Aboriginal Recommendations for Substance Use Intervention Programs

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ABSTRACT

Objective

To identify Aboriginal people's perceptions of residential alcohol (and other drug) intervention programs.

Method

Part of a wider Aboriginal-initiated study into Aboriginal perceptions of alcohol misuse and intervention, using a descriptive, grounded theory, participatory action design. Of 100 participants in individual and focus group interviews, only 22 people had personal or family experience of residential alcohol intervention programs. This paper presents the collated responses of this small group to qualitative, semi-structured interview questions regarding their perceptions of intervention programs – and compares them to the literature and to the wider study's findings.

Results

Positively evaluated components included 'time out', personal health gains, substance use education, life-skills training, support, socialising and – on dry communities – peace in 'country'. Criticisms focused largely on perceived long-term ineffectiveness, lack of skills development, culturally inappropriate environment and teaching style, accessibility to substances, separation from family, and staff skill/experience issues.

Conclusions and Implications

Among the small group of remote area Aboriginal people participating in this aspect of the study, recommendations for substance misuse intervention programs suggested the need for programs significantly different from those generally available. In comparison with the substance-misuse orientation of many available intervention programs – and consistent with themes emerging in the literature and in other aspects of the wider study – participants' responses implied the need for a priority expansion of intervention focus onto the teaching and strengthening of skills required for self-determination. Co-operative inter-agency contributions to existing programs may be one means to achieving this.

Keywords

Aboriginal/Indigenous model; substance use; program evaluation; capacity building; social determinants; vocational skills; life skills; education; self-determination; self-esteem; support.

This research was part of a wider in-depth study, undertaken at local Indigenous instigation, into Indigenous perceptions of Aboriginal alcohol misuse and its prevention, intervention and evaluation. A full study description is available on http://adt.curtin.edu.au/theses/available/adt-WCU20040120.094316/. The study provides an example of Indigenous Research Reform Agenda recommendations for Aboriginal priority-driven research, research brokerage, participatory methodologies, community development objectives, and quality control including transfer/dissemination of research findings[1:53] and was granted an Indigenous Research Methodology award at the 2005 conference of the Public Health Association of Australia.

The research was based in the Derby area of the West Kimberley region of north Western Australia. It originated with requests to the author (then Acting Kimberley Regional Coordinator with the WA Alcohol and Drug Authority) from local Aboriginal people frustrated with the ineffectiveness of existing programs, for an 'Aboriginal style' alcohol intervention program. As elsewhere, evaluation of substance misuse intervention programs in the general area had shown little effect[2-5] and remain scarce[6,7]. At the time of the study, the region's Indigenous population was estimated to be 55% of a total regional population of 7,171, with over half of this Aboriginal population living outside the two regional towns[8]. The area's post-European contact history spans approximately 130 years, with pastoral and pearling industry expansion, mission- and government-run institutional residence, and commercial and social service provision having dramatically impacted the lives of the region's Indigenous people. Indigenous employment and median income levels remain well below those of the non-Indigenous population[9,10]. Aboriginal and non-Aboriginal people and a host of government and commercial bodies identify substance misuse as a major regional problem.

Method

The study was based on a descriptive, grounded theory, participatory action study design. Procedures followed were in accordance with National Health and Medical Research Council guidelines[11]. For the full study, a variety of sampling strategies (purposive, opportunistic and snowball) resulted in a demographically comprehensive sample of 170 Aboriginal people comprising community and cultural leaders, identified community groups and a wide range of general community members. Qualitative, semi-structured interviews were held with three types of participant groups (24 key individuals, 13 community focus groups and 13 serial model-planning focus groups). Of the 100 participants in the former two groups, only 22 people had personal or family experience of residential alcohol intervention programs. This paper presents the collated responses of this small sub-sample to qualitative, semi-structured interview questions regarding perceptions of existing programs – and compares these findings with the literature and with findings from other aspects of the wider study.

Measurements

Content analysis of interview transcripts was performed using QSR NUD.ist (Revision 4) software, combined with some basic statistical description. Reliability, validity and triangulation were

addressed via the variety in sources and methods described above; and documentary data.

Results

Over three quarters of the study's 100 individual and focus group participants had no personal or family experience of residential alcohol intervention, a finding akin to other studies in the general region[12,13]. Of the 22 people with this experience, most described residential programs in Broome (7) or on 'dry' Aboriginal communities (6), a few people (3) having been to rehabilitation programs in Darwin. The remainder (6) preferred not to state location. When asked for their opinion of existing residential alcohol interventions, all 22 respondents made some positive observations about 'dry out' experiences:

The most common endorsement related to the 'time out' provided by residential programs, with participants talking of the value of giving their 'system a break', eating regularly and getting proper sleep (9):

Table 1: Participants' positive comments about 'dry out'

Comments	Number of respondents (n=22)*	Percentage of respondents
Drinkers can give their system a break	9	41
Some programs offer education about drinking effects and management	6	27
Some programs teach life-skills	5	22
Some programs offer support from staff and other clients	5	22
People can socialise and make friends	3	14
Dry community stays can provide peace, away from town and back in country	2	9

*Some participants gave more than one response.

> *"Well, the only thing I can think of is at least they give your system a break, a break without alcohol"*

> *"Well see, if you've been a drinker and it's your first two or three weeks without it, it takes times time for all your brain cells to have a clear mind to think for yourself"*

Only one person mentioned controlled drinking, saying they'd heard that at some 'rehabs' drinkers could learn strategies for this. Six people said programs educated people about the effects of alcohol on the body, about relapse management, and about the Alcoholics Anonymous 12-step program, including its spiritual aspects.

> *"On a Tuesday they would have the health side of it, they would do diabetes, on a Wednesday they would decide to do a liver thing and a heart thing. They talked to us to show us what it [alcohol] does to the human body and that's another thing that should be put into people's heads, to make them understand and realise that that's how they'll end up if they make that choice"*

> *"And they just say their serenity prayers in the morning, just to give them courage … we think there is no future left whereas religion reminds them that there is somebody, even if it is ceremonies, hunting or something"*

Five people noted the positive aspects of life-skills education including budgeting skills, dealing with domestic violence, and strengthening self-esteem

> *"Some people have a problem within themselves that alcohol just ends up combining with. Other problems that they have within themselves, like they could easily have marriage problems and things like that happening outside. Like with the courts and stuff like that and they don't know how to deal with it, so the one way out is combining it with alcohol. The alcohol's just part of their story .. when you're in rehab they give you choices to go to meetings for domestic violence at home as well, because that blends in with alcohol as well"*

> *"They teach them how to pick up a life, how to be independent, how to save their money and teach them how to budget … oh yeah, they even take you shopping, boy. I didn't know how to save – this was before I went to rehab. I just couldn't understand it, so my wages used to be busted in the X hotel, but when I went to this rehab I found out in the end that I saved a lot, I ended up buying myself a car"*

> *"They always say really lovely things in the morning to you to make them feel better inside them, to make them feel like being a person, cos a lot of them, a lot of us are resentful within ourselves, you know just keep doubting ourselves down"*

Other positive evaluations included five people's comments about the confidence and support gained from sharing the 'dry out' experience with other clients and supportive staff. Three people described the positive social aspect of rehabilitation programs, including the formation of new friendships.

> *'Well I think that is where I learned my confidence from because they even give you the chance to be somebody too, if you want to be that person, the person that makes you feel strong"*

> *"I just had to get through it and I did create new friends around me from lots of different country, everyone going through this thing together, and I am still friends with them"*

Two drinkers mentioned 'good things' about drying out 'in the bush'.

> *"It's good because it's my country, I'm home there. It's good to get away from town and all the noise, back in the bush. I can clean out there without temptations from town"*

> *"I have a break there, back in my country"*

In summary, the most widely endorsed aspects of 'dry out' programs were the health-building advantages of 'time out' (41%), with alcohol management education, life-skills and support from staff and other clients each endorsed by approximately one quarter (22-27%) of the respondents. A few clients provided specific examples of benefits related to these program components, but many more questioned their long-term effect in the absence of lifestyle changes at a deeper level. When asked which, if any, aspects of 'dry out'

they were not keen on, most participants' comments focused on the perceived long term ineffectiveness of substance use programs:

Table 2: Participants' criticisms of 'dry out'

Criticisms	Number of respondents (n=22)*	Percentage of respondents
People go 'straight back on the grog'	13	59
People don't learn new skills, nothing changes	6	27
Programs too institutional and teach too formally	5	22
Easy access to alcohol on or straight after 'dry' community stays	5	22
Programs can be far from family	3	14
Staff are untrained and/or personally inexperienced	3	14
'Dry' community stays inadequate, nothing changes	2	9

*Some participants gave more than one response.

Over half (59%) of the respondents observed that most people would 'just go straight back on the grog' after leaving funded 'dry out'.

"When they came back, they were trying really hard but the unfortunate thing about it was they were coming back into the same situation where the family was still fragmented. There was still drinking going on and there was still abuse and that still going on, you know how live with extended families and all that interlinking going on"

"So what you would see, they would go for a month and then you would see a gradual decline from then on, at first it might be just going down having a couple of drinks and then slowly the pattern would get worse until they were back to where they were"

"They get off the grog and all that, but I've never really known anyone that has been there to give up"

"They came back looking good, saying they'd never drink again, but soon they were back on the grog as bad as before"

Others felt that the programs focused on symptoms rather than causes and that as a result people didn't learn new skills, and returned to the same 'hopeless' situations in their communities (6).

"I had a cousin, he has died now, due to alcohol, but X [the rehabilitation program] was like a retreat – somewhere to get away from it all. But I don't think it really taught him how to cope, once he was exposed back into the world. They just got him out of the DTs, they built his health back up, but I don't think he, you know, learnt how to cope with some of the problems that are out there, and often it is just a retreat, somewhere to hide."

"It's always had this fascination to me – that alcohol was that bad that you had to put these types of institutions into being – especially when, you need to find out what the cause was that made these people drink."

"I s'pose you need to treat everyone like an individual person, they need to strengthen themselves before they can become strong for other people, so we really need to know what that person is about, what skills they've got, build on their strong points rather than push them down as far as their weak points are concerned. Everyone has strong points, might be very few, but you can build on that to the extent that it takes over their whole life and they can turn it around. Not just finish rehab and send them home to the same hopeless life."

These were frequently heard criticisms of existing 'dry out' programs – that there is little if any lasting change as a result of residential programs. There are exceptions, as some comments demonstrate, however in my experience as practitioner and researcher, the above sentiments characterised 'dry out' perceptions around the region. Among study participants' criticisms of funded 'dry outs', five people felt that existing 'formal' programs were too institutional, that people felt 'locked up there, like a prison camp', and that timetables were filled with 'meetings':

"I didn't fancy being locked up and if I'm gonna give up alcohol that means the courts and society telling me 'you must, you have to give up,' and I didn't really like that. I had to give up, if you're going to give something up you do it, that's what my grandparents told me: no-one else can tell you to do anything. But I end up going back there [to the rehab], doing my time, doing my time in 'prison' again."

"[The rehabilitation centre] is too institutional, it's not free, it is like the court says you're going there, you can't do that, you can't do this, there is too many demands."

"The impression I got, it was just like being in jail … there's too many [alcohol education] meetings there, you have to sit around, that's not helping, that would drive you back to drinking"

"Well, the rehab I was in – I was locked in – it had a full off fenced area right around and it looked like a prison camp, but really I had to understand in the end that the fence wasn't to keep the clients in, it was more or less to keep visitors out."

Most programs described by participants conveyed an institutional impression because of their proximity to, but isolation from, nearby towns; classroom-style teaching; 'timetabled' social events; and 'whitefella-style' buildings, environment and landscaping. There were exceptions, but the majority described regimented, urbanised, and timetable-dominated programs. Participants' comments indicated that classroom-style western teaching methods and materials created a further effect of 'non-Aboriginality'.

Although three people felt that existing 'formal' programs were too far from family, another person had benefited from distance from what they saw as negatively influential family members:

"Why send them to Darwin away from their families? … They'd rather be in their own town area, like X, he didn't like it down there, he kept saying I want my family to come and visit me."

"Most of the time I went to local area rehabs. That was good because my family could come and visit. Those people who'd come from far away would feel lonely and homesick, watching other people getting visitors, and eventually they'd leave. You get better results if your own community's involved and can visit you."

"Sometimes, well, visitors could be a bad influence at times when someone is trying to get dried out or be off the grog for a couple of months or whatever – it sort of makes them homesick and lonely, like they will start making decisions for themself to be independent if they don't have family hanging around. It's nice to have family, but it is probably harder if people are in the same town, got family in the same town, like it was easier for me because I didn't know anybody and there was no need for any visitor to come and visit me so I really concentrated myself"

Three people commented that 'dry out' staff were, in their opinions, generally untrained and inexperienced and/or had no personal experience of substance misuse:

"Most rehabilitation around the place, they weren't training people, they didn't have proper counsellors to teach you about the effect of alcohol. In a rehab you go over your life, you count the costs, you look at your future and it's better if you've got somebody around to talk to who's been trained you know, plus they know about drinking, real-life counsellors you know, so they don't lord it over you if you're still a drinker."

"I used to get peeved off with counsellors who was Aboriginal and they been a non-drinker, non-smoker and pure clean workers which I feel it shouldn't be. It should be someone who has experienced the past. They didn't have an understanding … as far as I can see an alcoholic understands an alcoholic. Some staff have got their job more or less from a university or from books."

It is important to note that some programs are attempting to address staffing issues through both recruitment and in-service training strategies – and that despite the above criticisms, the support provided by many staff was acknowledged as critical by a significant number of participants.

Seven people with experience of stays on 'dry' communities commented that drinkers could either still get alcohol there or would just go straight back to drinking when they left (5), that such interventions 'weren't enough', and that people returned unchanged to the same situations (2).

"He only stays a week, he comes back when he wants to drink. And anyway he can get alcohol up there if he wants it anyway. But it's not enough. More has to be done than just that."

"Most of them 'dry' communities – you can get grog on nearly all of them."

"He sends his kids up there for a break from drinking, they work and feel better, but they don't stay long, then they just come back to same boring life, nothing to do but drinking again."

In summary overall, criticisms of residential 'dry out' focused on the perceived lack of program components designed to establish lasting change in people's lives and circumstances, specifically through robust skills development and follow-up support. In addition, participants were critical of the institutional separation from family in some (though not all) funded programs; and what were perceived to be inadequately trained or experienced staff in some funded programs. As mentioned, these latter issues are among key aspects of recent re-structuring in some programs.

The positively evaluated aspects of 'dry out' focused on health-building 'time out', alcohol management skills, life-skills and support. The endorsement by a significant proportion of respondents for alcohol education and life-skills training, specifically budgeting and domestic violence management, appeared to be overshadowed by participants' majority call for broader skills training which would enable people to 'turn their life around' in a lasting way:

"We really need to know what that person is about, what skills they've got, and build on their strong points … you can build on that to the extent that it takes over their whole life and they can turn it around. Not just finish rehab and send them home to the same hopeless life"

Many of the educational, personal, family and support recommendations implied in these positive and negative program evaluations reflected the priority recommendations of participants in other aspects of the wider study – including those selected by study participants for their Aboriginal substance use intervention model. Collated recommendations from the full study sample indicated a clear prioritisation for a focus on vocational, educational, identity- and family-related intervention components.

Discussion

Possibly tellingly, only 22 of the 100 participants in the study's individual and focus group samples reported personal or family experience of residential alcohol intervention approaches. Participants' evaluations of these interventions endorsed the programs' physical and emotional support, substance use and life-skills education, and socialising aspects offered to greater or lesser extents. A few participants gave specific examples of life-skills training resulting in significant positive personal change, however there was a perception from over half of the respondents that programs were ineffective in the long term due largely to a lack of change in fundamental skills necessary for self-determination. Perceived deficits were also reported in program cultural style and staffing expertise, despite the dedication and acknowledged support of some staff. While some of the intervention programs considered here have made specific and meaningful changes[2] to program components over the past decade, study participants' key recommendation remains largely unaddressed regarding a shift in program focus from substance use symptoms to addressing perceived causes through self-determination skills training.

For remote-area people, few available programs[6,7,14,15] offer these aspects as priority components woven into their daily context and operation. Few are set within remote area 'Aboriginal-style' environments and operational contexts. Although some programs encourage family participation in residential intervention, in practice this can be difficult to arrange for non-local families, underlining the importance of localized service provision. Some programs[6] have made concerted attempts to

recruit well-trained staff and/or provide substantial in-service staff training. This aspect of service provision has improved markedly in some areas, but many lack employees trained and experienced in a broad range of Indigenous and western intervention approaches. The demanding nature of the work and its often remote location add to recruitment difficulties. Participants' implied call for a shift in key focus from symptoms to causes could be addressed through co-operative inter-sectoral contributions from other agencies, vocational trainers and elders.

Evaluations of intervention programs in remote areas have identified some of the issues raised here by study participants. These evaluations indicate that programs' long-term impact can be compromised by factors such as ill-defined program strategies and goals, under-resourced programs, under-trained workers and poor inter-sectoral co-ordination between prevention, intervention and post-program strategies [6,7,14,16]. They caution that post-program impact can also be compromised by a dearth of strategies relevant to the daily life realities of many Aboriginal people [6,7,14,17,18]. Among the latter, for some, shared residence and close relationships with family and peer groups in which excessive drinking is common can make controlled drinking or abstinence difficult, if not impossible, to maintain. Pressures include the group conformity and solidarity felt by many Aboriginal people to be essential survival skills in a hostile world[19]; and the force of kinship when decisions about drinking are being made [20,21].

While substance use programs can't possibly address all of the above issues, an expansion of key program components to include robust self-determination skills training may help to address the often disappointing impact of intervention programs despite the best efforts of dedicated program staff. Long-term substance misuse prevention, intervention and post-program strategies integrally based on self-determination components and post-program supports are rare. Many evaluators and reviewers see the establishment of robust self-determination strategies – in concert with other community structural changes which enhance options for meaningful everyday activity – as critical to prevention, intervention and post-program success [12,16,21-25].

Conclusion

As in the wider study, and in addition to life skills components currently provided, the key focus of this small group of participants was on the need for a priority expansion of substance use programming onto interventions which provide training in, and support of, robust, lasting self-determination skills.

Recommendations

Substance use prevention and intervention programmers are encouraged to incorporate a priority focus on expanding the provision, strengthening and follow-up support of robust self-determination skills development. One possible means for achieving this could be co-operative multi-agency and Aboriginal elder input woven integrally into everyday program activities. The wider study's Aboriginal model-planning group have designed a 'Bush College' model incorporating this approach.

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