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"Barriers to Attending Rehabilitation Treatment Centres:
A Case of the Gumbaynggir Nation".

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ABSTRACT

Key words: Culture as a form of healing and preventative agent in barriers to attending rehabilitation treatment centres.

Alcohol and Drug Rehabilitation Centres, operated by mainstream community and government bodies or by Aboriginal groups, acknowledge that attendance by Aboriginal peoples has consistently been found to be low.

This thesis is about examining what are the barriers and reasons for resistance by Gumbaynggir people, to attendance at either non-Aboriginal mainstream or Aboriginal Rehabilitation Treatment Centres.

Research was undertaken utilising a qualitative approach, incorporating content analysis of literature, and six in-depth interviews with Aboriginal people, both men and women, from the Gumbaynggir Nation of Aboriginal peoples. (The selected region is also defined as Mid North Coast Health Service Northern Sector New South Wales). Interview data was analyzed from both the content and narrative approaches. The criteria for interview participant selection specifically focused on Aboriginal participants who are currently experiencing or may have experienced alcohol and other drug problems. Consent for interview was gained not only from the University of Sydney Ethics Committee, but also from Elders of Gumbaynggir Nation of Aboriginal Peoples.

The research undertaken in this Thesis shows that several factors directly affect a persons decision as to whether they do participate in rehabilitation, programs, and the extent of their participation. The findings from both the Literature Review and the Interview transcripts have been represented together and detail a large range of identified barriers to attending treatment programs.

The main findings related to issues of transport, cost of service, location, presence of non-Aboriginal staff, gender, family needs, cultural needs, cultural clash, and the need for community and family Elders to be involved in counseling and support.

This research shows that service providers in the area of drug and alcohol rehabilitation need to take into consideration the identified needs of the community. Recommendations for future research and program needs are detailed.
BACKGROUND

This section is designed to provide the reader with an insight into the geographical study area, which covers a majority of a certain region that is colloquially known as the holiday coast. The study area exists within New South Wales and is located along the Eastern Coastline of Australia, approximately halfway between Sydney and Brisbane. It includes local government areas extending from the township of Red Rock Corindi in the north down along the eastern coastline of Australia taking in Woolgoolga, Coffs Harbour, Sawtell, Toormina, Bayldon, Urunga, Nambucca Heads, Macksville to Stuart’s Point in the south, out to Bowraville, heading along and inland westward towards the mountains taking in Bellingen, Dorrigo, Ulong and Coramba, also included are numerous other smaller populated outreach communities and holiday destinations. These areas are primarily sub tropical in climate and have historically in certain localities consisted of relatively isolated rural townships. Geographically along and within the Mid North Coast area, located is also a fair amount of Aboriginal tribal land that is identified as the local Indigenous Tribal Gumbaynnggir Nation (appendix A), which highlights and indicates the boundaries surrounding and within only one area of indigenous tribal land Australia wide.

Indigenous population North Coast Region.

The Aboriginal and Torres Strait Islander population in the North Coast region increased by 1,565 people, the equivalent of 22% between 1986 and 1991. In
comparison, the statewide population over this period only increased by 18%.
The region accounts for 12% of the total Aboriginal and Torres Strait Islanders at the time of the last census; a figure which is greater than the 1.2% recorded for New South Wales as a whole. Kempsey local government area had the greatest number of Aboriginal and Torres Strait Islanders in the region (1,317 people-15% of the regional total). Other relatively large Aboriginal and Torres Strait Islander communities in the North Coast are found in the local government areas of Tweed Heads, Lismore, Coffs Harbour and greater Taree. Of the relatively large communities in the region, population growth was particularly strong in the Coffs Harbour, Lismore and Tweed Heads local government areas.

The proportion of Aboriginal and Torres Strait Islanders in Coffs Harbour in 1996 was 2.4% up from 1.8% in 1991. The proportion in the Mid North Coast and New South Wales in 1996 were 2.8% and 2.7% respectively.

The local indigenous population residing within the townships and boundaries of the Gumbaynnggir Nation and the Mid North Coast Area Health Service (Northern Sector) area. As mentioned previously extends from Red Rock Corindi in the north, down to and taking in Woolgoolga, Coffs Harbour, Sawtell, Urunga, inland across to Bellingen, up the range to Dorrigo across the plateau to Ulong, Glenreagh and Coramba. Also included are numerous other smaller populated outreach communities. This immediate area is within a distance radius of approximately 150Klms alone. According to the Coffs
Harbour & District Local Aboriginal Land Council Statistics and local community knowledge they indicate the indigenous population residing within this area is between an estimated 3,000 to 3,500 people. The geographical areas just south of the above mentioned locations are also part of the Indigenous Gumbaynggir Nation and the Mid North Coast Health Service (Northern Sector). These include the townships of Nambucca Heads, Macksville to Stuart's Point in the south, inland towards Bowraville along the mountain range back to Bellingen and once again included are numerous other smaller populated outreach communities. The estimated indigenous population living within these localities are approximately between 2,000 to 2,500 according to Bowraville, Macksville and Nambucca Heads local Aboriginal Land Councils and based on their community members local knowledge.

If we combine the overall estimated indigenous population of the Gumbaynggir Nation it suggests there is approximately between 5,000 to 5,500 people which differs considerably from the Australian Bureau of Statistics 1996 which indicates indigenous population for these localities to be less (as mentioned above).

Family Background.

My father is a Gumbaynggir elder, my mother was originally from the Aboriginal Bundjalunng Nation which is located north of the Gumbaynggir
Nation previous to them being married. From my parent’s backgrounds I respect both Aboriginal Tribal Nations and personally do not favour one from the other, I feel closely tied to both because of the fact I was raised and identify as an Aboriginal person. Respecting our culture, tradition, spirituality, family and extended families was something that was instilled in me from a young age. Teaching and learning ways of surviving with people from different cultural backgrounds, respecting, sharing, and caring has been handed down through generations of family history and tradition. My family have lived in the past 1000’s of years and continue to live in both identified areas of the Mid North Coast and Gumbaynnggir Nation Region in the City of Coffs Harbour. I am the oldest son in our immediate family with three brothers and one sister. Schooling education began and completed at Coffs Harbour. I left school at a early age being the oldest to help my parents meet the needs to provide for the other family members to continue higher education, provide for food, clothing and helping with meeting the rent payments, these were hard years but our family improvised and survived. The pleasing and very rewarding result of these actions was my brothers and sister continuing with their higher education, completing their higher school certificates, which was something I never did, My dad, my mum, myself and our relatives were very proud of their achievement it provided them with a great stepping stone towards their future and eventually their families futures.

I am an indigenous Gumbaynnggir man, being recognised and recognising local community members shows acceptance and trust, as a local Aboriginal
person growing, living and eventually working in Aboriginal Health is an advantage in itself.

Our family community connections and personally being involved with local and broader Aboriginal activities provides a very strong bond towards research planning, processing and implementing Aboriginal health education programs.

Another advantage personally is being employed by the Mid North Coast Area Health Service for the past six years as a Aboriginal health worker, my official employed job title is the Mid North Coast Hospital Aboriginal Liaison Officer based at the Coffs Harbour Base Hospital. I am able to experience first hand the existing alcohol and other drugs problem affecting a selected number of local Aboriginal Gumbaynggir community members experiencing these problems first hand within this locality.

Job description requires providing Aboriginal health liaison service not only to Coffs Harbour Base Hospital but also Dorrigo, Bellingen and Macksville District Hospitals which are located within the Gumbaynggir Nation and the Mid North Coast Area Health Service (Northern Sector). Duty statement involves breaking down any barriers that occur or exists between Aboriginal and Torres Strait Islander inpatients, non-Aboriginal nursing staff, hospital residents, general practitioners, specialists, other health service providers and staff receptions. Support and advocate on behalf of inpatients if needed or
appropriate, referral and follow-up upon discharge from hospital, transport where necessary. Continued contact and consultation with Nurse discharge planner and Aboriginal health workers in particular the Aboriginal community nurse. Provision of Aboriginal health service at numerous times is required in not only the immediate local area but also the broader outreach laying communities through the approach of hands on Aboriginal health and Primary Health & Extended Care Services.
INTRODUCTION

Indigenous peoples continue to suffer a much greater burden of ill health than do other Australians. The health disadvantage of indigenous Australians begins early in life and continues throughout the life cycle (Australian Bureau of Statistics, 1999).

Aboriginal and Torres Strait Islander people are the least healthy of all Australians. They suffer a higher burden of disease and die at a younger age than non-Aboriginal Australians. The 1997 Australian Bureau of Statistics Report – The health and welfare of Australia's Aboriginal and Torres Strait Islander People, that smoking was twice as common among Aboriginal people than non-Aboriginal people. And while Aboriginal people are more likely to abstain from alcohol than the general population, those who do drink do so at harmful levels. Furthermore 51% of the urban Aboriginal population had tried at least one illicit drug compared to 38% of the general population. Moreover, indigenous inmates comprise 15.2% of the full-time prison population, a rise from 5.8% in 1982.

The poor status of Aboriginal people is well documented, in addition to serious health inequalities (National Aboriginal Community Controlled Health Organization, 1989).

Aboriginal people are the most disadvantaged group in socio-economic terms in the Australian community. Aboriginal people experience greater levels of
unemployment, lower levels of education, relative powerlessness, poor housing and unsatisfactory environmental health conditions. Evidence suggests that the disparity between Aboriginal and non-Aboriginal people, at least measured by mortality, has widened in recent years (Australian Bureau of Statistics, 1999).

Research indicates an apparent high incidence of substances dependence and abuse which continues to cause serious health and social problems for indigenous peoples around the world and in Australian Aboriginal communities (Khan et al., 1990).

Historically, it is well known that alcohol was first introduced into Aboriginal communities in Australia by European settlers in the early part of the nineteenth century (Langton, 1991).

Substance dependence and abuse continues to cause numerous serious health and social problems for aboriginal communities generally (Kahn, Hunter, Heather, & Tebbutt, 1990; Brady, 1991a; Langton, 1991; Weeramanthri, et al, 1994; Perkins, 1994), and the aboriginal communities within the Gumbaynnggir Nation in particular (Craig, 1997; Craig, 1998). The New South Wales Health Department has noted that in rural aboriginal communities, including the Mid North Coast Regional tribal group the Gumbaynnggir, that they are far from Drug & Alcohol treatment Centres and need assistance to attend (New South Wales Health, 2000; p. 32). The local
Coffs Harbour Base Hospital Aboriginal Hospital Liaison Officer agrees with this observation and has noticed Gumbaynnggir community members have shown an unwillingness to attend either Aboriginal or mainstream regional rehabilitation treatment centres for much needed treatment.

These substance abuse problems include those negatively affecting aboriginal health, emotional, physical, cultural and social living environments, and legal justice issues.

However, very few of the tribal group suffering these problems, and living within the Mid North Coast area seem to be attending regional substance abuse rehabilitation or detoxification centres. This avoidance of accepting treatment seems to be equally true when referrals are made to rehabilitation centres specifically designed for aboriginal people as for those referred to mainstream treatment centres.

Difficulties engaging aboriginal people into health treatments has been seen as incorporating a host of social, cultural and historical problems in the relationship between aboriginal identity and self determination as much as the specific health problem in question (Anderson, 1994).

In particular, there is concern at the growing numbers of Gumbaynnggir Nation community members who continue having substance abuse problems within our local communities. People who are either in denial of their problem
or unwilling to attend detoxification facilities for a period of time, and who then need to, but do not accept access to local or regional rehabilitation treatment centres (Craig, 2000).

The present research explores reasons for resistance by Gumbaynnggir Nation members with substance abuse problems to their attendance at available mainstream and aboriginal focused residential Drug and Alcohol rehabilitation centres. The study will explore what are the cultural, social and practical barriers that need to be overcome before these people are likely to accept treatment, and what actions and recommendations should be made to assist the overcoming of these barriers to treatment.
LITERATURE REVIEW

The essential factor in the treatment of Alcohol and Other Drugs is the engagement of substance abuse sufferers into treatment and this is especially relevant for Aboriginal people (New South Wales Health, 2000; p. 39). Therefore identifying and removing actual and perceived barriers to them entering treatment becomes a critical focus for clinicians in treatment settings in general, and in treatment settings servicing indigenous populations in particular due to their cultural differences.

The Association of Health Research (USA) argues that it is now more important than ever to examine barriers to access to treatment and to formulate strategies to overcome them (Schmidt, 1997). Schmidt stresses that this examination needs to be directed at individuals, organizations and society, and that we need to broaden our understanding of how people get treatment and of crucial barriers restricting access. Barriers to services should be minimized. Most people with alcohol use disorders do not enter alcohol treatment. Indeed, recent research estimates that anywhere from 75 percent to 93 percent of adults in the U.S. who need alcohol treatment, do not actually receive it (Grant & Perl, 1992). A critical question therefore, is why don’t more people who need alcohol treatment seek and receive such treatment? If we wish to improve access to and utilization of alcohol treatment, our understanding of barriers to treatment and the factors that influence individual’s decisions to seek help must be expanded.
Yet, most research to date on factors that influence alcohol treatment utilisation examines only those people who actually are in treatment, a group that represents only a small percentage of those who are in need. As a result, these studies offer no information on the population of greatest clinical and policy relevance - people with alcohol use disorders that are not in treatment. However, a recent USA population based survey examined individuals who are in current need of alcohol treatment, regardless of whether they have received it, and it’s data suggests that individual’s beliefs - including denial of a problem, lack of confidence in treatment effectiveness and fear of stigmatisation - are significant impediments to help – seeking (Grant & Perl, 1992).

In Australia, The Australian Disability Review identified several factors that directly affect an Aboriginal persons level of involvement and participation of services. These factors are identified as being, cultural beliefs, transport and isolation, location and features of services, community and professional education, access and rights, careers and respite care, employment, education, health awareness and Aboriginal involvement in decision making. (Gething, L 1995 p 77)

Current Australian research in the area regarding studies reviewing treatment effectiveness for substance abusing indigenous Australians, have revealed that there is little well researched evidence into what strategies are
particularly effective with Aboriginal peoples in engaging them into treatment for substance abuse problems (Wilson, 1987; Lyon, 1992; Moore, 1992; Alita, & Morton, 1995; Gray, Saggers, Sputore & Bourbon, 2000), and that treatment options have been limited (Mattick & Jarvis, 1993). Also there has been no thorough review of Aboriginal rehabilitation inpatient alcohol and drug treatment centres (Brady, 1995).
The failure of mainstream health care services was reflected in the widespread under utilisation of them by Aboriginal people (Martin, 1976). In turn, this was a contributing factor to the higher burden of morbidity and mortality among Aborigines, as without treatment relatively minor complaints developed often-serious complications. By the early 1970s, there were some within the mainstream health care service who, either recognising such problems or responding to Aboriginal criticisms, attempted to deal with these shortcomings. However, the creation of special state or territory programs to deal with Aboriginal health has had limited success. The crucial factors in this has been the related issues of lack of Aboriginal control over the planning and delivery of services, and the basically reactive nature of mainstream services which are of necessity always one step behind the community. The basic weakness of state and territory programs is that they are largely controlled by professionals, far removed socially and culturally from Aboriginal communities, who wish to provide services for rather than in conjunction with Aborigines. This is reflected in the comments of an Aboriginal health worker from the Victorian Aboriginal Health Service, who said:

"I just think myself that SSHS [Victoria's Special Services Health Section] is working under false pretences. Well, because of them the workers are just too far removed from the community and it's not the aide's faults, it's the heads. Like they'd like people to come and approach them in this office which just can't be done."
Well, they've been operating what for three years and the problems have accumulated over more years than that and so you have to go out and meet society on their own terms. Then, when the koories have enough faith in you, they'll come and see you and get good results” (Nathan, 1980:107).

The Northern Territory Department of Health was seen to have similar shortcomings. They don't have too much idea about people living in camps; like the sisters won't go into camps in the afternoon because they think it's too violent. People might be drinking, but they won't be violent (Nathan & Japanangka, 1983:168).
It has been argued that the basic principles for success in the provision of primary health care are political commitment to the social equity, community participation, and technical fit (Morley, Rohde & Williams, 1983; 325-6). These criteria are derived from study of successful health care programs and from the World Health Organisation’s Alma Ata Declaration which states that primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost to the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination (World Health Organization, 1981).

Although in this instance referring to primary health care, these criteria are useful in assessing health care at various levels. By any of them, health services provided for Aborigines in the late 1960s and early 1970s generally failed and many continue to do so. Health services were inaccessible to Aborigines for a variety of reasons. In some mission settlements, basic medical services were provided, but for many Aboriginals residing in remote areas of Australia, apart from regular, though infrequent, clinics conducted by the Royal Flying Doctor Service, there were simply no services available on a regular basis. This meant that although emergency evacuation for serious medical problems was available, many less serious problems went untreated or had to wait until the scheduled clinic. Among Aborigines living in country
towns or cities, health services were often inaccessible because people lacked transportation or because of the difficulties of using public transportation. Particularly for young mothers who might have two or three children under the age of five, catching a bus or train to a doctor's surgery can be a major undertaking.

While the absence of a universal health insurance scheme prior to the 1970s disadvantaged many poor and working class Australians, it presented even greater difficulties for Aboriginal people. Aborigines in towns and cities were more commonly unemployed or in low paying jobs, and were even less able to deal with the bureaucratic procedures which might enable them to receive free medical care.

Writing of the New South Wales town of Bourke, (Kamien, 1978; 197) stated that even if most Aboriginal people were entitled to receive the full subsidised medical benefit, not one had ever made permanent use of this system, owing to the ignorance of it or to lack of that degree of education necessary to master its intricacies.

The direct charges made for their services by medical practitioners or hospitals are only one component of the cost of seeking health care. In addition, people must often bear the costs of taking time off work and of transportation, as well as other indirect costs such as care of children. For people on low income these indirect costs are relatively high and are an
important barrier to the use of medical services. While the burden of the
direct costs of medical care have been alleviated through the introduction of
universal health insurance, the indirect costs remain.

Perhaps more important than issues of accessibility and cost is the fact that
many of the services offered to Aborigines were and continue to be
unacceptable to them and there is what (Kamien, 1978) has described as a
‘cultural chasm’ between Aboriginal patients and health care providers.

Studies of access at the individual level show that friends, family and people
in the workplace play important roles in promoting or inhibiting treatment
entry. Family, friends and colleagues can provide the needed social pressure
that leads a person to admit a drinking problem and seek help. But they may
also hinder treatment entry by denying or covering up the problem (Schmidt,
1997 p. 2).

**Barriers to Rehabilitation Treatment**

It is important to recognise the different worldviews about a particular illness
episode that may each be held by an Aboriginal person and a non-Aboriginal
health professional. In order to understand such differences, it has been
suggested that it is useful to adopt the ‘explanatory model’, which seeks to
identify not only the cause of the illness but all aspects of the illness that may
have meanings for the Aboriginal patient, and which may be completely
outside the professional and world view of the health practitioner (Mobbs, 1991). The doctor practitioner must therefore, have genuine interest in the meaning the sickness has for the patient, and make explicit to the patient his intent to draw on this essential information in constructing an appropriate treatment plan. Thus a question such as, “Why do you think it started when it did?” would be preferable to, “When did you get sick?” (Mobbs, 1991).

The doctor may also be assisted by learning as much as possible about the Aboriginal patient from that patient’s family, and from other Aboriginal and non-Aboriginal health personnel familiar with both the family and the community. (Shannon, 1994).

Among some Aborigines, there are different attitudes to illness and suffering. If a child is sick, for example, the concern is often to seek medical care immediately. The prime concern is the welfare of the child, not the convenience of the health service provider or the scheduled clinic hours. This difference often brings people into conflict with health care personnel.

Concepts of ‘shame’ associated with seeking help or acknowledging the need for drug & alcohol rehabilitation, is also a serious and valid factor in whether an Aboriginal person decides to seek assistance. Douglas Morgan, in a paper titled "Aboriginal philosophy and its impact on health care," clearly shows the significance of the concept of ‘shame’ to Aboriginal peoples. He notes that ‘shame’ is a profound concept and holds a different definition for Aboriginal
people than it does for European Australians, and that 'shame' is perhaps the most complex and sensitive Aboriginal concept and practice to deal with in a health clinic. Morgan recommends that it most cases, it is best to approach it indirectly by making changes to clinical settings and methods.

"Most European Australians have difficulty comprehending the way Aboriginal people understand 'shame'. Not surprisingly, its full impact in health and health care outcomes is either not noticed or misunderstood. Shame might be experienced by, or for, a person who acts, or who is forced to act, in a manner that is not sanctioned by the group and that it is in conflict with social and spiritual obligations. The fulfillment of obligations to the group is more important in Aboriginal society than isolated individual behaviour, especially individual assertiveness. Given their commitment to the extended social self, group cohesion and cooperation are not driven by economic and political expediency, they are the expressions of life itself." (Morgan D., & Slade M. 1997 p. 598)

Language, even though Aboriginal people may still speak their traditional language, they also speak English. However, the forms and conventions in their use of English may vary from those used by non-Aboriginal people. According to Eades (1991), the non-Aboriginal convention of questioning in order to elicit answers is not always appropriate, because Aboriginals will seek information by presenting it for confirmation or refutation. While clinicians are taught to avoid leading questions for Aboriginal patients, language should be phrased to allow the patient to agree, deny and elaborate on the problems. It is important to remember that it is not just the language that separates us;
it's the vast differences between our cultures. But these differences are not
insurmountable. Being prepared to take that extra step to help clients from
different cultural backgrounds is ultimately rewarding for Specialists, local
General Practitioners, Hospital Residents, Nursing Staff, non-Aboriginal health
professionals and their Aboriginal clients.

Aboriginal people communicate in a way that is quite different to that of non
Aboriginals. Communication can be complex. To you and I, 'yes' means yes,
but to an Aboriginal person, yes may mean 'go away I don't want to answer
your questions'. What may be construed by a doctor as uncooperative
behaviour, might in fact represent difficulties in communicating which the
Aboriginal patient feels. For example, Aboriginal people may appear slow or
reluctant to answer, or they may respond to questioning but not to offer any
new information. In this regard, Eades (1991) explains that In Aboriginal
society the passing of information doesn't result from a direct query, it is the
result of normal two-way interaction between people. It is also important to
recognise the significance of non-verbal communication in Aboriginal cultures.
For example, silence must be accepted as an important part of Aboriginal
communication patterns. Thus, the Aboriginal person may be quite happy to
sit, speak occasionally, and feel no obligation to keep the conversation
flowing. While long periods of silence can be difficult to tolerate, and prove
quite stressful, Eckerman et al. (1994) suggests that the only way to deal
with such a situation with an Aboriginal person, is to "sit back and to listen –
to relax with silences and to learn to tune into local speech patterns and
idioms”. It is useful in these circumstances to work with the client’s family and other relevant non-Aboriginal health personnel, the Aboriginal Hospital Liaison Officer, and clinical staff closer to home, this approach will help to gain as much information as possible about the patient and their illness from both a western and traditional perspective.

Geographical location inaccessible strongly suggests transport for Aboriginal people who must travel long distances to obtain an evaluation or treatment from an approved provider face particularly difficult barriers to care. Geographic inaccessibility may create hardships that are impossible for the most motivated clients to overcome. For example, a man presented at a hospital seeking admission for detoxification, he was counselled and assessed by a drug & alcohol worker. Referral was to attend a hospital setting 30kms away for five days detoxification period before hopefully continuing on to attend a rehabilitation treatment centre. The five-day detoxification period was not really a problem because of support from both Aboriginal and non-Aboriginal health workers along with transport provided by the Aboriginal Health Worker within the Area Health Service. The real problem began when it was suggested he continues and attends his rehabilitation treatment service outside his local area and the local area health service. Being away from his environment, family, relatives and friends, along with distance and transport issues were of great concerns.
Gender concerns and issues in regards to barriers and providing treatment and prevention for women with alcohol-related problems appear to have been inadequately addressed. To date, the alcohol and drug field has not met the range of women's needs in either prevention or treatment programming. Very few programs seem to be specifically designed for women. Most still seem to be intended for men, because they are based on methods used for males. Few programs provide childcare services; this has been found to be another most frequent barrier for both male and female people wanting to attend treatment centres. The fear of the loss of a dependent child or children, and also that they will be unable to regain custody of their children after completing treatment because of an identified alcohol and drug problem. Knowing this the person delays or avoids treatment.

In indigenous Australian society, women's and men's business are quite separate, and are governed by strict social rules that can result in punishment if these are breached. Thus, when a client of the opposite sex is treated by a health practitioner, it can be an experience of great embarrassment and shame these two points in themselves are reasons and cause barriers. Particularly in remote areas, many Aboriginal women regard male involvement in childbirth as unacceptable, consequently they are reluctant to make use of obstetric services. Similarly, for many Aboriginal women their roles as nurturers of their children take precedence over other roles and they sometimes become reluctant to administer medication to a child who refuses it. In such circumstances it is more appropriate for health care providers to enlist the support of other relatives in helping to care for the child. More
commonly, however, the mother is regarded as not providing care. Aboriginal women in these situations feel they are unable to speak openly in a conversation. This may also lead to complete withdrawal by the client. An example of this care of an Aboriginal woman by a male practitioner during pregnancy. Clearly, the response will depend, to some extent, on the individual doctor and client and the relationship already established.

In 1995 the review on Detoxification Services in New South Wales found that “most detoxification services are based on the notion that males are the predominant group” seeking detoxification treatment. Consequently there are many features about the design and operation of many specialist detoxification services that are more attuned to the needs of men than women. The importance of child care arrangements within or associated with specialist detoxification services to increase the accessibility of services by women is recognised. It is also recognised that ambulatory detoxification is an attractive option for women with children.

Aboriginal people, along with members of other lower socio-economic groups, commonly experience difficulties in accessing health services, resulting from factors such as a lack of transport and a limited cash flow. For example, this latter point is important in terms of processing the gap between the consultation fee and the medicare refund. The requirement to pay the account at the time of consultation and then seek the medicare rebate also places an interim stress on the finances.
Because of the overriding priority Aboriginal people accord their social relationships, health care, including keeping an appointment or following up on medical advice, may become secondary to the person's social responsibilities at the time (Shannon, 1994).

Another significant barrier to alcohol treatment is the cost. As cost containment has become a national priority, significant changes have occurred in the financing of alcohol treatment services. The field has seen reductions in inpatient care, increases in outpatient care, including outpatient detoxification. One of the greatest challenges facing alcohol treatment providers is maintaining the quality of care in the face of these constraints.

Unemployment and lower levels of education are identified as barriers to attending alcohol and other drug treatment. However, lack of higher education served to impede treatment entry only among respondents with prior alcohol treatment experiences, suggesting that consumer satisfaction may influence alcohol treatment seeking.

In other words, respondents with less education may not have the requisite skills or knowledge to perform well in various treatment settings or may not understand information about dealing with their disorder, either of which can lead to dissatisfaction with the care received.
The age of both genders is also another barrier for a majority of rehabilitation treatment centres, which tend to provide for 21-25 years or older. So the question remains, what happens to our younger generation under these ages who are experiencing alcohol and other drug problems.

As a Aboriginal health worker employed by the Mid North Coast Area Health Service it is of great concern not only for myself but also the families and relatives, community elders, and community members. It is very disturbing to know with local knowledge, in trying to provide a health service for our people, when it seems it is being blocked by protocol, guidelines, in-house rules and in-house decision making without looking at the need basis, the big picture and holistic view of rehabilitation treatment centres service provision in regards to age limit. (Craig, personal knowledge, 2,000).

Another cultural barrier to the provision of health care for Aboriginal people has been the environment in which it is provided. The impersonal nature of clinic facilities, the presence of relatively large numbers of non-Aboriginal people, and the operation of rules which are more for the convenience of the staff than for the benefit of the patients have served to intimidate and alienate Aborigines.

These factors are often exacerbated by the negative attitudes of non-Aboriginal service providers to Aboriginal patients. Providers are often judgmental and authoritarian. They commonly have paternalistic, if not racist,
attitudes to Aborigines which they themselves do not recognise. In a recent report from Western Australia, (Gray and Atkinson, 1990) recorded the following statements from people in the state health care system who claim to be sympathetic to Aborigines.

Aborigines don’t have the personality to get involved. If they had more enthusiasm they would learn. Between 50 and 80% of them (Aboriginal people) are psychopaths.

A lot of them are not intelligent enough to look at our views of health (1990:49).

Cultural factors. It is now accepted wisdom that services offered to Aboriginal clients should be ‘culturally appropriate’ – although there are few clear ideas about what this actually means (RCIADIC, 1991; Sibthorpe, 1998). One of the many problems of such notions is the assumption of cultural homogeneity, but aboriginal communities vary in traditional and contemporary values, attitudes and customs. I argue below that there are certain features of brief interventions which are appropriate for use with Aboriginal people in that they are respectful, sensitive and flexible – whether they are in keeping with local cultural and social processes is for Aboriginal people themselves to decide.

So far, it has been the residential treatment programs which have portrayed themselves as being culturally appropriate and they increasingly use icons of
Aboriginality, concepts such as ‘caring and sharing’ and even spirituality, in order to fulfil this promise. However, there are contradictory elements inherent in the techniques used in some residential programs that would seem, in fact, to be inappropriate (Brady, in press). One of these is the confrontational and public confessional nature of many of the group sessions, and at CAAAPU, the use of mixed sessions of this sort with both men and women present. These techniques have certainly provoked resistance among at least some clients (Miller & Rows, 1995).

Other barriers centre on Aboriginal social and economic disadvantage, and social constructions of drinking and personal autonomy among Aboriginal people. One of the reasons for the need to address these barriers is that there is support from two influential reports on Aboriginal health or related issues; both have recommended that early (or perhaps more accurately, earlier) interventions should be occurring in Aboriginal use.

Barriers to drug and alcohol interventions.

A number of barriers have been identified as impediments to greater involvement of generalist service providers in drug and alcohol problems (New South Wales Health Department, 2000). These barriers include the following:
• Belief that they do not have a legitimate role in providing drug and alcohol services.
• Negative attitudes to drug and alcohol patients and to interventions.
• Low levels of confidence in the ability to intervene in drug and alcohol problems.
• Perceptions of themselves as relatively ineffective when they do intervene.
• Inadequate drug and alcohol knowledge and skills.
• Belief that drug and alcohol patients lack motivation to change.
• Belief that it is not possible to shift patient's level of motivation.
• Perception of a lack of support from other service providers.
• Limited available materials to assist in providing of drug and alcohol interventions.
• Insufficient time to adequately intervene.

The National Aboriginal Health Strategy suggested that the staff of Aboriginal health services and other associated organizations should be provided with adequate and appropriate education to equip them to deal with people with problems of addiction (NAHSWP, 1989; Brady M. Technical Report No. 29.).

Local knowledge indicates that there are no available Aboriginal Alcohol and Drug Rehabilitation Treatment Centres within the boundaries of both the Aboriginal Gumbaynggir Nation within the Mid North Coast Area Health Service (Northern Sector). There are however, Aboriginal controlled drug and alcohol rehabilitation treatment centres in existence and available outside the
boundaries of the Gumbaynnggir Nation. There is only one existing alcohol
and other drugs rehabilitation treatment centre that is available for not only
members of the Aboriginal Gumbaynnggir Nation but also the broader non-
Aboriginal community members.

Existing service **WITHIN** the Gumbaynnggir Nation & the Mid North Coast
Area Health Service (Northern Sector).

**SHERWOOD CLIFFS**

Model - *Sherwood Cliffs* is a Drug Rehabilitation Farm, integrated into a
Christian Community

Barriers:

Sherwood Cliffs is based on Christianity which in reality is not culturally
appropriate for the overall majority of Aboriginal people of the Gumbaynnggir
Nation and maybe other non-Aboriginal people who are experiencing alcohol
& other drug abuse problems in accessing this service. It is a private service
which advertises for public use. The in-house rules once a client is accepted
are fairly demanding (as noted above). Sherwood Cliffs also works on penalty
points, where the clients have to do their chores. Depending on the client/s
condition this would be inappropriate especially if client/s are in need of
medication and rest. Cost is a significant barrier (2 weeks board in advance
on arrival) then $100:00 per week. Seems no consideration has been thought of and given to the low-income earners or the unemployed. Distance of 50 Kilometres, transport and language are also barriers. Family contact or visits are very, very restricted right from the beginning. These are only some of the barriers I personally feel and recognise would impede and certainly discourage our people from attending Sherwood Cliffs Christian Community Drug Rehabilitation Farm (see Appendix B).

Existing services OUTSIDE the Gumbaynnggir Nation & the Mid North Coast Area Health Service (Northern Sector).

*Benelong’s Haven*

*Benelong’s Haven* Kinchela, NSW. is a Family Rehabilitation Centre. The program seeks to re-establish the spiritual bonds in Aboriginal relationships, recognizing that the essence of Aboriginality is the relationship between people thence to the earth.

Barriers: Personal view

Cost again is a significant barrier, if you have a family taking in partners with one or even more children above the age of 2 years it would then seem, if we...
add the cost up of $90.00 per week plus $30.00 for the child or children, then it becomes very costly for the family. Especially if they are low-income earners or unemployed. Gender is another barrier where once again single Aboriginal women are not provided for who are experiencing alcohol and other drug problems. After making verbal inquiries with Aboriginal health workers from the Dungatti indigenous tribe (Kempsey area) and some Aboriginal community members who have attended, experienced and left this service for whatever reasons. The verbal feedback was Binalong’s Haven in house rules created a couple of other significant barriers that need to be mentioned (these rules are not mentioned in their brochure). These include hair length, wearing black, smoking red Winfield cigarettes and no contact or speaking to the opposite sex/gender within the centre (Appendix C).

**Namatjira Haven:** *Bundjalung Tribal Society Ltd. Alstonville NSW.*

Namatjira Haven is a Drug and Alcohol Rehabilitation Centre situated on the Far North Coast midway between Lismore and Ballina. The centre itself is located geographically in the Bundjalung Tribal Nation which exists outside the local Gumbaynggir Tribal Nation.

**Barriers: Personal view**

Namatjira Haven provides a service for single males only. The age limit proves to be the main barrier in service provision for indigenous people.
Age is definitely a barrier at Namatjira Haven 25 years over up to 55 years only, rehabilitation treatment does not cater for under 25 or over 55 years. Gender is another barrier. Indigenous females with alcohol and other drug problems are not even considered or provided for in service provision also non-accommodation and service provision for families experiencing alcohol and other drug problems creates another barrier. Cost and distance is once again barriers to consider for Aboriginal people of the Gumbaynnggir Nation and also Namatjira Haven uses the non-Aboriginal Alcoholic Anonymous program quite frequently on their agenda. This may not be a bad model to work from for some Aboriginal people but it obviously is not applicable to all Aboriginal people (Appendix C).

It has been noted that “with few exceptions the research in this area has been limited to brief and general descriptions....” (Kahn et al., 1990, p. 361).

No well researched treatment-outcome studies concerning barriers to treatments inhibiting Aboriginal attendance at rehabilitation centres has been found to date.
METHODODOLOGY

Rationale for Qualitative Methodology

The advantage of qualitative methodology is that research is able to explore the in-depth meanings of individuals and gain insight into how people feel about the experience of case management and the transitional treatment program. The material gained is initially descriptive in nature and formed by the context of time the research is conducted. While the generalisation of research findings in quantitative methods is usually dependent on the representative nature of the sample, the findings of qualitative research can be generalised due to the nature of their recognisability by a larger population. The method used for this research investigation is based on this premise.

The methodological approach taken to access this study, outlines the benefits of using qualitative research methods in the utilisation of health care services in Aboriginal communities and results for their people. Qualitative approaches explore all dimensions of human uniqueness especially when research is being carried out in Aboriginal communities targeting Aboriginal participants, this then would aid the researcher/s in understanding the meaning of the experience for the participants. Generally the number of participants, when using the qualitative approach, is smaller than the number of subjects needed when using the quantitative approach. Fewer subjects are intensively studied (qualitative) as compared with a larger number extensively studied.
(qualitative). The research activities of each approach reflects beliefs about the importance of context.

Using the qualitative method and approach begins by collecting bits of information and piecing them together, building a picture of the aboriginal experience, the people and the utilisation of health care facilities if any in Aboriginal communities or community or the people who are being studied. As with a mosaic, when a researcher steps away from their work, the whole picture emerges. This holistic picture transcends the bits and pieces and cannot be known from any one piece because Aboriginal people their culture, traditions, values and spirituality are one of the most studied indigenous races on earth.

Analysis of the qualitative data is based on a grounded theory approach which involves iterative categorisation and identification of core themes. Grounded theory is a well developed approach to qualitative data collection and analysis, especially where theory development is required. This approach presupposes that understanding is grounded in the population under study, and the researcher does not impose any theoretical assumptions prior to data collection. General questions are used in the first instance to develop rapport with the client, but it is the interview's perceptions that modify further data collection and the generation of variables for further study.
According to Glaser & Strauss (1967) data collection should involve gathering information from similar and different sources in a process they refer to as "theoretical sampling". It is up to the intuition of the researchers to find and obtain access to appropriate sources of data which may be directed by information obtained during the process of data collection itself. Data is continually analysed in order to tease out variables and further directions of study. At some point in the process it is likely that 'theoretical saturation' (Glaser & Strauss, 1967) will be reached when no new information is being obtained. The fact that similar data is gathered from different and like sources provides validity to the data.

**Aim**

To identify barriers to the acceptance of treatment in substance rehabilitation centres for Gumbaynggir Nation people with substance abuse problems and to identify any barriers discouraging selected Aboriginal community members of the Gumbaynggir Nation attending at substance abuse rehabilitation centres.

To identify any specific cultural, social, environment, transport, family support or family contact issues or other factors which may impede Gumbaynggir Nation people with substance abuse problems from attending regional Aboriginal or non-Aboriginal rehabilitation treatment centres.
Subjects

Subjects are selected community members of the Gumbaynnggir Nation. These consist of three males and three females over the age of eighteen years. The identified subjects will be approached and asked to participate in these interviews. They are identified by the researcher who in this case happens to be the Mid North Coast Hospital Aboriginal Liaison Officer (Northern Sector), who also may have helped them in the past as inpatients of Coffs Harbour Base Hospital with alcohol or other drug problems. The researcher is of Aboriginal decent, and is known to the subjects and their families. The targeted subjects are people who have experienced or are currently experiencing substance abuse problems and who have been referred to substance rehabilitation treatment centres and are unwilling to attend for whatever reasons.

Design

There are no studies researching barriers to treatment for indigenous Aboriginal or Torres Strait Islander peoples with substance abuse problems in the available literature. Therefore this present study is the first to explore this area of concern. As a new field of research, there is no suggestions from the research literature concerning the identification of are considered to be the key variables. Therefore this study is mapping the field of what might be barriers to drug and alcohol treatment for a particular tribal group in a specific
tribal locality. With no previous research to direct this study, I have selected a qualitative research approach since these methods are the most appropriate for such ground-breaking studies that are trying to identify the key research variables in the field.

The design chosen is a small-scale study using the qualitative research method approach of semi-structured. Interviews were informal but standardized. Interviews are administered by the researcher. The questionnaire consists of 5 open ended questions tapping barriers to accepting Alcohol & Other Drugs rehabilitation options for Gumbaynnggir Nation peoples suffering substance abuse problems (Appendix E). Upon completion of interviews the information will be transcribed and each interviewee will be name coded for reasons of confidentiality. The responses from these interviews will then be entered later into the data analysis research results.

Due to cultural tendencies on indigenous people to give brief answers to questions, various prompts will be needed to obtain relevant details of motivation and other circumstances which make their often short answers to the questions more comprehensive. Such prompts may also be needed due to the seminal nature of the research as it attempts to map the field of barriers to treatment for indigenous populations with substance abuse problems. The small-scale nature of this research also suits these ends.
Ethical Issues and Data Collection Protocol

General and written permission has been submitted and accepted by Gumbaynnggir Nation elders for the aims of the research and the specific questions and procedures for the interviews to be undertaken of Gumbaynnggir Nation people with substance abuse problems (Appendix F).

The aims and procedures of interview, meet the (NHMRC) National Health Medical Research Committee Guidelines on research in indigenous communities (1991). Also the design was approved by the University of Sydney Human Ethics Committee (Appendix H).

Before subjects are interviewed they are given a written Subject Information Statement (Appendix D). Subjects will be allowed to read it and ask any questions. It explains the study's intentions and assures them that their identities will be kept in confidence if they agree to participate. If they agree, before being interviewed, they are asked to sign the Participants Consent Form (Appendix G). If written consent has been received the identified subjects are then given 5 open-ended questions (Appendix E) by an aboriginal interviewer who is known to the interviewees and their families. He is a permanently employed Hospital Aboriginal Liaison Officer who may have helped them in the past, and who is a recognized elder of the Gumbaynggir
Nation and a member of the Coffs Harbour and District Local Aboriginal Land Council.

Subjects' answers were tape-recorded and have been transcribed for content analysis and coding.

Interviews took between 1 to 2 hours, with the place of interview determined by the interviewee, for their maximum sense of comfort.
Findings

"Non Aboriginal health workers, they tend to say, look there is no difference, but there is a big difference with Aboriginal people, and it is still there today, and there will always be."

Aboriginal interview respondent October 2000

The following findings are summaries and points of the Literature review highlighted with quotes and findings from the interview process. The interviews audio recordings were transcribed in full, and the quotations included in this section originate directly from the interview data. Respondents are not identified in any way. Confidentiality is assured throughout all stages of this research.

Major Findings

- Barriers restrict access to services and that these barriers must be minimized.
- To date, the alcohol and drug field has not met the range of women’s needs in either prevention or treatment programming.
- That barriers are in existence not only for client participation but also for service providers.
- Considering the Aboriginal population of the north coast, and in particular the Gumbaynggir Aboriginal Nation, together with the rates of alcohol and other drug misuse, the fact that there is no specific Aboriginal rehabilitation and detox service that serves and accommodate the population needs, is a serious health threat.
Specific findings

- Most people with alcohol use disorders do not enter alcohol treatment.
- Treatment options are limited.
- There is a widely spread under utilization of mainstream health care services by Aboriginal peoples.
- Under utilization of services results in a higher burden of morbidity and mortality rates amongst Aboriginal peoples.
- The creation of special state and territory programs to deal with Aboriginal people has had limited success. This was found to be related to several issues, these being:
  - lack of Aboriginal control over the planning and delivery of services, the reactive nature of mainstream services, programs largely controlled by professionals are removed socially and culturally from Aboriginal communities.
- The success factors in the provision of primary health care are political commitment to the social equity, community participation and technical fit.
- That friends family and people in the workplace, play important roles in promoting or inhibiting treatment entry.
- Most services still seem to be intended for men because they are based on methods used for males. Very few programs seem to be specifically designed for women.
- Few programs provide childcare services.
- Very few hospital based detoxification bed numbers are available in the study region.
Current requirement that a five day hospital based detoxification program be undertaken before continuing on to rehabilitation centres affects the participation of Aboriginal people in rehabilitation.

**Identified barriers and significant impediments to help seeking.**

The headings used below have been identified through the literature review and the content has been identified from the interviews.

*individuals beliefs*

Some respondents talked about the need for having their spiritual beliefs accommodated or encouraged through cultural practices in the programs.

"They have to look at spiritual healing as well as, you know, they’re giving up the group, and medical healing, but trying to get that spiritual healing and culture. Trying to pin back the culture with a lot of our people because you know that a lot of them identify with the culture a lot. I believe that if the culture was brought into rehab centers people would find themselves an look at their spirituality and find a driving force that would help them."

*cultural beliefs,*

"It is good to have an understanding of where this person is coming from, you know if someone was taking to you, well you, this is happening, or if I see spirits of my ancestors. Any whatever question is
it Schizophrenia, is it a disorder, or is it a part of the cultural stuff, that is coming in. There is all these aspects of our culture, it's a life time thing that we've acknowledged, that we've learnt to live with, to live and grow with. How do you cram that into non-Aboriginal people in two days, a week or whatever, what we have taken a lifetime to learn, yeah.”

*cultural differences*

“Non Aboriginal counsellors, they have the degrees, the knowledge, whatever, but they don't have the awareness of who we are and what we are, and what our culture is about, and I think you got to have that if you are going to genuinely assist in doing this type of work.”

And

“There is still a non understanding of Aboriginal communication, for instance women talking to males and vice, versa, a non Aboriginal people touching you,. On the shoulder or something, to Aboriginal people this could be looked at a different way particular of our culture again, and eye contact, our verbal tones in which we present something, you know, that can be taken differently. There is a certain way we speak to each other and present with each other.”

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program model (AA, Christian based etc)

"How does it come into play with a lot of things you know with what has happened with Aboriginal people. And again I think a lot of those people that have used AA have been had some strength or they have actually mixed within white society to feel comfortable in that surroundings, there has to be something or they have hit tragedy or there's something in their life that's made them turn away that way, but what happens to the other percentage that doesn't, always it's like everything else, things don't always work for the majority."

Another respondent noted that she was put off attending an AA model program because of the lack of Koori people running and attending the program.

"I felt that because there wasn't many other Koori people going there, that in your stages of recovery you feel like everybody is against you, even though they are not, they are there to help you So I just stuck with the person that I asked to sponsor me."

transport and isolation,

"Distance is another factor, because the majority of Aboriginal people don't own cars and living in rural societies you haven't got the transport to come in. plus I haven't got a licence. I mean if there is
transport in some areas, but then you are looking at financial aspects of bus trains, or whatever, that sort of thing, so there is all these factors that you've got to take into consideration."

**location of service,** this was seen as important by all the participants.

"I think it would be helpful if I could not go so far away from my family while I'm getting this treatment done. It would be good if we had one close on our own area here, so that we could feel as though we are not so far away from our family while we are having this treatment."

**access**

Lack of services, particularly for women, means that even if they did wish to enter into rehabilitation access was not available. Specifically, services for single women were not available in the region, single women are required to travel to Brisbane to access an Aboriginal drug and alcohol rehabilitation program. For example:

".......sending them to Brisbane, and the client didn't want to go away anyway because you are actually sending that person away from there traditional land and they really did not want to go there, so you've got to look at the factor to where and what tribal grouping they come from. They actually wanted to stay around their own tribal area and that was pretty much an impossibility."
rights (including right to choice and extent of treatment involvement)

Some programs were identified as not supporting the clients needs for choice or an active role in making the decisions over their treatment.

"Cause I know that when I was in the rehab you were more or less told what to do, you were treated like a kid, and that doesn't help a lot of people because it makes you more determined to get out of there as quick as possible instead of trying to settle in to the program and think to yourself, yeah this is going to help. Especially if people are still out there to negotiate or manipulate, but if you plant the seed, if it's plated properly in someone's head, that seedling will grow in that person or myself, will think, yeah, this will be a better way to go."

Clients are most often required to sign over pension and unemployment benefits to centers, leaving the client often with minimal funds.

"A lot of the responsibilities like the handling of your money, that responsibility was take away from me. I didn't see my money, everything was taken out before I got it."

features of services- in-house rules such as smoking rules, dress rules, in-house decision making.

Restrictions such as length of hair, the brand of cigarettes, wearing black coloured clothing, food menus and delivery etc were noted by interview men and women in some places were not allowed to talk to each other.
"There wasn't trust in the inmates there, and even with the boys coming over from the men's house when they brought over supplies, you weren't supposed to talk to them. Well I mean if one of them said hello to you, you were expected to turn around and walk away. And that's not in Koori culture. You know it seemed stupid to me at the time, I couldn't even see their reasoning but I suppose that that was one of their policies. It just seemed so stupid to me."

level of Aboriginal involvement in decision making and rehabilitation program content. (this was seen as important by all participants).

".....be out there and do our arts and crafts, all the things that we should be doing instead of our elders watching us go down the wrong track, and it would be good to get them out there with us, to get it all back again. Like the language they can teach us properly, the way that we should be.. Coming from the elders would make a lot of difference to the way that we think."

"I'm just speaking from my heart, I would like to see the culture coming back into it, the elders could teach us. When I speak the word of us I'm talking about every Aboriginal person in the country even the world."

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**language used by staff**

Issues of language were identified as being barriers to service usage. Not just the style of language but also differing definitions and use of terminology, for example: one respondent requested the researchers definition of what he meant by the term 'regional'.

Another participant mentioned.

"And it's the same as anything even if its there for their own good, a lot of us respond better if its another Koorie person helping them. Koories can be stubborn sometimes. Especially if its not another Koorie person that's trying to help them. You know who does he think he is, who is this white fellow trying to tell me what to do."

**cost of service**

All participants agreed

"So cost factors on some of these rehabs, aboriginal rehabs, are very steep and it shouldn't be."

**childcare issues- lack of childcare services**

Interview respondents commented on the fact that they were required to be separated from their children so as to enter a rehabilitation Centre. This was
because of two main reasons, being that centres did not provide childcare, and that they were mostly situated away from the clients homes.

"To be quite honest, I didn’t find that attending a Centre helped me. It hindered me more than anything. Because of the fact that it was so far away, I was separated from my kids and having been only able to visit them maybe once a week or once a fortnight, I found that very hard. I wanted to have my kids with me, but I wasn’t able to have them with me."

family needs

"I would just like to have close members of family, that do care, to be close by and could visit me now and then."

For this participant, the decision to enter into rehabilitation also included his family being involved or nearby to the process.

"I felt that I should have had close contact with my family during the first three months, because you really do need family support."

gender concerns

"I found a problem was they rejected clients if they were a certain age, if they were a certain sex because if they were single and a female you couldn’t get them in there regardless of bad the case was because it would interfere with other inmates which were all male, and
it was very very hard if non-existent, to get Aboriginal females into rehabs. Nothing for females."

age

One centre in the study region restricts participation to those people being over 25 years of age.

Presence of non Aboriginal staff

"If you look at it from a percentage point of view, say in 10% of drug and alcohol cases, you only get probably get 1% who will attend there, its back to this, the fear of non-Aboriginal people."

Findings in current Research

- Most research to date on factors that influence alcohol treatment utilization examines only those people who actually are in treatment. This represents only a small percentage of those in need.
- That there is little well-researched evidence into what strategies are particularly effective with Aboriginal peoples in engaging them into treatment for substance abuse problems.
- There has been no thorough review of Aboriginal rehabilitation in-patient alcohol and drug treatment centres.
Key Features of an alcohol and other drugs rehabilitationservice/model that satisfies the needs of Aboriginal clients.

What makes a culturally appropriate service?

Data from both literature and interview sources were compiled and
summarized to reveal several important aspects needed for a service to
develop culturally appropriate strategies.

- Non-Aboriginal staff need to hold a historical and real
  understanding of effects of colonization on Aboriginal peoples.

  "I think the thing that health departments don't really take into
  consideration, is the history and the atrocities that have been
  inflicted on Aboriginal people that has created these problems
  and these problems that continuously goes on for generations
  without being fully identified”

  (Interview respondent)

- Holistic approach

  “We in a lot of cases, look at it in an isolated individual case
  rather than identifying it from a holistic point of view and I think
  that needs to be done in Aboriginal communities.” (Interview
  respondent)
• **Gender based**

Both male and female centres and services are required. Aboriginal women centers should be run and staffed by trained Aboriginal women. Aboriginal men's services should be run and staffed by trained Aboriginal men.

• Rehabilitation centres in tribal areas. Eg Rehabilitation service for Gumbaynnggir Nation.

• **'Aboriginal run programs'**

Respondents noted that programs be run and staffed by Aboriginal people.

> "I think if we were to look seriously and genuinely at drug and alcohol and Aboriginal people, then we need to look into the direction of maybe creating our own, I mean Aboriginal indigenous drug and alcohol rehabilitation centres that cater to Aboriginal people and who are run by Aboriginal people who are there who know are culture, how are aware of our traditions and our ways and so that when we do go to these places that we are more comfortable and in our own environment. We don't feel as though we are being isolated from who we are and what we are." (Interview respondent)

• **Community input**

> "I'd like to think that maybe you can look at input from that community, in view, like in the line of Elders coming there as a support"
"group and just looking at those facts, but doing it from a very much
culturally perspective."

- **Counselling provision**

  Life skills training- for e.g. social skills, money managing etc.

  "......responsibility being taken away from you, no educational,
  no skills to help you come back into the real world, the
  community that you live in. There were no social skills, how to
  manage money."
Specific Findings of Existing service WITHIN the Gumbaynnggir Nation & the Mid North Coast Area Health Service (Northern Sector).

SHERWOOD CLIFFS:

Model - Sherwood Cliffs is a Drug Rehabilitation Farm, integrated into a Christian Community

Identified Barriers:

Sherwood Cliffs is based on Christianity which in reality is not culturally appropriate for the overall majority of Aboriginal people of the Gumbaynnggir Nation and maybe other non-Aboriginal people who are experiencing alcohol & other drug abuse problems in accessing this service. It is a private service, which advertises for public use. The in-house rules once a client is accepted are fairly demanding (as noted above). Sherwood Cliffs also works on penalty points, where the clients have to do their chores. Depending on the client/s condition this would be inappropriate especially if client/s are in need of medication and rest. Cost is a significant barrier (2 weeks board in advance on arrival) then $100:00 per week. Seems no consideration has been thought of and given to the low-income earners or the unemployed. Distance of 50 Kilometres, transport and language are also barriers. Family contact or visits are very, very restricted right from the beginning. These are only some of the barriers identified by the respondents that would impede and certainly discourage our people from attending Sherwood Cliffs Christian Community Drug Rehabilitation Farm (see Appendix B).
Existing services OUTSIDE the Gumbaynggir Nation & the Mid North Coast Area Health Service (Northern Sector).

BENELONG’S HAVEN:

Benelong’s Haven Kinchela, NSW. is a Family Rehabilitation Centre. The program seeks to re-establish the spiritual bonds in Aboriginal relationships, recognizing that the essence of Aboriginality is the relationship between people thence to the earth.

Identified Barriers:

Cost again is a significant barrier, if you have a family taking in partners with one or even more children above the age of 2 years it would then seem, if we add the cost up of $90:00 per week plus $30:00 for the child or children, then it becomes very costly for the family (especially if they are low-income earners or unemployed). Gender is another barrier where once again single Aboriginal women who are experiencing alcohol and other drug problems, are not provided for. After making verbal inquiries with Aboriginal health workers from the Dungatti indigenous tribe (Kempsey area) and some Aboriginal community members who have attended, experienced and left this service for whatever reasons. The verbal feedback was Benelong’s Haven in-house rules created a couple of other significant barriers that need to be mentioned (these rules are not mentioned in their brochure). These include hair length, wearing black, smoking red Winfield cigarettes and no contact or speaking to the opposite sex/gender within the centre (Appendix C).
NAMATJIRA HAVEN:

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Namatjira Haven provides a service for single males only. The age limit proves to be the main barrier in service provision for indigenous people. Age is definitely a barrier at Namatjira Haven 25 years over up to 55 years only, rehabilitation treatment does not cater for under 25 or over 55 years. Gender is another barrier. Indigenous females with alcohol and other drug problems are not even considered or provided for in service provision. There is no accommodation and service provision for families experiencing alcohol and other drug problems creates another barrier. Cost and distance is once again barriers to consider for Aboriginal people of the Gumbaynnggir Nation. Also Namatjira Haven uses the non-Aboriginal Alcoholic Anonymous program quite frequently on their agenda. This may not be a bad model to work from for some Aboriginal people but it obviously is not applicable to all Aboriginal people (Appendix C).

• Note: Not one of the above three local or regional rehabilitation treatment centres mentions providing a service, support or access for
Aboriginal people with disabilities who may be experiencing alcohol or other drug problems.

- Also they do not mention staff employed at these centres. Are they Aboriginal or non Aboriginal. Are they trained, skilled or educated staff?

**Personal point of view.** The above issues are also relevant barriers to attendance.

**Discussion**

**Interview process**

The research process, in this study, of in depth interviewing revealed several important factors that contribute to the research process of both this researcher, and those who may in the future be conducting research interviews with Aboriginal people.

Before the interview commenced each participant was handed the subject in formation statement and five planned interview questions in a written format and given time to read the questions before the interview began. Once they had read the questions, and stated that they were happy to continue the interview process, the were handed the participant consent form to read and sign.
All the interviews were recorded on audio cassette. The participants requested that prior to the tape being turned on that they could check the questions first. This was where an informal discussion and prompting for discussion began. Once this occurred as an ice breaking style of process, then the participants appeared to be more comfortable with being involved in the full interview.

The interview format kept to the five questions, in order, with prompting being necessary with some of the questions. The questions needed to be introduced and explained in a conversation style first, prior to the more formal language of the questions. This process worked for the researcher as it was a more collaborative approach, rather than one person asking questions and another answering. In terms of power, it was a more equal approach.

After each question was answered, the tape was stopped, and then the next question was introduced. A small conversation about whether the participants understood the question took place. Most participants seemed to be concerned as to whether they were repeating themselves when they answered questions.

It was found that the women participants spoke a lot more, and seemed to be more comfortable with the interview setting. The women chose to be interviewed at the researchers home setting, whereas the men chose to be interviewed in their own homes.
The women were older than the male participants in this study. They provided a lot of reflective experience in the way that they answered the interview questions. The women participants did not consume alcohol at the time of the interview, but they were all smokers. The men were a younger age group, two participants at the time of interview were consuming alcohol and smoking cigarettes. The interviewer did not impose any restrictions on the participants behaviour in regard to smoking or drinking. These two men are regular drinkers, and they chose to drink during the interview.

The men interviewed mentioned that they were unfamiliar with being interviewed, or had never been tape recorded before, yet the women interviewed were more familiar with the process.

Family support was important to respondents. They wanted to have access to rehabilitation and have their family close or near by. This did not necessarily mean that rehabilitation centers needed to be close to where they lived, but that wherever the rehabilitation was taking place family needed to be close by.
CONCLUSION AND RECOMMENDATIONS:

This research report was of necessity limited and touched "only the tip of the iceberg."

I am a local Aboriginal Gumbaynnggir person who is known to and by the participants and the community in which we live, also known to them on both a personal and professional level. I was accepted and trusted by them. Because of this I was able to interview and document their personal lifestyles and the factors which impede and contribute to their behaviour in relation to alcohol or other drug misuse. The study also identified the barriers to attendance at either local or regional rehabilitation treatment centres and the reasons why this particular group of Aboriginal Gumbaynnggir Nation community members are unwilling to attend at these centres.

The study results have identified and definitely revealed a number of major points for current and future rehabilitation policy.
Recommendations:

1. Perceived and actual barriers are identified and strategies are formulated to overcome them.

2. The strategies need to be directed at individuals, organisations and society levels.


Research Needs

4. Research needs to be conducted into barriers to participating in drug and alcohol treatment with people who are in-treatment, and particularly with people who are not participating in treatment programs.

5. Current research tends to be with a small percentage of participants. Larger studies need to be undertaken in this area.

6. A thorough review of Aboriginal drug and alcohol rehabilitation centres and programs be conducted at both state and national levels as the creation of special State and Territory programs to deal with Aboriginal people has had limited success.

Primary Health & Extended Health Care Services

7. That there be political commitment to social equity and community participation in service provision and resources, as well as decision making.

8. That there be more hospital based detoxification facilities available.

9. That specialised hospital-based detoxification facilities have appropriate staff.
Standards

10. That Primary health care standards as detailed by the World health Organization, most specifically the Alma Ata Declaration be held as benchmark standards for service development operations and delivery.

11. That the quality of care not be compromised by funding constraints.

Cost of services

12. That strategies to reduce costs to participants for treatment be examined and formulated.

13. That drug and alcohol rehabilitation services be fully funded to reduce costs to the client.

Model for Service Delivery

14. That a whole-family approach be taken to drug and alcohol rehabilitation program and service provision.

15. To implement an explanatory model which seeks to identify not only the cause of alcohol and drug abuse but the meaning of this for the Aboriginal client.

16. That the current requirement of a five day hospital-based detoxification program be undertaken before continuing on to rehabilitation centres be changed, and that detoxification facilities with trained staff be delivered by the rehabilitation centres themselves. There needs to be a choice for the client whether they undertake detoxification in a hospital environment or a rehabilitation centre environment.

17. That an awareness of language differences and communication techniques be included in service provision and that strategies be developed to
overcome any language barriers. Non Aboriginal health staff need to be in closer contact with Aboriginal health staff to assist in this process.

18. That cultural factors and traditions are part of program and service delivery design.

19. That the role of community Elders be included in service design and support needs of clients (particularly for cultural and spiritual advice and knowledge).

20. That Aboriginal health cultural awareness programs are very important and require comprehensive development. These programs and teachings are necessary for both Aboriginal and Non Aboriginal drug and alcohol counsellors and centre staff.

21. That ultimately Aboriginal drug and alcohol rehabilitation centres and programs need to be run by trained, skilled and educated Aboriginal people. Training and education is to be seen in the context of cultural and spiritual knowledge and practice, along with mainstream approaches.

22. That partnership approaches between Aboriginal health and mainstream health include provision for Aboriginal self determination of service options, along with acknowledging the realities and needs for cultural practices as part of service provision models.
REFERENCES


Gething, Lindsay, (1995) A Case study of Australian Aboriginal people with disabilities Australian Disability Review No 2 1995 77-87


Appendix A.

Gumbaynnggir Nation Geographic Boundaries

LEGEND
Boundaries +++++++++++
Appendix B

Existing service WITHIN the Gumbaynnggir Nation & the Mid North Coast Area Health Service (Northern Sector).

1. Sherwood Cliffs

Sherwood Cliffs is a Drug Rehabilitation Farm, integrated into a Christian Community.

Model:
Sherwood Cliffs is an inter-denominational fellowship associated with the Coffs Harbour Baptist Church. A committed staff of twelve lives permanently at Sherwood Cliffs and looks after its general running. The staff work united, bound together by a common commitment to the Lordship of Jesus Christ, and look to God for his wisdom and guidance in all matters.

Where the Money Comes From:
While it is their aim to become as self supporting as possible, by developing internal industry, “Sherwood Cliffs” is financed largely by generous giving of interested people. It is not a policy to solicit funds. Finance needed is literally prayed in for the specific project on hand.

Sherwood Cliffs:
(a) Is a ‘family’ who live on a farm 50 klms north of Coffs Harbour at the foot of a magnificent sandstone cliff. They all work, live and relax together sharing the common amenities.

(b) Is a rehabilitation centre where their family oriented program is an expression of their real concern for people. Up to 12 people with drug and alcohol problems can be accommodated at one time-usually 8 singles and 2 married couples.

(c) Is a learning experience—it is a time and place to understand better the nature and extent of difficulties and to be assisted in planning how the identified difficulties may be approached and dealt with. It is a time to learn new work skills, and to use “free” time positively.

Admission of agreement:
I agree to abide by the rules of “Sherwood Cliffs Christian Community” and state that I wish to enrol for at least a period of 6 months until it is decided, by both staff and myself, that I am ready to leave.

Specific rules:
I understand that I must arrive at Sherwood Cliffs at the agreed time and date. Failure to do so may result in my being turned away. If, for any good reason, I cannot arrive on the specified date and time I should call on the phone.

I agree to come for a 2-week trial period so that we may mutually agree that I am suitable for rehabilitation.
I agree to have blood tests taken for Hepatitis "B" and "C" and HIV prior to admission.

I understand that I will need to take a shower immediately after being checked into the program. Also I understand that my bags and belongings will be searched.
I will bring the following information with me:-

3 forms of identification for social security purposes.
Names, addresses and phone numbers of probation and parole officers, attorneys or public defenders.

Full information regarding court appearances, date, time, court, judge, charge etc.
Names and addresses of all members of my immediate family who might visit

General rules:

I understand that the most basic rules of Sherwood Cliffs are as follows:

This is a totally drug and alcohol free environment and while in the program drug taking, (whether on the property or away from the property for outings or weekends away) is prohibited. Withdrawal is "Cold-Turkey".

Participation in all community activities is compulsory, e.g. work, meals, church etc. Each person is responsible for their own self-control and self-discipline.

Personal:
I will not possess or use drugs, alcohol or cigarettes. (Drugs that are prescribed by a doctor must be administered by a staff member).
I will not fight.
I will not use bad language.
I will not talk about the street life of drugs to other seekers.
I will not use cassettes or CDs unless approved by the staff.

Family:
I will receive no phone calls for the first month (if there is an emergency, I will be given a message). I understand that I may make only 1 phone call during the first month (and this call cannot be made until after the first week).

I will be able to make phone calls on Thursday nights after the first month (the number of calls will be based on my conduct).

I will receive only letters from my immediate family for the first month. I can write to family and friends from the start of my rehabilitation. I understand that my mail will be checked.

I will be able to receive visitors only after the first month (these visits may only be members of my immediate family e.g. parents, brothers and sisters, wife and children.)
I will be able to receive other visitors after 2 months in the program.

**Money:**

I agree to pay $100:00 per week board (2 weeks board in advance on arrival).

I will bring sufficient money with me for my return fare.

I will not keep more than $1:00 on me at any time other than scheduled shopping trips.

Any money over $1:00 will be returned to the office after shopping.

I will not receive any money directly from family or others but understand that it must be administered through the office.
Appendix C

Existing services OUTSIDE the Gumbaynggir Nation & the Mid North Coast Area Health Service (Northern Sector).

(a) Benelong's Haven

*Benelong's Haven* Kinchela, NSW. is a Family Rehabilitation Centre. The program seeks to re-establish the spiritual bonds in Aboriginal relationships, recognizing that the essence of Aboriginality is the relationship between people thence to the earth.

**Origin:** Benelong's Haven was founded in 1974 by Val Bryant, O.A.M.

**Location:** The centre is situated on the Macleay River between Kempsey and South West Rocks, on the Mid North Coast of New South Wales. It provides dormitory accommodation for single males, plus family rooms for couples with or without children.

**Philosophy of care:** The program seeks to re-establish the spiritual bonds in Aboriginal relationships, recognising that the essence of Aboriginality is the relationship between people thence to the earth.

**Objectives:**

- Reduce alcohol and drug addictive amongst Aboriginal people
- Meet the needs of Aboriginal people in crisis due to D&A abuse
- Improve access to alternatives to jail for Aboriginal people with D&A related charges/problems
- To target the jail culture within the young Aboriginal population which has permeated into the contemporary young culture
- Increase knowledge of effects of A&D abuse amongst Aboriginal clients of Benelong's Haven
- Whilst in residential D&A rehabilitation provide health and medical service to clients
- To assist in the spiritual reconnection between Aboriginal people, theirs friends, families and other cultures
- To assist the development of pride in Aboriginal culture
- To provide a treatment environment which supports a balanced choice of whether to continue the use of alcohol and other drugs
- To provide professional counselling service for related psychosocial problems such as histories of family violence, child physical and sexual abuse and neglect
- Address the psychological and psychiatric needs of clients
- Reduce the incidence of Aboriginal suicide particularly related to clients in custody
- Provide access to education for children attending Benelong's Haven with their families
- Provide qualitative and quantitative research into client's progression and interaction with residential care
- Continuous evaluation
The program:

Alcoholic anonymous, family relationships and women's groups.

Activities:

Aboriginal dancing, Aboriginal culture, ballroom dancing, excursions-bush and beach, touch football, sewing classes and a registered psychologist visits weekly for family, group, and individual counselling.

Client classification:

Family units, single males and juveniles.

Admission criteria:

Clients must be between 17 and 55 years of age and suffering from alcohol and other drug related problems. Clients must be willing to undertake the program. They should be physically and mentally capable of participating in the program and also be willing to undertake any medical drug test. Clients must be sober on admission. They expect that co-dependent's would also participate in the program.

Cardinal rules:

The following actions will result in dismissal. The use or possession of any mood-changing drug, becoming emotionally involved with another client, gambling, leaving the premises without permission, non-participation in the program, abuse of staff and violence.

Treatment:

Treatment is drug free – no methadone available.

Cost:

Rent is $90:00 a week for adults, $30:00 for children and under 2 years – no charge.

(b) Namatjira Haven: Bundjalung Tribal Society Ltd. Alstonville NSW.

Namatjira Haven is a Drug and Alcohol Rehabilitation Centre situated on the Far North Coast midway between Lismore and Ballina. The Haven itself is located on 12 acres of spacious lawns and tendered gardens. The centre itself is located geographically in the Bundjalung Tribal Nation which exists outside the local Gumbaynggir Tribal Nation.

Up to 15 clients can be catered for at any one time in the program on offer.
Model:

The program, in the main, consists of daily group therapy sessions from Monday to Friday in conjunction with individual counselling when required. These sessions involve anything from Anger Management through to Nutritional Education. Audio and videotape development also plays a major part in therapy periods. Attendance of at least 3 A.A. meeting per week is incorporated in the aforementioned with 1 meeting being held in the Haven itself and others at nearby venues. It is compulsory for all clients to participate in all aspects of the program.

The program is a live in situation and is for a period of 3 months after which a further assessment is made regarding future rehabilitation.

Upon entering the Haven clients are allocated different duties aimed at improving their living skills. These can include anything from cleaning and gardening to kitchen chores.

Where applicable all clients receive sickness benefits upon entering and from this amount $90:00 per week is subtracted for full board and lodgings.

There are several house rules, which are made known on admittance that require adherence. Non-abeyance can result from discharge from the Haven.

Shopping excursions are held every Friday to local centres and an outing is held every Saturday, which can be anything from a day at the beach or a picnic in the prevailing picturesque countryside.

Video nights are held every Friday and Saturday with client selected movies, obtained from a local outlet.

It must be noted that a detoxification period of at least 5 days is required prior to admission.
SUBJECT INFORMATION STATEMENT:

An Aboriginal investigation study into members of the Gumbaynggir Nation, Reasons for Resistance to attendance at Substance Dependence Rehabilitation Centres.

This research investigation examines the barriers to attending Drug and Alcohol Rehabilitation Centres. It describes the beliefs, attitudes and feelings of the Gumbaynggir Nation members. Informed consent will be obtained from participants. All responses will be confidential.

Between 1-2 hours will be required for participants to be interviewed. These interviews will be recorded on audio-cassettes for later analysis. No identifying information will be revealed from tape transcripts.

The primary site of research undertaking is the geographical area designated within the boundaries of the Mid North Coast Health Service Northern Sector, Coffs Harbour, New South Wales.

The research investigation and results will be undertaken by Mr Reg Craig current employment status Mid North Coast Hospital Liaison Officer, Coffs Harbour. Also a student of Yooroang Garang Centre for Indigenous Health Studies, Faculty of Health Sciences University of Sydney.

Please feel free to phone Reg Craig on (02) 6659 1440 if you have any questions or enquiries in relation to this investigation study.

Any person with concerns or complaints about the conduct of this research investigation study can contact the Executive Officer of the Human Ethics Committee (HEC). The University of Sydney phone (02) 9351 4811 or fax (02) 9351 6706.
Appendix E

**QUESTIONNAIRE ITEMS: OPEN-ENDED QUESTIONS:**

(1) Do you think that you have a problem with alcohol or other drugs?

(2) Do you think that attending a regional drug and alcohol rehabilitation treatment centre will help?
   If so, Why?
   If not, Why?

(3) What are the barriers or reasons you feel that are preventing you from attending regional rehabilitation treatment centres? In other words why are you unwilling to attend at regional rehabilitation treatment centre/s?

(4) Do you think a 'culturally appropriate' rehabilitation treatment centre would benefit the members of the Gumbaynggir Nation?

(5) What for you would be the key features of a “culturally appropriate” rehabilitation centre?
STATEMENT OF CONSENT:

FROM: THE GUMBAYNGIRR NATION ELDERS

Date: Tuesday 19/10/1999

To whom it may concern,

We the undersigned Gumbayngirr Nation Elders, give our informed consent towards the Investigation Study into Reasons for Resistance from our Aboriginal Gumbayngirr Nation Members to attendance at Substance Dependence Rehabilitation Centres. We understand this research investigation examines the barriers, attitudes and concerns in attending Drug and Alcohol Rehabilitation Centres. We also understand the research will describe the beliefs and feelings of our people as described and explained in the Plain Language Statement supplied by Mr Reg Craig.

NAMES:

NEVILLE BUCHANAN
Barbara M. Beston
BARRY D. PHYLLIS
KEN INGWINZER
REG DAVIES
HAY M. JERRITT
LAWRENCE KILLY
COLIN JERRITT

SIGNATURES:

[Signatures]

[Seal]

TRIBAL ABORIGINAL ELDERS

CORPORATION
PARTICIPATION CONSENT FORM:

This Research study is an investigation into Reasons for Resistance by Gumbaynggir Nation Members to attendance at Substance Dependence Rehabilitation Centres.

I. ............................................................. have read the information above and any questions or enquiries I have asked about have been satisfactorily answered.

The aims of this research and reasons for questions asked of me have been explained to me before participating. I understand the interview will require between 1-2 hours and that the interviews will be recorded on audio-cassette for later analysis. I also understand no identifying information will be revealed from tape transcript. I therefore give my signed consent to participate. It has also been explained to me that I may withdraw my permission for participation at any given time.

I also agree that the gathered data for this research may be published, including part transcripts of my taped answers, providing that my name and other identifying details are not used.

Participant’s Signature............................................ Date ......................

Researcher’s Signature............................................. Date ......................

P.O. Box 170, Lidcombe, NSW 2141, Australia,
Telephone. (02) 9351-9393, Fax (02) 9351-9400
Appendix H

The University of Sydney
Room K4.01 Main Quad A14
Sydney 2006

Mr J Grojans
Youang Garang
Faculty of Health Sciences C42.

08 March 2000

Dear Mr Grojans

Title: An investigation into the reasons for resistance by Gumbaynggir Nation members to attendance at substance dependence rehabilitation centres

Ref No: 99/12/36

Thank you for your correspondence dated 3 March 2000 addressing comments made to you by the Committee. After considering the additional information, the Committee approved your protocol on the above study.

The additional information will be filed with your application.

In order to comply with the National Health and Medical Research Council guidelines, and in line with the Human Ethics Committee requirements the Chief Investigator’s responsibility is to ensure that:

(1) The individual researcher’s protocol complies with the final and Committee approved protocol.
(2) Modifications to the protocol cannot proceed until such approval is obtained in writing.
(3) The confidentiality and anonymity of all research subjects is maintained at all times, except as required by law.
(4) All research subjects are provided with a Subject Information Sheet and Consent Form.
(5) The Subject Information Sheet and Consent Form be on University of Sydney letterhead and include the full title of the research project and telephone contacts for the researchers.
(6) The following statement appears on the Subject Information Sheet: Any person with concerns or complaints about the conduct of a research study can contact the Manager of Ethics and Biosafety Administration, University of Sydney, on (02) 9351 4811.
(7) The standard University policy concerning storage of data should be followed. While temporary storage of audiotapes at the researcher’s home or an off-campus site is acceptable during the active transcription phase of the project, permanent storage should be at a secure, University controlled site for a minimum of five years.
(8) A progress report is provided by the end of each year. Failure to do so will lead to withdrawal of the approval of the research protocol and re-application to the Committee must occur before recommencing.
(9) A report and a copy of the published material is provided at the end of the project.

Yours sincerely,

Professor Barry Baker
Chairman
Human Ethics Committee

D:\\B\\HEC CORRESPONDENCE\99\00\23\99/12/36-1.doc

TOTAL P. 22
TOTAL P. 62