CHAPTER 15

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

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This chapter provides guidance on managing unhealthy alcohol use among Aboriginal and Torres Strait Islander peoples. This includes care of those who are drinking above recommended limits, whether or not there is an alcohol use disorder present. Content of this chapter is based on both consultation with Aboriginal and Torres Strait Islander health professionals and communities and on published research. Much of the published research on treatment approaches among Aboriginal and Torres Strait Islander peoples has been qualitative in nature.

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ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

DRINKING CONTEXT

Aboriginal or Torres Strait Islander peoples are less likely to drink alcohol than non-Indigenous Australians. Those who do drink, drink less often, but are more likely to drink at risky levels. There are few data on the prevalence of alcohol use disorder among Aboriginal or Torres Strait Islander communities.

For Aboriginal or Torres Strait Islander Australians, unhealthy alcohol use typically occurs on a background of social and economic disadvantage, and often on a personal and community-wide experience of trauma, grief and stress. Transgenerational trauma and enduring impacts of colonisation, including impacts of child removal policies and ongoing racism, are risk factors for poor mental health and unhealthy drinking. Alcohol consumption also typically occurs in the context of complex medical and sometimes mental health issues. Accordingly, treatment needs to be mindful of these factors, and be combined with support to address them where possible.

Aboriginal or Torres Strait Islander peoples can face many barriers to accessing mainstream (general population) alcohol treatment services, namely:

- a lack of cultural appropriateness of service delivery
- language barriers for those from remote regions
- concerns about confidentiality
- shame, fear of being judged, or discrimination

- fear of child removal
- lack of transport or childcare
- services which exclude clients who have significant mental or physical health comorbidities, those on opioid treatment programs, pregnant women or families
- lack of awareness of available services, including outpatient options.

Given these barriers to treatment services, respectful and non-judgemental care is required. Where possible and safe to do so, treatment should be provided at the point of detection of unhealthy drinking. If referral is needed, support should be offered to help a client access that service.

Engagement is key; engagement with individuals and ideally also with community. The Aboriginal or Torres Strait Islander perspective of wellbeing includes the individual in the context of family, community and country. Care should be holistic, considering mental and physical health, socio-economic needs including housing, relationships with family community, and culture. Where desired by the client, members of family or community can be involved in care.

Cultural training and resources should be available to non-Indigenous clinicians to help them work in a culturally appropriate way. Working in partnership with Aboriginal and Torres Strait Islander health staff can increase their capacity to deliver appropriate and accessible care.

	RECOMMENDATION	GRADE OF RECOMMENDATION
15.1	The clinician's approach should be informed by respect for the client's culture and awareness of their own cultural perspective and the privilege that may have come with it.	GPP
15.2	Clinicians and associated staff should seek cultural training, to ensure a culturally secure approach to engaging clients, asking about alcohol and offering treatment.	GPP
15.3	Recurrent relapse can cause shame, which may be increased in the presence of internalised racism. The clinician should understand and respond to alcohol dependence as a chronic, relapsing condition and be respectful and empathetic, framing relapse as a learning, rather than a defeat.	GPP
15.4	The clinician and treatment services should advocate for housing and social needs of their individual clients.	D
15.5	Provide flexibility of access to services where possible (e.g., drop in clinics), acknowledging the many family commitments or pressures on an individual's time.	GPP

IMPORTANCE OF ABORIGINAL AND TORRES STRAIT ISLANDER STAFF AND SERVICES

Mainstream (general population) alcohol treatment services can reduce barriers to treatment access and improve the cultural appropriateness of care by employment of Aboriginal or Torres Strait Islander staff. Where possible (and acceptable to the patient) non-Indigenous health professionals, should work in partnership with an Aboriginal or Torres Strait Islander health professional to increase understanding of the patient and their context, and ensure quality and secure care.

There are many pressures on Aboriginal or Torres Strait Islander health professionals, including service and community expectations. To develop and maintain a skilled Aboriginal and Torres Strait Islander drug and alcohol workforce, there is need for secure funding, job security, pay equity and ongoing opportunities for training and support.

	RECOMMENDATION	GRADE OF RECOMMENDATION
15.6	When acceptable to the patient and possible, non-Indigenous clinicians should work in partnership with an Aboriginal or Torres Strait Islander health professional.	GPP
15.7	Aboriginal health practitioners should be supported by increased job security, pay equity, and support for professional development.	GPP

Aboriginal or Torres Strait Islander Community-Controlled Health Services (ACCHSs) offer culturally acceptable, accessible and comprehensive healthcare to local communities. They have been shown to improve broad health outcomes for Aboriginal and Torres Strait Islander peoples. Accordingly, ACCHSs have great potential to provide alcohol screening, brief interventions (Chapter 6), and onsite treatment for Alcohol Use Disorders. However, there are many pressures for these services, including the complex health and social needs of their clients. Support for these services may be needed to make this possible. Partnerships between mainstream specialist services and ACCHSs can result in 2-way learning. However, such partnerships need sufficient time and funding to mature.

Where specialist services are available, support may be needed for clients to attend those, because of the many barriers to service access, such as stigma, or lack of transport.

	RECOMMENDATION	GRADE OF RECOMMENDATION
15.8	Given barriers to treatment access, Aboriginal community controlled organisations should be supported to offer the full range of ambulatory treatments for unhealthy alcohol use, including for alcohol dependence.	GPP
15.9	Mainstream and Aboriginal or Torres Strait Islander community-controlled health services should work in partnership where possible.	GPP

ENGAGEMENT, SCREENING AND ASSESSMENT

There can be sensitivities around discussing alcohol use, especially if the client perceives or fears discrimination or is ashamed of harms from their drinking. It is important for the clinician to take time to build rapport with the client. Ideally, screening will be preceded by informal conversation to build a relationship between clinician and client. Asking the client "Who's your people?" and "Where's your country?" may help to show respect and interest, as well as help the clinician place the healthcare needs of the client in a cultural context of their relationships to family and country. Wherever possible, a consultation should be long enough to allow an unrushed approach.

If the client seems uncomfortable in a face-to-face interview, sitting alongside the person rather than in front of them, and having a less clinical environment (e.g. with art on the wall, or being outdoors) may help. Some Aboriginal or Torres Strait Islander individuals from (or in) more traditional communities may find a series of direct questions intrusive. An unrushed, conversional style may be more comfortable. In more traditional Aboriginal or Torres Strait Islander communities it can be respectful (for patients and clinicians) to avoid eye contact. This should not be misinterpreted as evasiveness. The clinician should also be alert to other cultural protocols, including around interactions with the other gender, or respect for older people, and seek guidance as needed.

	RECOMMENDATION	GRADE OF RECOMMENDATION
15.10	The clinician should allow sufficient time for an unrushed and conversational approach. This can help to build a respectful relationship with the patient and for the patient to feel secure to share information about potentially sensitive issues, such as drinking.	GPP

Converting drinking into 'standard drinks' can be challenging for the patient (or the clinician), especially when drinking is from non-standard containers. The challenge is increased if the person is from a remote area where English is a second (or third, or fourth) language and where numbering systems may differ. Asking the type, size and fullness of containers that clients drink from is likely to improve the accuracy of screening. Visuals aids can be used to help identify containers. It is also important to ask about sharing of alcohol, as some clients may report on how much the group drank rather than their own drinking.

In terms of screening tools, the 3-item AUDIT-C (a shortened version of the Alcohol Use Disorders Identification Test, that only includes its three consumption questions) has been successfully used with Aboriginal or Torres Strait Islander patients in a primary care setting. It has been found to be less time-consuming and is potentially less 'invasive' than the full 10-question AUDIT, but provides comparable results.

The WHO-ASSIST (and ASSIST-Lite) which screen for alcohol and other drugs risk jointly have also been used, but not validated, in Aboriginal or Torres Strait Islander settings. The Indigenous Risk Impact Screen (IRIS) was developed and validated specifically for Aboriginal or Torres Strait Islander settings, and screens jointly for alcohol and other drug disorders and mental health issues.

In some communities, intermittent or episodic drinking may be common. Clients may have long "dry patches", where they may go months without drinking until there is a specific event (e.g. sorry business [grieving after a death], football grand final). Accordingly, the quantity-frequency method of asking about alcohol consumption, or asking about a "usual" drinking pattern may sometimes pose challenges. As an alternative screen for unhealthy drinking, the clinician can ask about the quantity of alcohol consumed on the last drinking occasion, and the timing (i.e. date) of the last 2-4 occasions. If a person says they do not usually drink, this may reflect their usual drinking status. Ask about high risk drinking on special occasions, such as football grand final or New Year.

	RECOMMENDATION	GRADE OF RECOMMENDATION
15.11	An annual health check in primary healthcare settings should include screening all patients for unhealthy alcohol use (drinking over recommended limits) at least once a year using a validated tool.	B
15.12	Validated alcohol screening tools include AUDIT-C or the quantity and timing of last two occasions of drinking. The IRIS tool can be used to provide joint screening for alcohol, drug and mental health disorders. ASSIST-lite can be used for screening for alcohol and drugs.	B

	RECOMMENDATION	GRADE OF RECOMMENDATION
15.13	Assessment of drinking should include asking about container type and fullness, sharing of alcohol, and irregular drinking patterns (e.g. special occasions only).	B
15.14	If a patient has not had access to alcohol (e.g. in prison or in a 'dry' region) the clinician should ask about drinking when the person last had ready access to alcohol.	GPP

ASSESSMENT

If a person has evidence of unhealthy drinking, fuller assessment is needed. This should include asking about past withdrawal symptoms, such as 'grog shakes' or history of seizures, in order to predict severity of future withdrawal. Individuals who drink episodically or intermittently may experience less severe (or no) withdrawal symptoms when they stop drinking despite a relatively high consumption per occasion and other features of dependence.

A sensitive assessment of harms can help the patient reflect on the impacts of alcohol on a number of areas of their life (e.g. exploring these issues gently and using reflective listening). One culturally secure example of a holistic approach to assessing the harms of alcohol or drug-related harms is the 'Seven L's' model of the Strong Spirit Strong Mind program[1]. This considers the individual in the context of family, community and culture.

	RECOMMENDATION	GRADE OF RECOMMENDATION
15.15	A holistic and integrated approach to assessment and care should be used, considering the client in the context of the family, the community, the country and environment (urban/remote).	GPP
15.16	When assessing likely withdrawal severity, consider episodic or intermittent drinking patterns as well as past withdrawal severity.	GPP

BRIEF INTERVENTION

Brief interventions (BI; or brief 'yarn' on alcohol; chapter 6) should be offered to support clients to re-think their drinking, at the point when unhealthy alcohol use is detected. This should be based on the client's priorities, which may reflect their priorities about family or community relationships, as much as their personal health.

[1] *https://www.mhc.wa.gov.au/about-us/our-services/campaigns-and-programs/strong-spirit-strong-mind-aboriginal-programs/*

	RECOMMENDATION	GRADE OF RECOMMENDATION
15.17	A discussion of drinking (brief intervention) and, where needed, treatment, should be offered at the point of detection of unhealthy drinking, even if referral to specialist services is also offered.	GPP
15.18	Brief intervention or treatment should be founded on the patient's priorities, whether about health, family or community.	GPP

TREATMENT OF ALCOHOL DEPENDENCE

Treatment approaches should be tailored to the individual, family and community contexts, and to patient preference. Patients can be offered the best of 'Western' and traditional care: for example, relapse prevention medicines, plus men's groups or cultural approaches.

Given the barriers to accessing specialist services, wherever possible and safe to do so, treatment for dependence and/or harm reduction approaches, should be initiated at the point of detection, even if referral to a specialist services is also needed.

Choices are important for treatment setting: some prefer the cultural security and holistic care of an ACCHS for treatment of alcohol dependence, and some like the anonymity of a mainstream specialist treatment service.

FAMILY, COMMUNITY AND CULTURAL APPROACHES

Treatment should consider available strengths in the individual, family or community. Sometimes individuals may be able to access the support of Elders in their efforts to change their drinking. If the individual lives with a relative or partner who drinks, consider assessing the need for treatment for that person.

A wide range of cultural approaches have been used by Aboriginal or Torres Strait Islander agencies or communities, including men's or women's groups, cultural enhancement, and returning to country. Activities that are meaningful and promote connectedness to (non-drinking) community members and family may help reduce drinking or support abstinence.

	RECOMMENDATION	GRADE OF RECOMMENDATION
15.19	Patients should be able to choose from available alcohol treatment services, whether that be mainstream, Indigenous-specific or a shared-care approach.	GPP
15.20	Consider the need to offer treatment to any drinking partner or close family member.	GPP

	RECOMMENDATION	GRADE OF RECOMMENDATION
15.21	Explore family, community, or cultural sources of strength and support that may help patients to change their drinking or maintain change. This includes men's groups and women's groups and alternative activities.	GPP

WITHDRAWAL MANAGEMENT

Ambulatory withdrawal management (e.g. 'home detox') offered through primary care services, can reduce barriers that Aboriginal or Torres Strait Islander peoples face in accessing withdrawal management. Patients need to be carefully selected given the high prevalence of medical or mental health comorbidity. If home environment is not suitable, another family member or friend may be able to provide a safer setting.

Individuals with complex medical, mental health or substance use histories, or repeated relapses are likely to require inpatient or residential treatment.

	RECOMMENDATION	GRADE OF RECOMMENDATION
15.22	Where it is medically safe to do so and appropriate, and when a safe and supportive environment is available, offer home withdrawal management for clients with less severe alcohol dependence.	D
15.23	Individuals with complex physical, mental health or social needs may require residential withdrawal management with or without residential rehabilitation.	GPP
15.24	There should be integration between various stages of treatment (e.g. withdrawal management, relapse prevention, ongoing care) with case management. This includes outreach or community case management as needed.	GPP

RELAPSE PREVENTION

Case management and continuity of care: Active follow-up support is important. Case management can strive to integrate treatment and support for medical, psychological and social/cultural needs.

Given the barriers to accessing specialised services, there is a need for seamless transition between services when a referral is made. This includes support for the transition between residential alcohol withdrawal management ('detox'), rehabilitation (when required), and aftercare.

Individual counselling or group approaches: Limited research has been conducted on one-on-one relapse prevention counselling in the management of alcohol use disorders in Aboriginal or Torres Strait Islander settings. Counselling approaches, such as Cognitive Behaviour Therapy (CBT), Dialectical Behavioural Therapy (DBT), Community Reinforcement Approach (CRA) and motivational interviewing, have been used among Aboriginal or Torres Strait Islander peoples with some adaptation.

Mainstream models of counselling often include only the clinician and patient. Some Aboriginal and Torres Strait Islander patients may prefer a family or community member to be involved.

Culturally-specific or culturally-informed approaches have been found to be beneficial (e.g. Strong Spirt Strong Mind program or cultural activities offered through ACCHSs or community). Aboriginal men's groups and women's groups have been observed to be helpful, and many clients perceive them as beneficial.

There is limited research on effectiveness of mutual support groups such as Alcoholics Anonymous (AA) or SMART among Aboriginal or Torres Strait Islander peoples. Some adaptations have been made to increase their acceptability, including making them more culturally appropriate, trauma-informed or linguistically inclusive. Peer support has been found helpful in other areas of Aboriginal and Torres Strait Islander health, but its role has not been formally evaluated in alcohol treatment.

Relapse prevention medicines: No research has been published on the effectiveness of alcohol pharmacotherapies among Aboriginal or Torres Strait Islander populations. Naltrexone, acamprosate (and less commonly, disulfiram) have been used and found acceptable by Aboriginal and Torres Strait Islander clients, including in ACCHS settings. Access to such pharmacotherapies appears to be poor, and there may be low awareness of these among potential prescribers and community. There have been suggestions that naltrexone would be a useful first-line medication for alcohol dependence due to its once-daily dosing, and potential to help those with episodic alcohol use to reduce the intensity of their drinking sessions. The ability to start it while a person is still drinking also offers potential.

Acamprosate on the other hand requires dosing three times a day, which may be hard to adhere to for a person with a complex life with many socio-cultural demands. However, its ability to reduce residual anxiety after withdrawal may be helpful in those with a burden of anxiety, for example related to past trauma. Acamprosate is contraindicated in renal failure.

Disulfiram is expensive to the patient, and so has limited accessibility. Also, in some patients' physical comorbidities may preclude its use.

	RECOMMENDATION	GRADE OF RECOMMENDATION
15.25	Aboriginal and Torres Strait Islander people with alcohol dependence should be offered the relapse prevention medicine which best meets their needs, considering physical and mental health comorbidities, patterns of drinking and complexities of their daily life.	GPP

	RECOMMENDATION	GRADE OF RECOMMENDATION
15.26	Given the likely low awareness of these medicines within Aboriginal and Torres Strait Islander communities, their role needs good explanation.	GPP
15.27	Where possible, offer Aboriginal and Torres Strait Islander patients a menu of choices: including both mainstream and Aboriginal-specific treatment and support.	GPP

RESIDENTIAL SERVICES

Aboriginal or Torres Strait Islander peoples can face many barriers to accessing residential rehabilitation services. The services may require access to a phone to arrange a bed, and may require payment of fees. Some mainstream services may not be culturally comfortable, or (for patients from remote areas) may not have staff who speak the patients language.

Many services exclude clients with significant mental or physical health comorbidities, or those who are on opioid treatment programs. There is a shortage of services that can take pregnant women, or women with babies or families.

Aboriginal or Torres Strait Islander drug and alcohol residential rehabilitation services can provide a broad range of treatment, including life skills, cultural education and counselling. Although these services vary by location, program length and services provided, fundamental to each is the integration of traditional values and Aboriginal or Torres Strait Islander concepts of health into the model of care.

	RECOMMENDATION	GRADE OF RECOMMENDATION
15.28	Services and clinicians need to strive to reduce barriers to accessing residential treatment services, such as the need to access a mobile phone or transport. This includes efforts to increase the number of family-friendly and youth services.	GPP
15.29	Residential treatment services should be resourced and staffed to allow them to accept individuals with comorbidities (mental health, physical health or other substance use disorders, including opiate maintenance treatment).	GPP
15.30	Residential treatment services should have closely linked or onsite withdrawal management services (outpatient or inpatient) to reduce gaps between withdrawal management and relapse prevention.	GPP

	RECOMMENDATION	GRADE OF RECOMMENDATION
15.31	Ensure culturally secure programs in residential treatment services.	GPP

COMORBIDITIES AND OTHER CONDITIONS

TRAUMA, GRIEF AND MENTAL HEALTH

Health professionals should be mindful of transgenerational trauma and grief, ongoing stress, and how alcohol use may be triggered by this, or may relieve or exacerbate symptoms. Trauma-informed (or healing-informed) care should focus not only on the individual but consider family, community and culture. Where needed, the clinician should seek cultural advice.

If a patient has recently ceased dependent alcohol use, stress can be heightened by the withdrawal. Supportive care may be the most appropriate in the short-term, with offer of specific counselling or treatment for trauma later, when the patient is more stable.

	RECOMMENDATION	GRADE OF RECOMMENDATION
15.32	The impact of past and/or present stress, grief, trauma or loss should be considered as a causative or perpetuating factor for unhealthy drinking and help, support or assistance offered for these where possible.	GPP
15.33	Outpatient or inpatient treatment should involve offer of care for mental health comorbidities where necessary. This should be done in a culturally secure way, and consider the person in context of family, community and culture.	GPP

PHYSICAL COMORBIDITIES

An alcohol use disorder can interfere with a person's ability to manage their other health conditions, such as diabetes. The clinician must also consider the impact of alcohol or alcohol withdrawal on physical comorbidities and offer treatment or advice accordingly. For example, consumption of alcohol on an empty stomach can cause hypoglycaemia in a person on diabetes medication, but chronic heavy use of alcohol can increase insulin resistance. Alcohol use also tends to be associated with increased smoking, which further increases risk of vascular disease.

	RECOMMENDATION	GRADE OF RECOMMENDATION
15.34	Consider the impact of drinking or of withdrawal on physical comorbidities, such as diabetes or heart disease, and advise clients on any likely interactions between these.	GPP
15.35	Treatment should include assistance with co-morbid nicotine dependence.	GPP

PREGNANCY OR BREASTFEEDING

For women of childbearing age, it is important to check awareness of the risk of alcohol to the unborn child. Contraception should be available to women who want to drink alcohol or who cannot stop drinking, to reduce the risk of FASD. For a pregnant woman who consents to have family involved in her care, informing partner or family members of her need to stay abstinent may allow them to support her. Women who are dependent on alcohol typically need access to residential treatment.

If a woman is breastfeeding it is important to check that she is aware of the risks of breastfeeding after drinking and of ways to minimise these risks.

	RECOMMENDATION	GRADE OF RECOMMENDATION
15.36	Provide or facilitate support for a pregnant Aboriginal or Torres Strait Islander woman who is drinking, and for her whole family where acceptable.	GPP
15.37	Provide education to women who plan to breastfeed on ways to reduce the risk of harms from alcohol to the baby.	GPP