



Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples

National Indigenous Drug and Alcohol Committee
The leading voice in Indigenous drug and alcohol policy advice

JUNE 2014

© Australian National Council on Drugs 2014

This work is copyright. Apart from any use as permitted under the *Copyright Act 1968*, no part may be reproduced by any process without the written permission of the publisher.

Published by the Australian National Council on Drugs

National Indigenous Drug and Alcohol Committee

PO Box 205, Civic Square ACT 2608

Telephone: 02 6166 9600

Fax: 02 6162 2611

Email: nidac@ancd.org.au

Website: www.nidac.org.au

Editor: Julie Stokes

The National Indigenous Drug and Alcohol Committee (NIDAC), a committee of the Australian National Council on Drugs (ANCD), provides advice to government on Indigenous alcohol and other drug issues.

The ANCD and NIDAC are supported by funding from the Australian Government Department of Health.

Acknowledgements

The National Indigenous Drug and Alcohol Committee would like to acknowledge and thank Professor Margaret Hamilton for her assistance in facilitating a workshop for NIDAC members which formed the basis of the information included in this paper.

Contents

Introduction	1
Background	1
Extent of alcohol and other drug use among Aboriginal and Torres Strait Islander peoples	1
Alcohol and other drug-related harms among Aboriginal and Torres Strait Islander peoples	3
Reasons for alcohol and other drug use among Aboriginal and Torres Strait Islander peoples	5
Addressing harmful alcohol and other drug use among Aboriginal and Torres Strait Islander peoples	5
Health and social and emotional wellbeing	5
Level of dependence	6
Policy context	6
National Drug Strategy	6
National Aboriginal and Torres Strait Islander alcohol and other drug framework	7
Closing the Gap	7
Other frameworks	7
Treatment	7
Who is being treated	8
Settings	8
Effective alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples	9
What we know works	9
Key principles to effective alcohol and other drug treatment	11
Evidence-based and evidence-informed	11
Cultural competency, safety and security	11
Family and community involvement	12
Aboriginal and Torres Strait Islander ownership of solutions	13
Integrated services and partnerships	13
What alcohol and other drug treatment should include	14
Evidence-based mainstream interventions	14
Culturally specific interventions	17
What constitutes success and what should be the goal of treatment	20
Further enablers to successful treatment outcomes	20
Workforce	20
Alcohol and other drug specialist treatment services	21
Non-specialist alcohol and other drug services in treatment	21
Data collection, monitoring and evaluation	22
Conclusion	22
References	23

Introduction

Alcohol and other drugs (AOD) treatment is one component of a multifaceted approach to reducing the impact of AOD-related harm to Aboriginal and Torres Strait Islander peoples and their communities.

According to the United Nations Office on Drugs and Crime, AOD treatment is 'considered to be any structured intervention aimed specifically at addressing a person's drug use' (United Nations Office on Drugs and Crime, 2006). Within the harm minimisation framework of Australia's National Drug Strategy, AOD treatment falls under the demand reduction pillar. It includes interventions that range from early intervention for people who are using alcohol and other drugs harmfully but who are not dependent, through to intensive treatments for those who have severe dependence problems.

This paper was developed by the National Indigenous Drug and Alcohol Committee (NIDAC) in response to a misperception that effective AOD treatment is not available for Aboriginal and Torres Strait Islander peoples. The paper aims to allay these misperceptions by outlining who can benefit from receiving treatment; what treatment is known to work; key principles that should guide the application of treatment; and what constitutes effective treatment for Aboriginal and Torres Strait Islander people.

The focus of this paper is upon interventions that are evidence-based and directly related to addressing AOD use. It does not cover interventions that have a prevention focus.

As well as considering available evidence on the topic, this paper draws from the wealth of expertise and knowledge that exists among NIDAC members, who are mostly Aboriginal and Torres Strait Islander people who work within the Aboriginal and Torres Strait Islander AOD and health sectors, research and other relevant areas.

The key target audience for this paper include: workers and organisations directly involved in working with Aboriginal and Torres Strait Islander people who experience problems related to their own or another's AOD use; policy workers; and government.

Background

Extent of alcohol and other drug use among Aboriginal and Torres Strait Islander peoples

AOD use is believed to be higher among Aboriginal and Torres Strait Islander peoples than among non-Indigenous Australians for many drugs, though it should be noted that available data sources are subject to a range of limitations and should be used with caution. An accurate account of prevalence levels is not possible with current datasets.

The 2010 National Drug Strategy Household Survey (NDSHS) found that, among those who drink alcohol, Aboriginal and Torres Strait Islander respondents to the survey were 1.5 times as likely as non-Indigenous people to drink at risky levels (Australian Institute of Health and Welfare, 2011). Thirty-one per cent of Aboriginal and Torres Strait Islander respondents drank at levels which put them at risk of lifetime harm, and 25 per cent drank at levels placing them at risk of acute harm at least once a week. In contrast, the figures for non-Indigenous people were 20 per cent and 16 per cent respectively. It should be noted that the sample included only a small number of Aboriginal and Torres Strait Islander people, and therefore caution must be used when generalising from these results.

Aboriginal and Torres Strait Islander people have been reported to be 1.4 times more likely than non-Indigenous Australians to currently abstain from drinking alcohol (Australian Institute of Health and Welfare, 2011). However, these figures hide the fact that the number of lifetime abstainers in both populations is similar but the Aboriginal and Torres Strait figures include a larger number of people who were previously drinkers but who have become abstinent because of ongoing alcohol-related health problems, who have successfully undergone treatment for alcohol dependence, or who have ceased drinking of their own accord (Brady, 1993; Commonwealth Department of Human Services and Health, 1996).

The 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) reported a lower rate, 18 per cent, of Aboriginal and Torres Strait Islander people who drank at levels that put them at risk of lifetime harm; and a rate of 54 per cent who drank at levels that put them at risk of single-occasion harm at least once in the previous year. These rates were similar to or slightly higher than those for non-Indigenous Australians, with differences by age group (Australian Bureau of Statistics, 2013). These figures too should be treated cautiously; information on alcohol-related harms (see the following section) indicates the likelihood of under-estimating actual consumption (National Drug Research Institute, 2014). The AATSIHS continues previous National Aboriginal and Torres Strait Islander Health Surveys (NATSIHS), the methodology of which was subject to criticism. It appears that some of the methodological problems identified have not been addressed (see explanatory notes in Australian Bureau of Statistics, 2013).

The proportion of Aboriginal and Torres Strait Islander people who smoke on a daily basis is more than twice that of non-Indigenous Australians. The AATSIHS reported a rate of 41 per cent of respondents aged 15 years and over (Australian Bureau of Statistics, 2013).

Twenty-two per cent of Aboriginal and Torres Strait Islander respondents to the AATSIHS had used an illicit substance in the previous year (Australian Bureau of Statistics, 2013). The NDSHS reported 25 per cent, in contrast to 14 per cent of non-Indigenous respondents (Australian Institute of Health and Welfare, 2011). While their figures are likely to be under-estimates, these surveys reported past-year use among Aboriginal and Torres Strait Islander respondents as follows:

- 19 per cent had used cannabis (NDSHS)
- 5.6 per cent had used analgesics/sedatives for non-medical purposes (National Aboriginal and Torres Strait Islander Social Survey (NATSISS))
- 4.3 per cent had used amphetamines or speed (NATSISS)
- 3 per cent had used ecstasy (NDSHS)
- 4 per cent had used meth/amphetamines (NDSHS)
- 1 per cent had used cocaine (NDSHS)
- 1.2 per cent had used kava (NATSISS) (Australian Bureau of Statistics, 2009; 2013; Australian Institute of Health and Welfare, 2011).

There is little data available on the prevalence of volatile substance use, though it is thought to affect Aboriginal and Torres Strait Islander people far more significantly than use by non-Indigenous people.

We also lack data on the misuse of pharmaceutical opioids among Aboriginal and Torres Strait Islander people. There is evidence that such misuse has increased over the last five to ten years among the general population, and anecdotal reports suggest this may be having a significant impact on some Aboriginal and Torres Strait Islander people (Nicholas, Lee & Roche, 2011). NIDAC is also aware of recent reports of increased use of amphetamine-type stimulants in some areas among Aboriginal and Torres

Strait Islander people (National Indigenous Drug and Alcohol Committee, forthcoming 2014). And while there is little data available on polydrug use, the 2004–05 National Aboriginal and Torres Strait Islander Health Survey found that 12 per cent of males and 7 per cent of females reported having used two or more (illicit) drugs in the last year (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2008). Those respondents who had used illicit drugs were also about twice as likely to smoke, and to drink at risky levels (Gray, Stearne, Wilson & Doyle, 2010).

Alcohol and other drug-related harms among Aboriginal and Torres Strait Islander peoples

AOD-related harms among Aboriginal and Torres Strait Islander people are correspondingly high and can affect physical, social and emotional wellbeing, and subsequently weaken connection to family and community.

Tobacco smoking has been estimated to account for 12.1 per cent of the total burden of disease among Aboriginal and Torres Strait Islander people, and for one-fifth of Aboriginal and Torres Strait Islander deaths. It is the largest contributing risk factor to deaths among Aboriginal and Torres Strait Islander men (Vos, Barker, Stanley & Lopez, 2007). In 2008–09, hospital admissions with a principal diagnosis related to tobacco use occurred at a rate of 3.3 per 1000 among Aboriginal and Torres Strait Islander people, in contrast to 0.8 per 1000 for non-Indigenous people (Steering Committee for the Review of Government Service Provision, 2011).

Alcohol accounts for 5.4 per cent of the burden of disease among Aboriginal and Torres Strait Islander people. The rate of deaths due to alcohol dependence and harmful use among Aboriginal and Torres Strait Islander people was estimated to be eight times higher for men, and 19 times higher for women, than among the non-Indigenous population (Vos et al., 2007). In 2008–09, Aboriginal and Torres Strait Islander people were hospitalised for alcohol-related conditions at 7.5 times the rate of non-Indigenous people (Steering Committee for the Review of Government Service Provision, 2011).¹

Illicit drugs account for 3.4 per cent of the burden of disease and injury among Aboriginal and Torres Strait Islander people. High contributors to the burden arising from illicit drugs are heroin use, polydrug use, hepatitis, cannabis dependence and suicide (Vos et al., 2007). In 2007–08, the rate at which Aboriginal and Torres Strait Islander people were hospitalised for cannabis-related mental and behavioural disorders was almost five times that for non-Indigenous people. For mental and behavioural conditions related to use of volatile solvents, the rate was more than 39 times that of non-Indigenous Australians (Australian Institute of Health and Welfare, 2011).

AOD use thus accounts for a significant proportion of the total burden of disease and injury among Aboriginal and Torres Strait Islander Australians, and contributes significantly to the ongoing health gap between Indigenous and non-Indigenous Australians (Vos et al., 2007).

The range of harms from AOD use can include mental health problems, violence, incarceration, blood-borne virus spread, and family breakdown. In 2008–09, Aboriginal and Torres Strait Islander people were hospitalised for mental and behavioural disorders caused by drug use at three times the rate for non-Indigenous people (Steering Committee for the Review of Government Service Provision, 2011). In

¹ For states for which data are available, namely New South Wales, Victoria, Queensland, Western Australia, South Australia and public hospitals in the Northern Territory.

2012–13, 30 per cent of Aboriginal and Torres Strait Islander people aged 18 years and over reported having high/very high psychological distress levels in the four weeks before interview, a rate 2.7 times that of non-Indigenous people (Australian Bureau of Statistics, 2013).

Alcohol in particular is a major contributor to unsafe communities (Morgan & McAtamney, 2009). Secondary analysis of the 2004 NDSHS found that 18 per cent of Aboriginal and Torres Strait Islander respondents stated they had perpetrated verbal abuse, and 5 per cent had perpetrated physical abuse, under the influence of alcohol (Wundersitz, 2010). Partner homicides involving an Indigenous perpetrator and victim are 13 times more likely to involve alcohol than other partner homicides (Morgan & McAtamney, 2009). Violence has been recognised to have a devastating impact on Aboriginal and Torres Strait Islander communities and families (Wundersitz, 2010).

While it is not known how prevalent intravenous drug use is among Aboriginal and Torres Strait Islander people (see Kratzmann et al., 2011), the proportion of respondents to yearly surveys undertaken at Australian needle and syringe programs who are Aboriginal or Torres Strait Islander has been consistent at 11–12 per cent since 2008. New notifications of HIV infection among Aboriginal and Torres Strait Islander people have been occurring at a similar rate to the non-Indigenous population (5.5 per 100 000 for Indigenous compared to 5.1 per 100 000 for non-Indigenous Australians in 2012). However, of concern, there have recently been increases in the proportion of new notifications among Aboriginal and Torres Strait Islander people who inject drugs (13 per cent of new notifications over the last five years, in contrast to 2 per cent among the non-Indigenous population). In 2012, hepatitis B infection among Aboriginal and Torres Strait Islander people occurred at three times the rate of other Australians, and hepatitis C at just over four times the rate (Kirby Institute, 2014).

AOD use is known to be a risk factor for contact with the criminal justice system and incarceration, and contributes to the over-representation of Aboriginal and Torres Strait Islander people in justice and correctional systems. In 2010, 74 per cent of Aboriginal and Torres Strait Islander police detainees tested positive to drugs, and over 60 per cent had consumed alcohol prior to their arrest. Approximately half of Aboriginal and Torres Strait Islander prisoners linked their offending to drug and alcohol use (for more detail, see National Indigenous Drug and Alcohol Committee, 2012). In a survey in New South Wales, Aboriginal and Torres Strait Islander prisoners were significantly more likely than non-Indigenous prisoners to be dependent on alcohol (Indig, McEntyre, Page & Ross, 2010).

Arrest or incarceration may lead to further harms, ranging from obtaining a criminal record (in turn, impacting on work and study opportunities) to mortality. In the immediate post-release period Aboriginal and Torres Strait Islander male prisoners were 4.8 times more likely to die, and Aboriginal and Torres Strait Islander female prisoners were 12.6 times more likely to die, than the general population (Rodas, Bode & Dolan, 2011). Overdose is known to be a leading cause of death among recently released prisoners (Kinner et al., 2011).

Parental AOD use is thought to be a factor in a high proportion of child protection notifications in Australia, with studies reporting rates of between 30 per cent (for alcohol use) and 80 per cent (Laslett et al., 2010; Battams & Roche, 2011).² Although numbers of child removals related to AOD use among Aboriginal and Torres Strait Islander women are not reported, we do know that Aboriginal and Torres Strait Islander children are over-represented in the child protection system, being over 10 times as likely as non-Indigenous children to be in out-of-home care (Australian Institute of Health and Welfare, 2013).

Available studies indicate that AOD use may play either a similar or a greater role in child removals from Aboriginal and Torres Strait Islander women than from non-Indigenous women. A study of women in

² It should be noted that parental AOD use does not necessarily impact upon parenting, and that in most cases other issues are present, such as poverty, domestic violence, mental health issues, or housing instability.

opioid treatment in New South Wales found that over one-third of the women currently had a child in out-of-home care or had had an investigation or service in the previous six months. Another quarter of the women had experienced such involvement previously. AOD use was the reason for 44 per cent of the child protection reports for this group. These variables did not differ significantly by Indigenous status for the women in this study (Taplin & Mattick, 2011). A study of children born in Western Australia between 1990 and 2005 reported that, in 47 per cent of substantiated child maltreatment cases among Aboriginal or Torres Strait Islander children, mothers had a previous AOD-related hospital admission. The figure for non-Indigenous cases in this study was 27 per cent (O'Donnell et al., 2010).

Reasons for alcohol and other drug use among Aboriginal and Torres Strait Islander peoples

Similarly to non-Indigenous people, Aboriginal and Torres Strait Islander people use alcohol and other drugs for a range of reasons. These may include: to be sociable and part of the group or community; to experiment; because of peer pressure; to feel good and have fun; or to escape or cope with boredom, stress or difficult social and economic situations or intensified feelings and behaviours (Atkinson, 2002; Wilkinson & Marmot, 2003).

Brady (1995b) writes that: 'Harmful AOD use is said by many Aboriginal and Torres Strait Islander peoples to have arisen from or been exacerbated by the deprivation and erosion of their cultural integrity as a result of colonisation and dispossession.' Disconnection from cultural values and traditions has led to a painful and meaningless existence for many Aboriginal and Torres Strait Islander people with many being impoverished, discriminated against, in a state of poor health, and with inequitable access to services including education, health and employment. Harmful AOD use has been one consequence of the trauma caused by this (Saggers & Gray, 1998).

Addressing harmful alcohol and other drug use among Aboriginal and Torres Strait Islander peoples

Health and social and emotional wellbeing

Interventions to address harmful AOD use among Aboriginal and Torres Strait Islander people need to be provided in the context of Aboriginal and Torres Strait Islander understandings of health and social and emotional wellbeing.

Aboriginal health means:

not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community. It is a whole-of-life view and includes the cyclical concept of life–death–life...

Health care services should strive to achieve the state where every individual is able to achieve their full potential as a human being and thus bring about the total wellbeing of their community (National Health Strategy Working Party, 1996).

Social and emotional wellbeing is a holistic concept which recognises the importance of connection to land, culture, spirituality, ancestry, family and community. Culture and cultural identity are critical to social and emotional wellbeing. The use of cultural practices, as well as individual and community control over their physical environment, dignity and self-esteem, and respect for Aboriginal and Torres Strait Islander people's rights are also important to social and emotional wellbeing.

Social and emotional wellbeing can be affected by various social determinants of health. These include homelessness, lack of or poor education, unemployment, harmful AOD use, and a broader range of problems resulting from grief and loss, trauma and abuse, violence, removal from family and cultural dislocation, racism and discrimination, and social disadvantage (Australian Government Department of Health and Ageing, 2013).

Good health and a positive sense of social and emotional wellbeing are essential for Aboriginal and Torres Strait Islander people to lead successful and fulfilling lives. Aboriginal and Torres Strait Islander people with poor social and emotional wellbeing are less likely to participate in education and employment, are less likely to access health services, and consume higher amounts of alcohol and other drugs (Australian Government Department of Health and Ageing, 2013).

Level of dependence

In a consideration of harmful AOD use, it is important to know the level of dependence of each person seeking assistance.

AOD dependence exists on a continuum from mild to severe and is generally perceived as a chronic relapsing condition characterised by periods of uncontrolled use, treatment, abstinence or controlled use and relapse. The Tenth Revision of the International Classification of Diseases and Health Problems (ICD–10) defines dependence as:

Being a cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take the psychoactive drugs (which may or not have been medically prescribed), alcohol, or tobacco. (World Health Organization, 2014)

It is important to note that not everyone who uses substances, including those who use them in a harmful way, become dependent. Many people seeking treatment are, in fact, not dependent. One estimation highlighted by King, Ritter and Hamilton (2013), focusing on alcohol, suggests that up to 50 per cent of problems are experienced by people who do not meet the ICD–10 criteria for dependence.

Policy context

A number of policy frameworks exist within Australia to guide how harmful AOD use is best addressed.

National Drug Strategy

In Australia the National Drug Strategy (NDS) provides a framework to minimise the harms to individuals, families and communities from both licit and illicit drugs. It is a cooperative venture between state and territory governments and the non-government sector and is aimed at improving outcomes for Australians by preventing the uptake of harmful AOD use and reducing the harmful effects of these substances.

The principle of harm minimisation has formed the basis of the NDS since 1985. This involves a comprehensive and balanced approach between the reduction of demand, supply and harm (known as the three pillars) associated with AOD use across sectors and jurisdictions.

Demand reduction aims to prevent the uptake and/or delay the onset of alcohol and other drugs; reduce the misuse of alcohol and the use of alcohol and other drugs in the community; and support people to recover from dependence and re-integrate with the community. Supply reduction aims to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control,

manage and/or regulate the availability of legal drugs. Harm reduction aims to reduce the adverse health, social and economic consequences of the use of alcohol and other drugs (Ministerial Council on Drug Strategy, 2011).

National Aboriginal and Torres Strait Islander alcohol and other drug framework

The Aboriginal and Torres Strait Islander Peoples Complementary Action Plan (the CAP) was developed in 2003. Like the NDS, the CAP is based on the principle of harm minimisation and was developed in recognition of the special needs and challenges in addressing harmful AOD use among Aboriginal and Torres Strait Islander people (Ministerial Council on Drug Strategy, 2006).

A National Aboriginal and Torres Strait Islander Peoples Drug Strategy, a sub-strategy of the National Drug Strategy, is currently being developed to replace the CAP.

Closing the Gap

The Indigenous Health Reform Agenda, *Closing the Gap*, is a commitment by all Australian governments to improve the lives of Aboriginal and Torres Strait Islander people, and in particular provide a better future for Aboriginal and Torres Strait Islander children.

Closing the Gap aims to reduce disadvantage among Aboriginal and Torres Strait Islander peoples with respect to life expectancy, child mortality, access to early childhood education, education achievement and employment outcomes. It has set measurable targets to monitor improvements in the health and wellbeing of Aboriginal and Torres Strait Islander peoples (Australian Government Department of Social Services, 2014).

Other frameworks

There are a range of other policy frameworks that influence and align with the NDS and the Aboriginal and Torres Strait Islander framework including the Petrol Sniffing Strategy, the National Aboriginal and Torres Strait Islander Health Plan and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

Treatment

Addressing harmful AOD use is important in restoring the health and social and emotional wellbeing of Aboriginal and Torres Strait Islander people, families and communities.

According to the United Nations Office on Drugs and Crime, AOD treatment is 'considered to be any structured intervention aimed specifically at addressing a person's drug use' (United Nations Office on Drugs and Crime, 2006). Within Australia, AOD treatment falls within the harm minimisation pillar of demand reduction of the NDS and includes interventions that range from early intervention for people who are using alcohol and other drugs harmfully but who are not dependent, through to intensive treatments for those who have severe dependence problems. In relation to dependence, it is important that treatment interventions take into account that it is a chronic relapsing condition with varying levels of severity.

To understand the role of treatment, it is important to acknowledge that people seek treatment for different reasons and at different times in their lives, while others do not willingly seek treatment at all. Aboriginal and Torres Strait Islander people seeking treatment may be heavily influenced by cultural beliefs and attitudes concerning AOD use (Brady, 1995b; Terrell, 1993; Chenhall & Senior, 2013). For many Aboriginal and Torres Strait Islander people there is shame associated with seeking treatment, as

well as concern about getting into trouble with the law. For many women, a concern over losing their children may also be a barrier to seeking help. Finding ways to address these barriers may make access to treatment more viable.

Who is being treated

Aboriginal and Torres Strait Islander people accessing AOD specific treatment are typically either:

- persistently intoxicated, but not dependent, and seeking change — the person has periodic episodes of being intoxicated which get them into trouble, e.g. needing to access hospital emergency departments; problems with family; problems with employment; committing violence towards others or self; committing crime (see Gray & Wilkes, 2010)
- dependent on alcohol and other drugs and seeking change — the person has episodic periods involving a high intake of alcohol and/or other drugs over a long period of time with impaired control over their use, and problems with being able to cut down or stop despite experiencing ongoing physical, psychological or social harms
- family, carers or community members seeking assistance for the person or themselves — this may involve providing a service directly to families, carers and/or communities who are seeking assistance to deal with a person's AOD use, or
- to a lesser extent, severely dependent on alcohol and/or drugs and mandated to receive specialist AOD treatment.

As well as issues relating to AOD use, people presenting at AOD specialist treatment services typically have complex, multiple needs. These can include physical health issues; high prevalence of mental health issues, including grief and trauma; cognitive impairment; legal issues; relationship or family issues, including child protection issues; housing issues; and unemployment. The extent of polydrug use also adds to the complexity of issues people face.

People experiencing less severe problems associated with AOD use may also seek assistance, or benefit from interventions such as brief interventions to address their AOD use. In such instances people are best placed to access these interventions from non-AOD specialist services such as primary health care services, e.g. Aboriginal Medical Services, general practitioners, clinics and hospitals.

Settings

Similarly to mainstream services, AOD treatment interventions for Aboriginal and Torres Strait Islander peoples generally occur in specialist AOD treatment organisations. Some specialist interventions may also be delivered in primary health care settings, such as Aboriginal Medical Services or other settings, as are initial screening and early interventions.

Specialist AOD treatment services may be provided by Aboriginal and Torres Strait Islander-run services or mainstream organisations. A report by Gray et al. (2010) indicates that in 2006–07 there were 340 Aboriginal and Torres Strait Islander-specific AOD intervention projects being conducted nationally within 224 organisations, of which 159 were conducted by Aboriginal community-controlled organisations.

These services are provided in urban, regional and remote locations and in places such as stand-alone AOD organisations, prisons, hospitals and mental health facilities.

Effective alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples

What we know works

The number of well-conducted evaluations of AOD treatment interventions among Aboriginal and Torres Strait Islander peoples is limited. There is however literature, both with other Indigenous groups overseas and within the area of mainstream AOD treatment, that provides guidance on what could work to reduce AOD-related harm among Aboriginal and Torres Strait Islander peoples (Gray & Wilkes, 2010). Connection to culture through meaning, family, spirituality and identity has been shown to be effective in treatment of harmful AOD use with Indigenous groups (McCormick, 2000). Mainstream evidence-based treatment consists of a broad range of interventions including: brief interventions; withdrawal management; cognitive behavioural therapy; relapse prevention; therapeutic communities; maintenance pharmacotherapy; outreach; and aftercare. More detailed information on these interventions can be found below in the section on 'What alcohol and other drug treatment should include'.

Interventions that have been found to be effective within Australia among the mainstream population have been less effective with Aboriginal and Torres Strait Islander people. However, such interventions may not be delivered in ways that are appropriate to Aboriginal and Torres Strait Islander people. Differences in values between Aboriginal and Torres Strait Islander people and mainstream health service providers are thought to be a barrier, as are issues with trust and intimacy. Considerable time may be required before a person is able to overcome these barriers and to open up and talk about their situation.³ This is consistent with the international literature (Terrell, 1993).

As such, there is a need to look beyond solely using mainstream interventions. Two alternatives are: developing cultural adaptations of evidence-based mainstream interventions for Aboriginal and Torres Strait Islander peoples; and interventions that are run and/or controlled by Aboriginal and Torres Strait Islanders.

Adaptations of evidence-based mainstream interventions that integrate culturally specific practices, including traditional values, spirituality and activities have been shown to be more effective than mainstream services. These elements increase the credibility and relevance to Aboriginal and Torres Strait Islander people (Terrell, 1993; Anderson, 1992; McCormick, 2000; Brady, 1995b; Gray et al., 2014).

Some may be concerned that when adapting mainstream interventions to take cultural considerations into account, the integrity of a particular intervention is compromised in ways that could threaten its effectiveness. However, the evidence (including evidence relating to culturally adapted mental health interventions) indicates that adaptations of evidence-based mainstream interventions can be a way to provide effective treatment for specific cultural groups (Smith, Rodriguez & Bernal, 2011).

The literature indicates a number of elements that are important in developing cultural adaptations of interventions. These include:

- Workers and services need to be flexible, open and culturally sensitive to the needs of people seeking treatment. For example, Aboriginal and Torres Strait Islander people often find it difficult disclosing information in group settings, so provision of one-to-one counselling options

³ While many Aboriginal and Torres Strait Islander people may choose not to access mainstream services, it should be noted that some prefer this option, as it provides them with greater privacy. They may also prefer to be seen by non-Indigenous staff for the same reasons (Sibthorpe, 1988).

may be more effective. Likewise, aftercare is often best provided face to face with the person rather than over the phone. People should be offered the most effective approach for their circumstances.

- Interventions need to be delivered in culturally meaningful ways.
- Traditional healing practices should be utilised.
- Respect for cultural differences is important (Draguns in Smith et al., 2011).

The culturally specific practices that have been found to work in Australia when integrated with mainstream interventions include the involvement of family, use of cultural traditions that are relevant to the person receiving treatment (e.g. returning to country), and the value of storytelling to share information (Nagel et al., 2009).

Aboriginal and Torres Strait Islander community-run and -controlled services have emerged in Australia in response to mainstream services not meeting the needs of Aboriginal people. These services are based on the cultural perspectives and needs of Aboriginal and Torres Strait Islander people and their communities. Over time, evidence has shown that: they provide better access to care; they make the health care provided more appropriate; they provide a more holistic approach to better serve people with complex needs; and they improve health outcomes (Councillor, 2003; Gray et al., 2010; Lavoie et al., 2010; Rowley et al., 2000; Larkins, Geia & Panaretto, 2006; Thomas, Heller & Hunt, 1998).

Whether treatment is provided by an Aboriginal community-controlled service or a mainstream service, the evidence also provides general guidance about the requirements for any intervention to be effective for Aboriginal and Torres Strait Islander people:

- Treatment interventions should be based on the outcomes of a comprehensive AOD assessment.
- Similarly to non-Indigenous people, Aboriginal and Torres Strait Islander people require a range of treatment options and settings to select from, as no one approach fits all. Matching the person and their goals to the most appropriate treatment is essential to its effectiveness (Ritter & Lintzeris, 2004).
- Accessibility of treatment options will determine outcomes (Ritter & Lintzeris, 2004).
- The therapeutic relationship between the person and the professional with whom they interact is critical to good treatment outcomes (Najavits & Weiss, 1994).
- On their own, withdrawal, education and persuasive programs have limited impact. To be more effective, they need to be utilised in conjunction with other AOD treatment interventions (Gray & Wilkes, 2010).
- The level of dependence will determine the type of treatment best suited to the person. Lack of or low levels of dependence and problems are best suited to brief interventions, whereas more moderate to severe levels may require withdrawal, additional treatment options in either residential or non-residential setting, and aftercare (United Nations International Drug Control Programme, 2002).
- AOD dependence is a chronic relapsing condition and, while treatment is effective, it is not realistic to expect that one episode of treatment will result in long-term abstinence or controlled use. For this reason, aftercare is essential and has been shown to reduce the frequency of relapse (McLellan, 2002; McLellan et al., 1996).
- AOD treatment has been shown to be potentially effective even when other issues such as employment have not yet been addressed, although these issues should not be ignored.

- Motivation to undertake treatment can be an important factor in whether that treatment will work. Programs that divert people from prison into treatment are a positive option, and can reduce recidivism. However, some programs can be coercive, as people may regard any option as better than prison. Treatment should not be forced upon people, given evidence demonstrating its effectiveness is limited and inconclusive (Broadstock, Brinson & Weston, 2008) and a contravention of people’s civil rights (Pritchard, Mugavin & Swan, 2007).
- Duration of treatment should vary according to the needs of the person and the intervention being offered. Adequate time needs to be allocated to enable a person to gain the benefits they need from treatment.

Specific elements of treatment that should be provided are discussed further below.

Key principles to effective alcohol and other drug treatment

The following principles provide the underpinnings for effective AOD treatment for Aboriginal and Torres Strait Islander peoples.

Evidence-based and evidence-informed

Under the *National Drug Strategy 2010–15* there is a continued commitment to evidence-based and evidence-informed treatment as the underlying basis for successful outcomes.

Evidence-based treatment refers to interventions that have been proven to be effective. For example, the continuing provision of detoxification, pharmacological therapies including opioid substitution therapies and cognitive behavioural therapies for AOD treatment is based on an extensive body of evidence in Australia and internationally.

Evidence-informed treatment involves integrating existing evidence with professional expertise to develop optimal interventions, including new innovative approaches in a given situation. This allows room for clinical experience as well as the constructive and imaginative judgements of practitioners and clients, who are in constant interaction and dialogue with one another, to be considered (Ministerial Council on Drug Strategy, 2011).

Cultural competency, safety and security

For workers and services, cultural competency can be understood to involve working within a framework that recognises and respects the central importance of culture and identity to Aboriginal and Torres Strait Islander people and communities, working in ways that safeguard the importance of culture, and supports Aboriginal and Torres Strait Islander people’s capacity to strengthen the place of culture and identity in promoting social and emotional wellbeing. Mutual understanding, respect, collaboration and partnership between non-Indigenous community services and Aboriginal and Torres Strait Islander organisations and communities are the keys to a non-Indigenous organisation’s capacity to develop its Aboriginal and Torres Strait Islander cultural competence (Secretariat of National Aboriginal and Islander Child Care Inc., 2010).

Cultural safety refers to an environment that is free from assault, challenge or denial of a person’s identity of who they are and what they need. Shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening are key components (Williams, 1999). Access to culturally safe treatment interventions greatly influences Aboriginal and Torres Strait Islander people’s decision to seek assistance (National Congress of Australia’s First Peoples, 2013).

On cultural security, the Australian Human Rights Commission notes:

Cultural security is subtly different from cultural safety and imposes a stronger obligation on those that work with Aboriginal and Torres Strait Islander peoples to move beyond 'cultural awareness' to actively ensuring that cultural needs are met for individuals. This means cultural needs are included in policies and practices so that all Aboriginal and Torres Strait Islanders have access to this level of service, not just in pockets where there are particularly culturally competent workers... Cultural security is built from the acknowledgement that theoretical 'awareness' of culturally appropriate service provision is not enough. It shifts the emphasis from attitudes to behaviour, focusing directly on practice, skills and efficacy. It is about incorporating cultural values into the design, delivery and evaluation of services. (Australian Human Rights Commission, 2011)

The Western Australian Network of Alcohol and other Drug Agencies' *Standard on Culturally Secure Practice (Alcohol and other Drug Sector)* (2012) provides a number of practice criteria to guide AOD services in ensuring their organisations provide culturally secure practices.

Family and community involvement

In general, family and community relationships play an important role in the lives of Aboriginal and Torres Strait Islander people. Accordingly, when working with Aboriginal and Torres Strait Islander people, involvement of family and community members can be pivotal in achieving best outcomes for an individual (Nagel et al., 2009). Families and communities may also need assistance in their own right in responding to those with an AOD problem (Lee et al., 2012).

Family and community involvement should be discussed at the time of assessment and, depending on the wishes of the person being assessed and the needs of the family and community, incorporated into further treatment planning.

Consideration of carers should also be given where they are involved.

An example of a family-focused Aboriginal and Torres Strait Islander community-run AOD program is CAAPS, the Council for Aboriginal Alcohol Program Services (see Example 1).

Example 1: Family-based program, CAAPS

CAAPS

The Council for Aboriginal Alcohol Program Services (CAAPS) is an Aboriginal community-controlled organisation based in Darwin in the Northern Territory. It is the largest not-for-profit centre in Northern Australia and provides community-based AOD treatment services that support Aboriginal and Torres Strait Islander families from across the Top End who are experiencing alcohol and other drug issues.

Aboriginal and Torres Strait Islander ownership of solutions

Aboriginal and Torres Strait Islander ownership of solutions was overwhelmingly identified as being an important principle in the consultations held by NIDAC to inform the development of the National Aboriginal and Torres Strait Islander People's Drug Strategy. Aboriginal and Torres Strait Islander people have a right to self-determination and to determine their own pathways out of poverty. An added dimension was the importance of this ownership being community-focused and -led (commonly referred to as community-controlled) rather than just being left to individuals. Indigenous ownership of solutions was identified as needing to occur from inception and planning, through to implementation and provision, and then monitoring and evaluation of any solutions. This understanding is consistent with international research (see Marmot, 2011) and the United Nations Declaration on the Rights of Indigenous Peoples (United Nations, 2007).

Integrated services and partnerships

Given the complex, multiple needs of people with AOD issues, it is important for specialist AOD treatment services and other services to be well integrated to ensure that people receive all of the services and support they need in a timely fashion and in a way that is easy to access. No one organisation is generally able to provide all of the required services. People accessing specialist AOD treatment services may come via many different pathways. They generally have had a lot of contact with other services, particularly primary health care services, which are extremely important as they play a key role in the prevention, screening, treatment and management of a range of health and social issues and help prevent the need for more complex and expensive specialist services.

Partnerships between these services are essential in removing barriers to accessing the range of services required for improving the health and social and emotional wellbeing of Aboriginal and Torres Strait Islander people (Ministerial Council on Drug Strategy, 2006), as are partnerships between mainstream and Aboriginal and Torres Strait Islander AOD workers.

An example of an Aboriginal and Torres Strait Islander community-controlled service that utilises the partnership between mainstream and Aboriginal and Torres Strait Islander workers to produce an effective program incorporating mainstream and culturally specific interventions is Safe and Sober Support Services (see Example 2).

Example 2: Effective partnerships, Safe and Sober Support Services

Safe and Sober Support Services

Safe and Sober Support Services is an initiative of the Central Australian Aboriginal Congress in Alice Springs, Northern Territory.

Safe and Sober Support Services help Aboriginal people who are looking for treatment and support to address harmful AOD use by working in a holistic and culturally appropriate way. People are provided assistance from teams comprising Aboriginal AOD workers, therapists and doctors. Referrals come from other services in town including Alice Springs Hospital, Congress Clinic, Corrections, and also clients or families can refer themselves.

Services provided by Safe and Sober Support Services include: women's and men's bush trips; art as therapy; Aboriginal workers who speak local languages; connect to country; health checks; psycho-education about the effects of alcohol; counselling; cognitive behavioural therapy; relapse prevention; and family/systemic therapies.

The goal of the program is to reach ultimate outcomes for clients, by encouraging them to assist in the development of their treatment pathways, so that they are empowered to make the changes they desire.

What alcohol and other drug treatment should include

A number of resources provide guidance on what AOD treatment for Aboriginal and Torres Strait Islander peoples should include. These include the *National Drug Strategy Aboriginal and Torres Strait Islander People's Complementary Action Plan 2003–2009* (Ministerial Council on Drug Strategy, 2006); *Alcohol Treatment Guidelines for Indigenous Australians* (Australian Government Department of Health and Ageing, 2007); *The Treatment of Alcohol Problems: a review of the evidence* (Proude et al., 2009); *The Grog Book: strengthening Indigenous community action on alcohol* (Brady, 1998); and *Strong Spirit Strong Mind: Aboriginal drug and alcohol framework for Western Australia 2011–2015* (Western Australia Drug and Alcohol Office, 2011).

There is no one best AOD treatment intervention for Aboriginal and Torres Strait Islander peoples. Instead a range of options should be made available, including: evidence-based mainstream interventions that have had culturally specific practices integrated into them; and wherever possible services developed and delivered by Aboriginal and Torres Strait Islander peoples and communities.

The understanding is that workers will utilise one or more of the following range of culturally adapted interventions depending on the specific needs of the person seeking treatment and the services provided by the organisation being accessed. Where the knowledge or skill level is beyond the skill level of a particular worker, then a referral to another worker or organisation should be made.

Evidence-based mainstream interventions

Screening and assessment

Screening and assessment of AOD use are conducted to determine whether a person is in need of treatment and, if so, what such treatment could entail. Once screening and/or assessment have been completed the person should be provided with information on treatment, treatment options and their location (Western Australia Network of Alcohol and other Drug Agencies, 2012).

Screening can help determine whether a person needs specialist AOD treatment and what type of information, support or treatment they might need. Screening can be done by individuals via self-assessment processes or by primary health care workers such as health workers and doctors, and by teachers or other professionals working with the person using alcohol or other drugs. A range of tools is available for screening for AOD problems.

Assessment is a more comprehensive process and involves a detailed structured approach of gathering information to plan for treatment. Level of dependence and motivation to change are two important components considered as part of assessment. A good assessment should be individually based and consider a person's AOD use within a wider context of need, including: physical and mental health; housing; employment; parenting, family and community considerations; and cultural considerations. Assessment should consider the person's level of dependence, situation and goals, and form the basis on which treatment is offered (Brady, 2002).

Treatment planning is part of the assessment process and should ensure that the person receives a coordinated and appropriate planned approach that best meets their needs. It should be jointly negotiated between the worker and the person, and structured around meeting the person's identified needs and goals and the factors considered to be important for treatment success.

The level of dependence will help determine the type of treatment best suited to the person. Low levels of dependence and problems are best suited to brief interventions, whereas more moderate to severe levels may require withdrawal and also additional treatment options in either a residential or non-residential setting.

Referral

Where required, referral to an appropriate service including specialist AOD treatment should occur following screening and/or assessment.

Brief interventions

Brief interventions are important for a number of people, particularly people experiencing problems with alcohol (Moyer et al., 2002) or cannabis (Copeland et al., 2001). On their own, they are not suitable for dependent persons.

They are most effective when utilised as an early intervention and, as such, they are well placed to be provided by non-specialist AOD services.

Brief interventions are the least intensive of all drug treatments and comprise a suite of possible interventions, including motivational interviewing, that aim to identify current or potential problems with AOD use and motivate those at risk to change their behaviour. They can range from five minutes of brief advice to 30 minutes of brief counselling.

They are commonly delivered by GPs and AOD workers, but can also be provided by other service providers such as primary health care workers or social and emotional health workers.

They can be conducted in a range of settings, in particular non-AOD specialist services such as primary care settings, including Aboriginal Medical Services and hospitals (including emergency departments).

Withdrawal management

There is good evidence to support medicated (e.g. benzodiazepines) alcohol withdrawal (Mayo-Smith, 1997); use of supportive counselling along with information such as structured reduction and cessation plan for cannabis (Gowing et al., 2001); supportive counselling and information, a safe environment and symptomatic relief for psychostimulants (Ritter & Lintzeris, 2004); use of gradually reducing doses of prescribed opiates, e.g. methadone or buprenorphine or symptomatic medications for heroin withdrawal (O'Connor et al., 1997; Gowing et al., 2001; Lintzeris, 2002). All withdrawal management interventions are only effective as short-term interventions and should be combined with other AOD treatment interventions to provide long-term benefits (Hulse, White & Cape, 2002).

Withdrawal from certain drugs, such as alcohol, when the drug has been used in large quantities on a regular basis may result in severe and life-threatening complications if unsupervised or poorly managed. Withdrawal management should encompass attention not only to physical symptoms of withdrawal but also to the psychological and social needs of the person and will depend on the drug being used and the level of use and dependence.

Supervised withdrawal can include medicated and non-medicated withdrawal management and can be undertaken in a number of settings, including in the user's home, community or outpatient withdrawal clinic, residential withdrawal setting, hospital setting and specialist withdrawal unit, or specified bush locations.

Decisions on whether withdrawal is required and where it could occur should be made following a thorough assessment and should be informed by factors such as severity of dependence, the type and quantity of the alcohol and or drug used, presence of physical illness, and the person's social and physical environment, supports and barriers.

Cognitive-behavioural therapy

Cognitive-behavioural therapy (CBT) is a frequently used, effective way to modify behaviour with people using alcohol and other drugs (Hulse et al., 2002) and refers to a broad range of therapeutic interventions which include training in specific social skills and adaptive living skills, as well as cognitive interventions. CBT's effectiveness is dependent on the ability to apply it over a wide range of situations.

Programs generally include: interpersonal problem solving; relationship and social skills; assertive behaviour; stress management; and skills for coping with urges and cravings to use drugs.

CBT can take place in a number of settings including residential and non-residential services and should be provided by workers skilled in these interventions.

Relapse prevention

Relapse prevention techniques are effective AOD treatment interventions (Daley & Marlatt, 1997; Allsop et al., 1997) that aim to teach a set of cognitive and behavioural coping strategies to enhance capacity to cope with high-risk situations that precipitate relapse.

Relapse prevention aims to reduce the likelihood that a person will recommence using alcohol or other drugs after they have succeeded in becoming abstinent for a period of time. It teaches the client a series of skills and interventions which they can use to improve their chances of remaining abstinent.

It can take place in a number of settings including residential and non-residential services and should be provided by workers skilled in these interventions.

Therapeutic communities

Therapeutic communities provide significant benefits, particularly for people who have severe drug use and other major psychosocial and health issues (Toumbourou et al., 1994; Ernst & Young, 1996). They are an intensive form of intervention generally offered in a residential setting.

A therapeutic community is a treatment facility in which the community itself, through self-help and mutual support, is the principal means for promoting personal change. In a therapeutic community residents and staff participate in the management and operation of the community, contributing to a psychologically and physically safe learning environment where change can occur.

In a therapeutic community there is a focus on social, psychological and behavioural dimensions of substance use, with the use of the community to heal individuals emotionally, and support the development of behaviours, attitudes and values of healthy living. (Australasian Therapeutic Communities Association, n.d.)

It is best suited to people who have moderate to severe levels of dependence and severe deterioration, less social stability and are at high risk of relapse. As these are characteristics of many Aboriginal and Torres Strait Islander people seeking AOD treatment, residential treatment may be the best (or only practical) option.

As this intervention can be quite restrictive, it is important that people undertaking it are assessed as being best suited for this form of intervention.

Maintenance pharmacotherapy

For the purposes of this paper maintenance pharmacotherapy refers to interventions that involve providing people with continuing medication to prevent relapse. In most instances the medication is of the same class as the drug of dependence.

Substitution programs using alternative opiate medications such as methadone are effective interventions for heroin dependence, most effective when used over prolonged periods of treatment (Mattick et al., 2003). Medications, e.g. naltrexone, are effective for alcohol dependence (Garbutt et al., 1999; Srisurapanont & Jarusuraisin, 2002). Provision of other AOD treatments, such as counselling or psychotherapy, further enhances pharmacotherapy maintenance treatment outcomes (McLellan et al., 1993; Woody et al., 1987). Maintenance pharmacotherapies should be used only for people who are dependent.

These legally prescribed and dispensed substitute therapies are available to assist in the treatment of nicotine, alcohol and opioid dependence. Though not effective for everyone, many find that pharmacotherapies have the ability to stabilise a person's condition, allowing them to have a better quality of life. Once stabilised, people may find they wish to strive for a drug-free existence by slowly reducing their dosage (abstinence program) or they may elect to continue on a maintenance program (Harm Reduction Victoria, 2014).

Pharmacotherapy programs are available throughout most of Australia with opioid pharmacotherapy provided typically from government-run programs or pharmacies.

Outreach

Outreach is effective in reaching hard-to-reach populations, and can facilitate entry into treatment (Wechsberg, 1993; Gleghorn et al., 1997; Gottheil, Sterling & Weinstein, 1997). They are typically provided to meet the immediate needs of the person with the goal of facilitating engagement with treatment.

It can occur in the person's own environment such as in their home, or in public space such as a park or a cafe.

Aftercare

Aftercare or continuing care results in improved treatment outcomes (McKay, 2005; Ito & Donovan 1986) with better outcomes occurring with the longer the aftercare (Moos & Moos, 2003). It involves the monitoring of client status on a regular basis, early detection of potential problems, referral to appropriate services, and referral back to treatment as required.

It should be provided after most forms of treatment from specialist AOD services particularly where a person has undergone intensive treatment in a residential setting, including prison. It may be needed for a considerable period of time (12 months plus) depending on the person's needs.

Aftercare can take place in a number of settings including residential and non-residential services or in the person's own environment.

Culturally specific interventions

There is no definitive list of cultural values, spirituality and activities, as these will depend on the person's specific cultural needs. However, their intent is to stress traditional cultural values, spirituality and activities that enhance self-esteem.

Culturally specific interventions:

- provide teachings on how to attain and maintain connection with creation
- are grounded in an understanding of the historical factors, including traditional life, the impact of colonisation and its ongoing effects
- utilise an Aboriginal family systems approach to care, control and responsibility

- support traditional ways of learning through watching and listening and trying things out
- are based on a strengths-based approach
- include use of traditional medicines and bush tucker and healers, including use of elders
- use approaches such as going 'out bush' or 'returning to country', which recognise the nurturing and healing effects of the land (see Western Australia Drug and Alcohol Office, 2011).

Such interventions can be interwoven into the framework provided by mainstream interventions.

An example of a state-based framework that incorporates culturally specific interventions into an approach to address harmful AOD use by Aboriginal and Torres Strait Islander people is the Strong Spirit Strong Mind framework (see Example 3).

Example 3: Effective culturally specific intervention

Strong Spirit Strong Mind

Strong Spirit Strong Mind is a Western Australian Drug and Alcohol Office initiative that promotes the uniqueness of Aboriginal culture as a central strength in guiding efforts to manage and reduce AOD-related harm in Aboriginal communities.

It articulates the importance of strengthening the Inner Spirit to enhance good decision-making and support behavioural change, not only at an individual level but also at a collective level with family and community. Supporting resources outline how working with the Inner Spirit can be applied in a therapeutic context and incorporate culturally secure cognitive behavioural therapy approaches. The models provide a framework for understanding the structure of traditional Aboriginal life, the implications of colonisation and the introduction of alcohol and other drugs, the effects of ongoing oppression and their continuing impact upon the lives of Aboriginal clients, their families and their communities.

An example of a residential-based treatment service that incorporates evidenced-based mainstream AOD interventions with culturally specific interventions is Milliya Remurra Alcohol and Drug Rehabilitation Centre (see Example 4).

Example 4: Effective alcohol and other drug treatment interventions in a residential setting

Milliya Rumurra Alcohol and Drug Rehabilitation Centre

Milliya Rumurra is an Aboriginal community-controlled AOD service located in Broome, in the Kimberley region on the north-west coast of Western Australia. It aims to reduce the level of AOD-related harm by providing a range of culturally secure environments that support positive behavioural change for Aboriginal community members. All programs are based on the National Drug Strategy principle of harm minimisation and utilise an evidence-based and client-centred approach, supporting continuity of care with the aim to realise sustained behaviour change for clients.

The service offers five key programs:

- Sobering-Up Shelter
- Residential Rehabilitation
- Day Program
- Continued Care and Support (aftercare)
- Outreach and Support.

Key elements incorporated into the program and service include:

- assessment — an initial assessment is conducted with people seeking assistance
- family model of care — clinical workers engage with the family during rehabilitation and post-rehabilitation
- holistic approach — the AOD problem is not considered in isolation and separate from family and community issues. Support services are integrated to include the families of clients
- sustainability — a key element in being able to be a strong and respected presence in the community
- flexibility — the organisation has adapted to the fluidity of mainstream policies and procedures by changing its focus from abstinence to harm minimisation, and embracing a holistic approach to treatment
- collaboration — the organisation has been successful in establishing and maintaining relationships with most services in Broome, and is represented on regional and state bodies
- good governance — includes sound management structure, established policies and procedures, and good communication between staff, management and the council
- qualified staff — the best qualified staff are sought, while endeavouring to include a high proportion of Indigenous employees.

What constitutes success and what should be the goal of treatment

Success of AOD treatment or intervention is hard to measure, partly because it can mean many things to different people. For one person, it can be admitting that they have a problem; for another, it can be abstaining for a period of time — each day they don't use can be a success.

Successful treatment outcomes are often measured in terms of the amount and frequency of AOD use during a pre-defined period of time following discharge from AOD treatment. A more meaningful picture of treatment success incorporates other aspects such as quality of life, reconnection with family and community, level of functioning in one's career or job, level of involvement with the legal system, and the extent to which a person requires medical care or hospitalisation for medical problems associated with AOD use.

In any consideration of success, thought needs to be given to the chronic nature of most people's AOD problems, which are often marked by cycles of recovery, relapse and repeated treatments sometimes spanning many years (Dennis & Scott, 2007). Treatment needs to be provided in a way that acknowledges this chronic nature.

Given that many people are unsuccessful in giving up on the first occasion, it is also important to note the benefit of multiple treatment efforts. Rather than being seen as a failure, the accumulated experience of periods of abstinence has been found to assist in the process of addressing harmful AOD use and even eventually long-term abstinence (see Hser et al., 1997; 1998).

Harm minimisation acknowledges that some people will continue to use alcohol and other drugs despite the harm that such use may cause to themselves and others. Accordingly the primary aim in treatment is to reduce the level of harm associated with the client's AOD use, whether the person continues to use or not.

Further enablers to successful treatment outcomes

Workforce

A well-trained and well-equipped workforce that is able to respond to AOD issues including emerging issues in a culturally appropriate and sensitive manner is essential in ensuring the success of AOD treatment (Gray et al., 2014).

A wide range of workers come into contact with Aboriginal and Torres Strait Islander people with AOD problems as part of their work. These include specialist AOD workers, health professionals (e.g. medical specialists, nurses, health care workers), allied health professionals (e.g. psychologists and social workers), and other non-health professionals (e.g. police, prison officers, employers and teachers). Few of these workers are Aboriginal and Torres Strait Islander people. This is despite the knowledge that employment of Aboriginal and Torres Strait Islander people, in both Aboriginal-specific services and mainstream services, contributes to the development and maintenance of culturally safe workplaces.

Aboriginal and Torres Strait Islander AOD workers need to have or be obtaining nationally recognised qualifications in AOD while also having qualifications in the AOD field; non-Indigenous AOD workers need to be culturally competent. Staff working in other roles should be competent in screening and brief interventions and receive ongoing supports to enhance this skill (Gray et al., 2014).

Appropriate salaries, career pathways, training, mentoring and supervision, and other forms of support via organisations such as professional bodies are important for supporting the AOD workforce, particularly the Aboriginal and Torres Strait Islander workforce where a lack of such support is noted (Gleadle et al., 2010).

Alcohol and other drug specialist treatment services

A wide range of services provides AOD specialist treatment for Aboriginal and Torres Strait Islander people. According to a report completed for NIDAC by Gray et al. (2010), in the 2006–07 financial year there were 340 Aboriginal and Torres Strait Islander-specific intervention projects being conducted by 224 organisations. Of these 224 organisations, 159 were Aboriginal community-controlled organisations.

For treatment to be successful, it is also essential that these services operate effectively. Spooner and Dadich (2008) reported that the long-term capacity of services to operate effectively is often hindered by the capabilities of their boards, management and staff. Accordingly it is important that services devote sufficient time, effort and resources to building the capacity and skills of their boards, management and staff.

Properly established and managed quality control and quality assurance systems are an effective and important means of addressing many of the issues that typically arise with boards, management and staff, as well as achieving good outcomes overall in services (Manghani, 2011).

It is important for all board members and staff to have a clear understanding of dependence and what constitutes effective AOD treatment and who is best suited to receiving this treatment. Resources are often expanded to providing services to people who are not best placed to benefit from specialist AOD treatment at the cost of other people missing out. Clear policies and procedures outlining the service's purpose, client group, staff and board members' roles and responsibilities and program requirements and practices are important in addressing this issue (Gray et al., 2014).

It is also important that treatment services have adequate infrastructure and funding to run the services that they provide. Often services will extend themselves beyond their resources in an effort to respond to perceived need when what may be required to be effective is to focus on one or two particular areas of service provision.

Non-specialist alcohol and other drug services in treatment

Non-specialist AOD treatment services provide a range of interventions that may be directly or indirectly related to AOD use but that are not identified as specialist AOD treatment per se. These services and the types of interventions they provide are important components in addressing the level of harmful AOD use among Aboriginal and Torres Strait Islander people as they provide opportunities for the identification of AOD problems, the provision of brief interventions and the referral to specialist treatment services (Brady, 1995a).

In particular, Aboriginal Medical Services have an important role to play in the early identification of harmful AOD use and provision of brief interventions for Aboriginal and Torres Strait Islander people.

Accordingly these treatment services need to be adequately supported and equipped to provide such intervention. Additionally they need to be linked to specialist AOD treatment services to facilitate easy access for people in need of specialist treatment.

Data collection, monitoring and evaluation

Ongoing data collection, monitoring and evaluation are critical to the success of any treatment as they ensure that existing interventions are appropriate, effective and efficient in the context of contemporary drug use patterns, trends and settings.

This can be achieved by:

- adopting continuous quality improvement programs that incorporate quality assurance processes to support data collection, monitoring and evaluation
- making more effective use of medical records and client information systems as evaluation tools
- improving reflective practices
- facilitating the development of dual internal and external evaluation of programs (National Drug Research Institute program enhancing the management of alcohol-related problems among Indigenous Australians).

An example of an Aboriginal and Torres Strait Islander community-run program that has been evaluated every three years since its inception is Makin' Tracks (see Example 5).

Example 5: Ongoing evaluation of an alcohol and other drug program, Makin' Tracks

Makin' Tracks

Makin' Tracks is a mobile state-wide holistic support service provided by the Aboriginal Drug and Alcohol Council (SA) Inc. The service supports and enhances AOD treatment interventions in selected rural and remote Aboriginal communities in South Australia.

It was established to address the shortage of Aboriginal and Torres Strait Islander AOD workers in the field and works with Aboriginal communities to develop community-led responses to petrol sniffing and the harmful effects of other drugs.

This program has been evaluated and modified in response to ongoing evaluation.

Conclusion

This paper sought to respond to the misperception that effective AOD treatment is not available for Aboriginal and Torres Strait Islander peoples by showing that there is ample evidence on what can be done to provide effective AOD treatment for Aboriginal and Torres Strait Islander peoples.

The paper outlined who can benefit from receiving treatment; what treatment is known to work; key principles that should guide the application of treatment; and what treatment should consist of to be effective for Aboriginal and Torres Strait Islander people.

References

- Allsop, S., Saunders, B., Phillips, M. & Carr, A. (1997). A trial of relapse prevention with severely dependent male problem drinkers. *Addiction*, 92(1): 61–73.
- Anderson, E.N. (1992). A healing place: ethnographic notes on a treatment center. *Alcoholism Treatment Quarterly*, 9(3–4): 1–21.
- Atkinson, J. (2002). *Trauma Trails, Recreating Song Lines: the transgenerational effects of trauma in Indigenous Australia*. Melbourne: Spinifex Press.
- Australasian Therapeutic Communities Association (n.d.). Therapeutic Community Model of Treatment. Available at: <<http://www.atca.com.au/wp-content/uploads/2012/07/Therapeutic-Community-Model-of-Treatment.pdf>>, accessed 7 May 2014.
- Australian Bureau of Statistics (2009). *National Aboriginal and Torres Strait Islander Social Survey, 2008*. Canberra: ABS. Available at: <<http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4714.0Main+Features122008?OpenDocument>>.
- Australian Bureau of Statistics (2013). *Australian Aboriginal and Torres Strait Islander Health Survey: first results, Australia, 2012–13*. Canberra: ABS. Available at: <<http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/4727.0.55.001Main%20Features12012-13?opendocument&tabname=Summary&prodno=4727.0.55.001&issue=2012-13&num=&view=>>>.
- Australian Bureau of Statistics & Australian Institute of Health and Welfare (2008). *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008*. Canberra: ABS and AIHW.
- Australian Government Department of Health and Ageing (2007). *Alcohol Treatment Guidelines for Indigenous Australians*. Canberra: Department of Health and Ageing. Available at: <[http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/B2AE1FDD080F9981CA257C71001E8A1E/\\$FILE/alc-treat-guide-indig.pdf](http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/B2AE1FDD080F9981CA257C71001E8A1E/$FILE/alc-treat-guide-indig.pdf)>, accessed 2 May 2014.
- Australian Government Department of Health and Ageing (2012). *Aboriginal and Torres Strait Islander Health Performance Framework: 2012 report*. Canberra: Commonwealth of Australia. Available at: <[http://www.health.gov.au/internet/main/Publishing.nsf/Content/F766FC3D8A697685CA257BF0001C96E8/\\$File/hpf-2012.pdf](http://www.health.gov.au/internet/main/Publishing.nsf/Content/F766FC3D8A697685CA257BF0001C96E8/$File/hpf-2012.pdf)>, accessed 1 May 2014.
- Australian Government Department of Health and Ageing (2013). *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*. Canberra: Commonwealth of Australia. Available at: <[http://www.health.gov.au/internet/main/publishing.nsf/content/B92E980680486C3BCA257BF0001BAF01/\\$File/health-plan.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/B92E980680486C3BCA257BF0001BAF01/$File/health-plan.pdf)>, accessed 2 May 2014.
- Australian Government Department of Social Services (2014). *Closing the Gap on Indigenous Disadvantage: the challenge for Australia – 2009*. Canberra: Department of Social Services. Available at: <<http://www.dss.gov.au/our-responsibilities/indigenous-australians/publications-articles/closing-the-gap/closing-the-gap-on-indigenous-disadvantage-the-challenge-for-australia-2009?HTML>>, accessed 1 May 2014.
- Australian Human Rights Commission (2011). *Social Justice Report 2010*. Sydney: AHRC. Available at: <<https://www.humanrights.gov.au/publications/social-justice-report-2010>>, accessed 2 May 2014.

Australian Institute of Health and Welfare (2011). *National Drug Strategy Household Survey 2010*. Canberra: AIHW.

Australian Institute of Health and Welfare (2013). *Child Protection Australia 2011–2012*. Canberra: AIHW.

Battams, A. & Roche A. (2011). Child wellbeing and protection concerns and the response of the alcohol and other drugs sector in Australia. *Advances in Mental Health*, 10(1): 62–71.

Brady, M. (1993). Giving away the grog: an ethnography of Aboriginal drinkers who quit without help. *Drug and Alcohol Review*, 12(4): 401–411.

Brady, M. (1995a). *Broadening the Base of Interventions for Aboriginal People with Alcohol Problems*. (Technical Report No. 29.) Sydney: National Drug and Alcohol Research Centre, University of New South Wales. Available at: <<http://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/T.R%20029.pdf>>, accessed 1 May 2014.

Brady, M. (1995b). Culture in treatment, culture as treatment: a critical appraisal of developments in addictions programs for Indigenous North Americans and Australians. *Social Science and Medicine*, 41(11): 1487–1498.

Brady, M. (1998). *The Grog Book: strengthening Indigenous community action on alcohol*. Canberra: Commonwealth Department of Health and Family Services.

Brady, M. (2002). *Indigenous Residential Treatment Programs for Drug and Alcohol Problems: current status and options for improvement*. (Discussion paper 236/2002.) Canberra: Centre for Aboriginal Economic Policy Research, Australian National University. Available at: <<http://caepr.anu.edu.au/Publications/DP/2002DP236.php>>, accessed 7 May 2014.

Broadstock, M., Brinson, D. & Weston, A. (2008). The effectiveness of compulsory, residential treatment of chronic alcohol or drug addiction in non-offenders. *Health Services Assessment Collaboration Report* 1(1).

Chenhall, R.D. & Senior, K. (2013). 'The concepts are universal, it is the picture you paint that is different': key issues for Indigenous Australian alcohol and drug residential treatment centres. *Therapeutic Communities*, 34 (2–3): 83–95.

Commonwealth Department of Human Services and Health (1996). *National Drug Strategy Household Survey: urban Aboriginal and Torres Strait Islander peoples supplement 1994*. Canberra: Australian Government Publishing Service.

Copeland, J., Swift, W., Roffman, R. & Stephens, R. (2001). A randomized controlled trial of brief cognitive-behavioural interventions for cannabis use disorder. *Journal of Substance Abuse Treatment*, 21(2): 55–64.

Councillor, H. (2003). Aboriginal community control in health. *Australian Health Consumer*, 2003–2004(1): 4–5.

Daley, D.C. & Marlatt, G.A. (1997). Relapse prevention. In J.H. Lowinson, P. Ruiz, R.B. Millman & J.G. Langrod (eds), *Substance Abuse: a comprehensive textbook*. 3rd ed. Baltimore: Williams & Wilkins.

Dennis, M. & Scott, C.K. (2007). Managing addiction as a chronic condition. *Addiction Science Clinical Practice*, 4(1): 45–55.

Ernst & Young (1996). Review of Long-term Residential Treatment for People with Alcohol and Other Drug Problems. Paper prepared for the National Drug Strategy. Canberra: Commonwealth Department of Human Services.

Garbutt, J.C., West, S.L., Carey, T.S., Lohr, K.N. & Crews, F.T. (1999). Pharmacological treatment of alcohol dependence: a review of the evidence. *Journal of the American Medical Association*, 281(99): 1318–1325.

Gleadle, F., Freeman, T., Duraisingam, V., Roche, A., Battams, S., Marshall, B. et al. (2010). *Indigenous Alcohol and Drug Workforce Challenges: a literature review of issues related to Indigenous AOD workers' wellbeing, stress and burnout*. Adelaide: National Centre for Education and Training on Addiction, Flinders University.

Gleghorn, A.A., Clements, K.D., Marx, R., Vittinghoff, E., Lee-Chu, P. & Katz, M. (1997). The impact of intensive outreach of HIV prevention activities of homeless, runaway, and street youth in San Francisco. *AIDS and Behavior*, 1(4): 261–271.

Gottheil, E., Sterling, R.C. & Weinstein, S.P. (1997). Outreach engagement efforts: are they worth the effort? *American Journal of Drug and Alcohol Abuse*, 23(1): 61–66.

Gowing, L., Proudfoot, H., Henry-Edwards, S. & Teesson, S. (2001). *Evidence Supporting Treatment: the effectiveness of interventions for illicit drug use*. (ANCD Research Paper no. 3.) Canberra: Australian National Council on Drugs.

Gray, D. & Wilkes, E. (2010). *Reducing Alcohol and Other Drug Related Harm*. (Closing the Gap Clearinghouse Resource Sheet no. 3.) Canberra: Australian Institute of Health and Welfare & Australian Institute of Family Studies.

Gray, D., Stearne, A., Wilson, M. & Doyle, M. (2010). *Indigenous-specific Alcohol and Other Drug Interventions: continuities, changes and areas of greatest need*. (ANCD Research Paper no. 20.) Canberra: Australian National Council on Drugs.

Gray, D., Wilson, M., Allsop, S., Siggers, S., Wilkes, E. & Ober, C. (2014). Barriers and enablers to the provision of alcohol treatment among Aboriginal Australians: a thematic review of five research projects. *Drug and Alcohol Review* [online ahead of print], DOI: 10.1111/dar.12137.

Harm Reduction Victoria (2014). What is Pharmacotherapy? Available at: <<http://hrvic.org.au/pharmacotherapy/general-information/what-is-pharmacotherapy/>>, accessed 2 May 2014.

Hser, Y-I., Anglin, M.D., Grella, C., Longshore, D. & Prendergast, M.L. (1997). Drug treatment careers: a conceptual framework and existing research findings. *Journal of Substance Abuse Treatment*, 14(6): 543–558.

Hser, Y-I., Grella, C., Chou, C-P. & Anglin, M.D. (1998). Relationships between drug treatment careers and outcomes: findings from the National Drug Abuse Treatment Outcome Study. *Evaluation Review*, 22(4): 496–519.

- Hulse, G., White, J. & Cape, G. (2002). *Management of Alcohol and Drug Problems*. Melbourne: Oxford University Press.
- Indig, D., McEntyre, E., Page, J. & Ross, B. (2010). *2009 NSW Inmate Health Survey: Aboriginal health report*. Sydney: Justice Health. Available at <<http://www.justicehealth.nsw.gov.au/about-us/publications/inmate-health-survey-aboriginal-health-report.pdf>>, accessed 1 May 2014.
- Ito, R.I. & Donovan, D. (1986). Aftercare in alcoholism treatment: a review. In W.R. Miller & N. Heather (eds), *Treating Addictive Behaviors: processes of change*, New York: Plenum Press, pp. 435–452.
- King, T., Ritter, A. & Hamilton, M. (2013). Setting the scene. In A. Ritter, T. King & M. Hamilton (eds), *Drug Use in Australian Society*. Oxford: Oxford University Press, pp. 3–26.
- Kinner, S.A., Preen, D.B., Karaminia, A., Butler, T., Andrews, J.Y., Stooze, M. & Law, M. (2011). Counting the cost: estimating the number of deaths among recently released prisoners in Australia. *Medical Journal of Australia*, 195(2): 64–68.
- Kirby Institute (2014). *Bloodborne Viral and Sexually Transmitted Infections in Aboriginal and Torres Strait Islander People: annual surveillance report 2013*. Sydney: Kirby Institute, University of New South Wales. Available at <<http://www.kirby.unsw.edu.au/sites/default/files/hiv/resources/2013ATSIP-ASR.pdf>>, accessed 1 May 2014.
- Kratzmann, M., Mitchell, E., Ware, J., Banach, L. Ward, J., Ryan, J. et al. (2011). *Injecting Drug Use and Associated Harms among Aboriginal Australians*. (ANCD Research Paper no. 22.) Canberra: Australian National Council on Drugs.
- Larkins, S.L., Geia, L.K. & Panaretto, K.S. (2006). Consultations in general practice and at an Aboriginal community controlled health service: do they differ? *Rural and Remote Health*, 6: 650.
- Laslett, A-M., Catalano, P., Chikritzhs, T., Dale, C., Doran, C., Ferris, J. et al. (2010). *The Range and Magnitude of Alcohol's Harm to Others*. Fitzroy, Victoria: AER (Alcohol Education and Rehabilitation) Centre for Alcohol Policy Research, Turning Point Alcohol and Drug Centre.
- Lavoie, J.G., Forget, E.L., Prakash, T., Dahl, M., Martens, P. & O'Neil, J.D. (2010). Have investments in on-reserve health services and initiatives promoting community control improved First Nations' health in Manitoba? *Social Science & Medicine*, 71(4): 717–724.
- Lee, K., Freeburn, B., Ella, S., Miller, W., Perry, J. & Conigrave, K. (2012). *Handbook for Aboriginal Alcohol and Drug Work*. Sydney: University of Sydney.
- Lintzeris, N. (2002). Buprenorphine in the management of heroin withdrawal. PhD Thesis. Canberra: Australian National University.
- Manghani, K. (2011). Quality assurance: Importance of systems and standard operating procedures. *Perspectives in Clinical Research*, 2(1): 34–37.
- Marmot, M. (2011). Social determinants and the health of Indigenous Australians. *Medical Journal of Australia*, 194 (10): 512–513.

- Mattick, R.P., Breen, C., Kimber, J. & Davoli, M. (2003). Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database of Systematic Reviews*, 2003(2): CD002209 [online].
- Mayo-Smith, M.F. (1997). Pharmacological management of alcohol withdrawal: a meta-analysis and evidence-based practice guideline. *Journal of the American Medical Association*, 278(2): 144–151.
- McCormick, R.M. (2000). Aboriginal traditions in the treatment of substance abuse. *Canadian Journal of Counselling*, 34(1): 25–32.
- McKay, J.R. (2005). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction*, 100(11): 1594–1610.
- McLellan, A.T. (2002). Have we evaluated addiction treatment correctly? Implications from a chronic care perspective. *Addiction*, 97(3): 249–252.
- McLellan, A.T., Grissom, G.R., Brill, P., Durell, J., Metzger, D.S. & O'Brien, C.P. (1993). Private substance abuse treatments: are some programs more effective than others? *Journal of Substance Abuse Treatment*, 10(3): 243–254.
- McLellan, A.T., Woody, G.E., Metzger, D., McKay, J., Durrell, J., Alterman, A.I. & O'Brien, C.P. (1996). Evaluating the effectiveness of treatments for substance use disorders: reasonable expectations, appropriate comparisons. *Milbank Quarterly*, 74(1): 51–85.
- Ministerial Council on Drug Strategy (2006). *Aboriginal and Torres Strait Islander People Complementary Action Plan 2003–2009*. Canberra: MCDS. Available at <[http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/545C92F95DF8C76ACA257162000DA780/\\$File/indigenous-action.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/545C92F95DF8C76ACA257162000DA780/$File/indigenous-action.pdf)>, accessed 1 May 2014.
- Ministerial Council on Drug Strategy (2011). *National Drug Strategy 2010–2015*. Canberra: MCDS.
- Moos, R.H. & Moos, B.S. (2003). Long-term influence of duration and intensity of treatment on previously untreated individuals with alcohol use disorders. *Addiction*, 98(3): 325–337.
- Morgan, A. & McAtamney, A. (2009). *Key Issues in Alcohol-related Violence*. (Research in Practice Summary Paper no. 4.) Canberra: Australian Institute of Criminology.
- Moyer, A., Finney, J.W., Swearingen, C.E. & Verquin, P. (2002). Brief interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment-seeking population. *Addiction*, 97(3): 279–292.
- Nagel, T., Robinson, G., Condon, J. & Trauer, T. (2009). Approach to treatment of mental illness and substance dependence in remote Indigenous communities: results of a mixed methods study. *Australian Journal of Rural Health*, 17(4): 174–182.
- Najavits, L.M. & Weiss, R.D. (1994). Variation in therapist effectiveness in the treatment of patients with substance use disorders: an empirical view. *Addiction*, 89(6): 679–688.
- National Congress of Australia's First Peoples (2013). *Submission on the National Aboriginal and Torres Strait Islander Health Plan*. Sydney: National Congress of Australia's First Peoples. Available at: <<http://nationalcongress.com.au/wp-content/uploads/2013/10/CongressNATSIHPSubmissionWeb.pdf>>, accessed 2 May 2014.

National Drug Research Institute (2014). *Submission to the House of Representative Standing Committee on Indigenous Affairs Inquiry into the Harmful Use of Alcohol in Aboriginal and Torres Strait Islander Communities*. Perth: NDRI, Curtin University.

National Health Strategy Working Party (1996). *A National Aboriginal Health Strategy 1989*. Canberra: Office of Aboriginal and Torres Strait Islander Health. Available at <<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-pubs-NAHS1998>>, accessed 1 May 2014.

National Indigenous Drug and Alcohol Committee (2013). *Bridges and Barriers: addressing Indigenous incarceration and health*. Rev. ed. Canberra: Australian National Council on Drugs.

National Indigenous Drug and Alcohol Committee (forthcoming 2014). NIDAC and NACCHO Survey of amphetamine-type substance use. Canberra: NIDAC/NACCHO.

Nicholas, R., Lee, N. & Roche, A. (2011). *Pharmaceutical Drug Misuse in Australia: complex problems, balanced responses*. Adelaide: National Centre for Education and Training on Addiction, Flinders University.

O'Connor, P.G., Carroll, K.M., Shi, J.M., Schottenfeld, R.S., Kosten, T.R. & Rounsaville, B.J. (1997). Three methods of opioid detoxification in a primary care setting: a randomised trial. *Annals of Internal Medicine*, 127(7): 526–530.

O'Donnell, M., Nassar, N., Leonard, H., Jacoby, P., Mathews, R., Patterson, Y. & Stanley, F. (2010). Characteristics of non-Aboriginal and Aboriginal children and families with substantiated child maltreatment: a population-based study. *International Journal of Epidemiology*, 39(3): 921–928.

Pritchard, E., Mugavin, J. & Swan A. (2007). *Compulsory Treatment in Australia: a discussion paper on the compulsory treatment of individuals dependent on alcohol and/or other drugs*. (ANCD Research Paper no. 14.) Canberra: Australian National Council on Drugs.

Proude, E., Lopatko, O., Lintzeris, N. & Haber, P. (2009). *The Treatment of Alcohol Problems: a review of the evidence*. Sydney: NSW Health & University of Sydney.

Ritter, A. & Lintzeris, N. (2004). Specialist interventions in treating clients with alcohol and drug problems. In M. Hamilton, T. King & A. Ritter (eds), *Drug Use in Australia: preventing harm*. 2nd ed. Oxford: Oxford University Press, pp. 221–235.

Rodas, A., Bode, A. & Dolan, K. (2011). *Supply, Demand and Harm Reduction Strategies in Australian Prisons: an update*. (ANCD Research Paper no. 23.) Canberra: Australian National Council on Drugs.

Rowley, K.G., O'Dea, K., Anderson, I., McDermott, R., Saraswati, K., Tilmouth, R. et al. (2000). Lower than expected morbidity and mortality for an Australian Aboriginal population: 10-year follow-up in a decentralised community. *Medical Journal of Australia*, 188(5): 283–287.

Saggers, S. & Gray, D. (1998). *Dealing with Alcohol: Indigenous usage in Australia, New Zealand and Canada*. Melbourne: Cambridge University Press.

Secretariat of National Aboriginal and Islander Child Care Inc. (2010). *Working and Walking Together: supporting family relationship services to work with Aboriginal and Torres Strait Islander families and organisations*. North Fitzroy, Victoria: SNAICC.

- Sibthorpe, B. (1988). "All our people are dyin'": diet and stress in an urban Aboriginal community. PhD thesis. Canberra: Australian National University.
- Smith, T.B., Rodriguez, M.D. & Bernal, G. (2011). Culture. *Journal of Clinical Psychology*, 67(2): 166–175.
- Spooner, C. & Dadich, A. (2008). *Non-government Organisations in the Alcohol and Other Drugs Sector: issues and options for sustainability*. (ANCD Research Paper no. 17.) Canberra: Australian National Council on Drugs.
- Srisurapanont, M. & Jarusuraisin, N. (2002). Opioid agonist for alcohol dependence. *Cochrane Database of Systematic Reviews*, 2002(2): CD001867 [online].
- Steering Committee for the Review of Government Service Provision (2011). *Overcoming Indigenous Disadvantage: key indicators 2011*. Canberra: Productivity Commission.
- Taplin, S. & Mattick, R.P. (2011). *Child Protection and Mothers in Substance Abuse Treatment*. (NDARC Technical Report no. 320.) Sydney: National Drug and Alcohol Research Centre, University of New South Wales.
- Terrell, M.D. (1993). Ethnocultural factors and substance abuse: toward culturally sensitive treatment models. *Psychology of Addictive Behaviors*, 7(3): 162–167.
- Thomas, D.P., Heller, R.F. & Hunt, J.M. (1998). Clinical consultations in an Aboriginal community-controlled health service: a comparison with general practice. *Australian and New Zealand Journal of Public Health*, 22(1): 86–91.
- Toumbourou, J., Hamilton, M., Fallon, B., Scott, J. & Skalls, W. (1994). *Out of Harms Reach: an evaluation of the effectiveness of different levels of treatment at Odyssey House*. (National Drug Research Report Series 1.) Melbourne: University of Melbourne, Department of Public Health and Community Medicine.
- United Nations (2007). *Declaration on the Rights of Indigenous Peoples*. Adopted at 107th Plenary meeting, 13 September 2007. Available at: <http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf>, accessed 2 May 2014.
- United Nations International Drug Control Programme (2002). *Contemporary Drug Abuse Treatment: a review of the evidence base*. New York: United Nations.
- United Nations Office on Drugs and Crime (2006). *Guidance for the Measurement of Drug Treatment Demand*. (Toolkit Module 8.) New York: United Nations. Available at: <http://www.unodc.org/documents/GAP/Module%208_English_06-52819_Ebook_Final.pdf>, accessed 1 May 2014.
- Vos, T., Barker, B., Stanley, L. & Lopez, A. (2007). *The Burden of Disease in Aboriginal and Torres Strait Islander Peoples 2003*. Brisbane: University of Queensland, School of Population Health.
- Wechsberg, W.M. (1993). A comparison of injecting drug users reached through outreach and methadone treatment. *Journal of Drug Issues*, 23: 667.
- Western Australia Drug and Alcohol Office (2011). *Strong Spirit Strong Mind: Aboriginal drug and alcohol framework for Western Australia 2011–2015*. Perth: WA Drug and Alcohol Office.

Western Australia Network of Alcohol and other Drug Agencies (2012). *Standard on Culturally Secure Practice (Alcohol and other Drug Sector)*. Perth: WANADA. Available at <<http://www.wanada.org.au/Quality-Framework-Programs/quality-framework-programs.html>>, accessed 2 May 2014.

Wilkinson, R. & Marmot, M. (eds) (2003). *Social Determinants of Health: the solid facts*. 2nd ed. Copenhagen: World Health Organization.

Williams, R. (1999). Cultural safety: what does it mean for our work practice? *Australian and New Zealand Journal of Public Health*, 23(2): 213–214.

Woody, G.E., McLellan, A.T., Luborsky, L. & O'Brien, C.P. (1987). Twelve-month follow-up of psychotherapy for opiate dependence. *American Journal of Psychiatry*, 144(5): 590–596.

World Health Organization (2014). Management of substance abuse: dependence syndrome. Available at: <http://www.who.int/substance_abuse/terminology/definition1/en/>, accessed 1 May 2014.

Wundersitz, J. (2010). *Indigenous Perpetrators of Violence: prevalence and risk factors for offending*. (Research and Public Policy Series no. 105.) Canberra: Australian Institute of Criminology.



AUSTRALIAN NATIONAL COUNCIL ON DRUGS



**For further
information contact:**

NIDAC Secretariat
PO Box 205
Civic Square ACT 2608

Tel: 02 6166 9600
Fax: 02 6162 2611

Email: nidac@ancd.org.au
Website: www.nidac.org.au