on to smoking regularly:

Carl: *No, I was about, yeah, I was about 12, 13 when I started smoking pot. ... So yeah.*

MD: ***And then you, you've never liked alcohol you were saying? [Yeah] Yeah***.

Carl: *Didn't drink alcohol.*

MD: ***You just, why was that?***

Carl: *'Cause I, I used to watch my, 'cause I had my, like you know how Koori families are? Well I grew up around alcohol and I didn't like what they were doing. They were bashing their women and … You know what I mean? Always arguments and fights. So, I didn't like what they were doing so I didn't, didn't like alcohol. ... You know what I mean?*

MD: ***So, you thought you'd stay away from that [Yeah] then and then you used the pot, [Yeah, yeah] and heroin instead? Yeah. Okay.***

Carl: *But I didn't start using heroin until later on, ... as, late teenage, you know. So…*

MD: ***You were saying when you were 15.***

Carl: *Yeah, 16. 16, 17, when I started using heroin. So later on ... just as, just ... as I was turning to a young man, so yeah. ...*

Carl had not known a time when cannabis and/or other drugs were not a seemingly normal feature in his life.

In general, the use of cannabis for the first time was often with siblings such as an older brother/s, or with other relatives around their own age such as cousins or friends, with cousins often referred to as friends. As described by 20-year-old Ray, who had been using the drug since the age of 11 or 12:

Ray: *At 12. ... 11, 12. ... My cousin gave me my first cone about 12. Just ever since then just we used.*

For alcohol, it was more common that the first time they had a drink it was supplied by a male family member. The first time they consumed alcohol was often recalled with some excitement and happiness and was generally talked about boastfully by the men as a

coming-of-age type event, as described by Lee who first drank with his uncles while he was in his country of birth:

> *Lee: It was fun bro…. It was fun…. It was fun and adults done that, and, yeah bro … Yeah. Adults drank, you know.*

The participants were very forthcoming when discussing and giving insight into their AoD use, and 25 of the men spoke about their first exposure to AoD in detail. From their descriptions of observing at a young age normalised AoD use within their family and/or in their neighbourhood or town, it is probable that some of the men had not lived in an environment where AoD use was not commonplace. For these men, the adult men they could model their future behaviour upon were seen to consume excessive amounts of alcohol or to have used cannabis regularly, if not daily.

Four of the 31 men spoke about seeing a family member inject drugs while they were still a child. For these four men, overdoses were part of life as a child, with one saying in an expressionless tone that his mother had died of an overdose, and another in a similar tone with an apathetic facial expression, that his stepfather had died of an overdose. Both these participants were under the age of 11 years at the time of these events. The loss of family and friends was a common occurrence for these men, as Gary, who grew-up with his maternal grandmother, described:

> *Gary: I've lost a lot of my fucking friends and that… When I was young, because of drugs, you know. My stepfather died, overdosed 'cause of drugs.*

Twelve of the 31 men spoke of their mother or father being alcohol or drug dependent, and in some cases both parents. The alcohol consuming parent or other adults in the family at times attempted to educate the participant about the dangers of drinking and not to end up in the same predicament. The men who experienced this stated, in no uncertain terms, using colourful language, that this attempt at education had no effect. As described by Bill, an Aboriginal man form Sydney who grew-up with his parents and had a large extended family that lived around his area:

> *Bill: …my family all drink. You know what I mean? Like ... it's hard to say no, don't do it … ... They used to say to me, when I was little, ..., ... and they used to tell me, "Don't touch alcohol," and, "Don't touch drugs," this, that. When they were drinking, I used to just go and grab what I wanted and just drink it anyway.*

For Bill, the adults around him were doing what they could to prevent alcohol use by younger members of the family, and even though the message was not taken seriously he did recall these events.

5.3.3 Preferred and Most Commonly used Drug or Alcohol

All of the men had a history of AoD use, even if a few did not view their use as being a problem. The preferred drug was also the most commonly used drug for the majority of Aboriginal and non-Aboriginal men, see Table 5.1. Fourteen of the 17 non-Aboriginal men most commonly used their preferred drug. There were three exceptions: Dean preferred heroin but his most commonly used AoD were heroin and alcohol, Alex preferred cocaine and alcohol but his most commonly used was alcohol, and for Cole, his preferred AoD was alcohol and cocaine but he most commonly used alcohol. For each of these men, this is probably a reflection of the ease of access to alcohol compared to illicit drugs.

The majority of Aboriginal the men also most commonly used their preferred AoD. Again, there were three exceptions: Rob preferred amphetamine but most commonly used amphetamine and buprenorphine; Ed preferred heroin but cannabis was his most commonly used drug, and Toby, whose preferred drugs were amphetamine and ecstasy but his most commonly used were amphetamine and alcohol. For Rob and Toby, it is likely that the affordability and availability of cannabis and alcohol may have been the reason for those drugs being more commonly used, while for Rob, he used buprenorphine because he was able to access this drug more readily than heroin in his environment. Table 5.1 on the next page sets out the preferred and most commonly used drugs, by Aboriginal status.

Table 5.1: Preferred and Most Commonly used Drug prior to Prison

Alcohol or drug	Preferred		Most commonly used	
	Aboriginal	Non-Aboriginal	Aboriginal	Non-Aboriginal
Alcohol	3	4	4	4
Heroin	7	5	7	5
Amphetamine	3	6	3	6
Cannabis	2	2	3	3
Cocaine	1	3	0	1
Ecstasy	1	0	0	0
Buprenorphine	0	0	0	2
Gambling	0	1	0	2

While clearly not a drug, gambling is included in this table because when the men were asked about their AoD use, at least two spoke about gambling as being part of their AoD use. Jack spoke of alcohol and gambling being his preferred AoD, and also said these were his most commonly used AoD. One other person, Joe, said he most commonly gambled as part of his AoD use behaviour. The focus of this research was on AoD treatment, but from the stories of these two men and the mention of gambling by other men, it was clear that gambling is part of the AoD use lifestyle for these men. There are separate treatment programs for gambling in Australian prisons, but the cross-pollination of gambling and AoD treatment programs is worth further exploration, though such exploration was beyond the scope of this research (3).

5.3.4 Alcohol and other Drug use and Contact with the Justice System

For the men who had contact with the police as a child or young person, their first offence did not appear to be a thought-through decision, but rather as an action that was mostly opportunistic, such as stealing or vandalism. There were two significant exceptions to this first offence experience. One man, Ray, who had been placed in care at a young age, stated he stood-up to, and fought back against, an abusive guardian who would otherwise have harmed his siblings. The other man, Rob, who had grown-up with his mother when he was not in juvenile detention, said he had to break into cars to steal money to buy food for himself and his younger siblings. Both Ray and Rob had to take adult responsibility for their siblings by protecting and/or providing for them because their parents did not fulfil this role

and had found themselves on the wrong side of the criminal justice system as a result of what were actions they believed they had to take. The stories of Ray and Rob, who are both Aboriginal men, are explored further in the following chapters.

Several of the men described being under the influence of drugs or alcohol at the time of their first offence. Cole, who was 42-years-old and had spent much of his life in prison, committed his first offence, an assault type offence resulting from having been in a brawl at a pub, as an adult:

> *Cole: …I was living down in [regional town] … with me cousin and that and got into a pub brawl … and we, we had a brawl with the bikies and that, and ... a few of them were hospitalised … That's when I first, that was my first charge.*

While Cole spoke of having to stand by his cousin, this situation was one in which Cole and his cousin could have chosen to leave. Cole's offence took place within the context of alcohol consumption. Not all the participants were under the influence of alcohol or drugs at the time of their first offence; however, as the offending continued almost all men reported AoD being in some way related to their offences.

In total, 30 men linked their current offence in some way to drugs or alcohol. Many of the men spoke about being in a group while committing the offences and feeling some level of peer pressure. Some men had committed offences to support drug use through stealing or armed robbery; were unable to control themselves while on methamphetamine or drinking alcohol resulting in assault type offices; or believed they would not have been in the situation that arose whereby they committed the offence if not for AoD use. For example, Gary, who had started regular drug use (cannabis) at age 12, so had been using drugs his whole adult life, discussed how difficult it was to raise enough money to support his drug use:

> *Gary: Every day. ... Yeah. Three, four. All depends how, how many, how many stick-ups or whatever I'd do a day to get the money. You know what I mean? If I had the money, I'll go all day. … It's not fucking cheap ... to have a drug habit.*

The use of drugs was normalised for Gary and others, with drugs or alcohol being a part of their day-to-day activities and a cycle of behaviour.

With 30 of the men linking their current offence in some way to AoD. The cycle that appears to be happening is one whereby the men undertake the offence/crime to get drugs because they feel they need the drugs to deal with unpleasant emotions and physical symptoms. This is particularly the case for the 20 men who had predominately used amphetamine and heroin, and at times consumed alcohol, with their drug use largely supported by offending. For Ed there was the added complication of breaking up with his partner as a result of his drug use:

> Ed: *I knew it was a big problem. [Yeah] Every time I use, I know it's a problem for me to go out and steal, [Yeah] you know, money and, and, to get back on, [To support] to support my habit. [Yeah] Sometimes I make heaps of money and give her (ex-partner) money because I'm not with her but I give her money for the kids [Yeah] to help her out. [Yeah] It's, I know it, [Yeah] it's, I, I feel real sad about it. [Yeah] I feel downhearted, [You feel] you know.*

Carl spoke of always having money by doing crime and spending the money on heroin:

> *Carl: I was always, like always had money. You know what I mean? Always, I was always going out doing crime so I always had money to, to, to support it. [Yeah] But all my money I used to just spend it on heroin, so [Yeah] …*

The offence heightens the unpleasant feelings, which the men then try to block out by using drugs, and for Ed it also blocked out the sadness of being separated from his family. This pattern of behaviour is similar to the positive and negative emotional feelings arising from the development of a drug and alcohol use problem in itself, and it is possible many of these man had also experienced these emotions (119). It is also likely that the men experienced a positive emotional response after the difficulty of committing the office from have a monetary reward and being able to buy more drugs. The drugs enable the men to temporarily deal with the unpleasant emotions and physical symptoms, but they need more of the drug which then compels them to commit further offences.

This was not always the case for the men as at different times during their offending that had had different motivations, not just one of alleviating the symptoms of drug withdrawal. It was normal for these men to have committed multiple offences that overlapped in terms of categorisation of offence which, if used, would include assault, stealing, break and enter, robbery including armed robbery, and driving type offences.

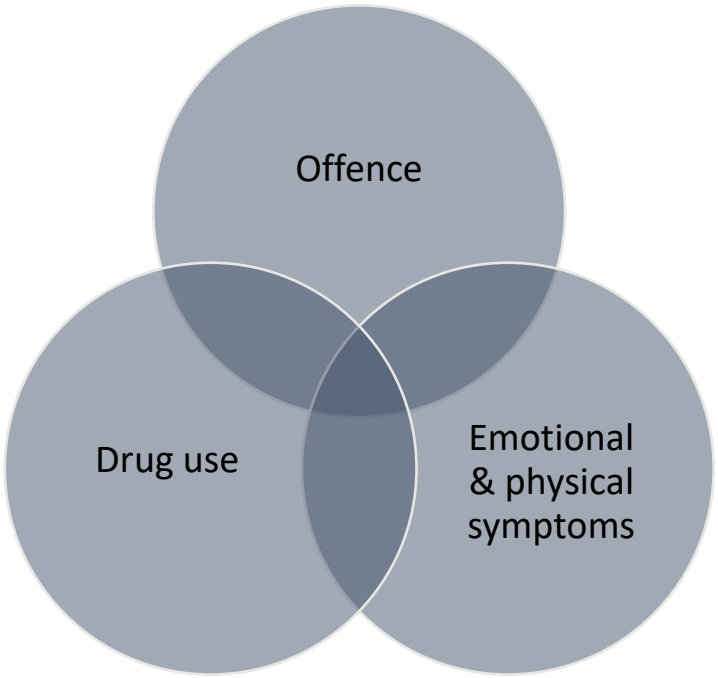


Figure 5.1: Intersecting Aspects of Drug and Alcohol use, Offending, and Emotional and Physical Symptoms of Withdrawal

As depicted in Figure 5.1 above, these three aspects overlap, and the cycle continues for many of these men until it is interrupted. The interruption in the cycle for many of these men was going to prison. The committing offences to support a drug use is well understood but punishing the person with prison in order to stop the crime yields limited results. While further research, such as this work, is needed, there is considerable potential to reduce crime through treating the drug use, as discussed by O'Callaghan and others (120).

Analysing the data and considering the behaviour as it related to AoD use and not as a category of offence, there were four themes that emerged:

1) AoD use and driving-related offences.
2) Offences to support AoD use, stealing break and enter, and robbery/armed robbery.
3) AoD use and assault offences.
4) Drugs, offending and social networks.

AoD use and driving offences were somewhat different from the other offences, as the men did not attribute these offences to being under the influence of AoD. Rather, the men believed they would have committed the offences even if they were not using AoD at the time.

- **AoD use and Driving-related Offences**

Five men that spoke about AoD use and driving offences said these were all more related to transport problems than to anything else. It was more the case that the driving offence was one among many other offences for these five men. However, there was one man, Dan, who directly linked his driving offence to this current term of imprisonment. At 39 years old, Dan was one of the older men interviewed. Dan was incensed at losing his licence and reasoned that there was no benefit to him or for the government from this punishment:

> *Dan: And the government thinks by taking my licence away from me that's gonna benefit me. In what way? I'm, I can't work so I'm gonna go on the dole. Like how does it, I can't work out their logic. Like give me a licence. I've never really held a licence. ... Do you know what I mean? ... I've been done drink driving, blah, blah, blah, but I've asked, give me the ... program. ... Give me a breathalyser on my ute so I can go to work. ... I don't drink every day. I'm not driving every day drunk. You know what I mean?*

For Dan and one other man, Jess, who were both self-employed as sole-traders, the loss of licence was part of a downward spiral as they then lost their source of income. These men felt bad about the offences but also felt a need to have done what they did for income. It is unlikely that either of these men will regain their licence immediately after being released and they may feel compelled to drive in order to earn an income. This is a precarious situation as they could be released onto parole and this would breach that parole as well as attract a new charge. If this is the case, some release planning as part of their AoD treatment programs around how they can start working on their business again without having to drive would be prudent.

- **Offences to support AoD use, Stealing, Break and Enter, and Robbery/Armed Robbery**

There were several men who committed offences in order to support their AoD use through stealing, break and enters, robbery or armed robbery. Kurt, a non-Aboriginal man, felt he had to steal in order to support his drug use:

> *Kurt: The simple thing was, if I didn't use meth, I wouldn't have stole. [Yeah] And I've never had to steal for any other reason except that when I'm really hanging out[7] [Yeah] and I would go in to do things I normally wouldn't do.*

[7] The term 'hanging out' was used in this context to indicate cravings for the drug of choice

As the nature of the offences were not the focus of these interviews, the exact details of Kurt's offences and those of the other participants was not discussed. What was discussed was how the offences related to AoD. What was critical to note here was that Kurt, like other men, said: *'I would go in to do things I normally wouldn't do'*.

John, a non-Aboriginal man, had a similar story, where he would break and enter in order to obtain money to pay for his drug use and gambling:

> *John: So, I was like instead of working I just thought steal. Take, take from others, [Yeah] which, you know, I know right from wrong - I'm not an imbecile - [Yeah, yeah] but I chose to do that, take the easy way out. [Yeah, yeah] Take the easy way out.*

John, like the other men, was clearly remorseful for his offence and he spoke about it as being the easy way out and went on to say that it would be better to work than to do break and enter type crimes.

Cole's offence also related to having to support his drug use, which he did through an armed robbery:

> ***MD: Was it like a violent charge or something?***
> *Cole: Yeah. [Okay] Armed robbery, you know. [Yep] Yeah. [Oh okay]*
> ***MD: But they didn't let you into rehab. [Nuh] When was the first time you ever went to drug and alcohol counselling or anything like that? When did you sort of -***
> *Cole: When was the first time?*
> ***MD: Yeah. When do you ever remember the very first time you … Like when you were young? Was that, was that when you went to gaol first? [Yeah] Or -***
> *Cole: It was, it was in gaol that I went to, that I went to drug and alcohol counselling, you know. [Yeah] That's the only time I've, yeah, [Yeah] I've been.*

Cole had a long history of AoD use starting at 13-years-old, but the first time he ever received AoD treatment was when he was in prison. The nature of these offences varied greatly, with Cole's offence of armed robbery being the most serious; however, the only objective for these men was to alleviate the unpleasant emotions and physical symptoms by making enough money to be able to use their drug of choice.

- **AoD use and Assault Offences**

Nineteen of the men had committed assaults whilst under the influence of alcohol and/or other drugs. Some of the men also spoke about committing offences because of the after-effects of the alcohol or drug use, known colloquially as being 'hungover'. Lee, who was 41-years-old and had spent much of his life in prison, reported that his drug of choice and most commonly used drug was amphetamine, but that when he was younger he drank alcohol and said this had contributed to him being in fights:

> *Lee: The second time, after the second time, that was it. And plus, plus I got into a lot of fights. [Yeah] Every time I drank, I recognised that I got into fights. [Yeah] I ended up in the hospital or putting someone in the hospital. All this kind of thing. [Yeah] And it was just a, it was ugly man. It was ugly.*

In reflecting on his behaviour, Lee believed his fighting was one of the reasons he had ended up in prison the second time. Similarly, Neil, one of the Aboriginal men, had been consuming alcohol at the time of his assault offence:

> *Neil: I'd, I'd been drinking alcohol, yeah. ... Got a bit fired up and, and, you know, I couldn't handle meself and, ... and, yeah, someone got hurt and, you know, I came to gaol. And ... there, there was, you know, some, some other offences there where, you know, money was taken and stuff but it, it weren't to, you know, to support a drug habit.*

Neil had been in prison, including juvenile detention, for most of his life, and neither he nor Lee had a substantial work history.

Joe, a non-Aboriginal man who had been living in Sydney with his 'wife', had a substantial work history but was gaining little financial advantage from his hard work as he had drug and gambling problems which absorbed his financial resources. Joe was under the influence of the amphetamine known as ice when he assaulted a police officer:

> *Joe: That was for hitting a policeman. ..... And then I had six weeks left and I committed the second offence, which I'm in for now. ..... Then I got resentenced on the assault police. ..... I got five months gaol for that. ... Yeah.*
>
> ***MD: Was the offence alcohol or drug-related at all?***
>
> *Joe: The one I'm in for? ... Yeah, it was. Yeah, I was on ice.*

Joe was stopped for a driving-related offence which may have only incurred a minor charge had he not assaulted one of the police officers. He was clearly upset during the interview about his drug use:

> *Joe: Upset with myself that I let myself get that far on the drugs. [Okay]*
>
> ***MD: Yeah. So you're upset with yourself that you ended up in here?***
>
> *Joe: Yeah. 'Cause of drugs. [Yeah] Or being, not being able to control myself while I was on drugs. [Yeah] Yeah*.

Joe had a substantial work history which indicates a good level of functionality, but when using ice, he felt he could not control his behaviour.

Anger and violence were also issues for Jay, but unlike Joe, Lee and Neil, Jay had not been using alcohol or drugs on the day of the offence. Jay's temperament had been affected by his use of the amphetamine known as ice the previous day:

> *Jay: … when I got back on the train the second time, there was this young fellow staring at me. And I was pissed off to the max, you know. So ... I cracked him. It was, ... maybe I shouldn't have cracked him but, yeah, they ended up putting me in gaol. ... And, yeah. ... So … no, drugs weren't actually involved with me crime but, I don't know, maybe if I wasn't on drugs, I would have thought about things a little bit different. ... You know what I mean? Maybe I wouldn't have cracked him so quick.*

Jay had been on his way to work when the assault occurred, and he had caught the wrong train which had agitated him.

These four men may not have committed their assault type offences if they had not used or recently used AoD. Along with another seven men in the interview sample, they had committed at one time or another assault type offences, and while the accounts of these offences varied greatly, the apparent loss of self-control was present in all of them. The other factor is that these men were dealing with the unpleasant emotional and physical symptoms of drug dependence. This has implications for access to AoD treatment, including diversion programs where, for example, violent offenders are not eligible for drug court. This may limit the community-based options for these men and make prison a more likely outcome from their AoD use.

The other aspect here is that the men themselves might not have thought of their AoD use as being serious until they went to prison. This was not Jay's first term in prison and at interview he said he thought all of his offences were in one way or another related to drug use. He was strongly of the view that if he could control his drug use then he would not reoffend, though this hindsight had come at some cost with this being his third term in prison.

- **AoD, Offending and Social Networks**

Fourteen men related their offence in some way to their drug-using associates or friends, rather than to their own drug use directly. There was considerable overlap between these reports and each of the four themes of offences to support AoD use identified earlier.

Sam and Ben were not under the influence of any substances when they committed their offences and made strong statements to this effect. Sam indicated that life events would have been different if he did not use drugs and he would not have been in the situation where he committed the offence:

MD: ***Was alcohol and drugs involved in your, your offence that led to your current term in prison?***

Sam: Not, not directly. Like it, it was indirectly but not directly related. [Oh okay]

MD: ***So indirectly …***

Sam: Well, in a roundabout way, if I wasn't using drugs, I probably wouldn't have been at the place I was but, [Yeah] but what happened and, and the reason I done it wasn't about drugs, [Yeah] if that makes sense. [Yeah, yeah]

MD: ***You wouldn't have been in the overall sort of situation. But -***

Sam: That's right. I wouldn't have been in the place I was at the time if I wasn't using drugs but the reason that ... … … the reason that it all happened wasn't drugs.

Sam had managed to function while using drugs and for some time holding down a job, but his drug use escalated, and his life became increasingly unmanageable. As drug use escalated, Sam became more involved with people who used drugs and became more involved in their networks. This highlights that for some of these men it may not just be a matter of behaviour when they take drugs, but also the behaviour of those around them, and as such these men may benefit from building different social networks.

The situation for Ben was quite different but was still related to an associate who was involved in drug use or possibly supply. Ben felt he had to stand-up to a man who had been

harassing him and his girlfriend (the other man was his girlfriend's ex-partner), but added that the man he seriously assaulted thought of himself, apparently unrealistically, as some kind of 'underworld heavy' involved in drugs:

Ben: *The reason I'm in gaol is because the girl I'm with, her ex thinks he's some heavy. You know what a heavy is, eh? [Yeah, well] He thinks he's a gangster and he's saying he's gonna do this and he's gonna do that. And I tried to let it go. And he just pushed it too far, you know. And I, he said he was gonna kill me and kill my girl. And he's known around town for being this and being that. Yeah, so I had to show him. I had to show him that there's no talking.*

MD: ***Yeah. So it wasn't really drug-related when you came in the last time? It was more ...***

Ben: *No, no, it was nothing to do with drugs. It was [Yeah] to do with my family. He was saying he was gonna kill my, he was gonna kill me and kill my girl he said.*

Ben, who had been living in Sydney with his girlfriend and their three children, had taken responsibility for the protection of his family, his offence was clearly not drug related, and his words show how invested he was in his relationship. The other aspect here is the toxicity and abusiveness of some relationships and the apparent need for some people involved in the drug world to project an image of being tough. It should be noted that the emotional and physical symptoms of AoD use are also likely to be having an effect not just on the men in this situation but on their partners, especially if they are also using drugs and therefore may have the same issues of dependence. Prison-based AoD treatment does aim to teach skills about how to avoid or defuse interpersonal conflict and Ben's story relayed here highlights the need for such content in AoD treatment programs.

Several other men interviewed also reported experiences of difficulties in relationships and violence. These may be important topics worthy of addressing within AoD treatment programs in prisons, beyond the focus on alcohol and drugs themselves specifically. This issue is explored further in the discussion and conclusions in Chapter Eight, as is the need for psychological assessments among those who have experienced violence, including for post-traumatic stress disorders.

5.3.5 Summary: Alcohol and other Drug use and Contact with the Justice System

In summary, the offences the men had committed during their lives were many and varied and overlapping. Thirty of the men linked their AoD use to their offending, with 29 believing

that they would not have committed their offences if they had not been involved in AoD use. Attributing offending behaviour to AoD use is not a new finding and has been reported on many times before (5, 121, 122). Just two men differed with the majority in this regard: Dan, who committed a driving-related offence because he said he needed to drive because it was his livelihood, believed he would have driven whether under the influence or not; and Toby, an Aboriginal man who did not link his AoD use to his prison term as he believed he did not have an AoD use problem. Toby's case will be discussed further in the next chapter.

Four themes emerged when considering their offending from the prism of AoD use: AoD use and driving-related offences; AoD use and assault offences; offences to support AoD use, stealing, break and enter, and robbery/armed robbery; and AoD, offending and social networks. The AoD use and driving offences theme differed from the other themes, as the men did not attribute their driving offence to their AoD use.

The majority of these men had had multiple previous offences, resulting in prison sentences, but they had continued to use alcohol and other drugs. The cumulative effect of having multiple offences increases the likelihood of being sentenced to a term in prison, and research shows that prison sentences are harsher and longer the more offences a person has (123, 124). If these men had come to the realisation by the time of these interviews with the researcher that if they controlled their AoD use in order to not offend and not be sent to prison, then in theory sentencing them to prison may have had the desired effect.

5.3.6 Alcohol and other drug use treatment: First AoD treatment

The men were asked where they first attended AoD treatment, which was followed by a discussion about their previous experience of prison-based AoD treatment. All but one of the men had undertaken AoD treatment previously by attending a 12-Step program or a Corrective Services NSW program in prison or in the community as mandated by the courts. The only one not to have been in treatment was Alex, a 26-year-old man who had been living with his mother in another state before his offence took place in NSW. Alex was somewhat ambivalent and dismissive when asked why he had not undertaken any AoD treatment previously:

> *Alex: No, if, if you want an honest straight out, yeah… That's the truth… But I mean no-one wants to sit in the classroom. You know what I mean? … Go learn about that. Like outside, when there's a lot of other things to do … You know what I mean? ... Maybe it would have been a good thing for me if I did do ...*

While Alex admitted drugs were the reason he was in prison, he did not necessarily think of himself as having a drug use problem and was undertaking the IDATP in order to gain parole faster. It appeared that Alex had lived an affluent life before he was imprisoned, but it was not at all clear how this was financed. Nonetheless, Alex was now in a CSNSW provided AoD treatment program and it would be his first time in treatment.

Four men had attended their first ever AoD treatment experience prior to involvement in the criminal justice system. Ed, Owen, Dan and Kurt were all compelled to attend treatment by family members. Two other men, Sam and Joe, were also compelled by family members to attend AoD treatment, but this was after they had appeared in court. Sam's and Joe's respective family members believed that taking action to address AoD use would be well regarded by the courts.

Five men had treatment organised by Juvenile Justice NSW and had either attended a program in juvenile detention (Bill, Carl, and Rob), in a youth rehabilitation service (Mark), or through an ordered stay at a youth hotel (Gary). Seven men attended their first ever AoD treatment by being ordered or coerced to attend AoD treatment by the courts. The remainder of the men, twelve in all, attended their first ever AoD treatment program in prison, either a 12-Step program or a CSNSW AoD treatment program. Twelve-Step programs are not operated by CSNSW as it is a volunteer-based peer support fellowship (3, 42). Twelve-Step programs were referred to in the interviews as program attendance by the participants, which is reflected in the way the results are reported.

In the result, for 26 of the 31 men, their first experience of an AoD treatment program in some way involved the criminal justice system. Twelve men received treatment in prison, seven men were court-ordered to attend, and five had treatment organised though Juvenile Justice (see Table 5.2 next page). This picture of the criminal justice system being the default AoD treatment service raises the question of the importance of providing early intervention before the criminal justice system is involved.

Table 5.2: **First Alcohol and other Drug Treatment Experience**

Name	First ever treatment	Aboriginality
Alex	Never previously been to AoD treatment	No
Ed	Before criminal justice system – compelled by family	Aboriginal
Owen	Before criminal justice system – compelled by family	No
Dan	Before criminal justice system – compelled by family	No
Kurt	Before criminal justice system – compelled by family	No
Sam	After court appearance – compelled by family	No
Joe	After court appearance – compelled by family	No
Adam	Drug Court/court ordered	No
Jay	Drug Court/court ordered	No
Kent	Drug Court/court ordered	No
Luke	Drug Court/court ordered	No
Jack	Drug Court/court ordered	No
Ian	Drug Court/court ordered	Aboriginal
Tom	Drug Court/court ordered	Aboriginal
Bill	Juvenile Justice/Detention	Aboriginal
Mark	Juvenile Justice/Detention	Aboriginal
Carl	Juvenile Justice/Detention	Aboriginal
Gary	Juvenile Justice/Detention	Aboriginal
Rob	Juvenile Justice/Detention	Aboriginal
Ben	Prison-based	No
Max	Prison-based	No
John	Prison-based	No
Lee	Prison-based	No
Cole	Prison-based	No
Ray	Prison-based	Aboriginal
Jess	Prison-based	Aboriginal
Neil	Prison-based	Aboriginal
Ryan	Prison-based	Aboriginal
Toby	Prison-based	Aboriginal
Jim	Prison-based	Aboriginal

5.3.7 Prison–based AoD treatment

The men had both negative and positive experiences of prison-based AoD treatment. The themes that emerged from the axial codes that encapsulated these experiences were: peer-

education and peer-support; trust and confidence; group dynamics, and program content. It was apparent that most of the negative and positive experiences within each of these four areas were the inverse of the same issue.

- **Peer-education**

What was reported to work well with prison-based AoD treatment was peer-education and peer-support. The terms peer-education and peer-support describe people who have experience of undertaking a behaviour presently or in the past, educating others who are engaging or have engaged in the same behaviour (125, 126). In this case, peer-education refers to people who had used drugs or consumed alcohol at hazardous levels but had stopped the behaviour and had been abstinent for several years, educating inmates about how to stop and remain abstinent from drug and alcohol use. The men were impressed by people who had lived experience similar to their own and who had been able to stop their drug or alcohol use long term. Cole explained:

> *Cole: What works well ... is, is people that, that, I don't know, people that have experienced like life in general. Like you know what I mean? They've, people that's gone through that situation, [AoD use problems] you know. ... And say like steps for, for me, like I find that if, if there were steps for people to take when, when they do get out ... into the community, ... as in if they can, if they felt like taking drugs or, or thingo, they can go somewhere.*

Cole referred here to people from 12-Step programs, and shared more about his insights and experience of 12-Step programs and of learning from others:

> *Cole: NA, AA, yeah. ... Program, yeah.*
>
> ***MD: And that, and did you find that better, that, because they had, they were ex drug addicts [Yeah, I, I did] or ex-drinkers? Or -***
>
> *Cole: I did. ... I found it better, you know, just to ... see the experience they, they went through, you know. ... Yeah. Everyone's experience is different, you know. Not everyone's, every, not every individual's ... have the same, you know, go through the same circumstances. ... And, yeah, I just, but it just opened your eyes to, to, you know, you, you wouldn't think other people go through that experience, you know. ... Then you find out when someone tells their story, you know, ... and tells you about it, you know, yeah.*

When asked, participants did not elaborate on the content of the 12-Step programs and there was no preference expressed toward or away from 12-Step programs over any other programs. The positive reflection on the 12-Step programs by the participants was more a function of the peer nature of the facilitators. As peers who were recovering from AoD use the 12-Step program facilitators had had similar life experiences that involved alcohol and/or drug use and addiction to the participants in this research.

The peer-education from people based in the community also had the benefit of introducing the men to possible support options they could access when they leave prison, as Carl noted:

> *Carl: That's what I do. You know what I mean? If, if I still get the chance to go to NA, I'll still go to NA. You know what I mean? I'd still like to know that little bit more about everything. You know what I mean? And what keeps me going. ... So yeah.*

Like Carl, Sam also reflected on the depth of the personal experience shared by the NA and AA members who visited the prison, and the hope given for an AoD-free life beyond prison. As Sam said, it was important that the person had had the *'same problem'* and that they had been *'addicted to drugs or alcohol'*, and it was important that people shared their stories about drug and alcohol use:

> *Sam: Well that's the whole thing about NA, you know. ... Like NA's just a group of people that have all had the same problem. They've all been addicted to drugs or alcohol, or whatever it was that their vice was. And you come together and, and everybody kind of shares their story. And, and I think I don't know exactly what it is about that set-up, about that situation that helps.*

Sam went on to discuss how important it was that people who had this lived experience of overcoming their own drug problems shared, and how much *'hope'* it gave him when he heard their stories:

> *Sam: I think it's seeing people that have been in your place and have been, been there and have been worse or, or, you know, been in the same situation and have turned around and have, have, have learnt to live their life straight, and have learnt to live their life without drugs, and, and I, I think seeing people that do that it gives them, it gives you hope, you know. It gives you, "Well ... if*

this guy can do it, there's no reason I can't", you know.

In line with much of the literature about peer-education, the participants showed that they related to the personal experiences and stories shared. There are, of course, limitations with peer-education which are recognised in the literature, however, including lack of professional technical knowledge about the subject at hand, and risks of breaches to confidentiality (125, 126).

There was concern shown by the men about confidentiality and lack of professional technical knowledge, but it was not raised directly in the context of peer-education. The concerns raised about confidentiality were in relation to the personal nature of what is disclosed in group programs, with the perceived risk to confidentiality being related to other participants and not the facilitators. The lack of professional technical knowledge for peer-educators was not directly mentioned either; however, an insight into this can be gained from the appreciation shown for the technical knowledge of the university educated program facilitators. Each of these concerns is addressed further in the findings in the next section.

What can be stated with certainty about peer-educators within this context, was that from the perspective of many of the inmates the best evidence that an AoD treatment program was effective was if the people facilitating the program had used that program in their own lives. This was particularly so if the peer-educator had been able to stop or moderate their AoD use over a sustained period. This was the observed evidence that the men had when attending 12-step programs in prison.

- **Trust and Confidence**

Trust was a central theme for the men when asked what makes for good prison-based AoD treatment. While trust encapsulates many concepts within this context, it was confidence to trust in three major areas. The men needed to be confident that they could: trust in the confidentiality of staff and other inmates; trust that the staff genuinely had their (the inmates) best interests at heart; and, trust in the professional ability of the staff.

The men needed to be confident that they could trust in the confidentiality of staff and other inmates. For Carl and other participants, the nature of being in prison, within a closed community, meant that confidentiality was a high priority. These men reflected upon the importance of one-on-one counselling as part of an AoD treatment program. It was critical for these inmates that they were able to discuss some subjects confidentially in private one-to-one with the therapeutic staff:

Carl: *It was all right 'cause I could talk about anything that I wanted to talk, you know. I wasn't in the group where, [Yeah] where you was thinking about what you were gonna say and what you couldn't say, and what you can say. [Yeah] One-on-one you could just say anything, you know. It just stayed confidential. You know what I mean? [Yeah] So it wouldn't leave the room. [Yeah] So whatever I talked about just stayed between me [Yeah] and the drug and* alcohol counsellor.

The men needed to be confident that they could trust that the staff genuinely had their best interests at heart. When asked how they knew the staff member was genuine and cared about the inmate/s progress, the men indicated that they knew staff had a genuine interest when they engaged interpersonally and encouraged people to do their best. It was particularly important that staff were aware of each individual's progress and that, as explained by Kurt, the staff were seen to be providing assistance to anyone in the group who was having particular difficulty:

MD: ***And what was, what was good about the facilitation?***

Kurt: *I think she, she was a good encourager. [Yeah] I didn't always agree with what she said [Yeah] but she tried to, I noticed, if someone was feeling a little awkward, [Yeah] she'd work with them. So [Yeah] I felt she was good that way. [Okay] So some of the people, other people who are confident, [Yeah] you know, and, yeah, and others I could tell that, if they weren't too good, she was very gentle, so I liked that about her. [Yeah] Yeah. She had, she had a good feel for … but, yeah, I didn't agree with everything she said. [Yeah]*

From what Kurt said, then, the program participants' determination of whether a staff member is genuinely interested is also made by observation of their behaviour with other inmates in the program as well as through their own interaction with the facilitator/s.

Finally, the men needed to be confident that they could trust in the professional ability of the staff. Several of the men spoke about how important it was to understand the psychological and biological aspects of their addiction, and to this end it was critical that staff be well-trained. In this context, this means staff who are able to explain in detail the psychology of addiction and to have knowledge about biomedical treatments such as medication used during detoxification from drugs, or substitution therapy, otherwise known as pharmacotherapies, such as methadone. To this end, university-trained staff were perceived

as being valuable for their expert knowledge. Owen discussed how important it was to have well-trained staff and was of the opinion that perhaps a combination of both professional staff and peer educator would work the best:

> *Owen: … like they're very important the textbook counsellors too ... People that go to uni and all that, and learn all that, that's very important. In other words, I'm not saying, I'm saying I don't think it'd be good if every single counsellor was an ex-addict. ... That's what I'm saying. Where before I used to think that. ... I used to think that, "Oh that's the only way, you know, that I'm gonna listen to 'em." ... 'Cause, if they've walked in my shoes [If they've been there] blah, blah, blah. ... Well now I don't think like that. I think ... that, you know, a mix is good and a bit of both.*

The other point of note here was that Owen's opinion had changed over time so that at the time of this research, he was more appreciative of the professional staff than he had been when he first encountered them.

It was clear also that it took time to establish a trusting therapeutic relationship between staff and inmates and between the inmates themselves. For example, Sam said he opened up more about his issues and worked through them when he got to know the staff:

> *Sam: Shit I didn't wanna tell him about. And, and, over time, we, he, he built a trust thing with me and I was able to open up and, and let all that out, and, and talk about it, and, and it, yeah, it, it helped me kind of deal with ... what was happening at the time.*

This quote from Sam again shows the importance of trust-building in the context of AoD treatment and the therapeutic relationships and that this is a process that takes time.

- **Group Dynamics**

Good group dynamics were important for a positive experience of AoD treatment programs. The participants reflected on the importance of humour in group sessions, and smiled when saying that it was good when the staff joked and used humour during group. It was important to have some fun as this helped with the group dynamics, including engaging more with AoD treatment program participants. Neil said:

Neil: *But going back to the, yeah, facilitators, I think that the best qualities they can have is just really put in*[8]*. [Yeah] Is really put in and [Yeah] I think, as long as they're, you know, good, as long as they're, you know, got a, a little bit of, you know, sense of humour, maybe, you know, on a -*

MD: ***A bit, bit of humour helps.***

Neil: *Yeah, a bit of humour [Okay] you know. A bit of someone that engages and gets right into it, and gets everyone motivated, and, [Yeah] and, you know, that, a lot of the time that works, you know.*

An underlying issue for participants was the concern that what they said in group sessions would not stay in-group, as was mentioned previously. When there was a perceived threat to confidentiality, inmates became unwilling to disclose personal information and experiences. A powerful factor in this was a residual level of distrust due to the problem of gossip in the form of idle talk or rumour within prison. The concern was that another inmate/s in the group session would repeat what was said in-group about personal experiences. Jack discussed concerns about sharing too much personal information:

Jack: *And there's not a lot happening in our life where we're usually idle most of the time, you know, just, just on a stand. So, you know, there's a lot of boredom, frustration, and sometimes you get people that like to tell tales and talk behind other peoples' back [Yeah] or talk about someone else [Yeah] in order to make themselves feel better or for whatever reason. … But the only thing that you, you do become a bit wary of I s'pose is how much you talk about and what you say when you're in the group [Oh yeah] because, because we're living with other inmates, you know, my philosophy is you can't really afford to trust anyone in here. [Yeah] No-one's my friend. No-one's really here to help me. They don't really give a shit about me. They only really give a shit about themselves.*

While Jack's approach to sharing in-group remained guarded, Jay noted that these privacy concerns were mitigated on an individual basis to some extent when the inmates in the AoD treatment program were housed together in the same wing of the prison:

[8] The term 'put in' in this case means to earnestly contribute

Jay: And the people in me group already through being in the wing with them and that, you sort of get to know 'em, like trust them a little bit. But … trust them enough like to have to do a program with them. You know what I mean?

- **Program Content**

When asked about program content that was found useful for their own learning and understanding of how they could address their AoD issues, participant answers tended to be brief. Learning how to avoid use, and in particular about triggers for drug use, were important learnings which came through for most participants. This practical aspect of avoiding drug use as well as thinking through and working out how much money was spent on AoD made sense to the men, as explained by Ed:

Ed: You know, like how much did you use, how much, what would you do, how would you spend your money, what would you do if you had a pouch and you wanted to get on drugs, and you owed a pouch back.

It was clear that at least some of the men appreciated the chance to discuss the harm their AoD use caused to family members and friends. Working through these issues was tremendously therapeutic for these men, and helped with motivation. Jake said he felt benefit from reflecting on this destructive behaviour, because it would help him to avoid it in the future:

Jake: 12 chapters and each of them was, entailed something about the effects and the consequences of drugs and alcohol... And they'll give you insight and knowledge about how it influences the public, how it affects your life, how it affects your family's life and the destructiveness of it, you know, basically. ... ... and then they talk about solutions and what your life would look like, and how your life could possibly be without, ... without having that negative trap in your life, ... that negative addiction that pulls you down.

Most importantly, this helped the participants develop plans for how these obstacles could be overcome when they returned into the community.

5.4 Discussion

The interviews with the 31 men taking part in this study have informed an understanding of AoD treatment experiences of men in prison which has allowed for a model for program

facilitation to be developed. This model, discussed in more detail later, was made possible by the men's willingness to be forthcoming in discussing the positives and negatives of prison-based AoD treatment.

There were 17 non-Aboriginal and 14 Aboriginal men taking part, with the geographical distribution of both groups broadly consistent with their respective populations within NSW. More than half the non-Aboriginal men were from Sydney (12 of the 17), with a more even distribution of the Aboriginal men where just under half were from Sydney and the rest from regional areas including regional cities. None of the men had completed to year 12 of high school.

Twenty-nine of the 31 men admitted culpability for their offence, and the offences they had committed during their lives were many and varied. Thirty of the men linked their AoD use to their offending, with 29 believing that they would not have committed their offences if they had not been involved in AoD use. This attribution is not a new finding, having been reported on a number of occasions previously, making these findings consistent with the broader literature (5, 121, 122). One man believed he would have committed the offence regardless, and one man did not accept that he had an AoD problem.

5.4.1 AoD use and Offending

As discussed above, there were three themes that emerged from considering the offences of the men within the prism of AoD use: AoD use and assault offences; offences to support AoD use stealing, break and enter, and robbery/armed robbery; and AoD use offending and social networks. Most of the men had committed multiple previous offences within one or more of these domains, and all had attended AoD treatment previously but had continued to use alcohol and/or other drugs.

This leads to the question of when it was that the 30 men - who had, at the time of interview, linked their offending to their AoD use - had come to that realisation, and if they had continued to offend after this had occurred. Up to this point, in any event, the threats of being sent to prison, and indeed of actually going to prison, clearly had not been effective in having these men change their AoD use. The cumulative effect of having multiple offences increases the likelihood of being sentenced to a term in prison, and research shows that prison sentences are harsher and longer the more offences a person has (123, 124). This is likely to be occurring with the men who took part in this research. This raises the important consideration of not only the personal cost for the men involved, but also of the financial costs for the state. The per-prisoner cost nationally of operating prisons was AUD$76,650

per annum in 2015-16, but the results of this research indicate that incarceration may not be having an impact on changing the behaviour of inmates with alcohol and other drug misuse issues (127, 128). Community-based treatment, in comparison to the cost of prison, has been comprehensively proven to be more cost effective (127). With about 80% of people in prison likely to benefit from an AoD treatment, the potential cost benefits of treating people with AoD use issues in the community and not in prison could be immense.

Shorter prison sentences are as likely to be as effective as longer sentences for these men, particularly given they continued to offend regardless of the possibility of going to prison. If the same effect on an offender's behaviour can be achieved from a short sentence, then the state should save its resources and impose shorter sentences. The research literature is supportive on this point, that is that longer sentences are no more likely than short sentences to reduce the likelihood of re-offending (120, 129). The data from the men would seem to indicate that when not using drugs and/or alcohol these men understand that offending is wrong, but the challenge for them is to be able to abstain from or to manage their use in such a way as not to cause harm to themselves or others. Within this context, it could be more productive of good outcomes to impose shorter sentences, and to invest more heavily in AoD treatment both in prison and in the community.

All but one of the 31 men in this study had previously been to an AoD treatment program: 26 attended treatment organised through the criminal justice system and four attended community-based programs voluntarily. It is therefore possible that these men were aware that their continued AoD use could lead to further complications with the criminal justice system, including possible imprisonment, from that point on. This is particularly likely for the seven men who had attended court-ordered AoD treatment and for the five men who had attended AoD treatment organised by Juvenile Justice. Notwithstanding this, these men continued their AoD use and were subsequently imprisoned, and are now in an intensive drug and alcohol treatment program. This could indicate that for some of the men the AoD use behaviour is so entrenched that no diversionary programs would have had an impact, highlighting the need for prison-based treatment programs to be as effective as possible.

Also, worthy of note is the fact that early intervention services were not accessed as juveniles by the majority of the men interviewed for this research. Evidence exists that early intervention can be effective in reducing the likelihood of young people continuing on to use drugs or alcohol in ways that are harmful to their health (130). Early intervention therefore has the potential to reduce or avert altogether the harms resulting from drug dependence as an adult, and the associated offending to support such use. This being so, it appears that

further investigation into increased provision of early intervention programs for at-risk youth is warranted.

5.4.2 Trust of Program Participants and Staff Attributes

Trust in the confidentiality of staff and other inmates is critical. Prisons are a closed community in which personal reputation is valuable, and the formation of trust is essential to the delivery of effective treatment programs (131). Trust is critical to AoD treatment whether in the community or in prison; it is an essential component of the therapeutic relationship (17, 25, 132). Without the establishment of trust, it becomes very difficult for health professionals to engage in a meaningful way with clients/patients (17, 25, 132). Trust and confidentiality are part of ethical practise for AoD treatment workers, and during the setting of group rules trust and confidentiality are normally discussed (25). One of the problems with developing trust in a prison setting may be that inmates are not ready to confront their own past behaviour and therefore issues of trust become a useful barrier to confronting and discussing their past use (25).

This research indicates that for the staff, it is important they be conscious of the importance of trust at all times, because any breach of confidentiality, can lead to a damaged reputation among the inmates from which it may be difficult to recover in the prison. For the inmates in treatment programs, trust between them was established through shared experiences of AoD. If what an inmate disclosed in the program was believed to be genuine, then that inmate could be perceived as trustworthy. The men interviewed were perceptive about the motivations of other inmates in any given AoD program, particularly if the other inmates were perceived to only be motivated by the possibility of early parole. It is important in treatment groups that all participants have the same gaol, that is, if everyone has a goal of abstinence but one individual does not, then this could be counterproductive to the therapeutic progress of the group. For example, if one individual were to suggest that they do not really need to stop drug use but just need to use less, then the group members who want to be abstinent may be drawn to revaluating their goals (25). It was clearly evident from the interviews that trust takes time.

Trust that the staff member genuinely had the inmates' interests at heart is also essential, and this intersects with staff believing in the effectiveness of a treatment program. The men interviewed believed that staff were genuine when the staff member was seen to help other inmates who were having difficulty and engaged interpersonally by discussing their own experiences. A sense of humour also helped when engaging the men in treatment programs as they needed to have a laugh and some fun as part of the AoD program. The AoD prison-

based treatment literature supports these findings, as well as the need for staff to be motivated and enthusiastic and supported by other professional staff (39).

Additionally, trust in the professional ability and the credibility of the staff was seen as important for treatment success. The men who discussed the knowledge of therapeutic staff thought there were tremendous benefits from having well-trained university graduates, such as a psychologist with expert knowledge in AoD use and behaviour. The AoD treatment literature supports the view that well-trained and supported professional staff are best placed to deliver treatment to even the most reluctant of prison inmates (39, 40). Well trained and experienced staff can have a level of confidence that flows through to people in group treatment programs and imparts some confidence in them that the program can work (25).

5.4.3 Peer-education

When asked to elaborate on their experiences of 12-Step programs, none of the men specified anything about the content which is based on the 12-Steps of the Alcoholics Anonymous program (42). Rather, they appeared to be preoccupied with the capabilities and personal attributes of the facilitators, speaking about the recovery and abstinence from alcohol and/or drug use by the 12-Step program group leaders/group facilitators[9] (42). It appeared that for these men the personal experience of the facilitator having seemingly overcome addiction to drugs and/or alcohol dependency was sufficient evidence that 12-Step programs can work, following the practise of 'seeing is believing'.

The advantages and benefits from the delivery of health education from peers is well established in public health discourse, including in the prison health literature. Examples of peer-education are found in the literature on responses to HIV/AIDS in Australia and other developed nations (126, 131). Research indicates that the most effective way to educate injecting drug users about transmission of HIV and other blood-borne viruses was for the education message to be delivered by their peers, as peers understood the language and the context of the people who inject drugs (126). There is evidence that peer education can bring about healthy lifestyle changes and can be an important component of health education with young adults (133). A systematic review by Bagnall et al. into the effectiveness, including the cost-effectiveness, of peer support and education in prisons, found that while the cost benefits were negligible, both peer-education and peer-support were effective in reducing risk and had a positive effect on inmates (131).

[9] The term facilitator is not entirely accurate when describing the leaders in a 12-Step program, but it has been used in this thesis as a point of reference.

Former drug users who have undertaken vocational or higher education and training in alcohol and drug counselling would be well placed to be effective educators within the prison system. There are detractors to this approach where having a peer as an educator may be seen to blur the professional lines which are needed for effective program delivery, and as such having two peer-educators that share their experience with AoD use and recovery may not be helpful (25). Notwithstanding these reservations, while Corrective Services may have security concerns about some of these counsellors, not all people who have used AoD at dependent levels have been involved with the criminal justice system. In the case of counsellors who have had prior offences, it would be useful if a policy that outlines core issues to be considered, and how these matters should be dealt with, could be developed. In determining whether these prospective counsellors posed a continued security risk, such a policy should take into consideration the length of time that had elapsed since the individual had committed their last offence as this would be an important indicator of risk.

Program content was not discussed in detail as the men were brief in their answers. It was clear, though, that the men found learning how to avoid triggers for AoD use important, as was reflecting on their AoD use behaviour and the effect this had on family members, because this provided enhanced motivation to change their behaviour. The financial impact of drug or alcohol use was another area that helped with motivation to change. The practicality of identifying triggers then helped operationalise their change in behaviour. As such, inclusion of these subjects is essential in AoD treatment programs.

The housing of other inmates in the AoD treatment program was important, with there being a preference for inmates in the AoD treatment program to be housed in the same wing. The peer support offered through undertaking the same treatment is extremely important as non-program participant inmates can have an adverse effect, particularly if a cellmate of a treatment participant either is using or wants to continue using drugs. This is well supported in the literature, which indicates that prison treatment programs work best when inmates in the program are separated from the general population into treatment-specific accommodation (44, 45). Peer-support is as important a part of group treatment programs in community as it is in prison settings (134). It is important for people in group treatment to have a shared goal that they can work together towards (25). In sum, peer-support can lead to better treatment outcomes for people in recovery from AoD (134).

5.5 Conclusion

This chapter explored research question three: *How can prison-based treatment for men be further developed to meet their needs?'*. Bearing in mind the need for care when

generalising from a small sample, the data from this study do provide a number of insights for consideration in the operation of prison-based AoD treatment programs.

The data support the notion that, in theory, a co-facilitation model would work best, with at least one of the facilitators having had personal experience of overcoming AoD use, and the other having university level or equivalent professional qualifications in AoD treatment and care. This would achieve a balance between aspects of peer-education and professionally trained facilitators, providing program participants with confidence in the facilitators' professional abilities and experience.

A strong theme emerging from the data was that facilitators need to be ever-vigilant of the importance of confidentiality within the group. They need also to be aware that their own behaviour is under constant surveillance by the program participants. As far as program content is concerned, theoretical learning in class needs to be accompanied by learnings which have practical benefits for the participants. The inclusion of such things as strategies for identifying personal triggers for AoD use, for example, were well received and seen to be a necessary part of AoD programs. Housing the participants together, separately from other prisoners, would help develop trust in-group, and this may alleviate some of the concerns about confidentiality. This finding is supported in the literature, as discussed in Chapter Two of this thesis, with the programs that were found most likely to be effective in reducing AoD use post-prison being the therapeutic community treatment programs.

This chapter has discussed and reported on the treatment experiences of all of the 31 men involved in the qualitative interviews for this study. In recognition of the over-representation of Aboriginal men in the Australian prison system, and of the differing social determinants of health and wellbeing known to exist for many Aboriginal people (135), the next chapter confines its focus explicitly to the backgrounds and experiences of the AoD treatment regime of the 14 Aboriginal men, as relayed by them in interviews with the researcher. It is important to specifically analyse these data to add to the current sparse body of knowledge about the provision of optimally effective AoD treatment for Aboriginal men. Understanding their experiences and adapting prison-based AoD programs accordingly will help reduce their vulnerability to AoD harms and, consequently, their over-representation in Australia's prison population.

Chapter Six: The Experiences of Aboriginal Men of Alcohol and other Drug use, related issues, and Prison-based Treatment

6.1 Introduction and aims

Research into prison-based AoD treatment specifically for Aboriginal men is limited: the systematic review presented in Chapter Two identified only one relevant paper published in the 21-year period from 1995 to 2015. This current chapter will build on the results and findings of Chapter Five, which reported on the in-depth-interviews with all 31 men. Specifically, it isolates and analyses the interview data from the 14 Aboriginal men. This chapter gives insight into the previous AoD use of these men and how this use relates to their imprisonment. The findings are considered in terms of how prison-based treatment for AoD use could be further developed to meet the needs of Aboriginal men in prison with histories of AoD harms.

The Aboriginal-specific focus in this (and the following) chapter was undertaken because of the substantial over-representation of Aboriginal people in Australian prisons, which is reflected in the NSW prison system. At the time of the research in 2014, Aboriginal people were over-represented in prison at a rate of 1,699.7 per 100,000 population compared to 150.7 per 100,000 population for non-Aboriginal people in NSW (7). Hazardous levels of alcohol and drug use have been identified as a leading contributing factor to this over-representation of Aboriginal people in prison (6).

The over-representation of Aboriginal people in prison is real and regrettable. In order to alleviate this over-representation in prison, some of the underlying education and economic as well as social disadvantages would need to be addressed (136). Understanding the circumstances related to the AoD use of Aboriginal men in prison is a necessary first step in improving AoD treatment options for them. Further, to more effectively respond to their AoD needs, the possibility of reducing rates of Aboriginal imprisonment through addressing their AoD use problems has merit: 72% of Aboriginal men in prison in NSW reported having been under the influence of alcohol and/or other drugs at the time of their offence (5). If the number of Aboriginal men returning to prison could be reduced, this would have an overall effect of reducing Aboriginal over-representation in Australian prisons.

6.2 Methods

The methods are reported in detail in Chapter Four but, in brief, this chapter uses the grounded theory method as described by Strauss and Corbin (53). The data from all 31 participants were analysed together using the NVivo software package and these results are reported in Chapter Five. For this chapter, a copy of the main data file with all 31 interviews was created, and then the interview data from the 17 non-Aboriginal men were removed.

There were seven domains of questions which became the axial codes:

1) Demographic information.
2) Imprisonment and offending history.
3) Education and employment.
4) Alcohol and other drug use.:
5) Alcohol and other drug use treatment.
6) IDATP and current term of prison.
7) Post-prison plans.

Of the seven axial codes, the data from codes 4 and 5 were re-analysed with just the data from the 14 Aboriginal participants. Through a process of constant comparison and reviewing, the Aboriginal-specific results and theory which are reported below were developed.

6.3 Results

There were 14 Aboriginal men interviewed in-depth. Six of these men had been living in Sydney, five in a regional town, and three in a regional city prior to their imprisonment. For two men it was their first term in prison, for three the second, four the third, one the fourth and four the fifth term in prison. Of the men who had worked, nine had worked in labouring or blue-collar jobs, two had worked in an office job, two had not worked, and one could not work due to disability.

6.3.1 Alcohol and other Drug use

All of the Aboriginal men interviewed had an early introduction to alcohol and cannabis use, with the first use of these substances often occurring simultaneously. For two men, alcohol and cannabis use occurred at age nine, one at 11 years of age, for seven men at age 12, for one at 13, one at 14 years old, and for the other two in their late teens. The first use of amphetamine or heroin for the majority of the men was at around the age of 15, although two men first used heroin at around 18 years old, having been introduced to the drug while in the criminal justice system. Even though most of the men were quite young at the time of their first AoD use, they appeared to remember their first use fairly well. Jim, a 42-year-old man from Sydney, spoke about his first use:

> *Jim: Well my first, probably got introduced to marijuana when I was nine I think. [Nine?] Around that time. But, yeah, wasn't 'til I was about 14 'til I probably smoked it properly, when I knew what I was doing.*

Many of the men smoked cannabis or were drinking alcohol with family members from the early age of 13 years old, as described by Ian, a 32-year-old Aboriginal man from a regional town in NSW who was serving his fourth term in prison:

> *Ian: But what ended up happening was I started just smoking pot normal. ... Like it was a normal thing. You know what I mean? Like having a cigarette. "Okay, we'll go and have a couple of cones." ... I smoked with my, my brothers accepted that, that I was smoking because ... they said, "If you're gonna smoke, smoke around us." ... At the end of the day, being the second youngest, I should have got a lotta advice and help with my older brothers, ... which they didn't do. You know what I mean? Like ... I'm a bit dirty on 'em, but, at the end of the day, what's done is done. ...*

The use of amphetamine and heroin for most of the men occurred sometime after they had smoked cannabis or consumed alcohol for the first time. This is what happened for Gary, a 27-year-old Aboriginal man from Sydney who had first used cannabis, or 'yandi' as it is known colloquially among some Aboriginal people, at age 12 or 13 years and then went on to other drug use later:

> *Gary: Mainly speed and that first off, yandi (?).*
>
> ***MD: Yandi? Yeah. [Yeah] What was the first, first drug you tried? [Yandi] Yandi? [Yeah] And how old were you then?***
>
> *Gary: 12, 13.*
>
> ***MD: How did you, how did that come about? Like how did you get, did somebody give you some or -***
>
> *Gary: Yeah, just everyone smokes, you know, in their own way, you know. [Everyone?]*
>
> *Gary Everyone.*
>
> ***MD: So is it pretty, pretty normal?* [Yeah] *Yeah. And then you, you said something about speed as well.***
>
> *Gary: Yeah. Then I started using speed. And about 15 that's when I hit the heroin, started using the gear and that was it. Haven't stopped since more or less.*

Gary first used heroin at age 15 years. Twelve years later, heroin was still Gary's drug of choice.

6.3.2 Factors Involved in Previous AoD use among the Aboriginal Men

There were multiple factors involved in why the men had used AoD, which could primarily be placed into the three categories of peer pressure, experimental, and family and social environmental influence.

- **Peer Pressure**

Peer pressure was felt to have been exerted by friends and family members in their age group. This was common only for cannabis and alcohol use, where the men spoke about in some way being encouraged to use these substances. Tom, who was from a regional town in NSW, was quite blunt in his assessment as to why he started smoking cannabis:

Tom: *Mate, I would have been about 13. [13?] 13, like 13, 14. [Okay] That was drinking. A bit of pot back those days, you know. [Yeah]*

MD: **And, and what, why did you do that? Was that …**

Tom: *I just, I don't know. All me mates were doing it, so I guess I jumped on the bandwagon. [Yeah] Peer pressure. [Yeah].*

The other factor here is that the cannabis was clearly ready and available to use; that is, it was not as if he and his 'mates' had to go out and get the cannabis before Tom felt any pressure to smoke. Tom's friends already had the cannabis, Tom was around them when they were smoking the cannabis, and he felt compelled to have a smoke with them.

- **Experimental**

Ryan, who was from a regional city in NSW, spoke about experimental use. Ryan said he had had a good upbringing with no AoD use issues in the home as a child. Of his own inclination, he wanted to experiment with different drugs:

Ryan: *Oh just me and me mate. [Yeah] Just wanted to give it a go. Had a go and liked it.*

Ryan was talking here about when he tried heroin for the first time, the drug that became his drug of choice. Ryan said he was 'instantly hooked' when he experimented the first time, going on to use heroin whenever he possibly could.

❖ **Family and Social Environmental Influence**

Two men said directly that they had used cannabis to fit in with family. More commonly, though, the men spoke about using cannabis and other drugs because it was what everyone did in their neighbourhood or town. Twenty-six-year-old Carl from Sydney said:

Carl: Yeah, yeah. [Yeah] But to me back in them days it was just normal and everyone was smoking. My whole family were smoking. You know what I mean? [Yeah] So yeah. [Yeah].

There was considerable discussion on what can be termed family environmental exposure to alcohol and cannabis use and intergenerational alcohol abuse. Alcohol and cannabis were the more socially acceptable drugs, particularly in the childhood family home.
Twelve of the men spoke of their mother or father being a heavy drinker or alcohol dependent (described as alcoholic by the men), and in some cases, this was both parents. Twenty-year-old Bill, from Sydney, witnessed extensive alcohol use not just by his parents but by his grandfather as well:

Bill: Well my family, my dad, he's a, he's a drinker, ... you know. And my mum was a drinker too ... My pop was a drinker. My uncles. My family, like I grew up around all that. ... You know what I mean? ... ... And, yeah, ... that's about it, yeah.

Similarly, Neil described intergenerational alcohol use among the men in his family:

Neil: Like my father he had a problem with alcohol. So did his father. Yeah, so, over the years, there'd been a lot of, yeah, you know, alcohol or, you know, domestic violence related to alcohol. ... But mainly just alcohol, yeah. ... Apart from myself and my elder sister, you know, there, there'd be no other, basically, well, apart from smoking pot or drinking, you know, ... the parents, that was the only drugs. It was about that, you know. ... I'd never known my parents or, or anyone else in my family environment to, to use other, drugs other than that.

6.3.3 Reason for Continued AoD use in the Aboriginal Men

The first use and history of AoD use was followed by a discussion on recent AoD use and the reasons for why they had continued to use. The men spoke about using drugs to block out feelings of emotional turmoil, financial difficulty, and stress caused by conflict in their

families. Heroin was spoken about by Ian and other men as having the best effect, both for stress relief and for reducing emotional difficulty:

Ian: *Since then it (heroin) was just … ... I won't lie: I loved it. You know what I mean? It's the ultimate. It's the ultimate ... drug. It takes all your problems away.*

MD: ***Yeah. I was gonna ask you that. So why were you using? It was taking your problems away?***

Ian: *Yeah. You just escaped ... reality... and -*

MD: ***What, what was it about reality you didn't like?***

Ian: *Everything. Everything in general. Like I had a lot of dramas with the family, in the family like side of things and then, when my girl, my own personal life, like the family dramas, my girl sorta playing games with my son, not letting me seeing him sort of thing.*

Several of the Aboriginal men described having to use AoD to be able to function 'normally'. Some of the men said that they used AoD to deal with emotional stress, and some said they were so used to AoD that they felt they needed to use to be able to go out in public. Upon reviewing the data, it became apparent that for some men, there was also an almost fatalistic view of the development of their own AoD use problems. It is possible that this fatalistic view was developed because of the entrenched AoD use within their respective families, since that made AoD use a known and likely life course.

6.3.4 AoD use concealed from families in the Aboriginal men

The use of heroin and the amphetamine colloquially known as 'ice', was generally concealed or away from direct view of family members, though some men did use with their partner. Thirty-five-year-old Ed, from Sydney, was one of those who did not use with his partner, and described saving up money for his amphetamine use so as not to arouse her suspicions:

Ed: *I'd sometimes sneak a bit of, a few dollars out and save it, save it up until, 'til the next shot, you know. [Yeah] Using.*

MD: ***So it wasn't every day. It was -***

Ed: *It was not every day. It was probably every week. [Oh okay] Every, every week, yeah. Once a week or maybe twice a week, [Yeah] if, if I'm lucky.*

The men who used heroin and amphetamine (ice) generally spoke about use with friends and not with family members such as siblings or parents, though, as mentioned earlier,

some men had used with their girlfriends. Jim, whose preferred drug was cocaine, spoke about his use of heroin, and described his use as being with a 'certain' group of people:

> *Jim:* *Exactly the same, like I said. [Yeah] There's certain, there's a circle of people that [That, yeah] … that you [Was that, yeah] … yeah, you know, you know who, who, who does what and, [Yeah] and you pretty much, you fall down to their level, you know. So you, [Yeah] you avoid … Like I've had good friends and friends that are, you know, live normal lives and, and you push them away once you start doing, [Yeah] you know, the wrong things and stuff like … [Yeah] you avoid them.*

When it came to heroin and amphetamine use, the men used with both Aboriginals and non-Aboriginals - or white Australians - as described by Carl in his use of the term *'Aussie'*:

> ***MD:*** ***Who, who were you using with?***
> *Carl:* *Mates. My friends. [Yeah] Yeah.*
> ***MD:*** ***Other Koori fellas?***
> *Carl:* *Oh yeah. Some were Koori. Some were Aussies, so yeah. [Yeah, yeah]*
> ***MD:*** ***Oh okay. And where was that happening?***
> *Carl:* *Yeah, around the, I was in, I live in Sydney so yeah.*

This was somewhat different from the cannabis and alcohol use, which tended to happen with other Aboriginal people, particularly family members.

6.3.5 Factors why some Aboriginal Men did not want to consume Alcohol

Another area that came through when reviewing and recoding the Aboriginal data was that these men spoke about the reasons why they did not want to drink alcohol. Many of the men had witnessed firsthand the harmful physical and social effects of alcohol abuse, and while there was some mention of cannabis in this regard, the use of cannabis seemed incidental with the main issue being alcohol consumption. Some of the men chose not to drink alcohol as the result of seeing the dysfunction caused in their families and in the broader community. One man, 20-year-old Bill from Sydney, described having had family and friends pass away from alcohol and drug use problems. However, Bill continued his use despite having seen these events:

> ***MD:*** ***What, do you know much about alcohol and drugs, the effects of them?***
> *Bill:* *Yeah, I know that. [Yeah?] My own family passed away. I've got a lot of*

friends and family that's passed away from that shit. You know what I mean? Like drinking and drugs, and all that. [Yeah] I've grown up all around it too.

The alcohol consumption and dysfunction within families was so significant for five of the men that they were removed from their family of origin by government welfare workers. After being removed, the men received no AoD education or counselling from, or organised by, the government agency that removed them. Mark had been removed from his family due to dysfunction and AoD use issues, but his first referral to AoD treatment in the community was by his parole officer the last time he was in the community:

MD: ***So did DOCS ever send you to drug and alcohol counselling*** *?* ***[Nuh] Did, did you ever get referred to drug and alcohol counselling by anybody? Like -***

Mark: Yeah, when I was, when I was, like when I was out this time, [Yeah] just before I come in, two, two and a half year ago, yeah, my parole officer.

Rather than receiving support from the government agency that removed him, Mark, like other interviewees, primarily received AoD treatment from the Corrective Services NSW. These experiences of the government removing them from their family and then leaving them in a precarious situation with no support appeared to have tainted the men's view of government departments.

6.3.6 AoD use of Aboriginal Men: Summary

Each of these men first used alcohol and other drugs before the age of 18, and for two of these men their first use was when they were just nine years old. The use of cannabis and alcohol was acceptable within their families, with the men reporting having consumed alcohol and smoked cannabis with their family members. The use of heroin and amphetamine was viewed differently, and the men used these drugs more discreetly and with a particular group of people who also used these drugs. The other possibility here is that these two drugs are less common, less readily available, and they cost more, so they have wanted to use the drugs discreetly so as not to have to share.

Alcohol and cannabis use was common among family members, with the men reporting what appeared to be intergenerational alcohol dependency, or at the least, intergenerational hazardous consumption of alcohol. The need for a whole-of-family approach in AoD treatment for Aboriginal people has been described in the treatment literature and would be prudent, given that these men will likely return to their families upon release. Since it is

neither practical nor feasible to enrol family members into prison-based AoD treatment, the subject of intergenerational AoD use should be incorporated if this has not already been done. This is both more realistic than family-based treatment, and more productive of tangible results, since many of these men have children or may have children in the future.

The findings from this study also clearly demonstrate that alcohol and other drug treatment programs in prison would benefit from including some work on understanding and dealing with social, emotional, and family stress. While not directly mentioned in the interviews, it seems too much of a coincidence that many of the Aboriginal men spoke about having to use AoD to go out in public. If indeed these men are encountering racism - and this would not be surprising given the extensive reports of racism against Aboriginal and/or Torres Strait Islander people (137, 138) - then an addition of this kind to treatment programs for the Aboriginal men could also include strategies for dealing with discrimination and racism.

6.3.7 Offending History for the Aboriginal Men

The majority of men had had contact with police and courts prior to the age of 18 years. First contact with police occurred between 11 to 13 years old for seven of the men, 14 to 17 years old for five, and at 18 years of age for two men. Nine of the 14 men had been to juvenile detention, and it appeared that involvement in the criminal justice system had been a part of their day-to-day life from a young age. First offences for the men that had been to juvenile detention were generally related to theft or vandalism as stated by Carl:

Carl: *I started getting in trouble when I was younger, when I was about 11, 11, 11, 12 years old. ... Yeah. I first, I first got locked up when I was 11, so yeah.*

MD: ***Yeah. [Yeah] What was going on at that time?***

Carl: *Just moving house-to-house, just running amok. Going out thieving, stealing, yeah.*

Carl spoke about his first contact with police and said that the first time he had been held in custody was at the age of 11 years. Other than general nuisance offences, three men – Ian, Gary, and Rob - had committed stealing offences when young that were linked to poverty. Rob tells his story below:

Rob: *When I was like eight, no, about nine, there was my older sister - she's two years older than me and there's me then there's my little brother and my little sister. Mum used to get the four of us. She used to take us down the pub. She used to go inside, and we'd be out the back. We were playing pool. We'd*

eat peanuts. We'd be drinking pub squash (soft drink). You get what I'm saying? [Yeah, yeah]. We'd be eating peanuts and chips, and pub squash, playing pool. Mum'd be in there playing the pokies.

Rob and his sibling were at the pub entertaining themselves instead of being at home, or somewhere else where children might better play. Their mother was busy either drinking (Rob describes her as being an alcoholic drug addict), playing the pokies, or socialising, or a combination of these activities. When they did go home, they did not have food in the house and Rob had to go out and fend for his siblings and himself:

Rob: *I'll go downtown. I'll break into a car. I'd get all the coins out of this car, get all the coins out of that car. I might get a handbag here, there. Get a wallet there. And, and I'll go home. I've got like fuckin' 80 bucks on me. I'm thinking, "Yeah, mad! I've got heaps of coins. Heaps of, a fuckin' couple of notes on me." I'd get my little brother and my little sister, my older sister. "Let's go!" We'd walk down to the shop. Go into the shop and little, little corner shop. It was like a little shopping centre. [Yeah] You get what I'm saying? [Yeah, yeah] And we're going in there. Said, "Yeah, there, we'll get potatoes then, then we'll get the butter, then we'll get some bread, then we'll get, then [Yeah, yeah] we'll get some tomato sauce and get some devon. And then we'll get, then we'll get the big bag of chips and, and get some cordial …*

Rob's offence was clearly stealing out of necessity, and at his age it is likely that he did not know about or may have been reluctant to access family support services. This was also likely to be the case for both Ian and Gary, neither of whom drew a direct link from stealing to the provision of day-to-day necessities. Both did, however, talk about stealing and using the proceeds to buy food. Both Rob and Gary have spent almost all their adult life in prison and therefore their opportunities to offend while in the community have been limited.

In contrast, Ian, together with Jim and Carl, who all lived in Sydney, indicated that their main income source to support their living expenses as adults was from crime. Carl, who had committed stealing offences as a child, talked about supporting himself as an adult with stealing offences:

Carl: Money-wise. You spend all your money. You go stealing. You've always got nothing. You know what I mean? [Yeah] But I was, I was always like always had money. You know what I mean? Always, I was always going out doing

crime, so I always had money to, to, to support it. [Yeah] But all my money I used to just spend it on heroin, so [Yeah] …

Each of the three men had had accommodation difficulties. Jim described being on the waiting list for public housing, but of becoming frustrated after waiting for several years and committing a robbery to obtain money for a private rental. Once Jim obtained the money, however, he bought drugs as well as paying for living expenses, but did not use the money to secure housing:

Jim: *I probably would have risked getting money ... 'cause I needed money. ... Drugs was just another side issue. ... The issue was I needed money. I needed to get … If I, I was that far up on the housing list ... I risked getting enough money to rent a house for 12 months. ... Until a house was available, you know. I was on the, I was on the housing list for four years, ... do you know …*

The other two men, Ian and Carl, both described how difficult it was to get by day-to-day. Ian described his stealing offences as needing money to get by and be able to feed himself, and said that his drug use was not a problem at the time, though he was using cannabis:

MD: ***So you were doing that to, to get money?***

Ian: *Yeah. I was doing … just to get money. Just to make ends meet. [Yeah] Feed meself.*

MD: ***If you, if you, were you using drugs at the time?***

Ian: *No, I wasn't. Oh a bit of pot. [Bit of pot?] But I don't look at that as a problem.*

There were others who spoke about being in difficult and/or impoverished situations, though they did not link their offending to their predicaments. Twenty-year-old Bill's current offence was extremely serious, but day-to-day life prior to the offence was not pleasant. His story was one of alcohol use, transience, and intergenerational alcohol abuse:

Bill: *I don't know. Like, yeah, you could say that. Like most of the time I'd do it when I'm drinking but I've done it before when I haven't, and I still do crime and what-not. I don't know. I was just battling you can say. [Yeah] Yeah. [Yeah].*

The majority of men had offended before 18 years of age, meaning that most of these men had been involved in the criminal justice system for a substantial part of their lives.

The first offence was often a nuisance-type offence; however, several of the Aboriginal men had offended for poverty-related reasons as children, with some of these men going on to offend for these same reasons as adults. The men in this research are no doubt affected by the broader disadvantage that affects most of the Aboriginal community, and it is possible that many members of their families could also have poverty-related problems (135). This being so, even were the men in this research to gain employment on release, there is a real possibility that significant demands would be placed on them by family members in need of help. Both individual and community-wide poverty, as well as the men having a long history of offending, need to be considered when developing AoD treatment programs for these men.

6.3.8 Prison, Offending and Continued AoD use among the Aboriginal Men

Five of the men had been to prison four or more times, seven had been to prison between two and three times, and only two men were serving their first term of imprisonment. Given that 12 of the 14 men had previously been in prison, it is critical that AoD treatment be provided to people the very first time and then each subsequent time they go to prison. This is particularly important when considering that, in interview, 13 of the men had linked their offending to their AoD use. It is therefore possible that they would have been less likely to re-offend if they had been provided with strategies to avoid using AoD at hazardous levels at an earlier point in their contact with the prison system.

Most said they were under the influence of alcohol and/or other drugs at the time of committing their current offence. The offence was usually committed to support their drug use, with break and enter and armed robbery being common, but as mentioned previously there was also some poverty-related offending. The one man who said his offence was not related to drug use had breached a restraining order that required him to stay away from his ex-partner. This man claimed he only occasionally used drugs, namely cannabis, and drank alcohol socially.

Mark, whose drugs of choice were cannabis and amphetamine, spoke about how he would be on drugs while committing offences. His story provides an example of this cycle of drug use and crime reinforcing each other:

> *Mark: I only like, 'cause ice keeps you awake... I use ice to do crime 'cause I can stay up all night and do crime. You know what I mean? ... So I'd stay up for like three or four days doing crime all night. You know what I mean? ... And then I'd go home for a couple of days and sleep non-stop. Sleep for two days*

straight. You know what I mean? ... And then I'd get up and do the same thing again. ... Do you know what I mean? That's, that's how, that's how it, ... that's how it all come to.

Mark believed his offending was linked to his drug use and the above quote shows this strong link. Mark used the amphetamine to help him commit the offences, and then used cannabis to come down from the amphetamine use. This was a common pattern of offending for the men who had identified as being primarily amphetamine (ice) users, to be absent from the home and then returning to rest after several days of offending and using drugs.

As discussed in the previous chapter (5.2.3), another common offending pattern was that some men reported being unable to control themselves when consuming alcohol or amphetamine (ice), and this had led to them becoming involved in assault type offences.

In relation to the men who identified as using heroin, their offences more generally fell within the category of stealing type offences. Neil, however, made it clear his offence was not related to drug use, but was much more to do with him being affected by alcohol:

Neil: *No. That was, that was due to, you know, being, you know, drinking, being violent, [Yeah] you know, while I was affected by alcohol and, [Yeah] you know, yeah. So it wasn't, yeah, it wasn't, it wasn't connected with a, you know, I had to, [Drugs?] I had to do crime for, to support a drug habit or anything like that, no.*

It seemed important to Neil that he made clear that his offence was not drug-related. He was nonetheless willing to attribute his offending to alcohol use. This perhaps indicates that various drugs or alcohol are perceived differently, and the men may respond differently to an AoD program if they perceive it to be for specific drugs or for alcohol that they do not believe is a problem to them. For Neil, whose drug of choice was heroin, it would be likely that he would feel uncomfortable or stigmatised if he were placed into an amphetamine-focused program while his drug of choice was heroin.

Ed described himself as being a heroin user and said that it was his main and the only drug he wanted to use. He said he supported his use predominantly through stealing:

Ed: *Just using [heroin]. 'Cause every time I use, if I start using again, … then I go out and steal money to get, to, to use more drugs. … That was my, … that was my downfall.*

Ed described his family of origin as a good family with no drug use problems, but said that he, as a self-described drug addict, was different to the rest of his family. Ed had been to prison multiple times and his ongoing addiction to heroin was the reason he continued to offend and return to prison.

6.3.9 Offending History: Summary

The Aboriginal men became involved in the criminal justice system at a young age, although there was not a direct link between first offences and AoD use. There was, however, a link between offending and AoD use as their AoD use progressed. Many of these men would have in some way been aware that their life course was heading towards prison, but they may not have had life choices immediately available that could have provided an alternative to incarceration.

6.3.10 Alcohol and other Drug Treatment Experiences of Aboriginal Men - First ever Treatment Program attended

Thirteen men had attended AoD treatment that was in some way organised through the criminal justice system. One man, Ed, had attended AoD treatment before involvement in the criminal justice system, having been compelled to attend treatment by his partner as she had had enough of his AoD use. Five of the men had first attended AoD treatment organised through Juvenile Justice, with Mark going to a youth rehabilitation service as a condition of being released from juvenile detention, and Gary being placed into a youth hostel by Juvenile Justice where he attended AoD education program/s. Two men, Ian and Tom, attended AoD treatment because they were ordered by the courts, and the other six men attended their first ever AoD treatment in prison (see Table 6.1 on the next page).

Table 6.1: Alcohol and other Drug Treatment Programs

Name	First ever AoD treatment	Prison-based (adult only)	Community (adult only)
Ed	Before criminal justice system	Yes (CSNSW Smart)10	Yes (AA, NA, Rehab (x3) 11, Aboriginal men's group)
Bill	Juvenile detention or through juvenile justice	Yes (CSNSW)	No
Mark	Juvenile detention or through juvenile justice	No	No
Carl	Juvenile detention or through juvenile justice	Yes (CSNSW Smart)	Yes (NA)
Gary	Juvenile detention or through juvenile justice	Yes (CSNSW Smart)	No
Rob	Juvenile detention or through juvenile justice	Yes (CSNSW Smart & Pegasus & Parklea)	Yes (rehab)
Ian	Drug Court/Court ordered	Yes (CSNSW)	Yes (rehab)
Tom	Drug Court/Court ordered	Yes (CSNSW)	Yes (AA)
Ray	Prison-based	Yes (NA, AA) briefly while on remand but got stopped because was not sentenced	Yes (CSNSW anger management, AA)
Jess	Prison-based	Yes (CSNSW, AA & NA)	Yes (CSNSW)
Neil	Prison-based	Yes (CSNSW Smart)	No
Ryan	Prison-based	Yes (CSNSW Smart & Think First & Managing Emotions & Violent Offenders)	No
Toby	Prison-based	Yes (CSNSW & Smart, AA)	Yes (Aboriginal men's group)
Jim	Prison-based	Yes (CSNSW Compulsory Drug Treatment program)	Yes (AMS[12])

6.3.11 Previous AoD Treatment as an Adult

At the time of interview 13 of the Aboriginal interviewees had previously attended some form of AoD treatment, either in prison and/or in the community before they arrived at IDATP. Twenty-one-year old Mark, who was serving his first sentence, was the only one to have not attended any AoD treatment as an adult either in prison or in the community. Several men

[10] Specifically named programs are in (brackets)
[11] Residential Rehabilitation Service (rehab)
[12] Aboriginal Medical Service (AMS)

said they had undertaken CSNSW programs, but they were unable to name them. The programs specifically mentioned were Get Smart, Smart Recovery, Compulsory drug treatment programs at Park Lea, Managing Emotions, Violent Offenders Treatment Program, and Anger Management. Get Smart and Smart Recovery are two separate programs, but the men did not distinguish clearly between them, so for this reason they have been listed as Smart in Table 6.3.1. Twelve-Step programs are listed as NA or AA in the table and these are not run by CSNSW but are run by volunteers who are members of the 12-Step programs.

Prison-based AoD treatment programs had been attended by 13 men. Prison-based Corrective Services NSW programs had been attended by 12 men, with the aforementioned Mark and 20-year-old Ray - who was the equal youngest of the Aboriginal men - not having attended a CSNSW program. Mark and Ray were both serving their first terms in prison. Twelve-step programs had been attended in prison by four men: Ray, Jess and Bill had been to both AA and NA in prison, while Toby had been to AA in prison.

As adults, community-based programs had been attended by nine of the men. Corrective Services NSW programs in the community had been attended by two men, Ray and Jess, with three men, Ed, Rob, and Ian referred by CSNSW and/or the courts to attend to a residential rehabilitation service. Ed had been to both NA and AA, Ray and Tom had been to AA and Carl had been to NA in the community. Two men, Ed and Toby, had been to Aboriginal men's groups and one man, Jim, had been to one-to-one counselling as an alternative to AA or NA while in the community.

The results about AoD treatment experiences have been separated into community-based and prison-based treatment. The men, when discussing their treatment experiences, tended to jump from one treatment episode to another. An example of this was that they did not distinguish well between the different CSNSW programs such as Get Smart and Smart Recovery, and several could not remember the names of programs that they had undertaken. This meant that it was not possible to distinguish the CSNSW program experiences from each other. It was easy to distinguish the 12-Step programs from the CSNSW programs but within the 12-Step programs, the men did not always make it clear if they were talking about AA or NA and as such it was not possible to distinguish the experiences of the two 12-Step programs from each other.

6.3.12 Community-based Programs

Five men - Bill, Mark, Gary, Ian, and Ryan - had not been to any community-based programs as adults; however, Bill, Ian, and Mark had been to residential rehabilitation services as juveniles. Gary, who had spent most of his adult life in prison, said he had not been offered any help when he was released:

> ***MD:*** ***Have you done any, you were saying you've only been out for 18 months in the last nine years [Yeah] but did you go to any, any alcohol, drug programs or anything [No] in the community? Anything like NA? [No] AA?***
>
> *Gary:* *That's what I mean, see, like all, all the years I've been coming to gaol, getting let out and on parole and that, they don't even fucking offer you any help. [Yeah?] You know what I mean?*

While not being offered any AoD treatment support from CSNSW, it is worth noting that, living in Sydney, Gary would have been able to access some form of AoD treatment, even if it was NA.

Ryan, too, had not been to any form of community-based AoD treatment, but this was because he did not believe it would be of any help:

> *Ryan:* *I think, and the main reason why I don't wanna do it is because, you know, and I hope, you know, I might sound a little bit arrogant or, or a little bit cocky, or something but I, I just somehow feel that, you know, if I go to a rehab or, or something like that outside, there's not much they can teach me that I don't already know, [Yep] you know.*

Not attending any services was a clear decision of Ryan's. He knew about services, as he named two AoD support services, but he still did not attend any AoD support services.

- **CSNSW Programs**

Ray and Jess were the only two to have undertaken CSNSW-operated community-based programs. Ray undertook an anger management program after being convicted of assaulting a police officer, and was also encouraged/directed by the court to attend AA. Ray said he had to attend AA because there were no AoD services in his town, and he described this time in his life as a time when he had wanted to quit AoD use:

Ray: *Yeah. That's the time that I tried quitting and it didn't work. [Yeah] The best thing that's probably ever happened for me is I come to gaol. [Yeah?] Now I don't need it.*

Jess attended the CSNSW programs because he was on parole:

Jess: No, I was on parole for it [Yep] while I was doing most of 'em [Yeah] but it was just like I was on parole, but I was doing the courses for parole and then like I was still drinking and smoking, and ended up fucking up, come back to gaol. [Yep, yep] But now I'm just at that point where I'm just sick of coming here.

Jess was clearly not ready to change his AoD use behaviour at the time, and did not elaborate on any of his experiences in the programs. However, in the interview with the researcher, he said he was now at a point where he wanted to change his behaviour.

- **Residential Rehabilitation Services**

Three of the men – Ed, Ian, and Rob – had been paroled to a residential rehabilitation service. While this was not a CSNSW-provided program, their attendance was organised though the criminal justice system. Ian explained how he did not want to pay any attention at the time:

Ian: *I'd been to rehab and [rehab and drug and alcohol] sorta, it was a wake-up call. Yeah, drug and alcohol counselling. Like I didn't wanna talk to him but. Like that [Yeah] old saying goes, you can't help a person that don't wanna help themselves. [Yeah].*

Neither Ian nor Rob stopped their AoD use behaviour and both continued using. Ed had first been referred/encouraged to go to a rehabilitation service by the courts but continued his AoD use and was subsequently imprisoned. He was released on parole to attend a residential rehabilitation service on two occasions. The first occasion did not work well for Ed as he suffered an acute mental health problem, and was admitted to a hospital, and from there went back to prison:

Ed: I didn't go, yeah. [Yeah, okay] Then I had to come back in and do 12 months review. You know, like the 12 months they review you again. [Yeah] They did, and they said to me to go to rehab again. [Yeah] And I went to rehab [Yeah] but I stayed there for a week or two and they kicked me out.

MD: The rehab kicked you out? Why? Why was that?

Ed: *Yeah, well they took me to the hospital, [Yeah?] hospital, [Yeah?] 'cause I was hearing voices. I'm diagnosed with schizophrenia. [Oh okay] And I take, I'm on medication. [Yep] I'm on [Yep] and Serracor at night time. Every night I, I take a Serracor to make me sleep.*

After Ed's mental health stabilised, CSNSW again released Ed on parole to attend a residential rehabilitation service. To the credit of CSNSW, it seems that staff in the department were not deterred by Ed's episode of mental ill health as a reason to not give him an opportunity to be released onto parole. Unfortunately, when Ed was released he did not make it to the service, instead opting to stay with his family after he had had some transport problems, which led to his return to gaol.

- **Twelve Step Programs (AA and NA)**

Twelve step programs were attended by four men when they were in the community. Ed had attended both NA and AA, Carl had attended only NA, and Tom and Ray had attended AA. The experience of attending these programs varied. Ed thought AA and NA were good, even if it was nerve-wracking speaking in front of a group:

Ed: *Yeah. [Yeah] One time, yeah, I had when I … it was nerve-wracking, as I said before, and [Yeah] I got up and, you know, spoke, spoke a few words to express my feelings and stuff like that about, especially about the drugs that I was on. [Yeah] A little bit personal, you know, about history and stuff like that, you know. [Yeah] Myself. [Yeah] A lot of people get up, you know, and they have their own opinions about themselves. And [Yeah] you know, it's something new. It's good. It's good to, good feedback for yourself 'cause sometimes it's, it's … What do you call it? You get the same.*

Carl did not connect well with NA, thinking it was 'all right' but not feeling comfortable enough to fully engage:

Carl: *It was all right. The only things I didn't like to talk about was personal issues, you know, when you say things about what happened in the past. You know what I mean? And what you experienced. I didn't really want to say anything about what I've experienced and that. You know what I mean? 'Cause that was like personal*.

Ray and Tom, who had attended AA, had both positive and negative experiences. Tom thought that gaining an understanding that people can get hurt from the use of alcohol by others was a positive outcome of his attendance:

MD: ***Well, in terms of, did you, did you get much out of going to AA, if that's already [No] … yeah?***

Tom: *Kind of, in a way. Like how you get hurt and that. Like I felt sorry a bit for 'em but, yeah, that was about it, [Yeah] you know.*

MD: ***So, did you learn sort of … you did sort of mention that then but that's the main thing you learnt.***

Tom: Yeah. That's it. Just like how you can hurt other people for car crashes and that, you know. [Yep] That's about it. [Yep].

Ray, however, did not like hearing about the problems of others:

MD: ***Well your experience when you did go to AA, was there something you didn't like about it?***

Ray: *Oh, just them whinging, you know, about drinking and fucking just responsible and that … yeah. Just little things. I can't really remember too much. I was only 17 when I went to it but yeah …*

In sum, the experiences of AA and NA in the community were mixed, appearing to depend on the attitude of the person at the time of their attendance. Of course, being in a state of readiness to change behaviours is an important ingredient for success in any AoD treatment program.

- **Aboriginal Services and Programs**

Four of the men had attended an Aboriginal service or program in the community. Aboriginal men's groups were attended by Ed and Toby, Jim attended one-to-one counselling at an Aboriginal Medical Service, and Rob had attended an Aboriginal residential rehabilitation service, if only briefly.

The Aboriginal men's groups did not have a formal drug treatment curriculum. Instead, the groups were safe places for the men to discuss personal issues in a group context with other Aboriginal males. Discussion in the group helped Ed and Toby, as well as other men in the groups, to work out how to deal with day-to-day life issues. A strong focus of these discussions in the group was hazardous AoD use and family violence problems. The two

men spoke about the benefits of the support from the group, and that they felt safe to be themselves and express emotions. Each of the men's groups was led by older Aboriginal men, with these older men being known to the families of the two participants. This is in line with how good practices in Aboriginal men's groups are described in the research literature (139). It also reflects an ancient cultural process, and demonstrates care, role-modelling and intergenerational care (139). Toby spoke about how he felt comfortable to say what was going on for him at home, which was not directly alcohol or drug related:

> *Toby: It was just, just sitting down with the same sort of brothers. You know what I mean? It didn't feel like you're sitting down with a psychologist or anything. You were sitting down with a cup of coffee and a bunger[13] in your hand, just having a yarn. [Yeah, yeah] And I don't know what it was but something about it just doing that made you feel good, [Yeah] you know. It was a place you could go and you feel pissed-off that your missus done something or you done something that you shouldn't have done something, you know. You could go there and just have a yarn about it, and a couple of other brothers might say, "Yeah, well I done that last year brother and, you know, like this is what I done to overcome that." And, [Yeah] you know, it was a place where you could go and just get your problems out [Yeah] and maybe there was some feedback offered to help you through that bit of time [Yeah] whatever.*

Group members, including Ed and Toby, were predominantly younger men between 20 and 40 years of age. Both men reflected that the age of the other men was important because it kept the topics of discussion relevant to them and their day-to-day life struggles, thus providing them with a form of peer support.

As Jim had had difficulty speaking in group programs, he and his parole officer worked out an alternative, which was attendance for one-to-one counselling at an Aboriginal medical service:

> *Jim: I can't talk in a group, ... you know. I said, "I'll go, I'll go there and sit, and be mute, and just get 'em to sign it for you, if you want, but I won't, I can't talk in a group." I said, "One-on-one maybe …" So she said …, well I went to the Aboriginal medical service in … she said, "Can you find someone to do one-on-ones?" and I said, "Yeah, probably." ... So I went to the Aboriginal medical*

[13] Bunger is a colloquial term for cigarette used by Aboriginal people in northern NSW

service in … and went to the drug and alcohol people there, and ... found, found someone that I was more comfortable with. And, [Yeah] and that's, I, I continued that when I was out, ... while I was on parole.

Jim thought it was beneficial to have an Aboriginal man who was older than him as his counsellor. He also felt that it was good that the man knew him and his ex-partner and their respective families, as the counsellors knew he had had a bad relationship breakup with his partner, with the breakup apparently leading to increased AoD use. Jim said that through the Aboriginal counselling service he learnt that his drinking lowered his inhibitions to use drugs, and that he needed to avoid alcohol if he wanted to avoid drug use:

Jim: *If I'm drunk and, and, and I have an argument or a bad day, and then I have a few beers, and then, you know, when you've got an addictive personality, you're just gonna go to the next one to the next one, yeah.*

Despite these positive steps, Jim relapsed with alcohol and subsequently with drug use, leading to the committing of offences related to supporting his drug use.

The other man, Rob, had attended but not stayed long at an Aboriginal residential rehabilitation service. Rob indicated that he would prefer to go back to an Aboriginal residential rehabilitation service because, unlike mainstream services, they had an understanding of who he is as an Aboriginal person:

Rob: *The Glen's an Aboriginal one. [Yeah, yeah, yeah] Glen's Aboriginal. That's a mad rehab that is. [Yeah, yeah] If I had another chance to go to rehab, I'd go to The Glen because that's a fuckin' good rehab man. Like it's set out that suits a Aboriginal person.*

Rob felt comfortable in a majority Aboriginal environment, not having to explain or justify his cultural beliefs or his family relationships and their importance.

As with previous other community-based AoD treatment, the Aboriginal-specific services and programs were clearly not effective in stopping these men from progressing in their AoD use. It is notable that while, for other community-based treatment negative and positive experiences were both recalled, for the Aboriginal-specific program only positive experiences were recalled. Most importantly, the four men that attended the Aboriginal programs were all willing to attend these services and programs again in the future.

6.3.13 Community-based AoD Services: Summary

It has been proposed that Aboriginal men in prison could be diverted to community-based residential rehabilitation services (6). There are currently no aggregated figures available that detail how many of the Aboriginal men in prison have previously been to a rehabilitation service in the community. What is known from this current study, however, is that eight of the Aboriginal participants had been to a residential rehabilitation service but had continued AoD use, and ended in prison. This suggests that prison-based AoD treatment programs are essential.

6.3.14 Prison-based AoD Treatment

Thirteen of the men had previously attended some form of AoD treatment in prison. Twelve had attended CSNSW-provided programs. Five of the men – Bill, Ian, Tom, Jess, and Toby - had attended CSNSW programs but were unable to recall the name of the program they had been in. A program titled Think First and another titled Managing Emotions had been attended by Ryan, Rob had attended a program call Pegasus, and the compulsory Drug Treatment Program at Park Lea had been attended by two men, Rob and Jim. Get Smart/Smart Recovery was attended by eight men: Ed, Carl, Gary, Rob, Neil, Ryan, Toby, and Jim, and Twelve-Step programs were attended by Ray. Jess and Bill had been to both AA and NA in prison, while Toby had been to AA in prison.

- **Think First, Managing Emotions and Pegasus Programs**

Ryan had attended Think First and Managing Emotions, and he gave a general description of why he undertook all these programs:

Ryan: *Managing Emotions. But I honestly do think I will benefit from this IDATP. [Yeah] I'm hoping to anyway. [Okay].*

MD: ***Yeah. That's the next question. So, so you are hoping to benefit from, from IDATP, so, and that's why you applied to come in here, 'cause you've gotta sort of apply to come into IDATP. In what ways did you think you, you, in what ways are you hoping to benefit?***

Ryan: *Just sort of hoping … I'm on the verge of getting to that age now where it's, it's not interesting me like it used to and maybe this program will finally [Claps hands] get me over the mark where heroin won't interest me at all. [Yep, yeah].*

MD: ***Okay.***

Ryan: *Just using it as a shove in the right direction I guess. [Yep, yep].*

Ryan was non-descriptive about the content of either of these two programs. Rob recalled having also briefly attended a program titled Pegasus, but did not finish the program as he was released from prison. All he said of that program was that *'it was alright'* from what he could recall.

- **Compulsory Drug Treatment Program**

Two of the men, Rob and Jim, were placed into a non-voluntary drug treatment, but judging from their comments these men were not resistant to the program. Both spoke about going to Park Lea Correctional Facility, which houses the Compulsory Drug Treatment Program. The men spoke well of the experience, and Jim was happy to have made it into the program:

> Jim: Park Lea, yeah. [Park Lea] It was a compulsory drug treatment program. [Yeah?] You had to, it was a minimum 18 months and a maximum three years program and, yeah, any violence, violent offences you weren't eligible, and … [Oh okay] and, and, and you had to have drug, drug history, obviously. But, yeah, I, I just scraped into that program.

Neither Jim nor Rob made any untoward comments about the programs. They both appeared to be impressed by the length and intensity of the Park Lea program, raising the possibility that these men were at a stage of change where they were ready to attend the program.

- **Get Smart Program (and Smart Recovery)**

Get Smart and Smart Recovery are two different but interrelated programs. The men did not distinguish between these two, though it would almost certainly have been the Get Smart program that they attended since Get Smart is a 10-session program while Smart Recovery is the maintenance program which is recommended after Get Smart. Having said that, there is no requirement to have completed Get Smart as a prerequisite to enter Smart Recovery. Eight men had undertaken the Get Smart program, with two doing so more than once: Ed, twice, Carl, four times, and Gary, Rob, Neil, Ryan, Toby, and Jess undertaking the program only once. Carl explained why he needed to undertake the program more than once:

> *Carl: I started, when I done the Smart program and that. [Yeah] Yeah. When I first come to gaol. [Yeah] A few times, so yeah.*
>
> ***MD: So you did the Smart program a few times? [Yeah] How did you find that one?***
>
> *Carl: Yeah, it was all right. [Yeah] Yeah, yeah … Like, when I first done it, I had to do it three times just to really, to really get something out of the program.*

[Yeah] So yeah, I done it four times now and the third and fourth, like the first two times I didn't get nothing out of it, so I done it again and again, then I started realising what I was getting out of it and what's this, and what's that. You know what I mean? And your thinking pattern and. All that kind of stuff. So [Yeah] …

Ed was the only one of the men to have given a description of the program content:

Ed: It's good. Like the feedback and the information they give ya, they're like the information we talk about, the group … you know, like it explains to, to you about how much you've been using and that. You know, like how much did you use, how much, what would you do, how would you spend your money, what would you do if you had a pouch and you wanted to get on drugs, and you owed a pouch back. You know, like [Yeah] little things like that, [Yeah] you know. And it was good to find out about all that.

Ed went on to say that he had benefited from discussing his emotions in group, and mapping out his AoD use behaviours while in group:

Ed: Like your, your moods, you know, and all of that [Yep] about drugs and stuff. [Yeah] You had to draw on big papers. [Yeah] We had to get in groups and discuss about a subject that we, that we were talking about and we'd explain it. We'd write it down on, on, on, on a piece of paper. [Yeah] Then we, after the, we finished, then we all formed back into a group and we, each group's gotta tell, tell the story [Yeah] about stuff like that. [yeah] Yeah. Like it could be, you could be starting when you first, when, when you wake up in the morning. You have a cup of coffee and then, then, at lunchtime, you go and see your girlfriend and, and you have, get on drugs, and you go and buy drugs at, you know, like stuff like that. [Yeah] And you do a little chart up. … Story of what happens, yeah. Stuff like that. It's good. I like, I like being, being in groups. [You like being, yeah?] Yeah, groups, group sessions.

Carl and Ed both had positive experiences of the program and thought they gained knowledge from it, as did Neil and Ryan who said much less but still reported a positive experience. Ryan described it as: *'Just using it as a shove in the right direction I guess'*. Rob was not descriptive; nor was Toby, but given that Toby thought he did not have a drug problem this was not unexpected. Jess gave the same description as of all his previous

programs, which was *'they were all shit'*. Finally, Gary said he could not really remember the program:

> *Gary: Information. That was all right. But I don't know. To be honest, I wasn't even taking notice of it. You know what I mean? I just had to do it to get my parole. [Yeah] You know what I mean? [Yeah] That's it.*

While Gary was the only one to explicitly state he did the program to get parole, it was implied by others that it had helped them gain parole as well.

- **Twelve Step Programs (AA and NA)**

Ray, Toby and Jess had attended AA or NA in prison. Ray attended one session of AA while in Long Bay but was not allowed to attend again as he had not been sentenced. Toby went to AA and was shocked to find that his Dad was one of the facilitators. Toby then attended AA regularly but said the AA meetings were cancelled by the prison staff. Toby said he thought this was because they found out his Dad was one of the facilitators and because the inmates were having too much of a good time attending:

> *Toby: Cause on, when I did me first lagging[14], it was, like I was still only a kid. I was only 18. [Yeah] My dad had given up the alcohol then and [Yeah] I remember it surprised the fuck out of me. I'd enrolled just to waste time, you know, in an AA course, in Junee. Everybody was, "Let's go do it! We get biscuits and tea", you know. [Yeah] And, fuck, me old man was there. [Yeah] He was the one doing the course.*
>
> ***MD: You were doing an AA thing?***
>
> *Toby: Yeah. I went, "Wow!" [Where?] In Junee. [In Junee, yeah] And he pulled his -*
>
> ***MD: So you were inside?***
>
> *Tony: Yeah, I was inside. [Yeah, yeah] Yeah. So, when we all walked in the room [Yeah] to get our bickies and tea, and that, 'cause it was just a waste of time for us, [Yeah, yeah] and I seen me old man there, and I went, "Fuck, boys, that's my old man!" I think it was an hour we were in there for. That hour turned into two hours or it might have been a half hour. That half hour turned into like an hour, hour and a half [Yeah] 'cause my old man was a big, he was a big, black, fat Elvis Presley sort of fella and [Yeah] the AA meeting went for about 10 minutes and the rest of the time was just yarning and bullshit talking, and [Yeah] yeah. And it just lingered on. I remember that, clearly.*

[14] The term 'lagging' is used in prison as a colloquial for 'prison sentence'

Jess had attended both AA and NA in prison, but, like others programs he had attended, he thought they were all *'shit'* and he did not gain anything from attending them.

6.3.15 Prison-based AoD treatment: Summary

Thirteen of the men had previously attended some form of prison-based AoD treatment, and the one man who had not, Mark, had attended AoD treatment in juvenile detention, and was serving his first term in an adult prison. Two men attended an involuntary program, but these men appeared to be willing participants of that program. One of the men, Ray, had only attended 12-Step programs and had only done so briefly as he was on remand and was unable to continue to attend the 12-Step program. It would seem practical to allow people on remand access to 12-Step programs as these programs are provided at no extra cost to CSNSW. However, the overall picture is that only one of these men had not been to any AoD treatment in prison, one had been to AA and twelve of the men had attended some form of AoD treatment provided by CSNSW.

6.3.16 Further developing Prison-based AoD treatment

The Aboriginal men had had both positive and negative experience of prison-based AoD treatment. These have been reported below under the theme heading for the different areas of AoD treatment. The approach in this section was not to be critical of treatment but to offer recommendations of how treatment could be augmented.

- **Access to Programs when on Remand**

Frustration at not being able to undertake CSNSW programs while on remand was an issue, with many of the men being held for periods of time on remand and some, but not all, being unable to attended AoD treatment. Jess's quote below expresses his sense of frustration, and the amount of time he had waited to access support for his health needs whilst on remand in prison:

> *Jess: Like I, I done 18 months on remand. I couldn't do no courses because I'm, 'cause on remand. I got sentenced. I come in here, when was it? pretty much the start of December. [Interviewed in June]*

There was frustration that this restriction from AoD treatment was extended to the non-CSNSW programs of AA and NA, which are run voluntarily by community members.

The proportion of people in prison that are being held unsentenced/on remand had increased overtime from 21.6% of inmates in 2006 to 31.4% of inmates in 2016 (7). About the same proportion of Aboriginal people in prison, 30.4% are unsentenced/on remand compared to 31.4% of non-Aboriginal people held in prison (7). Policy clarification on whether or not people being held on remand can or cannot attend prison-based AoD programs is needed. People in prison should be able to voluntarily attend AoD programs while unsentenced/on remand. This is particularly pertinent when considering that health services in prisons are meant to be equivalent to those delivered in the community (38).

- **Program Content**

There was benefit in being able to take printed learning resources back to their cells, so they could read and review and think about the knowledge gained in class, as Rob said:

> *Rob: Yeah, that was good. ... That was good because, ... because it gives you a book. ... Gives you a book and a bit of knowledge.*

Taking material back to the cell could be extremely helpful for the Aboriginal men who cannot read well. There was a strong statement by one of the older Aboriginal men, Ed, that it is shame, which is a particularly strong term for Aboriginal people, to admit they cannot read in front of the white fellas in prison:

> *ED: You know, if I, if I say I can't read or I can't write, you know, it's, I feel a bit shamed about it, you know.*
>
> **MD: In front of, but, yeah, in front of [Yeah] the white fellas?**
>
> *Ed: The white fellas [Yeah] 'cause they're more smarter in that, [Yeah] in that sense. You know what I mean? [Yeah, yeah, yeah, yep, yep] Yeah.*
>
> **MD: And, and, but with Koori fellas you feel different. Is that what you're saying?**
>
> *Ed: Feel different. You can, [Right] yeah, you can talk about, talk about stuff where you understand each other. You know what I mean? [Yeah] Yeah. Like we're on the same, same level as each other. Or, if you need help, you can ask him for help. [Yeah] You know what I mean? You can say, "What's that mean?" or, "What's that, what's that word mean?" or, "What's that say?" or, "What's she talking about?" [Yeah, yeah] And they, they, they can tell ya, you know, where it's different when you ask someone else, you know, like an Aussie fella.*

Prison is a tough environment, and as indicated by Ed, one needs to be selective when sharing vulnerabilities with others.

The only major problem raised about AoD program content was that the men did not like having to cover program content that was not relevant to their AoD use. An example of this was provided by Jim, who resented having to cover the link between offending and drug use when he believed his offence was not drug related:

> *Jim:* *… they're kind of like forcing their, their beliefs on you, you know. Their, their idea of what, why you're doing things and … you know. And that wasn't, a lot of it wasn't the case and I was telling them. And they, it didn't matter what I said, they'd always go back and say, "Look, you took drugs for a reason," or you … you know? ... Or, "You went and did the crime because you was doing drugs". You know what I mean? I said, "Wait a minute! You don't know me. I was a criminal before I even used drugs. You know what I mean?" ... I never, I, I went and did crime and didn't even, I didn't even spend it on drugs. ... I done crime 'cause I, I got the thrill of it and I, I could spend money on nice things.*

Jim was the only one of the Aboriginal men that clearly articulated this problem, with other men simply indicating that they found it irritating if they had to cover subjects not directly relevant to their AoD use problems.

- **Repeating Programs**

There was benefit in being able being able to repeat an AoD treatment program. Several of the men commented that they were not ready to learn while in class the first or second time they attended AoD treatment programs and needed to repeat the class.

> Carl: *Yeah, it was all right. [Yeah] Yeah, yeah … Like, when I first done it, I had to do it three times just to really, to really get something out of the program. [Yeah] So yeah, I done it four times now and the third and fourth, like the first two times I didn't get nothing out of it so I done it again and again, then I started realising what I was getting out of it and what's this, and what's that. You know what I mean? And your thinking pattern. All that kind of stuff.*

As noted above, Carl had had to undertake a program three to four times before he felt he understood the content. Clearly, there is benefit for some people to repeat AoD programs, as they may not have absorbed or understood all the information the first time around.

- **Facilitators: Personal and Professional Attributes**

The Aboriginal participants did not state a preference for having an Aboriginal facilitator, even though this was a direct proposition put to them. There was some indication that there was benefit in having an Aboriginal facilitator, having a gender balance, and having older facilitators, but it was not essential for a program's success. What was critically important was to have empathy towards the social circumstances for Aboriginal people:

> *Carl: But she was all right, especially with Aboriginal, with the Aboriginal boys. You know what I mean? ... She knew where we was coming from and if we lost a family, in our family. You know what I mean? 'Cause it's a big thing when we lose someone in our family or when we're going through relationship problems, or drug … You know what I mean? ... So yeah. I liked it. I liked … You know what I mean?*

The main qualification for an AoD program facilitator was to have expert knowledge. It was helpful but not essential from the perspectives of the Aboriginal men for the facilitator to have had personal experience of AoD use problems or AoD problems within their families or friendship groups.

- **Age of other Participants**

The issue of there being a significant age gap was raised as a problem for one of the men in the prison-based programs. As Toby explains below:

> *Toby: And a lot of these young fellas, like 'cause I was 29, 30 back then, and a lot of the young fellas that I was listening to were only fucking 20-years-old, 19, 18-years-old and the shit that they were doing I couldn't, I, I couldn't fathom on doing. And they were doing it on drugs. [Yeah] So I could sort of relate in a way ...*

Toby, and also Ed, had attended the Aboriginal men's groups in the community and had spoken positively about there being men in the groups that were around the same age as themselves.

- **Supportive AoD Treatment Relationship**

Establishing a supportive and useful AoD treatment environment was dependent on relationships and, as discussed in the previous chapter, the issue underpinning this was trust in the confidentiality of other inmates and the staff. Two other dimensions of trust also emerged as important from the full data set: trust that the staff genuinely had the inmates' best interests at heart and trust in the professional ability of the staff. After isolating the Aboriginal data, the main theme related to trust in the other inmates in treatment programs. Within this context, there was a unique bond of trust between Aboriginal men that should be considered when delivering AoD treatment in prison.

It is clear from the data that trust is a critical issue within prison generally, and all 14 Aboriginal men spoke of this inherent trust between the 'brothers', leading to a greater willingness to talk about their AoD use and related family issues. The mutual respect and bond of trust between Aboriginal men was immediately given without question, although sometimes Aboriginal men who had fair skin had to state their Aboriginal identity including who they were related to first.

Carl spoke about how he could trust the other Aboriginal (Koori in NSW) men, but this trust was not a given for men from other backgrounds:

> *Carl: Yeah, 'cause there's some things that you don't wanna say around ... white fellas or the Asians, or ... the Islanders. You know what I mean? ... Yeah, they sort of all make you feel funny where, if you're in a Koori group, you can say them things and get it off your chest. You know what I mean? And talk about issues.*

Confidentiality by other Aboriginal men was anticipated and treated as a fact, rather than an unknown which was the case with the non-Aboriginal men in the treatment group:

> *Carl: Where around them boys, around other nationalities, don't wanna say it 'cause they might sit there and laugh at ya ... or they might go, go back and talk about ya. You know what I mean? ... At the Kooris, yeah. And that's where us black fellas' instinct, we get, we get dirty, you know. ... We get angry.*

There was a feeling of being comfortable with the other Koori men in a group. This did not mean that the Aboriginal men did not feel comfortable with non-Aboriginal inmates. As

explained by Ed, he could have the same level of comfort with non-Aboriginal men if he got to know them well:

> *Ed:* *I don't know. It's comfortable when there's Koori fellas with ya, you know. ... If you've got other people there you don't know, ... then it's hard to face, you know, one-on-one. ... You know, conversations and that. If you know 'em real well, it's good. ... You've got no problems. But, when you're, when you're with Kooris, you feel more comfortable with them 'cause it's like your brother, you know, and you can say anything, you know. ... And to 'em, you know. ... It's, it's a difference I reckon. There's a bit of difference.*

Admitting any form of weakness in prison is not wise, and this includes not being able to read or write. The Aboriginal men could admit difficulty to each other, but not to other men. Ian talked about how the Aboriginal men will ask each other for help in class:

> *Ian:* *You can, [Right] yeah, you can talk about, talk about stuff where you understand each other. You know what I mean? [Yeah] Yeah. Like we're on the same, same level as each other. Or, if you need help, you can ask him for help. [Yeah] You know what I mean? You can say, "What's that mean?" or, "What's that, what's that word mean?" or, "What's that say?" or, "What's she talking about?" [Yeah, yeah] And they, they, they can tell ya, you know, where it's different when you ask someone else, you know, like an Aussie fella.*

Notably, one participant, Neil, said it was good for him and other Aboriginal men to be in mixed groups to see that non-Aboriginal people have drug problems too:

> *Neil:* *Yeah, it was, it was good. It was good because you can, you can, you know, you get to hear about other peoples' stories, ... you know, some background or, you know, upbringings that other people may have had, ... you know. And it's, you know, a lot of the black fellas doing it so we all come from a similar, you know, we can all relate to each other and, ... and, in some ways or another, you know, the other nationalities in the group, you know, you can understand where they're coming from, you know. Like, 'cause, ... yeah, you know, it's sort of, they're sort of, it's like they're relating to us, you know, because they come from a, you know, disadvantaged background or, you know, they mightn't, ... you know, they were unfortunate … you know, in them circumstances. But it's good, yeah. It's good knowing that, you know, seeing*

that other people going through that as well, ... you know. Like, in that sense, it's … I'd rather be there with it being multicultural, ... you know, than, than sitting at a, a table with all black fellas ...

It appeared that while there was clear benefit from having an Aboriginal-only group, there was also some benefit in mixed groups with both Aboriginal and non-Aboriginal men. The data from this study suggests that in short-term programs where the men do not spend as much time getting to know each other, it would be beneficial to have Aboriginal-only treatment groups. It may be beneficial for the Aboriginal men to be in mixed groups in the longer programs.

6.4 Discussion

This chapter addresses the third part of the research question, but with a specific focus on Aboriginal men: *How can prison-based treatment for men be further developed to meet their needs?* The specific focus on Aboriginal men was because of the vast over-representation of this group in Australian prisons, at a rate of 1,857 per 100,000 compared to 144 per 100,000 for non-Indigenous Australians (94). In order to address this research question, the interviews with the 14 Aboriginal men were separately analysed and from this data theories on how to improve AoD treatment in prison for Aboriginal men have been developed.

There are a multitude of AoD treatment services in the community and there are programs in the mainstream services that may have been specifically developed for Aboriginal people. (140). There are also many services that are Aboriginal-specific. These services are not meant to replace the mainstream services, but rather to offer additional services to a highly vulnerable community (140). Aboriginal-specific services by their very nature offer a safe environment for Aboriginal people that takes into account discrimination and disadvantage experiences of today as well the colonial history of the past that has contributed to these issues (140).

6.4.1 Alcohol and other Drug use

The men were interviewed at an intensive AoD treatment program, and for them to be accepted into that program they had to have had a history of harmful AoD use. Two had first used AoD by age nine years and eight men had commenced AoD use by 12 years of age. Early commencement of AoD use has been documented in a survey of juveniles in detention, and within this population 92.9% of young people in juvenile detention in NSW had used illicit drugs and 96.7% had been intoxicated with alcohol (141). This survey of

young people in NSW juvenile detention asked about their health and also about their AoD use prior to detention. The survey reported that the average age of a young Aboriginal person being first intoxicated in the community was 13.4 years, and the average first-use of cannabis was 12.7 years (141). In this study the reasons for AoD use were grouped into the three categories of peer pressure, experimental, and family and social environmental influence.

For the men in this study, the *peer pressure* for AoD use was not a direct pressure to use but much rather a social pressure. Peer pressure for AoD use is a well documented phenomenon, with young people being particularly susceptible to it (25). Overcoming peer-pressure in an assertive way has its challenges and young people need to be equipped with correct information, including awareness of what peer pressure is, and that they can choose to not participate (25). For young Aboriginal people it could be challenging to avoid peer-pressure when many of their peers are likely to be relatives and may continue to apply peer pressure at home or in the community (25). This is made even more difficult if there is a ready availability of AoD in the family home. The men in this study felt socially obligated to use AoD when they were with friends and family, as so many people around them were using AoD.

Experimental use was another reason given for first AoD use by the men in this study. This was often done in the company of a peer or peers, but was driven by the young men themselves in the sense that they wanted to see what the drug was like. It has been well documented that young people experiment with AoD use and the experimental use was possibly to do with their age and the adventurous nature of the young (142). However, when does experimental use become ongoing and hazardous AoD use and dependency? There are the AUDIT guidelines for alcohol use (24) and there are any number of warning signs for drug use. One model that was developed specifically for Aboriginal people to understand when AoD use is a problem is the Strong Spirit Strong Mind model, which outlines seven areas of: 1) Health, 2) Family and Community Relationships, 3) Aboriginal Law and Culture and Country, 4) Land/Country, 5) Grief and Loss, 6) Livelihood/Money and Work, and 7) Legal (143). This model, developed in Western Australia, is widely used among AoD workers who have Aboriginal clients to help the clients understand how their lives are being affected by AoD use. Applying this to the Aboriginal men in this research, most of them would be affected across multiple, if not all seven, domains.

The third category, *Family and social environmental influence*, was possibly the most concerning. The men spoke about AoD use by family members, including parents and

siblings, and also discussed intergenerational alcoholism. Alcohol and/or drugs (predominantly in the form of cannabis) were a part of life from as far back as they could remember. Within this context, AoD use was normalised, and it appeared to be unusual for some of these men, when young, to be in an environment where AoD was not used. The social dysfunction caused by alcohol use has been well described (22). In some regional and remote communities where Aboriginal people are the majority population there have been alcohol restrictions, and in some cases bans, to reduce the harms (144). These restrictions have had some positive impacts in reducing harm; however, these initiatives are highly localised in towns where there are only a small number of alcohol bottle shops (144). As well, people are free to visit or move to an area where there are not as many alcohol restrictions, and as such, there are limitations with this approach. It remains to be seen whether similar alcohol sale restrictions will ever be put in place in major cities.

Emotional turmoil was cited by the men as a major reason for continued AoD use, and this distress was caused by a number of factors. These included financial difficulty and conflict with family members, including their partner. The lower socioeconomic status of many Aboriginal families predisposed them to financial stress, and this, along with the intergenerational trauma from the colonisation process and the economic marginalisation from their exclusion in the mainstream economy, have been documented as contributing factors to AoD use among Aboriginal people (57). The effects of assimilation policies are intergenerational, with poorer mental health and increased AoD use among those children who were removed from their families and communities (145). The emotional turmoil created by these past policies continue for Aboriginal people today.

Australia is a wealthy country, but a higher proportion of Aboriginal people live in socioeconomic difficulty than do non-Indigenous Australians (26). Economic pressures can cause stress within families, which is likely to be further exacerbated if one or both parents have been or are in prison. Many of the men in this research said they had children. It is very possible that these children will grow up in families where there is financial stress which, together with those other causes of emotional distress discussed above risks predisposing another generation of Aboriginal people to seeking a perceived relief from these issues through AoD use.

The dysfunction in some Aboriginal communities and individual homes from AoD use had been well documented in the broader literature (22, 146). Violence between intimate partners is one of the leading causes of injury among Aboriginal people (36), and Aboriginal children are more likely to be removed from their families than are non-Aboriginal children

(147). For some of the men in this study, the AoD use and this dysfunction within the Aboriginal community was a reason the men gave for not using AoD, particularly alcohol. This response to harmful AoD use within Aboriginal families could be a fruitful area to be harnessed in prison-based AoD treatment discussions. This is an important point, as the men in this research (and possibly most men in prison) are likely to return back to the same or similar circumstances from which they came when released from prison back into the community. As has been outlined in other research there is a need to include the whole family when working with these Aboriginal men (6). This whole-of-family approach has its challenges, however, particularly if family members are not willing to address their own AoD problem if they have one and, as such, the utility of a family-based program can be limited.

6.4.2 Offending

Initially the offending of these men was not related to their AoD use, and there were indications that for some the offending was related to poverty and the need to pay for day-to-day living experiences including food. Alcohol and drugs cost money, and the use of AoD no doubt contributed to the poverty suffered by some of these men and their families.

As adults, several of the men said that the drug use, in particular amphetamine use, was entwined with their offending whereby they would use amphetamine and then go out and commit the offences needed to support the amphetamine use. Prison-based AoD treatment programs cover the link between offending and AoD use, and this data adds to the recognition of the importance of that link being covered in treatment programs.

6.4.3 Access to Prison-based AoD Treatment

Access to AoD treatment while on remand was mentioned by one of the Aboriginal men. Ray said he was unable to attend AoD treatment provided by CSNSW while on remand, but he was briefly able to attend an AA 12-Step program which is wholly run by external volunteers. The extent to which people in prison can or cannot undertake AoD treatment until they are sentenced is unknown. The provision of access to AoD treatment for people on remand is likely to be quite different depending upon the prison and the jurisdiction where the prison is located. Nonetheless, it would seem prudent for departmental policies to be reviewed, and if necessary changed, to allow people being held on remand to attend AoD programs, particularly those that are voluntary and operated by external providers.

6.4.4 Facilitators

As was reported from the complete data set in the previous chapter, there was an appreciation among the Aboriginal men taking part in this study for well-trained facilitators

who had expert knowledge. There were a number of factors that were desirable but not essential, including that the facilitator be slightly older than most of the men, and for there to be a gender balance. The Aboriginal men did not think it was essential for facilitators to have had personal experiences of AoD use problems in their family or community. This view allows for greater separation of the boundaries between therapist and client (25). The Aboriginal men were directly asked if they would prefer an Aboriginal facilitator, and the men indicated that that could be good but that the essential quality was not Aboriginality but for the facilitator to be empathetic towards the social circumstances of Aboriginal people.

Empathy and reflective listening are essential skills in AoD treatment, while confrontation and judgement are not recommended as these can be counterproductive (25). As mentioned in the discussion in the previous chapter, facilitators need to have a level of confidence, which may well be the result of being well-trained and experienced rather than from expert AoD knowledge (25). These Aboriginal men may be as much encouraged by the confidence that comes from such experience as they are by a facilitator with expert knowledge. The other implication here is that facilitators do not necessarily need expert knowledge on Aboriginal disadvantage and cultural considerations, so long as they are willing to learn while on the job. While mainstream training programs may cover Aboriginal related topics, it may be worthwhile for people working in prisons to undertake specific cultural training, if they do not already do so. Such training could be offered to all new staff and form part of an orientation package.

6.4.5 In-group Peer-support

Strong peer-support and having shared experiences of similar life events with others in AoD treatment was tremendously beneficial for the Aboriginal men. The peer-support identified in the analysis of the Aboriginal data was quite similar to the findings in Chapter Five for the whole group of 31 participants. However, the shared experience of similar life events was unique to the data from the Aboriginal men. It was clear there existed a certain credibility and trust between Aboriginal men which meant that they were more willing to discuss personal problems associated with AoD use and how they could address these problems.

Several Aboriginal men indicated that being with the ‘brothers’ (Aboriginal men) meant they were more willing to discuss and talk about their AoD use and related family issues. It is clear from the data that trust is a critical issue within the prison and all 14 Aboriginal men spoke of an inherent trust between the ‘brothers’. The mutual respect and bond of trust between Aboriginal men was immediately given without question. This trust could be

developed between Aboriginal and the non-Aboriginal men, however, when there was time to get to know each other.

6.4.6 Confidentiality

Confidentiality was a concern for the Aboriginal men, as was also reported as a concern for all the men in the study. Prisons have elsewhere been described as violent, punitive places that are not conducive to health or wellbeing (148, 149). Within this context, it is likely that inmates are reluctant to divulge personal information that could be used by other inmates against them. As previously mentioned, for therapeutic groups to work well there need to be some group rules in place (25), and it could be that the Aboriginal men already have agreed upon group rules and norms of expected behaviour. The Aboriginal interviewees generally found it easier in group sessions to discuss their AoD use, and related family and social issues with other Aboriginal men, unless they knew and trusted the non-Aboriginal man/men in the group.

6.5 Conclusion

This chapter has focused on the history of alcohol and/or other drug use of the Aboriginal participants in the study, and on how this has contributed to their offending and contact with the justice system. This has, in turn, drawn out specific issues that could be used in the development and delivery of prison-based AoD treatment programs to optimise their benefit for Aboriginal men.

The highest order concern for the Aboriginal men was who the other inmates in the AoD treatment programs were. For programs where the inmates do not have enough time to form interpersonal relationships it is advantageous to have an Aboriginal-only group; for longer programs where interpersonal relationship can be formed this is not necessary.
Facilitators should be 35 years or older, as 53.7% of the male prison population is under that age (7). The experience of the men suggests there should be a gender balance, and it is desirable for facilitators to have some personal experience with AoD problems in their family. Being Aboriginal is also desirable but not essential. What was felt to be essential was well-qualified, knowledgeable facilitators who had empathy with, and understanding of, the social circumstances that exist for Aboriginal people in Australia.

It is critically important to further develop prison-based AoD treatment programs. If improved AoD treatment is then to contribute to a reduction in Aboriginal imprisonment rates, the cycle of imprisonment and AoD use also needs to be better understood. The following chapter

reports on alcohol and other drug use in the cycle of Aboriginal re-imprisonment, and identifies ways in which this cycle can potentially be interrupted.

Chapter Seven: Alcohol and Drug use in the Cycle of Aboriginal re-Imprisonment

7.1 Introduction and Aims

During the data analysis and writing of the previous chapter, new themes and theories were developed that related not only to prison-based AoD treatment but to the cycle of AoD use and imprisonment of the Aboriginal men. This chapter will examine several new themes related to the cycle of AoD use, imprisonment, and clinical AoD services. It will outline how this cycle was occurring for the Aboriginal men and present some ideas for how this cycle may potentially be interrupted.

7.2 Methods

The methods are reported in detail in Chapter Four but, in brief, this chapter uses the grounded theory method as described by Strauss and Corbin (53). The data from all 31 interviews were analysed together using the NVivo software package and the results are reported in Chapter Five. A copy of the main data file, with all 31 interviews, was created and then the interview data from the 17 non-Aboriginal men were removed. The data from the 14 Aboriginal participants were re-analysed. Through a process of constant comparison and reviewing, the Aboriginal specific results and theory, as reported below, were developed.

7.3 Results

7.3.1 Alcohol and other Drug Withdrawal Services

The Criminal Justice System appeared to be the default clinical AoD treatment service provider for these 14 Aboriginal men. Nine of the men described AoD withdrawal experiences, with seven describing withdrawing from heroin (Carl, Gary, Neil, Ian, Ryan, Tom and Jim), one from alcohol and cannabis (Jess), and one from alcohol (Ray). Most of the Aboriginal men had at some stage used the amphetamine known colloquially as 'ice', but none of the men described withdrawal problems from that drug; however, several said they had used cannabis and to a lesser extent alcohol when coming down from amphetamine.

Community-based AoD withdrawal had been attended by some men but without any clinical support they had not succeeded. Jim described how difficult it is to withdraw from heroin and that he had to continue using heroin, even if at lower levels:

> *Jim:* *Yeah, but, like I said, with heroin, heroin is, is, is a terrible illness once you're withdrawing from heroin. So, I always kept it to a minimum. ... Low as possible, as I possibly could, ... 'cause I wasn't one for that sickness. ... But it still didn't stop me from using it. You know what I mean?*

Withdrawal was clearly extremely difficult. While none of the Aboriginal men said they were happy about entering prison, there did appear to be a shared sense of relief that imprisonment provided a space where they were able to withdraw from AoD use. This *'time out'* sentiment was expressed as follows by Ray:

> *Ray: That's the time that I tried quitting and it didn't work. ... The best thing that's probably ever happened for me is I come to gaol. ... Now I don't need it.*

Only one of the men, Ian, mentioned an attempt to be admitted into a medically supervised detoxification (detox) unit. However, he was not able to be admitted:

> *Ian: Well I was waiting to go there. ... My brother rang up there and got me accepted but I had to go to detox, which it was over the Christmas, New Year's period. ... End of 2012. You know what I mean? December. ... Which they wouldn't accept me. I had to go to detox and, because it was the holiday period, they wasn't gonna do nothing 'til the start of January. Well ... I got done .... I started doing crime. ... I got done for a break and enter.*

Ian described continuing to use heroin until he was arrested, and then withdrawing from heroin use with medical support while being held in custody.

7.3.2 Pharmacotherapy

Six of the 14 men were waiting to commence the opioid substitution treatment, methadone, and one was on methadone. Justice Health was the only treatment initiation service any of these men had ever accessed. Three – Gary, Ian, and Neil - had been on methadone previously, and three – Ryan, Mark, and Jim - were about to start for the first time. Carl, who was already on methadone, was on the medication for the first time. All seven men had received information about methadone in prison, predominantly through Justice Health, and felt confident in their knowledge base.

The three men, who had been on methadone when last released from prison, had been unable to maintain the routine of daily doses once back in the community. Neil did not elaborate on why this was so, but both Gary and Ian said they had had difficulty with travel to the dispensing pharmacy on a daily basis. As a result, all three men had missed doses and were terminated from their respective pharmacy-administered methadone programs. Shortly after termination from the methadone program, but not directly linked to the termination, the three men each had their parole revoked.

Ian explained that he had been paroled to a residential rehabilitation centre which had a nearby pharmacy, from which he obtained his methadone dose. However, his decision to instead visit and stay at his mother's home without prior approval was discovered and reported to his parole officer, who subsequently cancelled his parole. Gary had been paroled to live on an Aboriginal community with his mother - who Gary said later was his grandmother but that he referred to her as his mother because he had been in her care for so many years. Gary had to travel quite some distance daily for his methadone dose. The bus ran only twice a day, once in the morning and once in the evening. Gary explained:

Gary: I got out, went back home to [community] and I got kicked off it again for missing it.

MD: So, is that why you got kicked off? ... For missing? ... So -

Gary: There's no clinic out at home. I had to travel to get it, you know. ... It's just too much.

MD: How far did you have to travel?

Gary: About 80 Ks every day.

This was an unsustainable routine and extremely tough for Gary to continue performing every day, as it left him stranded in the next town for the whole day:

Gary: Like it was hard, you know, for me to go from home in [community] to [town] every day. You know, I had to get up early, f…ing walk around town to organise a ride over. It was just luck whether I got over there or not, you know, and I just got sick of it. "F… it, I can't keep doing this here!"

Despite the difficulty, Gary wanted to be on methadone again, as it relieved his need to have to support his drug use through crime. This was also the case for Ian and Neil.

Carl, the man who was already on methadone, was looking forward to being released from prison and not having to commit crime to support a drug habit. This was going to be a new experience for Carl:

Carl: That's right, yeah. ... 'Cause all I done is the last couple of times when I got out of gaol is put out of gaol, I met my old mates. Well they were going out stealing, supporting their habit. ... And now when I get out, I … You know what I mean? I don't have to go out and steal money for drugs. I'm, I'm on

methadone. So, what do I need to go and, ... you know, steal money for? You know what I mean? So ... I've already addressed my drug issue.

Carl's confidence is supported by the research, which reports that methadone has been proven to be an effective substitution for heroin use, meaning people using methadone do not have to commit offences to support heroin use (150, 151). Ryan, Mark, and Jim, the three men about to be on methadone for the first time, were also well aware of the benefits attested to by Carl, and these three men were looking forward to being on methadone. The overriding motivation for all seven men to be on methadone was to no longer have to go through a daily routine of securing drugs.

The only dissent from any of the men around the benefits of methadone came from Mark, who did not want to be on methadone long term. Mark's most commonly used drugs while in the community were cannabis and amphetamine, but during the interview he also disclosed he had been using non-prescribed buprenorphine regularly in prison and he now wanted to be on methadone. However, he wanted to cease and detox from methadone while still in prison, because he did not want to return to the community on methadone:

Mark: I'm not staying, I'm not gonna be like these methadone … far out mate, they're … nuh. [Yeah] It messes you up. You know what I mean? [Yeah]

MD: What's wrong with the methadone? It messes you up? Yeah.

Mark: It just like rots your teeth. It's just putrid. You know what I mean? And you see the blokes that are, every day they go and get their 'Done and they're just a mess. You know what I mean? Like they're all over the shop. [Yeah] There's no way I'm gonna get out looking like them.

Ed had been on naltrexone, which was the only other pharmacotherapy that was used for maintenance or substitution, and none of the other men had been on this medication. There was mention of buprenorphine being used for clinically supervised withdrawal, but it was only for short-term use. Ed had had a naltrexone implant to help stop his alcohol use. He had heard about this treatment through an Aboriginal men's group in the Sydney suburb of Redfern:

Ed: Used to go there and participate with the, with the Elders. ... And it was funny because they had a doctor come along and he, he had an idea with, they all spoke about it. They were talking about naltrexone ... ... as an implant in your stomach. ... They implant it and it stops you from using. Like you can

use. You can still use but it, if you take anything, you can't feel it because of the naltrexone.

Ed travelled to Melbourne with his father in-law for the implant. The implant appeared to have been effective in stopping Ed consuming alcohol, but he did not have a further implant once the effects of the first had worn off.

Ed, together with the Gary, Ian, and Neil, had all been on pharmacotherapy previously, Ryan, Mark, and Jim were about to commence, and Carl was the only man who was already on pharmacotherapy. All eight of these men were well aware of the benefits and all indicated in one way or another willingness to be on pharmacotherapy to help manage their AoD use problems.

7.3.3 Stigmatisation of Prison

To explore if the Aboriginal men relied upon prison-based AoD services, the data relating to how these men felt about being in prison was analysed. It is important to note in this section that within an Aboriginal context the word 'shame' or the term 'ashamed', in the experience of the researcher and Aboriginal supervisors, has a much deeper internal and emotional meaning than the word 'embarrassed'.

None of the Aboriginal men were happy about being in prison; however, there was apparently no social stigma about being in prison for 13 of the 14 Aboriginal men, who indicated they were not embarrassed, nor were they ashamed of being in prison, with there being a certain normality about the situation. Only one man, Ed, expressed a high level of embarrassment about his predicament, but only that he would be embarrassed if former work colleagues found out:

Ed: *I feel this, I feel ashamed, you know. Like all the people I know, all the good people I know I've worked with would think that, would think, they've never think about me being in gaol, you know. ... But I feel sort of ashamed as well, you know, being in gaol.*

The men seemed to have a level of apathy about their current situation, with some expressing a fatalistic view about their journey to prison, with three men (Carl, Ray, and Gary) being of the opinion they were always going to end up in prison. As Carl said, his family had warned him when young that he would end up in prison:

Carl: *Yeah, yeah. ... Like I knew. I knew when I was, from a young fella, that, I knew I was gonna go to gaol and gonna go to boys' homes, and … I just didn't listen to people. Didn't listen to Mum. Didn't listen to me uncles or nothing.*

The Aboriginal men spoke about being related to other inmates, their long-standing friendships with other inmates, and family connections to particular prisons. Two men spoke in detail about their father having been in prison. One explained how his father has 'low digits' on his prison personal identification number or 'master index number' known as a MIN, an assigned number given by CSNSW the first time an inmate enters prison and retained to identify the inmate for all subsequent sentences. A MIN number in 2016 was a sequence of six digits; Ryan was proud that his father had a sequence of five digits, which meant his farther had entered prison a long time ago. Current and former inmates with low digits apparently hold a position of respect and authority within prison culture. As explained by Ryan:

Ryan: You've got more respect for people in here, ... especially with people with low digits. You've got more respect for them 'cause they've done a lot of time.

MD: Low digits?

Ryan: Like I'm a five-one. Like a one-two. You know what I mean? ... That's my wing number. Five-one. ... But, yeah, people with low digits, you've got, you've gotta have respect for 'em. If you don't, other people will send ya. Different world in here.

MD: I didn't realise that with the wing numbers that the low digits .... goes, [Yeah] goes higher ....

Ryan: .... so you've got six digits all up. My dad's got ... a five digit. Yeah.

MD: He's got a five digit? So that, they add on another digit after … yeah.

Ryan: A long time ago. ...

MD: Was he, he still knows his digit?

Ryan: Yeah. He's got it tattooed on his neck. ...

Ryan had not had much contact with his father previously, but his father now visited him monthly. Ryan indicated that his father had a sense of pride that his son was an inmate at the prison he had been in, which indicated, at least for Ryan, that there was no social stigma about being in prison:

Ryan: Well he's the only one that's really supported me since I've been in here. ...

Everyone else, even my brothers and sisters, probably got about six visits off them since I've been in gaol. ... My dad he's come visit me pretty much every month, ... without fail. Everyone …

The other participant that spoke in detail about his father was Ed, the man concerned about former work colleagues finding out he was in prison. Ed had shared a cell with his father during his previous term in prison after applying to be transferred to be in the same prison. Ed described the day they were reunited with both parties overjoyed to spend time together, even though it was in prison. His father had served his sentence and had been released at the time of the interview with Ed. Ed himself had re-offended and returned to prison, which was how it came about he was interviewed for this research:

MD: ***So you've worked most of your life [Yeah] like when, when.***

Ed: *I was .... once I moved, 2000, as I was saying before, ... when I was at Bathurst, ... for the first offence, ... I rang my dad up. ... He rang me. ... Inter-gaol phone call and he called me. He said, "Why don't you come to John Morony? It's good here. You'll like it."*

MD: ***He was in prison at the time?***

Ed: *Yeah. He was here at the time. John Morony.*

MD: ***And he rang you, you in Bathurst? [Yeah] Yeah.***

Ed: *And my, one of my uncles was on his way here ... and he said, "Your father's at John Morony. Why don't you go to John Morony and spend some time with him?" So, and he rang me, and ... we had an inter-gaol phone call, and he spoke to me, and he said, "Why don't you .... and put a bluey in, ... a referral in, ... site referral, and ask them that you wanna move to another gaol?" ... And I did. ... I spoke to one of the bosses there ... at Bathurst and he, they made the change within two weeks. Transferred me to here.*

MD: ***And so your dad was here when you were here then?***

Ed: *My dad was here, yeah. ... I was the only one that got off the truck ... and he called out to me, and he goes, he says to me, "Ed", I go, "Who's that?" "It's me, your dad." "Oh, how are you going dad?" ... you know. He said, "Good mate. How was the trip?" "Yeah, good." He said, "I've got some groceries here for ya. I've got some bags for ya here." 'Cause he used to work in the canteen ... ... and he had bags full of food and all that for me. I was, I was ... excited. I was happy. ... I was looking forward to it. ... Got a one-out in A-wing. Got a one-out TV everything. ... I was all set. ... Only had 10*

months to go. Got out in 2000 and went to the knock-out[15], Aboriginal knock-out ... in ... Dubbo.

In summary, none of the Aboriginal men were happy to be in prison, but there was limited to no social stigma about being in prison. In fact, there appeared to be some benefits with stronger relationships being formed with male family members. If prison is only at best a mild deterrent, then warning these men that they will go to prison if they continue to use AoD is not going to work, and a different motivator is required. The default implication here is that AoD treatment once they are in prison is an added benefit for these men, particularly in relation to the clinical services available.

7.3.4 Release from Prison and Relapse back to AoD use

Two of the 14 men, Ray and Mark, were serving their first term in an adult prison. For the other 12 men, relapse back to AoD use upon release from prison is a part of their stories. At the time of interview, each of the men except Mark had attended some form of AoD treatment through the criminal justice system. On release, five men had used drugs within 24 hours, with several men saying they had had a drink of alcohol. While this is not an illegal activity, once drug and/or alcohol use recommenced there was a rapid progression in level of use.

The intended priority upon release from prison and the outcome of that priority remained true for all of the men, with the exception of Ed. Four men said they had intended to use drugs on the first day and that is what transpired, and eight said their priority when released was to spend time with their family, with seven of these men fulfilling that expectation. Neil explained his priority when released:

Neil: *First day I got released, drugs or anything like that we weren't, I didn't worry about it. I was happy to be out after so long. ... I was overwhelmed, you know, being back home with me family.*

Ryan, Gary, Rob, and Tom were the four men who indicated they were planning to use drugs as soon as they got released. Tom described his drug use as putting his old shoes straight back on:

[15] Knock-out is the name of the NSW Aboriginal Rugby League Tournament

Tom: Yeah, [Yeah] just got back in, put me old shoes straight back on, you know, and just went back to the old ways. [Yeah] And, yeah, come back to gaol again.

Tom clearly could see the outcome of his drug use was to be back in prison, and had no family restrictions on his drug use. This was not the case for Ryan:

Ryan: Straight back on the heroin.

MD: Straight back on? Was it like you got picked up by family and friends, and then got straight back on?

Ryan: Found the first available opportunity to sneak off [Yeah] every time. I hope, I, I need this time to be different.

Ryan said his family members did not themselves have AoD issues, and that he was the *'white sheep'* in the family.

Ed, the one man of the eight who did not want to use drugs on this first day but had done so, had had a transport issue en route to a residential rehabilitation service. Ed said that he had been granted parole from a regional prison to attend the rehabilitation service, with getting to the service his stated priority on that day. A relative who was to pick Ed up from a train station and take him to the rehabilitation service did not arrive. A taxi came past, and serendipitously the driver knew his extended family, and took Ed to his uncle's house, from where it was seemingly easy to find drugs to buy. Ed had money, having just been released, and said that he met a girl who he celebrated his release with. He asserts that he had not intended to use drugs nor to go to his relative's house, and that the following day his uncle, aunty, and other relatives tried to convince him to go to the 'rehab' but he did not want to leave his family:

Ed: I stayed at, I stayed at Nowra with my aunties and uncles. I stayed at my uncle's place. … And they wanted me. They, they, they were hustling me like this, "Go! Go! Go to rehab! You need to go," you know. ... I said, "I don't wanna go. I wanna stay here with my family," ... you know. And I was on the, I got on the drugs as well so ... it was hard. I couldn't do it. …
I wasn't planning it. No. … No, I wasn't planning it. I was on my way. I was, … I was waiting for a taxi to take me straight to Bomaderry ... but another taxi dropped someone off.

No doubt his family members were very glad to see Ed, and he felt the same way. The other factor was that he had been in prison, and while he was modest in his description of meeting the girl, it was clear that having sex was a high priority. Like Ed, Rob, who had planned to use drugs and had been paroled to a residential rehabilitation service, also met up with his girlfriend and absconded.

A strong commonality between the six men who relapsed was a rapid increase in quantity and frequency of AoD once they had recommenced use, with there seemingly being no way back after they had started using again. Neil said he had been doing well for three months until he went in to the city in Sydney one day and met a friend he used to use heroin with:

> *Neil: You know, I was just went out most weekends with the, with the boys and went clubbing, and, …. you know, I … And I was still staying at home. Everything was good and, yeah, I, then, then I slowly, you know, I went in the city one day and, yeah, I went in the city one day and bumped into a, an old friend [Yeah] in the city, yeah. And she had, she was a woman. Yeah, she had heroin. [Yep] And, and, you know, I, [Yeah] I took some back home, you know. I smoked it and, and even then it sorta, I didn't wake up the next day and think I'm gonna go and buy any or I want some. You know, it sort of weren't a problem, yeah, until I started frequenting the, the city more. I started going in there more and then each time I was in there I started, yeah. I, you know, I [You started, yep] … it was sort of the environment, yeah. I kept going back.*

Unlike Neil, who did not relapse until three months after release, most of the men had used within two to four weeks of release. Another thing these 11 men had in common was that none of them spoke about any constructive and/or work-related activities post-release. Once they began AoD use, failure to report to parole officers leading to parole revocation followed. At least five of the 12 men who had been previously released from prison spoke about committing new offences while on release.

7.3.5 Activities other than AoD use

There were indications that AoD use occurred after release from prison because there were limited activities available other than AoD use. When considering this issue, it was clear that a lack of direction was a long-standing one for all 14 Aboriginal men, including Toby. None of the men had a substantial work history, with ongoing employment having been hampered by drug use. The men who had worked at some stage had worked predominantly in labouring

type roles, although two of the men had held positions in government departments and they regretted losing their respective jobs. The men that had worked really saw and enjoyed the benefits; Neil, for example, talked about having enjoyed working in a government department:

> *Neil: I was doing, I was a field officer in the National Parks and Wildlife Service. … And [Be a good job] yeah, it was the, the, the best job ever and I think at, you know, in some sense, like it was at the worst possible time, … you know, I got that job. I tried to maintain it. I tried to, you know, go to work. … I did go to work, but I found myself, you know, going to work and then, you know, still doing crime to, [Yeah] to pay for the drug habit, yeah.*

An early symptom of the looming unemployment as an adult was perhaps the poor school attendance and low educational attainment level of the men. Twelve of the 14 men had attended high school, but none had completed year 12, with the other two of the 14 men having only attended primary school. Two of the 12 men who went to high school passed year 10 before leaving school in year 11. Five of the men were expelled before completion of year 10, with one other suspended and not returning to school after that event. Three men said they had mainly attended high school in juvenile detention and one other said he dropped out of high school because he did not like going. Ed was one of the men who had been doing reasonably well in high school until he left to start work:

> *Ed: At Shoalhaven High School I was going to. ... And I completed Year 10 then I went through Year 11. Half-way through Year 11 I got meself a job working with my uncle at a Removalists.*
>
> ***MD: And then you left school then to, [Then I left] to work at -***
>
> *Ed: Then I left school then to work with him, yeah. ... Not for long.*

None of the men were socially integrated into their high school, with there being no expression of fondness towards the school or the teachers of the academic subjects, and no particular academic subjects of interest. There was no other engagement with the exception of with sport. There was some engagement with teachers in the physical education classes, which is perhaps not surprising as most of these men said they had been good athletes. Racial bullying which resulted in fighting and either suspension or expulsion was a strong theme of the men's experiences of high school. While the Aboriginal student was expelled or suspended for these incidents, it appeared there was no action taken against the non-

Aboriginal students involved. Ian had alluded to racism in high school, but it wasn't until he was directly asked that he said the following:

> ***MD: Did you, did you find racism an issue at school?***
>
> *Ian: Yeah. It was a big issue. ... That was pretty much, I got suspended, expelled. I punched-on with, I threw, threw a chair at a teacher ... because, at the end of the day, I got jumped by a couple of Islander blokes ... and I stabbed one of them in the face with a pencil. ... And I was defending myself. ... Five of them bum-rushed me, ... which pretty much attacked me...*

The men did not have future career goals while in high-school, and the only life goal that was commonly articulated was to play rugby league football, the primary 'brand' of football played in New South Wales. As described by Jim:

> *Jim: There was a lot going on in me head. I can't, ... I can't really pinpoint it. I, I … I s'pose I, I just felt, I felt different. Like I, I didn't think I could, I didn't think I was the type that would hold down a job or something. I could never find anything in my head that I wanted to do as I got older but play football. ... You know, no profession or going to uni, anything like that. It was, my mind was always scattered like that. Everyone could, ... everyone had a dream to be someone but I didn't; I only just had football and, ... and, when I ruined that, I was probably, I was really confused and, you know, my mind was pretty scattered by then ...*

For Ian, increased alcohol or drug use coincided with leaving school, with a rapid progression from regular use of cannabis and or alcohol to heavy daily use, and the commencement of heroin and amphetamine use as part of the progression.

An absence of career goals, with low educational attainment and being socially isolated, as well as living in areas where AoD use was common, were a bad combination for the men when young. As adults, they continued to have limited constructive activities, to be unengaged socially and to use AoD, leading to them becoming involved in the criminal justice system.

7.3.6 Accommodation post-prison

Only the three Aboriginal men who were paroled to a residential rehabilitation service - Ed, Rob, and Ian - were not returning to their pre-prison environment upon release. The majority

when released returned to the same or a similar situation from that they had been in prior to being in prison. This was the case for Jess:

> *Jess: I got out, moved up with Mum to Grafton. Me and her had a bit of an argument so I went to a mate's house. Had a bit of a yarn. He was drinking and that, so I started drinking with him. … Ended up getting in a bit of a state. Went to a party. … He wanted to go get pot and that, so I thought, "Well fuck it, I may as well come for a drive. I'm not going home to put up with Mum's shit." Went out there and, yeah …*

There is no doubt that returning to the same environment was problematic for these men. None of the men said they had been directly pressured into AoD use, but some felt besieged by the surrounding AoD use, as well as with other social dysfunction including interpersonal violence. The majority of the men had intended not to use AoD when last released from prison, but did eventually relapse into use.

7.4 Discussion

7.4.1 Alcohol and other Drug Withdrawal Services

By the time they entered upon this term in prison, several men had reached crisis point with their drug use and had attempted drug withdrawal unsuccessfully in the community. At least one of the men, Ian, spoke about having tried to attend a detoxification service but being unable to be admitted because there was no intake at that time of the year. Eventually, for Ian and others, the AoD use circuit-breaker was being taken into custody. These difficulties post-prison are not necessarily unique to these men, as Adams et al. (2011) Binswanger et al (2011) and Binswanger et al. (2012)(152-154) all reported similar issues. These studies from the United States showed that people leaving prison had difficulty connecting with services and this had a detrimental effect on their further prospects, with them likely to return to prison.

It would be helpful for future research to be undertaken to investigate whether Aboriginal people entering prison who had engaged in daily or almost daily AoD use had attempted to access a detoxification service in the community. If men involved in the criminal justice system who have reached a crisis point in their AoD use are unable to access health services for help, then ways in which this issue can be overcome need to be developed. To provide such services would be of benefit for the individual and for the community, since the

longer these men continue to be using AoD at levels they themselves want to reduce, the longer they could be committing offences to support their AoD use.

7.4.2 Pharmacotherapy

At the time of the interviews, two of the men had previously been on methadone, and six others were being worked up to shortly commence on this pharmacotherapy. Methadone has been shown to be effective and is a critically important tool in addressing heroin dependency for people. It is also effective in reducing the economic impact of drug dependency by alleviating the perceived or real need to commit offences to support drug use (150, 151, 155). While there has been extensive research in the methadone field, it appears the research into methadone use by Aboriginal people is somewhat limited. Some of the challenges the men in this research faced are similar to those described in mainstream research (156-158). However, further specific research in this area could outline the extent of treatment compliance problems for Aboriginal people being released from prison, and how these could be overcome or at least minimised. One aspect for examination within this research would be the difficulty of complying to single-dose methadone regimes whereby the dose must be picked up every day, in some cases from locations at an unworkable distance away.

7.4.3 Attitudes towards Prison

Social isolation in the community began for these men at a young age. In prison, however, social isolation and discrimination against Aboriginal people is not a problem as they make up a quarter of the prison population. The men were not happy to be in prison, but it was not a stigmatising event for these Aboriginal men. There was also a nostalgia for two men when they spoke of their respective fathers having been in prison, and others were happy to catch-up with old friends they had known. This indicates that prison may not be an effective deterrent for Aboriginal men, particularly where there are seen to be benefits to being prison.

7.4.4 Released from prison and relapse back to AoD use

While to use drugs was the intention of four of the men the moment they were released, most had no such intention. For eight of the men, the stated priority was to spend time with their family. One of these eight recommenced AoD use on the day of release, but for the others it was anytime between two weeks and up to three months later. Once drug use had commenced the progression to daily or almost daily use was rapid.

Post-release support is critical for a successful community reintegration, and programs are used to help reduce AoD use and the likelihood of return to prison (39, 44, 45). Though the

evidence on reducing AoD use is not conclusive, there is evidence that such programs do reduce re-offending (39, 45, 105). It would be beneficial to provide the family also with support and information about AoD use. This approach is termed a whole-of-family approach, and it has been argued that it is the way in which AoD treatment should be provided to Aboriginal people (6, 132, 140). This whole-of-family concept is not new – and these issues of difficulties in addressing addiction can, of course, also be seen in other cultures, albeit in different contexts - and it has been theorised in the past that treating addiction in this way may be more beneficial (159). It appears that there has been limited published peer-reviewed research into whole-of-family support programs upon release from prison of a family member, and further work that identifies how best this can be done would be extremely useful.

7.4.6 Activities other than AoD use

When released these men had few activities, if any, other than reporting to their parole officer. A lack of constructive activities was a longstanding issue. Most of these men, once they were expelled from or voluntarily left high school, progressed with their AoD use to dependency levels quickly. It would have been advantageous for these men to have remained in school for a number of reasons, including to delay the progression of AoD use and to improve the prospects of employment later in life. Importantly, higher levels of education reduce the likelihood of imprisonment. This supports the need for early intervention to support young Aboriginal people who have difficulty in school.

The only career/employment option the men had considered in life was to play professional football, namely rugby league. None of the men made it to the elite level of rugby league, and the men who had been employed had been in work sporadically in mainly labouring roles for short periods of time because of the unmanageability of their drug use. The dream of becoming a professional football player is an enduring one many young Aboriginal men aspire to, but during their younger years there is also a need for role models that have careers that are more realistic and attainable. It is of note to mention here that when asked about career or study plans, the participants asked the researcher for guidance on university entry.

7.4.7 Social determinants of health

There are external influences that have shaped the lives of these men, and consequently had an impact on their AoD use, from the moment they were born. The social determinants of health as first described by Marmot et al. (1991) indicate that the health outcomes for these men were not likely to be good (160). None of the men completed high school and it

appeared that, to a large extent, other than on the sports oval, they were socially excluded and/or experienced racism at school. The health outcomes of people who experience social exclusion and have lower educational levels are diminished in comparison to those with a good education and social acceptance (161).

Most of the men in this study, in common with many other Aboriginal men, are excluded from the mainstream economy. While they may conceptualise this as not being able to get a job because of their criminal record, the pattern of high unemployment among Aboriginal men more generally is undeniable and is consistent with economic exclusion (26, 57). Furthermore, while Aboriginal people are entering politics, they still have limited political power in Australia, which was best evidenced by the rejection of the Statement from the Heart by the Coalition Government in 2017. The Statement from the Heart arose out of a lengthy consultation process with Aboriginal and Torres Strait Islander people across Australia and is a consensus statement, which is in itself ground-breaking. The Statement specifically mentions incarceration:

> *Proportionally, we are the most incarcerated people on the planet. We are not an innately criminal people. Our children are alienated from their families at unprecedented rates. This cannot be because we have no love for them. And our youth languish in detention in obscene numbers. They should be our hope for the future* (appendix 9).

7.5 Conclusion

Twelve of the 14 men included in the interviews had been in prison previously. Nine of these men returned back to their families on release and, as such, into the same environment they were in before they went to prison. The potential for a whole-of-family intervention has been proposed in AoD treatment research (132, 140), and future AoD treatment programs should consider including, and evaluating the impact of, such an intervention as part of a release plan for these men. This type of approach would ideally focus on assisting the whole family to recognise and address their AoD related issues, and link the family into support services. This chapter also identified the likely benefit of engaging individuals leaving prison in structured, daily activities if they are not in employment. Although this concept is unlikely to be a new proposition, how it might be systematically integrated into post-release programs is unknown. At a minimum, if Aboriginal men are not engaging in post-prison activities, the reason for this should be identified and potential strategies considered.

Three of the men were transferred directly into residential rehabilitation services from prison. Where this does not already happen, such transfers should take into consideration the need for these young men to spend time with their family. The other matter for consideration, and one which does not appear to have been researched previously, is the possibility of allowing some flexibility for these young men to relax in the community and to spend time with an intimate partner. This appeared to be an issue for two of the three men who were to be transferred directly to residential rehabilitation services from prison prior to their release back into the community.

The men had limited role models, low education levels, and unrealistic or non-existent career plans. It is not difficult then to understand how they began a journey to AoD use and criminal offending, culminating in being imprisoned. It seems that a more engaging school environment, coupled with a more accepting and active social environment, including having local role models other than sports stars, may be a good start to begin to steer future generations of young Aboriginal men away from the criminal justice system.

In conclusion, it is clear that returning to the same social circumstances post-prison, with limited or no support either for themselves or for family members, provides little opportunity to break out of established patterns of behaviour, or the cycle of AoD use, offending, and repeated imprisonment.

Chapter Eight: Discussion and Conclusions

8.1 Introduction

This mixed-methods thesis, titled 'Prison-based alcohol and other drug use treatment for Aboriginal and non-Aboriginal men', researched AoD treatment for men in prison in NSW. The work was undertaken because there had been limited previous research into prison-based AoD treatment in Australia. It is hoped that the findings from this research will inform the further development of AoD treatment for men in prison in the future. Improved AoD treatment has the potential to result in reduced AoD use by men leaving prison, with a consequent possible reduction in the likelihood of these men reoffending and returning to prison. Reduced AoD use by these men would also likely benefit their families, their neighbourhoods, and the broader community.

The work was inclusive of both Aboriginal and non-Aboriginal men, but had a particular focus on Aboriginal men because of the vast over-representation of this group in Australian prisons. Aboriginal people were imprisoned at a rate of 2,038.6 per 100,000 compared to 162.8 per 100,000 population for other Australians in 2016 (7). The Aboriginal focus was also because the researcher is Aboriginal, and as such had a personal interest in seeing Aboriginal imprisonment reduced.

The use of mixed methods enabled both an understanding of the breadth of the research subject and an in-depth understanding of the details of the subject from people who had direct lived experience of prison-based AoD treatment. The detailed understanding which has been developed in this thesis would not have occurred had only one method been utilised. The use of quantitative methods alone would have meant that only predetermined questions would be asked, resulting in limiting responses from those interviewed about how AoD treatment in prison can be further developed. For example, a question could have been asked about whether Aboriginal-only treatment would be a good idea, but the intricacies about why this might be a good idea would not be drawn out or explored in any detail. On the other hand, the qualitative work alone would not have shown the scale of hazardous AoD use by people in the population, since this is something that needs a population-wide perspective. The use of both methods and the exploration of the relationship between them was necessary to capture different aspects of AoD treatment for men in prison.

In this final chapter a summary overview of how the research question was addressed is presented. The core findings for each of the chapters are brought together and recommendations are made for how prison-based AoD treatment for men can be further developed. Major policy implications and future research directions have been identified, as

well as the strengths and limitations of the work. The thesis concludes with a recommended AoD treatment model for Australian prisons.

8.2 Overview: Answering the Research Questions

Chapter One outlined the background, the significance of this work and the research question. There were three interrelated research questions:

1) What is the international evidence for the effectiveness of prison-based alcohol and other drug treatment for men?
2) What is the level of need for such treatment programs in New South Wales?
3) How can prison-based AoD treatment for men be further developed, and how can it be further developed specifically to meet the needs of Aboriginal men in prison?

These research questions were answered in Chapters Two to Seven, and a brief summary of each is presented below.

The systematic review in Chapter Two answered the first research question. To this end, the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) method was used in conjunction with the Dictionary for the Effective Public Health Practice Project Quality Assessment Tool for Quantitative Studies (QATQS, Appendix 5 & 6)(49, 50, 90) to assess and rate the methodological strength of the included papers. In total 13,047 records/references were retrieved from the initial search of the Australian and international databases. After an extensive process of selection, there were 25 papers published in a peer-reviewed journal between 1995 and 2015 that met criteria for inclusion.

The majority of papers, (n=15), were from the United States. Twelve of the 25 papers were assessed as being methodologically sound, with nine of those papers published between 2006 and 2015. This chapter concluded that, while the evidence is not strong, prison-based therapeutic communities with post-release care are the most likely to reduce AoD use post-prison. The chapter was submitted for publication to a peer-reviewed journal in February 2018.

The paucity of methodologically sound research and the need for further research into prison-based AoD treatment was clearly illustrated by the findings of the systematic review undertaken in Chapter Two. Additionally, the review identified just two research papers that met criteria for inclusion that reported the outcomes of AoD treatment specifically for Indigenous peoples (27, 84). This is despite the over-representation of Indigenous peoples in prison populations around the world (96). Neither of these papers were rated as being

methodologically sound, and neither reported statistically significant results that indicated a reduction in AoD use post-prison. This evidence of limited research in this field, within Australia and internationally, confirmed the need for an Aboriginal (Indigenous) focus in this work.

Chapter Three answered the second research question, *'What is the level of need for such treatment programs in New South Wales?'*. Quantitative methods were used to analyse a data set of 200 men (n=40 Aboriginal) entering prison in NSW. Results indicated that 79% of men in the sample required some form of alcohol, drug or combined alcohol and drug treatment. The chapter concluded there were similar needs for AoD treatment for both Aboriginal and non-Aboriginal men. The major difference was that significantly more Aboriginal men had used cannabis daily than had non-Aboriginal men, and as such a focus on cannabis use may be useful for AoD treatment for Aboriginal men. This chapter was published as a paper in the *Health & Justice* journal in 2015 (Appendix 4).

Chapters Four and Five answered the first part of the third research question: *'How can prison-based AoD treatment for men be further developed?'* To this end, a qualitative grounded theory study was conducted in which 31 men in prison voluntarily participated, out of which a theory of how to improve the delivery of AoD treatment was developed. A key finding from this study was the desirability of co-facilitation of treatment sessions involving both a facilitator with personal experience in recovery from AoD dependency, and one with professional qualifications such as a psychology degree. This finding is elaborated on below. Further major findings from these chapters are incorporated with findings from Chapters Two, Three, Six and Seven, and reported in section 8.4 below.

Chapters Six and Seven answered the second part of the third research question, *'How can it [prison-based AoD treatment] be further developed specifically to meet the needs of Aboriginal men in prison'*. For this purpose, an analysis of the interview data from the 14 Aboriginal men who participated in the qualitative grounded theory study was conducted.

A model of how to improve AoD treatment for Aboriginal men was developed in Chapter Six. Trust of other inmates in a treatment program was found to be critical for a productive group treatment program. For example, while Aboriginal men in prison immediately trusted each other, even if they had not met previously, they needed time to get to know and feel comfortable with non-Aboriginal men in order to build trust. As such, treatment programs that run within a short timeframe are likely to be more productive with an Aboriginal-only group.

The cycle of AoD use and imprisonment for Aboriginal men was explored in Chapter Seven. A key finding was that men leaving prison to attend a residential facility should have a family visit built into their transfer plan, between exit from prison and entry into the residential facility. Only a small number of the men interviewed had been through the process of transfer, but most of these discussed wanting to spend time with family and with an intimate partner, citing the need to have this time as part of the reason they had absconded. This and other findings from Chapters Six and Seven, are incorporated with findings from Chapters Two, Three, Four and Five and are reported later in this chapter under section Chapter 8.4.

8.3 Strengths and limitations

As with all research, this work has strengths and limitations. The major overall limitation is that the primary data collection was undertaken at one site located in Western Sydney and, as such, generalisability across NSW and Australia may be limited. In addition, there could be recall bias as some of the 31 participants were recalling events that had taken place several years previously (162). A major strength was that the qualitative method for primary data collection allowed for a detailed understanding of the participants' previous experiences of AoD treatment (52, 65). This meant that complex and sensitive issues were discussed in depth and that the researcher could ask participants to elaborate further on issues of particular interest.

The researcher being Aboriginal was also a strength as the Aboriginal participants may have felt more comfortable in discussing sensitive personal and social issues such as racial discrimination (163). Nevertheless, the Aboriginality of the researcher could also be a limitation in the sense that the non-Aboriginal participants may have modified their responses so as to be less critical of Aboriginal people (163).

The systematic review in Chapter Two, is limited by the inclusion and exclusion criteria for the papers (as described in section 2.2.2). The focus of the review was to investigate what programs work best for addressing AoD use for men in prison. Excluded were papers that reported on; 1) previously published data; 2) pharmacotherapy-based substance abuse treatment; 3) mental health and substance abuse comorbidity treatments; 4) women-only studies, and 5) grey literature. This limits the broader applicability of the systematic review and focuses results on prison-based behavioural AoD treatment for men.

There were several limitations of Chapter Three, which reported AoD use of men entering prison. There was limited statistical power as the sample had n=200 participants with n=40

being Aboriginal. Data collection occurred some time ago (between September 2003 and June 2004) and AoD use patterns may have changed since that time. Similar to a limitation of the primary data collection, the data for this chapter are from a single site and may not reflect the AoD use of men entering prison in different regions of NSW or Australia.

The expert knowledge of the supervisory team and the project reference group were strength of this research. Members of the team are leading Australian experts in research on alcohol and other drug use, the health of people in the prison population, and the health of Aboriginal Australians more broadly. The reference group was comprised of Aboriginal and non-Aboriginal people from a diversity of organisations and provided valuable and practical input during the project. Finally, a further strength was that the data were analysed and reported on with an Aboriginal lens. This was important because the interpretation of research results from interviews with minority groups can be a challenge, but having an Aboriginal person conducting the research and having two Aboriginal supervisors meant this was a majority Aboriginal research project. This was a strength that enhanced the understanding of some underlying issues, such as racial discrimination, socioeconomic status, and background of poor health in the Aboriginal community, which affect almost all Aboriginal people (163).

8.4 Prison-based Alcohol and other Drug use Treatment for Aboriginal and non-Aboriginal Men.

Under the principle of equivalence of care, governments are obligated to provide health services in prison, and these should be equivalent to those that could be accessed within the general community. Almost all the men in this research indicated that AoD use was involved in their offence. It is therefore reasonable to infer that if AoD use were reduced or ceased, then the likelihood of reoffending and return to prison would decrease. Within this context, it is important that the best possible AoD treatment be available for those within the prison system.

Prison-based therapeutic community (TC) treatment programs that lasted nine months or longer, and that had a post-prison care component, were determined to be the mostly likely to reduce AoD use post-release. The evidence for this finding about TC is presented in Chapter Two, and the finding aligns well with those arising from Chapters Five and Six. Participants in this study indicated that being housed in the same wing together had numerous benefits. One such benefit was in being able to focus on the AoD treatment program and limiting other distractions. Specifically, being in the same wing together meant

being with other inmates who did not want to use or were aiming to stop using drugs while in prison. As such it was a more supportive environment than would otherwise be the case. Critically, being housed together helped build trust between treatment participants which flowed into the group treatment sessions, making them more productive for all group members.

Stand-alone post-release residential programs are also vitally important as they have the potential to yield benefits almost equal to the prison-based TC (75). A major advantage of a residential post-release program is that it can alleviate accommodation problems and place the person in a supportive environment. For the Aboriginal men in particular, it was apparent that most of their families had AoD use issues and that being returned to the same environment had previously resulted in a return to AoD use. The families that have AoD use problems might also benefit from being engaged in AoD treatment, and it would be ideal if the men and their family could enter a residential treatment program, or some form of structured treatment, together. This is a whole of family approach and is consistent with the broader Aboriginal AoD treatment literature (6, 132, 140).

Interviews with the Aboriginal men indicated that the transition for this group from prison to a post-release residential care programs was critical important. As already mentioned, the transition could be hampered by a desire to spend time with their family upon release. If not already in place, future release planning should incorporate time with family when they arrive at the residential treatment program. Consideration may also need to be given to allowing the men to have time in private with an intimate partner, though further research is needed before this could be reported as a finding. Additionally, it is important for all the men being released from prison, whether to a residential program or not, that supportive and constructive activities are available and accessible, as this may also help to reduce the likelihood of AoD use.

8.4.1 Supportive In-Group Relationships

The establishment of supportive in-group relationships within prison-based treatment groups is essential (131). Trust between participants in a group is crucial and the men in this research said it is developed when all treatment participants fully engage in the group discussion. The evidence of engaging fully is when one shares their personal story of addiction and related matters when in-group. The men felt a connection as a peer as they talked about their common troubles with AoD use, and it possible they found this a source of encouragement as they would also have spoken about how to overcome these challenges.

This process would also have allowed the men to find commonalities other than AoD and may have helped in forming friendships which would have been extremely beneficial.
It seems reasonable that participants who are in-group and are not fully engaging could be removed from the group until they are ready to fully engage. This is because the presence of an individual who is not participating fully could inhibit the therapeutic progress of the entire group, given other group members may then also become reluctant to share their stories fully and to engage in the group discussion/s.

8.4.2 Program Content

For an AoD treatment program to be effective, the participants need to be able to see the practical benefits within the program content. An example of a practical benefit was understanding their own triggers for AoD use, while another was working-out how much money they would spend on AoD use and what that money could be spent on instead. Being provided with learning resources to take back to the cell after group sessions was regarded as extremely useful and the provision of such material should continue. The learning material helped the men to reflect on previous behaviour and on how to change their behaviour/s in the future.

Another finding was that inmates placed into the wrong AoD treatment (that is, focused on something other than their drug of choice) and who could not see the practical benefits of the program may become resentful. It is possible that inmates in the wrong program could become withdrawn in-group, which would inhibit the therapeutic progress of the entire group. As such, every effort should be made to ensure placement into the appropriate program to best meet individual need.

Several of the men interviewed talked of relationship difficulties and of issues around family and intimate partner violence. The implication from many of the men was that the stress of these issues created fertile ground for AoD use and other undesirable behaviours. These topics are generally covered within group discussions as part of AoD treatment programs in prisons and ought to continue to be included.

There were a number of men who reported experiences of racial discrimination, not just for the Aboriginal men but for all those with dark skin pigmentation. Given this, it seems likely that the subject of racism would have arisen in prison-based AoD treatment programs, and it would be worthwhile to undertake research to understand if such a topic needs to be formally covered in the learnings. If men leaving prison were better equipped with how to

deal with racism when they encountered it, it may help them to better navigate day-to-day life in Australia.

8.4.3 Program Facilitation

Prison-based AoD programs are generally co-facilitated by staff who are qualified psychologists or similar professionals. A finding from this research is that the most effective way to deliver prison-based programs would be through co-facilitation, with one of the two staff having personal experience with recovery from AoD use. Preferably there should also be a gender balance, with a male and a female facilitator, and one or both facilitators the same age or older than the men in the group, as younger facilitators are not afforded the same level of credibility.

Program facilitators with personal experience in recovery from AoD use are peer-educators and have a high level of credibility with inmates. A major advantage a peer-educator has is that they can explain facts and concepts in ways and in language that can be more easily understood by the intended recipients. A peer-educator can also become a role model for how AoD use can be overcome. Seeing the educator can give hope to the inmates that they can make the necessary life changes themselves. Professional training is, however, also tremendously important as the inmates in AoD treatment programs need to have confidence in a facilitator's ability. Participants in this research appreciated program facilitators who had extensive technical knowledge and could answer any questions and help them to understand the psychological and physiological aspects of addiction.

In summary, co-facilitation should continue, but in order to maximise the impact of a program one facilitator could be a peer-educator, and at least one facilitator should have professional training in AoD. Wherever possible, there should also be a gender balance, and facilitators should the same age or older than most of the group participants.

8.4.4 Aboriginal-Specific Programs

A finding of this research is that there is an inherent trust between Aboriginal men in prison; this trust is immediately given even if they do not know the other Aboriginal man directly. For Aboriginal men, short-term programs that do not allow enough time for the development of trust between participants would be most effectively delivered in an Aboriginal-only group. Programs that last for longer would not need to be restricted in this same way, as program participants have the time to develop trust. Having both Aboriginal and non-Aboriginal men in groups within such longer-term programs is beneficial for Aboriginal men, as they have the

opportunity to hear that men from different backgrounds also have AoD use problems, and that Aboriginal people are not the only ones in Australia to have such problems.

The program facilitator in an Aboriginal-only group does not have to be Aboriginal, though that would be an advantage. The main attribute required for working with Aboriginal men is to be empathic and understanding of the socioeconomic and social problems faced by Aboriginal people, with a good general knowledge of AoD issues. An essential skill that was a finding only from the Aboriginal-specific data was that the facilitator needed to have a sense of humour and for the session to be light-hearted when possible.

Finally, it is clear from this research that being arrested and taken into custody can create an opportunity for Aboriginal men to access clinically supervised withdrawal services. That being so, program content in an Aboriginal group should include, if it does not already do so, information about AoD withdrawal and how and where to access AoD withdrawal health services in the community.

8.4.5 Pharmacotherapy for Aboriginal men

Seven of the Aboriginal men discussed the use of methadone as a pharmacotherapy for addiction. One of the men was on methadone at the time of interview, and six were eagerly waiting to commence, with three of the six previously having been on methadone. The men had all been provided with the relevant information about methadone, the benefits of which are well documented (150). There were issues with dose compliance for the three men who had previously been on methadone and it is likely that, while the treatment is effective, issues around compliance could be problematic in the future. Daily dosing, for example, represents a possible interruption to daily life, posing challenges for holding a fulltime job, and transport can be difficult for people who can not afford the costs and/or do not have family members who can assist. One of the men spoke of problems around access to reliable transport to travel a considerable distance each day to the pharmacy where the daily dose of methadone was to be dispensed.

For the men that had been on methadone, once they failed to report for their dose, there was a quick decline into drug use. While these issues are not unique to Aboriginal men, the general background of dysfunction within the families of these Aboriginal men made compliance all the more difficult. The Aboriginal men knew the benefits and were all keen to start on methadone. However, it maybe that initiating people in prison onto methadone treatment before release could be inadvertently setting people up to fail. Further research is needed to understand this more fully.

8.4.6 Post-release care for both Aboriginal and non-Aboriginal men

The post-release experiences of the Aboriginal men were explored in chapter 7, but many of the men in this study, not only the Aboriginal men, had been to prison and previously released. For these men, going to prison had not resolved their issues, including their AoD use. There is a clear need for post-release care in Australia, particularly if the care is residential since this helps resolve the critical issue of accommodation. The systematic review showed that good stand-alone post-release AoD programs can be almost as effective as a prison-based program that has post-release support (75). Keeping people from returning to prison is one of the most positive ways through which the prison population can be decreased. It would be worth investing in further research to determine the cost benefits and the most effective form of post-release care and support for prisoners with AoD issues.

8.5 Policy Implications for Prison-based Treatment

The provision of AoD treatment in prison is essential for many reasons. A primary reason is to afford the offender the opportunity to rehabilitate and change their behaviour so as to reduce the likelihood of them re-offending after release. The provision of health care to people in prison is also a human right, and policy in NSW is that people in prison who need AoD treatment should receive such treatment (1-3). Results from this research show that access to AoD treatment is being withheld from people on remand. The reason cited by participants for this restriction was that they were told by CSNSW staff they needed to be sentenced before they could be placed into AoD treatment programs. Restricting AoD treatment from people on remand contravenes human rights as the convention of health care provision to people in prison does not stipulate any such exemptions (1-3). All people being held in prison must have access to health care and the practise of restricting people on remand from access to AoD treatment should cease.

Placement into the right prison-based AoD treatment program is important since being placed into the wrong program can have adverse effects (39, 109). To this end, the policy in NSW is that people in prison are screened using the LSI-R to help determine their rehabilitation and care needs(43). This research shows that although many Aboriginal people need a cannabis focused treatment program, there are no cannabis-specific programs, nor are there Aboriginal-specific programs available in NSW prisons. This means that, despite the results of screening from the LSI-R, some Aboriginal people in prison will not be placed into a program that meets their needs, and as such, the need for the development of an Aboriginal-specific program that has a cannabis focus is indicated.

This research further shows that peer-educators would be valuable additions to staffing in the delivery of prison-based AoD treatment. Peer-educators may, however, have a criminal record that they acquired when they were using AoD. While they could well have had several years, if not decades, of not using AoD and not re-offending, CSNSW has policies for the employment of people who have a record in positions that have contact with prison inmates. It appears from the information available on the web that for those with more serious past offences there is a case-by-case review process. This process may deter some potential peer-educators and as such a clearly articulated policy would be useful. It may also be that for peer-educators to work within a prison, new and carefully considered policy that outlines the permissible conditions for their employment needs to be developed.

8.6 Future Research

Multiple areas of future research are needed to better understand AoD treatment for people involved in the criminal justice system. One area, arising out of the findings from this project as discussed in Chapter Seven, is the need for further research into the use of opioid substitution therapy (OST) such as methadone for Aboriginal people involved in the criminal justice system. While there has been extensive research into OST more generally, there appears to be a paucity of research into the use of OST for Aboriginal people. Future research could explore treatment compliance for Aboriginal people released from prison, and how issues with compliance, if any, could be overcome or minimised.

A second area of particular need is post-release care for all people leaving prison. Further research into AoD treatment for people who are imprisoned should include research into post-release care. There has been limited research into this area in Australia, and more needs to be done to better understand the effect of post-release care, including how effective it is in conjunction with prison-based AoD treatment programs. This research is critical as people need to be supported so as not to relapse back in to AoD use. Qualitative and quantitative methods should be utilised to investigate both the benefits and costs of such programs, and to understand how programs could be further developed to meet the needs of individuals in the post-release care program.

8.7 Conclusion

It is very clear from the research undertaken for this thesis that early intervention is paramount for both Aboriginal and non-Aboriginal young men and boys who begin to use AoD at a young age. The 31 men who kindly participated in this research may have a long road ahead to

address their AoD use, and might not ultimately achieve an AoD-free life. Their stories and their current circumstances emphasise how important it is for the future that early AoD intervention be provided to young men at risk. As younger men, almost all of the participants in this research had few role models, with the Aboriginal men having virtually no localised role models. A lack of positive role models, coupled with discrimination and marginalisation while at high school, had an extremely detrimental effect on the Aboriginal men, particularly if they were expelled from school.

For many of the Aboriginal and non-Aboriginal men when they left school, through expulsion or by choice, the combination of a lack of direction, little daily structure, and few positive role models was disastrous. These factors culminated in heavy AoD use and their eventual contact with the criminal justice system and imprisonment. Further work towards keeping youth - and particularly Aboriginal youth - in school is important in terms of addressing educational problems, providing opportunities for more productive pursuits, and the development of relationships with others that do not involve AoD use and criminal behaviour. To complement school-based programs, community-based programs for high-risk young Aboriginal people would also be likely to reduce their risk of AoD harm and imprisonment.

Finally, governments have an obligation to provide AoD treatment, as health care in prison is expected to be at equivalent levels to that available in the broader community. Governments also need to provide people in prison with an opportunity to rehabilitate and to change the behaviour that culminated in their imprisonment. There is also the need to minimise possible harm to the community when people are released from prison. The criminal justice system will inevitably have considerable involvement in the delivery of AoD treatment programs, since three-quarters of people in prison require some form of AoD treatment (5). Given this, prison-based alcohol and other drug treatment programs should be delivered in the best possible way to meet the needs of the participants and be optimally cost-effective. This research concludes that prison-based therapeutic community programs that operate for nine months or longer, that have a post-prison care component, and that are delivered by a combination of peer and professionally skilled facilitators, would represent current best-evidence practice for *Prison-based treatment for alcohol and other drug use for Aboriginal and non-Aboriginal men*.

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Appendices

Appendix 1: Alcohol Use Disorder Identification Test

Box 10

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.
Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Appendix 2: Ethics Approval Corrective Services NSW

NSW GOVERNMENT
Corrective Services
Attorney General & Justice

20 Lee Street
SYDNEY NSW 2000
GPO Box 31 SYDNEY NSW 2001
Tel 02 9346 1333 Fax 9346 1385
www.correctiveservices.nsw.gov.au

D14.147450

27 March 2014

Mr Michael Doyle
Kirby Institute
University of NSW
45 Beach Street
Coogee NSW 2034

Dear Mr Doyle

I refer to your research application entitled "*Formative assessment of the Intensive Drug and Alcohol Treatment Program (IDATP).*"

The study will seek to evaluate the is to formatively assess the delivery of Alcohol and Other Drug (AOD) and personal development services at the IDATP to explore the different needs (if any) between Aboriginal and non-Aboriginal inmates.

I am pleased to inform you that conditional approval has been given for your research project. The conditions of approval are that you comply with the '*Terms and Conditions of Research Approval* [Attachment A]

I wish you every success in your endeavours.

Yours sincerely

PETER SEVERIN
COMMISSIONER

Appendix 3: Ethics Approval, Aboriginal Health and Medical Research Council

AH&MRC ETHICS COMMITTEE

18th June 2014

Michael Doyle
The Kirby Institute for Infection and Immunity in Society
The University of NSW
High Street
Kensington NSW 2052

Dear Michael,

RE: 1013/14 - Formative Assessment of the Intensive Drug and Alcohol Treatment program

The Aboriginal Health and Medical Research Council (AH&MRC) Ethics Committee has considered your original application received on 24th March 2014 for ethics approval for the above project. Additional information provided on 13th and 28th May 2014 are considered to form part of the application.

The Committee agreed to approve the application, subject to the Standard Conditions and Special Conditions of Approval below:

Standard Conditions of Approval (where applicable to the project)

1. The approval is for a period from **18th June 2014** until **18th June 2015** (12 months after), with extension subject to providing an Annual Progress Report on the research by **18th June 2015.**
2. All research participants are to be provided with a relevant Participant Information Statement and Consent Form in the format provided with your application.
3. Copies of all signed consent forms must be retained and made available to the Ethics Committee on request. A request will only be made if there is a dispute or complaint in relation to a participant.
4. Any changes to the staffing, methodology, timeframe, or any other aspect of the research relevant to continued ethical acceptability of the project must have the prior written approval of the Ethics Committee.
5. The AH&MRC Ethics Committee must be immediately notified in writing of any serious or unexpected adverse effects on participants.
6. The research must comply with:

Supported by the NSW Ministry of Health

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- the *AH&MRC Guidelines for Research in Aboriginal Health – Key Principles;*
- *National Statement on Ethical Conduct in Research Involving Humans* (April 2007);
- the *NSW Aboriginal Health Information Guidelines.*

7. The final draft report from the research, and any publication or presentation where data or findings are presented, must be provided to the AH&MRC Ethics Committee to be reviewed for compliance with ethical and cultural criteria prior to:
   - any submission for publication; and/or
   - any dissemination of the report.
8. A copy of the final published version of any publication is to be provided to the AH&MRC Ethics Committee.

Special Conditions

9. Nil

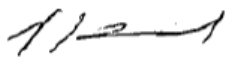
Please acknowledge receipt of this letter and your acceptance of the above conditions within fourteen (14 days).

Please find attached an Annual Progress Report pro forma for use at the end of the approval period.

We appreciate your agreement that the research findings will be made available in order to assist the future development of policy and programs in Aboriginal health.

On behalf of the AH&MRC Ethics Committee,

Yours sincerely,



Val Keed
Chairperson
AH&MRC Ethics Committee

Appendix 4: Published version of Chapter Three, Alcohol and other drug use among Aboriginal and non-Aboriginal men entering prison in NSW

Doyle et al. Health and Justice (2015) 3:15
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RESEARCH ARTICLE Open Access

Alcohol and other drug use among Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander men entering prison in New South Wales

Michael F Doyle[1*], Tony G Butler[1], Anthony Shakeshaft[2], Jill Guthrie[3], Jo Reekie[1] and Peter W Schofield[4]

Abstract

Introduction and aims: Prison entrants commonly have a history of problematic alcohol and other drug (AoD) use. Aboriginal and Torres Strait Islander (Indigenous) Australians are vastly overrepresented in Australian prisons with an incarceration rate 16 times that of non-Indigenous Australians. Relatively little attention has been given to the patterns of AoD use among prison entrants and we hypothesise that they may differ between Indigenous and non-Indigenous entrants. The aim of this paper is to compare the prior AoD use among Indigenous and non-Indigenous prison entrants and identify the implications for AoD treatment provision within prisons.

Design and method: Cross-sectional random sample of 200 men recently received into New South Wales (NSW) criminal justice system.

Results: During the 12 months prior to imprisonment, 106 prison entrants consumed alcohol at levels at which an intervention is recommended. Additionally during the four weeks prior to prison, 94 inmates had used illicit drugs daily. There was some overlap between these two groups; however, heroin users were less likely to consume alcohol at harmful levels. Relative to non-Indigenous entrants, Indigenous entrants prior to imprisonment used more cannabis but less amphetamine on a daily basis. There were no other significant differences between the alcohol or drug use of Indigenous and non-Indigenous prison entrants.

Discussion and conclusion: Both Indigenous and non-Indigenous men entering prison have a history of high levels of AoD use but a slightly different treatment focus may be required for Indigenous inmates.

Keywords: Alcohol; Illicit drug; Prisoners; Aboriginal; Treatment

Background

Problematic alcohol and other drug (AoD) use is common among those in prison with many inmates reporting they had been under the influence of alcohol and/or other drugs at the time of their offence (Butler et al. 2011a; Australian Institute of Health and Welfare 2013; Indig et al. 2010a). Nationally, just under half (46 %) of prison entrants reported consuming alcohol at 'harmful' levels (as defined by Alcohol Use Disorders Identification Test (Babor et al. 1992)) and 70 % had used illicit drugs once or more during the 12 months prior to prison (Australian Institute of Health and Welfare 2013). The 2009 New South Wales Inmate Health Survey reported that at the time of their current offence, 22 % of Indigenous men and one fifth of non-Indigenous men were intoxicated with alcohol, 29 % of Indigenous and 16 % of non-Indigenous men were under the influence of both alcohol and other (illicit) drugs, and 21 % of Indigenous and 22 % of non-Indigenous men were under the influence of illicit drugs only (Indig et al. 2010a). Over half (52 %) thought there was a link between their AoD use and their imprisonment (Indig et al. 2010a).

Injecting drug use, is widespread among prisons entrants with a large proportion (44 %) having previously injected and over half (56 %) having injected in the month prior to imprisonment (Butler et al. 2011a). In

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NSW methamphetamine was used daily/almost daily prior to prison by 14 % of men; crystalline methamphetamine (ice) was used daily/almost daily by 11.8 % of men; and heroin was used daily/almost daily by 8.5 % of male inmates (Indig et al. 2010a). Daily/almost daily illicit drug use (including injecting) in the year before prison was more common among Indigenous men (51 %) compared to non-Indigenous (38 %) with cannabis being the most commonly used illicit drug for both groups (Indig et al. 2010b). Despite the over-representation of illicit drug use among prisoners, relative to the general population, the most commonly used drug among inmates is nicotine; 83 % of Indigenous and 71 % non-Indigenous men reported being a current tobacco smoker (Indig et al. 2010a).

While high rates of AoD use in offender populations are well-established, the availability, uptake and efficacy of in-prison programs for these disorders is far less clear. In NSW half of the men with a history of AoD use had sought alcohol and or drug treatment prior to prison, with 61 % of this group stating they wanted help for their alcohol use problem (Indig et al. 2010a). Relative to this potential level of need alcohol treatment for people in prison is not common (Doyle et al. 2011), with a national survey of prisoner health reporting that only 17 % of Indigenous and 10 % of non-Indigenous inmates leaving prison had received treatment for problematic alcohol use (Australian Institute of Health and Welfare 2013).

Within Australian prisons there is a need to have a focus on Indigenous Australians as they are vastly overrepresented, making up 27 % of the prisoner population but only 2.5 % of the overall Australian population (Australian Bureau of Statistics 2014a; Australian Bureau of Statistics 2012). New South Wales has the largest Indigenous prisoner population with 2,492 (23.6 %) of the 10,566 Indigenous prisoners held in Australia's prisons in 2014 (Australian Bureau of Statistics 2014a). The rate of Indigenous imprisonment further highlights the overrepresentation at 1,857 per 100,000 compared to 144 per 100,000 for non-Indigenous Australians (Australian Bureau of Statistics 2014a). Problematic use of AoD has been identified as a leading factor in the high rate of Indigenous imprisonment (Weatherburn 2008; Australian National Council on Drugs NIDaAC 2013), and first highlighted over 20 years ago by the 1991 Royal Commission into Aboriginal Deaths in Custody (Royal Commission into Aboriginal Deaths in Custody 1992). A number of strategies to address this nexus between Indigenous imprisonment and AoD use have been proposed (Australian National Council on Drugs NIDaAC 2013; Martire and Larney 2009). The strategies range from restrictions on alcohol supply in Indigenous communities to improved availability of treatment services and initiatives such as sobering up shelters as an alternative to police custody (Weatherburn 2008; Australian National Council on Drugs NIDaAC 2013; Royal Commission into Aboriginal Deaths in Custody 1992). Despite these initiatives the rate of imprisonment is higher in 2014 than it was at the time of the Royal Commission in 1991 (Doyle et al. 2011; Rodas et al. 2011).

One third of people entering prison are released within 12 months and over half are released after 24 months (Australian Bureau of Statistics 2014a). This window of opportunity suggests that effective screening for AoD problems on entry to prison is appropriate to enable treatment and referral pathways to be initiated during the incarceration period. There has been limited research in this area in Australia (Doyle et al. 2011), however, international evidence suggests that treatment for AoD disorders may be effective within prison (McGuire et al. 1991). It is unclear if the AoD treatment needs of prison entrants in Australia are being met, and the extent to which AoD problems and treatments ought to be tailored to the specific needs of Indigenous prisoners, such as levels of dependence severity. As far as we are aware, relatively little attention has been given to the patterns of AoD use among prison entrants. We hypothesise that those needs may differ between Indigenous and non-Indigenous entrants. Thus, this study aims to compare the prior AoD use among Indigenous and non-Indigenous prison entrants and identify the implications for AoD treatment provision in prisons.

Methods

Participants

The sample comprised 200 men recently received into the criminal justice system in the Hunter Region of New South Wales between September 2003 and June 2004. Full details of the study are published elsewhere, the data was collected as part of a study examining reported past Traumatic Brain Injury (TBI) (Schofield et al. 2006a; Schofield et al. 2006b; Perkes et al. 2011). Participants were randomly recruited and their TBI status was only determined after they had been recruited. The participants were recruited after being received into a police cell complex or a reception prison and included both those on remand for sentencing by the Courts and those recently sentenced. The project officer was primarily responsible for recruitment and due to resourcing, recruitment usually occurred one day per week. Either the project officer or a nurse within the prison reception unit administered the 11 page survey, with results being self-reported by participants. The project officer recruited 57 % of participants with only 3 % of those approached by them declining to take part, no refusal data was recorded by other recruiters. The cross checking of data showed similar participant responses between those interviewed by the project officer and other recruitment staff.

Recruitment was sequential; however, on days when resources did not permit sequential recruitment due to high volume of inmates entering custody, potential participants were identified by the last digit of their unique Corrective Services NSW assigned identification (ID) code in order from highest digit (nine) to lowest. In over 95 % of the cases the participant had been given this number when previously incarceration or arrest. Consequently, there was little likelihood of any association between the last digit of the number and the temporal sequence in which they had been received into custody for the current offence (Perkes et al. 2011; Butler and Allbutt 2003; Armand et al. 1997).

Measures

Alcohol use was measured using the 10-item World Health Organization's (WHO) Alcohol Use Disorders Identification Test (AUDIT) (Babor et al. 1992). Drug use questions asked about any, and daily, drug use in the past four weeks (nicotine, cannabis, heroin, amphetamines, prescribed medications). Any illicit drug use was defined as having used any or; anaesthetics, anabolic steroids, non-prescribed methadone or opioid other than heroin, heroin, cocaine, amphetamine (and other related stimulants), cannabis, hallucinogens, volatile solvents and volatile inhalants daily in the past four weeks.

Mental health status was assessed using the 10-item Kessler Psychological Distress Scale (K10), to measure levels of psychological distress (Butler et al. 2011b) and the International Personality Disorders Examination (IPDE), to measure impulsive personality (Fazel and Danesh 2002). IPDE is a screening tool used to detect mental health disorders and along with the K10 is widely used in epidemiological studies of mental health (Butler and Allbutt 2003). Other data reported are those recorded by the health staff when assessing inmate risk upon entry to prison, such as previous episodes of mental health treatment and self-harm episodes including previous suicide attempts. Details of previous TBI were reported as this was the main outcome measure of the original study (Schofield et al. 2006a; Schofield et al. 2006b). For this analysis TBI was defined as any injury ever to the head that caused a feeling of being 'dazed or confused' and or 'loss of conciseness/blackout'. It was established that answers from these inmates were quite accurate as some results were cross checked using medical records (Kessler et al. 2003).

Ethics

The study had ethics approval from Justice Health NSW and the Hunter New England Area Health Services' Human Research Ethics Committees. Informed consent was required for participation.

Statistical analysis

Participants were described by Indigenous status (yes/no), age (18–24 years, 25–39 years and 40+ years), marital status (married/defacto or single/separated), country of birth (Australia or other) and educational attainment (did not complete year 10, completed year 10, and completed year 12 or post school quantifications). For offending history, respondents were asked if they had been to juvenile detention or not. The primary offence for which they were in custody was categorised as being violent or non-violent, with a violent offence being one whereby harm was inflicted on another person.

Individual items on AUDIT are scored 0–4 and aggregated to a total from 0–40. Respondents' scores were categorised two ways. First, using the standard WHO categories (Armand et al. 1997): 0 (no alcohol consumption); 1–7 (low-risk alcohol consumption); 8–19 (harmful/hazardous risk to health from alcohol consumption); and ≥20 (high-risk of harm from alcohol consumption and/or possibly alcohol dependent). Second, since WHO recommends an alcohol intervention for people who score ≥8, respondents' AUDIT scores were categorised as either <8 (no treatment) and ≥8 (treatment recommended). Other drug use was categorised as yes, no or missing for daily use in the past 4 weeks.

For mental health status, each item on the IPDE was scored as positive or negative, with three or more positives in a single domain being an indication of that particular personality disorder (Armand et al. 1997). The K10 is scored numerically with a score of ≤19 indicating a minimal level of distress, 20 to 29 indicating an elevated level of distress, and ≥30 indicating a severe level of distress (Kessler et al. 2003). Only the most severe distress level category was used for analysis because entry to prison can of its own be a cause of distress. Answers to items for previous mental health treatment, suicide attempts, family member attempted suicide and self-harm episodes were categorised as yes, no or missing.

Data were analysed using IBMs' software Statistical Package for the Social Sciences (SPSS) version 22. The characteristics of Indigenous and non-Indigenous participants were compared: Chi-square tests were used to compare categorical variables and Mann Whitney U tests for continuous variables. Logistic regression analysis was used to investigate factors associated with an AUDIT score of ≥8 (treatment recommended group). Variables with $p < 0.1$ level significance in univariate analysis were included in the multivariate model as well as Indigenous status and age.

Results

Inmate characteristics

Over half of the sample was aged between 25 and 39 years, 72 % were single, and 95 % were born in Australia

(Table 1). One fifth (20 %) identified as being Indigenous, which reflects the Indigenous composition of the male prisoner population in NSW at the time of the study (Australian Bureau of Statistics 2014a). Educational attainment levels were similar between Indigenous and non-Indigenous inmates. For their current term of imprisonment, more Indigenous offenders (64 %) than non-Indigenous offenders (50 %) had committed offences categorised as violent. A similar number of Indigenous (80 %) and non-Indigenous (77 %) inmates scored 30 or over on the K10, indicating 'severe' distress. Two fifths (42 %) of non-Indigenous inmates and over half (53 %) of Indigenous inmates screened positive for impulsive personality (IPDE). There was a high prevalence of brain injury for both Indigenous and non-Indigenous participants, but there was not a statistically significant difference between the groups. Overall, none of the differences between Indigenous and non-Indigenous respondents were statistically significant.

One quarter of non-Indigenous inmates reported that they did not consume alcohol in the 12 months prior to prison as indicated by an AUDIT score of 0 (Table 2). Over half of all Indigenous (55 %) and non-Indigenous (53 %) inmates scored ≥8 on the AUDIT, indicating a need for an alcohol intervention. Possible alcohol dependence was indicated among 22.5 % of both Indigenous and non-Indigenous respondents (scored ≥20 on AUDIT).

Cannabis was the most common illicit drug used on a daily basis in the past 4 weeks, with statistically significantly greater use among Indigenous (46 %) than non-Indigenous (37 %) inmates ($p = 0.05$). Overall, compared with cannabis, considerably fewer inmates, both Indigenous and non-Indigenous, reported having used either amphetamine (14 %) or heroin (13 %). However, a statistically significantly smaller proportion of Indigenous inmates than non-Indigenous had used amphetamine on a daily basis in the past four weeks (3 % vs 17 %, $p = 0.03$). There were no statistically significant differences in the use of heroin or prescribed methadone/buprenorphine/naltrexone by Indigenous status.

AoD use and mental health status

Although 24 % of respondents were alcohol abstinent, two thirds (64 %) of alcohol abstainers had consumed illicit drugs on a daily basis (Table 3). The majority of inmates had not been treated previously for a mental health problem, even though there were high levels of severe distress (K10) reported across all AUDIT categories. Three quarters of inmates reported daily nicotine use with high prevalence across all AUDIT categories.

The univariate analysis showed that the odds of daily heroin use in the past four weeks were statistically significantly reduced (OR = 0.33, $p = 0.02$) among the alcohol treatment recommended group (Table 4). There was no significant difference between the treatment recommended and no treatment groups in their reported use of nicotine, cannabis and amphetamine in the past four weeks. The odds of the alcohol treatment recommended group using any illicit drug daily in the past four weeks were statistically significantly lower than the no treatment group (OR = 0.48, $p = 0.01$). However, when daily heroin use was excluded from the any illicit drug use category, the odds of reduced use by the alcohol treatment recommended group, compared to the no treatment group, were no longer significantly different (OR = 0.66, $p = 0.15$).

The multivariate analysis showed that the odds of heroin use by those in the alcohol treatment recommended group remained significantly lower (OR = 0.37, $p = 0.04$) among those who had used heroin daily when Indigenous status, age and any illicit drug use (excluding heroin) are factored into the model. There was no statistically significant association between the treatment recommended group and Indigenous status, age, TBI or drug use (excluding heroin).

Discussion

Based on the AUDIT scores, over half (106) of the sample met the criteria for requiring an alcohol intervention and 45/106 (43 %) of that group warranted further investigation for possible alcohol dependence. We found no significant differences between Indigenous and non-Indigenous inmates in regard to alcohol use, suggesting that problematic alcohol use is equally spread between these two groups. These results would imply that about 50 % of prison entrants could benefit from an alcohol intervention and that supervised withdrawal from alcohol may be required for between 20 and 25 % of prison entrants. The extent to which case management occurs for alcohol use disorders in Australian prisons is unknown.

Illicit drug use was common among inmates, with almost half reporting daily use. Inmates who reported using heroin on a daily basis either consumed less alcohol or no alcohol. The major differences by Indigenous status were that Indigenous inmates were more likely to use cannabis ($p = 0.05$), but less likely to use amphetamine on a daily basis than non-Indigenous inmates ($p = 0.03$). Tobacco use was high among Indigenous and non-Indigenous inmates with 150/200 (75 %) smoking on a daily basis implying a role for smoking cessation interventions. Of the 200 study participants, based on our screening measures, only 42 (21 %) did not merit any AoD behavioural treatment, 64/200 (32 %) warranted an alcohol (but not illicit drug) intervention; 52/200 (26 %) required help for illicit drug use (but not alcohol) and 42/200 (21 %) required assistance for both alcohol and illicit drug use. Despite these differences it is likely that if these inmates were to receive

Table 1 Demographic, offending history and mental health characteristics by Indigenous status

Characteristic	Indigenous ($n = 40$)	Non-Indigenous ($n = 160$)	Total	*P*-value
Age (years)	Median 28.7	Median 30.0		0.20[1]
	IQR 23 to 35	IQR 24 to 37		
Age category (years)				
18–24	14 (35.0 %)	43 (26.9 %)	57 (28.5 %)	0.36[2]
25–39	22 (55.0 %)	88 (55.0 %)	110 (55.0 %)	
40+	4 (10.0 %)	29 (18.1 %)	33 (16.5 %)	
Marital status				
Married/de facto	10 (25.0 %)	40 (25.0 %)	50 (25.0 %)	0.86[2]
Single/separated	27 (67.5 %)	116 (72.5 %)	143 (71.5 %)	
Missing	3 (7.5 %)	4 (2.5 %)	7 (3.5 %)	
Country of birth				
Australia	38 (95.0 %)	151 (94.4 %)	189 (94.5 %)	0.89[2]
Other	2 (5.0 %)	9 (5.6 %)	11 (5.5 %)	
Educational attainment				
Did not complete year 10	17 (42.5 %)	51 (31.9 %)	68 (34.0 %)	0.42[2]
Completed year 10	13 (32.5 %)	57 (35.6 %)	70 (35.0 %)	
HSC/Certificate/Degree	10 (25.0 %)	52 (32.5 %)	62 (31.0 %)	
Juvenile detention				
Yes	16 (40.0 %)	53 (33.1 %)	69 (34.5 %)	0.43[2]
No	24 (60.0 %)	106 (66.3 %)	130 (65.0 %)	
Missing	-	1 (0.6 %)	1 (0.5 %)	
Offence type				
Violent	25 (62.5 %)	80 (50.0 %)	105 (52.5 %)	0.10[2]
Non-violent	12 (30.0 %)	75 (46.9 %)	87 (43.5 %)	
Missing	3 (7.5 %)	5 (3.1 %)	8 (4.0 %)	
Number of arrests, Mean and median	Median 15.0	Median 10.0		0.06[1]
	IQR 1.0 to 7.5	IQR 1.0 to 11.0		
Kessler psychological distress scale (K10)				
No distress: 10–19	3 (7.5 %)	12 (7.5 %)	15 (7.5 %)	0.84[2]
Mild to moderate: 20–29	5 (12.5 %)	26 (16.2 %)	31 (15.5 %)	
Severe distress: 30+	32 (80.0 %)	122 (76.3 %)	154 (77.0 %)	
Impulsive personality (IPDE)				
Positive	21 (52.5 %)	67 (41.9 %)	88 (44.0 %)	0.23[2]
Negative	19 (47.5 %)	93 (58.1 %)	112 (56.0 %)	
Ever treated for a mental health problem				
Yes	13 (32.5 %)	48 (30.0 %)	61 (30.5 %)	0.76[2]
No	26 (65.0 %)	108 (67.5 %)	134 (67.0 %)	
Missing	1 (2.5 %)	4 (2.5 %)	5 (2.5 %)	
Have previously attempted suicide				
Yes	8 (20.0 %)	25 (15.6 %)	33 (16.5 %)	0.52[2]
No	31 (77.5 %)	130 (81.3 %)	161 (80.5 %)	
Missing	1 (2.5 %)	5 (3.1 %)	6 (3.0 %)	

Table 1 Demographic, offending history and mental health characteristics by Indigenous status *(Continued)*

Family member attempted suicide				
Yes	5 (12.5 %)	28 (17.6 %)	33 (16.5 %)	0.46[2]
No	33 (82.5 %)	126 (78.7 %)	159 (79.5 %)	
Missing	2 (5.0 %)	6 (3.7 %)	8 (4.0 %)	
Have previously self-harmed				
Yes	4 (10.0 %)	10 (6.2 %)	14 (7.0 %)	0.42[2]
No	35 (87.5 %)	144 (90.0 %)	179 (89.5 %)	
Missing	1 (2.5 %)	6 (3.8 %)	7 (3.5 %)	
Traumatic brain injury				
Yes	33 (82.5 %)	131 (81.9 %)	164 (82.0 %)	0.57[2]
No	7 (7.5 %)	29 (18.1 %)	36 (18.0 %)	

[1]Mann Whitney U Test
[2]Chi-square test

an AoD intervention program, that program would be focused on illicit drug use only or alcohol and illicit drug use, but not focused on alcohol specifically, as discussed further below.

The IPDE scores indicated that 44 % of inmates potentially had impulsive personalities and the K10 results showed that 77 % (n =154) had severe psychological distress. The K10 result, , should be interpreted with caution as entry to prison can be a distressing event but, nonetheless, the findings here are broadly consistent with the well-established high levels of poor mental health among people in prison (Butler et al. 2011b; Fazel and Danesh 2002). Both the IPDE and the K10 are screening tests and further assessment is required before a diagnosis can be made, but it is highly likely that a significant proportion of the participants in this study would benefit from support for their mental health.

Alcohol and other drug treatment needs for Indigenous and non-Indigenous prison entrants may be different. The results indicate that there is some scope for

Table 2 Indigenous and non-Indigenous alcohol and daily illicit and licit drug use in the past 4 weeks

Alcohol and daily illicit and licit drug use		Indigenous (N = 40)	non-Indigenous (N = 160)	Chi-square p-value
No consumption	AUDIT 0	7 (17.5 %)	40 (25.0 %)	0.76
Low-risk	AUDIT 1–7	11 (27.5 %)	36 (22.5 %)	
Harmful/hazardous	AUDIT 8–19	13 (32.5 %)	48 (30.0 %)	
High-risk/dependent	AUDIT 20+	9 (22.5 %)	36 (22.5 %)	
Nicotine daily (drug) use past 4 weeks	Yes	33 (91.7 %)	117 (77.5 %)	0.06
	No	3 (8.3 %)	34 (22.5 %)	
	Missing	*4*	*9*	
Cannabis daily (drug) use past 4 weeks	Yes	17 (45.9 %)	55 (36.7 %)	0.05
	No	20 (54.1 %)	95 (63.3 %)	
	Missing	*3*	*10*	
Heroin daily (drug) use past 4 weeks	Yes	5 (13.2 %)	18 (12.3 %)	0.89
	No	33 (86.8 %)	128 (87.7 %)	
	Missing	*2*	*14*	
Amphetamine daily (drug) use past 4 weeks	Yes	1 (2.8 %)	24 (16.8 %)	0.03
	No	35 (97.2 %)	119 (83.2 %)	
	Missing	4	7	
Prescribed methadone/buprenorphine/naltrexone daily (drug) use past 4 weeks	Yes	3 (8.1 %)	11 (7.4 %)	0.88
	No	34 (91.9 %)	138 (92.7 %)	
	Missing	3	11	

Table 3 Alcohol, nicotine and illicit drug use, and mental health status by AUDIT category

Alcohol use	Daily nicotine use in past 4 weeks	Daily illicit[3] drug in past 4 weeks	K10[4] ('severe' distress)	Previously treated for mental health problem	Total
No consumption	32 (21.3 %)[1]	30 (31.9 %)	36 (23.4 %)	16 (26.2 %)	47 (23.5 %)
AUDIT = 0	(68.1 %)[2]	(63.8 %)	(76.6 %)	(34.0 %)	
Low-risk	35 (23.3 %)	22 (23.4 %)	41 (26.7 %)	13 (21.3 %)	47 (23.5 %)
AUDIT = 1 to 7	(74.5 %)	(46.8 %)	(87.2 %)	(27.7 %)	
Harmful/hazardous	50 (33.3 %)	23 (24.5 %)	47 (30.5 %)	15 (24.6 %)	61 (25 %)
AUDIT = 8 to 19	(82.0 %)	(37.7 %)	(77.0 %)	(24.6 %)	
High-risk/dependent	33 (22.0 %)	19 (20.2 %)	30 (19.5 %)	17 (27.9 %)	45 (22.5 %)
AUDIT = 20+	(73.3 %)	(42.2 %)	(66.7 %)	(37.8 %)	
Subtotal	150 (75 %)	94 (47.0 %)	154 (77 %)	61 (30.5 %)	200 (100 %)
Indicated no use	37	97	46[5]	144	-
Missing	13	9	-	5	-
Total	200	200	200	200	200

[1]Percentage within column
[2]Percentage within row
[3]Includes: Anaesthetics, anabolic steroids, non-prescribed methadone or opioids other than heroin, heroin, cocaine, amphetamine (and other related stimulants), cannabis, hallucinogens, volatile solvents and volatile inhalants
[4]Only severe distress was reported as entry to prison can be a distressing event
[5]Refers to a K10 score that did not indicate 'severe distress level'

recommending a focus on cannabis among Indigenous inmates, as more Indigenous than non-Indigenous men reported daily use (46 % versus 37 %, $p = 0.05$). Other data supports a focus on cannabis use for Indigenous Australians not just in prison but in the general population. The National Drug Household Survey (2011) reported cannabis use among Indigenous respondents was 19 % versus 10 % for non-Indigenous respondents (age of ≥14) (Australian Institute of Health and Wealfare 2011), and the National Aboriginal and Torres Strait Islander Health Survey reported that one in five (19 %) of Indigenous respondents (aged ≥15) had used cannabis in the previous 12 months (no comparative figure for non-Indigenous use) (Australian Bureau of Statistics 2014b). However, within Australian prisons there appears to be no cannabis specific programs for either Indigenous or non-Indigenous inmates (Doyle et al. 2011; Rodas et al. 2011), even though it is the most commonly used illicit drug among prison inmates (Indig et al. 2010a).

Alcohol and other drug treatment needs of prison entrants are possibly different from those of other inmates. Within this study there was some difference in AoD use relative to the findings of the 2009 NSW Inmate Health Survey (Indig et al. 2010a). For example, based on AUDIT scores, an intervention for alcohol use would have been indicated for 53 % in this sample but for 63 % of respondents in the Inmate Health Survey. There could be a number of factors as to why such a difference occurred, including 3 years difference between the data collection dates. Another notable difference is that the participants for this sample are all prison entrants from one site, while the Inmate Health Survey represents a cross section of the whole prisoner population in NSW, with many of those inmates having been in prison for 12 months or more. Another possibility is a difference in recall, which is a strength of this study as participants in this survey were asked to recall recent use of AoD rather than recalling AoD use that occurred several months or even years earlier. With this group participants some caution is due when interpreting results as prison entrants could possibly be reluctant to answer questions that relate to criminal activity (i.e. consuming illicit drugs). However, inmates responses in this study had a high degree of consistency with the notes recorded in their medical records and as such can be thought to be fairly accurate with their responses (Schofield et al. 2011). Compared to the 2009 NSW Inmate health Survey, the numbers in this study, particularly of Indigenous participants limits the statistical power.

Court based and mandated referral pathways into drug treatment occur regularly. Drug Courts operate in every Australia jurisdiction, but the national response to the most commonly used substance, alcohol has been much less coordinated (Payne et al. 2008). Alcohol has been included as an extension of the Drug Court in some, but not all, Australian jurisdictions (Payne et al. 2008). This extension is used predominantly in areas that have a higher proportion of Indigenous Australians as residents, which is predominantly away from the large state capital cities and major population centres (Payne et al. 2008). These results demonstrate that more than half of this sample may benefit from an alcohol intervention and that non-Indigenous men are in equal need of an alcohol related intervention.

Table 4 Alcohol intervention and non-intervention groups by demographics/health issue

Demographic/Health issue[1]		AUDIT < 8 (no treatment) (n = 94)	AUDIT ≥ 8 (treatment recommended) (n = 106)	Univariate O.R. (95 % CI)	*P*-value
Indigenous status	Indigenous	18 (19.1 %)	22(20.8 %)	1.0	
	Non-Indigenous	76 (80.9 %)	84 (79.2 %)	0.90 (0.45–1.81)	0.78
Age in years	18–24	25 (25.6 %)	32 (30.2 %)	1.0	0.78
	25–39	52 (55.3 %)	58 (54.7 %)	0.87 (0.46–1.66)	0.68
	40+	17 (18.1 %)	16 (15.1 %)	0.75 (0.31–1.74)	0.48
Traumatic brain injury	Yes	74 (78.7 %)	90 (84.9 %)	1.0	
	No	20 (21.3 %)	16 (15.1 %)	0.66 (0.32–1.22)	0.26
	missing	0	0		
Daily nicotine use in past 4 weeks	Yes	67 (77.9 %)	83 (82.2 %)	1.0	
	No	19 (22.1 %)	18 (17.8 %)	0.76 (0.37–1.57)	0.47
	Missing	8	5		
Daily cannabis use in past 4 weeks	Yes	38 (44.7 %)	37 (36.3 %)	1.0	
	No	47 (55.3 %)	65 (63.7 %)	0.70 (0.39–1.27)	0.24
	Missing	9	4		
Daily heroin use in past 4 weeks	Yes	16 (18.8 %)	7 (7.1 %)	1.0	
	No	69 (81.2 %)	92 (92.3 %)	0.33 (0.13–0.84)	0.02
	Missing	9	7		
Daily amphetamine use in past 4 weeks	Yes	14 (17.3 %)	11 (11.2 %)	1.0	
	No	67 (82.7 %)	87 (88.8 %)	0.60 (0.26–0.26)	0.25
	Missing	13	8		
Daily prescribed methadone/buprenorphine/ naltrexone in past 4 weeks	Yes	5 (5.7 %)	5 (4.9 %)	1.0	
	No	82 (94.3 %)	98 (95.1 %)	0.44 (0.14–1.37)	0.16
	Missing	7	3		
Any illicit drug use daily (excl. heroin)	Yes	45 (51.1 %)	42 (40.8 %)	1.0	
	No	43 (48.9 %)	61 (59.2 %)	0.66 (0.37–1.17)	0.15
	Missing	6	3		
Any illicit drug use daily	Yes	52 (59.1 %)	42 (40.8 %)	1.0	
	No	36 (40.1 %)	61 (59.2 %)	0.48 (0.27–0.80)	0.01
	Missing	6	3		

[1]No statistically significant differences between the AUDIT identified no treatment and treatment recommended groups by demographic characteristics of marital status, country of juvenile detention , offence type, K10, Impulsive personality, ever been treated for a mental health problem, have previously attempted suicide, family member attempted suicide, Data not shown

There is limited aggregated data on the provision of AoD treatment within prison but yet there are prison based AoD programs operating in every Australian jurisdiction (Doyle et al. 2011; Rodas et al. 2011). It is not known how many inmates commence and complete these, nor is it known how long the average wait time from prison entry and assessment to commencement of an AoD treatment program. There appears to be no published research into the long term outcomes of those who complete the AoD programs and it is not known if people who undertake these programs are any less likely to return to prison. With such sparse research into prison based AoD treatment it is not known if Indigenous inmates have different outcomes to others, what is clear is that there are few jurisdictions that have Indigenous specific programs. Further research in this area is essential, particularly with the view to improving services for Indigenous Australians who are vastly over represented in the Nations prisons.

Alcohol and other drug treatment in prison can be effective, but such treatment should be specific to the individual's needs or it can be harmful (McGuire et al. 1991; Office of the Insepector General of Custodial Services 2008). Prison-based AoD treatment programs are operated in all states and territories in Australia. Inmates are assessed by staff and are referred to or placed into the AoD treatment programs (Doyle et al. 2011; Rodas et al. 2011). There are different AoD programs which have different focuses, but generally program classes consist of about up to 12 to 20 inmates attending a one to two hour class two to three times a week for around 12 weeks (Doyle et al. 2011; Rodas et al. 2011). Limited aggregated data are available on the number of inmates that undertake and complete AoD treatment programs and it is not known how long a wait there is between entry to prison and commencement of an AoD program (Doyle et al. 2011; Rodas et al. 2011). What is quite clear, however, is that few of these programs are specifically alcohol focused, most are for alcohol and other drug use, and few AoD programs are specifically for Indigenous people (Doyle et al. 2011; Rodas et al. 2011). This research indicates that while both Indigenous and non-Indigenous prison entrants would benefit from AoD treatment there is possibly a need for different focuses between these groups.

Competing interests
The authors declare that they have no competing interests.

Authors' contributions
MD led the analysis of the data and drafted the manuscript. TB, AS, JG, JR and PS revised the manuscript and advised MD on intellectual content. All authors read and approved the final manuscript.

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Appendix 5: Quality Assessment Tool for Quantitative Studies Dictionary

Quality Assessment Tool for Quantitative Studies Dictionary

The purpose of this dictionary is to describe items in the tool thereby assisting raters to score study quality. Due to under-reporting or lack of clarity in the primary study, raters will need to make judgements about the extent that bias may be present. When making judgements about each component, raters should form their opinion based upon information contained in the study rather than making inferences about what the authors intended.

A) SELECTION BIAS

(Q1) Participants are more likely to be representative of the target population if they are randomly selected from a comprehensive list of individuals in the target population (score very likely). They may not be representative if they are referred from a source (e.g. clinic) in a systematic manner (score somewhat likely) or self-referred (score not likely).

(Q2) Refers to the % of subjects in the control and intervention groups that agreed to participate in the study before they were assigned to intervention or control groups.

B) STUDY DESIGN

In this section, raters assess the likelihood of bias due to the allocation process in an experimental study. For observational studies, raters assess the extent that assessments of exposure and outcome are likely to be independent. Generally, the type of design is a good indicator of the extent of bias. In stronger designs, an equivalent control group is present and the allocation process is such that the investigators are unable to predict the sequence.

Randomized Controlled Trial (RCT)
An experimental design where investigators randomly allocate eligible people to an intervention or control group. A rater should describe a study as an RCT if the randomization sequence allows each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. If the investigators do not describe the allocation process and only use the words 'random' or 'randomly', the study is described as a controlled clinical trial.

See below for more details.

Was the study described as randomized?

Score YES, if the authors used words such as random allocation, randomly assigned, and random assignment.

Score NO, if no mention of randomization is made.

Was the method of randomization described?

Score YES, if the authors describe any method used to generate a random allocation sequence.

Score NO, if the authors do not describe the allocation method or describe methods of allocation such as alternation, case record numbers, dates of birth, day of the week, and any allocation procedure that is entirely transparent before assignment, such as an open list of random numbers of assignments.
If NO is scored, then the study is a controlled clinical trial.

Was the method appropriate?

Score YES, if the randomization sequence allowed each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. Examples of appropriate approaches include assignment of subjects by a central office unaware of subject characteristics, or sequentially numbered, sealed, opaque envelopes.

Score NO, if the randomization sequence is open to the individuals responsible for recruiting and allocating participants or providing the intervention, since those individuals can influence the allocation process, either knowingly or unknowingly.

If NO is scored, then the study is a controlled clinical trial.

Controlled Clinical Trial (CCT)
An experimental study design where the method of allocating study subjects to intervention or control groups is open to individuals responsible for recruiting subjects or providing the intervention. The method of allocation is transparent before assignment, e.g. an open list of random numbers or allocation by date of birth, etc.

Cohort analytic (two group pre and post)
An observational study design where groups are assembled according to whether or not exposure to the intervention has occurred. Exposure to the intervention is not under the control of the investigators. Study groups might be non-equivalent or not comparable on some feature that affects outcome.

Case control study
A retrospective study design where the investigators gather 'cases' of people who already have the outcome of interest and 'controls' who do not. Both groups are then questioned or their records examined about whether they received the intervention exposure of interest.

Cohort (one group pre + post (before and after)
The same group is pretested, given an intervention, and tested immediately after the intervention. The intervention group, by means of the pretest, act as their own control group.

Interrupted time series
A time series consists of multiple observations over time. Observations can be on the same units (e.g. individuals over time) or on different but similar units (e.g. student achievement scores for particular grade and school). Interrupted time series analysis requires knowing the specific point in the series when an intervention occurred.

C) CONFOUNDERS

By definition, a confounder is a variable that is associated with the intervention or exposure and causally related to the outcome of interest. Even in a robust study design, groups may not be balanced with respect to important variables prior to the intervention. The authors should indicate if confounders were controlled in the design (by stratification or matching) or in the analysis. If the allocation to intervention and control groups is randomized, the authors must report that the groups were balanced at baseline with respect to confounders (either in the text or a table).

D) BLINDING

(Q1) Assessors should be described as blinded to which participants were in the control and intervention groups. The purpose of blinding the outcome assessors (who might also be the care providers) is to protect against detection bias.

(Q2) Study participants should not be aware of (i.e. blinded to) the research question. The purpose of blinding the participants is to protect against reporting bias.

E) DATA COLLECTION METHODS

Tools for primary outcome measures must be described as reliable and valid. If 'face' validity or 'content' validity has been demonstrated, this is acceptable. Some sources from which data may be collected are described below:

Self reported data includes data that is collected from participants in the study (e.g. completing a questionnaire, survey, answering questions during an interview, etc.).

Assessment/Screening includes objective data that is retrieved by the researchers. (e.g. observations by investigators).

Medical Records/Vital Statistics refers to the types of formal records used for the extraction of the data.

Reliability and validity can be reported in the study or in a separate study. For example, some standard assessment tools have known reliability and validity.

F) WITHDRAWALS AND DROP-OUTS

Score **YES** if the authors describe BOTH the numbers and reasons for withdrawals and drop-outs.

Score **NO** if either the numbers or reasons for withdrawals and drop-outs are not reported.

The percentage of participants completing the study refers to the % of subjects remaining in the study at the final data collection period in all groups (i.e. control and intervention groups).

G) INTERVENTION INTEGRITY

The number of participants receiving the intended intervention should be noted (consider both frequency and intensity). For example, the authors may have reported that at least 80 percent of the participants received the complete intervention. The authors should describe a method of measuring if the intervention was provided to all participants the same way. As well, the authors should indicate if subjects received an unintended intervention that may have influenced the outcomes. For example, co-intervention occurs when the study group receives an additional intervention (other than that intended). In this case, it is possible that the effect of the intervention may be over-estimated. Contamination refers to situations where the control group accidentally receives the study intervention. This could result in an under-estimation of the impact of the intervention.

H) ANALYSIS APPROPRIATE TO QUESTION

Was the quantitative analysis appropriate to the research question being asked?

An intention-to-treat analysis is one in which all the participants in a trial are analyzed according to the intervention to which they were allocated, whether they received it or not. Intention-to-treat analyses are favoured in assessments of effectiveness as they mirror the noncompliance and treatment changes that are likely to occur when the intervention is used in practice, and because of the risk of attrition bias when participants are excluded from the analysis.

Component Ratings of Study:

For each of the six components A – F, use the following descriptions as a roadmap.

A) SELECTION BIAS

Strong: The selected individuals are very likely to be representative of the target population (Q1 is 1) **and** there is greater than 80% participation (Q2 is 1).

Moderate: The selected individuals are at least somewhat likely to be representative of the target population (Q1 is 1 or 2); **and** there is 60 - 79% participation (Q2 is 2). 'Moderate' may also be assigned if Q1 is 1 or 2 and Q2 is 5 (can't tell).

Weak: The selected individuals are not likely to be representative of the target population (Q1 is 3); **or** there is less than 60% participation (Q2 is 3) **or** selection is not described (Q1 is 4); and the level of participation is not described (Q2 is 5).

B) DESIGN

Strong: will be assigned to those articles that described RCTs and CCTs.

Moderate: will be assigned to those that described a cohort analytic study, a case control study, a cohort design, or an interrupted time series.

Weak: will be assigned to those that used any other method or did not state the method used.

C) CONFOUNDERS

Strong: will be assigned to those articles that controlled for at least 80% of relevant confounders (Q1 is 2); **or** (Q2 is 1).

Moderate: will be given to those studies that controlled for 60 – 79% of relevant confounders (Q1 is 1) **and** (Q2 is 2).

Weak: will be assigned when less than 60% of relevant confounders were controlled (Q1 is 1) **and** (Q2 is 3) **or** control of confounders was not described (Q1 is 3) **and** (Q2 is 4).

D) BLINDING

Strong: The outcome assessor is not aware of the intervention status of participants (Q1 is 2); **and t**he study participants are not aware of the research question (Q2 is 2).

Moderate: The outcome assessor is not aware of the intervention status of participants (Q1 is 2); **or** the study participants are not aware of the research question (Q2 is 2); **or b**linding is not described (Q1 is 3 and Q2 is 3).

Weak: The outcome assessor is aware of the intervention status of participants (Q1 is 1); **and** the study participants are aware of the research question (Q2 is 1).

E) DATA COLLECTION METHODS

Strong: The data collection tools have been shown to be valid (Q1 is 1); **and** the data collection tools have been shown to be reliable (Q2 is 1).

Moderate: The data collection tools have been shown to be valid (Q1 is 1); **and** the data collection tools have not been shown to be reliable (Q2 is 2) **or** reliability is not described (Q2 is 3).

Weak: The data collection tools have not been shown to be valid (Q1 is 2) **or** both reliability and validity are not described (Q1 is 3 and Q2 is 3).

F) WITHDRAWALS AND DROP-OUTS - a rating of:

Strong: will be assigned when the follow-up rate is 80% or greater (Q2 is 1).

Moderate: will be assigned when the follow-up rate is 60 – 79% (Q2 is 2) **OR** Q2 is 5 (N/A).

Weak: will be assigned when a follow-up rate is less than 60% (Q2 is 3) or if the withdrawals and drop-outs were not described (Q2 is 4).

Appendix 6: Quality Assessment Tool for Quantitative Studies Dictionary: Tool

QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES

EPHPP
Effective Public Health Practice Project

COMPONENT RATINGS

A) SELECTION BIAS

(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?

1 Very likely
2 Somewhat likely
3 Not likely
4 Can't tell

(Q2) What percentage of selected individuals agreed to participate?

1 80 - 100% agreement
2 60 – 79% agreement
3 less than 60% agreement
4 Not applicable
5 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

B) STUDY DESIGN

Indicate the study design

1 Randomized controlled trial
2 Controlled clinical trial
3 Cohort analytic (two group pre + post)
4 Case-control
5 Cohort (one group pre + post (before and after))
6 Interrupted time series
7 Other specify _____
8 Can't tell

Was the study described as randomized? If NO, go to Component C.

No Yes

If Yes, was the method of randomization described? (See dictionary)

No Yes

If Yes, was the method appropriate? (See dictionary)

No Yes

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

1

C) CONFOUNDERS

(Q1) Were there important differences between groups prior to the intervention?

1 Yes
2 No
3 Can't tell

The following are examples of confounders:

1 Race
2 Sex
3 Marital status/family
4 Age
5 SES (income or class)
6 Education
7 Health status
8 Pre-intervention score on outcome measure

(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?

1 80 – 100% (most)
2 60 – 79% (some)
3 Less than 60% (few or none)
4 Can't Tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

D) BLINDING

(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?

1 Yes
2 No
3 Can't tell

(Q2) Were the study participants aware of the research question?

1 Yes
2 No
3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

E) DATA COLLECTION METHODS

(Q1) Were data collection tools shown to be valid?

1 Yes
2 No
3 Can't tell

(Q2) Were data collection tools shown to be reliable?

1 Yes
2 No
3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

F) WITHDRAWALS AND DROP-OUTS

(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?

1 Yes
2 No
3 Can't tell
4 Not Applicable (i.e. one time surveys or interviews)

(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).

1 80 -100%
2 60 - 79%
3 less than 60%
4 Can't tell
5 Not Applicable (i.e. Retrospective case-control)

RATE THIS SECTION	STRONG	MODERATE	WEAK	
See dictionary	1	2	3	Not Applicable

G) INTERVENTION INTEGRITY

(Q1) What percentage of participants received the allocated intervention or exposure of interest?

1 80 -100%
2 60 - 79%
3 less than 60%
4 Can't tell

(Q2) Was the consistency of the intervention measured?

1 Yes
2 No
3 Can't tell

(Q3) Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?

4 Yes
5 No
6 Can't tell

H) ANALYSES

(Q1) Indicate the unit of allocation (circle one)

community organization/institution practice/office individual

(Q2) Indicate the unit of analysis (circle one)

community organization/institution practice/office individual

(Q3) Are the statistical methods appropriate for the study design?

1 Yes
2 No
3 Can't tell

(Q4) Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?

1 Yes
2 No
3 Can't tell

GLOBAL RATING

COMPONENT RATINGS

Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

A	**SELECTION BIAS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
B	**STUDY DESIGN**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
C	**CONFOUNDERS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
D	**BLINDING**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
E	**DATA COLLECTION METHOD**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
F	**WITHDRAWALS AND DROPOUTS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	Not Applicable

GLOBAL RATING FOR THIS PAPER (circle one):

1	STRONG	(no WEAK ratings)
2	MODERATE	(one WEAK rating)
3	WEAK	(two or more WEAK ratings)

With both reviewers discussing the ratings:

Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings?

No Yes

If yes, indicate the reason for the discrepancy

1	Oversight
2	Differences in interpretation of criteria
3	Differences in interpretation of study

Final decision of both reviewers (circle one):

1	**STRONG**
2	**MODERATE**
3	**WEAK**

Appendix 7: List of validated survey tools from Table 2.2

1. Bergeron J., Landry M., Ishak I., Vaugeois P., Trépanier M. Validation of an Instrument for Evaluation of the Serverity of the Probleams Associcated with Drug Use and Alcohol, Addiction Severity Index. Montreal, Canada: Research Papers RISQ; 1992.
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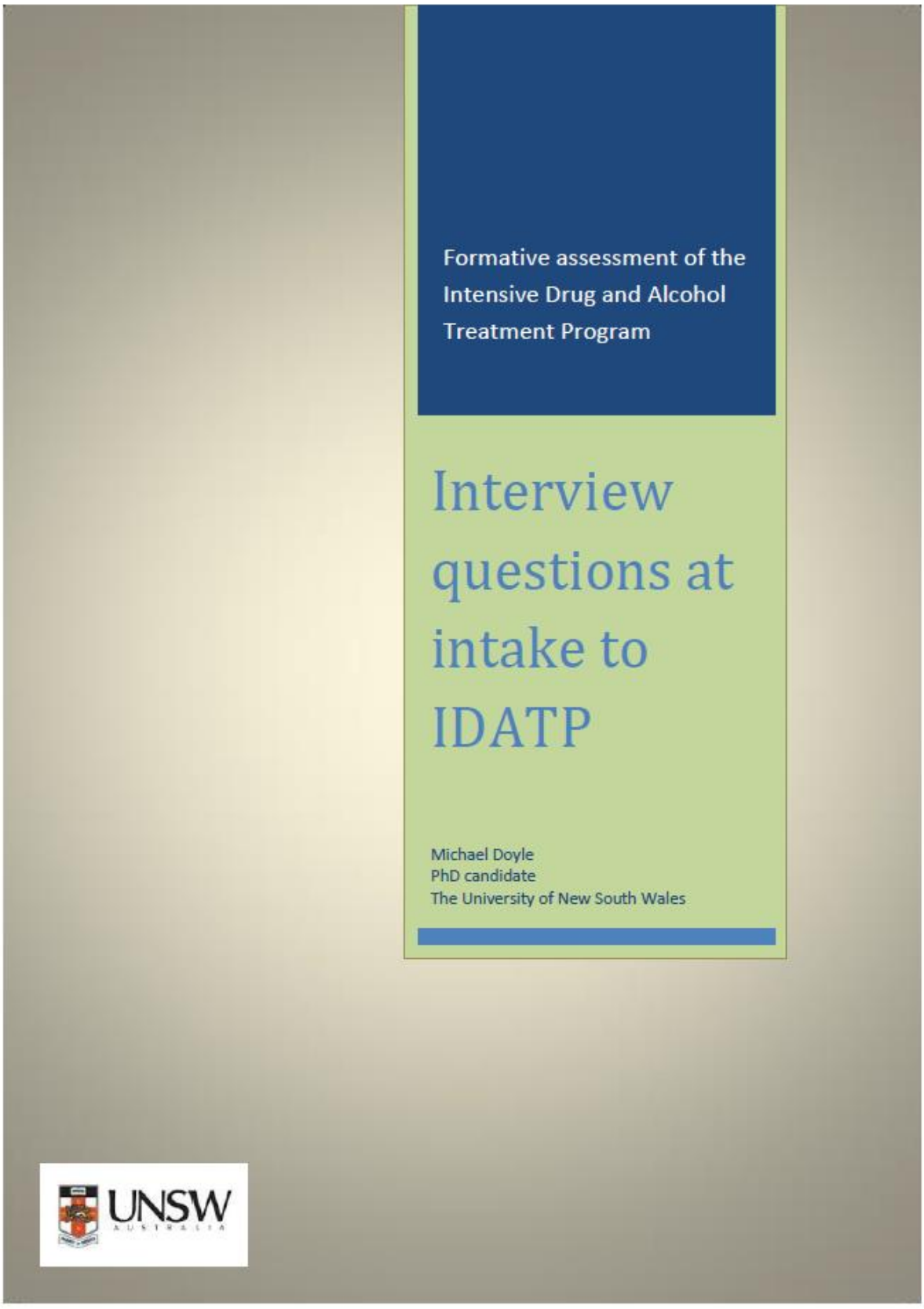
Appendix 8: Question guide for qualitative interviews



Demographic information

What suburb and state did you spend most of you time in during the 12 months before prison?

1.1 State? _____
Suburb? _____

1.2 Were you living alone, with a partner and/or family or with friends?

1.3 Year of birth? _____

1.4 Are you Aboriginal and/or Torres Strait Islander? YES NO

1.5 Preferred language? _____

1.6 Do you have family responsibilities such as looking after children? If so can you briefly describe them?

Imprisonment

2.1 Is this your first time to prison? _____

2.2 When did you first get in trouble with the law?
- Have you been to juvenile detention?
- Have you been on a community based order?

2.3 Do you find it embarrassing (or shame) to be in prison? Why is that?

Education and employment

3.1 How old were you when you left school? If you left early, why was that?

3.2 How would you rate your reading and writing skills? And compared to your family and friends?
- Would you like to learn to read or write better?

3.3 Do you have any qualifications?

3.4 Do you plan on studying while at IDATP? What sort of study would interest you?

3.5 Were you working and/or studying before your current term in prison?
- If not, why was that?

3.5 Have you ever held a job for a long time? How long? and why did you leave?

3.6 Did you enjoy working? Was it of much benefit to you (did you get much out of it)?

Or if not previously working; Do you think you would enjoy working? Do you think it would be of much benefit?)

Alcohol and other drug use

4.1 How old were you when you first starting drinking and or using drugs? And why did you start using?

4.2 What was your preferred drug in the past year before prison (this can including alcohol?
- Was it also your most commonly used drug (including alcohol)?

4.3 Was alcohol and/or drug use involved in the offence/s that led to your current term of imprisonment?

4.4 Do you think if you didn't use drugs or drink alcohol that you might not get in trouble with the law? Why do you think that?

4.5 When you were drinking or using drugs who did you most commonly use or drink with? And where did you most commonly use or drink?

4.6 Have you ever felt like drinking or using drugs to fit in or because it's what's expected?

4.7 Do you have friends or family that don't drink or use drugs that you spend social time (hangout) with? Why is that?

Previous - alcohol and drug treatment

5.1 Have you even been referred to and/or attended alcohol and other drug treatment before?

- If No, why not? If YES, what sort of treatment? (Eg one to one counselling, group therapy)

5.2 What were the best things about the treatment program you were in? What sort of stuff did you learn? Was the program on-going? Was there any follow up (maintenance)?

- Why do you think you ended up going back to alcohol or drug use?

5.3 What were the things that you didn't like about the treatment program you were in?

Intensive drug and alcohol treatment program (IDATP)

6.1 You are now in the IDATP program, which is a voluntary program that you need to apply to be put into, why did you apply?

6.2 Did you talk with others (inmates) in prison about alcohol and drug use before you got to IDATP? If yes, is it in a good or bad way?

6.3 What do you want to gain or learn from the IDATP program?

Reintegration

7.1 Can you tell me a bit about you plans once you get out of prison?

7.2 What sorts of support do you think you need to avoid going back to drinking and drugging in the same way as before?

7.3 If you have been released from prison previously, can you tell me a bit about the day you got released? (Eg picked up from prison by family & shouted a drink or drugs)

Appendix 9: Uluru Statement from the Heart

ULURU STATEMENT FROM THE HEART

We, gathered at the 2017 National Constitutional Convention, coming from all points of the southern sky, make this statement from the heart:

Our Aboriginal and Torres Strait Islander tribes were the first sovereign Nations of the Australian continent and its adjacent islands, and possessed it under our own laws and customs. This our ancestors did, according to the reckoning of our culture, from the Creation, according to the common law from 'time immemorial', and according to science more than 60,000 years ago.

This sovereignty is *a spiritual notion: the ancestral tie between the land, or 'mother nature', and the Aboriginal and Torres Strait Islander peoples who were born therefrom, remain attached thereto, and must one day return thither to be united with our ancestors. This link is the basis of the ownership of the soil, or better, of sovereignty.* It has never been ceded or extinguished, and co-exists with the sovereignty of the Crown.

How could it be otherwise? That peoples possessed a land for sixty millennia and this sacred link disappears from world history in merely the last two hundred years?

With substantive constitutional change and structural reform, we believe this ancient sovereignty can shine through as a fuller expression of Australia's nationhood.

Proportionally, we are the most incarcerated people on the planet. We are not an innately criminal people. Our children are aliened from their families at unprecedented rates. This cannot be because we have no love for them. And our youth languish in detention in obscene numbers. They should be our hope for the future.

These dimensions of our crisis tell plainly the structural nature of our problem. This is *the torment of our powerlessness.*

We seek constitutional reforms to empower our people and take *a rightful place* in our own country. When we have power over our destiny our children will flourish. They will walk in two worlds and their culture will be a gift to their country.

We call for the establishment of a First Nations Voice enshrined in the Constitution.

Makarrata is the culmination of our agenda: *the coming together after a struggle.* It captures our aspirations for a fair and truthful relationship with the people of Australia and a better future for our children based on justice and self-determination.

We seek a Makarrata Commission to supervise a process of agreement-making between governments and First Nations and truth-telling about our history.

In 1967 we were counted, in 2017 we seek to be heard. We leave base camp and start our trek across this vast country. We invite you to walk with us in a movement of the Australian people for a better future.