2023

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

Australian Indigenous HealthInfoNet

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celebrating 25 years 1997-2012

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

Core funding is provided by the Australian Government Department of Health and Aged Care

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Australian Indigenous Health*InfoNet*

The mandate of the Australian Indigenous Health*InfoNet* (Health*InfoNet*) is to contribute to improvements in both Aboriginal and Torres Strait Islander peoples' health by making relevant, high quality knowledge and information easily accessible to policy makers, health service providers, program managers, clinicians and other health professionals (including Aboriginal and Torres Strait Islander Health Workers) and researchers. The Health*InfoNet* also provides easy-to-read and summarised material for students and the general community.

The Health*InfoNet* achieves its commitment by undertaking research into various aspects of Aboriginal and Torres Strait Islander peoples' health and disseminating the results (and other relevant knowledge and information) mainly via the Australian Indigenous Health*InfoNet* website (**https://healthinfonet.ecu.edu.au**), the Alcohol and Other Drugs Knowledge Centre (**https://aodknowledgecentre.ecu.edu.au**), Tackling Indigenous Smoking (**https://tacklingsmoking.org.au**) and WellMob (**https://wellmob.org.au**). The research involves analysis and synthesis of data and other information obtained from academic, professional, government and other sources. The Health*InfoNet*'s work in knowledge exchange aims to facilitate the transfer of pure and applied research into policy and practice to address the needs of a wide range of users.

Recognition statement

The Health*InfoNet* recognises and acknowledges the sovereignty of Aboriginal and Torres Strait Islander people as the original custodians of the country. Aboriginal and Torres Strait Islander cultures are persistent and enduring, continuing unbroken from the past to the present, characterised by resilience and a strong sense of purpose and identity despite the undeniably negative impacts of colonisation and dispossession. Aboriginal and Torres Strait Islander people throughout the country represent a diverse range of people, communities and groups, each with unique identities, cultural practices and spiritualities. We recognise that the current health status of Aboriginal and Torres Strait Islander people has been significantly impacted by past and present practices and policies.

We acknowledge and pay our deepest respects to Elders past and present throughout the country. In particular, we pay our respects to the Whadjuk Noongar peoples of Western Australia on whose Country our offices are located.

Contact details

Professor Neil Drew (Director)
Australian Indigenous Health*InfoNet*
Edith Cowan University
2 Bradford Street
Mount Lawley, Western Australia 6050

Phone: (08) 9370 6336
Email: **healthinfonet@ecu.edu.au**
Website: **healthinfonet.ecu.edu.au**

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We welcome and value your feedback as part of our post-publication peer review process. Please let us know if you have any suggestions for improving this Summary.

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

Publication team

Joanne Hoareau
Ashleigh Parnell
Marianne Durbin

Publication layout
Michelle Pierre

Executive editor
Professor Neil Drew

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Further information

This *Summary* is part of a resource package including the full review, a fact sheet and a short video. These resources and more information about alcohol and drug treatment for Aboriginal and Torres Strait Islander peoples can be viewed at: **aodknowledgecentre.ecu.edu.au/treatments-and-services**

Cover artwork

Pilbara Travels
by Melanie Robinson

Featured icon artwork

by Frances Belle Parker

The Health*InfoNet* commissioned Frances Belle Parker, a proud Yaegl woman, mother and artist, to produce a suite of illustrated icons for use in our knowledge exchange products. Frances translates biomedical and statistically based information into culturally sensitive visual representations, to provide support to the Aboriginal and Torres Strait Islander workforce and those participating in research and working with Aboriginal and Torres Strait Islander people and their communities. Frances came to prominence winning the Blake Prize in 2000, making her the youngest winner and the first Indigenous recipient over the 65 year history of the prize.

"Biirrinba is the Yaygirr name for the mighty Clarence River (NSW). It is this river that is the life giving vein for the Yaegl people. And it is this river which inspires much of my artwork. I am deeply inspired by my Mother's land (Yaegl land) and the Island in the Clarence River that my Mother grew up on, Ulgundahi Island. The stories which are contained within this landscape have shaped me as a person as an artist and most recently as a Mother. This is my history, my story and it will always… be my responsibility to share this knowledge with my family and my children."

Contents

Introduction

This summary is based on the *Review of alcohol and drug treatment for Aboriginal and Torres Strait Islander peoples.* It provides an overview of the available evidence for treatment approaches to help a person reduce or stop substance use. These are treatments for when a person has evidence of either hazardous use or problem alcohol and other drug (AOD) use (see Box 1 for terms used). Some approaches to address substance use are not included in this summary (e.g. for tobacco cessation or volatile substance use).

This summary presents information on:

- the available research and other evidence that underpins AOD treatment approaches for Aboriginal and Torres Strait Islander peoples
- considerations for specific groups and settings
- policy, future research and recommendations.

Box 1: 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 [1].

This 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 a 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 [1].

Dependence: where 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 over other aspects of life [1].

Problem AOD use: is used as an umbrella term to include AOD use that has already led to problems, whether that is harmful or dependent use. 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.

(Note: The *Diagnostic and statistical manual* (DSM-V) [7], uses the term 'substance use disorder' to describe the continuum of AOD problems, from mild to severe. So, DSM-V 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 [9]. Pregnant women and young people aged under 18 are advised to not drink at all.

Context and prevalence of alcohol and other drug 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 avoid problem AOD use, or helped those who have encountered problems with substance use to make positive changes [2].

Alcohol is one of the biggest contributors to loss of healthy life for all Australians [3]. However, the ongoing impacts from colonisation and differences in social determinants of health place Aboriginal and Torres Strait Islander Australians at increased risk of harms from AOD use when compared with non-Indigenous Australians [4-6].

Alcohol and illicit drug use remain **among the top four risk factors for death and sickness** in Aboriginal and Torres Strait Islander peoples [4].

Alcohol use

There are big differences between and within Aboriginal and Torres Strait Islander communities in reported alcohol consumption [8]. Questions have also been raised about the accuracy of past national survey data due to small samples and survey methods used [10].

Several surveys have reported Aboriginal and Torres Strait Islander Australians are less likely to drink in the past year than other Australians, but when they do drink they are more likely to consume quantities that put their health at risk [11].

A meta-analysis of all available surveys of drinking among Aboriginal and Torres Strait Islander peoples [8] found that:

59% of respondents reported any alcohol consumption in the past 12 months

34% reported drinking more than four drinks per occasion at least monthly.

Illicit drug use

In national surveys of recent AOD use **cannabis was the most commonly reported illicit drug (15%)** among Aboriginal and Torres Strait Islander Australians, **followed by pain relief medicines (not over-the-counter) and opioids (5.9%)** [11]. There is little information available on the prevalence of use of stimulants.

Most commonly reported illicit drugs

15% **cannabis**

5.9% **pain relief medicines and opioids**

General principles of culturally secure treatment provision

A number of core principles underpin how best to offer culturally secure treatment or care.

The importance of engagement

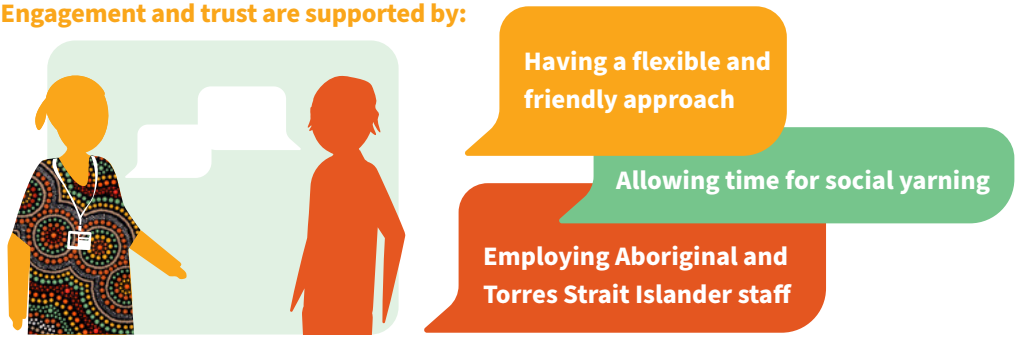
Efforts to engage and build trust between health workers and potential clients are important - otherwise individuals may not seek support because of the stigma linked to problem AOD use [12].

Individuals who could benefit from help may be concerned about:

- negative stereotypes around substance use by Aboriginal and Torres Strait Islander peoples
- discrimination that they may have experienced or witnessed
- negative reactions from members of extended family or community.

Stigma can also be internalised and felt as shame in individuals and families with problems from AOD use.

Engagement and trust are supported by:



Health incorporates social and emotional wellbeing

Supporting social and emotional wellbeing for Aboriginal and Torres Strait Islander people includes supporting connection to family, community, Country, culture, identity and spirituality [13, 14]. In keeping with this, treatment for problem AOD use should be holistic wherever possible [15].

Cultural aspects of treatment

Many treatments for problem AOD use that have been shown to be effective for general populations are also used in treatment for Aboriginal and Torres Strait Islander peoples (e.g. counselling approaches, medicines). However, a culturally secure approach to how this care is provided is recognised as important [12].

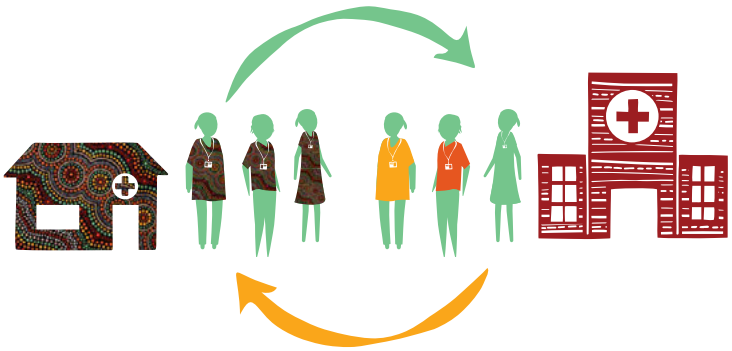
Depending on the individual's priorities this can include [2, 16, 17]:

- using a yarning style to start a conversation with a client before asking about their AOD use,
- an offer to include family in the treatment process [12].

Emerging evidence suggests that creating a welcoming environment and including aspects of Aboriginal and Torres Strait Islander culture and spirituality in care can improve treatment access and outcomes [18-23]. This is often routinely done in community controlled services.

Cultural activities can be included as an element of treatment for individuals with problem AOD use. These may be activities in women's and men's groups, caring for Country, use of traditional skills such as hunting, smoking ceremonies, making art and music [24] .

Academic literature does not describe the specific elements of culture involved and these may vary based on local protocols.



Adapting mainstream treatments or services

Mainstream services and treatments can be adapted to improve suitability for Aboriginal and Torres Strait Islander people [16, 25].

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 the local community, community controlled services and Aboriginal and Torres Strait Islander staff from that community [16, 24, 26, 27].

The importance of 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 [12, 28, 29].

In surveys or consultations, respondents have expressed a preference for an Aboriginal or Torres Strait Islander staff member to be involved in their care, should they have a problem with AOD use [16, 30, 31]. Cultural protocols influence which staff member should talk with a client about their substance use [24, 32, 33].

However, choice is also important as in close-knit communities, some individuals with problem AOD use prefer the anonymity of a mainstream service [16, 27].

Treatment approaches

Treatment can be provided across settings ranging from community-based location, primary health care services, through to specialised residential AOD treatment services.

Brief intervention

Brief intervention is a short, structured conversation that aims to help a person reflect on their substance use, and to make a change [34, 35]. In general populations brief intervention has been shown to be effective for hazardous or problem alcohol use, with some evidence for effectiveness in cannabis and methamphetamine use.

Brief intervention can happen after an AOD problem has been discovered, for example by pro-active screening. Screening can occur in settings such as primary care, the emergency department or mental health services. Several screening tools for substance use have 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 [36-39]. The Indigenous Risk Impact Screen (IRIS) [40] is a tool designed to screen for any AOD problem, as well as for mental health conditions [40].

Culturally adapted brief interventions have been implemented in a number of Aboriginal Community Controlled Health Services (ACCHSs) [37, 41, 42] and other settings [43]. There have been encouraging results for a study of the use of brief intervention as part of culturally tailored care

for individuals with mental health and problem AOD use. Currently, use of screening and brief intervention tools in ACCHSs is still relatively low [37, 44]. Many services are working to increase this.

Potential barriers to using screening and brief intervention in health services can include:

- that talking about drinking may be difficult, particularly for an Aboriginal or Torres Strait Islander health worker who may be a relative or community member of the client [36]
- time pressures, particularly given the complex health challenges that are common among Aboriginal and Torres Strait Islander clients [45]
- a lack of referral options [45].

Psychological interventions ('talking therapies')

Several psychological interventions (or 'talking therapies') have been shown to be acceptable in helping Aboriginal and Torres Strait Islander people reduce or cease hazardous or problem AOD use [12, 36, 43, 46].

The two most commonly used psychological therapies in mainstream settings are motivational interviewing and cognitive behavioural therapy (CBT) [12, 47]. Motivational interviewing has been used with Aboriginal and Torres Strait Islander Australians to enhance and sustain motivation for change in problem AOD use [36, 43]. Nagel and colleagues (2009) used elements of motivational interviewing within a brief intervention that was adapted to align with Aboriginal and Torres Strait Islander cultural priorities [43]. Similarly, the training associated with the IRIS program, included skills in motivational interviewing.

CBT is recommended in mainstream alcohol treatment guidelines as a first-line psychological intervention [47]. One form of CBT, the Community Reinforcement Approach (CRA), helps a person identify ways to reshape their life and social interactions, so that it can 'reward' staying sober, and avoid rewarding drinking [22, 39]. A study in rural NSW found an adaptation of this approach to be very acceptable to Aboriginal Australians [22, 39, 46]. Early research suggests promising outcomes when CRA is used to help individuals change problem AOD use [22].

One (non-randomised) study examined the outcomes of counselling, including CBT with motivational interviewing, for individuals with alcohol problems in a remote community [19]. The study faced challenges, including short funding timelines, recruiting suitable staff, and contacting and engaging clients, and the results were inconclusive. While 79% of participants ceased or reduced their alcohol use, 70% of those who received no treatment also ceased or reduced drinking [19].

Other counselling approaches such as narrative therapy, mindfulness-based approaches, and dialectical behavioural therapy have reported to be acceptable and beneficial when used in a culturally secure manner, however, no research has been done on their role or effectiveness in this population.

Community based research has highlighted the likely importance of broader psychological factors that restore individuals' and communities' sense of self-determination in supporting efforts to prevent and treat problem AOD use [48].

Group-based approaches

A range of group approaches to therapy or treatment for problem AOD use has been used among Aboriginal and Torres Strait Islander Australians [49]. Groups can provide peer support and learning as well as an alternative social circle to the drinking group.

Men's groups and women's groups

Men's groups and women's groups may include health education and peer support, and often involve cultural activities [20, 24]. An informal approach to groups, with additional support such as child care, and providing food and a range of activities has been found to be acceptable and feasible [20]. Aboriginal and Torres Strait Islander health staff can lead the group (or play a key role in it) and offer support for issues that arise [20, 50, 51].

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 it was not officially integrated into the SMART Recovery program [52]. SMART Recovery has been evaluated for its cultural utility in two studies [52, 53] .

Recommendations were made to:

- adapt the language to make it more culturally appropriate and accessible
- provide supplementary storytelling resources
- create culturally meaningful program activities
- create opportunities for greater community engagement and networking.

There is no published research on outcomes of SMART Recovery participation among Aboriginal and Torres Strait Islander peoples.

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 way of being [54]. Some Aboriginal and Torres Strait Islander AA members consider that the AA 'higher power' can be thought of as encompassing Aboriginal spirituality [55].

Engaging family, carers and community

Families can provide significant support for individuals with problem AOD use. 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 [12]. An understanding of which close contacts of an individual seeking treatment may be sources of strength and support, and which may drink or use drugs with them can help inform treatment.

Partners, family, carers and community also experience the effects of AOD use in those close to them [56]. The stigma of problem AOD use can make family members feel isolated and influence whether they seek help [51, 56].

Fear of involvement of government child protection authorities can also pose a barrier to accessing AOD treatments for parents or even extended family carers [12, 20] .

Two approaches that incorporate family into supporting healthy behaviours are the Community Reinforcement Approach (CRA) and Community Reinforcement and Family Training (CRAFT) [46]. CRA helps an individual recognise family and community interactions that could help them change their AOD use. CRAFT focuses on teaching one or more family members the skills of self-care, as well as ways to help their relative with problem AOD use to engage with treatment. Aboriginal community members viewed both approaches as highly acceptable ways of responding to problem alcohol use [46]. Early research in a rural community suggests promising outcomes [22].

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 [12, 21, 57].

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, most inpatient detoxification is only provided in mainstream services. Lack of access to withdrawal management is reported as a barrier to accessing rehabilitation for Aboriginal and Torres Strait Islander people [58-60].

Access to non-residential (outpatient) withdrawal management may be increased through non-medical staff in services providing support, while local GPs prescribe medicines if required [60]. Illawarra Aboriginal Medical Service in regional NSW is an example of one service that piloted a model for non-residential withdrawal management [31]. Carefully selected participants (e.g., with no history of seizures) were successfully managed in the community through supportive counselling, monitoring, daily dispensed diazepam, and use of relapse prevention medicines.

Medicines for relapse prevention

Several medicines are used to reduce the risk of relapse back to substance use dependence or to support individuals to cease use. There is no specific research to suggest that certain medications are more or less useful for Aboriginal and Torres Strait Islander people than for non-Indigenous people.

Alcohol relapse prevention medicines have been used in ACCHS [19, 31] and in mainstream settings. For opioid substitution treatment programs, services report that a holistic, friendly and client-centred approach contributes to improved access and continuity of care [2, 27, 61] . As with other groups, Aboriginal and Torres Strait Islander people on opioid substitution treatment are increasingly on buprenorphine preparations rather than on methadone [62].

Residential rehabilitation

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

Aboriginal and Torres Strait Islander community controlled residential rehabilitation services vary greatly in approach, but most deliver mainstream therapeutic approaches alongside programs with cultural elements [12, 54, 63]. Clients report feeling more at home in Aboriginal community controlled rehabilitation services compared with mainstream services [55] and were more likely to complete treatment there [18].

A study of six Aboriginal community controlled rehabilitation programs in NSW analysed quantitative data on which people left the program 'early', to better understand how services might provide more tailored approaches. The authors found that clients were more likely to leave residential rehabilitation early if they were referred from the justice system and had used opioids or stimulants (such as ice) as their main substance [63].

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. Typically, Aboriginal and Torres Strait Islander residential rehabilitation centres ensure good communication between client and family and include family in discharge planning.

Support after discharge from residential rehabilitation is recommended [32, 46, 55, 63, 64].

Approaches used in specific Aboriginal or Torres Strait Islander populations

Rural and remote communities

Community-based psychological therapies are reported to be acceptable and feasible in rural settings [22]. The cultural security of care becomes even more important in remote regions, where Aboriginal and Torres Strait Islander communities may have distinct culture and language. An AOD worker from that community has a particular advantage in providing care, in that they know the language, culture and context, and also are likely to know key individuals who may be able to offer support. Staffing shortages and the need to travel long distances for treatment can be barriers for people seeking support to address problem AOD use in rural and remote areas [19, 24, 28, 62].

Young people

There is a shortage of treatment options for Aboriginal and Torres Strait Islander young people with problem AOD use [46]. Residential rehabilitation can be particularly challenging to arrange.

Some remote communities have developed programs for young people with problem AOD use, such as Mt Theo [21] and the Ilpurla residential and community support program [32]. Each of these programs included cultural enhancement and involvement of Elders.

Young urban Aboriginal people who use illicit drugs or who drink alcohol above recommended limits, 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 [65].

Individuals with other health issues

Co-occurring physical or mental health issues, can influence access to residential services or to certain treatment options. They can also affect a person's journey through treatment.

Mental health comorbidity occurs frequently in those with problem AOD use in any population, and may have a higher prevalence in the Aboriginal and Torres Strait Islander peoples because of the ongoing impacts of colonisation [12]. This can include grief, loss and trauma, as well as the well known associations between methamphetamine or cannabis use and psychosis [51, 56].

People with co-occurring mental health conditions and problem AOD use can experience barriers to treatment access. There is a need for more friendly and flexible services which can help individuals with both mental health and problem AOD use [51].

A range of approaches to mental health and AOD comorbidity is used in Aboriginal and Torres Strait Islander community controlled services [14]. These incorporate the benefits of holistic care and increased connection, sometimes including music and art in therapy, and offer opportunity for traumatic memories to be acknowledged or gently processed.

Trauma informed care is increasingly being recognised as a key component to AOD treatment. Trauma-informed services provide safety, and build trust, collaboration and empowerment with individuals in treatment, and avoid re-traumatising the person [66]. Many Aboriginal and Torres Strait Islander communities offer programs to support healing from grief, loss or trauma.

Specific treatment settings

Aboriginal community controlled health services

ACCHSs have a unique capacity to deliver culturally secure 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 [67].

ACCHSs can offer screening and brief intervention for hazardous or problem alcohol use, and many offer specific treatment or care for problem AOD use. They also often offer shared care or continuity of care with mainstream AOD treatment services. Services are typically delivered in a friendly, flexible and holistic manner [2, 12].

Outreach services

Outreach assists in reaching individuals who want or need treatment within the community setting but who would otherwise be unable to engage with services. It can involve meeting the person where they are, either at their home or a public place, and where possible, help with their most immediate needs [12].

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 [56]. Discrimination, both because of the problem AOD use and because of direct or indirect racism [68] can occur in some mainstream services.

Some hospitals have Aboriginal or Torres Strait Islander AOD workers or liaison officers who can contribute to culturally secure care or facilitate access to specialist AOD treatment post discharge.

Prisons and the justice system

Aboriginal people in custody are less likely to access AOD treatment services in the community than non-Aboriginal prisoners [69-71], with authors suggesting lack of culturally specific options as one reason for this [69].

There is considerable variety in the provision and availability of AOD programs in custodial settings across Australia [71]. Most are group programs, designed to help individuals avoid or reduce substance use, with a goal of reducing recidivism [70]. Aboriginal participants 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 [72].

Involuntary AOD treatment within the health system

Compulsory AOD treatment options, that are initiated based on health concerns, are provided for by legislation in three states: NSW, Victoria and Tasmania. Though the Tasmanian legislation is being repealed [73]. Program lengths vary (e.g. up to 14 days in Victoria, up to 84 in NSW) [74].

These programs differ from the past mandatory alcohol treatment program in the Northern Territory 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) [75]. 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 [76]. An evaluation of the NSW program found no improvement in health status for clients who had received involuntary treatment compared to a control group [76].

NSW clinicians described a dilemma when considering referral for an Aboriginal client to involuntary treatment [77]. On one hand, they feared re-traumatising the person and on the other hand they perceived that involuntary treatment was potentially life-saving, and Aboriginal clients should not be denied it.

Treatment availability and accessibility

Aboriginal and Torres Strait Islander individuals and families can face numerous practical barriers to accessing AOD treatments [20, 30, 50].

These can include:

- transport and distance challenges (even in urban areas)
- lack of childcare options
- demands of the workplace.

Some withdrawal clinics and residential centres have restrictions which can make engaging with treatment difficult such as:

- bans on tobacco smoking
- not accepting individuals receiving opioid substitution treatment
- being unable to cater for individuals with co-morbid mental health issues [51].

Collaboration between community controlled and mainstream services can increase treatment access as well as appropriateness and continuity of care [2, 16, 26, 27].

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. Harm reduction services also can provide an avenue through which clients are linked into treatment.

Harm reduction services include:

- sobering up centres [78]
- needle syringe programs
- medically supervised injecting centres [79]
- provision of, and training to use, take-home naloxone [80].

One peer-led program, Deadly Liver Mob, successfully used incentives to encourage Aboriginal and other clients to seek treatment for Hepatitis C and other blood borne viruses [81].

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 [82].

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:

- the *National Drug Strategy: Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009* [83]
- The *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-19* [84]
- the *National Drug Strategy 2017-26* [85].

In parallel, the *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 AOD problems, and their links to transgenerational trauma [86].

Aboriginal and Torres Strait Islander clinicians and services, report that short-term and limited funding [87] has constrained the range of treatments available through community controlled services. For example, most community controlled residential rehabilitation services are not funded to employ registered nurses, which means that opioid substitution treatment cannot be offered, and few can afford a clinical psychologist.

Research needs

Most of the research to date on treatments for problem AOD use among Aboriginal and Torres Strait Islander people has consisted of descriptions of treatment approaches, and the authors' perception of their value, or a qualitative evaluation of treatment. Only a small number of studies provide quantitative data on treatment outcomes [18, 19, 22, 43]; none provides definitive results and each has methodological limitations.

There is a need for 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 [15].

Where it is culturally acceptable to do so, descriptions of cultural elements of treatment or care should be documented. Though it is recognised that cultural care elements may not be directly translatable from one community to another.

Future research needs to be done in a way that is acceptable to Aboriginal and Torres Strait Islander communities. This work can build on approaches being used in AOD research among Aboriginal and Torres Strait Islander peoples, such as yarning interviews and modified Delphi methods [52, 82, 88]. Also, a treatment enhancement can be introduced to services, one service at a time, to see if this improves outcomes (step-wedge design).

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, and there is a need for work examining current and potential approaches.

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 the individual or the service level. There is need for research to examine the effectiveness of different treatment approaches, including the treatment of 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 can include 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 care has been widely recognised. Evidence also 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 and cultural appropriateness. 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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