Delivering culturally appropriate residential rehabilitation for urban Indigenous Australians: a review of the challenges and opportunities

Abstract

Objective: To review the challenges facing Indigenous and mainstream services in delivering residential rehabilitation services to Indigenous Australians, and explore opportunities to enhance outcomes.

Methods: A literature review was conducted using keyword searches of databases, on-line journals, articles, national papers, conference proceedings and reports from different organisations, with snowball follow-up of relevant citations. Each article was assessed for quality using recognised criteria.

Results: Despite debate about the effectiveness of mainstream residential alcohol rehabilitation treatment, most Indigenous Australians with harmful alcohol consumption who seek help have a strong preference for residential treatment. While there is a significant gap in the cultural appropriateness of mainstream services for Indigenous clients, Indigenous-controlled residential organisations also face issues in service delivery. Limitations and inherent difficulties in rigorous evaluation processes further plague both areas of service provision.

Conclusion: With inadequate evidence surrounding what constitutes 'best practice' for Indigenous clients in residential settings, more research is needed to investigate, evaluate and contribute to the further development of culturally appropriate models of best practice. In urban settings, a key area for innovation involves improving the capacity and quality of service delivery through effective inter-agency partnerships between Indigenous and mainstream service providers.

Key words: Indigenous, Aboriginal, alcohol and drug, residential rehabilitation, best practice, evidence, urban.

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Excluding poly drug use, alcohol continues to be the most common and chronically mis-used substance by Indigenous* Australians. In terms of treatment, residential rehabilitation is the preferred option, with research indicating that more than 50% of Indigenous clients 'choose' residential services over other forms of treatment. Yet approaches to residential programs are varied, and divergent views exist regarding the appropriateness and efficacy of residential treatment in a mainstream or Indigenous community-controlled setting. This is compounded by a paucity of research on the effectiveness of residential programs for Indigenous Australians, particularly in an urban setting.

This literature review was conducted to explore the challenges facing Indigenous and mainstream services in delivering residential rehabilitation, particularly in an urban setting, to Indigenous clients. In an environment challenged by resource limitations, complex co-morbidity and the need for culturally congruent evaluation models, the development of effective partnerships between Indigenous and mainstream services is considered a key requirement for improving Indigenous residential treatment outcomes.

Method

Nine electronic databases (MEDLINE, Meditext, Synergy, Australian Public Affairs, National Library of Australia, Google Scholar, Science Direct, Ovid, Informit) were systematically searched for abstracts that contained combinations of the key words Indigenous/Aboriginal, alcohol, urban, mainstream and residential rehabilitation from the period 1984 to 2009.

The Joanna Briggs Institute states that in the absence of quality evidence derived from rigorous research, discounting expert opinion as non-evidence is not appropriate. Due to the paucity of research conducted in this field, non-research information in journal publications, position papers and reports that responded to the search terms ('grey' literature) were also retrieved.

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Footnote: The term ‘Indigenous’ refers to the Aboriginal and Torres Strait Islander people of Australia.
Alcohol

Abstracts were then reviewed for information related to:

i) the challenges facing Indigenous and mainstream residential rehabilitation services;

ii) issues facing Indigenous clients in accessing these services;

iii) delivering culturally appropriate residential services; and

iv) challenges in assessing and evaluating what works for Indigenous clients in residential services.

Full articles were then retrieved following the indication in abstracts of relevance to these issues.

Retrieved articles were assessed by the authors for their 'strength' through a collaborative process based on criteria developed for each source type, conferring with other authors as required. Qualitative research was assessed for sampling methodology, quality of reporting, reliability/validity strategies and Indigenous perspectives.10 Grey literature was assessed for quality of opinion, the ability to convince, authority of the source and indication of alternate views.9 One of the research team was Indigenous, so all documents were assessed for inclusion from an Indigenous perspective.

This collaborative review and assessment process aimed to reduce bias and improve rigor, and resulted in the inclusion of qualitative research papers (n=7), non-research journal publications (n=8), research centre report/discussion papers (n=12), expert consultant reports for government (n=6), industry reports (n=1), conference proceedings (n=2), books (n=2) and Indigenous position papers or books (n=6). Selected sources were read and re-read to ensure content familiarisation, then key ideas within each source were coded and these codes collated under broad descriptive themes.11 Citation snowballing was used to locate primary sources that were referred to in the initial document where necessary. The main issues identified in the literature related to residential rehabilitation for Indigenous clients in both Indigenous and mainstream services are reported below.

Results

Issues facing mainstream residential rehabilitation services

It is widely recognised that Indigenous people face complex circumstances related to financial, cultural and social barriers in accessing mainstream health services.12 13 However, Australia’s colonial legacy means that even when accessed, many Indigenous clients remain deeply suspicious of mainstream services,14 while the absence of shared concepts of illness and health between the Indigenous client and mainstream providers creates further challenges.15 Although increasing Indigenous staff in mainstream services is a strategy increasingly being used to make programs more culturally accessible,4 this can also be problematic. Indigenous staff have identified difficulties working in a mainstream setting that expects a certain type of health practice that is often incongruent with their socio-cultural responsibilities,16 while others argue that high community need is a potent catalyst to change drinking practices.27 Clearly, the different needs of individual clients necessitate program choices.

Debate also surrounds the mechanisms to address the collective and individual aspects of Indigenous drinking. The design for the Indigenous residential program at Benelong’s Haven was based on the idea that since Indigenous Australians drink in groups, they must become sober in groups.28 Yet Brady’s ethnography of Indigenous drinkers who had stopped drinking on their own illustrates autonomy operating in Indigenous society.29 Indigenous reviewers have explained how autonomy and relatedness are not separate. While individualism is important, it is held within a collective context of responsibility and identity.30 The paradox is that treatment aiming to be autonomous or collective is misdirected. Rather, the main requirement is to locate individual autonomy within Indigenous cultural tradition if treatment outcomes are to be strengthened.30

Challenges facing Indigenous residential rehabilitation services

The literature indicates that many Indigenous programs also face service difficulties. Reviews have found problems with a lack of skilled staff, management issues, chronic resource shortages and poor record keeping intertwined with destabilising political complexities.7,19,22–24 An absence of organised alcohol counselling and operating in a recuperative rather than treatment-based context has also been a feature of Indigenous programs.19,25 Government financial administration processes have often caused Indigenous services to operate in isolation,2 while shifts to funding less resource-intensive approaches, such as harm reduction and early intervention,1 have caused many Indigenous services that advocate abstinence to be financially affected.26

Paradoxes in developing culturally appropriate residential treatment models

While the need for appropriate residential services for Indigenous Australians is widely acknowledged,2 there are different views regarding what this actually means.15 The relationship between the Indigenous social context and patterns of drinking has influenced thinking that programs need to target the individual in concert with kin relationships to be effective.24 Yet Indigenous clients do not universally welcome the involvement of the family in their treatment. Research has shown that while some prefer to be away from family influences, others find family separation has a negative affect.4,13 Other research has shown that while in some cases family and social relationships can drive drinking patterns, in other situations family relationships and responsibilities are powerful catalysts to change drinking practices.27 Clearly, the different needs of individual clients necessitate program choices.

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Group psychotherapy within residential treatment programs has also been criticised for being culturally inappropriate for Indigenous clients. However, ethnographic research suggests group approach to psychotherapy actually relates to the Indigenous social context by facilitating relationships and importantly, a collective cultural redevelopment that reinforces differences from mainstream society.20,23 With research showing the recognition of culture (along with education, life skills and employment) is one of the most important factors identified by Indigenous clients for treatment success,17 programs that demonstrate supporting cultural redevelopment are critical.

The similarities between Indigenous Australians and other Indigenous communities in terms of colonisation and substance abuse has resulted in many Australian services looking to international models for inspiration in delivering culturally appropriate substance treatment.26,13 The Canadian ‘Nechi’ residential model, based on abstinence and 12 steps with a cultural flavour, has become the most widely adopted approach.15,28 This program has been applauded by Indigenous researchers for its indigenisation of the Alcoholics Anonymous (AA) model26 and training of ex-alcoholics.26 It is the spiritual undercurrent of the AA model that Brady suggests has been particularly attractive to the Indigenous Australian community25,15 for its connection between health and mind-body-spirit healing.

However, the cultural appropriateness of the AA and 12-step model has also drawn criticism from mainstream and Indigenous commentators.7,15,33 An evaluation in the mid-90s of a rural residential treatment program in Central Australia found that aspects of the AA-inspired approach, such as gender mixing and confrontational therapy, conflicted with cultural perspectives.24 The ‘family disease’ model has also been criticised as inappropriately contextualising the family in the alcohol process rather than the community.22 There has also been debate that the addiction/disease/abstinence model can actually be culturally dis-empowering, by prompting people to change their drinking social circles and sever important kinship ties.8,13

Brady argues that differences between the adaptive capacity of Indigenous traditional healing techniques and Native American traditional practices requires different treatment approaches.15 Further, while sharing stories with other Indigenous cultures is important, reclaiming the very uniqueness of Australian Aboriginality is part of the empowerment process because “To apply other indigenous peoples’ culture, as a central form of treatment in our country … is another form of … oppression. Contemporary Aboriginal cultural ways and values must be central to the solutions we develop for any issues in our lives” (p.17). Importantly, taking cultural practices into treatment programs requires a sensitive approach that does not lead to a ‘superficiality’ that negatively impacts traditional systems.30

### Challenges for residential programs servicing urban Indigenous clients

Even though the effects of using alcohol in a harmful manner are similar across urban, rural and remote areas, it is the remote areas that have generally been the focus of research and interventions.12 This rural bias, arguably from the legacy of ethnography combined with the difficulties in identifying the Indigenous ‘community’ in the urban setting, is likely to have hindered the design of culturally appropriate urban treatment programs.37 The question for residential services is how to incorporate the cultural differences of urban Indigenous clientele into their treatment programs. Sagens and Gray caution that subjectifying cultural groups into common drinking characteristics can avoid addressing the impact of the wider social context, or identifying similarities between different cultures in relation to alcohol use and misuse.38 The temptation to ‘match’ the Indigenous patient to singular ‘culturally appropriate’ treatment models can radically oversimplify the complexities of dealing with an urban heterogeneous population – and fail to accommodate the individuality of the client.

In the urban context, the ready availability of alcohol requires a different approach to programs operating in rural and remote areas, where alcohol is often limited in supply. Offering harm minimisation to urban Indigenous clients in the residential environment may assist the development of alcohol management skills, which may be vital when clients leave treatment and return to an urban setting. The shift from abstinence to harm minimisation has been suggested as a major reason for the success of the Indigenous-run Miliya Rumurra Alcohol and Drug Rehabilitation Centre in Broome.38 Broadening treatments also requires addressing appropriate processes for the high percentage of urban Indigenous youth; high poly drug use,4,19 the different needs of Indigenous women; and the role of political factionalism in drinking within urban Indigenous culture.37 Chenhall’s suggestion that clients remain attached to the residential facility when leaving treatment is also important in considering clients re-entering urban environments where the wider structural issues have not altered.28

### Problems in evaluation and identifying best practice

Evaluating residential programs and identifying what works for Indigenous clients in a residential setting is challenged by the lack of standardised outcome measures, multi-variable analysis26 and the limitations created by traditional ‘outcome’ indicators.40 While classic indicators have been length of abstinence, for the chronic drinker, even a short period of abstinence in residential care is beneficial in terms of health relief.41 Further, relapse does not mean there have not been other improvements in a person’s life (e.g. employment).40 The contradictions in evaluating success are contextualised poignantly by one Indigenous client who explains, “Just because someone is sober, doesn’t mean they are healthy …” (‘Mona’ cited p.155).28 Further, with evaluation indicators generally constructed based on the funding body’s paradigm and philosophy,46 an evaluation can seriously undermine the value of cultural appropriateness.7,24,42

### Including ‘culture’ in evaluation

Calls for culturally appropriate evaluation models for programs for Indigenous clients have received much attention.24,42 Members of the Indigenous community have criticised the ‘diagnosing’ of indigenous clients based on non-Indigenous criteria,8 while other review sources have highlighted the inherent differences between the medical statistical approach to evaluation and the qualitative, holistic perspective often favoured for evaluating Indigenous health programs.43 As Spurte has argued, the heterogeneity of the
Indigenous Australian population means the key to an effective evaluation is to adapt the method of research to reflect the setting. Alati also suggested more appropriate methods of evaluation could use Indigenous socio-cultural systems - such as community networking - to obtain information about behaviour. Saggers and Gray propose that best practice evaluation must have a pluralistic methodology of quantiative and qualitative data collection. Furthermore, the individual’s role is so significant that success may not be about the program at all, but rather the individual interacting with it. Perhaps one of the most important components to an evaluation is to be able to conceptualise that the journey of healing takes time.

The continuum of care: the importance of mainstream and Indigenous partnerships

Although relapse and re-entry is known to be high in residential centres, most programs lack appropriate relapse prevention strategies for Indigenous clients. However, discharge of a person from rehabilitation into a home or community environment that has not changed will almost certainly a patient to relapse. With the connection between Indigenous drinking, kinship and social obligations well recognised, the interaction of the client with these dynamics necessitates a comprehensive model of service support and aftercare. This post-treatment period is potentially when the client is most vulnerable, and possibly requires more attention then whether the client has been in a mainstream or an Indigenous residential setting.

A potential approach for improved treatment outcomes is for Indigenous and mainstream services to develop strong and effective collaborative arrangements. Clients need to be able to access the most appropriate option for their individual needs, and this should be borne in mind regardless of whether the first service accessed is Indigenous or mainstream – more blended models of service through partnership arrangements may have something to offer. The complexity of issues facing many Indigenous clients in their community, combined with the resource limitations that are endemic to health services necessitates service partnerships to provide Indigenous clients with a more seamless continuum of care. Such partnerships will also deliver more culturally secure services due to the different angles of agency engagement. The variation in service capacity, coupled with integrated care between residential and community settings, may be most the important predictor of a better outcome.

Conclusion

Residential alcohol rehabilitation for Indigenous people is a treatment approach to a complex health problem that often occurs in individuals with a range of social, economic and legal difficulties. While major inadequacies clearly exist for mainstream services in treating Indigenous clients, Indigenous organisations also face a host of challenges that impact their service capacity. Diverse views regarding the appropriateness of particular treatment approaches for Indigenous clients also exist. Importantly, the debate surrounding what interventions work for Indigenous people is driven by inherent differences in the perceptions of what is the cause of the harmful use of alcohol – a dichotomy that Brady and Martin argue cannot be reconciled easily. Any intervention must be supported by appropriate cultural evaluation mechanisms to improve the delivery of residential rehabilitation treatment programs. In terms of widening the capacity for services to respond to the diverse needs of clients, as well as the complexity of their issues and the vulnerability they face when they leave a residential facility, partnerships between mainstream and Indigenous services provides a critical opportunity for improving client outcomes. Finally, it is important to note that this review is not based on scientific literature that resulted from experimental interventions, but rather on published information, including grey literature which often utilises observational and qualitative approaches in a way that constrains the certainty of the conclusions drawn.

References


