



Drug and Alcohol Services Council (DASC)
South Australia

Tincture of opium and the use of heroin in Adelaide's Vietnamese community

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EXECUTIVE SUMMARY

Knowledge about the problems associated with the use of heroin and other opiates in the Australian Vietnamese community is limited. The present study sought add to the available knowledge by examining issues relating to heroin use within the Vietnamese community in Adelaide, and to look at potentially useful treatment approaches for this community, including the use of tincture of opium. It should be emphasised that, while this research has focused on drug use problems within particular ethnic minority groups, it was not the intention to stigmatise these groups. It is important to acknowledge that the majority of Vietnamese people in Australia do not use drugs. This research has aimed to clarify the special problems faced by drug users within the Vietnamese community in Adelaide, and look at potential ways of intervening for such individuals.

There is some anecdotal evidence from workers in the drug and alcohol field of increasing heroin use in the Vietnamese community. Furthermore, media stories and police intelligence have highlighted the involvement of some Vietnamese and other South-East Asian groups in heroin trafficking. However, there has been a paucity of research information to support claims about the scale of drug use and related crime problems in the Vietnamese community. Research by Maher and Swift (1997) in Sydney, and by Croft et al in Melbourne have suggested that patterns of opiate use in Vietnamese communities differ from those in the wider community. Attitudes to treatment also appear to differ, with a feeling among service providers that the number of Vietnam-born clients using their services is not representative of the number of Vietnam-born opiate users in the wider community.

Methadone maintenance is an established treatment option for heroin dependence, but appears to have had limited acceptance among members of the Vietnamese community. The reasons for this lack of acceptance are not clear, but it has been suggested that alternative pharmacotherapies may be more attractive to the Vietnamese community. Tincture of opium is one possible alternative pharmacotherapy that has been successfully used in countries of the Asian-Pacific region.

Given this situation, the present study sought to investigate two areas:

- (1) the extent of heroin use, the route of administration, and attitudes to treatment among members of the Vietnamese community in Adelaide, Australia;

- (2) the pharmacology of the use of tincture of opium in clients in treatment settings in the Asian region.

In order to investigate issues relating to the use of heroin in the Vietnamese community in Adelaide, a study was carried out to provide a comparison with information already obtained interstate. This study involved a community survey of drug users and a series of key informant interviews in the Adelaide Vietnamese community.

The Adelaide Vietnamese community differs in some respects from communities in Sydney and Melbourne. At approximately 10,000 people, the community is considerably smaller than those in the other two cities. It is a tightly knit community, in which the community organisations play an important role. Vietnamese workers in mainstream agencies tend to be aware of other Vietnamese workers, and there is a strong network of support services across the city. It is more difficult to maintain a particular individuals' anonymity in the smaller community

One of the strengths of the strong links within the Vietnamese community is that people can be easily supported and referred across a range of agencies. However, this also means that many individuals who may have drug-related problems resist seeking help from agencies within their community because of the shame attached to seeking help, and the stigma associated with drug use. Furthermore, a reluctance for heroin or other drug users within the Vietnamese community to utilise mainstream treatment services, perhaps because the services are not sufficiently tailored to meet their problems or deal with culturally unique issues, means that there may be problem users in the Vietnamese community whose treatment needs are not being met. A further corollary of this situation is that drug users in the Vietnamese community may not have the same level of exposure to appropriate harm reduction information regarding issues such as safer injecting drug use.

The Vietnamese community is not an easy community for researchers or service providers to gain access to, particularly if they try to approach the community without a sufficient understanding of cultural issues unique to the community. Considerable time is needed to establish credibility and develop trust. Drug users in the Vietnamese community do tend to be wary of researchers and service providers, as they value their anonymity and privacy. For the drug user interviews conducted for this project, it was found that injecting drug users were reluctant to come forward for interview, except in cases where there was a pre-existing relationship with someone from within the community.

Eleven injecting drug users were recruited for the study of heroin use among members of the Vietnamese community in Adelaide. Information was sought from the users and from key informants on the extent of heroin use within the community, the knowledge and understanding among members of the community regarding problems associated with heroin use, and the utilisation of alcohol and other drug treatment services by the community. The drug users and key informant interviews showed a diversity of views and knowledge regarding drug use issues within the Vietnamese community, and highlighted the need for more in-depth investigation in this community.

The interviews showed that members of the Vietnamese community, both in general and within health and welfare agencies, do not feel confident of their ability to deal with alcohol and other drug issues. This is partly due to a general lack of knowledge within the community about drugs and drug-related issues and problems. The problem is further compounded by the fact that members of this cultural group are not accustomed to seeking outside help for problems of this type. Traditionally, the Vietnamese family unit has often dealt with issues such as mental health problems. The family has also often dealt with behaviour that brings shame on the family name, and drug use appears to be one such behaviour.

The community survey showed a tendency within the community to view heroin use and dependence as a moral issue rather than a medical problem. The concept of harm minimisation is a difficult one for the Vietnamese community at large to accept, and there is a frequently stated feeling that to embrace harm minimisation is to condone behaviour that is viewed as unacceptable. The reluctance to accept harm minimisation as a philosophy is not confined to the management of drug issues, but extends into such areas as parenting and schooling.

There is little interest within the Vietnamese community in replacing one addiction (heroin) with another (methadone), particularly when the replacement drug (methadone) is a long-term option. Many users, community workers and members of the general Vietnamese community view the concept of maintenance therapy as an unacceptable option, as its use implies an acceptance of drug use, and requires a commitment to ongoing treatment. The user survey and key informant interviews showed a strong preference for detoxification for treatment, preferably within a support group such as a family.

The current route of heroin administration for nearly all of the users interviewed was injecting, although in only one case did heroin use begin with injecting. In general, heroin use started with smoking and quickly moved to injecting, as the injection route is reported to give a more potent effect for the same or lesser amount of drug used. This pattern of progression in routes of administration was also borne out by information given by key informants.

Two distinct groups of users in the Vietnamese community emerged from the study of users and key informants – an older group that is predominantly male, and a group of younger adolescents who are indulging in indiscriminate poly-drug use. Most of the older group of users have traumatic refugee histories, are in Australia without other family members, have limited English language skills, and are unable to rely on networks apart from the group of other users. Many of the young people are dealing with the issue of belonging to two cultures and are having difficulty in meeting the expectations of both. It appears that respect for their family may provide the incentive to break the cycle of drug use, but clearly, further assistance is needed for this group.

Heroin users in any society tend to be marginalised, and this appears to be so in the Vietnamese community. A significant obstacle to heroin users seeking help from health services within their community is the fear of being identified or recognised by workers or other members of the community. This will remain a problem for users within the community until such time as community attitudes change towards a greater acceptance of harm minimisation. Meanwhile, there is a need for targeted education for drug users within the community on health risks associated with drug use, particularly relating to injecting and heroin overdose. There also appears to be a need for mainstream health and drug and alcohol services to be more able to cater to the specific needs of drug users of Indo-Chinese background.

The pharmacological study of the efficacy of tincture of opium in treating opioid dependence suggested that it may have a useful role here, but that more work needs to be done in determining optimal dose amounts and frequency of administration for effective management of withdrawal. Tincture of opium did bring about some relief of withdrawal symptoms in the group included in this study, although it seems that these subjects may not have been given adequate doses to achieve most effective reduction of symptoms.

This study found that Vietnamese heroin users' experience of success with maintenance pharmacotherapies, methadone in particular, is limited, for a number of reasons. These

include a lack of faith in the treatment, and problems associated with staying on programs, such as feelings of isolation and lack of support. There is also the barrier of the cultural attitudes towards this type of treatment, which is viewed as less successful than detoxification. There was almost no awareness among the heroin users interviewed of tincture of opium and its potential role as a treatment agent for heroin dependence. It seems that the Vietnamese heroin users now in Australia are sufficiently removed from their home country and region, where tincture of opium is still used, to have no knowledge of it or preference for it over other pharmacotherapies. A treatment program using tincture of opium could be trialed among Vietnamese heroin users, if it was done so with associated activities aimed at providing education and support that helped the users to stay on the program. This might have to follow further studies of appropriate dosage levels and frequencies for the use of tincture of opium in these individuals.

Heroin use and related crime has emerged as a significant concern within Indo-Chinese (Cambodian, Laotian and Vietnamese) communities in Australia. While research data have been lacking, media reports have focused on heroin seizures and problems relating to heroin use and crime in Indo-Chinese communities, particularly in South West Sydney. In recent years, research has been conducted in New South Wales and Victoria to explore the nature of the health and social problems associated with heroin use in their Indo-Chinese communities. However, there has been very little epidemiological or ethnographic research looking at drug use and related problems within smaller Vietnamese or other South-East Asian communities in jurisdictions other than New South Wales and Victoria.

Recent research in New South Wales has highlighted a disturbing upward trend in the use of heroin among young people of Indo-Chinese origin, including Vietnamese (Maher & Swift, 1997), mainly in South-West Sydney. These young people are indulging in high-risk behaviours such as sharing of injecting equipment, and are reluctant to acknowledge their injecting drug use, due partly to cultural attitudes towards injecting drug use. In Victoria, a recent study of Vietnamese injecting drug users (IDU) in Melbourne (Louie et al, 1998), most of whom were injecting heroin, found substantial sharing of injecting equipment, and very high prevalence of blood-borne viruses in comparison with Caucasian IDU. This study also found that this group of Vietnamese IDU had very poor awareness of their infection status for the Hepatitis B and C and HIV viruses. There was very low utilisation of needle exchange services, and previous treatment seeking for drug use problems was lower among the Vietnamese sample than among other IDU groups.

The increasing use of heroin among Indo-Chinese communities is causing concern not only in Australia; many South East Asian countries are experiencing a surge in heroin use, with the attendant risks of transmission of blood-borne viruses. The World Health Organisation is managing substance abuse programs in a number of countries, including Thailand, Laos, Myanmar and Vietnam.

Limited studies on attitudes towards substance use and awareness of substance use problems among migrant communities in Australia have been undertaken

since 1987 (Trimboli & Ridoutt, 1987; Spathopoulos & Bertram, 1991; Bertram & Flaherty, 1992). These studies indicated a lack of knowledge of, or trust in, mainstream drug and alcohol services among non-English speaking communities. There is also anecdotal evidence to suggest that members of non-English speaking backgrounds in general make limited use of mainstream services.

Methadone is the most widely accepted treatment option in Australia for those opioid users who do not want to commit themselves to a drug-free state immediately. Methadone maintenance treatment has been shown to be effective in reducing illicit opioid use and associated criminal activity, to decrease mortality and morbidity among those on maintenance programs, and to reduce the transmission of HIV and other infections (Ward, Mattick & Hall, 1998). However, although these programs are widely available across Australia, it is the experience of service providers that few Vietnam-born clients are registered.

It appears that methadone is not an attractive treatment option for heroin users of Indo-Chinese origin. At present, there is no study that identifies definitively why this might be so. It is possible that other pharmacotherapies would be more acceptable to people of Indo-Chinese origin, particularly given the long-standing use of traditional remedies in South East Asian countries and the traditional routes of administration of opiates in these countries. Many countries in this region have a history of opium smoking as the most common method of opiate use, and this practice still continues in some areas (eg the hills country regions of Thailand). Although intravenous administration of heroin appears to be gaining popularity, smoking still seems to be a preferred route of administration for opioids at the beginning of the drug-using career among Indo-Chinese, both in Australia and in other countries.

One response to the treatment needs of opiate users in a number of sites in South East Asia has been the use of tincture of opium, a solution of opium in alcohol and water (known in Western countries as laudanum). This preparation has the advantage of being much less expensive than methadone. It is being used to treat withdrawal from both heroin and opium and, in a more limited fashion, as a maintenance treatment for dependency. The acceptance of tincture of opium in a number of South East Asian sites suggests that it may be a more

culturally acceptable treatment option among Indo-Chinese heroin users in Australia.

The present project was in part devised to build on the earlier valuable research carried out in the Indo-Chinese communities in South West Sydney (Maher & Swift, 1997), by exploring the extent of heroin use and related problems in the Indo-Chinese community of Adelaide. This research component took the form of a survey of Vietnamese heroin users in Adelaide. The research has occurred at a time when there has been much interest and research undertaken in the area of alternate pharmacotherapies for heroin dependence.

Given the apparent lack of acceptance of methadone as a treatment option among people of Indo-Chinese origin in Australia, and the use of tincture of opium in South-East Asian countries, a separate study of the effectiveness of tincture of opium for the treatment of heroin dependence was undertaken. This study involved the collection of blood samples and physiological measurements from heroin or opium dependent clients from a drug treatment centre in Thailand.

The rationale, methods, results and discussion for each of the two main studies are presented separately in this document, as follows:

Section 3: Survey of Vietnamese heroin users in Adelaide

Section 4: Acceptability & efficacy of tincture of opium in the treatment of opioid dependence

2.1 Vietnamese communities in Australia

Australia is a multi-cultural society with a substantial South-East Asian population, particularly from the Indo-Chinese countries of Cambodia, Laos and Vietnam. Of these, Vietnamese-born people make up the largest group, with over 151,000 Vietnamese people residing in Australia, according to the 1996 Census (Australian Bureau of Statistics).

The largest Vietnamese communities in Australia are in New South Wales and Victoria. The 1996 Census of Population and Housing indicated that there were over 61,000 Vietnamese-born people in New South Wales. A substantial proportion of this group resides in South-West Sydney (ie. Fairfield/Cabramatta). The 1996 Census showed that Victoria had 55,000 Vietnamese-born people, many of whom live in the Western and Inner City suburbs of Melbourne. It should be noted that, while the Census data show the number of people born in Vietnam now residing in various parts of Australia, the Vietnamese communities would actually be somewhat larger if Australian-born children of Vietnamese-born parents are considered.

The 1996 Census also showed that South Australia has a sizeable Vietnamese-born community of around 10,500. The South Australian Vietnamese population is very similar in size to the Vietnamese populations of Queensland and Western Australia (1996 Census of Population and Housing, Australian Bureau of Statistics). The Adelaide Vietnamese population accounts for around 43% of all people born in South-East Asia residing in Adelaide (Gardner, 1997). A large proportion of the Vietnamese living in Adelaide reside in the North-Western suburbs, particularly in Mansfield Park, Woodville, Wingfield, Angle Park, Ferryden Park and Athol Park. The Australian Bureau of Statistics notes that a substantial proportion of Vietnamese people in Adelaide arrived as refugees in the late 1970s and early 1980s, and that many of them were initially accommodated in the Pennington migrant hostel before settling in nearby suburbs of North-Western Adelaide (Gardner, 1997).

While the participation of Indo-Chinese ethnic groups in Australian society has no doubt enriched our culture in many ways, their communities face problems

arising from social isolation and their minority status. Unemployment in Vietnamese communities is considerably higher than in the Australia-born population, and substantial proportions of these groups have poor English language skills (Ezard, 1997). These factors may result in people from Indo-Chinese communities not having the same access to preventive public health education messages and treatment options as the English-speaking communities.

The acceptability of mainstream public health services to different ethnic groups is subject to many factors: whether the group is a migrant or a refugee group; whether there is a large support community in areas in which newcomers have settled; and traditional views on how health problems are dealt with. In the case of the Vietnamese community, which is the principle focus of the present project, a significant portion of the community in Australia is made up of refugees, for whom language barriers, family separation and some degree of social isolation would no doubt have been significant problems. Cox (1978) outlined the destabilising influences of the refugee experience – the frightening and unstable environment which the individual is leaving, the impulsiveness of the decision to leave, the frequently hazardous crossing of borders, the unknown future and long-term guilt and frustration at the lack of contact with family and communities back home.

Boman and Edwards (1984) published an overview of the Indo-Chinese refugee experience in Australia, with particular focus on Vietnamese refugees. They highlighted the relevance of personality and cultural factors (including concepts of health and mental illness) to the provision of services to any ethnic community. The authors described the unwillingness of the Vietnamese to express their feelings openly, particularly to those with whom there is no close relationship. Burley (1995) expands on these cultural characteristics in her study of Vietnamese within the South Australian justice system. These authors emphasise the centrality of the family within Vietnamese culture. Despite the fact that almost twenty five years have passed since the first wave of Vietnamese refugees began arriving in Australia, the family remains the focus of most Vietnamese lives. For people from this generation, Boman (1984, p. 41) pointed out that the predicament of having to leave relatives behind in Vietnam left Vietnamese in Australia 'inclined to a sense of loneliness and isolation'. Health

and well being in this community is viewed as being closely tied with family roles. While traditional healers were responsible for treating most physical and psychological maladies, the family provided the care and support required for people who were psychiatrically ill or in need of counselling.

Maher and Swift (1997) and other authors have pointed out the strong reliance upon traditional folk medicine among many Indo-Chinese people living in Australia. Western notions of psychological and psychiatric disorders do not have the same recognition in the traditional Vietnamese health system as in Western medicine. Eyton and Neuwirth (1984) reinforced the lack of credence given to psychological disorders and the tendency among members of a number of cultures (including Vietnamese) to give their psychological concerns a physical description. In addition, Maher and Swift (1997) point out that their reliance on traditional medicine may sometimes make Western medical treatment more difficult, because presentation to treatment is delayed or does not occur (p.38). They also argue that 'health promotion and disease prevention are alien concepts to many South East Asian migrants' (p. 38).

Manderson and Mathews (1985) noted that most discussions of the difficulties faced by different ethnic groups in dealing with the Australian health care system focused on the lack of adequate interpreters and information in appropriate languages. They concluded that the 'literature remains patronising towards members of various ethnic groups', and is 'ethnocentric by the presumption that Western scientific medicine is the right and only way to understand disease and other changes in health status and therefore that alternative perceptions of sickness and health are inferior and invalid' (Manderson and Mathews, 1985, p. 249). The notion of ethnocentrism in health studies, with particular reference to Vietnamese, was explored by Eyton and Neuwirth (1984) with particular emphasis on the inadequacy of usual survey methods and the problems of categorising illness complaints to accurately reflect the health experience of Vietnamese people. With regard to the provision of drug and alcohol services to Vietnamese people, this suggests that special care needs to be given to trying to effectively communicate important concepts such as drug tolerance, dependence and harm minimisation.

2.2 Ethnicity and drug use problems

Evidence for an expected increase in psychological and substance abuse problems within communities that have suffered trauma is given by Boman and Edwards (1984), who use the examples of the influx of central European refugees after World War II and the evacuation of many thousands from Darwin after Cyclone Tracy. Studies of these groups have shown that communities consisting of individuals who have experienced severe dislocation or who are not able to remain within their community after severe trauma, are an at-risk group for 'maladaptation, emotional disturbance, psychosomatic illness, addiction' (Boman & Edwards, 1984, p. 48). More recently, O'Hare and Van Tran (1998) suggest that a significant increase in substance abuse problems can be expected among the Indo-Chinese communities in America as a result of mental health disorders and the acculturation process. A similar trend could be expected to occur in Australia.

In Australia, we are now seeing a second generation of Vietnamese – young people who may have been born in Australia, and whose parents may have been refugees. These young people may have better English language skills, but may still have problems with racist attitudes in the community, and still suffer from some degree of social isolation. There is evidence that Vietnamese youth involved in drug use may be using drugs in hazardous ways, perhaps in different ways from older Vietnamese (Maher & Swift, 1997).

There is a perception among workers in the drug and alcohol field in Australia that people of Indo-Chinese background do not use mainstream alcohol and other drug services. It appears that mainstream services are either not known about or are viewed as being inappropriate by members of the Vietnamese community. Counselling in particular is viewed with suspicion (Bertram & Flaherty, 1992); as indicated earlier, Vietnamese and other Indo-Chinese community groups appear to share a reluctance to discuss issues such as drug use or mental health problems with people outside of the family structure or the network of traditional healers.

As already indicated, there is a range of social and cultural factors associated with refugee or minority group status that can have an impact on the extent to which mainstream health services are utilised. With regard to drug and alcohol

issues, cultural differences in the way substance use problems are viewed and handled will have an impact on the extent to which available services are used. As Maher and Swift (1997) point out, there is a tendency among Indo-Chinese to appear stoic in the face of problems such as drug addiction, and to only seek outside help when somatic illness appears (p.39). While drug use, especially heroin use, no doubt goes on, within segments of Indo-Chinese communities, there remains a strong reluctance to talk about the problems associated with drug use because of fear of creating problems for the family unit or bringing shame upon the family.

An earlier study by Trimboli (1987) surveyed four migrant communities (Greek, Italian, Lebanese and Vietnamese) to determine patterns of usage of alcohol and other drugs. At this time, the Vietnamese sample indicated a low level of hazardous drug use, with alcohol and tobacco being the most commonly reported substances used. The study was limited because it omitted most illicit drugs; the survey included only marijuana, the reported use of which was negligible. Spathopoulos and Bertram (1991) surveyed the available literature, and concluded that there was insufficient available research at that time to permit detailed analyses of patterns of substance use within various non-English speaking background (NESB) communities. Again the focus was primarily on the licit drugs, alcohol and tobacco. Despite the deficiencies in available data at that time, the authors concluded that there was a lack of knowledge among NESB communities about drugs and their effects, and about drug and alcohol services in general.

Bertram and Flaherty (1992) reported on a survey of a substantial sample of Vietnamese people in Sydney. As with earlier research, greater attention was given to the consumption of licit drugs, as they were felt to have the greatest potential for harm within the community as a whole. The study found that, while use of tobacco was higher amongst Vietnamese men than in the general community, reported use of alcohol and illicit drugs was lower than in the general community. The reported lifetime use of heroin was around 1% in this sample. The authors also found that understanding of drug issues was much lower in the Vietnamese community than in the general community. Illicit drug use was generally viewed as being confined to a small group of males, and it was felt that the use of illegal drugs would be limited by the stigma attached to it

by the community. Heroin use was regarded as being confined mainly to those who were unemployed, homeless or otherwise traumatised by family rejection, refugee experience or other factors. Key informants in this study felt that the community as a whole did not recognise the use of illicit drugs within the community, and therefore did not see it as a problem. Some felt that the stigma associated with illicit drug use would result in drug users being extremely reluctant to talk about their use, and to seek help for drug use problems. The researchers also added a caution that key informant data could be unreliable because of the relatively hidden nature of the problem. This study highlighted the fact that heroin use and its associated problems were well hidden within the Vietnamese community, and that it was difficult to know who the users were. A general community survey such as this, with a random or consecutive sample, is clearly unable to reach relatively hidden groups of heroin users. Other methods involving targeted recruitment are required to enable sufficient numbers of heroin users to be contacted for in-depth study.

2.3 Measuring illicit drug use: methodological issues

Mainstream surveys of drug use such as the household surveys conducted by the National Drug Strategy (NDS), formerly the National Campaign Against Drug Abuse (NCADA), have consistently shown a lifetime prevalence of heroin use of between one and two percent across the whole of the Australian population (Makkai & McAllister, 1998). This proportion has been consistent across the five national surveys conducted between 1985 and 1995, with a slight increase in 1998 to just under 3% lifetime prevalence (Australian Institute of Health & Welfare, 1999). In these surveys, less than one in ten of those who report ever having used heroin indicate use in the previous week. Thus, community surveys based on random or systematic sampling of households are not able to identify sufficient numbers of current regular heroin users for detailed study. For the purposes of research into heroin use among ethnic minority groups, the NDS Household Surveys are of limited value, as they are not usually large enough to include sufficiently large samples from different ethnic communities to enable drug prevalence rates to be determined for these groups.

Hall (1995) has argued that household surveys of drug use are likely to underestimate the true number of heroin users, for a number of reasons: heroin users are less likely to have conventional living arrangements, and less likely to

be at home when a survey interviewer calls; they may be more reluctant to be interviewed; and they may be less likely to accurately report the extent of their heroin use because it is illegal and has substantial stigma associated with it. Finally, Hall makes the point that household population surveys give imprecise estimates for low prevalence behaviours such as heroin use, and that these surveys focus mainly on lifetime or past year prevalence, which do not give a satisfactory indication of the extent of heroin dependence or regular use. In order to investigate in detail a behaviour such as heroin use, targeted studies of samples of heroin users are required.

Hall used a variety of methods to try to arrive at a realistic assessment of the number of heroin users, both dependent and recreational, in the Australian population. Hall came to the conclusion that, based on various data sources and methods, the numbers of irregular and regular (or dependent) heroin users in Australia increased substantially between the mid 1980s and the early 1990s. Hall estimated that for the period 1988-1993, the total number of all heroin users in Australia was 172,000, of which 59,000 were regular users. The contribution of Vietnamese heroin users to these estimates is difficult to gauge. Hall also estimated that the proportion of heroin users currently in methadone treatment increased from around 17% in 1987 to around 30% in 1992 (Hall, 1995). Once again, the degree to which these figures might also apply to Vietnamese heroin users is uncertain.

Thus, population drug use prevalence studies are useful for giving placing heroin use in the context of other drug use in the community at large, but have major limitations in giving insight into patterns of heroin use, particularly among minority groups. In order to explore heroin use among the Vietnamese in Australia, targeted studies of users are required. There has been little research done in Australia looking at patterns of illicit drug use, particularly injecting drug use behaviours, among non-English speaking background communities. Very few studies have explored drug use patterns and risk behaviours in detail among the Vietnamese or other South-East Asian communities. Community surveys of drug use in the Vietnamese community (eg. Bertram, Flaherty & Everingham, 1996) have shown lower prevalence of licit and illicit drug use than in the general community, but such surveys have not targeted users of illicit drugs, nor provided insights into drug use patterns among regular users.

2.4 Illicit drug use among Vietnamese communities in Australia

Swift and colleagues reported the findings of one of the first in-depth studies of heroin use behaviours amongst Indo-Chinese in Australia (Swift et al, 1997). As the authors note in their report, “Cabramatta has the dubious distinction of being Australia’s heroin capital” (p. 12), and the subject of ongoing media attention. With the dearth of useful research data on heroin use and related social factors among the substantial Indo-Chinese population in this part of Sydney, the authors collected data from a sample of 200 Caucasian and Indo-Chinese heroin users from South-West Sydney. Of the 100 Indo-Chinese heroin users in the sample, 95% were born in Vietnam, and 40% had had previous treatment for heroin use problems. While the age of first heroin use and first heroin injection were similar for both Caucasian and Indo-Chinese sub-samples (around 20 years), the routes of first heroin use differed. Whereas 73% of the Caucasian sub-sample had injected heroin on first use of heroin, only 28% of the Vietnamese group had first injected heroin. Their most common route for the first use of heroin was smoking, which was reported by 58% of the sub-sample. A further 13% reported first taking heroin via “snowcones” (heroin mixed with cannabis). Among the Indo-Chinese group, 36% reported smoking as the only route of heroin administration they had ever used, and 38% reported that they had only used heroin by smoking over the previous 6 months (compared with 2% of the Caucasian sub-sample). While the majority of the Indo-Chinese group (55%) reported injecting exclusively over the previous 6 months (vs. 74% of Caucasian group), this study highlighted the substantial reliance on smoking as a route of heroin administration among Indo-Chinese. Furthermore, it found that 34% of Indo-Chinese respondents had switched from smoking to injecting, while none had made the transition from injecting to smoking Swift et al, 1997).

Researchers from the Macfarlane Burnet Centre for Medical Research in Melbourne (Louie et al, 1998) conducted an interview study of 100 Vietnamese injecting drug users during late 1995. Most (85%) of the sample had come to Australia as refugees, and they were recruited via social networks and “snowballing”. The average age at which subjects had first injected was 21 years, and for the majority (83%) the first drug injected was heroin. For nearly all interviewees, the most frequently injected drug was heroin. Most (95%) reported using drugs primarily with other Vietnamese, and a similar proportion indicated

that they would mostly buy their drugs from other Vietnamese. This highlights the fairly close-knit nature of this group. This research also highlighted a number of health concerns: only around a third of subjects kept clean injecting equipment on hand, and about one fifth reported sharing used injecting equipment over the previous 12 months.

The study included finger-prick blood testing for HIV, Hepatitis B and Hepatitis C viruses. Only about a third of the sample provided blood samples for testing, and around a third reported that they had previously been tested for these viruses, with only one person self-reporting positive status for Hepatitis C. The finger-prick blood results highlighted the problems with relying on self-reports; all of those tested for Hepatitis C (n=27), most of whom believed themselves to be negative, were in fact found to be positive for the virus. In addition, around half of those tested for Hepatitis B via finger-prick sample were found to be positive, all of whom believed themselves to be negative for this virus. No subjects were found to be HIV positive. Of concern was the finding that 69% of the sample had never used needle exchanges. About 60% had sought drug treatment, primarily methadone maintenance, although the group highlighted problems that affected use of services, such as discrimination due to ethnicity, the need for more methadone outlets and legal services, and the need for information and services in Vietnamese language. In summary, the study showed the Vietnamese group to have substantially higher levels of Hepatitis B and C infection compared to non-Vietnamese IDU, and to have a poorer profile in terms of using needle exchange services and seeking treatment. This study highlighted that injecting as the route for drug use in the Vietnamese community is an increasing problem, especially for young drug users, and that there appears to be a relative lack of awareness among Vietnamese IDU of risk factors for blood-borne viruses and available information and health services. The authors conclude by emphasising the urgent need for appropriate responses to the specific needs of non-English speaking background IDU, especially in the Vietnamese community – there is a need to provide information and services that are culturally appropriate in order to reduce the significant risks to this drug using group.

Turning Point Alcohol and Drug centre in Victoria has recently undertaken a review of heroin use in the Vietnamese community in Victoria, as a component of the Victorian trial of alternative pharmacotherapies (Ezard, 1997). The review

emphasises the difficulties in gauging the extent of heroin use within the Vietnamese community in Victoria, and the reliance upon anecdotal material on what is going on within the community in relation to heroin use. Interestingly, the authors note that, while there was no significant difference in 1995/96 between numbers of Vietnam versus Australian-born opiate-related hospital admissions in Victoria, there was a substantial over-representation of Vietnamese in opiate-related deaths from 1993 to 1995. Furthermore, Vietnamese were significantly over-represented in criminal justice statistics, particularly for drug-related crime. While it is unclear as to the extent to which the higher rates of arrest and incarceration among young Vietnamese in Victoria indicates higher levels of drug use, these institutional data source highlight the significant problem that heroin use is for the Vietnamese community as a whole.

2.5 Illicit drug use and the Vietnamese community in Adelaide

Reliable research-based information has been lacking about the nature and extent of drug use among the Vietnamese community in Adelaide. However, concern regarding drug use problems has been growing within Adelaide's Vietnamese community for a number of years. In 1992, the first attempt to address the issues of drug use within the community was made with the establishment of the Hoi Sinh project, developed by the Vietnamese Community Association in South Australia (VCASA) in association with the Drug and Alcohol Services Council (DASC). This project included data collection from service providers and young people to enable the development of a profile of the Vietnamese drug-using population, including the identification of drug use patterns among Vietnamese youth, and the identification of relevant services (Luong et al, 1994).

Drug use in the Adelaide Vietnamese community, primarily among younger people, was explored in the Hoi Sinh project primarily by qualitative methods. The use of a range of substances was covered, and the report acknowledged that the project was limited in its ability to gauge the extent of use of heroin and the associated criminal activities. The authors suggested that approximately 50 intravenous drug users were resident in the Western suburbs of Adelaide in 1993/94, although it is very difficult to know the reliability of this figure. The anecdotal nature of much of the information gained, and the limitations of the key informant approach used mean that this project may not have been able to truly gauge the extent of heroin use within the Adelaide Vietnamese community.

The hidden nature of heroin use in this community, and the community's views on heroin use and addiction, suggests that reliance on anecdotal reports of the extent of heroin use may lead to an underestimation of the extent of the problem.

Despite the limitations of the Hoi Sinh project in accurately quantifying the extent of the heroin use problem in the Adelaide Vietnamese community, it was able to provide valuable ethnographic information on some of the risk behaviours occurring in relation to drug injecting. The authors reported a lack of information among young Vietnamese IDU about harm minimisation. They reported that substantial needle sharing was occurring, and that there was a lack of awareness of the risk of transmission of HIV/AIDS and other blood-borne illnesses, and a lack of awareness of DASC services, including needle exchange programs. The report concluded that the level of intravenous use within the Vietnamese community was higher than within other non-English speaking background communities.

Since the establishment of the Hoi Sinh project, and as a result of it, the Vietnamese community in Adelaide has moved towards a greater awareness of drug use issues and an acceptance of its role in dealing with drug use problems. In line with the recommendations of the Hoi Sinh project, the Indo-Chinese Community Project was developed by DASC, and a project officer appointed to deal with alcohol and other drug-related problems. However, in general there has been an assumption that the major drug of concern is heroin. A half-day community conference held in November 1997 received considerable reportage in the local community newspaper, and a number of heroin users took advantage of the referrals identified in the paper. There is also an increasing awareness among workers from this community that they are themselves ill-equipped to provide advice and are poorly educated about alcohol and other drugs.

More recently, South Australian Police have initiated "Operation Mantle" in Adelaide, which aims to detect low level drug dealers and users, with a view to gaining intelligence information on higher level dealers. Anecdotal reports suggest that much of the heroin being sold in Adelaide is being brought in from the Eastern states by Vietnamese drug dealers, with distribution occurring largely through Vietnamese dealers, many of whom are quite young and are associated with youth gangs. Following some much publicised episodes of

heroin dealing occurring in the central shopping precinct of Rundle Mall, South Australian Police through Operation Mantle have made concerted efforts to apprehend and prosecute these young heroin dealers, many of whom are Vietnamese. SA Police report anecdotally that, despite their greater level of intervention at this level, they have managed to gain the respect and trust of a number of young Vietnamese. Furthermore, they have heard a number of reports from heroin users regarding their desire to detoxify from heroin, and the difficulties they face in approaching treatment agencies for help. There appears to be a growing demand within the Vietnamese heroin-using community for “underground” detoxification procedures, which by and large do not have proper medical supervision, and may involve the use of stolen medications such as benzodiazepines, naltrexone, and others.

2.6 Acceptability of methadone and other treatments

Methadone maintenance treatment is the most widely used of pharmacotherapies in the treatment drug dependence in Australia, with proven efficacy (Mattick & Hall, 1993; White, Ryan & Ali, 1996). However, substitution or maintenance therapies do not appeal to all heroin users. People of South-East Asian background do not generally figure prominently among clients of methadone programs. There is anecdotal evidence to suggest that Vietnamese heroin users do not favour methadone because it is regarded as being addictive, and that these users particularly dislike the notion of substituting one addiction for another. This may be a culturally conditioned view, as the Vietnamese community seems to hold the strong opinion that dependence brings shame and loss of face for both the user and the family. Furthermore, the concept of harm minimisation is perhaps still new to this community, given language barriers and lesser access of the Vietnamese community to appropriate information and services. Thus, the rationale for a long-term treatment option such as methadone, in terms of harm reduction, may be less well understood among Vietnamese heroin users compared with Caucasian users.

The review of heroin use in Victoria's Vietnamese community conducted by the Turning point Drug and Alcohol Centre (Ezard, 1997) included a key informant study of Vietnamese people involved in service delivery and in heroin use. Interviews with regular heroin users revealed that methadone had been tried and was felt to be unsatisfactory in a number of ways, particularly because it was

regarded as being as addictive as or more addictive than heroin. Furthermore, it was felt that withdrawal from methadone was worse than from heroin, and that methadone had other undesirable side effects. This lack of satisfaction with methadone may well be partly based on users' expectations of treatment not being met. Buprenorphine was the pharmacotherapy that was viewed as being the best potential alternative to methadone.

This study also highlighted the experience of some Vietnamese heroin users with home detoxification programs, including the self-administration of benzodiazepines and other medications (Ezard, 1997). The long-term effectiveness of these approaches in helping these heroin users remain drug free is unclear, particularly as many users appear to have tried these approaches in an un-supervised manner. Other reviews have failed to demonstrate enduring benefit when detoxification is conducted in isolation from further intervention (Ward, Mattick & Hall, 1998). In Adelaide, there are anecdotal reports of growing interest within the Vietnamese community for home detoxification programs, perhaps reflecting the experience of heroin users with problems in accessing or staying on methadone programs.

As Maher and Swift have noted (1997), counselling is not a well accepted concept among Vietnamese. Nonetheless, counselling has been reported by some Vietnamese heroin users as being helpful (Ezard, 1997), but only if counsellors are non-judgmental and non-racist in their approach. This suggests that counselling, if tailored to the language and cultural requirements of Vietnamese drug users, can be an important part of treatment for heroin dependence.

2.7 Tincture of Opium

Tincture of opium is a pharmacotherapy that is used at various sites throughout the Asia Pacific region (notably Thailand, Laos and Myanmar) to treat withdrawal from opioids. An attraction of tincture of opium is the cost advantage it has over methadone, the purchase and import of which has a significant impact on the limited health budgets of many South-East Asian countries. Tincture of opium can be produced locally for much less than it would cost to purchase methadone. One of the difficulties for these countries in using tincture of opium has been the lack of standardisation of the amount of opium and alcohol in the mixture, and

the consequent lack of certainty in what is being given to those in treatment. It appears to be used more for detoxification than as a maintenance therapy.

The use of tincture of opium throughout the region is not universal, and practices appear to vary widely. In Vietnam, tincture of opium is sometimes mixed with benzodiazepines by opiate users as a drug of choice. However, tincture of opium is not officially recognised by the Vietnamese government for use either as a detoxification or as a maintenance agent. In India, opiate-dependent people are not treated with tincture of opium, although opiate users will use tincture of opium or poppy pod water when the street supply of heroin and other opiates becomes limited or expensive.

Tincture of opium, or laudanum, has a very long history of use in folk medicine in many cultures. Many different variations of tincture of opium have been available, such as the opium-based liquid known as “paregoric”, which was camphorated tincture of opium. Such preparations, as well as various patent medicines containing opium derivatives, became very popular in Europe during the 19th century as a form of self-medication for a wide variety of ailments. Tincture of opium or laudanum, when its use was widespread, was inevitably responsible for addiction problems in many people who used it (Booth, 1996).

There has been very little documented research of the use of tincture of opium as a treatment for dependence on other opioids. Its use for this purpose in Western societies in the 20th century has been minimal. Most recently, a paper published by researchers in France (Auriacombe, Grabot, Daulouede, Vergnolle, O'Brien & Tignol, 1994) reported on the use of tincture of opium with a very small number of French injecting heroin users. This research was carried out in the context of methadone not being available for the treatment of heroin dependence. Six heroin dependent persons received tincture of opium daily, while another 12 received buprenorphine. The duration of the treatment was 17 months, and the authors report that heroin use was found to have decreased from daily to less than once a month. The study was limited in scope, and results were not published separately for subjects receiving tincture of opium and those receiving buprenorphine. Nonetheless, this study does demonstrate that tincture of opium does have potential as an alternative to methadone maintenance therapy for heroin dependence.

There is some clinical evidence to suggest that some substances are metabolised at different rates by people of different racial backgrounds (Yue, Svensson, Sjoqvist, & Sawe, 1991; Zhang, Reviriego, Lou, Sjoqvist & Bertilsson, 1990; Zhou, Sheller, Nu, Wood & Wood, 1993), although the limited results are somewhat difficult to interpret. If this does occur, it is conceivable that a reluctance to use methadone among Vietnamese is partly related to the rate at which it is metabolised by people of an Asian genetic make-up. Tincture of opium, which has a shorter half-life than methadone, may be more attractive as a treatment option to this group of heroin users.

In the absence of any standardisation of tincture of opium preparations, and the lack of literature on its pharmacological efficacy, it is very difficult to assess the relative potential of tincture of opium in comparison to methadone or other treatments in detoxification and maintenance therapy for heroin dependence. The fact that tincture of opium is in wide use in South-East Asian regions suggests that it does have utility in the treatment of opiate dependence. However, further information on the pharmacodynamics and pharmacokinetics of tincture of opium is required, as well as on its efficacy in comparison to other pharmacotherapies. The present study in part aims to address these issues by investigating the effectiveness of tincture of opium as a treatment for heroin and opium dependence.

3.1 Rationale and research aims

As discussed in the previous section, the magnitude of the heroin use problem within Vietnamese communities in Australia has recently been a cause for great concern among Vietnamese and also within the wider community. The apparent under-utilisation of methadone maintenance programs and other treatments by members of the Vietnamese community has prompted examination of methods of improving information about and access to the existing services, or of tailoring services so that they are more acceptable to Vietnamese heroin users and more sensitive to their cultural requirements. An extension of this approach is to investigate novel treatments that may have greater acceptance among Vietnamese heroin users. In this regard, the recent review undertaken by Turning Point Drug and Alcohol Centre (Ezard, 1997) of the potential acceptability of new pharmacotherapeutic agents among Vietnamese in Victoria is a preliminary step in trialing approaches that may have greater cultural acceptability and success for treating heroin dependence in this group. Tincture of opium is one possible alternative pharmacotherapy that already has some history of successful use in countries of the Asia-Pacific region.

The exploration of the potential acceptability of tincture of opium among Vietnamese in Australia required a greater understanding of the Vietnamese heroin-using community in the chosen research location of Adelaide, Australia. Consequently, the present study sought to investigate the extent of heroin use, routes of administration, and attitudes to treatment among members of the Vietnamese community in Adelaide, Australia.

The study of the use of heroin in the Vietnamese community in Adelaide was in part intended to provide comparative information to that already obtained interstate (Maher & Swift, 1997; Louie et al, 1998). This study involved two components: a survey of drug users in the Adelaide Vietnamese community, and a series of key informant interviews with members of the community.

The community survey and key informant interviews sought to gather information on:

- perceptions of the extent of the heroin use problem within the Vietnamese community in South Australia;
- preferred routes of heroin administration among Vietnamese heroin users (ie. smoking versus injecting);
- what treatment regimes for heroin dependence are considered desirable among Vietnamese heroin users, and what are the barriers to utilisation of services.

The following sections outline the methodology and results of the study of Vietnamese heroin users in Adelaide, including the interview study of heroin users and the key informant study.

3.2 Methodology

There were two components to this study of heroin use within the Adelaide Vietnamese community:

- an interview study of Vietnamese heroin users, involving the collection of both quantitative and qualitative data via a questionnaire;
- interviews with key informants on aspects of the Vietnamese community and how heroin use is perceived and dealt with;

3.2.1 Vietnamese heroin user survey

Recruitment of interviewer

It was originally intended to recruit a bilingual interviewer who could conduct interviews in either Vietnamese or English. It was also viewed as important that the interviewer had some contacts with the Vietnamese heroin using community, be able to foster trust among the users, and elicit truthful information during study interviews. It was also desirable that the interviewer had experience in other research in the Vietnamese community.

It was initially thought that an older male person might be preferred for the interviewer role, because such a person would perhaps be accorded greater respect due to his seniority. It transpired that a middle-aged woman was appointed as the project interviewer, as she had experience in social research in this community and had valuable connections to the heroin-using group.

The survey instrument

A modified version of a questionnaire used by Swift and colleagues in South-West Sydney (Swift et al, 1997) was developed for use in this study. The questionnaire included items on demographic characteristics, level of educational attainment, English language fluency, family/living situation, contact with health and welfare services, drug use history, transition between routes of heroin administration, recent drug use (ie in the month previous to interview), injecting practices, level of heroin dependence, social context of heroin use, general health status, treatment history, and factors influencing use of treatment options.

Other more open-ended questions attempted to gather information relating to participants' views about different routes of administration, experience with street methadone, attitudes to various treatments options, and responses to the possibility of tincture of opium being used as treatment for heroin dependence.

It was made explicit at the outset of this project that the interviews with heroin users would not include questions seeking information about users' sources of heroin supply. Advice from workers who had experience with the Vietnamese community suggested that funding of drug use and sources of drug supply were sensitive issues for the drug-using group. It was felt that the inclusion of questions on these issues might result in interviewees feeling very uncomfortable, and possibly refusing to participate in the study. Accordingly, no attempt was made to investigate how users obtained their heroin or other drugs.

Recruitment of respondents

Early discussions with workers who had experience with the Vietnamese community suggested that recruitment of respondents for this study would be difficult. The experience of the project staff was that recruitment of respondents was even more difficult than anticipated. A range of strategies was employed to recruit heroin users into the study, including: personal contact with known users; fliers distributed through doctors, pharmacists, community health workers and clinics; referral from Drug and Alcohol Services Council staff; and requesting other health and welfare workers to refer users to the project. Personal contact was the most productive strategy. Only one person agreed to be interviewed as a result of the fliers, and this person was a young man who was born in Australia

and whose first language was English. No referrals were received from doctors or other community workers. Those users who were not personally known to the interviewer, but who agreed to be interviewed, participated as a result of personal contact with an individual who arranged the interview on behalf of the interviewer. In all, eleven Vietnamese heroin users were interviewed.

Interview procedure

Interviews were conducted either in public places or in private homes that were known to the interviewer. Participants were assured of anonymity and, although informed verbal consent was obtained in each instance, no records were retained of participant's names. With only one primary interviewer working in close contact with the project manager, there was no possibility of any respondent being interviewed twice. Each interview took between 45 and 60 minutes to complete. Interviews conducted by the Vietnamese-speaking interviewer tended to take longer because of customs relating to the process of interaction between members of the Vietnamese community. Each participant was offered \$20 for their time spent on the interview, although one interviewee refused to accept the payment.

3.2.2 Key informant interviews

Interviews were conducted with people who were able to provide insight into the Vietnamese culture, or who had an understanding of the issues facing Vietnamese heroin users. These interviews were conducted by the project officer, for periods ranging from 30 minutes to one hour, and recordings of the interviews were transcribed. The interviews were largely unstructured in nature. Although core issues were covered in each instance, the scope of the conversation was determined by the experiences and insights of the informant. The focus of these interviews was the experience of working within the Vietnamese community; perceptions regarding the extent of heroin use; understandings of attitudes to health care and sickness among Vietnamese; and insights into how cultural influences might impact upon acceptability of government services.

3.3 Results

3.3.1 Vietnamese heroin user survey

Characteristics of the survey respondents

Eleven Vietnamese heroin users were recruited for face-to-face interviews, and information was collected from them using the questionnaire developed for this study. Although all potential interviewees had been identified through the bilingual interviewer and her contacts, and it was intended that this interviewer conduct all of the interviews, some young people were not prepared to be interviewed by a member of their own community. In these few cases, the English-speaking Caucasian project officer conducted the interview.

Table 1 Characteristics of the survey respondents (Total n=11)

Mean age (range)		30.1 years (16–41 years)
Gender	– male	n=10
	– female	n=1
Employment	– unemployed	n=9
	– full-time	n=1
	– other (prison, remand, etc)	n=1
Country of birth	– Vietnam	n=10
	– Australia	n=1
Time in Australia	– 5–10 years	n=4
	– 11–15 years	n=5
	– over 15 years	n=2
Country of schooling	– Vietnam	n=6
	– Australia	n=2
	– both Vietnam and Australia	n=3
Years of education	– less than 10 years	n=7
	– 10 or more years	n=3
	– unknown	n=1
Post-secondary education	– completed courses	n=2
Speaking English language	– very well/fluently	n=2
	– quite well	n=3
	– not well	n=5
	– unknown	n=1
Reading English language	– very well/fluently	n=2
	– quite well	n=3
	– not well	n=6
Marital status	– single	n=9
	– other (divorced, separated)	n=2
Children	– yes	n=4
	– living with you	n=0
Living situation	– with family	n=2
	– with people other than family	n=7
	– alone	n=2

Table 1 shows that this sample was largely comprised of Vietnamese-born unemployed single male heroin users, with an average age of around 30 years. The majority of the group had had limited years of education, and about half reported having poor English language fluency. No respondents reported living in a stable relationship with a partner, while only two were living with family members. Most were living with friends. Two respondents reported having no fixed abode, one of whom described this as living alone, while the other described this as living with others. The two respondents who had been married were now living with friends. Of the four respondents who reported having children, none were currently living with their children.

It should be emphasised that this small group is not necessarily representative of Vietnamese heroin users in Adelaide. The majority of this sample were known to each other and to a number of Vietnamese community workers, and had a history of contact with government agencies. Anecdotal evidence from the key informants suggests that there are other groups of users who are difficult to access and who were not accessed by this project. The sample for this study had few young people (only two subjects under 25 years of age). Furthermore, there were no users in the sample who had non-Vietnamese partners, which may be more common among younger Vietnamese people. Our sample also did not appear to access Vietnamese drug users who fund their heroin use by criminal activity.

One of the respondents had been born in Australia. All of the others had been born in either South or Central Vietnam, and six indicated that they had spent time (from one to seven years) in refugee camps before arriving in Australia. The Australian-born respondent had an Australian mother. The parents of all other respondents were Vietnam-born. Most respondents were residing in North-Western Adelaide, with one living in a southern suburb. This residential distribution is consistent with the picture shown by the casenote audit and with the actual residential clustering of Vietnamese in Adelaide (Gardner, 1997).

Six of the respondents considered themselves to be Roman Catholics, and another three indicated that they were Buddhists.

The respondents had a mean of 8.2 years of schooling (range 4–12 years). Nine of the eleven attended school in Vietnam, with three completing their schooling in Australia and one other enrolling in a post-secondary course here. In general, those who spent time in a refugee camp tended to have spent less time in school (mean of 7.5 years).

Services contact

Respondents were asked whether they had accessed a range of different services in the previous twelve months. This list encompassed a wide range of general health and welfare services that individuals may have approached for assistance. This question was included to identify services acceptable to Vietnamese drug users, and to help identify the appropriate workers for training in alcohol or other drug problems, and appropriate referral mechanisms. Advice on the services to be included in this list had been sought from Vietnamese workers, but contact with the services listed was very variable. All of the respondents had contacted a doctor, and all had had contact with the Department of Social Security. Seven respondents had made contact with a Vietnamese community worker, and 7 had contacted the Housing Trust. No respondents had contacted the Migrant Health Service or Australian refugee Association.

Table 2 Respondents contacts with health services in previous 12 months

Service	n
Doctor/GP	11
DSS	11
Vietnamese community worker	7
Housing Trust	7
Social worker	5
CES	4
Psychiatrist/psychologist/counsellor	4
FACS	2
Hospital	2
Community health centre	1
Church/religious leader	1
Telephone counselling	1
Migrant Health Service / Australian Refugee Association	0

Drug use history

The average age at which heroin use commenced among this sample was 23.3 years (range 12–34 years), while the average age for first trying a drug was 20.7 years (range 11–29 years). Cannabis was the first drug tried by five of the participants, heroin the first for three of them, and tranquillisers for the other three. Regular heroin use began at a mean age of 23 years (2 missing responses; range 14–34 years).

Respondents were asked whether they had ever tried eight types of drugs associated with illicit use (alcohol and tobacco were not included).

Table 3 Lifetime use of illicit drugs

Drug	Ever Tried (n)	Ever Injected (n)
heroin	11	10
tranquillisers	10	1
cannabis	7	–
amphetamines	4	1
hallucinogens	4	0
cocaine	1	1
barbiturates	0	0
ecstasy	0	0

Most of the respondents had used a limited range of drugs, with the younger users reporting having tried a greater number of drugs. Heroin had been tried by all respondents, and all but one had tried tranquillisers. Cannabis had been tried by seven respondents. Less than half of the sample had used amphetamines, hallucinogens or cocaine, and not one had used ecstasy or barbiturates.

Only one of the respondents stated that they had never injected any drug. Ten respondents had injected heroin, and only one had ever injected each of amphetamines, cocaine or tranquillisers.

Heroin use:

Mode of heroin administration

Most of the respondents (n=8) had smoked, chased, snorted or used snowcones (a mixture of heroin and other drugs) as their first route of administration for heroin, and all eight had used heroin in only this way for a period of time. The other three had started using heroin by injecting. Of these three, only one did not

report a period of time in which they had only smoked. Thus, there was only one respondent who had never smoked heroin for a period of time.

Within the previous six months, however, only one respondent said they had only smoked heroin. Seven others had only injected over the prior six months. One had mostly injected, with occasional smoking, while another one had mostly smoked and occasionally injected. Only one person reported that they had at some point in their drug using career changed from injecting to smoking – this person was currently injecting, but expressed a preference for smoking whenever possible.

Reasons for smoking rather than injecting heroin

Smoking was the first mode of administration for most of the users interviewed. At the time that they started using, most of their heroin-using acquaintances were smoking, and users expressed an initial dislike of needles. One person also commented that they believed smoking was less harmful than injecting.

Don't like injecting – too bad. All of my friends are against it. (25 yr old man, 12 years in Australia)

I was scared of the needles. I still prefer smoking to injecting so I smoke whenever I can. Maybe the community's view about people who smoke is more positive than about people who inject heroin. (39 yr old man, 15 years in Australia)

Chasing is less harmful than injecting. (33 yr old man, 7 years in Australia)

Reasons for injecting rather than smoking heroin

The respondents indicated that in most cases they were introduced to injecting by friends, and that since they have been injecting, smoking has not provided the desired effect. Furthermore, less heroin was required, meaning that their expenditure on heroin was less.

After changing to injecting, smoking gave me no feelings at all (41 yr old man)

Better feelings. Cheaper. Prolonged effects. (33 yr old man)

Smoking doesn't give me the same feelings as injecting. (30 yr old man)

Got stoned easily with injecting and this helped me to overcome problems. (39 yr old man)

Less expensive. Injecting is affordable. (30 yr old man)

Can't smoke. Injecting gives me the same effect as morphine – painkiller. (31 yr old man)

Similar reasons were given for changing to injecting heroin. In general, users felt that injecting heroin was more affordable than snorting it. They felt that injecting gave them more intense effects with rapid onset, and more prolonged effects. One user also felt that injecting was less damaging to the brain than snorting. Another user who in general preferred smoking said that they had found injecting to be better during a stressful period in their life.

Recent drug use

Respondents were asked about their drug use in the previous month (Table 4). Tranquillisers (mostly benzodiazepines) were the most frequently used drugs within the previous month, with seven respondents reporting their use. This compared with six respondents who reported use of heroin in the previous month. Only two of the eleven respondents said they had never tried tranquillisers. Three of the seven who said they had used tranquillisers in the previous month had used them every day, and another two had used them an average of three days a week.

Table 4 Illicit drug use in the previous month

Drug	Used in previous month (n)
tranquillisers	7
heroin	6
methadone	3
alcohol	2
cannabis	2
amphetamines	1
other opiates	1
inhalants, cocaine, hallucinogens & barbiturates	0

Among those who reported use of heroin in the previous month (n=6), the frequency of use ranged from once in the month to every day. Two subjects reported daily use of heroin in the previous month, one of them using four times

a day. Methadone had been used by three respondents in the previous month, all of whom used it daily. One of these respondents had also used heroin on one occasion.

Only two respondents reported using cannabis, and two reported use of alcohol in the previous month. One respondent reported using amphetamines and other opiates in the previous month. This same person had also used tranquillisers and alcohol on a daily basis, and cannabis almost daily over the previous month, and had used heroin twice in that time.

Injecting practices

The age of first injection ranged from 14 years to 36 years of age. All respondents said that they used less heroin after switching to injecting. Five respondents said that they used less of other drugs after starting to inject heroin, while another five said that their use of other drugs had remained constant. At the time of changing to injecting, all respondents were living with people who injected drugs, and most had a circle of friends who were mostly injecting.

Only one user indicated a lasting preference for smoking heroin over injecting, although this person was currently injecting heroin. Only one respondent reported not currently injecting heroin at all. None of the other ten respondents indicated that they were likely to switch from injecting to smoking exclusively. In all cases, these users had been introduced to injecting by other people who had administered the first injection.

Only two respondents reported daily injection of any substances in the previous month. Two respondents had used a needle after someone else in the preceding month (one person had done so more than ten times, and after up to five other people had used the same needle). However, five respondents were positive that they never shared needles. Those respondents that had shared indicated that they mainly did so with friends - regular partners were not nominated, as most of the respondents were not living with partners. Only one respondent stated that they never cleaned needles, and this person claimed to always be the first to use a needle, although a number of people might subsequently use the same needle.

Severity of dependence scale

The questionnaire included the Severity of Dependence (SDS) scale. SDS scores ranged between 1 and 15, with a mean (SD) score of 9 (4.2). Nine of the eleven cases scored more than 6 on the scale. SDS scores greater than 6 are generally considered indicative of severe dependence (Gossop et al, 1995).

Social context of heroin use

Friends and associates

Only one of the eleven respondents stated that none of their associates used heroin. All other respondents reported that more than half of their associates were heroin users, the majority being injectors of heroin. All of those surveyed currently spent time with people who used heroin, and 9 of them reported that they spent at least half of their free time with heroin users.

Most (eight) respondents reported both their own home and that of a friend as the places at which they usually used heroin. One respondent reported only the home as the usual place of use, one reported only a friend's home, and one reported a public place as the usual location for heroin use. These preferences were reflected in respondents' answers to a question on where they had used heroin in the previous six months. Nine of the eleven respondents reported using heroin at home, and nine reported using at a friend's house. Four of the eleven reported having used in public places, while three reported having used heroin in a car, three at a party, and one stated that he used heroin 'anywhere'.

Use of heroin alone

Using heroin by oneself is of concern in any situation, because of the possible risk of overdose at a time when no-one else is present to provide assistance. Two of those surveyed said they always used heroin when they were alone, and another said they used it alone most of the time. Six respondents said they used heroin alone some of the time. Two stated that they never used heroin when they were alone.

Health

One of the respondents indicated that they had tested positive for HIV. Another six reported that they were positive for Hepatitis C, and one of these also reported being positive for Hepatitis B.

The general state of health of the respondents was measured by the health subscales of the Opiate Treatment Index (OTI) (Darke et al, 1992). The mean score on the health scale items was 17.5 (range 3–36). This compares with an average of 13.8 found in the research carried out among Indo-Chinese heroin users South West Sydney (Maher & Swift, 1997). Darke et al (1992), in their validation study of the OTI, reported a mean health scale total of around 13 for a sample of opiate users. Thus, the health score for this Adelaide sample is higher, suggesting a higher level of health problems. Of course, the small size of the Adelaide sample means that caution must be exercised in drawing conclusions about the relative degree of health problems in the Adelaide and Sydney samples of heroin users.

Experience of heroin overdose

Five of the eleven respondents reported that they had personally experienced a heroin overdose at some time. One person had had a single overdose, three persons had had two overdoses, and one person reported having had over ten overdoses. All respondents who had experienced a heroin overdose had done so following the use of heroin by injection; none had been smoking heroin at the time of overdose.

Two of the five respondents who had overdosed on heroin reported no other concurrent drug use. Of the three who reported heroin and other drug use at the time of overdose, one had used tranquillisers, one had used tranquillisers, alcohol and other opiates, and one person reported using tranquillisers, alcohol, cannabis and amphetamines.

Three of the respondents reported having been present at some time when another person overdosed on heroin. One person had witnessed a heroin overdose once, while the other two reported witnessing several overdoses.

Treatment history

All eleven respondents stated they had sought help for their drug use at some time, although only 5 were in treatment at the time of the survey. Of these five, two were in the public methadone program, two were in the private methadone program, and one was receiving outpatient counselling.

Respondents were asked to indicate how many times they had undertaken any particular treatment program, the average length of stay in any program, and how many times a particular program had been completed. Generally, respondents had difficulty in recollecting the number of times they had entered different programs and there was particular difficulty in estimating the average length of time on each program.

Two respondents had previously been in the public methadone program, one of whom was still in the program. This person reported being on the public methadone program 15 times previously, with an average duration of treatment of one month. The other person reported one prior time on the program, lasting 7 days. Of the three respondents who had entered the public program, none felt that they had completed their program.

In the case of the private methadone program, five respondents had been on the program at some time, and two of these were still on the program. Most reported only one occasion on the private program, although one subject had been on the private program four times previously, and was no longer in treatment. Two subjects who were still on the private program reported being in treatment for one and two months respectively, at the time of interview. One respondent reported that they had completed their treatment on the private methadone program.

Four respondents had been through an in-patient detoxification program, three of whom were currently on a methadone program. The length of time in detoxification treatment ranged from 2 to 7 days. Only one respondent reported that they had completed their detoxification program.

One respondent had been in a residential treatment program on two occasions, for periods of 4 and 5 months respectively, and had also previously been on the public methadone program.

One respondent reported prior outpatient treatment, but no other treatment. Another respondent reported prior treatment by a general practitioner on a few

occasions, mainly involving the prescription of tranquillisers, but no other previous or current treatment.

None of the respondents had undertaken a twelve-step program, or private hospital-based treatment.

Factors influencing decision to enter or stay in treatment

Seven respondents answered questions about their reasons for seeking treatment. A range of factors were nominated, including family pressure to stop heroin use, wanting to get a job, problems with money, feeling out of control and the desire to be a better parent.

A few respondents identified reasons why they had not completed treatment, whether it be outpatient or in-patient treatment. These reasons mainly related to social isolation and other difficulties experienced by the respondents, which made it difficult for them to either initiate or maintain their involvement in treatment programs. One subject reported that he had started methadone treatment on a number of occasions without success, withdrawing from the program after finding that he did not like the clinic environment, and being told by friends that the treatment would not work. Another reported problems with police that meant that the treatment was not continued. Others who had discontinued in-patient or residential treatment felt isolated and found it hard to remain in the clinics, particularly with other things in their lives requiring their attention.

Perceptions of heroin smoking vs injecting

Most respondents mentioned that they knew many people who smoked heroin, including family, friends and acquaintances. Mostly, these people were also Vietnamese. A number of respondents had first been introduced to heroin when living in Vietnam.

The reported methods by which heroin was smoked on the first occasion were varied, and included “chasing the dragon” (heating on foil), mixing heroin with different substances in a pipe, or mixing it with cannabis. Not everyone was able to give a name to the way in which they smoked, although “chasing the dragon”

and “snowcones” were both offered as descriptive terms. “Snowcones” were described as mixtures of different drugs smoked with the heroin in a pipe, eg. speed, crushed sleeping tablets, cannabis.

A number of respondents believed that smoking heroin was something that only heroin users who were financially well off could do, as it cost more to buy enough heroin to get the same effect as from injecting. These respondents felt that dealers were more likely to smoke because of their ready access to the drug.

It was felt by a number of respondents that heroin injectors had low self-esteem, feelings of guilt, humiliation or isolation, and generally looked unwell compared to heroin smokers. The view was expressed that heroin smokers were more in control of their lives. Indeed, some believed that regular heroin injecting was “an end of your life”, or that heroin injectors were at the “bottom of the community”. These views related to the beliefs expressed that injecting heroin meant that the user was out of control, having to resort to crime to pay for their habit.

While there were these differences in the perception of how heroin smokers and injectors felt about themselves, the respondents indicated that smokers and injectors were no different (apart from self-perceptions and financial status), in that they were all drug users with heroin habits.

Knowledge of tincture of opium and other treatment options

None of the respondents had ever heard of tincture of opium as a possible treatment for heroin dependence. Two respondents indicated that they would be interested in trying it, while another two said they would need more information in order to decide if it was a worthwhile treatment. The remainder of the sample did not indicate a response – among these respondents there may have been some suspicion of pharmacotherapies in general, based on their or their friends’ experiences with methadone. The respondents were not keen to try other treatments - only one respondent nominated methadone, and another nominated tranquillisers (Valium and Rohypnol) as treatments they would like to try, while another said that they would avoid methadone.

The respondents seemed to have stronger preferences for the setting of treatment rather than the pharmacotherapeutic agents used in treatment. Only one respondent had heard of “home detoxification” as a descriptive term, but 8 out of the 11 respondents had tried some form of “self-detoxification”, only one of whom reported any lasting success. Despite this, there was a strong preference for trying to detoxify from heroin outside of a medical setting, with the close support of family or friends – 7 of the 11 respondents said that this would be their preferred treatment approach. Two respondents said that medically supervised detoxification in a clinic setting would be their preferred option, while another reported that it would be their second choice after home-based detoxification.

3.3.2 Key informant interviews

Key informant interviews were conducted with a total of thirteen individuals, including young people who were involved in the drug scene, Vietnamese community health workers, and other people who work with members of the Vietnamese community.

While each of the informants provided different information, there were a number of common themes that emerged throughout the interviews. Of particular prominence were observations relating to different age groupings within the Vietnamese drug using community, and to conflicts between members of different generations in the community.

Different age groups

The key informants described the existence of distinct heroin-using groups at different age levels, which differed from each other in drug-using behaviour, degree of dependence and prognosis for long term behaviour. The group of users accessed for the survey questionnaires was an older group with relatively poor English language skills, poor employment prospects and limited family support. A number of them had arrived in Australia from Vietnam as unaccompanied minors or had spent a number of years in refugee camps. In contrast, there was a group of adolescent users, described by the key informants, who had spent most of their formative years in Australia, were less likely to have spent time in camps, had good English language facility and, in

most cases, were either living at home or had a family to which they could return.

One informant mentioned that a large number of young men had arrived in Australia as unaccompanied minors during Vietnam's war with Cambodia. These people often have no idea of how old they really are because their parents falsified their ages (ie. registered them as younger to avoid conscription into the army, or older to make them eligible for immigration).

There was fairly general acceptance that Vietnamese people under the age of about 25 years would prefer to be interviewed in English, as English was likely to be the language in which they were most proficient. They were regarded as feeling more comfortable in talking in English about behaviours such as drug use, as it would minimise the chances of them being identified as users by authority figures in the community.

As indicated earlier, the Vietnamese cultural group tends to have a strong commitment to family values. Informants stated that even those Vietnamese who are not living with their family tend to develop support groups of peers, which may serve as de facto families. Within such a group, dole cheques are often shared, and members of a group are generally looked after by other members. Membership of these groups can be cross-cultural (involving Anglo-Australians as well as Indo- Chinese). Young Vietnamese women in these groups are often much younger than the young men.

Young drug users who were key informants indicated that their involvement with the drug scene was waning, primarily because of the pull of their family responsibilities. This influence was reinforced by other key informants who indicated that over 90% of the young people who leave home and become involved with drugs return home to their families in later adolescence.

Young Vietnamese people were uncomfortable talking to members of their community. One Vietnamese teacher highlighted the difficulty young people experienced in being open with adults, particularly adults from their community, until they had developed trust. This informant emphasised the difficulty of working with such young people without considerable experience.

One young female informant believed that many Vietnamese heroin users were young adolescents who came to Australia late, do not speak English, and do not study – they are attracted by the possibility of dealing in heroin and making money. This was reinforced by informants from the law enforcement sector, who indicated that the involvement of young Vietnamese adolescents in heroin dealing was substantial, and that they were often selling to young Vietnamese people as well as older heroin users from outside the Vietnamese community.

Informants felt that increasingly, Vietnamese adolescents do not see themselves as members of the Vietnamese community, and are therefore more reluctant to access services provided by the community. Many young Vietnamese people increasingly want to have closer involvement with other cultural groups in Australian society. On the other hand, it was pointed out that young Vietnamese drug users were sometimes reluctant to use mainstream community health services because such services often catered to Vietnamese parents and children, and they ran the risk of being identified by adults they might know. The expectations of parents were viewed as being an important factor in creating stress for young Vietnamese people, creating a climate in which involvement in the drug-using sub-culture was an attractive option for some.

Some of the Vietnamese workers also acknowledged that, with the small size of the Vietnamese community in Adelaide, fear exists among drug users of possible recognition by other members of the Vietnamese community, which affects their willingness to access alcohol and other drug services. These informants therefore recommended that such services continue to be based in mainstream agencies.

Aboriginal/Vietnamese connection

There was a general feeling that the Aboriginal and Vietnamese communities did not see themselves as being close to each other. Nevertheless, two workers with responsibility for programs for either Aboriginal or Vietnamese indicated that communication occurred between Aboriginal and Vietnamese when it came to drug use. Vietnamese were reported as supplying heroin to Aboriginal people. One informant also speculated that such transactions may have developed as one way to avoid 'white man's control', and that issues of community and personal

safety might underlie the development of links. Prison was given as the most obvious example of a situation in which such connections were formed.

Prison

A Correctional Services staff member confirmed that the number of Vietnamese inmates in South Australian correctional institutions was low; one researcher with a major research interest in the interaction of Vietnamese with the justice system indicated that the numbers had been very low but were on the increase. One informant believed that there was a surprising number of Anglo-Saxon women in jail who had Vietnamese partners, and that 'a lot of women do time for their men because it is thought they will get less'.

The number of Vietnamese women in prison was believed to be 'very, very low'. A comparison was made with the situation regarding offending by Aboriginal women: the number of Aboriginal women in jail used to be very low, but it is now increasing. Interestingly, the only female user who was identified and who agreed to participate in the survey, was in a correctional facility (She was also the only young – 16 years old – person who agreed to be interviewed by the Vietnamese interviewer).

Confidentiality issues for the community

Nearly every non-Vietnamese worker who agreed to be interviewed for this survey highlighted the difficulty associated with using workers who are well-known in the community to address sensitive issues such as illicit drug use.

The concept of confidentiality as understood by Western professionals is viewed differently by many people in the Vietnamese community. Although workers agreed that perceptions were changing, Vietnamese traditionally have tended to believe that any information gained about one member of the family could legitimately be passed on to other members of that family. Consequently, workers were acknowledging that many members of the community, particularly the young, were reluctant to seek advice from any worker who might know them or their family. This situation is changing as Vietnamese workers develop a sensitivity to the difficulties of second-generation adolescent migrants, and enter

into professional relationships with organisations which require employees to abide by strict confidentiality protocols.

The family

As indicated earlier, the family is the central unit of the Vietnamese community. The obligations of children to their parents exist throughout the children's lives, and parents feel responsible for their children well beyond an age at which the majority of Australian children are assuming responsibility for their own lives. The continuing emphasis on the family in the community is both an advantage and a disadvantage. The family becomes a powerful force for change in those individuals who maintain contact with parents or the extended family. Conversely, if children or other family members do not live up to expectations, and may be viewed as having brought shame and disgrace on the family group.

Nearly every informant mentioned the expectations that Vietnamese parents placed on their children and the difficulty some children have in living up to these expectations. A number of informants, both Vietnamese and non-Vietnamese, emphasised the importance of educating Vietnamese parents who find themselves at odds with the Australian perception of family. Traditionally, the family is the primary source of discipline and values, and parents' wishes are paramount. Many of these parents perceive Australian children, particularly teenagers, as having too much freedom and lacking application. The idea that parents should consult with their children and discuss various situations in order to arrive at a negotiated outcome is contrary to their understanding of the respective roles of parents and children.

Nevertheless, the family (or its surrogate) remains a potent force in the recovery prospects for drug users from the Vietnamese community. For those who do not live with their family, either because they have no close family in Australia or because they have been disowned or have left home, their peer group becomes their family. For users such as those interviewed for our survey, their peer group is other users, who may also be without family, employment, English language skills or other support mechanisms.

For young people who are perhaps reacting to the perceived limitations of traditional roles, the alternative family is their group of young peers. This is in

contrast to the environment in the family home where parents seek to impose a very structured environment on their children.

Informants reported that there are programs being run by Vietnamese workers to help parents improve their interaction with their children, particularly teenage children. It was commented that one of the issues is to confront parents' concern about community reaction to their children's behaviour (this concern was cited several times as the reason for disowning their children once their drug use became known). One male worker is working with fathers and working within the hierarchical structure of the community. This worker's interest is in protecting the community so that it survives into the future as a cohesive and valued entity. However, he is also concerned to ensure that the community can function within the Australian society.

In contrast, two young people who were key informants, while not using heroin, had been involved with drug users for a number of years. In both cases they were reducing their use of other drugs (pills and cannabis) and were returning to school and to their families. They both cited the strength of family expectations and their obligations to their parents as reasons for their movement away from their drug-using friends. One of the workers confirmed that the family was a major support mechanism, but that parents needed counselling and support as well.

Treatment options and attitudes

The general practitioner in the Vietnamese community has considerable status and influence. Thus, if general practitioners are ambivalent about seeing drug users in their practice and attach strong moral values to drug use, their disapproving attitudes can be reflected in the general community. However, general practitioners can be a considerable force for change in the community.

Doctors that we spoke for this study to were generally reluctant to have methadone patients in their general surgeries, feeling that they may intimidate their other patients. (This attitude is not restricted to Vietnamese doctors.) One doctor suggested that a methadone clinic should be established at a site centrally located within the Vietnamese demographic area and that interested doctors use this site on a sessional basis to prescribe methadone and see

heroin-using patients. This conflicted with other information (often and strongly expressed) that Vietnamese users would be reluctant to attend a clinic that was identified as being for alcohol and other drug users (let alone methadone patients).

One worker supported the view that the use of mainstream services provided a greater feeling of security among Vietnamese patients – there was less risk of the patient running into the counsellor, doctor, nurse or receptionist when walking down the street. It was felt that many Vietnamese people would prefer not to see a Vietnamese counsellor for drug-related problems. This feeling was reinforced by a young person who said '*I feel uncomfortable talking about drugs to an Asian person*'.

Informants believed that problems relating to the Vietnamese community's moral arguments against drug use should be dealt with by provision of community awareness-raising activities about what constitutes a drug and alcohol problem, and what appropriate solutions might be - but that such answers may take time to be accepted. Many members of the Vietnamese community were felt to have problems with the concept of harm minimisation, as it is a concept that is foreign to their cultural traditions. Acceptance of a harm minimisation philosophy implies an acceptance of the behaviour. For mainstream agencies that are built upon a philosophy of harm minimisation, this presents a barrier to working with the Vietnamese communities. While some Vietnamese workers have come to accept the principle of harm minimisation to varying degrees over time, they acknowledge the difficulty in working among a culture that believes that discipline is paramount.

One worker commented that the family could be a hindrance to treatment-seeking, once they discover that a family member is using drugs. In their anxiety to prevent others from finding out, they may not seek out appropriate services, or they may deny the existence of any problem. The reluctance to use available services can be in part due to the fact that the family feels that workers might discuss their cases with other members of the community, or that if a patient is seen entering a particular clinic by someone who knows them, it is likely that many people will quickly know.

Informants reported that a problem for Asian clients using mainstream detoxification services was isolation – the lack of other Asians among the in-patients meant that they often did not talk to anyone.

Trauma and refugee experience

A large proportion of the Vietnamese population in Australia has a refugee background. The trauma accompanying the refugee experience is well documented. The Vietnamese community, in common with a number of more recent migrant communities, arrived in Australia at a time when employment opportunities in manufacturing industries were limited. The experience of the Vietnamese refugee community has often been one of unemployment, either because of a lack of jobs or because of a lack of recognition of skills, qualifications and experience gained in Vietnam.

One of the Vietnamese workers stated that the refugees largely comprised professionals (eg doctors, teachers, engineers, high ranking military officers) who could pay their way, with smaller number of people who worked on boats, organised passage, or were otherwise connected to these people.

It was further commented by informants that there is high incidence of post-traumatic stress syndrome within the community, manifested in gambling, drinking, depression and other mental illness. None of these conditions are ones that the community has traditionally dealt with well.

Access to community

There was general consensus among the non-Vietnamese informants that the community was difficult to access, but that it was often the case that the community was able to identify certain needs that might eventually result in the establishment of advantageous relationships beyond the community.

It is tempting to view the community as homogenous. However, informants noted that the Vietnamese community, as all other communities, is comprised of many different interest groups and factions. Alliance with one of these groups may work against acceptance by other groups. Thus, for a non-Vietnamese worker, better access is likely if the worker or their organisation maintains an independent position. Young people are also subject to the effects of factions. They may not understand the factional differences that are so important to their

parents. Young people in general appeared to feel that the peak community welfare body did not address their needs. The welfare group caters very much for parents and young children (to the extent that the posters on display tend to be only of these age groups and do not reflect adolescents). This may have to do with the fact that young children can be taught about their parents' culture (and this is an important role of the community welfare body), but adolescents want to learn about Australian culture. It may be that mainstream agencies are particularly relevant for accessing adolescents.

Informants discussed the need to keep the community abreast of research projects and the need to provide the community in general with information relevant to issues that affect them – both health-related and more general concerns. Informants mentioned that appropriate avenues for keeping members of the community aware and informed would be through Asian grocery stores, Vietnamese language newspapers, and the Vietnamese language program on SBS radio.

One problem that has been highlighted is the ongoing difficulty of producing health-related material in the community's language. In particular, it is difficult to find good translators who properly translate the intention of the writer. This has implications for the use of information materials written in English on drug-related issues – potentially, some of the key concepts (such as harm minimisation) may not be conveyed to Vietnamese-language readers if materials have not been well translated.

Drug using experience

Two young key informants provided information about the initiation of drug use and drug using experience, based on their own experiences with illicit drugs. Both of these individuals were introduced to drug use by their friends, although for both of them, heroin was not the first drug experienced. However, once a dependency pattern of drug use was established, the problems of money and criminal behaviour to support drug use became evident. It was stated that young men in the community tend to deal drugs to support a habit, while young women might steal (shoplifting or housebreaking) goods to make money. Dealing is viewed by some young Vietnamese as an opportunity to make a substantial amount of money, which confers high status among their peers.

In general, reasons for initiation and continuance of drug use included: increased availability of drugs; absence of a family network; conflict between Vietnamese and Australian cultures, and perceived poor outlook for themselves. The cultural conflict that was described relates to a trend towards conflict in the family, as young people reject some of the traditional values of their culture.

Paradoxically, while family problems were sometimes considered the motivation for drug use, the family unit could also contribute to the cessation of drug use in some young people who have tried various drugs. In the case of heroin use, informants described the family's response — a young person might be sent back to family in Vietnam, or be locked in a room or secure place (eg. shed) until heroin withdrawal was complete.

The two informants described fairly indiscriminate use of a range of drugs among many young users, including use of marijuana, hallucinogens, pills, and amphetamines. Marijuana was reported as being available at school, and use of it may have started at school.

Informants supported the information gained from the survey interviewees, in that smoking of heroin was common. However, heroin injecting was widespread, and as people became more dependent, or heroin was less easy to obtain, there was a transition to injecting.

Community attitudes to heroin use

In general, there is limited recognition of drug use in general as being an ongoing health problem. Detoxification or some sort of "cure" is often seen as the preferred solution. As already pointed out, harm minimisation is not a widely understood or embraced concept in the Vietnamese community, and these is often antipathy to any form of maintenance treatment.

Historically, opium smoking has been quite widespread in Vietnam. But the way in which heroin is used by Vietnamese, both in Vietnam and in Australia, differs greatly from opium use. The community's rejection of heroin use and of family members who use drugs was stated as partly relating to the reasons that families chose to come Australia – having come to Australia seeking a better life,

parents were said to feel that young people's rejection of this better life in favour of drugs was more or less a rejection of the family. The community was reported as is also being keen to maintain a good image within Australian society. This may in turn have an impact on willingness of Vietnamese people to access mainstream services for drug problems.

3.4 Discussion

This study identified a small group of Vietnamese heroin users in Adelaide, with ages ranging from 16 to 41 years (mean age 30 years). The key informant group was able to supplement the information provided by the users survey in important areas. The small sample in the user survey cannot be said to be representative of all Vietnamese heroin users in Adelaide: the sample comprised mainly older users, while there are indications that heroin use is becoming more common among Vietnamese youth. Nonetheless, the users and key informants interviewed for this study provided many insights into the use of heroin among Vietnamese in Adelaide.

The drug use histories of the users interviewed was quite varied, with heroin and tranquillisers being the most commonly used substances. Key informants indicated that marijuana and other drug use was more common among younger heroin users. Dealing in heroin appears to be increasingly common among younger users, as a way to finance their own use, and as a marker of status - the ability to make a substantial amount of money from the sale of heroin, without getting caught by police, is a goal among this group.

The current route of heroin administration for nearly all of the users interviewed was injecting, although in only one case did heroin use begin with injecting. In general, heroin use started with smoking and quickly moved to injecting, as the injection route is reported to give a better effect for the same or lesser amount of drug used. Heroin smoking was regarded as an activity for those who were financially better off, such as dealers. This pattern of progression in routes of administration was also borne out by information given by key informants. Many of the users interviewed felt that moving to injecting meant that the user had lost control of their heroin use and their life, and that they were alienated entirely from their community.

The interviews showed that needle sharing and other risky behaviours were common among this group of Vietnamese heroin injectors, with reported sharing of needles being fairly high. While the sample was small, this finding is cause for concern, and suggests that more effort is needed in getting harm reduction messages to this group. The use of heroin when a user was alone, a risk factor for fatal overdose, was also fairly common in this group, and need addressing.

The group of users interviewed had a reasonable prevalence of blood-borne viruses. Experience of previous heroin overdose was also common. Again, the sample was small, but these findings are perhaps not surprising given the length of injecting career and the degree of risky injecting behaviours among the group. The group showed a substantial level of health problems, as measured by the health sub-scales of the Opiate Treatment Index. They also showed a high level of dependence on heroin, according to the Severity of Dependence Scale.

The user survey reinforced the view that the Vietnamese community tends to view heroin use and dependence as a moral issue rather than a health issue. Related to this is the finding that Vietnamese heroin users do not seem to regard methadone as an ideal treatment for dependence, as it is viewed as merely represents replacing one addiction for another. Users reported only limited experience and success with public and private methadone programs. There was a view held by some users that methadone treatment did not work. The lack of acceptance of methadone by some respondents suggested that methadone is viewed as an interim step, and that participation in a program equated to failure of that treatment. This in turn relates to the common view held among members of the Vietnamese community that harm minimisation in general, and maintenance therapy, imply an acceptance of drug use. The user survey and key informant interviews showed a strong preference for detoxification as the preferred option for treatment, although respondents reported little success with such programs. Among the reasons for not completing treatment programs, users indicated that they found it difficult to remain in residential or in-patient settings because they felt a strong sense of isolation, and alienation from their familiar social or family groups.

It may be that the opinions about substitution therapies in general extended to potential treatments such as tincture of opium. As indicated, none of the

respondents had heard of it, although there was some interest in trying it. More interest focused on the setting of treatment, with a majority of respondents indicating that they would like to try detoxification with the support of family or friends in a familiar setting. There was also some support for clinic-based detoxification. Given the relative lack of success that the respondents had previously had with various forms of detoxification, their willingness to try different approaches is encouraging.

Two distinct groups of users in the Vietnamese community emerged from the study of users and key informants. There is an older group that is predominantly male, most of whom have traumatic refugee histories, limited English language skills, and are unable to rely on networks apart from other users. The other group comprises younger heroin users who are using a wider range of other drugs in addition to heroin, and are fluent in English. Many of these young people are dealing with the issue of belonging to two cultures, and are and are having difficulty in meeting the expectations of both. While family ties were reportedly strong among these young users, they increasingly tend not to see themselves as members of the Vietnamese community. For many of these younger users, drug use was viewed as part of the process of breaking away from the family and community values. However, it appears to be respect for their family that may provide the incentive to break the cycle of drug use, but clearly, further assistance is needed for this group.

The interviews showed that members of the Vietnamese community, both in general and within health and welfare agencies, do not feel confident of their ability to deal with alcohol and other drug issues. This is partly due to a general lack of knowledge within the community about drugs and drug-related issues and problems. The problem is further compounded by the fact that members of this cultural group are not used to seeking outside help for problems of this type. Traditionally, the Vietnamese family unit has often dealt with issues such as mental health problems.

In important issue that emerged from interviews was that of confidentiality and anonymity. Vietnamese heroin users were acutely aware of their community's condemnation of drug use, and did not wish to bring shame upon themselves or their families. Key informants reported that there has been a tendency for

workers in the Vietnamese community to share information about a person with members of their family. Users were often reluctant to utilise health services where they might be recognised as heroin users by members of their community.

A consistent theme was the importance of the family in the Vietnamese community. This was less of a factor for the older heroin users, although there appears to be strong reliance in this group on other heroin users for dealing with day-to-day issues. The family plays a significant role in the lives of younger users. To a large extent, adolescents may adopt drug use as a reaction to the expectations of their families, and as a way to gain greater status among their peers, both Vietnamese and Australian. On the other hand, the strength of the Vietnamese family is reported as the reason for many young people moving away from drug use after a period of involvement.

4.1 Rationale and research aims

Opioid dependence is a very old problem dating back almost 4000 years, and results from the repeated use of opium or one of its active components, such as morphine or codeine, a derivative of one of these compounds (e.g. heroin), or a synthetic opioid. Dependence appears to be virtually identical whichever of these drugs is used. Withdrawal is characterised by a range of physical signs including elevated blood pressure, heart rate and body temperature, runny nose, diarrhoea as well as irritability, insomnia, joint and bone pain and a craving for the drug. Whilst not an essential component of dependence on opioids, physical dependence can play a major role in ongoing use of these drugs.

While heroin is an increasing problem in Australian society, this is also the case in many South-East Asian countries. In some of these developing countries, traditional smoking of opium continues, while heroin administered intravenously or smoked is gradually becoming the most common method of opioid use. Methadone is currently the gold standard drug for opioid substitution, since it has been shown to satisfy all the criteria for a successful substitution program (eg. rehabilitation and socialisation of the individual, reduction in mortality and morbidity and crime and retention in program). However, its high cost precludes it from widespread use in many developing countries. One response to this has been the use of tincture of opium for opioid dependence. This is an extemporaneous preparation of opium with alcohol and water as solvents, and in pharmaceutical preparations, is standardised to contain 1% morphine. It has been used in a number of sites in South-East Asia to treat opioid withdrawal arising from use of both opium and heroin. Tincture of opium appears to be a more culturally acceptable alternative to drugs such as methadone, due to it being perceived as a traditional medicine, at least in some parts of South-East Asia. In addition, its potential low cost in countries with little to spend on health care is an added advantage over methadone. However, there are no reports of its effectiveness or side effects compared to methadone.

The aim of this project was to evaluate the effectiveness of tincture of opium as a treatment for heroin and opium dependence.

4.2 Methods

Fifteen subjects were recruited in each of two treatment groups:

1. patients (14 male/1 female; 19-54 (mean 34) years; 43-88 (mean 57) kg with a history of intravenous heroin administration (0.25-20years) who were administered oral methadone (1 subject 5 mg, 5 subjects 10mg, 4 subjects 15mg, 5 subjects 20mg) every 12 hours to prevent withdrawal;
2. patients (all male; 20-51 (mean 35) years; 42-52 (mean 48kg) with a history of opium smoking (2-20 years) who were administered oral tincture of opium (4 subjects 3.33 mg morphine, 10 subjects 6.66mg morphine, 1subject 10 mg morphine) every 12 hours to prevent withdrawal.

All subjects were patients of the Northern Drug Dependence Treatment Centre, Chiang Mai, Thailand and had received a minimum of 4 days treatment at constant dose prior to the study. Subjects who were known to be HIV positive or were pregnant or breastfeeding were excluded.

Each subject was studied over a single inter-dosing interval of 12hours. The following were carried out at times 0, 1, 3 and 8 hours:

1. collection of a 10 ml blood sample
2. measurement of heart rate, blood pressure, temperature and respiration rate
3. recording of self-reported opioid effects and opioid withdrawal symptoms
4. videotaped recording of the pupil

Video tapes, blood samples and raw data were air freighted to the Department of Clinical and Experimental Pharmacology, University of Adelaide, for subsequent analysis.

Blood samples were analysed using high performance liquid chromatography (HPLC) for determination of either morphine or methadone (as R-(-)- and S-(+)-methadone).

4.3 Results

Equivalent sets of results from the two groups are presented in Figures 1 and 2.

Plasma concentrations:

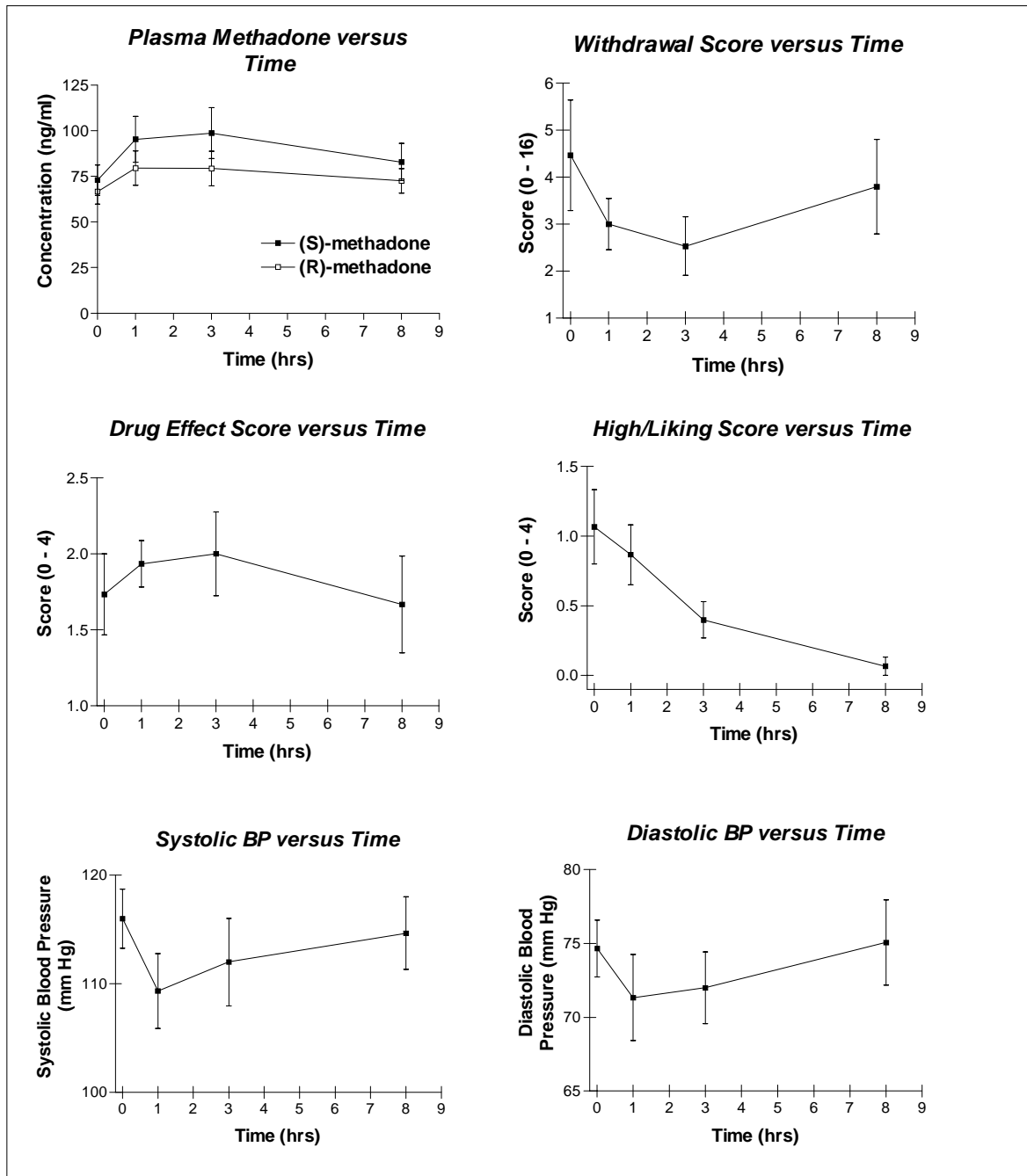
For the methadone treated subjects, we measured morphine concentrations in the zero time sample as an index of methadone effectiveness. The morphine concentrations were zero in 12 patients and less than 1ng/ml in the remaining 3 patients, indicating that they were not obtaining illicit heroin. Methadone concentrations increased from the trough level at the time of dosing and reached a peak 3 hours after administration. The mean peak concentration of the active R-methadone was 80 ng/ml (Figure 1).

For the tincture of opium treated subjects, morphine concentrations in plasma from tincture of opium treated subjects ranged from 1-20 ng/ml. The zero hour samples contained substantial amounts of morphine (average 12 [range 1-20] ng/ml), and were similar to the 1 hour sample (average 12 [range 7-19] ng/ml). After this peak, plasma morphine concentrations declined rapidly, such that at 8 hours they were on average 2.5 [range 1.1-5.6] ng/ml (Figure 2).

Self-report Measures:

For both groups, withdrawal scores and drug effect scores were inversely related (Figures 1 & 2). Withdrawal scores were maximal at the time of dosing, and minimal 3 hours later. Withdrawal scores were higher amongst the tincture of opium treated subjects, with a mean of over 9 symptoms out of a possible total of 16 at the time of dosing. Minimum withdrawal scores were over 6.5 for this group - a higher value than the mean for the methadone group at the time of dosing. Both methadone and tincture of opium treated subjects reported experiencing a drug effect, with a maximal score 3 hours after dosing. There was a temporal relationship between the time course of plasma R-methadone concentration and the time courses of withdrawal scores and drug effect, but no such relationship for morphine. Scores for other opioid effects were very low or showed no consistent pattern. Scores of high/liking were low for methadone (Figure 1) and higher for tincture of opium (Figure 2).

Figure 1 Results from subjects treated with methadone



Objective measures:

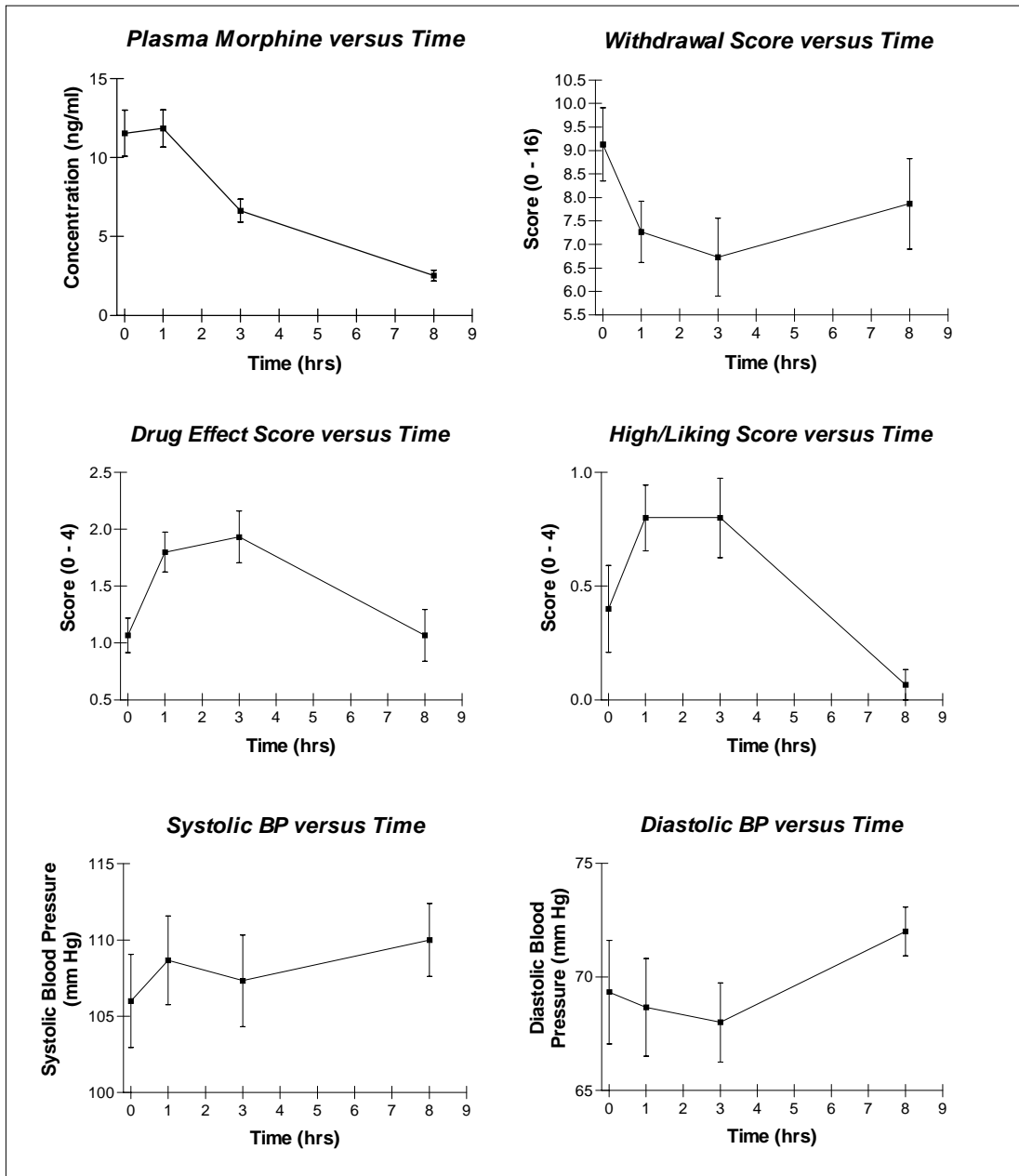
In both groups, changes occurred in systolic and diastolic blood pressure across the dosing interval. For the methadone treated subjects, there was a clear drop in blood pressure that was maximal 1 hour after drug administration (Figure 1).

For the tincture of opium treated subjects, the diastolic blood pressure changed

in a manner that would be consistent with an opium effect, but systolic blood pressure changes were less regular (Figure 2).

Pupil diameter showed little change across the inter-dosing interval, but significant difficulties with the quality of some video recordings may have masked any effects present (data not shown).

Figure 2 Results from subjects treated with tincture of opium



4.4

Discussion

The use of methadone in this population is effective in controlling withdrawal from heroin. This is evidenced by the relatively low withdrawal scores in this group. There was clear evidence of a methadone effect, with decreases in blood pressure and increases in perceived drug effect 1-3 hours after administration. In contrast, there was little change in high/liking scores, indicating that the drug was not being administered at a level that produced pronounced positive subjective effects. These changes were related to the pattern of plasma methadone concentrations that have previously been reported for a group of Caucasian methadone maintenance patients.

For opium smoking subjects treated with tincture of opium, there was less relief of withdrawal. The temporal pattern was consistent with an effect of the drug, but was not related to the pattern of plasma morphine concentration, suggesting another alkaloid in tincture of opium may be responsible. Nevertheless, across the dosing interval, the magnitude of the withdrawal scores was considerably greater than in the methadone treated subjects. Opium-treated subjects reported a drug effect, but as with methadone, high/liking scores were low throughout. This evidence, together with the low plasma concentrations of morphine, suggests that patients were under-dosed with tincture of opium. Whilst the drug had an effect with a duration of action similar to methadone, the degree of withdrawal relief could have been enhanced by use of higher doses.

In summary,

- Methadone was effective in controlling withdrawal
- Tincture of opium was less effective in controlling withdrawal
- Tincture of opium may be a useful alternative to methadone, but optimal dose size and frequency of dosing need to be investigated.

This study of Vietnamese heroin users in Adelaide has reinforced the view that the Vietnamese in Australia do view heroin and other drug use differently from mainstream Australian society, in a way more in keeping with their traditional views on health and individual responsibility. This means that the messages of harm minimisation may take some time to be embraced by the community, as perceptions gradually change. There is no doubt that the drug use problems of the Vietnamese community today are somewhat unique, having arisen in the context of a community that established itself in Australia after a traumatic history. Problems for drug users of isolation and alienation within the Vietnamese community, and within Australian society have made it more difficult for them to seek appropriate help.

The challenge will be to raise knowledge and awareness within the Vietnamese community of the specific health problems and risk behaviours in relation to heroin use that need to be addressed, and to make it easier for heroin users to seek treatment. While it may take time for community attitudes to shift, there is an urgent need to undertake targeted education activities that aim to bring about reduction of risk behaviours among Vietnamese heroin users. The acknowledged reluctance of Vietnamese heroin users to seek help from services within their own community, for fear of recognition and rejection, means that mainstream services must be sensitive to the requirements of these users when they present. As the Vietnamese community and heroin users from within that community recognise the value of a harm minimisation approach to heroin use, mainstream health and drug and alcohol services will be more attractive to them, and these services must be better able to tailor treatment programs to their needs (eg. through funding of more Vietnamese-speaking clinical staff). It may be that an appropriate approach in the short term is to establish a service specifically for Vietnamese or Indo-Chinese drug users within the mainstream service provision setting, that is separate from other health services targeted at these communities, so that concerns about confidentiality and anonymity can be addressed.

The pharmacological study of the efficacy of tincture of opium in comparison to that of methadone suggested that tincture of opium may have a useful role in the treatment of opioid dependence, but that more work needs to be done in determining optimal dose amounts and frequencies for effective management of withdrawal. Tincture of opium did bring about some relief of withdrawal symptoms in the group included in this study, although it seems that these subjects may not have been given adequate doses to achieve effective reduction of symptoms.

It is difficult to say whether tincture of opium might be viewed as a more acceptable treatment option for Vietnamese heroin users in Australia, than methadone or other agents. As highlighted in this study, users' experience of success with maintenance pharmacotherapies, methadone in particular, is limited, owing to lack of faith in the treatment, or to difficulties in staying on programs, including feelings of isolation and lack of support. There is also the barrier of the cultural attitudes towards this type of treatment, which is viewed as less successful than detoxification. It may be that the Vietnamese heroin users now in Australia are sufficiently removed from their home country and region, where tincture of opium is still used, to have no knowledge of or preference for it over other pharmacotherapies. Nevertheless, the fact that the small group studied had tried various therapies and were open to consideration of alternatives suggests that a treatment program could be trialed with tincture of opium among Vietnamese heroin users, if it was done so with associated activities aimed at providing education and support that helped the users to stay on the program. This might have to occur after more in-depth studies of appropriate dosage levels and frequencies had been completed.

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