Strengthening and supporting Indigenous residential treatment programs

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Abstract
Indigenous residential treatment programs developed from the mid 1970s and have been funded largely by the Commonwealth. Because of its special status and needs, the Indigenous sector has often been cut off from developments in the broader community. Poor or no training, geographical isolation and a degree of separatism have all been contributing factors. Major influences on programming have derived from AA, and from Indigenous Canadian treatment entrepreneurs. Broadening the approaches taken in these programs requires more vigorous networking and interchange with similar therapeutic communities in the wider community.

There are at present 28 Australian Government-funded residential drug and alcohol facilities in Australia specifically for Indigenous Australians - although some also have non Indigenous clients from time to time. Half a dozen additional residential facilities are funded by different States. Usually known as 'rehab centres', residential facilities have been developed since the mid 1970s, and they account for a substantial slab of the overall expenditure on Indigenous alcohol and other drug projects: between a third and a half of the total funds. The rehab centres are Indigenous-run and managed, and usually employ Indigenous staff who are ex-drinkers, and who have varying levels of training (Brady 2002).

Residential programs are, of course, an important part of the overall approach to dealing with alcohol and other drug abuse. Apart from anything else, they are particularly relevant for Aboriginal drinkers as they provide time out and time away from the normal home environment which is frequently characterised by abusive drinking. Their indirect functions include providing employment for the ex drinkers who work in them, and supporting the sobriety of these workers. Indigenous people are more likely to use residential forms of treatment than are non Indigenous people, where the overall trend is towards the use of *non*-residential services.

Most Australian government funded AOD services for Indigenous people *do not report* to the National Minimum Data Set (AIHW 2008:13). I am not sure why this might be. However, the latest NMDS noted that of rehab episodes in Australia as a whole, 12% were individuals of Aboriginal and or TSI origin (AIHW 2008:23) – this is much the same the 13% which was calculated in 1996.

In 2005, the 28 Indigenous residential services saw 2,500 clients of whom 20% were non Indigenous (OATSIH 2006). Most clients were aged 26 and older and most were male. 500 clients (that is 20%), stayed for less than two weeks. Treatment episodes involving Indigenous clients involve the same four principal drugs of concern as the overall population: Alcohol, cannabis, heroin, and amphetamines. However for Indigenous clients, alcohol is more likely to be nominated as the principal drug of concern. Abstinence is the most common treatment goal for Indigenous substance misuse programs (78% in 2004-5). By way of contrast, less than one in six mainstream agencies rely exclusively on abstinence (OATSIH 2006:24).

How Indigenous programs developed

In order to highlight the challenges faced by these Indigenous residential programs – and to suggest how mainstream therapeutic communities might be able to assist – I need to describe how these Indigenous facilities have developed over time. It is within this history that the seeds of many present day difficulties were sown.

The first independent Aboriginal run residential program was Benelong's Haven, started in 1974 by a long term AA member, Val Bryant (Chenhall 2007). As the program grew, Val and her co-workers travelled throughout

Queensland and New South Wales spreading the word about Benelongs and holding AA meetings for Aboriginal people. This spawned several offshoots of Benelongs, in Moree, Darwin, Lismore, Palm Island and Perth. In this way the 12 step model was disseminated widely among Aboriginal people for the first time.

In the 1970s these community controlled residential centres attracted their own funding from the old federal Department of Aboriginal Affairs (DAA), which gave them independence from the other major Indigenous community controlled sector competing for funds – the Aboriginal Medical Services. The AMS had developed around the same time in order to provide primary health care to people who previously had none at all. The two movements were established by different groups of activists, who took different approaches to problem drinking. In the early years of the AMS, the activists and volunteer health professionals who set them up had no inclination to take on alcohol problems, and concentrated instead on providing basic health care. Dealing with alcohol problems has never been a popular area within medicine.

For the Aboriginal medical services (particularly in Sydney and Melbourne), influenced by radical activists, such as Gary Foley and Gordon Briscoe, dysfunctional drinking was a *political* problem associated with colonisation. This argument did not go unnoticed by Val Bryant, the founder of Benelongs. She told a government enquiry that *her* organisation was primarily concerned with alcoholism rather than politics, land rights, social and racial questions, which were (she said) 'matters for decisions of the alcoholic after he or she leaves Benelongs'. In turn, the AMS took exception to the hard-line abstinence position taken by Benelongs Haven and its proponents, arguing that this echoed the paternalistic policies of Aboriginal prohibition. The medical services objected to the idea that all staff should be non-drinkers; whereas this was an absolute requirement for workers at Benelongs and its sister programs. This antipathy between the AMS and the Aboriginal addictions programs meant that there was little opportunity for the developing discourse on primary health care to incorporate alcohol interventions (Brady 2004). And it meant that the growing number of residential programs failed to network with any local Aboriginal medical service in their vicinity.

DAA funding for the residential programs came without performance requirements, any advice on best practice or program support, or requirements that the services should have partnerships with outside professional service providers. In order to receive funding from DAA, the programs were required to have an Aboriginal board or management committee. Most boards– according to an Aboriginal commentator – were made up of well meaning people in the aboriginal community. They had no training in management or governance, and many did not know what their role was; there was frequent confusion and conflict within boards, and between boards and employees of programs. Board members certainly had little background in alcohol and other drug issues, other than perhaps some personal experience with AA. The Department had insufficient field staff to give the kind of on going support that would disentangle some of these problems.

Once established, the residential programs continued to receive the bulk of available funding year after year – simply because of historical precedent – and despite regular questions being asked about how viable and competent they were. In the mid 1980s DAA attempted to redirect funding giving a greater emphasis on prevention and education and away from tertiary treatment. This was in line with the changing direction of national drug and alcohol policies at the time, and the National Campaign against Drug Abuse. The process was interrupted when ATSIC (the Aboriginal and Torres Strait islander Commission) was formed and the old Department dissolved.

The late 1980s saw a resurgence of emphasis among Indigenous people on the importance of residential facilities – at a time when *mainstream* interventions were shifting towards primary and secondary prevention. This included the role of primary health care, and the opportunistic use of brief interventions and motivational interviewing were being promoted. This resurgence of interest in residential treatment for the Indigenous sector was triggered by Aboriginal contacts with visiting Indigenous treatment activists from Canada.

The Canadians

In the 1970s and early 80s, a few Aboriginal alcohol and health workers had travelled to the US and Canada on scholarships or special travel awards, to look at native treatment programs there. But in the early 1990s there was a flurry of Canadian visitors to Australia, and of Aboriginal people visiting Canada. The visits coalesced around the most prominent and well-endowed of the Indigenous treatment and training centres in Canada: the Nechi Institute and Poundmakers Lodge in Edmonton, Alberta. The Nechi Institute offers addictions and counsellor training, and Poundmakers is its treatment wing. It is the longest-established such organisation in Canada [founded in 1974] and even produces its own post card! Representatives of Nechi and Poundmakers travelled widely throughout Australia in 1991 and 1992 disseminating their model. Their charismatic and optimistic approach to Indigenous alcohol problems produced numerous invitations from Aboriginal organisations across Australia, as well as giving them the opportunity to address government audiences. Several visitors were supported by generous ATSIC- funded consultancies.

The Canadians saw the solutions to indigenous drug and alcohol problems to lie in reclamation of Aboriginal culture and spirituality and a revival of ‘traditional’ ways. To this end, the Canadian addiction programs were enriched with cultural practices and paraphernalia – sweat lodges, pipe ceremonies and prayer rooms, dream catchers, eagle feathers, and purification rituals using burning sweetgrass and sage.

Most importantly though, the Canadians saw the solutions to lie in abstinence-based and separate Aboriginal-run residential treatment programs (cf Smart and Ogborne 1996). Their Australian audiences were impressed by their articulate presentations. These people had real flair. Not only did the

Canadians hold up a model of high-class facilities to house those being healed, they impressed Aboriginal people with the structured and established nature of their treatment ideology, and with their professionalism. They placed great stress on the need for training. Aboriginal observers noted this, and commented unfavourably on the situation in Australia. Reinforcing the message conveyed by visiting First Nations people was the inauguration of an international indigenous 'healing our spirit' movement. This was the brainchild of Maggie Hodgson, the executive director of the Nechi Institute. The first of what turned out to be a series of conferences called *Healing our Spirit Worldwide*, was hosted at Edmonton in July 1992, and others have taken place since then. *Dozens* of Aboriginal people from across Australia attended that first meeting. Co-sponsored by the National Native Association of Treatment Directors and the National Association for Native American Children of Alcoholics, the conference was devised to address substance abuse and 'to promote addiction free lifestyles'.

Attending these conferences had a big impact on Aboriginal drug and alcohol workers. They realised they shared similar problems with other indigenous groups, and were reinforced in their existing views that alcoholism was a disease, that treatment was the answer, and that abstinence was the only solution. Treatment centres were described in Canada as being 'miracle machines', that could transform communities from universal drunkenness and dying cultural practices, to virtual total sobriety, cultural vigour, and produce people with university qualifications (Brady 2004:77). There was inevitably a touch of the magic bullet in it all.

The Canadians had arrived in Australia at a time when harm reduction vs abstinence was being hotly debated – particularly in Northern Territory Indigenous circles. The Northern Territory's *Living with Alcohol* program was in full swing: its title reveals its orientation. Living with Alcohol ran from 1991 to 1997 as a comprehensive public health strategy to *reduce alcohol related harm* in the Territory. It was funded by a small levy on alcoholic drinks and its outcomes have since been positively evaluated (National Drug Research Institute et al 1999). The program director of the Aboriginal unit of *Living with Alcohol,* had in fact made a presentation at the second *Healing our Spirit Worldwide* conference - She was pretty much a lone voice saying that alcohol 'is always going to be with us. We need to decide how *to live with it'*.

Significantly, she urged Aboriginal people in Australia to *look to each other first* and to the resources we already have before seeking other cultures for the solutions. In fact some aboriginal people felt some 'cultural defensiveness' about the Canadian influence – and expressed reservations about transplanting a model from another indigenous group - especially one that had cultural elements to it. One prominent Alice Springs woman described the Canadian approach to me as '*AA with a smokescreen'*. It was their promulgation of residential treatment and its philosophies, in which the Canadians had most impact. They also argued that treatment in old demountables was not acceptable; people recovering from alcoholism needed attractive, even luxurious treatment centres. People should, they said, 'want to choose the *treatment centre* over and above the Hilton hotel'. !

So the outcome of all this was to *accelerate Aboriginal requests* for new residential treatment centres. The federal government began to receive funding applications for millions of dollars, and ATSIC regional councils were asked for funds to employ Canadian consultants to write proposals and strategic plans for such programs. Many requests were successful, and subsequent planning documents for facilities were complex documents, strongly influenced by a small number of First Nations consultants. These developments constituted a move away from local attempts to provide more holistic approaches that included primary and secondary alcohol prevention strategies, and community-based action.

In Alice Springs, consultants from Nechi drove the development of a new residential alcohol program. It was a model largely imported from Canada. At its core was a 12- steps based program, including some native Canadian cultural practices. This program came to be known as CAAPU. One of its Aboriginal founders, Doug Walker said on his return from Poundmakers Lodge in 1991:

'I have just returned from Alberta, Canada, where the gaols are emptying out as Native Indian people are beating the grog in their communities. Governments over there had faith in Indian treatment and training programs and funded them well. This faith has paid off as they are saving millions. We won't need a new gaol in Alice if we can get our programs up and running'

While today in many Aboriginal residential facilities, treatment programs are largely composed of meetings along AA lines and lecture-style education sessions, it is not easy to say whether this has anything to do with their earlier contact with Canadian ideas. While abstinence is still the official 'line' for the majority of residential programs, at the coal face *in* the community, a more pragmatic orientation to harm minimisation is occurring. Some programs have managed to broaden their approaches offering choice in their goals, as well as harm minimisation advice and advice on community development (See Strempel, Saggers, Gray, Stearne 2003:44).

Several Aboriginal residential programs introduced a morning smoking ceremony into their program, using burning gum leaves (or even sage sticks imported from Canada). This 'ceremony' is often accompanied by the recitation of the serenity prayer, and handshakes all round. Such ceremonies have strong echoes with the practices at treatment centres in Canada. At CAAAPU, in Alice Springs, a specially built smoking pit was constructed for this purpose. However, it has recently fallen out of use. In Victoria, an adapted version of the smoking ceremony is now used in Aboriginal alcohol programs, men's and family violence groups.

All the issues I've described here combined in such a fashion that Indigenous approaches to chronic alcohol problems became simultaneously innovative and fossilised. There were new networks forged with Indigenous alcohol activists overseas, and the notion that 'culture' could be used in treatment

received a boost of energy. The Canadians promoted the need for trained Indigenous workers and showed how this could be achieved. But they cemented existing Indigenous thinking about addiction and the disease model, and reinforced antipathy towards ideas of harm reduction. They reinforced the idea that Indigenous programs were closed systems, and they diverted attention from creating the networks and accessing the supports available closer to home.

Program content

Several recent reviews have voiced concerns about whether Indigenous treatment programs provide *a range* of treatment models to meet the needs of different clients, or are locked into just one model of treatment that tends to dominate (Mattick and Jarvis 1993; Brady 2004) - or indeed whether they offer any treatment at all! The dominant model in the Indigenous facilities is a 12 steps approach – and some simply provide for an AA meeting on their premises. As Richard Mattick noted in a Quality Assurance Review,

*There is currently no convincing evidence supporting the use of treatment based **solely** upon the 12 step model .. it is unacceptable that agencies or government bodies allow the continuance of interventions that are of unproven efficacy … (Mattick and Jarvis 1993:220).*

Indigenous programs still almost invariably focus on alcoholism as a disease or a chemical dependency. This can be a problem, because not all their clients fit the mould of the classic alcoholic or dependent drinker. Many clients are episodic heavy drinkers, are young, and use alcohol in conjunction with other drugs. (Although alcohol is still the principal drug problem for most Aboriginal clients, it *has* declined as the main issue, with opiate use being increasingly mentioned.). While there are many social benefits of thinking of alcohol abuse as a disease, in the Indigenous context there may be a downside to this. Several researchers have observed that the disease analogy can leave a community feeling powerless and fatalistic over the problem; and that it reinforced the idea that only a small proportion of 'sick' 'alcoholic' people in the community created the drinking problems (cf Brady 2004:102).

While the residential programs tend to have a narrow treatment focus, many of these Indigenous facilities do offer variety in other ways. Some provide agriculture and horticulture experience, building and carpentry skills, permaculture training, healing circles, Reiki massage, approaches identified by them as 'cultural' such as fishing, making artefacts, collecting wood for artefacts, and morning 'smoking ceremonies'.

Nevertheless, despite the cultural and recreational activities on offer, the rehabs do need to be encouraged to have a structured program, and to broaden the range of skilled counselling and treatment approaches offered to clients while they are resident. In some cases, activities at residential

programs are so ad hoc that they hardly constitute a program at all. As a result, local communities view them as ‘not a rehab, but a rest place’.

The differing *expectations of clients* are an ongoing problem underlying the provision of formal regular activities, including counselling. One evaluation team in the Kimberley found that clients were divided. One group of clients *wanted* to take decisive action to change their drinking behaviour, and wanted the program to help with this. The other group wanted to have a *break from drinking, i*mprove their health and get away from alcohol for a while. Having both groups in the same program was problematic, as those individuals with no intention of taking long term action about their drinking were not interested in counselling or a structured program. The clients who *did* want to change their behaviour were frustrated at the lack of a program, complaining that existing so-called ‘counselling’ was ‘just gossiping’ (Sputure et all 1998:39-40).

Obviously Indigenous programs need to be flexible in order to cater to clients from a wide range of backgrounds and regions of the country. Too much rigidity would be counterproductive. But considering that these programs use a large proportion of the overall Indigenous budget, are an essential component of any overall approach to alcohol and other drug problems, and are *believed by community members* to be important – strengthening their ability to deliver appropriate and practical programs should be a priority for government funders and relevant peak bodies.

There is also room for further strengthening of professional medical support to Indigenous rehab programs, for example in terms of detox. Detoxification is a term that is widely misunderstood in the Indigenous community. It is often confused with long term residential treatment, rather than being understood to be the *process of reducing the risks during withdrawal from a drug.* Outpatient detox can be much more difficult for Aboriginal clients, primarily because their environment is not safe, and not free of the drinking behaviour of others. Indigenous rehab programs do not always have clear guidelines about whether clients who need detox, have had supervised withdrawal before entry to their program.

Regular access to a medical practitioner is also important because for many clients a GP associated with a residential program may be their *only point of contact* with the health care system.

This means these practitioners have *the only available opportunity* to assess these clients for psychiatric co-morbidity, and if the opportunity is not taken, it is unlikely that further specialist consultation would take place. A GP can also help a resi program with care plans, can undertake biological tests for liver damage and provide personalised feedback, they can do routine screenings for STIs and TB, prescribe thiamine, prescribe other pharmacotherapies, give vaccinations, and provide brief alcohol interventions to reinforce the clients experiences in rehab.

Many Indigenous residential rehabs suffer from a high degree of insularity. Their managers and boards operate within a relatively small network of strong ties to others known to them, and are not exposed to the wider, looser networks of professionals and other treatment providers. In this way the status quo is maintained, there are few challenges to it. In some cases, there is a conscious resistance to the formation of wider, outward looking linkages with other service providers and organisations. Some of this can be explained by the history of the development of these Indigenous programs, and I mentioned earlier the failure of funding bodies to provide management training, or to insist on active partnerships being formed.

So what are the problems and challenges faced by these programs?

Governance is always an issue in small community-based organisations. Staff members often have strong family connections with board members, which can mean that staff wield considerable power and influence in decisions about recruitment and policy. In small communities, Board members can all be related; they may hold their positions unchallenged for many years with no procedures in place for regular changes in membership.
Clients of the program who are related to board members, may receive special concessions or exemptions from rules.

There is frequently a confusion of roles between board members and staff of the service. Board members may, for example, have too much influence over the program's philosophy – in some cases this militates against the staff adopting more flexible or alternative counselling techniques, or taking up offers of help from other organisations. Some boards are over-involved in the day-to-day running of the facility. In one case, a manager had to ask permission of the board before attending an inter-agency networking meeting.

Programs may have inadequate procedures in place. For example, the initial assessment of the client can be inadequate, omitting to ask crucial questions such as when a client last used, what were their levels of consumption, whether they use additional drugs, their withdrawal status, and their readiness for change.
Failure to provide this information means counsellors do not have enough background to help their work with clients. On occasions, clients may be dropped off by government agencies with no assessment process taking place at all. Most Indigenous residential programs do not have the capacity to undertake follow up at discharge, and have no funding or procedures in place to try to facilitate this kind of outreach work.

Some Indigenous programs have high rates of absconding.
In one case up to 30% of clients were absconding within a week. Absconding leads to the creation of a gaol-like atmosphere in facilities – several have high wire fences and CCTV as a result – not conducive to a healing environment.

There are usually great difficulties in attracting trained staff. Many Indigenous residential facilities are in small towns, which offer a small catchment population from which to access qualified AOD professionals. Even

in larger towns such as Alice Springs, the AOD workforce *in general* can hold few specific qualifications. High level skills in conducting evidence-based treatments, such as cognitive behaviour therapy, can be in very short supply. Low wages and poor access to professional supervision add to the difficulties associated with recruiting and retaining staff. A rule of complete sobriety among staff (which is very common) also contributes to difficulties in recruitment. There are frequently no professional development opportunities for staff, no in-house training or upskilling, and no clinical supervision for them.

Political problems can also limit networking
As a result of some of the historical and developmental factors I mentioned earlier, Indigenous residential programs can often have poor working relationships with other organisations, both Indigenous and non Indigenous. These are often political problems associated with attitudes of the Non government towards the government sector, or a history of friction with other Aboriginal organisations (health services for example). These contribute to isolationism, lack of awareness of what other organisations can offer, and a failure to benefit from the expertise available in other sectors such as mental health, and indeed the mainstream therapeutic communities.

There is a problem of mandated places. In the Australian population as a whole, most alcohol-involved treatment episodes take place for people who referred themselves (AIHW 2008:23).In the Indigenous sector on the other hand, some residential treatment services are dominated by clients who are mandated for treatment by Corrections departments. Some may have no self referrals at all.

This means there is little treatment capacity for voluntary clients, who are the ones most likely to benefit from the program. Having a majority of mandated clients can lead to perceptions in the community that 'You have to go to goal to go to rehab'. The residential program comes to be seen as a restricted place only accessible through a court order. This practice leads to a lack of accountability in the service, and decline in program quality. Because a service does not *need* to have a good reputation in the community –it is full even without any community referrals.

How could mainstream Therapeutic Communities be of assistance?

I guess there are two issues here. The first is how therapeutic communities that are not indigenous-specific can make themselves more accessible and attractive to Indigenous clients. The second issue is how could therapeutic communities offer outreach or support to assist Indigenous specific programs.

1. **Making mainstream facilities more simpatico**

At least *some* Indigenous clients are already accessing mainstream long-term residential programs. However, an evaluation by Turning Point of 4 Victorian residential programs found that there was *minimal* Aboriginal participation. They suggested that this was because the services had limited capacity to

house family members, and one of the centres evaluated dealt with polydrug use rather than alcohol misuse. It is also possible that Aboriginal services do not refer their clients to mainstream programs.

Turning Point evaluators noted that the therapeutic communities in their study were attempting to increase the receptivity of their programs to Indigenous clients by training their staff, liaising with an Aboriginal service, and undertaking a cultural diversity audit (Dept of Human Services Vic 1999). These are all worthwhile ideas. The evaluation recommended setting up networks for the sharing of successful treatment strategies for ATSI people (Dept of Human Services Victoria 1990.). It's worth remembering that some Aboriginal people may *prefer* a mainstream treatment program to an Indigenous specific one – much as some people prefer to use their own GP than sign on with an Aboriginal medical service. This can be because of confidentiality fears, local or family politics, or just a desire to 'get away' from everyone familiar.

Some suggested questions for TCs hoping to attract Indigenous clients are:

- Do managers or staff of the Therapeutic community have personal contacts with any local Indigenous organisations - either formal and informal contact?
- Do these Indigenous agencies *know about* what goes on in the TC? Have they ever been invited to visit?
- Can the TC cater for family members?
- Do they have any Indigenous staff?
- Are there indigenous cultural markers around the facility – art works, books, Aboriginal designed pamphlets
- Are there opportunities for bush outings, artefact-making etc.or for Aboriginal clients to share local knowledge with others in the TC?

2. Networking/supporting Indigenous specific facilities

I have shown how for a number of historical and political reasons, residential Indigenous programs have become relatively insulated from outside influences, visiting professionals and regular contact with similar non Indigenous organisations. For many, their networks are made up of strong ties to a relatively narrow range of organisations and individuals – who all think the same way. This tends to deprive programs of information from a range of sources, keeps them uninformed about new ideas and new debates, and generally restricts their horizons.

One solution to this is better networking with other agencies, NGOs and mainstream facilities of a similar nature. Therapeutic communities could form partnerships with a similar Indigenous-specific organisation in their area. One of the most useful contributions to make would be to have staff exchanges with a local Indigenous program. The Indigenous worker would get the chance to see how a mainstream program operates, be mentored by a staff member, and participate in the daily life of that program. This would expose them to TC

regimes that are not necessarily reliant on the Twelve steps model but which use a combination of approaches. (Some training courses already allow for staff placements with services as part of their course). The mainstream staff member in turn, would gain an insight into the way in which an Indigenous program operates. Not all Indigenous programs have easy access to comparable mainstream residential programs, so a staff exchange strategy may only suit programs in cities or larger rural towns.

I wonder if there could be opportunities for offering in-house training opportunities, perhaps setting up a buddy system of support and mentoring to workers from an Indigenous program?

A mainstream TC may be able to assist with policy making, and set an example of how boards operate. Indigenous board members could be invited to observe board meetings of the larger organisation – joint meetings would also be an option.

Until quite recently, most Indigenous residential rehabs were not affiliated to the mainstream peak bodies such as NADA and ATCA. This situation has improved somewhat, and efforts should be made to encourage all Indigenous rehab programs to become members. This would open up their attendance at workshops, conferences and forums with these 'outside' NGOs, help to form new networks, and provide the practical support that has been lacking from governments over many years.

In Conclusion --There is no decrease in the intensity of substance abuse problems in the Indigenous population, and there is an increased variety of the substances in use. Residential facilities that do offer a 'program' should now be under pressure to become more competent, in touch with the wider world of therapeutic approaches and more willing to provide alternatives to their clients.

Cultural exceptionalism is no longer defensible if it means that treatment programs are isolated enclaves out of touch with the activities taking place in the wider AOD and public health context. Aboriginal treatment programs need to network and learn from wider treatment community, and in turn share *their* insights with it.

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