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**Abstract:** Limited access to care is frequently identified as a reason for poor health in Indigenous communities. This study aimed to identify the proportion of Aboriginal women accessing mainstream non government organisation (NGO) drug treatment in New South Wales (NSW) compared to non Indigenous women. Statistical analysis of two NGO subsets of the Australian Alcohol and Other Drug Treatment Services National Minimum Dataset (AODTS-NMDS) for years 2005 to 2007 was conducted. A statistically significant relationship was found between gender and Indigenous status ($\chi^2 = 4.582$, df=1, p=.001) in the two stages of analysis. Among NSW Aboriginal people who have accessed episodes of drug and alcohol treatment in the NGO sector, there is a significantly greater proportion of females versus males (37%F vs 63%M, n=3,080 episodes) compared to the non Indigenous service users (29%F vs 71%M, n=21,791 episodes). Aboriginal women are more likely to be referred from criminal justice settings. However, both groups of women complete treatment at the same rate. Treatment providers perceptions of their inability to successfully intervene with Aboriginal women may be a barrier to treatment. Agency client data should be examined for both race and gender details before treatment providers decide if what they supply is accessible to Aboriginal and Torres Strait Islander populations. This study demonstrates the importance of using evidence rather than assumptions about access to and effectiveness of service provision to Aboriginal women. Analysis of agency, State, and national datasets can inform policy and practice evaluations. Social workers can then support a more hopeful future for Aboriginal women, families, and communities.

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Who starts, who finishes and where do they come from?: Aboriginal and non-Aboriginal Women in NSW NGO D&A Treatment and the implications for social work

Abstract
Effective service provision for Aboriginal and Torres Strait Islanders is a vexed issue for Australia. Limited access to care is frequently identified as a reason for poor health in Indigenous communities. This study aimed to identify the proportion of Aboriginal women accessing 'mainstream' NSW non-government drug treatment compared to non-Indigenous women.

Statistical analysis of two NGO subsets of the Australian Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS) for years 2005-2007 was conducted.

A strong significant relationship was found between gender and Indigenous status ($\chi^2=4.582$, df=1, p=0.001) in the two stages of analysis. Among NSW Aboriginal people who have accessed episodes of drug and alcohol treatment in the NGO sector, there is a significantly greater proportion of females versus males (37%F vs 63%M, n=3,080 episodes) compared to the non-Indigenous service users (29%F vs 71%M, n=21,791 episodes). Aboriginal women are more likely to be referred from criminal justice settings. However, both groups of women complete treatment at the same rate. Treatment providers’ perceptions of their inability to successfully intervene with Aboriginal women may be a barrier to treatment. Agency client data should be examined for both race and gender details before treatment providers decide if what they supply is accessible to Aboriginal and Torres Strait Islander populations.

This study demonstrates the importance of using evidence rather than assumptions about access to and effectiveness of service provision to Aboriginal women. Analysis of agency, state and national datasets can inform policy and practice evaluations. Social workers can then support a more hopeful future for Aboriginal women, families and communities.

**Key Words:** Aboriginal and Torres Strait Islander women, access, drug and alcohol treatment

Word count main text including references 5,300 text only 4,222
Who starts, who finishes and where do they come from?: Aboriginal and non-Aboriginal Women in NSW NGO Drug & Alcohol Treatment and the implications for social work

Introduction

Effective service provision for Aboriginal and Torres Strait Islanders is a vexed issue for Australia. The nation has poorer Aboriginal and Torres Strait Islander health status than other countries with similar Indigenous and non-indigenous populations (Gray, Saggers, Atkinson & Wilkes 2007; Ring & Firman 1998). Racially specific and appropriate health services are considered an important way of improving Aboriginal and Torres Strait Islander health status and there is a widespread perception that most mainstream health and community services are inappropriate and ineffective (Hayman, White, Spurling 2009; Baum, 1998; Saggers & Gray 1991). While health status is not directly related to the provision of care, ensuring access for disadvantaged populations is one course of action available to service providers (Legge 2001).

Access to health and community care encompasses supply, utilisation and outcomes (Gulliford, Figueroa-Munoz, Morgan et al 2002). Indigenous populations’ experience of racial discrimination is considered a factor in health care outcomes even when services are supplied (Westerman 2004). Racial inappropriateness is described as a fundamental barrier to the use of available services by many Indigenous populations (Gruen, Weeramanthri, et al. 2002; Wood, Montaner, Li et al. 2007). Social, racial and financial barriers to full participation in society experienced by Indigenous populations are identified as an impediment to effectiveness even when mainstream services are used (Gulliford, Figueroa-Munoz, Morgan et al 2002).

Drug and Alcohol Treatment

Access to drug and alcohol (D&A) treatment services is particularly salient for Australia as the nation is paying considerable attention to risky drug and alcohol use. For example bipartisan support by Commonwealth, State and Territory governments is given to the National Drug Strategy (Ministerial Council on Drugs Strategy 2004).
The strategy incorporates a framework to allocate resources for reducing supply, demand and harm related to D&A use (Ministerial Council on Drugs strategy 2004). Alcohol is of particular concern. The Commonwealth government has identified alcohol as a focus for its Preventative Health Taskforce noting the significant cost of addressing alcohol related harm and the damaging effects on the health of Australians (Preventative Health Taskforce 2008).

Aboriginal and Torres Strait Islander Australians are concerned about drug and alcohol related harm within their communities. Substance use in combination with poverty, poor housing and limited educational attainment is identified as a key reason for the seventeen year gap in life expectancy between Aboriginal and Torres Strait Islander and non-indigenous Australians (Gray, Saggers, Atkinson & Wilkes 2007). Aboriginal and Torres Strait Islander drug use, primarily alcohol, is described as the cause of serious health problems, imprisonment for D&A related offences and endemic family violence (Brady, 2007, Weatherburn, 2008, AIHW 2008).

Access to treatment has been identified as the most significant factor in reducing D&A related harm for disadvantaged populations (Swift & Copeland 1996). Reports about treatment outcomes for Aboriginal and Torres Strait Islander Australians are minimal and generally reflect either limited utilisation or few treatment completions (Steering Committee for the Review of Government Service Provision Overcoming Indigenous Disadvantage 2005; Gray, Saggers, Sputore, Bourbon 2000). For example;

Specific alcohol and drug use services only reach a small proportion of Indigenous people who are affected by alcohol and substance misuse. Specialist treatment services for substance misuse for the general population (to which Indigenous people theoretically, but not practically, have access) are provided by a wide range of mainstream government and non-government services (Gray, Saggers, Atkinson, Strempel, 2004).

In one of the few studies to investigate racial factors in Australian mainstream drug and alcohol service provision, treatment providers state they perceive their knowledge and skills are inadequate to properly address Aboriginal and Torres Strait Islander
clients needs and note that mainstream services need to be improved (Roche, Pidd, Duraisingam 2009).

**Gender differences in Drug and Alcohol Treatment**

There are gender disparities in D&A treatment records that suggest further barriers to treatment access for Aboriginal and Torres Strait Islander women in particular. Worldwide, men comprise the greatest proportion of the treatment population, consistently receiving around 70% of all treatment episodes (Acharyya, Zhang 2003). In Australia 66% of all closed treatment episodes are provided to men (AIHW 2007).

A study of Aboriginal and Torres Strait Islander specific treatment programs found that they primarily targeted men (Alati 1996). Prevalence studies have found that in general, women use drugs and alcohol less than men but that women’s use is increasing (Grella & Greenwell 2007; Greenfield, Brooks, Gordon, Green et al 2006; Forero, Bauman, Chen & Flaherty 1999). Women’s family and caring responsibilities, limited education and lack of practical and financial support have been identified as reasons for substantially lower treatment usage rates (Greenfield, Brooks, Gordon & Green et al 2006). Additional reasons given for caution or reluctance in seeking treatment include pregnancy and fear of prosecution or removal of children by child protection authorities if they become aware of drug use, particularly of illicit drugs (Pelissier & Jones, 2005).

**Racial factors in treatment for women**

Race has been identified as a factor in women’s treatment outcomes. Several United States studies have investigated women’s ethnicity or race as a factor affecting outcomes of drug treatment. For example, one study compared drug treatment motivation in white and African-American pregnant women. It found that white women were eight times more likely to be motivated for treatment and complete it (Mitchell, Severtson & Latimer 2008). Another study reported that African-American and Hispanic women admitted to drug treatment upon parole from prison were found to have a lower likelihood of treatment completion than white women (Grella & Greenwell 2007).

Some Aboriginal and Torres Strait Islander women are likely to need drug and alcohol treatment programs and to experience racial and gender barriers to accessing
mainstream treatment. As a group they experience low incomes, high rates of unemployment, low educational attainment and tend to have children at an early age (Briskman 2007; Forero, Bauman, Chen & Flaherty 1999). There are risks from legal and child protection systems associated with disclosing drug use and seeking treatment (Chikritzhs & Brady 2006; Pelissier & Jones 2005). Few treatment episodes are likely to be provided to Aboriginal and Torres Strait Islander women. When treatment is provided to Aboriginal and Torres Strait Islander women in mainstream services fewer treatment completions could be expected.

**Drug and alcohol treatment data collection**

Australian drug and alcohol treatment programs are provided by both government and non-government agencies. The Australian Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS) measures supply of publicly funded mainstream drug and alcohol treatment. AODTS-NMDS data collection is managed by state and territory health authorities (AIHW 2007).

Treatment provided includes one or more types of intervention such as medicated withdrawal, assessment, counselling, rehabilitation, case management and education or information. Aboriginal and Torres Strait Islander specific treatment agencies do not participate in this data collection reporting their treatment episodes to a different collection (DASR 2006). The AODTS-NMDS identifies 10% of all mainstream treatment episodes are provided to Aboriginal and Torres Strait Islander people. Of these treatment episodes 6.4% are to Aboriginal and Torres Strait Islander men and 3.7% to Aboriginal and Torres Strait Islander women (AIHW 2007).

In the remainder of the paper the term Aboriginal is used to refer to Australian Indigenous women rather than Aboriginal and Torres Strait Islander women. Aboriginal people were the first inhabitants of the area now known as NSW. Aboriginal is considered the most appropriate term to use for a study based on NSW data (NSW Health 2004).

**Method**
The study was conducted as part of a multi-method action research project examining drug and alcohol service provision in rural NSW. The research was approved by Charles Sturt University Ethics in Human Research Committee. A three stage statistical analysis was conducted of NSW non-government organisation AODTS–NMDS records for the years 2005-07. In NSW approximately one third of service providers are non-government organisations (NGOs) providing 43% of all treatment episodes (AIHW 2007). Significant advantages of using this dataset in analysis include a high quality data collection instrument, monitored collection processes encouraging a high response rate and large sample sizes (Thomas, 2005). The dataset was analysed using a combination of descriptive and inferential statistical techniques (Altman, Gill & McDonald 2004). These analyses were generated using the statistical computer program SPSS 16.0 for Windows (SPSS Inc, Chicago, Ill, USA).

The study aimed to identify the proportion of Aboriginal women accessing NSW non-government D&A treatment compared to non-indigenous women. Similarities and differences in referral source, principal drug of concern and treatment completion between the two groups of women were investigated.

Data analysis
Before analysis, data screening was conducted for all variables to identify any missing values or outliers and to determine the accuracy of data entry. Agencies responsible for individual data variables were contacted if inconsistencies were identified. The dataset had four categories related to Australian Indigenous status: Aboriginal and Torres Strait Islander, Aboriginal but not Torres Strait Islander, Torres Strait Islander only and neither Aboriginal nor Torres Strait Islander. For the analysis the first three categories were recoded as Aboriginal and the fourth as non-Indigenous.

The only variables used from the dataset in this study were categorical variables. Frequency data were generated and displayed in tabular or graphical form. Global differences between groups of bi-variate categorical variables were investigated using the chi-square test of independence. To more objectively make pairwise comparisons the Marascuilo Procedure was used as a post-hoc test (with 0.05 level of significance) to identify the proportions which are different.
Firstly, using the AODTS–NMDS submitted by NSW NGOs, the number of treatment episodes provided to Aboriginal and non-indigenous men and women across the state were identified (n= 24,871). This dataset will be referred to as: ‘All episodes in all NSW NGOs’ (dataset 1). Frequency data were generated from these episodes based on the variables: referral sources, principal drug of concern and reason for treatment cessation. Chi-square tests of independence were applied to identify any statistical significant differences between Aboriginal and non-Indigenous women.

Secondly, a single agency was selected on a convenience basis. The selected agency provided 14% of all NGO treatment episodes in NSW – the second highest number of treatment episodes of any agency. It was chosen because it provided treatment to adult men and women including Aboriginal people; provided a range of treatment types and because when contacted, agency staff agreed to check their records if any data errors or inconsistencies were identified during the analysis. Treatment provided by the agency included assessment, inpatient and outpatient withdrawal, residential rehabilitation, outreach counselling, information and education and family support to men and women from urban, regional and remote areas of NSW and interstate. Treatment episodes measure the amount of service provision and may record the same person attending different agencies and/or the same agency on multiple occasions. The agency’s minimum dataset records for the three year period (n=3511) were analysed to investigate the percentage of treatment episodes provided to Aboriginal and non-indigenous women. This dataset will be referred to as: ‘All episodes single agency’ (dataset 2).

This dataset was then rigorously cleaned and reduced by using unique client codes cross matched with date of birth and Aboriginal status to identify individual client episodes (n= 1,549). This was possible because the agency uses the same client code across all its service types. The state wide sample could not be reduced in this manner because each agency allocates its own client code resulting in many instances of the same client code linked to different individuals. The final dataset represented unique individuals but remained relatively large ensuring that the study had sufficient power to detect statistical differences (Gardner & Altman 1989). This final dataset will be referred to as: ‘Unique individuals-single agency’ (dataset 3).
Results
The results for the examination of gender versus Aboriginal status for each of the three datasets are summarised in Table 1. The percentages in the row column need to be read across the Table and provide the total numbers and percentages of male and females for the indigenous group and non-indigenous group respectively. The column percentages need to be read down the Table and provide the total numbers and percentages of females (indigenous and non-indigenous) and males (indigenous and non-indigenous) respectively.

Table 1: Gender and Aboriginal Status for the datasets

<table>
<thead>
<tr>
<th>Dataset</th>
<th>Female</th>
<th></th>
<th></th>
<th>Male</th>
<th></th>
<th></th>
<th>Total</th>
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<td>%row</td>
<td>%col</td>
<td>n</td>
<td>%row</td>
<td>%col</td>
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<tr>
<td>All episodes in all NSW NGOs (n = 24871)</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Aboriginal</td>
<td>1149</td>
<td>37.3</td>
<td>15.2</td>
<td>1931</td>
<td>62.7</td>
<td>11.1</td>
<td>3080</td>
<td>100</td>
<td>12.4</td>
</tr>
<tr>
<td>Non- Indigenous</td>
<td>6397</td>
<td>29.4</td>
<td>84.8</td>
<td>15394</td>
<td>70.6</td>
<td>11.1</td>
<td>21791</td>
<td>100</td>
<td>87.6</td>
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<tr>
<td>Total</td>
<td>7546</td>
<td>34.6</td>
<td>100</td>
<td>17325</td>
<td>65.4</td>
<td>100</td>
<td>24871</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>All episodes single agency (n=3511)</td>
<td></td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>Aboriginal</td>
<td>238</td>
<td>30.7</td>
<td>27.7</td>
<td>537</td>
<td>69.3</td>
<td>20.2</td>
<td>775</td>
<td>100</td>
<td>22.1</td>
</tr>
<tr>
<td>Non- Indigenous</td>
<td>621</td>
<td>22.7</td>
<td>72.3</td>
<td>2115</td>
<td>77.3</td>
<td>79.8</td>
<td>2736</td>
<td>100</td>
<td>77.9</td>
</tr>
<tr>
<td>Total</td>
<td>859</td>
<td>24.5</td>
<td>100</td>
<td>2652</td>
<td>75.5</td>
<td>100</td>
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<td>Unique individuals single agency (n= 1549)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal</td>
<td>109</td>
<td>29.5</td>
<td>27.9</td>
<td>261</td>
<td>70.5</td>
<td>22.3</td>
<td>370</td>
<td>100</td>
<td>23.9</td>
</tr>
<tr>
<td>Non- Indigenous</td>
<td>282</td>
<td>23.9</td>
<td>72.1</td>
<td>897</td>
<td>76.1</td>
<td>77.7</td>
<td>1179</td>
<td>100</td>
<td>76.1</td>
</tr>
</tbody>
</table>
Note. Episodes with unknown gender or Aboriginal status have been removed (718 from dataset 1, 19 from dataset 2 and 11 from dataset 3).

A highly significant relationship was found between gender and Aboriginal status in the ‘all episodes in all NSW NGOs’ dataset ($\chi^2=80.7$, df=1, $p=0.001$). In this dataset, females were a significantly larger proportion of indigenous service users (37.3% versus 62.7% males) compared to females among non-indigenous service users (29.4% versus 70.6% males). The same significant relationship was found for the ‘all episodes in single agency’ dataset ($\chi^2=21.0$, df=1, $p=0.001$). The relationship between gender and Aboriginal status was weaker, but remained significant, in the ‘unique individuals, single agency’ dataset ($\chi^2=4.6$, df=1, $p=0.032$).

Analysis of ‘all episodes in all NSW NGOs’ dataset
The ‘all episodes in all NSW NGOs’ dataset was analysed to determine if there were differences between Aboriginal and non-indigenous women for the variables: referral sources, principal drug of concern and reason for cessation of treatment. The results are summarised in the bar charts below.

Referral Source
There were twenty one referral sources identified in the dataset. This item recorded the pathway into drug treatment for each treatment episode. Missing and ‘not stated’ values were omitted from this analysis. More than half the sources had very low numbers – less than 3% each, with one source (Medical supervised injecting centre) applying to just 2 episodes in the whole dataset. The number of categories was reduced by combining smaller categories. This was done for two reasons. The first reason was so the assumptions behind the Chi-square test would be satisfied. The second reason was because some sources were very similar and should be considered as one group. For example, the categories ‘General Practitioner’ and ‘Medical Officer’ were combined to make a new category ‘General Practitioner/Medical Officer’. Other examples include combining general health and mental health services which are otherwise the same.
The Chi-square test found there was a significant difference between some of the referral sources between Aboriginal and non-indigenous women ($\chi^2 = 243.9$, df=11, $p < 0.001$). The twelve (recoded) referral sources for female treatment episodes are presented in figure 1.

![Fig. 1 Aboriginal and non-Indigenous referral sources – all treatment episodes](image)

There were 1141 episodes for Aboriginal women and 6368 episodes for non-indigenous women.

The bar chart reveals several differences in the two groups of women. Post-hoc analysis using the Marascuilo Procedure found referrals from the criminal justice system (Court Diversion and Other Criminal Justice Setting) have a higher proportion of episodes for Aboriginal women than all the other sources. There were 24.0% of
episodes for Aboriginal women referred from a criminal setting (10.1% from Court Diversion, 13.9% from Other Criminal Justice Setting), compared with only 9.0% for non-indigenous women (3.7% from Court Diversion, 5.3% from Other Criminal Justice Setting). The other pattern the Marascuilo procedure identified was the difference of referrals between Family Member/Friend and Non-Health Service Agency. Less episodes of care were initiated by Family or Friends for Aboriginal women (9.6% of their episodes) compared to non-indigenous women (14.9% of their episodes). In contrast, more episodes of care were initiated by Non-Health Service Agencies (for example, a family and child protection service) for Aboriginal women (8.5% of their episodes) compared to non-indigenous women (6.4% of their episodes).

Principal drug of concern

There were eleven categories recording principal drug of concern with no missing values. However, the smallest four categories (Ecstasy, Caffeine, Nicotine and Organic opiate analgaesics) represented in total less than 1% of all episodes and hence were combined into one group (Other). Figure 2 shows the results for Aboriginal and non-Indigenous treatment episodes. The majority of treatment episodes were provided for alcohol, heroin and cannabis use for both groups. However, there were significant differences in the principal drug of concern between Aboriginal and non-indigenous women ($\chi^2=38.5$, df=7, $p<0.001$). The Marascuilo Procedure was used to identify some of these differences. The proportion of episodes for Aboriginal women compared to non-indigenous women was less for the principal treatment of Alcohol, Amphetamines or Benzodiazepines; but greater for Heroin or Cannabis.
Fig. 2 Principal drug of concern recorded in all treatment episodes. There were 1149 episodes for Aboriginal women and 6397 episodes for non-indigenous women.

Reason for cessation of treatment
There were ten categories in the dataset to record reasons for treatment ending. These included completion of treatment, referral to another service and categories that indicated problems with treatment such as left involuntarily and left against advice. Figure 3 shows the results for this item (categories which correspond to less than 2% of treatment episodes have been combined to give the Other category for both clarity and to meet the assumptions of the statistical test). It demonstrates that there are no significant differences in the rate of female treatment completions for Aboriginal and non-indigenous treatment episodes in this dataset ($\chi^2=2.9$, df=5, p=0.72). In particular, 37.9% of treatment episodes for Aboriginal women and 38.9% of treatment episodes for non-indigenous women were completed (a nonsignificant difference). For the purposes of the statistical test, the ‘Not stated/inadequately described’ category was omitted since it corresponds to missing data. This category represented 10.0% of all treatments, which was high. However, even when including this category, the differences remained nonsignificant.
There were 1015 episodes for Aboriginal women and 5775 episodes for non-indigenous women.

Stage 2– Identifying unique individuals from multiple treatment episodes

Demographic information of ‘unique individuals, single agency’ dataset

The second stage of analysis removed multiple treatment episodes for individuals from the ‘all episodes, single agency’ dataset. The number of individuals was 45.5% the size of the number of episodes therefore some individuals received multiple treatment episodes. This analysis of client codes identified that 23.0% of individuals receiving treatment were Aboriginal. Aboriginal women were 27.9% of the female treatment population. Aboriginal men were 22.5% of the male treatment population. The demographics of unique individuals from the single agency are reported in the third part of Table 1.

A Chi square test showed that Aboriginal status and gender proportions were not significantly different for the single agency datasets (all episodes and unique
individuals). The chance a patient received multiple treatment episodes was not biased (for this agency) by Aboriginal status or gender.

In the ‘unique individuals, single agency’ dataset there were 109 Aboriginal women represented out of a total sample size of 1549. Aboriginal women thus comprised 7.0% of the treatment population. The agency, from which this data was collected, was situated in a region where Aboriginal women made up between 1.5% and 2.5% of the population (Australian Bureau of Statistics 2006). There was not a precise drawing area for this agency (some clients travelled a great distance; from urban, rural and remote areas), thus a lack of precision in the estimate. Regardless, Aboriginal women were well over represented in this agency’s treatment population.

**Discussion**

Females were a larger proportion of Aboriginal service users, who accessed NSW non-government drug treatment agencies, compared to females among non-Indigenous women. This is contrary to the expected finding. The results do not support the common view that mainstream services are not utilised by Aboriginal women. Equally, or even more surprising, was the finding that Aboriginal women complete treatment at the same rate as non-Indigenous women. Treatment completion in this sample seems unrelated to race. This is a significant finding for the non-government treatment sector that perceives all of their services are inaccessible and ineffective for Aboriginal and Torres Strait Islander Australians (Roche, Pidd & Duraisingam, 2009).

It is a critical point that Aboriginal women in this study are less likely to have a choice about entering drug treatment as they are more likely to be referred from legal settings. Those with disadvantaged social circumstances are over represented in criminal justice settings and are most likely to come to treatment from this arena (Rooney 2004). This explains why Aboriginal women are over-represented in the treatment population. A great deal of debate occurs in the drug and alcohol field about motivation for, and coercion into, treatment.

Self referral into drug treatment suggests a degree of choice and control over healthcare access and is usually linked to motivation and associated positive treatment
outcomes (Grella & Greenwell 2007; Mitchell, Severtson & Latimer, 2008). However, coercion into treatment does not only refer to legal mandates. Klag, Creed & O’Callaghan (2006) suggest that all individuals seeking rehabilitation are coerced because of pressure exerted on them by family, friends, employers or financial problems. Several studies (e.g. Wild, Cunningham & Ryan 2006; Marlowe Kirby Bonieskie et al 1996) have found that personal coercion from these sources may have a greater effect on a decision to enter treatment than legal measures. Since Aboriginal women in this study are less likely than non-Indigenous women to self refer or be referred by family and friends, the criminal justice system could enable necessary access to treatment. This is a challenging perspective when involvement with criminal justice agencies is more commonly perceived as negative.

The role of the criminal justice system in enabling access to treatment cannot be ascertained from the results of this study. While it is estimated that ninety per cent of women in NSW Correctional centres have a significant history of illicit drug use, we know little about their circumstances outside those centres (ANCD 2004). This study does not identify the reasons women are in the criminal justice system, why or how they are referred for treatment nor if there is any degree of choice or preference involved. Rather than enabling access it is more likely the high number of referrals from the criminal justice system portrays a high degree of control and surveillance over Aboriginal women’s lives. Pathways into treatment and Aboriginal women’s perceptions of choice and coercion require investigation. Greater knowledge and understanding about the events and processes that occur prior to treatment could minimise criminal justice involvement for Aboriginal women if treatment was what was required.

The literature suggests that the few Aboriginal women in mainstream treatment are unlikely to complete it because of access barriers and because of the apparent lack of choice and related motivation to remain in treatment (e.g. Brady Nicholls Henderson & Byrne 2006; Pelissier & Jones 2005). The results of this study indicate that this is not always the case. There may be more factors in common between the two groups of women than differences. If treatment providers focus only on Indigenous status, perceiving they cannot provide effective treatment to Aboriginal women, they are likely to be missing other reasons women do not complete treatment. It is important to
note the frequency data in this study finds that around one-third of all women leave treatment before completion. The circumstances of these treatment episodes are unexplained. Women may find the treatment program or the environment unacceptable; or their personal or family circumstances prevent them remaining in treatment. Incomplete treatment episodes require further investigation.

**Limitations of the study**

This study uses an observational dataset from NSW NGO drug and alcohol treatment services only. While the NGO sector provides nearly half of the state’s treatment episodes there may be significant differences in client demographics and referral sources across the other treatment agencies. Government treatment agencies are more likely to provide opiate replacement programs and one to one counselling than NGO agencies. The single agency dataset is a convenience sample and not representative of all NSW NGO agencies and treatment episodes. Given these limitations care should be taken in generalising the findings to other settings.

There is an assumption in this paper that treatment completion is a positive outcome associated with some improvement in substance misuse and/or health and wellbeing. There may be serious penalties for people leaving treatment who are referred from criminal justice settings that could affect completion rates. Investigation of D&A treatment outcomes for Aboriginal and non-Indigenous people is an important area for future study.

**Implications for Social Work Practice**

A limitation of the study has important implications for social work practice. The treatment data comes only from the NSW non-government drug and alcohol sector. This sector provides just less than half of all drug and alcohol treatment in the state and employs few social workers (NCETA 2007). The government treatment sector may provide different types of treatment and these may be less accessible to Aboriginal women. However, social workers are more likely to be employed in the government health sector (AASW 2008) where they may be less likely to come into contact with Aboriginal women. As substance misuse is identified as an important problem facing Aboriginal and Torres Strait islander communities, it is an area where social workers need to develop skills and experience. Opportunities are more likely in the NGO sector.
It is important to use evidence, rather than assumptions, to evaluate existing policy and practice in all social work arenas. Epidemiological data can provide evidence to reflect on, and evaluate, social work practice. There is a perception of unmet demand for drug and alcohol services that is supported by treatment providers’ reports of their inability to provide acceptable and effective services to Aboriginal and Torres Strait Islander clients. Combined with media depictions of uncontrollable drug and alcohol use in remote Aboriginal communities and its related impacts (e.g. Callinan 2006), ineffectiveness of treatment services seems inevitable. A history of damaging and traumatic interventions with Aboriginal communities, families and individuals, combined with appropriate caution and concern about racial competence in helping activities, has resulted in many workers fearing they will contribute to further damage (Gilbert 2005, Briskman 2007). The large scale Northern Territory Intervention and problems implementing any positive aspects of that action only substantiate concerns. Literature designed to assist in developing racially appropriate approaches (e.g. ADF 2004), may inadvertently support assertions of mainstream unacceptability by presuming Aboriginal preferences for and outcomes of interventions or treatments.

There are many examples of poor health outcomes for Aboriginal and Torres Strait Islander populations (e.g. Gray, Saggers, Atkinson, Strempel 2004; Westerman, 2004; Gruen, Weeramanthri, et al. 2002). It is likely these poor outcomes are more closely related to the social determinants of health and related racial discrimination than treatment for specific disease or disorder (Gulliford, Figueroa-Munoz, Morgan et al 2002, Ring, Firman, 1998). Social work has an important role to play in ensuring services are available, acceptable and appropriate for Aboriginal and Torres Strait Islander people. This study demonstrates that social workers need to be critical of, and informed about, what services are accessible and what they provide rather than assuming all mainstream interventions intrinsically lack racial sensitivity and are doomed to failure where Aboriginal clients are concerned. The similarities between disadvantaged groups require investigation as well as the differences.

Reconciliation with Australian Aboriginal people needs to move forward from saying sorry about the past to informed action to address current and ongoing injustice. Social workers and other health and human service professionals can then support a more hopeful future for Aboriginal women, families and communities.
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