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Working with the effects of colonialism and developing culturally suitable programs for First Nations Australians in prison

Michael Doyle

I. Introduction: My story

My name is Michael Doyle. I am an Associate Professor in the Sydney Medical School at the University of Sydney. My presentation is titled “Working with the effects of colonialism and developing culturally suitable programs for First Nations Australians in prison.” This is part of the “Decolonising global health: How our health is damaged by colonialism” symposium.

Today's presentation has four parts. I will tell you a little bit about my story, so you understand my perspective on Aboriginal health and on some of the subjects we are speaking about. I will be talking about First Nations in Australia, and we are Aboriginal and Torres Strait Islander peoples regarded as First Nations people of Australia. I will speak a bit about some completed research, and this research has been the basis upon which my current research is based. And that is where I will be rounding off this presentation and talking to you about the development of a new “Social and emotional wellbeing program for Aboriginal and Torres Strait Islander people in prison.”

This is a bit of my story, so I will start this by drawing your attention to the top right-hand corner (of a slide shown during the presentation), which you will see there is a map of the western part of the Australian continent. My people, the Bardi people, are from the far northwest region of the Kimberley, and you can see there in black text a place called Djarindjin Community, which is my home community. The picture in the middle there was taken between the time of World War I and World War II, and that is a photo of my grandfather and his contemporaries. So, this photo is quite old now and most of the people in my community are related to one of these men. I have a number of degrees. You would have read this from my bio, but I completed my PhD from the University of New South Wales, and I currently work at the University of Sydney as I mentioned before. I do try to get home to my community as often as I can.

I thank my partner, Justin, for his ongoing support throughout my career. Unfortunately, he is not going to be able to attend the lecture at Sophia University as he has travelled home to Sydney on the 7th of January. That photo was taken about a year ago on the beach just near my community.

II. Aboriginal and Torres Strait Islander people: Health and substance use

I will talk about Aboriginal and Torres Strait Islander people’s health and substance use. Have a look at the map (on the slide). There is great diversity among Australia's First Nations peoples. On the top left-hand corner there, there is a red circle that shows you where Bardi country is, which is my homeland, and then you will see up on the very top of the map an area which is the Torres Strait Islands. This is a group of islands that are located between the northern tip of Australia and Papua New Guinea. Torres Strait

Islander people are a distinct group of First Nations Australians. They have both links to Australia, of course, and to Papua New Guinea, and there is a freedom of movement treaty between Australia and Papua New Guinea, which allows the Torres Strait Islander people to move freely between both countries. Torres Strait Islander people live across the whole of the country, and in my own family, we have a number of people who are intermarried with Torres Strait Islander people. Just to round out this slide again, there is a great diversity. Each of these different colours you can see on the map represent different nations, and each of those nations have fairly distinct languages and cultural traditions in their own right.

Invasion and colonisation have been experienced by the different Aboriginal and Torres Strait Islander peoples differently across the nation. This has largely to do with the size of the Australian continent. It is not possible to give you an in-depth view of all of this, so I will give you a very high-level brief summary. The first European settlement was in Sydney, and that was set up as a penal colony in 1788. After that date there were different European settlements around the nation. 1837 was when the Europeans visited and claimed the Kimberley region, and then in 1870, there was an ongoing settlement.

The impacts of invasion and colonisation are ongoing. They did not stop; they continue on at present. The initial economic impact was that we became dependent upon the new European economy. This is largely because we were unable to do hunting and gathering or those kinds of traditional activities which we did to support ourselves, as we lost that direct access to our own lands, and we were then forced to remain in a single location. There is a myth that Aboriginal nations were nomadic. This is actually not true. Different Aboriginal nations peoples would move from different parts of their homelands at different times of the year, so they may spend what you would call summer in a particular location, then spring in another location, and winter and autumn in different locations of their traditional homeland. But there would be this cycle that they would go through to different locations. However, we were then forced to live in a single location, and this was often the worst possible areas of towns with the places where Europeans did not wish to live themselves.

In terms of education, we were forced not to speak our own languages and were forced to learn English. The Australian education system is done within the British colonial tradition, as you may say, and all teaching is within that structure. So the actual education system was not and continues to be not suitable for many Aboriginal and Torres Strait Islander people, where you have much more theory-based classroom-type learning, whereas for Aboriginal people, very generally speaking, it is more of an apprenticeship-type learning model where you would be mentored and taught how to do the things that you need to do as you mature into adulthood. These are ongoing effects that we continue to deal with.

We have lower levels of income on average than the rest of the Australian population, including lower home ownership and those kinds of things as well. We also have lower levels of completion of high school and lower levels of the number of Aboriginal and Torres Strait Islander people who attain or complete university degrees.

Intergenerational trauma, or, if you like, transgenerational trauma from colonisation is a continuing issue for Aboriginal and Torres Strait Islander people. I just want to highlight here that you do not have to have actually experienced an event to be affected by that event. What I found in my research is that

often people do not think that what they are going through, or the way in which their life is being lived at the moment, is a result of intergenerational trauma. What is interesting is when you interview people, sometimes they will sit and think, “Oh, hang on! Maybe this wasn't always the way in which my family lived!” But it is not something that somebody would necessarily think of unless they spend some time reflecting upon their own family history. The effects of intergenerational or transgenerational trauma can be for the individual and the family, and there can be this sort of collective effect. For Aboriginal and Torres Strait Islander people, we have collectively not necessarily experienced the best treatment from the Australian government, so that then translates into a collective distrust of Australian government. There is also this transference effect that happens, and if you have not necessarily experienced the best when dealing with Europeans, that may be transferred into a general distrust of all Europeans.

I will now discuss the impacts from colonisation or the health and social disparities between Aboriginal and Torres Strait Islander people and that of other Australians. In terms of life expectancy, Aboriginal and Torres Strait Islander men and women have a lower life expectancy than that of other Australians. Regarding child removals, we make up around 3.8% of the Australian population, but around 50% of children in out-of-home care are Aboriginal and Torres Strait Islander.

It is highly disproportionate in terms of mental health. There are a number of mental health indicators. Here are just a few summary points. Aboriginal and Torres Strait Islander people are more likely to have high levels of anxiety or very high levels of psychological distress than that of other Australians. Unfortunately, self-harm is more common among Aboriginal and Torres Strait Islander people than that of other Australians.

There is research into the impacts of racism on health in Australia, and this is showing us that there really is a difference in the way in which the Australian healthcare system operates when working with Aboriginal and Torres Strait Islander people. There is also difference in the impact. The mental health impact of racism can also have a very real psychological impact, which also affects one's mental health. This is a growing area of research in Australia, and it will be good to see more of that research as it matures over time.

Now into my area, which is alcohol and other drugs, as you would have seen from my bio. I work in the discipline of addiction medicine at the University of Sydney, and this is more the area of Aboriginal health that I focus on. Thinking about tobacco use and tobacco being the leading cause of premature death for Aboriginal and Torres Strait Islander people, we see there is a very high proportion of Aboriginal and Torres Strait Islander people that smoke and continue to smoke. Now, while these figures are a little bit old, you can see they go from 2001 through 2018. These are still fairly good, and, I believe, fairly accurate at this point in time. We have seen a reduction in the number of smokers for Aboriginal and Torres Strait Islander people who do not live in remote areas. These are people who live in major cities such as Sydney, Melbourne, and Perth. Compared to people who live in remote communities, which may include my home community of Djarindjin, we have seen this reduction in smoking for the urban population, but not so much for the remote population. There is continuing work within this area, but, unfortunately, the high level of smoking tobacco continues.

Regarding use of different substances by Aboriginal and Torres Strait Islander people over the age of 15, we see here that cannabis is by far the most commonly used substance. But there is also some use of drugs such as methamphetamines or amphetamines, as it is listed here, and other drugs as well. We do not have particularly good figures for illicit drug use, partly because it is illicit, so it is an illegal activity and there are small population numbers. So, there is a whole range of reasons why we do not have particularly good figures. But this gives you a bit of an idea around all those substances that are being used.

Now, we are looking at alcohol consumption within the Aboriginal community. This is an area of high levels of stigmatisation, and that is that people tend to say Aboriginal people are drinkers. That is not necessarily true. What I am going to show you is just a snapshot of a meta-analysis that was done by some colleagues of mine, and what they did was they pulled all of the data that they could from different surveys that had been done around the entire nation on alcohol consumption by Aboriginal and Torres Strait Islander people. The table (on the slide) is from James Conigrave and coauthors' meta-analysis. You see there that Aboriginal and Torres Strait Islander people are the pink bars and the non-Aboriginal and Torres Strait Islander people are the grey bars. Within the pink bars, you will see there, represented by a brown line, the confidence interval. They confirmed that less Aboriginal and Torres Strait Islander people consumed alcohol than non-Aboriginal and Torres Strait Islander people, but after that not very much is certain. It is not clear whether Aboriginal people are more likely to consume more alcohol on a single drinking occasion than non-Aboriginal people. However, what we do know from other data is that health harms from alcohol consumption are likely to be higher among Aboriginal and Torres Strait Islander people, and there definitely are overlapping factors that contribute to that. But just to summarise this, we do not know for sure what the difference in alcohol consumption patterns is between Aboriginal and Torres Strait Islander people and non-Aboriginal people in Australia.

III. Completed research

In the presentation today, we are looking at some completed research, and this research is the foundational basis of my current research. Research I am presenting here has been published, and here are a couple of papers I have provided a copy for (on the slide).

I want to highlight the disparity in imprisonment between Aboriginal and Torres Strait Islander people and that of other Australians. On the slide in front of you, you will see the rate of imprisonment from 2005 to 2023. There are two stories being told on this slide, which is an ever-increasing rate of imprisonment for Aboriginal and Torres Strait Islander people, while there has remained a fairly stagnant rate of imprisonment for others. How high will it go? Hopefully, not too much higher, but we do need a lot more political will and a lot of other changes within Australian society to bring about a change to this increasing imprisonment rate.

Have a look at the patterns of alcohol and other drug use before custody for Aboriginal and Torres Strait Islander people in New South Wales. This bit of work is more quantitative. Do have a read of the entire paper, but for the purpose of this presentation, I will be presenting a couple of tables from our paper.

In this paper we use the Alcohol Use Disorders Identification Test (AUDIT), which was developed by the World Health Organisation. It is a series of ten questions, and you can score from a 0, which would mean no alcohol consumption, to a possible score of 40. A score of 1 to 7 indicates low-risk alcohol consumption. A score of 8 to 19 would indicate hazardous, possible harmful alcohol consumption. And a score of 20 or higher indicates high-risk possible alcohol dependence. This is a screening tool; it is not a diagnostic tool. But we have used it in this research to indicate alcohol use consumption patterns. Now, when we did a Chi-square test, looking at the difference between Aboriginal and non-Aboriginal men, we found there was a significant difference. When you run your eyes across that (chart on the slide), you can see that there is a greater concentration of Aboriginal compared to non-Aboriginal men in the high-risk possible-dependent category. We see a similar pattern for Aboriginal women and overall. We see from this pattern that there was a statistically significant difference in the alcohol consumption categories between Aboriginal and non-Aboriginal people.

Here (in the chart on another slide), we use the Alcohol Use Disorders Identification Test (AUDIT) and use those same four categories you saw in the previous slide. We wanted to see if there were particular differences with the tobacco use or selected illicit drug use by AUDIT category. What we found was that for tobacco, there was no particular difference between categories. We saw that for cannabis there was indeed a statistically significant difference that we saw through the Chi-square test, while Chi-square is not necessarily a directional statistical test. If you run your eyes across this (on the slide), you can see there is a greater number of people who use cannabis regularly who are also in the harmful/hazardous, high-risk/possible-dependent category. In terms of heroin or opioids, there was no particular pattern in amphetamine-type stimulants. There was also no particular pattern that was observed for all of the illicit drugs together. When you merge those, and then you look at the Alcohol Use Disorder Identification Test categories, there is no particular pattern.

This paper was rounded out by undertaking some bivariate and multivariate analyses. For this we combined the no-consumption and low-risk into one category with AUDIT scores of 0 to 7, and then we combined the high-risk possible-dependent and hazardous categories into one, which was for people with a score of 8 or higher on the order. You can see there in the bivariate analysis, when looking at those two categories for Aboriginal men and Aboriginal women, that there was a difference for cannabis use. There was also a difference for regular heroin use as well. There was a difference between those two categories, but I should note here that I am only showing you the statistically significant findings that we found from the bivariate analysis.

In terms of the multivariate analysis, when we added all the different factors in together, there was not a difference seen between Aboriginal men and Aboriginal women, whether they were more likely to be in the high-risk or low-risk of alcohol consumption categories. The observation remained true that regular cannabis use was more likely within the high-risk group, that is, a group that scored 8 or more in AUDIT and for regular heroin use as well. What we found was that it remained true from the bivariate to the multivariate analysis that people who use heroin regularly were less likely to be in the high-risk alcohol use group. Put another way, people who used heroin were more likely to be in the low-risk alcohol

use group, or more likely to have gotten an AUDIT score of between 0 and 7.

Looking at some of the qualitative research that I have undertaken, you will find some more information about the findings I am reporting here in these two papers (shown on the slide). There has also been a couple of other papers published from this qualitative work. I interviewed 14 Aboriginal men, who were all out at the John Morony Correctional Centre, which is located about 40 or 50 kilometres from the centre of Sydney. It is in the outskirts far away from the city itself. For this we undertook thematic analysis of the in-depth interviews. All of the people that I interviewed were at John Morony to attend the intensive drug and alcohol treatment program, which is a six-month-long program. All of these people had some form of alcohol and/or other drug use issue. We got ethics approval from the Aboriginal Health and Medical Research Council of New South Wales and Corrective Services New South Wales for this research.

Among the 14 Aboriginal participants, some spoke of intergenerational alcohol use. Many of them have been removed from their families and many of them had experienced insecure housing and poverty. This is a story here from Neil, and this is a pseudonym or a fake name. Neil here is saying that, like his father, he had a problem with alcohol, and so did his father. And he says, “Yeah, so, over the years, there’d been a lot of alcohol use within the family, and domestic violence related to alcohol. … But mainly just alcohol.” Neil's story is fairly consistent with that of other people within this particular sample. But you can see here some of what I spoke about at the beginning of this presentation around child removals and around insecure housing and poverty which may be related to economic factors.

Men that I interviewed about previous drug and alcohol treatment programs in the prison said they had undertaken a variety of programs which mainly included Alcoholics Anonymous or 12-Step programs, cognitive behavioural treatment (CBT) programs, motivational treatment programs, and psychoeducational health promotion type programs. In terms of the facilitators of these programs, there was appreciation for really well-trained staff that knew what they were talking about as well as peer educators. I will come back to that a little bit more about why peer educators were important. Empathy was the most important quality and being Aboriginal was a bonus, but the ability to connect and be empathetic towards other people was the overriding important quality for program facilitators. Gender balance was preferred, so, where possible, having both male and female facilitators was preferred. They specifically preferred not to have two men facilitating the program. They felt that discussions got a bit out of control when there were two male facilitators, so a gender balance was definitely preferred.

Some lived experience was also preferred, and this relates to the peer educators. Having some personal experience of having overcome drug and alcohol use personally, or having worked with family members around these issues was seen as a real bonus if the program facilitators had that kind of background as well. Confidentiality was key. Programs are within a prison environment. Information is a premium, and so confidentiality of the program facilitators and being able to trust them with your information is critically important at all times. Also, there was this appreciation for program facilitators being slightly older. So, for example, if you were 35 or 40 or so, and your drug and alcohol treatment program facilitator is 21 or 22, then that did not work so well. So, they preferred people being middle

aged or older.

The following slide is about the content of different programs and what they liked or did not like about the content of these prison-based programs. They said that the content needed to be relevant to their AoD (alcohol and other drug) use. For example, for people who were mainly drinkers or consumed alcohol, they did not like sitting through lessons that were looking at injecting drug use, which is abbreviated as IDU. The lessons had to be practical, useful, and fun. So, for example, if you are talking about cannabis use, you might want to talk about how much money you spend on cannabis and what you could spend that money on instead. You might work out how much food you could buy with the same amount of money you would be spending on the cannabis. Again, they needed to be practical and useful, and they needed to be fun. People also spoke about wanting to repeat lessons. This is an issue in prison. There are limited resources, and often you might have the opportunity to only do one program because of the limited resources and the high demand on those resources. Something there to perhaps work through is having greater resources, so people can do repeat lessons.

In terms of the therapeutic group itself, this is a group of people you do a program together. It had to be a supportive group. It was really critical that you trusted the other people in the group. Now you have got Rob here; this is a pseudonym as well. I am not going to read that verbatim, but what Rob is saying is that if you go to a therapeutic group where you do not know the other people, then that can be a problem. But if you go to a therapeutic group, and everybody else is Koori so everybody in the group is Aboriginal, then you automatically trust the rest of the Koori fellows and there is a big difference. Then, you get to this point of having this therapeutic cohesion within the group much faster than you would if it was a mixed group.

To summarise out the previous research I have undertaken, we Aboriginal and Torres Strait Islander people are vastly overrepresented in the Australian prison system. We are 3.8% of the Australian population but represent 35% of the Australian prison population. I did not present this today, but just for comparison purposes, the First Nations peoples of Canada are 5% of their country's population but 32% of the country's federal prison population. And in New Zealand, the Māori are 17% of New Zealand or Aotearoa, as the Māori say as a traditional name for New Zealand, but 52% of their country's prison population.

Also, when we looked at drug and alcohol treatment needs, there is definitely a need to include alcohol in programs. We saw that because there was a higher number of Aboriginal and Torres Strait Islander people within the high-risk possible-dependent alcohol consumption within this particular sample of people who go into the prison system. What we also found was that there is a great proportion of Aboriginal people within the prison population that had consumed cannabis regularly. Now we found the combination of both, which is what I presented in the multivariate and bivariate analyses where we saw people who use cannabis were also more likely to be in the high-risk possible-dependent alcohol consumption categories.

As for co-facilitation of programs, there is appreciation for peers with experience or that within their family, so people could speak about their own experience of drug or alcohol use. There also was an

appreciation for having both male and female facilitators together. It is critically important for therapeutic success to have a therapeutic group of people that you trusted, and in the first instance it may be good to have a treatment program that is Aboriginal-specific where all the participants are Aboriginal. If you have a longer treatment program, then a mix of both Aboriginal and non-Aboriginal people could work within that group. But, as I said, in the first instance, consideration about having an Aboriginal group should be given. Finally, programs need to be relevant and fun, and, as mentioned, they do need to be practical as well, so the people in the program need to be able to directly relate the learnings of that program to their own situation.

IV. New research currently in progress

I will discuss the projects are currently undertaking, and I am going to look at a specific one which is directly related to the data presented around prison-based drug and alcohol treatment programs.

We have been successful in a grant application to secure funding for a new project which is titled, “Developing a culturally-based social and emotional wellbeing program for young Aboriginal and Torres Strait Islander people in prison.” I am the lead chief investigator on this project, and there are a number of other chief investigators whom you can see listed there (on the slide). I do also want to specifically mention Dr. Alison Evans, who is in charge of the day-to-day management of this particular project.

I decided to develop a social and emotional wellbeing program rather than a drug and alcohol treatment program for a number of factors. But, in summary, having taken on advice from elders and from Aboriginal people who work in drug and alcohol treatment and also looking at the literature, it becomes quite evident that we should be thinking of being more holistic and not specifically looking at drug and alcohol treatment but also thinking about the overall wellbeing of the individual. Thus, we would be treating and helping work with some of the underlying factors that may then bring about drug and alcohol use, and we ended up getting funding for this particular project. The other aspect I want to point out here is that while we do say “program for young Aboriginal and Torres Strait Islander people” in this program, we are hoping it will be for everybody within the prison population itself, and not just for the younger Aboriginal and Torres Strait Islander people within prison.

There are two phases. In Phase 1, we will be conducting a scoping review for First Nations specific programs delivered in prison. This is a global scoping review, but we do have a specific focus on the great literature or the government-published literature from Australia, New Zealand, the United States, and Canada. The reason for that is that these are countries with a similar colonial history to Australia. We have actually completed the search for that literature, we are now doing the analysis, and I will present a little bit of that data in just a moment. In this phase, we are also conducting a series of interviews with First Nations health professionals to understand how to better support people who have been to prison, who have alcohol and or other drug use issues.

And from those two sources, we are then going to develop the first draft of what would be the culturally-based social and emotional wellbeing program for prison. We will then take that draft of that curriculum, and we will do a thing called a Delphi study, which is a series of interviews with professionals

or experts in that area. We will interview them and refine the curriculum, and we interview the same person several times and refine the curriculum again and again. The reason why that is important is that we want the program to really be suitable for use within a prison environment, which is somewhat different to a community-based environment. We are then going to test the curriculum for suitability with a group of young Aboriginal and Torres Strait Islander people for a follow-up project, which we are going to be applying for research funds in the next 12 months. To extend this project further, we would want to further refine the program, run a trial as a treatment program within a prison setting, and then evaluate that trial.

We have completed the search for both grey literature and the sort of grey literature from government departments as well, as you can see there (on the slide). I will not go through everything on this slide, but we have about 75 programs that are suitable for being included within this scoping review, and we are currently undertaking an analysis of those programs.

This is a very preliminary look at the analysis. What we have found so far is that a lot of programs have a cognitive behavioural treatment (CBT) approach as well as traditional approaches, so it is a combination of both of those together. There is also a number of programs that have a traditional treatment approach. Some programs are specific for First Nations peoples globally but are cognitive behavioural treatment (CBT) in approach. And then there are a couple that are psychoeducational in terms of the delivery and most of them are group programs. These are all group programs we are looking for, but what we are also interested in is if there is a combination of both group as well as one-to-one counselling, and some of the programs have group work as well as one-to-one counselling as well. The majority of the programs we have found globally are Indigenous-led or led by First Nations peoples. The data is not exactly clear on this, but a lot of the programs have co-facilitators with First Nations people and people who are not First Nations co-delivering the programs together. We are currently on holidays now back in Australia, but everybody should be back this week, undertaking the analysis and writing up the results for this scoping review.

As mentioned, we are undertaking as part of this project a series of interviews with Aboriginal and Torres Strait Islander health professionals, and this is to learn how they support Aboriginal and Torres Strait Islander people who have been to prison, who perhaps have drug and alcohol use issues and other issues that they are supporting them with. The purpose of this is to understand how cultural practices are used as part of therapeutic programs within a community setting, so as to learn how this knowledge can then inform prison-based programs. We have undertaken a series of qualitative, semi-structured interviews, and the Yarning methodology was used for that. Yarning means that it is more a two-way conversation rather than a situation where a researcher asks a series of questions and the participant answers them. You engage in a free-flowing conversation as part of that interview. So, we are applying an Aboriginal lens, of course, to all of the data analysis throughout the entire project with a particular emphasis with this section of the project.

We have completed these interviews, and here are the demographics for the people we interviewed. There were 27, but you can see that 56% or a bit over half were male and you have got a little bit under

half a female. There were four areas we did interviews in, which were metropolitan and regional areas. Some interviews were in Sydney, just north of Sydney, up in my remote Kimberley region where I am from, and also in Perth, which is a major city in Western Australia. The workers had a diverse background and experience in case management. Some or a lot of them actually had lived experience of drug and alcohol use issues or had family members who had overcome these issues themselves, and some of them have been leads in community-based social and emotional wellbeing programs. The data analysis is currently in progress, so I do not want to give too many results of that at this point in time, but it is something we are working on at present.

Thank you for listening to the presentation, delivered at Sophia University on the 17th of January. I want to specifically thank my research team at the Edith Collins Centre (ECC), which is part of The University of Sydney: Dr. Alison Evans, whom I already mentioned; Karrah McCann, who unfortunately left in December, but Karrah has very much been part of the work; as well as Anna Grager and Kai Clancy. And I want to specifically thank Professor Paul Haber, who is the Director of ECC and is actually also my direct line manager, for his continued support of my research and our whole research team. I want to close by thanking Associate Professor Hyangsuk Kwon for the invitation to come and present at Sophia University, and my old friend, Professor Yeonghae Jung, who organised for that invitation. Thank you.

Michael Doyle (Associate Professor, Sydney Medical School, The University of Sydney)