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Review of alcohol and drug treatment for Aboriginal and Torres Strait Islander peoples

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Review of alcohol and drug treatment for Aboriginal and Torres Strait Islander peoples

Abstract

This review provides an overview of treatments for problem alcohol and other drug (AOD) use for Aboriginal and Torres Strait Islander people. It includes information on the available research and discusses core principles for providing treatment. The review outlines how effective mainstream treatment approaches can be adapted to be more suitable for Aboriginal and Torres Strait Islander ways of being or worldview. It also highlights that services, such as those offered by Aboriginal community controlled health organisations are in a unique position to offer culturally secure treatment approaches. The barriers to accessing treatment are discussed as well as recommendations for future strategic directions in service delivery such as collaboration and two-way learning.

This review is part of a suite of knowledge exchange products that includes a summary, video, and factsheet.

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Keywords

Alcohol, drug use, Aboriginal and Torres Strait Islander health, treatment, services, culturally secure, primary health care, strategies, policies

Introduction

Aim

This review provides a summary of treatments for alcohol and other drug (AOD) problems for Aboriginal and Torres Strait Islander people and the research evidence available about their use. It is not designed to be a clinical guide, or to cover every treatment in detail, but instead to provide an overview of treatment approaches.

About this review

Key focus

This review focuses on treatments to help an Aboriginal or Torres Strait Islander person reduce or stop AOD use. These are treatments for when the person already has evidence of either hazardous use or problems from their substance use. Those problems may be in the form of the person experiencing harms or causing harms as a result of their use or experiencing dependence on (or 'addiction' to) that substance (World Health Organization, 2019).

We do not focus on:

- programs whose prime focus is on preventing hazardous AOD use from ever occurring, including those that address underlying social determinants of health
- programs which have a community-wide focus, except in the context of supporting treatment
- assessment of AOD use - except where explanation of this is needed to explain the treatment
- treatment targeting tobacco cessation, volatile substance use (including petrol sniffing), or fetal alcohol spectrum disorder (FASD), as these are covered in separate reviews on the Australian Indigenous Health*InfoNet* Alcohol and other Drugs Knowledge Centre (Colonna et al., 2020; Hamilton et al., 2021; Marel et al., 2016)
- historical examples of mandatory 'treatment' for AOD use, which are triggered by law-and-order rather than health and wellbeing concerns. These have often been culturally inappropriate (Brady, 2007). However, it is noted that such programs may have left a legacy of erosion of trust in mainstream treatment services (Taylor et al., 2013).

Sources

We have drawn together key information sources as a narrative review - a descriptive summary of the findings - rather than as a systematic review (which would examine in a detailed, structured way the methods used). Our main sources are:

- peer-reviewed, published original research
- key articles from the grey literature that were founded on consultation with Aboriginal and Torres Strait Islander health professionals and communities. In particular, this includes reports written by the National Indigenous Drug and Alcohol Committee (NIDAC). That committee was set up by the federal government (Gray et al., 2010) and existed from 2004 to 2014. NIDAC members included senior Aboriginal and Torres Strait Islander AOD health professionals

and experienced AOD researchers. NIDAC conducted regular consultation with other Aboriginal and Torres Strait Islander health professionals, services and communities Australia-wide.

- selected key national surveys, policy documents, reviews and guidelines.

This literature can be found on the Australian Indigenous Health*InfoNet*'s Alcohol and other Drugs Knowledge Centre: https://aodknowledgecentre.ecu.edu.au/key-resources/publications/. Box 1 provides detail on the search strategy.

Box 1. Search strategy

Inclusion criteria: treatments aimed at helping an Aboriginal or Torres Strait Islander person to reduce or stop AOD use, where that person already has evidence of either hazardous use, harms from use or dependence on that substance (World Health Organization, 2019) (See Box 2 for description of terms used).

Exclusion criteria:

- treatment of harms to health that have arisen because of substance use, such as overdose or liver disease
- historical examples of mandatory 'treatment' for AOD problems that have been dictated from a law-and-order rather than a health perspective
- specific focus on treatment for tobacco cessation, volatile substance use or FASD.

Our search strategy had three main components:

1. *Peer-reviewed published original research:* We searched for articles on treatments for repeated AOD use that has led to harms or resulted in dependence among Aboriginal and Torres Strait Islander peoples. The search was narrowed to publications in scientific journals between January 1, 2000 to August 31, 2022. We identified this literature through searching relevant databases, through Google and Google Scholar, citation chaining, and via consultation with a drug and alcohol librarian. Search terms included Aboriginal and Torres Strait Islander people, alcohol, drug, cannabis, methamphetamine, opioid, illicit, treatment and variations of all these. We found 25 articles meeting our criteria. Seven of these were published prior to 2012.
2. *Key articles in grey literature based on consultation with Aboriginal and Torres Strait Islander health professionals or communities*: In particular, we searched for reports by NIDAC that focused on AOD treatment or treatment services.
3. *Additional key articles:* Where necessary for the understandability of the review, selected additional articles are cited that provide context, explanation or reflect broad professional consensus. This includes national clinical guidelines and selected key review articles.

Overview

First, we present a brief summary of the context and range of AOD use within the Aboriginal and Torres Strait Islander communities, then core principles that underpin AOD treatment approaches for Aboriginal and Torres Strait Islander people. After looking at the range of treatment approaches used and research evidence for them, we then consider groups with specific needs, such as young people, some specific settings, and key policy considerations.

Terms used in this review

In keeping with the Australian Indigenous Health*InfoNet* nomenclature guide we use the term 'Aboriginal and Torres Strait Islander' (rather than 'Indigenous'). However, some sources have used the terms 'Aboriginal', 'Indigenous' or 'Torres Strait Islander' only. When referencing information from those reports, the terms from that source are used. As a result, these terms are sometimes used interchangeably. If you have concerns, please contact the Australian Indigenous Health*InfoNet* for further information.

We use World Health Organization (WHO) terms to describe the spectrum of AOD use that can occur in any community (Box 2). These terms are set out in the International Classification of Disease, 11th revision (ICD-11) (World Health Organization, 2019). They describe that while some people may use a substance (like alcohol) with low risk of harms (e.g. when drinking within nationally recommended limits), others may be at either risk of future health harms or have already experienced problems from their AOD use.

For example:

- a person may face future health risks (including cancer, or lung or liver disease) because of their substance use, but not have experienced any harms related to their use – 'hazardous use'
- others may have experienced (or caused) harms because of their substance use, but are not dependent on (addicted to) that substance – 'harmful use', or
- the smallest group in the community are those who have become dependent on that substance (for example losing control over their AOD use or experiencing sickness or withdrawal symptoms when they stop).

The type of treatment that is offered is influenced by the severity of the AOD problem, and by the individual's strengths, challenges, and preferences, as well as by their family and community context.

Box 2: Terms used in this review to describe substance use

Hazardous use: repeated use of alcohol or another substance which carries the risk of future harms. No harms or dependence are being experienced (World Health Organization, 2019).

The term is most often used in relation to alcohol consumption above recommended limits (National Health and Medical Research Council, 2020) (or where some evidence of risk from drinking is detected by an alcohol screening tool).

Harmful use: repeated use of a substance that results in actual harm (physical, mental, or social) but does not meet criteria for dependence (World Health Organization, 2019).

Dependence: there is a powerful inner drive to continue to use a substance. Key features include impaired control over use, tolerance and/or withdrawal symptoms, and the substance use takes a higher priority than other aspects of life (World Health Organization, 2019).

Problem AOD use: We use this is an umbrella term to include AOD use that has already led to problems, whether that use is harmful or dependent. We chose this term instead of the term commonly used in the academic literature, 'substance use disorder', to help make the review as readable as possible.

(We note that the Diagnostic and Statistical Manual (DSM-V) (American Psychiatric Association, 2013), uses the term 'disorder' to describe the continuum of AOD problems, from mild to severe. So for example, mild substance use disorder is similar

to 'harmful' use in ICD-11, and 'moderate to severe substance use disorder' is similar to dependence).

Drinking above recommended limits:

The *Australian guidelines to reduce health risks from drinking alcohol* recommend that healthy adults drink no more than 10 standard drinks a week and no more than 4 standard drinks on any one day (National Health and Medical Research Council, 2020). Pregnant women and young people aged under 18 are advised to not drink alcohol.

Context and prevalence of AOD use and related harms

Aboriginal and Torres Strait Islander peoples have shown continuing resilience in the face of the many challenges resulting from colonisation. These strengths – of individuals, families and communities – have helped many people to avoid problem AOD use, or have helped those who have encountered problems with substance use to make positive changes (Freeburn et al., 2021). Many communities, for example, have developed approaches to protect against or deal with problem AOD use (Gray et al., 2010; Preuss & Brown, 2006).

Community controlled services range from holistic primary care services through to residential rehabilitation or harm reduction services. Such services are typically managed via a board elected from community members. As such they are well able to be in touch with local needs and strengths and are aware of local cultural protocols. Many community controlled services have also advised or supported mainstream AOD treatment services (e.g. those run by government or by various non-government organisations) to improve the accessibility and cultural security of their care (see below).

The ongoing impacts of colonisation place Aboriginal and Torres Strait Islander Australians at increased risk of harms from AOD use (Australian Institute of Health and Welfare, 2022a). Disruption of connection to land, language, culture, and family have led to intergenerational trauma. Ongoing experience of disadvantage or discrimination, and of recurrent grief and loss due to illness, death, and over-imprisonment, all can add to stress and distress. Together, these social determinants of health, place Aboriginal and Torres Strait Islander Australians at increased risk of mental health conditions and of harms from substance use (Gracey & King, 2009; King et al., 2009). Where harms linked to AOD use occur, as in the general population, these harms include physical and mental health conditions, and harms to family and community. And while problem AOD use can arise because of intergenerational trauma, it can also contribute to that cycle of continuing trauma. Quality treatment and support for problem AOD use is important to help interrupt cycles of trauma.

Overview of prevalence data on AOD use in Aboriginal and Torres Strait Islander peoples

For all Australians, AOD use is a key contributor to poor health and to deaths. In fact, alcohol is the lead contributor to loss of healthy life for all Australians aged from 15 to 44 years (Australian Institute of Health and Welfare, 2019). Similarly, among Aboriginal and Torres Strait Islander peoples, AOD use is among the top four factors contributing to the burden of disease in in 2018 (Australian Institute of Health and Welfare, 2022a). Because of this, accessible and effective prevention and treatment remains a priority in ensuring health and wellbeing.

Alcohol: Several surveys, though not all (Zheng et al., 2021), have reported that Aboriginal and Torres Strait Islander Australians are less likely to drink alcohol at all in the past year than are the remainder of the population; but when they drink are more likely to consume amounts that could place them at short term risk (more than four standard drinks per day) (National Health and Medical Research Council, 2020).

A meta-analysis of available surveys of drinking among Aboriginal and Torres Strait Islander Australians, showed that 59% of participants reported consuming any alcohol in the past 12 months (Conigrave et al., 2020), which is lower than the prevalence of drinking in the general population (77%) (Australian Institute of Health Welfare, 2020). Just over a third (34%) of Aboriginal and Torres Strait Islander Australians reported drinking more than four drinks on any one day at least monthly (slightly higher than the prevalence for the general population, 26%) (Australian Institute of Health and Welfare, 2017; Australian Institute of Health Welfare, 2020).

As with the general population, Aboriginal and Torres Strait Islander men were more likely to consume alcohol than women – this difference was greater for Aboriginal and Torres Strait Islander populations (men were 2.5 times as likely as women to report any consumption). As with general populations, younger people were more likely to drink above four standard drinks per day on single occasion drinking than older people, while older people were more likely to have an average consumption of more than two standard drinks per day (Australian Institute of Health Welfare, 2020; Conigrave et al., 2020).

A survey of two communities, using an interactive, visual, computer-based survey tool (Lee et al., 2019; Zheng et al., 2021) found that individuals often have long ‘dry’ periods between occasions when they drink to intoxication (Zheng et al., 2021). The prevalence of alcohol dependence was estimated as 2.2% (Weatherall et al., 2021) - similar to past estimates for general populations (1.4%) (Teesson et al., 2010).

There is great variation between and within communities in prevalence of any drinking or risk from drinking (Conigrave et al., 2020).

Illicit drug use: In national surveys, cannabis is the most common recently used illicit drug (reported by 16% of respondents) followed by strong pain relievers (not over-the-counter) and opioids (5.9%) (Australian Institute of Health Welfare, 2020). Numbers of Aboriginal and Torres Strait Islander individuals in these national surveys tend to be small, so results need to be interpreted with caution. Because of those small sample sizes, prevalence for other substances, such as methamphetamines, was not presented.

Prevalence of cannabis use (or use of any substance) can vary greatly by region. In two remote regions heavy daily cannabis use has been reported to be common, with evidence of dependence and associated depression and other mental health impacts, and other harms (Lee et al., 2008; Lee et al., 2015). A recent Australian Indigenous Health*InfoNet* Alcohol and other Drugs Knowledge Centre review provides details on cannabis use, harms, and risk factors for use (as well as some culturally appropriate approaches to reducing harms) (Butt et al., 2022).

General principles of culturally secure treatment provision

Whatever the AOD treatments that are chosen, a number of core principles underpin provision of culturally secure treatment or care. This section sets out some of these principles.

The importance of engagement

Focusing on engagement and building trust between health workers and individuals is important given the stigma that can be experienced around problem AOD use and fear of negative consequences. Stigma can be a greater factor than for general populations, because of discrimination and negative stereotypes around substance use experienced by Aboriginal and Torres Strait Islander peoples (National Indigenous Drug and Alcohol Committee, 2014). This stigma can be internalised and result in shame in individuals suffering from problems with AOD use, or in their families (Gendera et al., 2022). Services need awareness and processes to ensure access to treatment for individuals who may not seek treatment because of fear of negative reactions from members of extended family or community if they find out about their problem AOD use.

It has been advised that health workers can facilitate engagement by using a flexible and friendly approach, with time for social yarning before questions on sensitive issues (Lovett et al., 2014; Teasdale et al., 2008; Wallace & Allan, 2019). Access to treatment and support can be facilitated by Aboriginal and Torres Strait Islander staff including health workers, AOD workers, liaison officers (in mainstream services), peer workers and others (Gendera et al., 2022).

Health incorporates social and emotional wellbeing

Health for Aboriginal and Torres Strait Islander peoples (and all people) is broader than just absence of mental or physical illness (World Health Organization). Connection to family, community, Country, culture, cultural identity, and spirituality are some of the foundations on which individuals can thrive (Dudgeon et al., 2014; Reilly et al., 2020). Supporting social and emotional wellbeing for Aboriginal and Torres Strait Islander people is considered key to healing from problem AOD use (Dudgeon et al., 2014; Gendera et al., 2022; Nagel et al., 2009; National Indigenous Drug and Alcohol Committee, 2014; Reilly et al., 2020).

Reconnecting to Country can be part of healing from problem AOD use, stress or distress (Freeburn et al., 2021; Gendera et al., 2022; James et al., 2021; Munro et al., 2017; Taylor et al., 2013). This typically involves the person returning to their traditional Country, to which they have spiritual connection. In contrast, disconnection from Country can have adverse impacts on mental health (Dolan et al., 2015; James et al., 2021; Taylor et al., 2013).

Because of the importance of family in wellbeing, it is appropriate to offer the option of including family in the treatment process (National Indigenous Drug and Alcohol Committee, 2014), where the client is willing.

In keeping with an Aboriginal and Torres Strait Islander model of health and wellbeing, treatment for problem AOD use should be holistic wherever possible – where physical, mental health and social needs are all considered (Purcell-Khodr et al., 2020). This treatment can build on strengths of the individual, family, community and culture (Gendera et al., 2022). Provision of AOD treatment or care within a primary care setting can facilitate integrated care (Freeburn et al., 2021). Where specialist AOD treatment services are also needed, the primary care service can help ensure continuity of care.

Cultural aspects of treatment

Many treatments for problem AOD use (e.g. counselling approaches, medicines) that have been shown to be effective for general populations are also used in treatment for Aboriginal and Torres Strait Islander peoples. However, a culturally secure treatment delivery approach is recognised as important (National Indigenous Drug and Alcohol Committee, 2014). This includes recognition of an individual's priorities, such as connection to Country

and culture, and the creation of a welcoming treatment environment (Freeburn et al., 2021; Teasdale et al., 2008; Wallace & Allan, 2019). For example, having a yarn (Purcell-Khodr et al., 2022), and asking a person 'Where is your Country?' (Lovett et al., 2014) can be culturally secure ways to start a conversation with a client, before asking about AOD use. Assessment and counselling are also typically done in a conversational or yarning style (Assan et al., 2021).

Community controlled AOD treatment services typically include aspects of Aboriginal or Torres Strait Islander culture and spirituality as part of treatment or in the treatment environment (Chenhall & Senior, 2013; Gendera et al., 2022; Kelly et al., 2022; Munro et al., 2017; Taylor et al., 2013).

Cultural activities are often included in treatment or care for individuals with problem AOD use (Conigrave et al., 2021; Dzidowska et al., 2022; Farnbach et al., 2021) and can include focus on caring for Country, use of traditional skills such as hunting or fishing, or a smoking ceremony (Purcell-Khodr et al., 2022). Traditional music and art are also often described as part of therapeutic interventions (Chenhall, 2008; Munro et al., 2017; Nagel et al., 2009). Aboriginal and Torres Strait Islander men's or women's groups are one context in which cultural activities can be conducted (Purcell-Khodr et al., 2022) (see *Group-based approaches*).

Academic literature often does not describe specific elements of culture involved, and these may vary based on local protocols. Typically, local communities are well aware of relevant elements of culture. More detailed descriptions of use of culture in care for individuals with AOD problems are found in reports of community interventions for young people (see *Young people*).

There is evidence emerging that culturally informed services and cultural aspects to AOD treatment - that build on Aboriginal and Torres Strait Islander ways of knowing, being and doing - can improve both treatment accessibility and outcomes (Calabria et al., 2020; d'Abbs et al., 2013; Kelly et al., 2022; Lee et al., 2013; Munro et al., 2018; Preuss & Brown, 2006). For example, Aboriginal and Torres Strait Islander men attending a community controlled rehabilitation centre were much more likely to complete treatment compared to those in mainstream services (Kelly et al., 2022). However, the direct effect on outcomes of including cultural elements has not been quantified by scientific research.

Adapting mainstream treatments or services

Not all Aboriginal and Torres Strait Islander people seeking support for AOD issues are able to access treatment in Aboriginal community controlled services. Sometimes such a service is not locally available. Other individuals prefer the anonymity of a mainstream service. Several authors have described the need to assess and adapt mainstream services and interventions to improve their suitability for Aboriginal and Torres Strait Islander Australians (Gray et al., 2014; Teasdale et al., 2008). Cultural differences between communities can be large, so a 'one-size-fits-all' approach cannot be applied. Treatment services need to be planned and delivered in partnership with local community, community controlled services and local Aboriginal and Torres Strait Islander staff from that community (Purcell-Khodr et al., 2022; Taylor et al., 2013; Teasdale et al., 2008; Williams et al., 2006).

In one urban mainstream service, consultation was conducted with the local Aboriginal community controlled health service (ACCHS), which provides holistic primary health care to that community. Also, Aboriginal health professionals and Aboriginal clients of the mainstream service were consulted on how that mainstream service could be improved (Teasdale et al., 2008). The results suggested a need for increased service flexibility, a more human and person-centred approach, a less clinical environment (for example with Aboriginal art on the wall), more Aboriginal staffing and creation of an Aboriginal women's group (Teasdale et al., 2008). A similar consultation process was conducted in an urban site in another state (Williams et al., 2006). That process also suggested the need for flexibility in the form of outreach services, as well as the need to develop an opioid substitution program within an existing family-friendly mainstream primary health service (Williams et al., 2006).

Consultation has also been conducted to develop a set of guidelines for all mainstream AOD services in New South Wales (NSW) to improve the way they work with Aboriginal and Torres Strait Islander clients (Farnbach et al., 2021; Wallace & Allan, 2019). This consultation was with community controlled organisations such as ACCHSs and Aboriginal AOD rehabilitation centres, as well as with Aboriginal health professionals and Aboriginal community members with lived experience of AOD problems (Farnbach et al., 2021; Wallace & Allan, 2019). Six key domains of action were described: 1) Creating a welcoming environment; 2) Service delivery (culturally informed, flexible and where possible, immediate assistance); 3) Voice of the community (community consultation and engagement); 4) Engagement with Aboriginal organisations and workers; 5) Culturally capable staff; and 6) Organisation's responsibilities (including Aboriginal staffing, and organisational changes to create and maintain change) (Farnbach et al., 2021). A pre-post audit of 15 mainstream AOD services demonstrated that these steps could be implemented with a high degree of fidelity (Farnbach et al., 2021).

As well as mainstream services seeking advice from community controlled services on service delivery, successful ongoing collaborations between ACCHSs and mainstream services have been reported, which have been reported to result in benefits of two-way learning, more integrated care, and increased access to services (Freeburn et al., 2021; Williams et al., 2006).

In addition to service-wide adaptations, specific mainstream treatment approaches have been adapted in both mainstream (Teasdale et al., 2008; Williams et al., 2006) and community controlled services (d'Abbs et al., 2013; Nagel et al., 2009; Reilly et al., 2020; Taylor et al., 2013; Teasdale et al., 2008; Williams et al., 2006). This includes having increased flexibility in treatment program delivery (d'Abbs et al., 2013), and anchoring treatments in Aboriginal or Torres Strait Islander priorities (Nagel et al., 2009).

The importance of employing Aboriginal and Torres Strait Islander staff

The importance of Aboriginal and Torres Strait Islander staff in ensuring culturally secure, accessible and effective treatment is well recognised (Ella et al., 2015; National Indigenous Drug and Alcohol Committee, 2014; Roche et al., 2013). In community-based surveys or consultations, respondents express a preference for an Aboriginal or Torres Strait Islander staff member to be involved in their care should they have an alcohol problem (Brett et al., 2017; Teasdale et al., 2008; Weatherall et al., 2021). An Aboriginal AOD worker was the most endorsed source of help around cutting down or stopping alcohol use in a sample of n=775 individuals, across two communities in remote and urban South Australia (selected by 75% of respondents) (Weatherall et al., 2021). In contrast, in close-knit communities, some individuals with problem AOD use prefer the anonymity of a mainstream service and staff (Teasdale et al., 2008; Williams et al., 2006). Accordingly, choice is important (Wallace & Allan, 2019).

Purcell-Khodr et al. (2022) report on interviews with 17 Aboriginal and Torres Strait Islander staff working at 11 ACCHSs about how culture influences their work with individuals with hazardous or problem alcohol use. Respondents describe culture underpinning all their interactions - with both clients and community (Purcell-Khodr et al., 2022). This includes taking time to 'yarn' with clients, to help make them comfortable (Purcell-Khodr et al., 2022). Cultural protocols also influence who is the best positioned staff member to talk with a client (Purcell-Khodr et al., 2022). At the simplest level, this includes gender matching of clients to staff where possible (Chenhall & Senior, 2013; Purcell-Khodr et al., 2022 ; Shaw et al., 2011). Similarly, in a residential rehabilitation centre, culture underpins Aboriginal staff interactions with clients; for example, staff may formally welcome a client to Country if they have come from another region (Taylor et al., 2013).

As well as understanding culture, local Aboriginal and Torres Strait Islander staff often understand the family and community context of their client and can recognise who is the best community member to provide support (Purcell-Khodr et al., 2022).

However, Aboriginal and Torres Strait Islander AOD staff can experience considerable pressures (Ella et al., 2015; Roche et al., 2013). Supporting these staff is recognised as important to avoid burnout and staff turnover (Brady et al., 2002; Calabria, Clifford, Rose, et al., 2014; Chenhall & Senior, 2013; d'Abbs et al., 2013; Munro et al., 2017; Roche et al., 2013). This support could include clinical supervision and cultural mentoring (Ella et al., 2015; Roche et al., 2013). Several states or territories have training and support programs for Aboriginal and Torres Strait Islander AOD workers. In NSW, there is a peer-led network, the Aboriginal Corporation Drug and Alcohol Network (ACDAN) (Lee et al., 2017). There have also been calls from Aboriginal and Torres Strait Islander AOD workers for a national representative body (National Indigenous Drug and Alcohol Council, 2013b).

Treatment approaches

A range of treatment approaches are used for individuals with problem AOD use. Treatment can be provided across settings ranging from in the community or primary health care services through to specialised residential AOD treatment services. It can include: withdrawal management where needed, approaches to helping someone avoid returning to using alcohol or other drugs, supporting the client to get treatment for physical or mental health issues, reducing harms if someone cannot or will not stop using a substance, and peer support. As described above, cultural elements can also be used either as a specific treatment approach, or to support treatment, rehabilitation, or broader healing.

Brief intervention

Brief intervention is a short, structured conversation designed to help a person to reflect on their AOD use and to make a change (Babor et al., 2017). In general population studies, when hazardous or harmful (non-dependent) alcohol use is detected, a brief intervention has been shown to be effective in reducing consumption (Kaner et al., 2009). However, no effectiveness studies have yet been completed for Aboriginal and Torres Strait Islander peoples (Brady et al., 2002; Dzidowska et al., 2022).

Early or brief intervention can happen after an AOD problem is incidentally discovered. Or it can happen after pro-active screening, for example in settings, such as primary care, the emergency department, or mental health services. A range of screening tools for substance use has been used among Aboriginal and Torres Strait Islander Australians, including the three item AUDIT-C (Alcohol Use Disorders Identification Test – Consumption questions) and its variants (Brady et al., 2002; Calabria, Clifford, Shakeshaft, et al., 2014; Conigrave, Harrison, et al., 2021; Islam et al., 2018). The Indigenous Risk Impact Screen (IRIS) (Schlesinger et al., 2007) is a tool that was designed to screen simultaneously for any AOD problem, as well as for mental health conditions (Schlesinger et al., 2007).

At the time of writing, implementation of alcohol screening and brief intervention in ACCHSs remains patchy (Conigrave, Harrison, et al., 2021; Panaretto et al., 2010). Barriers to implementation include the perceived sensitivity of talking about drinking, particularly for an Aboriginal or Torres Strait Islander health worker who may be a relative or community member of the client (Brady et al., 2002). Other barriers include time pressures, particularly given the complex health challenges that are common among Aboriginal and Torres Strait Islander clients (Clifford et al., 2012). System-wide issues including a lack of referral options may also discourage detection of problem alcohol use (Clifford et al., 2012).

Several projects have encouraged implementation of culturally adapted brief interventions into ACCHSs (Brady et al., 2002; Conigrave, Harrison, et al., 2021; Dzidowska et al., 2022). Clifford (2013) found that after support was provided to staff on the use of brief intervention, recording of brief interventions for eligible clients increased from 26% to 48% ($p<0.001$; in a study without a control group) (Clifford et al., 2013). In contrast, in a cluster-controlled trial involving 22 ACCHSs, a service-wide model of support resulted in a small but statistically significant increase in alcohol screening but no increase in recorded brief interventions (Conigrave, Harrison, et al., 2021; Dzidowska et al., 2022).

The authors suggest that practice software changes may help to prompt clinicians to deliver both brief intervention and make it easier to record it (Dzidowska et al., 2022).

A longer form of culturally adapted brief intervention was developed and examined in three remote Northern Territory (NT) communities (Nagel et al., 2009). In a randomised controlled trial, brief intervention and motivational care planning for chronic mental health disorders and problem AOD use was compared against treatment as usual among 49 participants (Nagel et al., 2009). Nagel et al. describe motivational care planning as involving four steps: 'discussion about family support, exploration of strengths and of stresses, followed by goal-setting.' Most (n=40; 82%) participants used substances - mainly alcohol or cannabis, and of these, 92% were judged to be psychologically dependent on that substance. The intervention included two one-hour sessions, including problem-solving, motivational therapy and self-management principles, plus psycho-educational videos. Goal setting aligned with the individual's cultural perspective, and family were involved in the sessions. General mental health outcome measures improved in the intervention group more than in the treatment as usual group (Nagel et al., 2009). A reduction in severity of alcohol dependence in the intervention arm compared with treatment as usual did not reach statistical significance (p=0.05). The authors reported a reduced prevalence of 'substance misuse' in participants who received the intervention based on observations of Aboriginal mental health workers (41% at baseline, 16% at 18-month follow up), but no comparison data for the control arm were presented (Nagel et al., 2009).

At least three other brief intervention approaches have been described, however none of these have been evaluated for effectiveness. Firstly, the IRIS program (Gray et al., 2010; Schlesinger et al., 2007) provided training nationally on screening and brief interventions for both mental health and problem AOD use. The brief intervention incorporated principles of motivational interviewing (see *Psychological interventions ['talking therapies']*) but was founded in Aboriginal and Torres Strait Islander cultural priorities. Secondly, in a very different approach to brief intervention, a computer application (app) was developed to provide brief intervention to individuals identified as having hazardous or problem alcohol use through an interactive and visual app using a tablet (Lee et al., 2021). Informal feedback from participants suggested that the survey about alcohol use on the app, followed by the brief intervention prompted reflection on drinking (Lee et al., 2021). Finally, a group-based approach to alcohol screening and brief intervention was piloted in an urban setting (Conigrave et al., 2012). Existing groups of Aboriginal men or women were offered individual self-administered AUDIT screening with pen and paper with confidential feedback of scores. Then group discussion on alcohol use took part, with visual aids following the framework of brief intervention. Observers commented that the process appeared acceptable and engaging to participants (Conigrave et al., 2012).

Psychological interventions ('talking therapies')

Several psychological interventions (or 'talking therapies') have been shown to be acceptable in helping people reduce or cease AOD use in Aboriginal and Torres Strait Islander populations (Brady et al., 2002; Calabria et al., 2013; National Indigenous Drug and Alcohol Council 2014). These have sometimes been provided one-on-one, sometimes with family members or involving community members. The two most commonly used psychological therapies in mainstream settings are motivational interviewing and cognitive behavioural therapy (CBT) (Haber & Riordan, 2021, National Indigenous Drug and Alcohol Council 2014).

Motivational interviewing has been used among Aboriginal and Torres Strait Islander Australians to enhance and sustain motivation for change in problem AOD use (Brady, 2002; Nagel et al, 2009). This approach includes helping an individual to weigh up the things they like and the things they do not like about AOD use, so that the person might build their motivation for change. This approach respects the individual's right to choose whether or how they use a substance, and links to that person's priorities (Dudgeon et al., 2014; Miller & Rollnick, 2012). As mentioned above, the brief interventions used by Nagel et al. (2009), as well as those used in the IRIS training (Schlesinger et al., 2007), included

elements of motivational interviewing, aligned with Aboriginal and Torres Strait Islander cultural priorities.

CBT is recommended in mainstream alcohol treatment guidelines as a first-line psychological intervention (Haber & Riordan, 2021) and is designed to help a person change their thinking and behaviour around substance use. It is most often delivered as individual therapy over several sessions. When combined with medicines for alcohol dependence it can have even greater benefits (Haber & Riordan, 2021). CBT is also used in a group context in SMART Recovery (see *Group-based approaches*).

Central Australian Aboriginal Congress planned to use CBT together with motivational interviewing, goal setting and problem solving with individuals and with families, as one of three arms of a pilot treatment program for problem alcohol use (d'Abbs et al., 2013). The second arm of therapy included relapse prevention medicines, such as naltrexone, to be prescribed by GPs of the service; and a third arm provided social and cultural support (housing, employment, reconnecting with identity etc.). The authors describe that the study was limited by a short funding timeline and difficulty hiring suitably qualified staff for the CBT (a registered psychologist was needed to obtain the government rebate under a mental health care plan). A flexible treatment manual was developed which allowed the therapist to identify areas of focus with participants rather than following a rigid plan of sessions. Other challenges included trying to contact or engage clients referred to the program: 42 of 129 referrals were uncontactable and a further 18 did not engage. A relatively small number (n=19) of participants received at least one arm of treatment, and of these 79% ceased or reduced alcohol intake. However, clients who received no treatment did almost as well as well (70% reported reduced use or cessation of alcohol) (d'Abbs et al., 2013). Regardless, the program helped illustrate both potential challenges and opportunities of community treatment.

Calabria and colleagues examined the acceptability of two forms of CBT that aim to help an individual reduce alcohol use by drawing on relationships with family and community. These were the Community Reinforcement Approach (CRA) and Community Reinforcement and Family Training (CRAFT) (Calabria et al., 2013). CRA focusses on helping the individual to find ways of receiving more 'reward' (positive reinforcement) for situations or interactions that do not involve alcohol, than for situations that do include drinking (Calabria, 2014).

CRAFT is a related approach aimed to directly help the family members to support change in the person with problem AOD use (see *Engaging family, carers and community*). In a survey of 116 Aboriginal participants (from an ACCHS and a community based AOD treatment service) both CRA and CRAFT were found to be highly acceptable (Calabria et al., 2013). Suggested adaptations included having a local health worker with respect in the community to deliver counselling, having at least five sessions, and ensuring follow-up (Calabria et al., 2013).

Calabria and colleagues then consulted with working groups involving 22 health care providers (3 of them Aboriginal) (Calabria, Clifford, Rose, et al., 2014) on how to further tailor CRA and CRAFT to Aboriginal participants. Suggestions included use of groups as well as one-on-one delivery, adapting the language to phrasing used by Aboriginal people, and including more Aboriginal-relevant scenarios (Calabria, Clifford, Rose, et al., 2014). The tailored CRA was then delivered to 55 individuals (44% of them Aboriginal) with problem AOD use in rural NSW community-based settings (Calabria et al, 2020. Participants reported that they saw the therapy as acceptable and effective. Three-month outcomes suggested improvement in substance use, wellbeing and empowerment compared to baseline (Calabria et al, 2020). However, just over half the participants were lost to 3-month follow-up, and there was no control group.

The importance of broader psychological and social factors (not just substance use) was pointed out by another study - a community-based survey among Aboriginal Australians. This showed that where drinking alcohol meets a person's basic psychological needs (i.e., makes that person feel more free, more connected, more competent) that person is likely to drink more and to have more symptoms of alcohol dependence

(Conigrave, Bradshaw, et al., 2021). Accordingly, the authors suggest that measures to restore individuals' (and communities') sense of self-determination are likely to be beneficial alongside treatment (and prevention) efforts. This resonates with Aboriginal and Torres Strait Islander peoples' calls for self-determination, and knowledge of mental health and wellbeing.

Anecdotally, a wide range of other counselling approaches have been used among Aboriginal and Torres Strait Islander clients and have found to be acceptable and beneficial when used in a culturally secure manner. These include narrative therapy, mindfulness-based approaches, and dialectical behavioural therapy (DBT). No research has been done on the role or effectiveness of these approaches in this population.

Group-based approaches

A range of group approaches to therapy or care for problem AOD use has been used among Aboriginal and Torres Strait Islander Australians. As well as offering peer support or learning (Dale et al., 2019), groups can provide an alternative social circle to the drinking group. Group settings also can allow increased treatment access, because of larger numbers.

Men's groups and women's groups

Men's or women's groups can be offered in a range of settings, including ACCHSs (Purcell-Khodr et al., 2022), mainstream AOD treatment services (Lee et al., 2013; Lee et al., 2014), or in residential rehabilitation services (Kelly et al., 2022).

Men's groups and women's groups may include health education and peer support, and often involve cultural activities. During groups, participants may share experiences in a non-judgemental space, complete social activities such as barbeques, and cultural activities (Lee et al., 2013; Purcell-Khodr et al., 2022). An informal approach to groups, with additional support such as childcare, and providing food and a range of activities has been found to be acceptable and feasible (Lee et al., 2013). Aboriginal and Torres Strait Islander health staff can lead the group (or play a key role in it) and can offer support for issues that arise in an informal setting (Conigrave et al., 2012; Lee et al., 2013; Lee et al., 2014).

When community members (n=775) were asked in a survey what help would they recommend to a person with alcohol problems, they selected men's or women's groups more often than mainstream-derived peer support groups such as Alcoholics Anonymous (AA) (see below) (Weatherall et al., 2021).

Peer support groups

Peer support groups include SMART Recovery, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).

SMART Recovery is a CBT-based peer support program, led by a trained facilitator. A handbook to modify the program to increase suitability for Aboriginal and Torres Strait Islander participants was developed some years ago, but was not officially integrated into the SMART Recovery program (Dale, Conigrave, et al., 2021). The adapted SMART Recovery handbook was evaluated for its cultural utility in a Delphi study, with expertise from 11 Aboriginal and Torres Strait Islander health professionals (Dale, Conigrave, et al., 2021). Participants identified the importance of involving Aboriginal and Torres Strait Islander peoples in the design and delivery of SMART Recovery. They suggested further adaptations to the language to make it more culturally appropriate and accessible; culturally meaningful program activities; supplementary storytelling resources; and customisation for diverse community contexts (Dale, Conigrave, et al., 2021). In a second study, 10 Aboriginal SMART group facilitators and 11 participants of Aboriginal-led SMART Recovery groups were interviewed (Dale, Lee, et al., 2021). The respondents suggested improvements to SMART Recovery including using a more flexible, yarning approach; integration of Aboriginal perspectives; creation of an Aboriginal-specific program; and greater community engagement and networking opportunities (Dale, Lee, et al., 2021).

Research on outcomes of SMART Recovery participation among Aboriginal and Torres Strait Islander peoples has not been published.

AA and NA are available in many parts of Australia. Adaptions have been made to these peer support models to better fit an Aboriginal or Torres Strait Islander worldview (Chenhall, 2008). The second step of the 12-step model used in AA and NA, is, 'coming to believe that a power greater than ourselves could restore us to sanity.' (American Addiction Centers Editorial Staff, 2022). Some Aboriginal and Torres Strait Islander AA members consider that the 'higher power' described in AA can be thought of as encompassing Aboriginal spirituality (Munro et al., 2017).

Engaging family, carers and community

For Aboriginal and Torres Strait Islander peoples, strong ties with family and community mean that culturally safe care should involve offering inclusion of family in the treatment process (National Indigenous Drug and Alcohol Committee, 2014). Also, understanding the family and community context is important. This includes knowing sources of strength and support. On the other hand, it also involves knowing if the individual is drinking or using substances with family or friends.

Families can provide significant support for individuals with problem AOD use. Partners, family, carers and community feel the impacts of AOD use from those close to them (Gendera et al., 2022; Lee et al., 2014). The trauma and grief experienced when a family member has problem AOD use, can be exacerbated by the stigma associated with that person's substance use (Gendera et al., 2022). This stigma can make family members feel isolated and influence whether they seek help for themselves or their family member (Gendera et al., 2022). Lack of accessible treatment for the individual can place additional burden on family (Gendera et al., 2022). Individuals who use drugs (particularly methamphetamines / ice) express a need for support to stay connected to family and community (MacLean et al., 2017). But their families in turn have significant need for support (Gendera et al., 2022).

As mentioned above, CRAFT is a model of CBT that focuses on helping a family member to support their relative to reduce or stop AOD use (Calabria et al., 2013). CRAFT teaches one or more family members to help their relative to gain more reward from activities or interactions that don't involve substance use, than from activities that do. The family member also learns to maintain their own wellbeing, and to support their relative to engage with treatment. As described above, both CRAFT, and the related individual therapy, CRA (the Community Reinforcement Approach), were seen as highly acceptable by Aboriginal community members (Calabria et al., 2013). These approaches have also been tailored to an Aboriginal setting by Calabria et al, including with delivery in groups rather than just one-on-one (Calabria et al., 2014).

Negative experiences with government child protection authorities can pose a barrier to accessing AOD treatments for parents, or even for extended family carers (National Indigenous Drug and Alcohol Committee, 2014). Holistic support can be provided as part of AOD treatment, including services such as parenting support for carers of children (Lee et al., 2013), and (by observation) psychological or educational services for children and free legal services.

The demand for treatment and its potential effectiveness is likely to be influenced by community-wide prevention measures, ranging from addressing social determinants of health, through to specific health promotion efforts, and related policies, including supply reduction (Lee et al., 2008; National Indigenous Drug and Alcohol Committee, 2014; Preuss & Brown, 2006). The community-wide prevention efforts may target a specific substance-related issue or may target AOD use in general. There have been some successful efforts to reduce the toll of alcohol use, and to reduce drinking in pregnancy and so the risk of FASD (Symons et al., 2020). It is not within the scope of this report to cover these in detail.

Withdrawal management (detoxification)

Individuals who become unwell when ceasing or cutting down on substance use may need a period of withdrawal management (detoxification), which typically lasts up to a week. A hospital or other residential setting is needed if withdrawal symptoms are likely to be severe, including when there is a risk of seizures (such as in severe alcohol or benzodiazepine withdrawal). Inpatient withdrawal management is also needed where cravings cannot be managed at home, or where the home environment is not suitable.

Many residential rehabilitation services require people to be alcohol and illicit drug free and to have completed any withdrawal management before admission. While Aboriginal community controlled rehabilitation services are available in many parts of Australia, we have observed that inpatient detoxification is mostly provided only in mainstream services. Lack of access to withdrawal management is reported as a barrier to accessing rehabilitation (Brett et al., 2014; Brett et al., 2016, National Indigenous Drug and Alcohol Council, 2013a).

Brett et al. (2014) described approaches used to increase access to ambulatory (non-residential) withdrawal management for Aboriginal and Torres Strait Islander Australians. This included non-medical staff in services providing support, while local GPs prescribed the diazepam (with regulated dispensing). Anecdotally at least one NSW rural residential rehabilitation unit collaborates with local GPs to provide on-site withdrawal management.

Illawarra Aboriginal Medical Service (in regional NSW) piloted a model for ambulatory withdrawal management (Brett et al., 2017). In a case series of n=8 clients, the authors found that withdrawal could be successfully managed in a community setting for carefully selected individuals (e.g., with no history of seizures). General supportive counselling, daily withdrawal monitoring and daily dispensing of diazepam was offered (Brett et al., 2017). Planning for relapse prevention was started during the withdrawal, including consideration of relapse prevention medicines (Brett et al., 2017).

Medicines for relapse prevention

Several medicines are used to reduce the risk of relapse back into dependent AOD use or to support individuals to cease use. There are no specific Aboriginal and Torres Strait Islander population studies to suggest that certain medicines are superior or less useful than in general populations.

Alcohol relapse prevention medicines have been used in ACCHS settings (Brett et al., 2017; d'Abbs et al., 2013), although, one remote ACCHS reported limited prescribing of these (d'Abbs et al., 2013). Anecdotally alcohol relapse prevention medicines are used in many mainstream AOD treatment services.

The environment in which a medicine, such as an opioid substitution treatment, is provided may assist with access, cultural appropriateness and continuity of care (Black et al., 2007; Freeburn et al., 2021; Williams et al., 2006). For instance, one AOD treatment program in an ACCHS has been sustained for over 20 years and provides culturally appropriate opioid substitution treatment and other therapies (Freeburn et al., 2021). Authors suggest that part of the success of the service relates to its Aboriginal staffing and a holistic, friendly, and client-centred approach (Freeburn et al., 2021). Several other ACCHSs prescribe opioid substitution therapy (Black et al., 2007; Freeburn et al., 2021).

As with other groups, Aboriginal and Torres Strait Islander people on opioid substitution treatment, are increasingly on buprenorphine preparations rather than on methadone (Australian Institute of Health and Welfare, 2022b). This includes growing numbers on extended release, injectable buprenorphine (Freeburn et al., 2021) which can last up to a month

Residential rehabilitation

Following management of withdrawal symptoms (detox) some people with AOD dependence may choose or need a period of rehabilitation to allow time to adjust to life without substance use in a supportive and therapeutic environment.

Aboriginal and Torres Strait Islander community controlled residential rehabilitation services operate in several regions, including NSW, Western Australia (WA) and the NT (Aboriginal Drug and Alcohol Residential Rehabilitation Network, 2022; Alcohol and Other Drugs Knowledge Centre; National Indigenous Drug and Alcohol Committee, 2014). These vary greatly in approach, but most deliver mainstream therapeutic approaches alongside programs with cultural elements (Chenhall, 2008; James et al., 2021; National Indigenous Drug and Alcohol Committee, 2014). Clients report feeling more at home in Aboriginal community controlled services compared with mainstream AOD treatment services (Munro et al., 2017). Kelly and colleagues report that Aboriginal men at a community controlled rehabilitation centre experienced lower levels of symptom distress, greater clinical improvement at 60 days, and were more likely to complete treatment when compared to Aboriginal men admitted to mainstream services (Kelly et al., 2022).

James et al., (2021) describes the six Aboriginal community controlled rehabilitation programs in NSW as having six components: cultural healing, case management, education/life skills, therapeutic activities, time out from substances and aftercare planning and support. The same authors also analysed quantitative data on reasons why people left Aboriginal residential rehabilitation centres in NSW early to better understand how services might provide more tailored approaches. Service-initiated discharge (e.g. for violence, or drug use) was found to be more likely if clients were referred from the justice system, had opioids or stimulants as their main substance use, or were under 30 years old (James et al., 2021). Aboriginal clients were more likely to leave rehabilitation centres early if stimulants were their main substance used and such clients were almost eight times more likely than other clients to be readmitted within two years (relative risk 7.91 $p <= 0.001$) (James et al., 2021).

Consultation with senior Aboriginal and Torres Strait Islander health professionals suggests that the policy of some mainstream residential rehabilitation centres to discourage mobile phone calls for a period of time can be particularly challenging for Aboriginal and Torres Strait Islander clients. When family are not physically present, typically Aboriginal and Torres Strait Islander residential rehabilitation centres ensure good communication between client and family and include family in discharge planning. Some rehabilitation centres in remote settings, allow whole families to attend, providing housing for families, schooling for children, and the opportunity for partners to be involved in the treatment process.

Where Aboriginal and Torres Strait Islander rehabilitation services provide post-discharge support this is described by participants in the studies, and/or authors, as a desirable part of the programs (Calabria et al., 2013; James et al., 2021; Munro et al., 2017; Nathan et al., 2020; Shaw et al., 2011). Further work is underway in NSW, to clarify key principles of an Aboriginal model of care for residential rehabilitation, as well as developing meaningful outcome measures (James et al., 2017) (see *Research needs*, below).

Approaches used in specific Aboriginal or Torres Strait Islander populations

Rural and remote communities

Aboriginal and Torres Strait Islander people are more likely to live in urban (38%) and regional areas (44%) making up 1.09% of the total population in major cities. In contrast, 17% Aboriginal and Torres Strait Islander people live in remote and very remote areas making up 32% of Australians living in these areas, with 9.8% speaking one of the 150 Indigenous languages at home (Australian Institute of Health and Welfare, 2022d).

Community based psychological therapies are reported to be acceptable and feasible in rural settings (Calabria et al., 2020). The cultural security of health care becomes even more important in remote regions, where Aboriginal and Torres Strait Islander individuals may have distinct culture and language. An AOD worker from that community has a particular advantage in providing health care (Purcell-Khodr et al., 2020). They know the local language, culture and context, and are likely to know key individuals who may be able to offer support. Though it should be noted, staffing shortages in remote areas can present

challenges for AOD service delivery (d'Abbs et al., 2013) and increase the burden on local Aboriginal and Torres Strait Islander AOD staff (Ella et al., 2015).

Over a third of the Aboriginal and Torres Strait Islander people in regional or remote areas who sought treatment for AOD use travelled for an hour or more to reach services (Australian Institute of Health and Welfare, 2022b). This can mean that the need for residential treatment must be balanced against the desire to remain on Country, and its benefits (Brett et al., 2016).

Young people

Survey data have suggested a shortage of treatment options for Aboriginal and Torres Strait Islander young people with problem AOD use (Calabria et al., 2013). Residential rehabilitation treatment can be particularly challenging to arrange. Nathan et al. (2020) describe significant improvements in the self-reported use of substances (tobacco, alcohol and stimulants) in young Aboriginal and Torres Strait Islander Australians three months after leaving residential treatment (after a stay of at least 30 days), however follow up data were only available for 89 of 247 possible participants.

Some remote communities have developed programs for young people with problem AOD use such as Mt Theo (Preuss & Brown, 2006) and the Ilpurla residential and community support program (Shaw et al., 2011). Each of these programs included cultural enhancement and involvement of Elders. The Mt Theo program was initiated by a local (NT) Aboriginal community and relocated young people who were sniffing solvents to an outstation (Preuss & Brown, 2006). There, they took part in cultural and other activities. The authors describe '...Elders(:) talk with young people about issues in their lives and Jukurrpa (Dreaming); take them hunting for bush foods; and love, care and pray for the young people' (Preuss & Brown, 2006). This outstation care of young people identified as using solvents occurred at the same time as a community-wide youth development program, providing activities seven days a week (Preuss & Brown, 2006). Similarly, the Ilpurla residential and community support program involved 'handing over' young people who have significant solvent use to family-type care where they were observed and supported by an older person (Shaw et al., 2011). This is described as 'kanyirninpa', meaning the older person protects the younger person and supports them to 'grow up the right way' with the younger person in turn being required to respect them (Preuss & Brown, 2006; Shaw et al., 2011).

Young urban Aboriginal people with hazardous or problem AOD use reported a preference for a 'one-stop shop' for their needs, where AOD counselling is available at the same site as practical support and general health care (Dowsett et al., 2019). They also expressed a desire for cultural learning (Dowsett et al., 2019).

Individuals with other health issues

Physical comorbidities can be more common among Aboriginal and Torres Strait Islander people with problem AOD use, than in their general population peers, because of the background of higher prevalence of physical health disorders in community (Australian Institute of Health and Welfare, 2022c). Accordingly, co-occurring physical health issues need to be considered when selecting options for AOD use treatments. For example, a history of unstable diabetes means that the outpatient (or ambulatory) setting may not be appropriate for withdrawal management (Brett et al., 2014).

Mental health comorbidity occurs frequently in those with problem AOD use in any population and may have a higher prevalence in Aboriginal and Torres Strait Islander peoples because of the ongoing impacts of colonisation (National Indigenous Drug and Alcohol Committee, 2014). This can include grief, loss and trauma, as well as the well-known associations between methamphetamines or cannabis and psychosis. Several reports describe the stress for individuals who suffer from such comorbidities and often for their families (Gendera et al., 2022; Lee et al., 2014). Experience of grief, loss and trauma is common – either occurring well before the substance use started or occurring during the period of substance use and making addressing substance use harder.

Despite their high need, people with co-occurring mental health concerns and problem AOD use can experience barriers to treatment access. Interviews with women with problem AOD use and mental health concerns and their families, describe a need for more friendly and flexible services which can cater for both issues (Lee et al., 2014).

A range of approaches to mental health concerns and AOD comorbidity is used in Aboriginal and Torres Strait Islander community controlled services (Dudgeon et al., 2014). Many of these resonate with findings of international research on the benefits of increased connection, on the potential role of music and art in therapy, and of indirect approaches to offer opportunities for traumatic memories to be acknowledged or gently processed (Gupta et al., 2020; Kapuaahiwalani-Fitzsimmons, 2015).

Trauma-informed care is increasingly mentioned as a key component to AOD treatment. It assumes that many people accessing AOD treatment have been impacted by traumatic experience/s. Trauma-informed services provide safety and trust, ensure that staff interactions with individuals in treatment are collaborative and empowering, and avoid re-traumatising the individual (New South Wales Government, 2022). Many Aboriginal and Torres Strait Islander communities offer programs to support healing, from grief, loss or trauma, sometimes including specific cultural activities (National Indigenous Drug and Alcohol Committee, 2014). Staff training in Mental Health First Aid and in the IRIS (Schlesinger et al., 2007) have been reported as valuable by professionals in the field.

The value of specific trauma therapies, such as eye movement desensitization and reprocessing (EMDR), among Aboriginal and Torres Strait Islander individuals with post-traumatic stress disorder (PTSD) and problem AOD use has not been examined. Nor has the role of DBT or mindfulness-based approaches (including Dadirri) or narrative therapy been examined, despite reports of effectiveness from Aboriginal or Torres Strait Islander and other health professionals or community members.

Specific treatment settings

Aboriginal community controlled health services

Aboriginal community controlled health services (ACCHSs) have a unique capacity to deliver culturally secure health care. There is a network of over 140 ACCHSs across Australia. These deliver holistic general health care and have been shown to improve health outcomes for Aboriginal and Torres Strait Islander communities (Campbell et al., 2017).

ACCHSs can also offer screening for AOD issues, and many offer specific treatment or care for problem AOD use, or offer shared care with mainstream AOD treatment services. Services are typically delivered in a friendly, flexible and holistic manner (Freeburn et al., 2021; National Indigenous Drug and Alcohol Committee, 2014). ACCHSs also play an important role in ensuring continuity of health care for those individuals who are referred on to a specialist ACCHS AOD treatment service. Some ACCHSs have specific AOD workers or teams and many have social and emotional wellbeing or mental health teams (Freeburn et al., 2021). Several ACCHSs offer opioid substitution treatment (see above) (Black et al., 2007; Freeburn et al., 2021). However the range of AOD treatments available from ACCHSs varies greatly.

Outreach services

Outreach assists in reaching individuals who want or need treatment within the community setting who would otherwise be unable to engage with services. It can involve meeting the person where they are at, such as their home or a public place, and where possible practically, resolving their most immediate needs (National Indigenous Drug and Alcohol Committee, 2014; Williams et al., 2006).

Emergency services

Gendera et al. (2022) report the challenges that family and carers face when trying to assist a relative with methamphetamine-related problems to access emergency services. They often had negative interactions with staff (Gendera et al., 2022). Discrimination, both because of problem AOD use (Habib & Adorjany, 2003), and/or because of direct or indirect racism, (Awofeso, 2011) can occur in some mainstream services.

Some, but not all, hospitals have Aboriginal or Torres Strait Islander AOD workers or liaison officers or who can contribute to culturally secure health care or facilitate access to specialist AOD treatment post discharge.

Prisons and the justice system

Two-thirds of all those incarcerated in Australia had an AOD use problem prior to custody (Doyle, Guthrie, et al., 2022). Aboriginal and Torres Strait Islander people in custody who have AOD use issues are more likely to access treatment for this in prison than when they were in the community (Dolan et al., 2015; Doyle et al., 2020; Doyle, Guthrie, et al., 2022). However, they are less likely to access AOD treatment in the community than non-Aboriginal prisoners (Dolan et al., 2015), with authors suggesting lack of culturally specific options as one reason for this.

There is considerable variety in the provision and availability of AOD programs in custodial settings across Australia (Doyle, Guthrie, et al., 2022). Most are group programs, designed to help individuals avoid or reduce substance use, with a goal of reducing recidivism (Doyle et al., 2020). Aboriginal participants in treatment programs in one group treatment program in a NSW prison reported that they value facilitators who are skilled as well as those who have lived experience (Doyle, Williams, et al., 2022). Doyle, Williams, et al. (2022) point to the benefits of having inmates who want to address their substance use living in a separate section of the prison to individuals who are not interested in changing their use.

Involuntary AOD treatment within the health system

Compulsory AOD treatment options, which are initiated based on health concerns, are provided for by legislation in three states: NSW, Victoria (Vic) and Tasmania - though that Tasmanian legislation is currently being repealed (Parliament of Tasmania, 2019). Program lengths vary (up to 14 days in Vic, up to 84 in NSW) (Lee, Bullen, et al., 2022).

These programs differ from the past mandatory alcohol treatment program in the NT where individuals were sent for treatment based on law-and-order concerns. That program was repealed in 2017 due to lack of efficacy and because of excessive referrals of Aboriginal and Torres Strait Islander Australians (97% versus 3% of other Australians; 2014-15) (PricewaterhouseCoopers Indigenous Consulting, 2017). In comparison, in NSW, in one report, 7.4% of people admitted to the NSW Involuntary Drug and Alcohol Treatment program identified as Aboriginal or Torres Strait Islander (Vuong et al., 2020).

Consistent with global reports on the effectiveness of involuntary treatment (Hall et al., 2014), an evaluation of the NSW Involuntary Drug and Alcohol Treatment Program found no improvement in health status for its clients compared to a control group (Vuong et al., 2020).

NSW clinicians describe a dilemma when considering referral for an Aboriginal client to involuntary treatment (Lee, Bullen, et al., 2022). On one hand, they feared re-traumatising the person. However, most interviewees also felt that the health care that would be provided through involuntary treatment was potentially life-saving, and Aboriginal clients should not be denied it. The report sets out potential ways of empowering individuals who are receiving treatment against their will, such as advising them of their right to appeal to the magistrate and providing them with any choices possible around treatment or transport details (Lee, Bullen, et al., 2022).

Treatment availability and accessibility

Aboriginal and Torres Strait Islander individuals and families can face numerous practical barriers to accessing AOD treatments. This can include distance and transport challenges (even in urban areas), lack of childcare options, and demands of the workplace (Conigrave et al., 2012; Lee et al., 2013; Weatherall et al., 2021).

Some withdrawal clinics and residential centres have restrictions on tobacco smoking which may deter some individuals from attending. Many do not accept individuals receiving opioid substitution treatment (for withdrawal from other substances). In addition, as mentioned above, individuals with co-morbid problem AOD use and mental health issues can face significant barriers to access (Lee et al., 2014).

Most residential rehabilitation units do not have onsite withdrawal management options, so clients in some rural regions are sometimes requiring transport many hours away to access withdrawal management, before driving to another site to access residential rehabilitation (Brett et al., 2017).

Collaboration between community controlled and mainstream services can increase treatment access as well as appropriateness and continuity of care (Freeburn et al., 2021; Taylor et al., 2013; Teasdale et al., 2008; Williams et al., 2006).

Harm reduction

Harm reduction strategies may be needed at several points along a person's journey with problem AOD use, including before, alongside and after treatment. It is unlikely that everyone will achieve abstinence from the start of treatment. Relapse is also a common occurrence. Accordingly, harm reduction services complement treatment. Harm reduction services also can provide an avenue through which clients are linked into treatment.

The range of harm reduction services includes sobering up centres (Brady et al., 2006), needle syringe programs, medically supervised injecting centres (Australian Government Department of Health, 2020) or provision of, and training to use, take-home naloxone (Conway et al., 2021). One peer-led program, Deadly Liver Mob, successfully used incentives to encourage Aboriginal and other clients attending needle and syringe services to recruit other individuals who inject drugs to receive information about harm reduction strategies, and to be screened and (if needed) for treatment of hepatitis C and other blood borne viruses (Treloar et al., 2018).

Treatment policy

Good policy, that allows effective, accessible and culturally appropriate AOD treatment, will be important in closing the current gaps in health and social outcomes between Aboriginal and Torres Strait Islander peoples and the remainder of the Australian population (Hill et al., 2022). Improved AOD treatment is likely to contribute to progress towards many of the targets set out by the National Agreement on Closing the Gap – an agreement between Australian governments and the Coalition of Aboriginal and Torres Strait Islander Peak Organisations (the Coalition of Peaks) (Department of the Prime Minister and Cabinet, 2020). For example, improved AOD treatment policy is likely to help reduce incarceration, help families to raise healthy children and engaged youth, and will contribute to social and emotional wellbeing across the Aboriginal and Torres Strait Islander community.

Aboriginal and Torres Strait Islander clinicians and services, report that short-term and limited funding (Gray et al., 2010) has constrained the range of treatments available through community controlled services, and whether or not services and programs are evaluated. Short-term funding contracts (Gray et al., 2010), that have been at times as short as 12 months for treatment services or programs have limited forward planning and staff workforce development. Also, the amount of funding provided to services has appeared to prevent employment of additional clinical staff. For example, most residential

rehabilitation services are not funded to employ registered nurses, which means that opioid substitution treatment cannot be offered. Similarly, despite the widespread occurrence of complex PTSD among Aboriginal and Torres Strait Islander clients with problem AOD use, few Aboriginal and Torres Strait Islander community controlled services are funded to afford a clinical psychologist.

A number of Commonwealth policies give broad guidance around principles of treatment for Aboriginal and Torres Strait Islander peoples with problem AOD use:

These are:

- *National Drug Strategy: Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009* (Ministerial Council on Drug Strategy, 2006) – one of the most detailed plans which was developed after extensive consultation conducted by NIDAC.
- *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-19* – a strategy which drew on NIDAC consultations (Intergovernmental Committee on Drugs, 2017) and sits under the umbrella of the *National Drug Strategy 2017-26* (Australian Government Department of Health, 2019).
- *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* - notes the interconnected nature of mental health conditions and harmful substance use, and their links to transgenerational trauma (Department of the Prime Minister and Cabinet, 2017). That document points to the need for integrated mental health and drug and alcohol treatment.

Research needs

As outlined in this review, most of the research to date on treatments for problem AOD use among Aboriginal and Torres Strait Islander people has focused on descriptions of services or treatment approaches and the authors' perception of their value; or qualitative evaluation of treatment acceptability and perceived effectiveness. Even in that body of research, descriptions of treatments or interventions have typically been brief. Only a small number of studies provide quantitative data on treatment outcomes (d'Abbs et al., 2013; Calabria, 2020; Kelly et al., 2022; Nagel et al., 2009); none provide definitive results, and each has methodological limitations.

There is a need for more investment in research on effectiveness of existing (or new) treatment approaches that is led by, or conducted in close partnership with, Aboriginal or Torres Strait Islander services or communities. Many treatment or care approaches that have been widely reported as important by Aboriginal and Torres Strait Islander clinicians or communities, have not been evaluated through research. For example, until recently, research on cultural approaches to treatment was more often described in overseas literature than in Australian peer-reviewed articles (Purcell-Khodr et al., 2020). This has often related to a lack of funding for evaluation. It may also relate to relatively low numbers of Aboriginal and Torres Strait Islander researchers in the field until recently (Lee, Wilson, et al., 2022).

Where it is culturally acceptable to do so, descriptions of cultural elements of treatment or health care should be documented; although it is recognised that there is vast diversity of Aboriginal and Torres Strait Islander populations and that cultural care elements may not be directly translatable to other communities.

Research on treatment or health care for problem AOD use needs to be conducted in a way that is feasible, and that is acceptable to Aboriginal communities. If randomisation at a client level in a controlled trial is not acceptable, then cluster randomisation may be more suitable. For example, one group of treatment services can be allocated to receive a service enhancement, and then another group of services (the wait control group) receives the same enhancement at a later date (Harrison et al., 2019). A step-wedge design, where services start receiving the enhancement one-by-one is a similar concept.

Implementation studies of particular treatment approaches can be combined with outcome studies, using hybrid designs, to fast-track the research process (Dzidowska et al., 2020). Work is underway to determine what are the best outcome measures for Aboriginal (and other) residential rehabilitation services (James et al., 2017). For example, improvements in individual and family functioning, health and quality of life are often equally or more important than changes in substance use. Similarly, Berry and colleagues describe a community-created outcome measure, the Growth and Empowerment Measure (Berry et al., 2012) to measure response to treatment.

Future work can also build on foundations being applied in AOD research among Aboriginal and Torres Strait Islander peoples such as modified Delphi methods, which incorporate yarning methodology (Dale, Conigrave, et al., 2021; Stearne et al., 2022) and the interpretation and contextualisation of interview data using an Aboriginal healing framework (Hill et al., 2022).

Given the widespread agreement of the key role of trauma in contributing to problem AOD use, there is surprisingly little Australian research on trauma-informed or trauma-focused approaches to healing outside of tobacco management. There is a need for more work examining current and potential approaches (cultural or mainstream or bicultural).

Recommendations and conclusions

Many promising approaches have been reported in treatment of problem AOD use among Aboriginal and Torres Strait Islander peoples, though there is a shortage of outcome evaluations at an individual and service level. There is a need for research to examine the effectiveness of different treatment approaches, including the treatment of coexisting mental trauma and problem AOD use.

The importance of culturally secure treatment, and of Aboriginal and Torres Strait Islander services and staffing has been stressed. Treatment has included cultural approaches, mainstream approaches and adaptations that include the best of both. The value of Aboriginal and Torres Strait Islander staff in culturally secure and accessible health care has been widely recognised and evidence points to the likely value of cultural awareness training and cultural audits for non-Indigenous staff and mainstream services.

Collaboration and two-way learning between Aboriginal and Torres Strait Islander community controlled and mainstream services can offer gains in service access on one side and cultural appropriateness on the other, both of which are likely to benefit Aboriginal and Torres Strait Islander community members. Quality treatment needs to be supported by broader AOD policy and secure funding.

While imperfect, the available literature provides valuable learnings to inform treatment service delivery, policy and research.

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References

Aboriginal Drug and Alcohol Residential Rehabilitation Network. (2022, 31 August 2022). *ADARRN (website)*. Retrieved 31 August 2022 from https://www.adarrn.org.au/

Alcohol and Other Drugs Knowledge Centre. (5 July 2022). *Aboriginal Drug and Alcohol Residential Rehabilitation Network (ADARRN)*. Australian Indigenous HealthInfoNet. Retrieved 31 August from https://aodknowledgecentre.ecu.edu.au/key-resources/organisations/1430/?title=NSW+Aboriginal+Residential+Healing+and+Drug+and+Alcohol+Network+

American Addiction Centers Editorial Staff. (2022, 19 September 2022). *Alcoholics Anonymous step 2: Find a power greater than yourself*. American Addiction Centres. https://recovery.org/alcoholics-anonymous/step-2/

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association. https://doi.org/https://doi.org/10.1176/appi.books.9780890425596

Assan, R., Zheng, C., Wilson, S., Freeburn, B., Boffa, J., Purcell-Khodr, G., Doyle, M., & Conigrave, K. M. (2021). Aboriginal and Torres Strait Islander peoples. In P. S. Haber & B. C. Riordan (Eds.), *Guidelines for the treatment of alcohol problems* (4th ed., pp. 209-221). Faculty of Medicine and Health, The University of Sydney. https://alcoholtreatmentguidelines.com.au/pdf/guidelines-for-the-treatment-of-alcohol-problems.pdf

Australian Government Department of Health. (2019). *National framework for alcohol, tobacco and other drug treatment 2019-29*. Australian Government Department of Health. https://aodknowledgecentre.ecu.edu.au/key-resources/publications/39534/?title=National+framework+for+alcohol%2C+tobacco+and+other+drug+treatment+2019-29&contentid=39534_1

Australian Government Department of Health. (2020). *National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2018-2022*. https://www.health.gov.au/resources/publications/national-aboriginal-and-torres-strait-islander-blood-borne-viruses-and-sexually-transmissible-infections-strategy-2018-2022

Australian Institute of Health and Welfare. (2017). *National Drug Strategy Household Survey: 2016: data tables*. https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia,

Australian Institute of Health and Welfare. (2019). *Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015*.

Australian Institute of Health and Welfare. (2022a, 24 August 2022). *Alcohol, tobacco & other drugs in Australia*. Australian Institute of Health and Welfare. https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia

Australian Institute of Health and Welfare. (2022b, 24 August 2022). *Alcohol, tobacco & other drugs in Australia, priority populations, Aboriginal and Torres Strait Islander people*. Australian Institute of Health and Welfare. https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/aboriginal-and-torres-strait-islander-people

Australian Institute of Health and Welfare. (2022c, 7 July 2022). *Indigenous health and wellbeing*. Australian Institute of Health and Welfare. https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing

Australian Institute of Health and Welfare. (2022d, 7 July 2022). *Profile of Indigenous Australians*. Australian Institute of Health and Welfare. https://www.aihw.gov.au/reports/australias-health/profile-of-indigenous-australians

Australian Institute of Health Welfare. (2020). *National Drug Strategy Household Survey 2019*. https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019

Awofeso, N. (2011). Racism: a major impediment to optimal Indigenous health and health care in Australia. *Australian Indigenous Health Bulletin*, *11*(3), 1-8. https://healthbulletin.org.au/articles/racism-a-major-impediment-to-optimal-indigenous-health-and-health-care-in-australia/

Babor, T. F., Del Boca, F., & Bray, J. W. (2017). Screening, brief intervention and referral to treatment: implications of SAMHSA's SBIRT initiative for substance abuse policy and practice. *Addiction*, *112*(S2), 110-117. https://doi.org/10.1111/add.13675

Berry, S. L., Crowe, T. P., Deane, F. P., Billingham, M., & Bhagerutty, Y. (2012). Growth and empowerment for Indigenous Australians in substance abuse treatment. *International Journal of Mental Health and Addiction*, *10*(6), 970-983. https://doi.org/10.1007/s11469-012-9393-2

Black, A., Khan, S., Brown, R., Sharp, P., Chatfield, H., & McGuiness, C. (2007). An evaluation of opioid replacement pharmacotherapy in an urban Aboriginal Health Service. *Australian and New Zealand Journal of Public Health*, *31*(5), 428-432. https://doi.org/https://doi.org/10.1111/j.1753-6405.2007.00113.x

Brady, M. (2007). Equality and difference: persisting historical themes in health and alcohol policies affecting Indigenous Australians. *Journal of Epidemiology and Community Health*, *61*(9), 759-763. https://doi.org/10.1136/jech.2006.057455

Brady, M., Nicholls, R., Henderson, G., & Byrne, J. (2006). The role of a rural sobering-up centre in managing alcohol-related harm to Aboriginal people in South Australia. *Drug and Alcohol Review*, *25*(3), 201-206. https://doi.org/10.1080/09595230600644657

Brady, M., Sibthorpe, B., Bailie, R., Ball, S., & Sumnerdodd, P. (2002). The feasibility and acceptability of introducing brief intervention for alcohol misuse in an urban Aboriginal medical service. *Drug and Alcohol Review*, *21*(4), 375-380. https://doi.org/10.1080/0959523021000023243

Brett, J., Dawson, A., Ivers, R. G., Lawrence, L., Barclay, S., & Conigrave, K. M. (2017). Healing at home: Developing a model for ambulatory alcohol “detox" in an Aboriginal community controlled health service. *International Journal of Indigenous Health*, *12*(1), 24-38. https://doi.org/10.18357/ijih121201716906

Brett, J., Lawrence, Ivers, R., & Conigrave, K. M. (2014). Outpatient alcohol withdrawal management for Aboriginal and Torres Strait Islander peoples. *Australian Family Physician*, *43*(8), 563-566.

Brett, J., Lee, K. S. K., Gray, D., Wilson, S., Freeburn, B., Harrison, K., & Conigrave, K. M. (2016). Mind the gap: What is the difference between alcohol treatment need and access for Aboriginal and Torres Strait Islander Australians? *Drug and Alcohol Review*, *35*(4), 456-460.

Butt, J., Wilson, M., Jones, J., & Lenton, S. (2022). Review of cannabis use among Aboriginal and Torres Strait Islander people *Journal of the Australian Indigenous HealthInfoNet*, *3*, Article 1. https://doi.org/10.14221/aihjournal.v3n3.1

Calabria, B., Clifford, A., Rose, M., & Shakeshaft, A. P. (2014). Tailoring a family-based alcohol intervention for Aboriginal Australians, and the experiences and perceptions of health care providers trained in its delivery. *BMC Public Health*, *14*(1), Article 322. http://doi.org/10.1186/1471-2458-14-322

Calabria, B., Clifford, A., Shakeshaft, A., Allan, J., Bliss, D., & Doran, C. (2013). The acceptability to Aboriginal Australians of a family-based intervention to reduce alcohol-related harms. *Drug and Alcohol Review*, *32*(3), 328-332. https://doi.org/10.1111/j.1465-3362.2012.00525.x

Calabria, B., Clifford, A., Shakeshaft, A. P., Conigrave, K. M., Simpson, L., Bliss, D., & Allan, J. (2014). Identifying Aboriginal-specific AUDIT-C and AUDIT-3 cutoff scores for at-risk, high-risk, and likely dependent drinkers using measures of agreement with the 10-item Alcohol Use Disorders Identification Test. *Addiction Science & Clinical Practice*, *9*(1), Article 17.

Calabria, B., Shakeshaft, A. P., Clifford, A., Stone, C., Clare, P. J., Allan, J., & Bliss, D. (2020). Reducing drug and alcohol use and improving well-being for Indigenous and non-Indigenous Australians using the Community Reinforcement Approach: a feasibility and acceptability study. *International Journal of Psychology*, *55*(S1), 88-95. https://doi.org/10.1002/ijop.12603

Campbell, M. A., Hunt, J., Scrimgeour, D. J., Davey, M., & Jones, V. (2017). Contribution of Aboriginal Community-Controlled Health Services to improving Aboriginal health: an evidence review. *Australian Health Review*, *42*(2), 218-226. https://doi.org/10.1071/AH16149

Chenhall, R. (2008). What's in a rehab? Ethnographic evaluation research in Indigenous Australian residential alcohol and drug rehabilitation centres. *Anthropology and Medicine*, *15*(2), 105-116. https://doi.org/10.1080/13648470802122024

Chenhall, R., & 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.

Clifford, A., Shakeshaft, A., & Deans, C. (2012). How and when health-care practitioners in Aboriginal Community Controlled Health Services deliver alcohol screening and brief intervention, and why they don't: a qualitative study. *Drug and Alcohol Review*, *31*(1), 13-19. https://doi.org/10.1111/j.1465-3362.2011.00305.x

Clifford, A., Shakeshaft, T., & Deans, C. (2013). Training and tailored outreach support to improve alcohol screening and brief intervention in Aboriginal Community Controlled Health Services. *Drug and Alcohol Review*, *32*(1), 72-79. https://doi.org/https://doi.org/10.1111/j.1465-3362.2012.00488.x

Colonna, E., Maddox, R., Cohen, R., Marmor, A., Doery, K., Thurber, K. A., Thomas, D., Guthrie, J., Wells, S., & Lovett, R. (2020). Review of tobacco use among Aboriginal and Torres Strait Islander peoples. *Australian Indigenous HealthBulletin*, *20*(2). https://aodknowledgecentre.ecu.edu.au/learn/specific-drugs/tobacco/

Conigrave, J. H., Bradshaw, E. L., Conigrave, K. M., Ryan, R. M., Wilson, S., Perry, J., Doyle, M. F., & Lee, K. S. K. (2021). Alcohol consumption and dependence is linked to the extent that people experience need satisfaction while drinking alcohol in two Aboriginal and Torres Strait Islander communities. *Addiction Science & Clinical Practice*, *16*(1), Article 23. https://doi.org/10.1186/s13722-021-00231-z

Conigrave, J. H., Harrison, K. H., Lee, K. S. K., Dobbins, T., Hummerston, B., Hayman, N., Perry, J., Ivers, R., Haber, P. S., Wilson, S., Johnson, D., & Conigrave, K. M. (2021). Support can increase use of the AUDIT-C in Australian Aboriginal Community Controlled Health Services: a cluster randomized trial. *Addiction*, *116*(9), 2304-2315. https://doi.org/10.1111/add.15428

Conigrave, J. H., Lee, K. S. K., Zheng, C., Wilson, S., Perry, J., Chikritzhs, T., Slade, T., Morley, K., Room, R., Callinan, S., Hayman, N., & Conigrave, K. M. (2020). Drinking risk varies within and between Australian Aboriginal and Torres Strait Islander samples: a meta-analysis to identify sources of heterogeneity. *Addiction*, *115*(10), 1817-1830. https://doi.org/10.1111/add.15015

Conigrave, K., Freeman, B., Caroll, T., Simpson, L., Kylie Lee, K. S., Wade, V., Kiel, K., Ella, S., Becker, K., & Freeburn, B. (2012). The Alcohol Awareness project: community education and brief intervention in an urban Aboriginal setting. *Health Promotion Journal of Australia*, *23*(3), 219-225. https://doi.org/10.1071/HE12219

Conway, A., Valerio, H., Peacock, A., Degenhardt, L., Hayllar, J., Harrod, M. E., Henderson, C., Read, P., Gilliver, R., Christmass, M., Dunlop, A., Montebello, M., Whitton, G., Reid, D., Lam, T., Alavi, M., Silk, D., Marshall, A. D., Treloar, C., Dore, G. J., & Grebely, J. (2021). Non-fatal opioid overdose, naloxone access, and naloxone training among people who recently used opioids or received opioid agonist treatment in Australia: The ETHOS Engage study. *International Journal of Drug Policy*, *96*, 103421. https://doi.org/10.1016/j.drugpo.2021.103421

d'Abbs, P., Togni, S., Rosewarne, C., & Boffa, J. (2013). The Grog Mob: lessons from an evaluation of a multi-disciplinary alcohol intervention for Aboriginal clients. *Australian and New Zealand Journal of Public Health*, *37*(5), 450-456. https://onlinelibrary.wiley.com/doi/epdf/10.1111/1753-6405.12122

Dale, E., Conigrave, K. M., Kelly, P. J., Ivers, R., Clapham, K., & Lee, K. S. K. (2021). A Delphi yarn: applying Indigenous knowledges to enhance the cultural utility of SMART Recovery Australia. *Addiction Science & Clinical Practice*, *16*, 2. https://doi.org/10.1186/s13722-020-00212-8

Dale, E., Kelly, P. J., Lee, K. S. K., Conigrave, J. H., Ivers, R., & Clapham, K. (2019). Systematic review of addiction recovery mutual support groups and Indigenous people of Australia, New Zealand, Canada, the United States of America and Hawaii. *Addictive Behaviors*, *98*, 106038. https://doi.org/10.1016/j.addbeh.2019.106038

Dale, E., Lee, K. S. K., Conigrave, K. M., Conigrave, J. H., Ivers, R., Clapham, K., & Kelly, P. J. (2021). A multi-methods yarn about SMART Recovery: first insights from Australian Aboriginal facilitators and group members. *Drug and Alcohol Review*, *40*(6), 1013-1027. https://doi.org/10.1111/dar.13264

Department of the Prime Minister and Cabinet. (2017). *National strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing 2017-2023*. https://aodknowledgecentre.ecu.edu.au/key-resources/policies-and-strategies/33834/?title=National+strategic+framework+for+Aboriginal+and+Torres+Strait+Islander+peoples%27+mental+health+and+social+and+emotional+wellbeing+2017-2023&contentid=33834_1

Department of the Prime Minister and Cabinet. (2020, 4 November 2022). *National Agreement on Closing the Gap*. Commonwealth of Australia. https://www.closingthegap.gov.au/national-agreement-closing-gap-glance

Dolan, K., Rodas, A., & Bode, A. (2015). Drug and alcohol use and treatment for Australian Indigenous and non-Indigenous prisoners: demand reduction strategies. *International Journal of Prisoner Health*, *11*(1), 30-38. https://doi.org/10.1108/IJPH-02-2014-0005

Dowsett, M., Islam, M. M., Ganora, C., Day, C., Lee, K. S. K., Dawson, A., Joseph, T., White, A., Freeburn, B., & Conigrave, K. M. (2019). Asking young Aboriginal people who use illicit drugs about their healthcare preferences using audio-computer-assisted self-interviewing. *Drug and Alcohol Review*, *38*(5), 482-493. https://doi.org/10.1111/dar.12957

Doyle, M. F., Guthrie, J., Butler, T., Shakeshaft, A., Conigrave, K., & Williams, M. (2020). Onset and trajectory of alcohol and other drug use among Aboriginal men entering a prison treatment program: a qualitative study. *Drug and Alcohol Review*, *39*(6), 704-712. https://doi.org/10.1111/dar.13123

Doyle, M. F., Guthrie, J., Butler, T., Shakeshaft, A., Conigrave, K., & Williams, M. (2022). Opportunities for intervention for alcohol and other drug use problems for men before prison: a qualitative study. *Health Promotion Journal of Australia*, *Early view*. https://doi.org/10.1002/hpja.617

Doyle, M. F., Williams, M., Butler, T., Shakeshaft, A., Conigrave, K., & Guthrie, J. (2022). Perspectives of prisoners on alcohol and other drug group treatment approaches. *International Journal of Prisoner Health*, *18*(1), 55-65. https://doi.org/10.1108/IJPH-05-2021-0043

Dudgeon, P., Milroy, H., & Walker, R. (2014). *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (2nd ed.). Kulunga Research Network.

Dzidowska, M., Lee, K. S. K., Conigrave, J. H., Dobbins, T. A., Hummerston, B., Wilson, S., Haber, P. S., Gray, D., & Conigrave, K. M. (2022). Support for Aboriginal health services in reducing harms from alcohol: 2-year service provision outcomes in a cluster randomized trial. *Addiction*, *117*(3), 796-803. https://doi.org/10.1111/add.15712

Dzidowska, M., Lee, K. S. K., Wylie, C., Bailie, J., Percival, N., Conigrave, J. H., Hayman, N., & Conigrave, K. M. (2020). A systematic review of approaches to improve practice, detection and treatment of unhealthy alcohol use in primary health care: a role for continuous quality improvement. *BMC Family Practice*, *21*, Article 33.

Ella, S., Lee, K. S. K., Childs, S., & Conigrave, K. M. (2015). Who are the New South Wales Aboriginal drug and alcohol workforce? A first description. *Drug and Alcohol Review*, *34*(3), 312-322. https://doi.org/10.1111/dar.12199

Farnbach, S., Allan, J., Wallace, R., Aiken, A., & Shakeshaft, A. (2021). Formative process evaluation of a guideline-driven process for improving the cultural responsiveness of alcohol and drug treatment services. *BMC Health Services Research*, *21*(1), 352. https://doi.org/10.1186/s12913-021-06367-7

Freeburn, B., Loggins, S., Lee, K. S. K., & Conigrave, K. M. (2021). Coming of age: 21 years of providing opioid substitution treatment within an Aboriginal community-controlled primary health service. *Drug and Alcohol Review*, *41*, 836-845. https://doi.org/10.1111/dar.13345

Gendera, S., Treloar, C., Reilly, R., Conigrave, K. M., Butt, J., Roe, Y., & Ward, J. (2022). Even though you hate everything that's going on, you know they are safer at home: The role of Aboriginal and Torres Strait Islander families in methamphetamine use harm reduction and their own support needs. *Drug and Alcohol Review*, *41*(6), 1428-1439. https://doi.org/10.1111/dar.13481

Gracey, M., & King, M. (2009). Indigenous health part 1: determinants and disease patterns. *The Lancet*, *374*(9683), 65-75. https://doi.org/10.1016/S0140-6736(09)60914-4

Gray, D., Stearne, A., Wilson, M., & Doyle, M. (2010). *Indigenous-specific alcohol and other drug interventions: continuities, changes and areas of greatest need*. Australian National Council on Drugs.

Gray, D., Wilson, M., Allsop, S., Saggers, 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*, *33*(5), 482-490.

Gupta, H., Tari-Keresztes, N., Stephens, D., Smith, J. A., Sultan, E., & Lloyd, S. (2020). A scoping review about social and emotional wellbeing programs and services targeting Aboriginal and Torres Strait Islander young people in Australia: understanding the principles guiding promising practice. *BMC Public Health*, *20*, 1625. https://doi.org/10.1186/s12889-020-09730-1

Haber, P. S., & Riordan, B. C. (2021, November 2022). *Guidelines for the Treatment of Alcohol Problems (4th edition)*. Specialty of Addiction Medicine, Faculty of Medicine and Health, The University of Sydney. https://alcoholtreatmentguidelines.com.au/

Habib, S. E., & Adorjany, L. V. (2003). Hepatitis C and injecting drug use: the realities of stigmatisation and discrimination. *Health Education Journal*, *62*(3), 256-265.

Hall, W., Farrell, M., & Carter, A. (2014). Compulsory treatment of addiction in the patient's best interests: more rigorous evaluations are essential. *Drug and Alcohol Review*, *33*(3), 268-271. https://doi.org/10.1111/dar.12122

Hamilton, S., Doyle, M., & Bower, C. (2021). Review of Fetal Alcohol Spectrum Disorder (FASD) among Aboriginal and Torres Strait Islander people. *Australian Indigenous HealthBulletin*, *2*(1), 1.

Harrison, K. H., Lee, K. S. K., Dobbins, T., Wilson, S., Hayman, N., Ivers, R., Haber, P. S., Conigrave, J. H., Johnson, D., Hummerston, B., Gray, D., & Conigrave, K. (2019). Supporting Aboriginal Community Controlled Health Services to deliver alcohol care: protocol for a cluster randomised controlled trial. *BMJ Open*, *9*(11), e030909. https://doi.org/10.1136/bmjopen-2019-030909

Hill, B., Williams, M., Woolfenden, S., Martin, B., Palmer, K., & Nathan, S. (2022). Healing journeys: experiences of young Aboriginal people in an urban Australian therapeutic community drug and alcohol program. *Health Sociology Review*, *31*(2), 193-212. https://doi.org/10.1080/14461242.2022.2091948

Intergovernmental Committee on Drugs. (2017). *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-19*.

Islam, M. M., Oni, H. T., Lee, K. S. K., Hayman, N., Wilson, S., Harrison, K., Hummerston, B., Ivers, R., & Conigrave, K. M. (2018). Standardised alcohol screening in primary health care services targeting Aboriginal and Torres Strait Islander peoples in Australia. *Addiction Science & Clinical Practice*, *13*(1), 5.

James, D., Shakeshaft, A., Munro, A., & Courtney, R. J. (2017). The need to move from describing to evaluating the effectiveness of Indigenous drug and alcohol residential rehabilitation services: a systematic review. *Current Drug Abuse Reviews*, *10*(1), 52-67.

James, D. B., Lee, K. S. K., Dronavalli, M., Courtney, R. J., Conigrave, K. M., Conigrave, J. H., & Shakeshaft, A. (2021). Predictors of length of treatment, discharge reason, and re-admission to Aboriginal alcohol and other drug residential rehabilitation services in New South Wales, Australia. *Drug and Alcohol Review*, *41*(3), 603-615.

Kaner, E. F. S., Dickinson, H. O., Beyer, F., Pienaar, E., Schlesinger, C., Campbell, Saunders, J. B., Burnand, B., & Heather, N. (2009). The effectiveness of brief alcohol interventions in primary care settings: a systematic review. *Drug and Alcohol Review*, *28*(3), 301-323.

Kapuaahiwalani-Fitzsimmons, M. (2015). *Critical success factors in Kaupapa Māori AOD residential treatment: Māori youth perspectives* University of Otago.

Kelly, P. J., Coyte, J., Robinson, L. D., Deane, F. P., Russell, S., Clapham, K., Dale, E., Longbottom, M., Solley, R., & Baker, A. L. (2022). Evaluating an Aboriginal community controlled residential alcohol and other drug services: Use of benchmarking to examine within treatment changes in wellbeing. *Drug and Alcohol Review*, *41*(4), 953-962. https://doi.org/10.1111/dar.13432

King, M., Smith, A., & Gracey, M. (2009). Indigenous health part 2: the underlying causes of the health gap. *The Lancet*, *374*(9683), 76-85.

Lee, K., Conigrave, J. H., Ansari, M. A., Wilson, S., Perry, J., Zheng, C., Freeburn, B., Room, R., Callinan, S., Hayman, N., Chikritzhs, T., Slade, T., Gray, D., & Conigrave, K. M. (2021). Acceptability and feasibility of a computer-based application to help Aboriginal and Torres Strait Islander Australians describe their alcohol consumption. *Journal of Ethnicity in Substance Abuse*, *20*(1), 16-33. https://doi.org/10.1080/15332640.2019.1579144

Lee, K. S., Conigrave, K. M., Clough, A. R., Wallace, C., Silins, E., & Rawles, J. (2008). Evaluation of a community-driven preventive youth initiative in Arnhem Land, Northern Territory, Australia. *Drug and Alcohol Review*, *27*(1), 75-82. https://doi.org/10.1080/09595230701711124

Lee, K. S., Freeburn, B., Ella, S., Wilson, S., Harrison, K., McEwan, M., & Conigrave, K. M. (2017). Supporting the Aboriginal alcohol and other drug workforce in New South Wales, Australia. *Drug and Alcohol Review*, *36*(4), 523-526. https://doi.org/10.1111/dar.12465

Lee, K. S. K., Bullen, L. M., Zheng, C., Dawson, A., Munro, A., & Conigrave, K. M. (2022). Beliefs and attitudes of drug and alcohol clinicians when considering referral of Aboriginal clients to involuntary drug and alcohol treatment: A qualitative study. *Drug and Alcohol Review*, *Early view*. https://doi.org/10.1111/dar.13549

Lee, K. S. K., Clough, A. R., Jaragba, M. J., Conigrave, K. M., & Patton, G. C. (2008). Heavy cannabis use and depressive symptoms in three Aboriginal communities in Arnhem Land, Northern Territory. *Medical Journal of Australia*, *188*(10), 605-608. https://doi.org/10.5694/j.1326-5377.2008.tb01803.x

Lee, K. S. K., Conigrave, J. H., Callinan, S., Wilson, S., Room, R., Perry, J., Slade, T., Chikritzhs, T. N., Hayman, N., Weatherall, T., Leggat, G., Gray, D., & Conigrave, C. M. (2019). Asking about the last four drinking occasions on a tablet computer as a way to record alcohol consumption in Aboriginal and Torres Strait Islander Australians: a validation. *Addiction Science & Clinical Practice*, *14*(15), 15. https://doi.org/10.1186/s13722-019-0148-2

Lee, K. S. K., Dawson, A., & Conigrave, K. M. (2013). The role of an Aboriginal women's group in meeting the high needs of clients attending outpatient alcohol and other drug treatment. *Drug and Alcohol Review*, *32*(6), 618-626. https://doi.org/10.1111/dar.12068

Lee, K. S. K., Harrison, K., Mills, K., & Conigrave, K. M. (2014). Needs of Aboriginal Australian women with comorbid mental and alcohol and other drug use disorders. *Drug and Alcohol Review*, *33*(5), 473-481. https://doi.org/10.1111/dar.12127

Lee, K. S. K., Sukavatvibul, K., & Conigrave, K. M. (2015). Cannabis use and violence in three remote Aboriginal Australian communities: Analysis of clinic presentations. *Transcultural Psychiatry*, *52*(6), 827-839. https://doi.org/10.1177/1363461515589047

Lee, K. S. K., Wilson, S., Stearne, A. E., Hayman, N., Conigrave, J. H., Doyle, M., Bullen, L., Weatherall, T. J., James, D., Reynolds, T., Perry, J., & Conigrave, K. M. (2022). Walking side-by-side: Supporting Aboriginal and Torres Strait Islander Australians to lead the way in alcohol research. *Drug and Alcohol Review*, *Early view*. https://doi.org/10.1111/dar.13523

Lovett, R., Dance, P., Guthrie, J., Brown, R., & Tongs, J. (2014). Walan Girri: developing a culturally mediated case management model for problematic alcohol use among urban Indigenous people. *Australian Health Review*, *38*(4), 440-446. https://doi.org/10.1071/AH13148

MacLean, S., Hengsen, R., & Stephens, R. (2017). Critical considerations in responding to crystal methamphetamine use in Australian Aboriginal communities. *Drug and Alcohol Review*, *36*(4), 502-508.

Marel, C., MacLean, S., & Midford, R. (2016). Review of volatile substance use among Aboriginal and Torres Strait Islander people. *Australian Indigenous HealthBulletin*, *16*(2).

Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: helping people change*. Guilford press.

Ministerial Council on Drug Strategy. (2006). *National Drug Strategy: Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009*.

Munro, A., Allan, J., Shakeshaft, A., & Breen, C. (2017). "I just feel comfortable out here, there's something about the place": staff and client perceptions of a remote Australian Aboriginal drug and alcohol rehabilitation service. *Substance Abuse Treatment, Prevention, and Policy*, *12*, 49. https://doi.org/10.1186/s13011-017-0135-0

Munro, A., Shakeshaft, A., Breen, C., Clare, P., Allan, J., & Henderson, N. (2018). Understanding remote Aboriginal drug and alcohol residential rehabilitation clients: who attends, who leaves and who stays? *Drug and Alcohol Review*, *37*(S1), S404-S414. https://doi.org/10.1111/dar.12656

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. https://doi.org/10.1111/j.1440-1584.2009.01060.x

Nathan, S., Maru, K., Williams, M., Palmer, K., & Rawstorne, P. (2020). Koori voices: self-harm, suicide attempts, arrests and substance use among Aboriginal and Torres Strait Islander adolescents following residential treatment. *Health & Justice*, *8*, 4. https://doi.org/10.1186/s40352-020-0105-x

National Health and Medical Research Council. (2020). *Australian guidelines to reduce health risks from drinking alcohol*. https://www.nhmrc.gov.au/about-us/publications/australian-guidelines-reduce-health-risks-drinking-alcohol

National Indigenous Drug and Alcohol Committee. (2014). *Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples.* https://aodknowledgecentre.ecu.edu.au/healthinfonet/getContent.php?linkid=592238&title=Alcohol+and+other+drug+treatment+for+Aboriginal+and+Torres+Strait+Islander+peoples&contentid=27794_1

National Indigenous Drug and Alcohol Council. (2013a). *National Indigenous Drug and Alcohol Committee March meeting communiqué*. http://www.atoda.org.au/wp-content/uploads/NIDACAugust2014Communique.pdf.

National Indigenous Drug and Alcohol Council. (2013b). *NIDAC online consultation: a professional body for Aboriginal and Torres Strait Islander alcohol and other drug workers*. https://aodknowledgecentre.ecu.edu.au/key-resources/publications/25740/?title=NIDAC+online+consultation%3A+a+professional+body+for+Aboriginal+and+Torres+Strait+Islander+alcohol+and+other+drug+workers

New South Wales Government. (2022, 17 August 2022). *What is trauma-informed care?* NSW Health. https://www.health.nsw.gov.au/mentalhealth/psychosocial/principles/Pages/trauma-informed.aspx

Panaretto, K., Coutts, J., Johnson, L., Morgan, A., Dallas Leon, D., & Hayman, N. (2010). Evaluating performance of and organisational capacity to deliver brief interventions in Aboriginal and Torres Strait Islander medical services. *Australian and New Zealand Journal of Public Health*, *34*(1), 38-44.

Parliament of Tasmania. (2019). *Fact sheet: Alcohol and Drug Dependency Repeal Bill 2019*. https://www.parliament.tas.gov.au/bills/Bills2019/pdf/notes/40_of_2019-Fact%20Sheet.pdf

Preuss, K., & Brown, J. N. (2006). Stopping petrol sniffing in remote Aboriginal Australia: key elements of the Mt Theo Program. *Drug and Alcohol Review*, *25*(3), 189-193. https://doi.org/10.1080/09595230600644640

PricewaterhouseCoopers Indigenous Consulting. (2017). *Evaluation of the Alcohol Mandatory Treatment program*.

Purcell-Khodr, G., Webster, E., Harrison, K., Dawson, A., Lee, K. K., Conigrave, K., (2022). The importance of culture in alcohol care: Listening to Indigenous staff in Australian Aboriginal Community Controlled Health Services. *International Indigenous Policy Journal*, 13(3). https://doi/10.18584/iipj.2022.3.13.14030

Purcell-Khodr, G. C., Lee, K. S. K., Conigrave, J. H., Webster, E., & Conigrave, K. M. (2020). What can primary care services do to help First Nations people with unhealthy alcohol use? A systematic review: Australia, New Zealand, USA and Canada. *Addiction Science and Clinical Practice*, *15*, 31. https://doi.org/10.1186/s13722-020-00204-8

Reilly, R., Gendera, S., Treloar, C., Roe, Y., Conigrave, K., Azzopardi, P., & Ward, J. (2020). Identifying risk and protective factors, including culture and identity, for methamphetamine use in Aboriginal and Torres Strait Islander communities: relevance of the 'communities that care' model. *Social Science & Medicine*, *266*, 113451. https://doi.org/10.1016/j.socscimed.2020.113451

Roche, A. M., Duraisingam, V., Trifonoff, A., Battams, S., Freeman, T., Tovell, A., Weetra, D., & Bates, N. (2013). Sharing stories: Indigenous alcohol and other drug workers' well-being, stress and burnout. *Drug and Alcohol Review*, *32*(5), 527-535. https://doi.org/10.1111/dar.12053

Schlesinger, C. M., Ober, C., McCarthy, M. M., Watson, J. D., & Seinen, A. (2007). The development and validation of the Indigenous Risk Impact Screen (IRIS): a 13-item screening instrument for alcohol and drug and mental health risk. *Drug and Alcohol Review*, *26*(2), 109-117.

Shaw, G., Ray, T., & McFarland, B. (2011). The outstation model of rehabilitation as practiced in Central Australia: the case for its recognition and acceptance. *Substance Use & Misuse*, *46*(sup1), 114-118.

Stearne, A. E., Lee, K. S. K., Allsop, S., Shakeshaft, A., & Wright, M. (2022). First Nations Australians' self-determination in health and alcohol policy development: a Delphi study. *Health Research Policy and Systems*, *20*, 12. https://doi.org/10.1186/s12961-022-00813-6

Symons, M., Carter, M., Oscar, J., Pearson, G., Bruce, K., Newett, K., & Fitzpatrick, J. P. (2020). A reduction in reported alcohol use in pregnancy in Australian Aboriginal communities: a prevention campaign showing promise. *Australian and New Zealand Journal of Public Health*, *44*(4), 284-290. https://doi.org/10.1111/1753-6405.13012

Taylor, K. P., Bessarab, D., Hunter, L., & Thompson, S. C. (2013). Aboriginal-mainstream partnerships: exploring the challenges and enhancers of a collaborative service arrangement for Aboriginal clients with substance use issues. *BMC Health Services Research*, *13*, 12. https://doi.org/10.1186/1472-6963-13-12

Teasdale, K. E., Conigrave, K. M., Kiel, K. A., Freeburn, B., Long, G., & Becker, K. (2008). Improving services for prevention and treatment of substance misuse for Aboriginal communities in a Sydney Area Health Service. *Drug and Alcohol Review*, *27*(2), 152-159.

Teesson, M., Hall, W., Slade, T., Mills, K., Grove, R., Mewton, L., Baillie, A., & Haber, P. S. (2010). Prevalence and correlates of DSM-IV alcohol abuse and dependence in Australia: findings of the 2007 National Survey of Mental Health and Wellbeing. *Addiction*, *105*(12), 2085-2094.

Treloar, C., Hopwood, M., Cama, E., Saunders, V., Jackson, L. C., Walker, M., Ooi, C., Ubrihien, A., & Ward, J. (2018). Evaluation of the Deadly Liver Mob program: insights for roll-out and scale-up of a pilot program to engage Aboriginal Australians in hepatitis C and sexual health education, screening, and care. *Harm Reduction Journal*, *15*(1), 1-12.

Vuong, T., Larney, S., & Ritter, A. (2020). *A data linkage evaluation of the outcomes of the NSW Involuntary Drug and Alcohol Treatment (IDAT) program* (NSW Ministry of Health, Issue. http://handle.unsw.edu.au/1959.4/unsworks_73416

Wallace, R., & Allan, J. (2019). *Alcohol & other drugs treatment guidelines for working with Aboriginal & Torres Strait Islander people in a non-Aboriginal setting*, Network of Alcohol and other Drug Agencies, https://nada.org.au/resources/alcohol-and-other-drugs-treatment-guidelines-for-working-with-aboriginal-and-torres-strait-islander-people-in-a-non-aboriginal-setting/

Weatherall, T. J., Conigrave, J. H., Conigrave, K. M., Perry, J., Wilson, S., Room, R., Chikritzhs, T., & Kylie Lee, K. S. (2021). Alcohol dependence in a community sample of Aboriginal and Torres Strait Islander Australians: harms, getting help and awareness of local treatments. *Addiction Science & Clinical Practice*, *16*, 65. https://doi.org/10.1186/s13722-021-00274-2

Williams, N., Nasir, R., Smither, G., & Troon, S. (2006). Providing opioid substitution treatment to Indigenous heroin users within a community health service setting in Adelaide. *Drug and Alcohol Review*, *25*(3), 227-232. https://doi.org/10.1080/09595230600644699

World Health Organization. (n.d.). *Constitution*: *WHO remains firmly committed to the principles set out in the preamble to the Constitution – health is a state …* World Health Organization. Retrieved 2022 from https://www.who.int/about/governance/constitution

World Health Organization. (2019). *International classification of diseases and related health problems (11th ed.)*. World Health Organization. https://icd.who.int/

Zheng, C., Conigrave, J. H., Conigrave, K. M., Wilson, S., Perry, J., Chikritzhs, T. N., Fitts, M. S., & Lee, K. S. K. (2021). Patterns of drinking in Aboriginal and Torres Strait Islander peoples as self-reported on the Grog Survey App: a representative urban and remote sample. *Drug and Alcohol Review*, *41*(1), 114-124.