The International Indigenous Policy Journal

The Importance of Culture in Alcohol Care
Listening to First Nations staff in Australian Aboriginal Community Controlled Health Services

Gemma Purcell-Khodr, Emma Webster, Kristie Harrison, Angela Dawson, Kim San Kylie Lee and Katherine Conigrave

Volume 13, Number 3, 2022

URI: https://id.erudit.org/iderudit/1096496ar
DOI: https://doi.org/10.18584/iipj.2022.13.3.14030

See table of contents

Publisher(s)

Scholarship@Western (Western University)

ISSN

1916-5781 (digital)

Explore this journal

Cite this article

Purcell-Khodr, G., Webster, E., Harrison, K., Dawson, A., Lee, K. & Conigrave, K. (2022). The Importance of Culture in Alcohol Care: Listening to First Nations staff in Australian Aboriginal Community Controlled Health Services. *The International Indigenous Policy Journal*, *13*(3), 1–29. https://doi.org/10.18584/iipj.2022.13.3.14030

Article abstract

Integration of cultural knowledges and healing practices with Western medical approaches to alcohol care has been reported for residential and community settings. However, there is little evidence on how culture features in alcohol care in primary health settings. We analysed data from semi-structured interviews (from a broader study) with 17 First Nations Australian staff (n=8 men, n=9 women) from 11 Aboriginal and Torres Strait Islander Community Controlled Health Services. We used grounded theory and the 8-ways Aboriginal pedagogy in analysis. We describe three key themes: 1) interpersonal processes; 2) a both-ways approach to healing and alcohol care; and 3) service-wide strategies to achieving both-ways healing. We discuss policy implications of facilitating bicultural alcohol care in primary health settings.

The International Indigenous Policy Journal

Volume 13 | Issue 3

December 2022

The Importance of Culture in Alcohol Care: Listening to First Nations Staff in Australian Aboriginal Community Controlled Health Services

Gemma Purcell-Khodr
University of Sydney, Australia, gemma.khodr@sydney.edu.au

Emma Webster
University of Sydney, Australia, emma.webster@sydney.edu.au

Kristie Harrison
University of Sydney, Australia, Kristie.harrison@sydney.edu.au

Angela Dawson
University of Technology Sydney, Australia, angela.dawson@uts.edu.au

K. S. Kylie Lee
University of Sydney, Curtin University, and Latrobe University, Australia, kylie.lee@sydney.edu.au

Kate Conigrave
University of Sydney and Sydney Local Health District, Australia, kate.conigrave@sydney.edu.au

Recommended Citation

Purcell-Khodr et al., (2022). The importance of culture in alcohol care: Listening to First Nations staff in Australian Aboriginal Community Controlled Health Services. *The International Indigenous Policy Journal, 13*(3).
https://10.18584/iipj.2022.3.13.14030

The Importance of Culture in Alcohol Care: Listening to First Nations Staff in Australian Aboriginal Community Controlled Health Services

Abstract

Integration of cultural knowledges and healing practices with Western medical approaches to alcohol care has been reported for residential and community settings. However, there is little evidence on how culture features in alcohol care in primary health settings. We analysed data from semi-structured interviews (from a broader study) with 17 First Nations Australian staff (n=8 men, n=9 women) from 11 Aboriginal and Torres Strait Islander Community Controlled Health Services. We used grounded theory and the 8-ways Aboriginal pedagogy in analysis. We describe three key themes: 1) interpersonal processes; 2) a both-ways approach to healing and alcohol care; and 3) service-wide strategies to achieving both-ways healing. We discuss policy implications of facilitating bicultural alcohol care in primary health settings.

Keywords

Indigenous Peoples and alcohol care, cultural healing, alcohol use disorder

Acknowledgments

This work was supported by the NHMRC through a Project Grant (APP1105339), the Centre of Research Excellence in Indigenous Health and Alcohol (APP1117198), and a Practitioner Fellowship for KC (APP1117582). We are also grateful to the services who took part in this study, the First Nations health professionals who took part in the interviews, Kaylie Harrison who conducted/transcribed interviews alongside, the support from Mustafa Al Ansari in preparing data for analysis, invaluable lessons learnt from Allan Hall and Yvonne Hill on 8-ways Aboriginal pedagogy, and Mennatallah Alnaqa for thoughtful graphic design work on the figures.

The Importance of Culture in Alcohol Care: Listening to First Nations staff in Australian Aboriginal Community Controlled Health Services

While alcohol harms are a universal concern (World Health Organisation, 2018), they disproportionately affect colonised Indigenous Peoples worldwide (Australian Institute of Health and Welfare, 2015; Health Canada, 2014; Health Promotion Agency, 2017). In Australia, a higher proportion (29.3%) of Indigenous Peoples (Aboriginal and Torres Strait Islander) are non-drinkers compared with non-Indigenous Australians (23.8%) (Australian Institute of Health and Welfare, 2020). Despite this, at a population level, Indigenous Australians experience twice as many alcohol-related hospitalisations as their non-Indigenous counterparts (Australian Institute of Health and Welfare, 2011; Gray et al., 2018). Similar patterns are seen with Indigenous Peoples in New Zealand (Health Promotion Agency, 2017), the United States of America (USA) (Substance Abuse and Mental Health Services Administration, 2019) and Canada (Health Canada, 2015).

Disproportionate rates of harm are in part due to episodic heavy drinking (Australian Institute of Health and Welfare, 2020; Shore et al., 2006; Zheng et al., 2022). This drinking pattern is linked to a colonial legacy of dispossession (Gracey & King, 2009), where Indigenous Peoples continue to be socially and economically marginalised, experience intergenerational trauma, racism and have poorer opportunities for sharing traditional cultural values and practices with younger generations (Dudgeon et al., 2016; King et al., 2009; Wynne-Jones et al., 2016). Indigenous Australians have used their culture, including traditional healing techniques, to maintain wellbeing for over 60,000 years. This cultural knowledge has been suppressed due to colonisation during the last 230 years. Reconnection to culture is an essential part of healing. Therefore, supporting services to reinstitute Indigenous knowledges and healing traditions in health care is needed to promote good health and wellbeing post-colonisation (Department of the Prime Minister and Cabinet, 2020).

Primary care is a critical setting for incorporating culture into care for unhealthy alcohol use (including hazardous use through to dependence). This setting is crucial to engage clients as it is the gateway to the broader healthcare system. There can be cultural, financial, institutional, and stigma-related barriers with referral to specialist alcohol treatment services. The primary care setting allows for a range of treatment across the spectrum of unhealthy alcohol use. For example, brief interventions for hazardous and harmful use, motivational interviewing, home detoxification (for carefully selected clients), and relapse prevention medicines are available for clients with alcohol dependence (Rombouts et al., 2020). Primary care is especially important for rural and remote communities that are less likely to have access to specialist care.

In Australia, there are more than 140 Aboriginal and Torres Strait Islander Community Controlled Health Services (ACCHSs). ACCHSs are primary care services controlled by the local Indigenous community via elected boards of management (National Aboriginal Community Controlled Health Organisation, 2020). Volunteers initially developed these services to provide free, holistic healthcare to under-served Indigenous communities. Today these services have government funding and often employ local Indigenous staff, provide community transport, home visits and (generally) flexible consultation practices compared to mainstream services (Australian Institute of Health and Welfare, 2016). Culturally appropriate and safe care has been shown to increase access by Indigenous Australians (Campbell et al., 2018).

Literature Review

Peer-reviewed literature on alcohol care in primary healthcare settings for Indigenous communities is scarce. A recent systematic review of literature on alcohol treatment approaches suited to primary care from Australia, New Zealand, the USA, and Canada identified just 28 studies published between 1968 and 2018 (Purcell-Khodr et al., 2020). Of all the studies, over half (n=16) were set in primary care services. The remaining studies (n=12) featured various forms of ambulatory treatment (outpatient programs) or care in settings feasible for primary care delivery (e.g., at home or community-based).

Of the studies in primary care settings, all but one (n=14/16) featured treatment approaches set in or facilitated by Australian ACCHSs. These studies almost exclusively focused on assessing staff and client perceptions of Western treatments (n=13). They often they investigated the accessibility and acceptability of brief interventions or counselling techniques. One study trailed a model of ambulatory detoxification ('home detox') facilitated by an ACCHS with at-home care and clinical supports (e.g., dispensing of relapse prevention medicines at home or at the service). Only two of the Australian studies in this setting were classified as bicultural (Indigenous and Western). However, neither discussed the cultural treatment elements in detail. For example, the study 'Walan Giri' described a culturally-influenced form of brief intervention—introduced by questions on traditional homelands and kinship connections. Details of the development or implementation were not provided. The one study set in a primary care setting outside Australia, was based in the USA (Hirchak et al., 2018). This study documented the acceptability and cultural tailoring of contingency management ('reinforcers' to support and promote abstinence) with Elders and Indigenous community members.

The other 12 studies featuring ambulatory treatment (n=12/28) were most frequently based in residential services with outpatient programs and supports. Community-based settings also featured in several studies. Almost half of the studies in ambulatory care settings (n=5/13) documented bicultural treatment approaches and another three studies documented a solely cultural (Indigenous) approach to treatment. Sweat-lodge use was widespread in the USA and Canada, facilitated by residential services with outpatient and general community access. Numerous other healing techniques were also documented (e.g., pipe ceremonies, fasting camps, sacred chanting, group prayer, and administration of traditional medicines). While approaches varied by location and country, core themes were reiterated several times, including in survey responses from clients and service providers in New Zealand (Huriwai et al., 2000a; Robertson et al., 2001). Common themes were the importance of employing local Indigenous staff, incorporating Indigenous languages and language speakers; practicing traditional medicine, healing ceremonies and traditional arts; following cultural protocols; instilling pride in client heritage; and providing access to genealogical services (e.g., to reconnect families and understand the impact of colonisation on family displacement). Western treatment approaches included three US trials of alcohol relapse prevention medicines, and two Australian studies on counselling approaches.

Among the peer-reviewed literature in this field, there are clues to the rich nature of cultural and bicultural alcohol care in publications going back 50 years. Given the limited evidence on integrating these approaches in primary care, we examine how Indigenous staff incorporate culture into the delivery of alcohol care in ACCHSs. In particular, we explore the strengths and challenges involved in doing so.

DOI: 10.18584/iipj.2022.13.3.14030

Methods

Overview

This qualitative data was collected at baseline in a large cluster randomised, wait-control trial[1] (Conigrave et al., 2021). That trial was designed to test the effectiveness of tailored support for ACCHSs to enhance the uptake of alcohol screening, brief intervention, and treatment approaches. The primary aim of the qualitative interviews conducted with Indigenous and non-Indigenous staff (collected by Kristie Harrison [KHH] and Kaylie Harrison [KBH]) was to inform the development of the multipronged model of training and support (Harrison et al., 2019). The resulting support model has been published (Dzidowska et al., 2021) and included a national workshop, on-site training, regular data feedback, practice software assistance, a private online platform with resources and financial support for purchasing alcohol education tools. This paper draws on the Indigenous participant interviews and presents a deeper analysis of the meta-theme of culture (identified in that work), and how it informs alcohol care in ACCHSs.

Ethics

Ethical approval was obtained from eight ethics committees: the Aboriginal Health and Medical Research Council of New South Wales (NSW; 1217/16); Central Australian Human Research Ethics Committee (CA-17-2842); Northern Territory Department of Health and Menzies School of Health Research (2017- 2737); Central Queensland Hospital and Health Service (17/QCQ/9); Far North Queensland Human Research Ethics Committee (17/QCH/45-1143); Aboriginal Health Research Ethics Committee, South Australia (SA; 04-16-694); St Vincent's Hospital (Melbourne) Human Research Ethics Committee (LRR 036/17); and Western Australian Aboriginal Health Ethics Committee (779).

Indigenous contributions and community participation

The overarching trial has significant contributions by Australian Indigenous researchers, services, and communities (Conigrave et al., 2021). Indigenous staff of two state-wide umbrella agencies for ACCHSs (in SA and NSW) were involved in formulating the research question and design of that study. KHH is a Wiradjuri woman who played a key role in recruiting services, conducting face-to-face training, and interviews with service staff. The present study is led by a Gundungurra author Gemma Purcell-Khodr (GK).

Setting

Participants were comprised of staff from 11 ACCHSs across four states and territories of Australia (New South Wales [NSW], South Australia [SA], Queensland [QLD], and Northern Territory [NT]).

[1] Registration number: ACTRN12618001892202

Recruitment

Services were eligible for inclusion in the trial if they were an ACCHS, serviced at least 1000 unique clients per year and used Communicare patient software (Harrison et al., 2019). A total of 132 services were assessed for eligibility, and the first 22 services who agreed to participate were recruited. Services were then stratified into one of three remoteness categories (urban, regional, remote) using the Australian Statistical Geography Standard Remoteness Structure (Australian Bureau of Statistics, 2016). The services were then randomly assigned by stratum into a trial arm (early support ['intervention'] or late support [waiting-list control]). Interview participants were nominated by the participating services in the early support trial arm. At each service, these included two nominated service 'champions' for the project and up to three other staff members (n=44). Services were encouraged to include Indigenous staff members in the study. Only data from the n=17 Indigenous participants have been included in this analysis.

Data collection

Semi-structured phone interviews were conducted with 17 Indigenous (Aboriginal) Australian staff. Interviews were conducted by two Wiradjuri (Indigenous) Aboriginal health professionals (KHH and KBH) with past work experience in the ACCHS sector and conducting research interviews. KHH and KBH were aware of the potential sensitivities around discussion of alcohol, and cultural protocols which may impact on interactions.

KHH interviewed the majority of participants, with KBH acting as the live transcriber. The transcription was typed near verbatim, with any gaps filled in immediately after the interview. At other times these roles were reversed. In addition to the transcript the interviewer made a memo immediately after the interview concluded. KHH and KBH cross-checked both documents after each interview.

Informed written consent was provided prior to the interviews. Interviews were conducted between July and December 2017 (approximate duration: 40-90 minutes). The majority of interviews (65%; n=11/17) occurred before the two-day national workshop that marked the start of the first service support phase (intervention) of the project (August 29, 2017). The workshop included training for service champions on screening, brief intervention and treatment for the range of unhealthy alcohol use. There were opportunities for small group discussion where staff who had already been interviewed may have talked with those who were yet to be interviewed. The remaining six interviews were held after the workshop. The model of training and support was refined after all interviews were completed.

Interview framework

Interviews employed a strengths-based approach in asking about alcohol care (Gibson et al., 2020). Staff were asked about: approaches that they or their service use to make it easier to talk to clients about their drinking; ways that more people could be asked about alcohol; what their service offers regarding alcohol care; what skills and knowledge were needed for themselves and other staff to provide the best alcohol care at their services; innovative ways they or their services may have

DOI: 10.18584/iipj.2022.13.3.14030

worked out to help people who may be at risk because of their alcohol use; other successful programs which may give insight on how best to help with alcohol; and any other ideas staff may have to improve the way their services work with clients around alcohol.

As the interviews were conducted to inform a model of support for the trial, participants were not explicitly asked about culture in care and probing questions were not posed. This study analyses the content on culture that was raised spontaneously by Indigenous staff during interviews.

Theoretical perspective underpinning analysis

The analysis was informed by the pluralistic notion that both 'Western' scientific knowledge and Indigenous knowledge systems co-exist. Each have unique beliefs (ontology), value systems (axiology) and ways of knowing what truth is (epistemology) that guide study methodology and ultimately knowledge validation (Gone, 2012; Teffo, 2011). In acknowledging these divergent knowledge systems, value is given to the experiential, therapeutic approaches rooted in Indigenous cultural knowledge. This approach was chosen to capture conceptual nuances which may be overlooked using only Western-based analysis methods (Webster et al., 2017).

From a Western lens, grounded theory (Corbin & Strauss, 2014) and inductive coding techniques (open, axial, and selective) were applied to synthesise the data. Theoretical sampling was not applied, as the lead researcher (GK) entered the project after the data had been collected. That approach also may not have been desirable or feasible due to the busy health care settings in which staff worked. Grounded theory methods were selected to provide a structured process to aid the construction of a theory based on participants' views and practices. This was necessary because an Australian perspective on this topic has not yet documented in the literature.

The analysis was underpinned by 8-ways Aboriginal pedagogy, a unique Indigenous Australian lens (Yunkaporta, 2009). The 8-ways pedagogy resulted from collective cultural knowledge built over tens of thousands of years and passed on by Aboriginal Elders. The 8-ways provide a framework for learning which focuses on the culturally acceptable processes or ways of doing. Using this framework as a lens to analyse data does two things. Firstly, it ensures processes described by participants (consciously or unconsciously) are respected and considered whilst systematically engaging with all data. Secondly, the framework provides a unique Aboriginal Australian method to identify, examine and interpret patterns and themes in the data. A summary of the results and penultimate versions of the diagrams were shown for feedback and ratification to two Aboriginal educators who were part of the original team who had constructed the 8-ways pedagogy. The educators hold respected positions within Aboriginal communities of Western New South Wales, and as such their opinion rates highly in the Indigenous knowledge system of this area.

Data analysis

Grounded theory analytic techniques and Aboriginal pedagogical processes were applied in cycles of coding and theme refinement using the process of constant comparison. Discrepancies were highlighted for further reflection.

Transcripts and memos were first printed, read several times, and inductively open coded. Data were then imported into NVivo, and a final set of open codes were assigned. GK then applied the 8-ways

Aboriginal pedagogical processes to construct a sense of the 'whole' or conceptual understanding of a cultural approach to alcohol care described by participants. Perceived core elements of the whole were written on paper cards and grouped on a cork board (these cards were then referred back to in the axial and selective rounds of coding). A visual learning map (composed of three figures) was drafted to represent the macro-level emergent concepts. NVivo coding resumed and as data were recategorized and simplified, codes were assigned to different levels of processes represented in the diagrams. The final stage of analysis, informed by the Aboriginal pedagogy, involved the visual representation of the emergent meta-themes, themes and sub-themes in symbolic form.

All transcripts were analysed by GK. One-third of transcripts (n=5/17) were analysed independently (by EW), then discussed with GK. No major discrepancies were identified, although nuances resulting from an Indigenous and Western perspective were discussed. A larger group then discussed findings from all 17 transcripts (all authors except KHH). Kylie Lee (KL) reviewed all drafts of the diagrams and final versions of diagrams were discussed with all authors.

Results

Summary

Of the 17 staff interviewed, most (n=15/17) were aged 35 years or over, with almost equal male and female participants (males n=8/17). Staff held a range of professions, including a doctor, patient transport driver, frontline workers, managers, and a research coordinator. All participants had a clinical background regardless of their current role. There was an almost even spread of staff across geographical remoteness (Table 1).

DOI: 10.18584/iipj.2022.13.3.14030

Table 1. Aboriginal Community Controlled Health Service Interview Participant Characteristics (n=17)

Remoteness	Gender	Age	Role*
Urban (n=6)			
	Female	<35	Other
	Female	≥35	Other
	Male	≥35	AoD**
	Male	≥35	General clinical***
	Male	≥35	General clinical
	Female	<35	General clinical
Regional (n=6)			
	Male	≥35	General clinical
	Female	≥35	General clinical
	Female	≥35	General clinical
	Male	≥35	AoD
	Female	≥35	AoD
	Male	≥35	Other
Remote (n=5)			
	Female	≥35	AoD
	Male	≥35	AoD
	Female	≥35	Other
	Male	≥35	AoD
	Female	≥35	General clinical

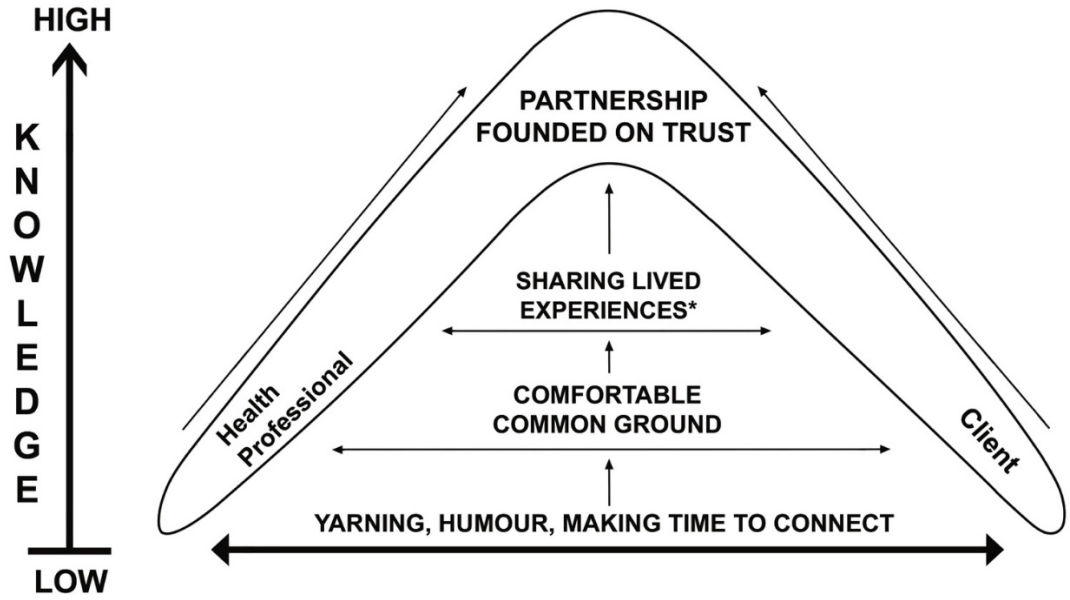
*We have used broad occupation categories to disguise the identity of participants. All participants, regardless of role titles, were providing or had experience in providing frontline clinical care. A number of staff with clinical duties were also listed as managers or team leaders.
**AoD = Alcohol and other drug worker.
***The 'general clinical' category included staff such as a doctor, Aboriginal health workers, and other frontline workers providing alcohol care in the service and or community setting

Three themes encompassed the participants' perspectives on how alcohol care was delivered in a culturally safe and respectful way: 1) interpersonal processes; 2) a both-ways approach to healing and alcohol care; and 3) service-wide strategies to achieving both-ways healing. Each is described in detail below.

Interpersonal processes

Five interpersonal processes were identified as being central to establishing a connection with clients, making clients comfortable, and building a trusting therapeutic partnership to work on alcohol care and wellbeing goals. These processes were yarning (conversations), humour, making time to connect, establishing a comfortable common ground, and sharing lived experiences. The dynamic between the five elements is depicted in Figure 1.

Figure 1. Interpersonal processes used by Aboriginal staff to build therapeutic partnerships for alcohol care and wellbeing with Aboriginal clients in ACCHS settings



*Any personal story could be used to connect with clients. Some health professionals may choose to share their own healing journey, where applicable. This was seen as sharing 'authentic knowledge' and helped clients feel comfortable and understood

This diagram is adapted from 8-ways Aboriginal pedagogy, originally developed with knowledges from Traditional Owners across western New South Wales, Australia (Yunkaporta & McGinty, 2009). The returning boomerang diagram illustrates the process of a health professional and a client, sharing information two-ways. Together they build a relationship and ultimately a therapeutic partnership to discuss the client's alcohol care and wellbeing goals. To do this, both parties have yarns (conversations) while following cultural protocols and try to go from low to high knowledge of one another.

DOI: 10.18584/iipj.2022.13.3.14030

Yarning

Yarning was mentioned by nearly all participants as a friendly and relaxed way to talk with clients about alcohol and to build rapport:

> It's gotta be a friendly approach. I've seen people do an assessment, they are so abrupt and straight forward and it's not on. (male, remote, AoD)

Two-way sharing between clients and staff was an essential element of yarning:

> They do need to get to know me. They haven't seen me around here before, so I suppose I am learning from them as much as they are giving back to me. We share a lot of information. I give them as much as I can and friendships are starting to build up. It's just easing your way in. You need to speak to them and gain trust. If they don't know you, they don't trust you. But once they get to know you, that's good. (male, urban, AoD)

All participants described the importance of following cultural (gender) protocols when yarning about alcohol or taking on a new client:

> [If] I'm showing them respect and speaking to an older lady I will step back and ask if I can speak to her, not just walk right up to her. And I'll say that I can put this forth to a female worker if they want. (male, remote, AoD)

Humour

Participants found humour a useful and natural way to put their clients at ease:

> At first I sorta joke about it, it helps drop their guard. (male, regional, other)

While humour felt intuitive to most staff, there appeared to be tension between what is considered "professional" communication and a cultural approach to communicating and connection building:

> If I was doing it with a friend or something I would probably lighten things with humour and approach it softly. It's bit different at work; you're meant to be a health professional – but you can always bring a bit of humour into it – they feel more comfortable. (female, regional, general clinical)

Making time to connect

Making time to work with clients and community in the 'right way' (e.g., yarning to get to know one another and taking clients outside clinic) was perceived as a cultural obligation. It was also seen as best practice when engaging with Indigenous clients. This sometimes was at odds with management's expectations on time management:

> One thing I found working in [state/territory], they [management] don't have really good understanding of time … you have to be careful about amount of work you can do with a client. (male, remote, AoD)

Developing a comfortable common ground

Developing a mutual sense of comfort was perceived as a necessary step in building rapport. This sense of comfort was related to the health professional or other staff member "being on the same level" as the client:

> They are more relaxed when in the car, they are more comfortable, feel like we're on the same level. I'm not some trained-up person sitting in front of them. I think that helps. (male, regional, other)

This theme was strongly intertwined with yarning:

> Start a general conversation is easiest. So, you're at their level, so they don't think you're intimidating them. (female, regional, general clinical)

Having the service flexibility to take clients out of the clinic (or meet them outside, planned or by chance), sit at the park or river or other culturally appropriate location was also helpful in relaxing clients and staff (i.e., helping health professionals to feel comfortable to do their best work). This was seen as creating a relaxed, culturally safe dynamic:

> we go sit down with them and discuss where we want to meet, doesn't have to be at service, can be outside, at the beach, wherever community feel safe. (female, remote, other)

Participants from one remote service mentioned a trial of community-based workers, who also described delivering health promotion and support outside the clinic in a natural environment:

> The ladies and the men like to walk around communities and some of our community-based workers go pick people up and take them fishing and we take flipcharts and information to talk to people. (male, remote, AoD)

One participant described facing structural constraints within their service when conducting 'meet-n-greets' in the community (i.e., outreach and or initial consultation with new clients):

> I had a bit of a disagreement with management, I was going out to meet someone for the first time and they wanted me to take paperwork out with me and I said that wasn't going to, it was gonna turn them off right away. (male, remote, AoD)

To navigate around these service requirements that same participant took mental notes and transcribed them post-consultation.

> instead of going out with lots of paperwork, we have to sign confidentiality report and that, but I go out and make notes in my head and I come back and write them down later. (male, remote AoD)

Sharing lived experiences

Several participants described using their lived experiences with alcohol use disorders to connect with clients. For some, this meant sharing their own journey, and for others it was being known in

DOI: 10.18584/iipj.2022.13.3.14030

the community to have moved past this issue in their lives. These participants described being perceived as having credibility and authentic knowledge in community:

> Talking to clients is the easiest part for us coz [because] it just comes naturally coz we've been there. Drug and alcohol clients don't value you if you haven't lived a life… you don't know. They don't find them credible. (male, regional, AoD)

> Everyone knows what I used to do, I can't hide it, it's a positive for people coming to talk to me. (male, regional, general clinical)

A Both-Ways Approach to Healing and Alcohol Care

The philosophy

All participants described practices and treatment approaches which involved bicultural elements. This was described as blending scientific (Western) medical knowledge with local Indigenous (cultural) knowledges, healing techniques or delivery according to local cultural protocols:

> I think [our service] have got it right. Management have put trust into local Indigenous staff to run with it, and know we know our people and they acknowledge we know what's best for our people, because it's both-ways. We acknowledge strength of mainstream ways and [the local Aboriginal people's] ways and bringing them together. (female, remote, other)

To deliver bicultural care, it was considered important to have strong foundations in both spheres of knowledge. For cultural aspects, this was seen as involving strong links with the local community and Elders. Strong relationships with non-Indigenous clinicians gave Indigenous frontline workers confidence in their clinical knowledge of alcohol and related harms. This enabled staff to translate their knowledge of a Western treatment approach into a cultural program, or deliver health information in a culturally appropriate manner:

> We do cultural training. It is very important, need to have an understanding of how culture works here in [state] if they don't understand they won't be able to work with community. (male, remote, AoD)

> the Aboriginal Health Workers are the middle person between client and [non-Indigenous] doctor … if you miss this opportunity…you won't see them again. (female, urban, general clinical)

Urban, regional, and remote service participants described bicultural care in similar language. A universal experience was described in navigating 'two-ways', though contextualising (tailor to local 'ways') your approach was emphasised:

> if you get the right validated scientific tools and as well as a cultural view, our patients listen to us. (male, urban, general clinical)

> You need to get stuff but adapt it locally…with us we integrate with mainstream. It's tough but I think you just have to get that one standard model and everyone from their own area [cultural perspective] can add to it. (male, regional, other)

Overall, participants described seeing their clients not as individuals, but part of a family and community:

> You are not just working with one person you are working with the family. (male, remote, AoD)

Finding balance and the space for cultural care

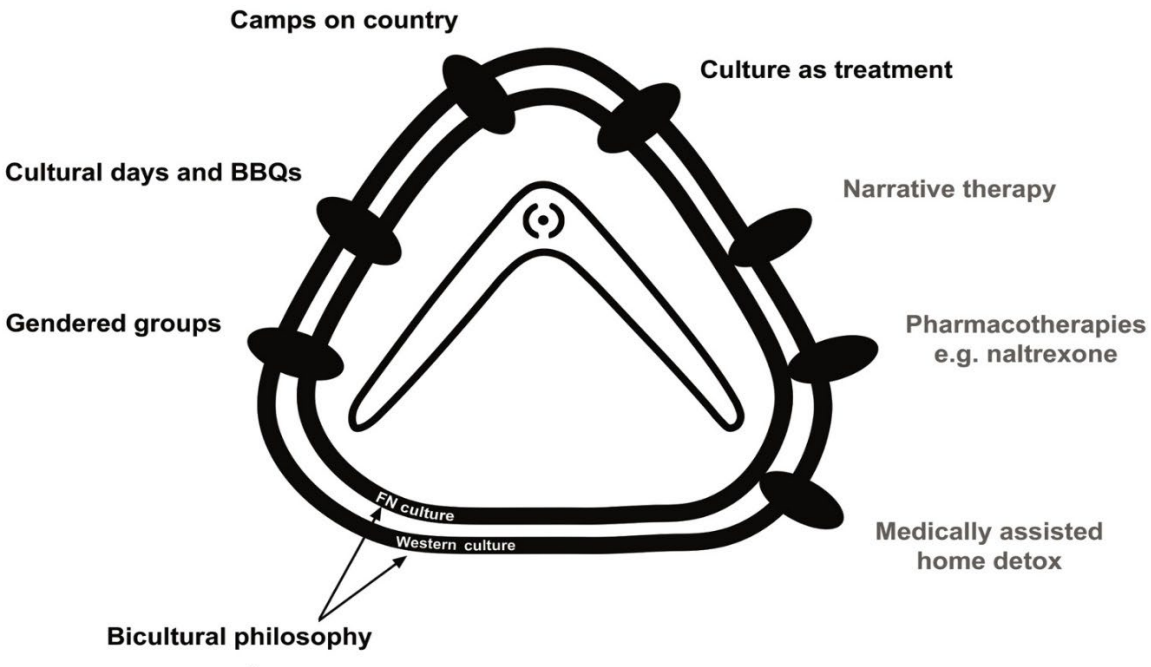
One participant described the struggles their service had in retaining Indigenous health workers due to how dominant the Western approach was in providing care:

> the lady [Aboriginal health professional] I started with, she ended up leaving because CBT [cognitive behavioural therapy] was pushed so much. She was narrative, sit in the dirt with our Mob. But now it's like they have to have an appointment to come see us and that is frustrating. (female, remote, AoD)

Culturally-informed approaches to healing

Four main therapeutic approaches were discussed by participants in working with clients. These are gendered group activities; cultural days and barbeques; camps; and culture as treatment. A graphic summary of both the care philosophy and the four specific therapeutic approaches is presented in Figure 2.

Figure 2. A both-ways approach to healing and alcohol care



DOI: 10.18584/iipj.2022.13.3.14030

Figure 2 depicts the bicultural philosophy implemented at some ACCHSs as described by participants. The two concentric lines represent the two knowledge bases working side-by-side, with dots intersecting at varying points (First Nations, FN; western culture). The treatment or healing approaches in black type had a strong bicultural focus, whilst those in grey are examples of predominantly Western approaches that can be delivered in a culturally inclusive model. The interpersonal processes, represented by the returning boomerang at the centre, facilitate delivery of these Western treatments in a trusting partnership. Similarly, the therapeutic partnerships developed (in the inner layer) may be impacted by what treatments staff can offer clients.

Gendered groups

Gendered group activities were talked about by almost all participants. Men's and women's groups were the most common. This was followed by culturally-modified SMART Recovery (Dale et al., 2021), 'Mums and Bubs' groups, and a Men's Shed (domestic violence-focused yarning circles with alcohol focus):

> If you can engage a small group, cousins and sisters they can support each other. (female, remote, AoD)

Gender segregation in groups was seen positively:

> we try keep it culturally appropriate, so women with women [separately] … I work with some partners, but mostly keep separate. (female, remote, AoD)

Groups were run at the service and off-site for daytrips, and longer overnight camps:

> We had a 'walk-the-talk' program, go out bush and walk around and the old fulla's [men] would start pointing out trees or plants and we yarn up about anything and everything and sometimes it brings back memories. Especially the lads that know about it, but don't want to talk about… We never talk about negative stuff, always positive stuff, to keep our spirit strong and our mind healthy. (male, urban, AoD)

Cultural days and barbeques (for staff and clients)

These therapeutic activities were described as popular events, giving clinicians or health workers an opportunity to present a short talk on a health issue followed by a barbeque and yarn:

> Sometimes we might go have an all-men's things barbeque, we'll put on movies about dialysis, chronic liver disease, domestic violence and how drinking impacts on it, and then we talk about all of it. (male, remote, AoD)

Cultural days and barbeques were also used to prevent worker burnout while bonding with clients and celebrating culture:

> We used to go on Cultural Days and go hunting for half a day...they love it. It works out both-ways, we don't want to lose it [the culture]. (male, urban, AoD)

Cultural days for women were described by one participant as a positive group activity, but offering these was hindered by a lack of car seats for children:

> We used to do cultural days with women. It would be hard coz [because] you say "You can't bring the kids", but we'd say "No, it's a break for you" and we didn't have car seats, so it's a safety thing… but I'd like to see more work with family. (female, remote, AoD)

Camps on country

This approach was mentioned exclusively by participants from remote services. Camps for men and women were typically held in the bush, away from the distractions of day-to-day worries:

> We go out camping where mobile phones don't work. (male, remote, AoD)

> could be on homelands or somewhere local. (female, remote, AoD)

When organising camps, staff would screen interested clients with tools such as IRIS (Indigenous Risk Impact Screen) (Schlesinger et al., 2007) and a general health check:

> Before people come to camps (men's, women's) they have to go and do a full screen and health check...Most of our questions on alcohol come from communities themselves. We go yarn and they choose the topics that they want to talk about. It's usually grog [alcohol], gunja [cannabis], and DV [domestic violence]. It works way better than us trying to jam things down their throat. (male, remote, AoD)

Camps were typically run for existing social support groups by the ACCHS:

> Our team identifies a target group for camp, a lot of time the group has issues with alcohol and other drugs, we meet with them and invite to attend. (female, remote, AoD)

The health goals for camps varied but all involved bicultural approaches. Cultural elements such as reconnecting to country were intertwined with health promotion messages, positive reinforcement of healthy behaviours, counselling, and health education:

> There's group discussions and opportunities to sit around fire, share what's going on with them and their communities, we can invite other stakeholders to attend, chat about effects of alcohol etc. and there's hunting and fishing and allowing guys to connect to land, cultural activities, education and re-connecting to country is definitely a big one. (female, remote, AoD)

Two interviewees emphasised the direct healing (therapeutic) benefits of connecting to country:

> My higher power are my people and my country, getting back to culture, that's what saved me. (male, regional, AoD)

DOI: 10.18584/iipj.2022.13.3.14030

Culture as treatment (and ceremony in the healing process)

One participant described a smoking healing ceremony conducted at their ACCHS and at a local festival (facilitated by staff and an Elder):

> a man doing traditional song with clapsticks, they go under the sheet and inhale the steam and can bite on bark… it depends on what they want to get out of it, it's a time to reflect on any wrong doings, find respect for self or community or for people suffering illness. Done in complete silence, apart from song and clapsticks. They are under there for probably 2-3 minutes then go on their way and continue journey as cleansed. We talk before about ceremony, what it is about, time to reflect on life, where they want to go, what person you want to be. (female, remote, other)

Western treatment approaches perceived as culturally appropriate

A range of standard treatment approaches were perceived as culturally acceptable and effective in alcohol care. Prominent approaches discussed by participants included narrative therapy and CBT. Culturally appropriate residential rehabilitation services were seen as highly desirable to clients (in their treatment approach and being located on country) but difficult to access or not available:

> people what to go to rehab, but people don't want to leave [local area or country]. We did have facility here, it got shut down. (female, remote, other)

> We support 1-2 options for detox/dry out and they can go to AA [Alcoholics Anonymous] which is mainstream. 1 or 2 rehabs for Blackfulla's, there is nothing apart from that. (male, urban, general clinical)

There was a shared interest (between staff across service remoteness) in alcohol relapse-prevention medicines and desire to implement 'home-detox' (ambulatory withdrawal) more frequently:

> I haven't referred anyone [to in-patient detox at hospital] for over 2 years, first of all it's seen as part of Health Department, and a lot of stigma and distrust. They [clients] would trust us to help them detox at home. I believe, we could have good system to support them, GPs, Health Workers, nurses, they would trust us. (male, urban, general clinical)

Service-wide strategies to achieving both-ways to healing

Participants discussed three broad approaches which they perceived their services have used to satisfy the bicultural expectations of staff and community members. These are: employing local Indigenous staff, home visits, and 'social advocacy' as a cultural responsibility (Figure 3).

Figure 3. Service-wide strategies to achieving both-ways healing

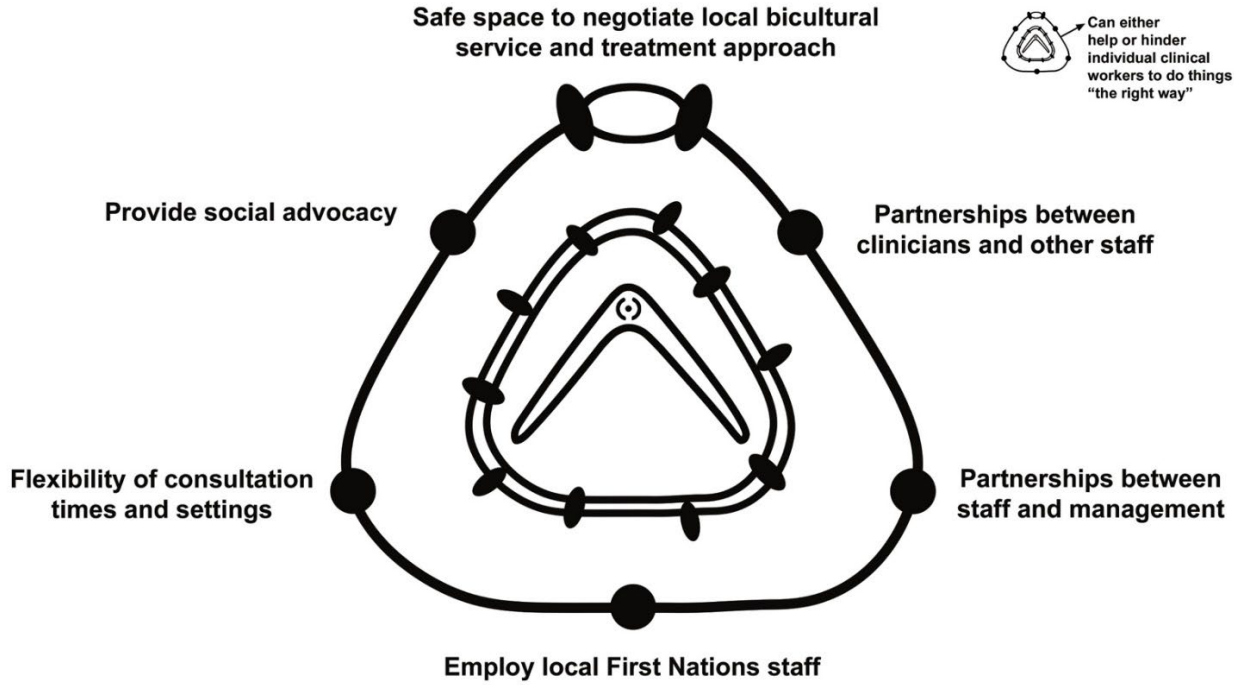


Figure 3 depicts the service-wide strategies employed by ACHHSs to meet the bicultural expectations of staff and community. All factors in the outer layer can impact on the specific therapeutic approaches available at the service, as well as the interpersonal relationships between staff and their clients.

Employing local Indigenous staff

The benefits of employing local Indigenous staff were mentioned by several participants for the reasons set out below.

Increasing client comfort

Generally, having local people employed at the ACCHS was seen to make clients more comfortable. The ability to talk with clients outside work hours in the community (chance meetings) was also perceived as a positive, putting people at ease to yarn honestly:

> They feel more comfortable with Aboriginal staff, they really open up and are honest, even after hours, a lot of them want to talk then, I don't know if they feel more comfortable with us out of uniform. At work, coz [because] they know us they come in. (male, regional, general clinical)

Although there was overwhelming recognition for the positives associated with employing locals with family connections to the area, issues around shame and privacy were raised:

> when they come in, they walk into the AMS and think they don't want to talk here, there's too many people or too much family work there, they get shy. (male, urban, AoD)

Kinship (family ties)

In remote sites when kinship ties were mentioned, the ability to talk frankly with clients, knowing the context of all that was going on for clients in their lives was perceived positively, particularly at a point of crisis (e.g., where justice system may be involved with alcohol-related issues):

> Also, at times we are family… that's the benefit, local people working with community and being family, we can have a strong talk with them. (female, remote, other)

Connecting the right people (cultural practice)

Connection to the local area allowed workers to identify the right family or community members to be involved in supporting a client's care. Family ties to the area were not a prerequisite for strong connections with clients, though were seen as very helpful:

> [after receiving referral] … decide who is most appropriate to sit down with that person, consider authority of clan, someone [related] through kinship, will identify the best person to sit with them and initiate discussion. (female, remote, AoD)

For workers in remote services, communication with Elders and other appropriate people when the client was away from their home country was essential. This involved staff contacting with the right people in the homeland and getting the 'OK' for someone to be transported home; it included negotiating an agreement as to who would support the client once back. The role of local Indigenous workers is vital as these conversations can only be conducted with the right people, at the right time, in culturally appropriately terms, and potentially in the traditional language:

> Furthest homeland from here is three hours there and back. Big deal to be able to offer them that option, to head back out. Wouldn't just be transport, it would be contacting Elders: "This person wants to come back would you support them?" (female, remote, other)

The cultural practice of connecting people was also expressed by staff in regional and urban services:

> It's about finding someone in the area that has networks in their area, connecting people. (male, regional, AoD)

One staff member discussed supporting non-Indigenous colleagues to make these connections:

> We can do the introductions so that the [non-Indigenous] workers can see there is so much more behind the scenes… (male, urban, AoD)

Language and cultural interpreters

In remote sites, locals who are bilingual (English and Indigenous languages) were seen as an essential asset to the team. They were able to act as translators, as well as being culturally appropriate

workers for specific clan groups. Barriers to their recruitment and retention (in remote sites) included social pressures and responsibilities to large extended families:

> to get someone good and with language they probably have lots going on at home, lots of people going on. We need Aboriginal people, local people with language. (female, remote, AoD)

Home visits

Offering home visits was seen as important to several participants. Home visits reduced clients' worry over shame and privacy associated with coming into the clinic:

> it's important that their business is their business, so they don't think the whole service is going to be judging them; that's for the privacy of the client, make them feel comfortable. (female, regional, general clinical)

Social support and advocacy as a cultural responsibility

Staff understood that clients can have a lot going on in their lives. Providing social supports (e.g., assistance with housing and food) and advocacy (e.g., with child welfare services) was perceived as a cultural responsibility. In one instance a doctor described supporting family of a client as part of culturally appropriate caring:

> I pick up kids and take them to school in the van and that's not formalised and other parts of the service may not know we do that but if you are doing holistic care, this is why I signed up … we need to be better at getting out, being in the community, we are part of the community. (male, urban, general clinical)

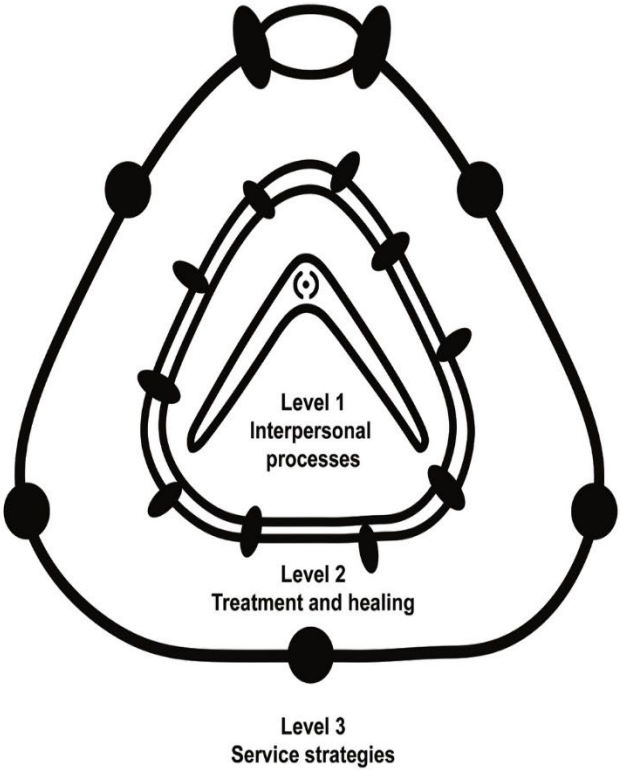
At times this balance between attending to social needs and focusing on alcohol use can be difficult for health workers to navigate. Setting personal boundaries was also important to strike the right balance between meeting community and service management expectations:

> my boundaries need to get a bit tighter; I feel like I'm not getting into the alcohol stuff as I'm dealing a lot with the social stuff and trying to build rapport but trying to be a boss and that scares people away. Sometimes I feel like taxi driver and I'm not empowering them. (female, remote, AoD)

Drawing the three themes together

The findings of staff interviews cover three interconnected levels of alcohol care: interpersonal processes, a both-ways approach to healing (philosophy and treatments), and service-wide strategies to achieving both-ways to healing (Figures 1-3). If one considers all three figures as a whole, they form a meta-theme, a comprehensive model of alcohol care as described by participants. An overview of that model of care is depicted in Figure 4.

Figure 4. Comprehensive bicultural model of alcohol care described by ACCHS staff



Discussion

This is the first study to comprehensively examine the importance of culture in alcohol treatment in primary care settings for Indigenous Peoples of either Australia, New Zealand, the USA, or Canada. The study gives insight into culturally-influenced care, routinely delivered by Indigenous Australian clinical and other staff from 11 independent community-controlled services. These service locations represent a range of geographical areas, from urban to remote, in four Australian states and territories. We identified common themes and described approaches of care which were consistent across service remoteness, with local cultural nuances also noted.

Building partnerships to address alcohol care

Key to delivering alcohol care on the frontline are interpersonal relationships between the health professional or other staff members and their client. Yarning is a core part of these relationships. This narrative style communication philosophy is common throughout Australia's Indigenous communities (Fredericks et al., 2011). The best-known aspect of yarning is the social yarn (Bessarab & Ng'andu, 2010). Social yarning serves as the introduction to a conversation and is an important way to build common ground. Between Australian Indigenous peoples social yarning commonly involves a conversation about 'country' (traditional homelands) and 'mob' (what family you come from, and possible shared connections) (Lin et al., 2016; Lovett et al., 2014). However common ground could be established through discussion of any topic, for example, family, sports, or local community matters (Bessarab & Ng'andu, 2010). The ability to establish meaningful connections through yarning has been recognised in the broader health literature (Bacon, 2007; Lin et al., 2016).

In this study, Indigenous staff used the two-way sharing principle of yarning to build rapport and ultimately a therapeutic partnership with their clients. This contrasts with communication techniques taught in Western medicine, which stem from a biomedical model of care and paternalistic culture (Kaba & Sooriakumaran, 2007). In that model, information is elicited from the client by the clinician using probing and direct questioning (Kaba & Sooriakumaran, 2007). The lack of sharing by the clinician can result in them appearing aloof. Research suggests personal and interactive communication, like that described by participants, is important to peoples of all ethnic backgrounds, and relational processes are central to improved client outcomes (Rocque & Leanza, 2015).

The interpersonal processes described by study participants share many similarities with Western models of patient-centred care (Australian College of Nursing, 2020; Barry & Edgman-Levitan, 2012; Epstein & Street, 2011; Pelzang, 2010; Stewart, 2001). What sets the present findings apart is the depth of two-way sharing, and the elements of cultural humility, such as the process of self-reflection and openness to learn about other cultures (for staff not from the local community). For non-Indigenous health professionals working with Indigenous clients this two-way sharing and cultural humility may be even more important given racism experienced by many Indigenous people in healthcare settings (Awofeso, 2011; Taylor & Guerin, 2019). In this study the connectedness of client, staff, and the whole service to family and community was also seen as central.

A bicultural philosophy in alcohol care

At the core of participants' approaches to alcohol care was a bicultural treatment philosophy. The philosophy takes into account Western and local *Indigenous ways of knowing* (including cultural protocols and healing techniques, both traditional and contemporary). A bicultural approach (often termed 'two-ways' or 'both-ways' by participants) has not previously been investigated in the Australian or international literature on alcohol care in primary healthcare settings (Purcell-Khodr et al., 2020). Indeed, descriptions of any cultural elements of care in these settings have been minimal (D'Abbs et al., 2013; Lovett et al., 2014) despite widespread use in other addiction treatment settings (Berry, 2013; Brady, 1995; Gone, 2011; Huriwai et al., 2000b; James et al., 2018; Legha & Novins, 2012; Munro et al., 2017). While international studies suggest a desire of Indigenous communities to incorporate Indigenous knowledges and healing alongside Western medicine, there has sometimes been opposition by mainstream providers, where institutional racism and scepticism can remain challenging (Bourke et al., 2019; DeVerteuil & Wilson, 2010).

Gendered groups and cultural reclamation

In this study, the most common therapeutic approach facilitated by the 'both-ways' (bicultural) philosophy were gendered groups (e.g., men's and women's groups). While gender-specific roles often have a negative association in modern Western societies, they still play an important part in many Australian Indigenous communities and have been associated with the movement to reclaim cultural practices and traditional identities (Fredericks et al., 2017). The presence of cultural protocols and content described in gendered groups in this study differentiate these from peer-to-peer models in mainstream services. Sharing of personal stories of addiction is also part of Western approaches to mutual support groups (e.g., Alcoholics Anonymous, SMART Recovery). However, the group dynamic described in this study was typically freer in nature rather than following a set structure, and settings were flexible. This was illustrated in the discussion of informal barbeques with

staff and clients and camping trips on country. Such activities were also noted as a time for staff to connect to culture and reduce stress. As alcohol and other drug worker burnout rates for Indigenous staff have been described as an issue (Deroy & Schütze, 2019; Roche, Duraisingam, Trifonoff, Battams, et al., 2013; Roche, Duraisingam, Trifonoff, & Tovell, 2013) such initiatives may also aid in the retention of the Indigenous AoD workforce.

Service strategies

A key element at this macro level was creating a culturally safe work environment. This allowed staff to have open conversations about client needs and communities' cultural expectations and preferences. This environment facilitated the formation of partnerships within the clinic (e.g., between management and staff, between clinicians and other frontline staff) which contributed to delivering a pragmatic bicultural service and treatment philosophy. A tension was seen between satisfying management whilst upholding the staff member's obligations to clients and community. Thus, factors at the macro level have the ability to help or hinder frontline staff in delivering care according to their sense of best practice (Roche, Duraisingam, Trifonoff, Battams, et al., 2013). Ongoing tensions are likely to damage trust in relationships between the service and community, and further strain workers who have responsibilities to both parties.

A bicultural model of alcohol care in the ACCHS sector

Considering the three major themes discussed by ACCHS staff, a comprehensive model of alcohol care emerged (Figure 4). Each level of care is connected and somewhat interdependent. For example, to abandon or devalue Indigenous staff members' cultural duty of care at Level 1 (interpersonal processes) or 3 (service strategies) would jeopardise client and community relationships. Meanwhile insensitive or inflexible service practices (Level 3) could inhibit staff from delivering cultural and bicultural treatments (Level 2). Likewise, from a Western medical perspective, failing to uphold principles of evidence-based practice would not be in the best interests of clients, nor would it meet community expectations.

Policy Implications

The principle of merging Indigenous and Western knowledges in a healthcare setting is in line with the World Health Organization's (WHO) policy directives going back almost twenty years (Zhang & World Health Organization, 2002). WHO advocates for the integration of traditional healing practices with national health care systems, particularly in primary care settings (World Health Organization, 2013). Indigenous traditional knowledges from Australia, New Zealand, Canada, or the USA have not been a major focus in this WHO strategy compared to better known systems such as Chinese medicine, naturopathy or Ayurveda medicine. Future research into Australian Indigenous cultural approaches to healing should focus on a bicultural framework, given the existing global support for pluralism in primary care settings.

The principles of care described by staff can be incorporated into policy and practice in a clinical setting where staff and management wish to optimise their engagement with Australian Indigenous clients. The findings on interpersonal processes and the associated model of partnership building identified in this research may be relevant to clients of any ethnic and cultural background, but especially for other minority groups. In applying these principles of care, it is important to consider

all levels of care, including structural and system-level, service-wide factors, and broader policy and funding. Without attention to these factors undue strain may be placed on frontline workers (Roche, Duraisingam, Trifonoff, Battams, et al., 2013), and ultimately on retention of staff.

Government funding for ACCHSs into siloed areas of need (e.g., drug and alcohol, mental health, diabetes, kidneys) (Commonwealth of Australia Department of Health, 2020) may be a barrier to services in tailoring of holistic treatments to local needs. Similarly, key performance indicators for services are typically focused on individual elements of mainstream Western practice (Australian Institute of Health and Welfare, 2019).

More research is needed on the full scope of alcohol care discussed in this paper. A culturally focused qualitative study could further investigate the role of culture and bicultural treatment philosophies and therapies being practised. Effectiveness studies would also be valuable. Positive findings would encourage such cultural approaches to be incorporated into national alcohol treatment guidelines and may enhance funding for such approaches.

These findings are likely to be relevant to primary care service providers in New Zealand, Canada, and the USA where similar bicultural models are being called for. Future research could also investigate the model of care and theories described in this study to see if they hold in other treatment areas and mainstream healthcare settings.

Limitations

Interviewees were not asked specifically about culture in alcohol care. However, this study is in keeping with the original goal of the service interviews, which was to document the strengths of the services in alcohol care. As probing questions were not asked when cultural elements were discussed it is possible that culturally relevant information could have been missed in this study. Additionally, although interviewees were selected by services, their views may not be representative of the whole service, or of all ACCHSs. However, they give valuable insights into a broad picture of alcohol care provided by frontline staff in a range of independent services.

Conclusion

This study describes a holistic system of bicultural alcohol care delivered by Indigenous staff in Australian ACCHS primary care settings. Core principles of the approach are mirrored in addiction treatment models in residential and community settings internationally. The few existing studies of bicultural approaches in primary care also hint at similar themes, however this is the first study to present an in-depth analysis. Extension of bicultural models from residential and community settings into primary care is logical as barriers to alcohol treatment are enduring despite government and service efforts. Integrating a bicultural model of care may increase treatment accessibility and acceptability to Indigenous clients, and in turn may increase treatment effectiveness. However, implementing such a model may require some restructuring of clinical consultation times, settings, treatment options, and hiring of Indigenous staff, where these are not already in place. Widespread adoption of a bicultural model of care would be facilitated by policy changes at national and state levels to afford service flexibility. The framework described here could potentially be tailored to mainstream as well as Indigenous health services and to other health conditions. Consultation with

health professionals and community members would be required implement this framework effectively.

References

Australian Bureau of Statistics. (2016). *The Australian Statistical Geography Standard (ASGS) Remoteness Structure.* ABS. https://www.abs.gov.au/statistics/statistical-geography/remoteness-structure

Australian College of Nursing. (2020). *Position Statement: Person-Centred Care*. https://www.acn.edu.au/wp-content/uploads/position-statement-person-centred-care.pdf

Australian Institute of Health and Welfare. (2011). *Substance use among Aboriginal and Torres Strait Islander people: Alcohol use*. AIHW. https://www.aihw.gov.au/getmedia/7eb356be-c2cd-4562-a240-010cbbe257f2/11503.pdf.aspx?inline=true

Australian Institute of Health and Welfare. (2015). *The health and welfare of Aboriginal and Torres Strait Islander peoples 2015: Determinants of Health – Alcohol*. AIHW. https://www.aihw.gov.au/getmedia/584073f7-041e-4818-9419-39f5a060b1aa/18175.pdf.aspx?inline=true

Australian Institute of Health and Welfare. (2016). *Healthy Futures—Aboriginal Community Controlled Health Services Report Card 2016*. AIHW. https://www.aihw.gov.au/getmedia/8d2079f7-c3bf-4e5d-840d-91907a1c86ef/20178.pdf.aspx?inline=true

Australian Institute of Health and Welfare. (2019). *National Key Performance Indicators for Aboriginal and Torres Strait Islander Primary Health Care: Results to June 2018*. AIHW. https://www.aihw.gov.au/getmedia/7bcf0d06-431f-4cb6-9de0-b847a204cd5a/NKPI-for-Aboriginal-and-Torres-Strait-Islander-Primary-Health-Care-Results-to-June-2018.pdf.aspx?inline=true

Australian Institute of Health and Welfare. (2020). *Alcohol, tobacco & other drugs in Australia*. Canberra: AIHW. https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/about

Awofeso, N. (2011). Racism: A major impediment to optimal Indigenous health and health care in Australia. *Australian Indigenous Health Bulletin, 11*(3), 1-8.

Bacon, V. (2007). What potential might narrative therapy have to assist Indigenous Australians reduce substance misuse? *Australian Aboriginal Studies, 1*(1), 71-82. https://search.informit.org/doi/10.3316/informit.715952694372581

Barry, M. J., & Edgman-Levitan, S. (2012). Shared decision making—the pinnacle patient-centered care. *New England Journal of Medicine, 366*(9), 780–781. https://doi.org/10.1056/NEJMp1109283

Berry, S. L. (2013). *Culture in treatment for Aboriginal Australian men in New South Wales residential drug and alcohol rehabilitation services.* [Doctoral dissertation, University of Wollongong]. https://ro.uow.edu.au/theses/3758

Bessarab, D., & Ng'andu, B. (2010). Yarning about yarning as a legitimate method in Indigenous research. *International Journal of Critical Indigenous Studies, 3(1), 37-50.* https://doi.org/10.5204/ijcis.v3i1.57

Bourke, C. J., Marrie, H., & Marrie, A. (2019). Transforming institutional racism at an Australian hospital. *Australian Health Review, 43*(6), 611-618. https://doi.org/10.1071/AH18062

Brady, M. (1995). Culture in treatment, culture as treatment: A critical appraisal of developments in addictions programs for Indigenous North Americans and Australians. *Social Science & Medicine, 41*(11), 1487-1498. https://doi.org/10.1016/0277-9536(95)00055-C

Campbell, M. A., Hunt, J., Scrimgeour, D. J., Davey, M., & Jones, V. (2018). Contribution of Aboriginal Community-Controlled Health Services to improving Aboriginal health: An evidence review. *Australian Health Review, 42*(2), 218-226. https://doi.org/10.1071/AH16149

Commonwealth of Australia Department of Health. (2020). *Government to invest almost $35 million in Indigenous health projects including Indigenous blindness, deafness and chronic kidney disease* [Press Release]. https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/government-to-invest-almost-35-million-in-indigenous-health-projects-including-indigenous-blindness-deafness-and-chronic-kidney-disease

Conigrave J.H., Harrison K., Lee K., Dobbins T., Hummerston B., Hayman N, Perry, J., Ivers, R., Haber, P. S., Wilson, S., Johnson, D., & Conigrave, K. M. (2021). Support can increase use of the AUDIT-C in Australian Aboriginal Community Controlled Health Services: A cluster randomised trial. *Addiction, 116*(9), 2304-2315. https://doi.org/10.1111/add.15428

Corbin, J., & Strauss, A. (2014). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (4th ed.). Sage.

D'Abbs, P., Togni, S., Rosewarne, C., & Boffa, J. (2013). The Grog Mob: Lessons from an evaluation of a multi-disciplinary alcohol intervention for Aboriginal clients. *Australian and New Zealand Journal of Public Health, 37*(5), 450-456. https://doi.org/10.1111/1753-6405.12122

Dale, E., Conigrave, K. M., Kelly, P. J., Ivers, R., Clapham, K., & Lee, K. S. K. (2021). A Delphi yarn: applying Indigenous knowledges to enhance the cultural utility of SMART Recovery Australia. *Addiction Science & Clinical Practice, 16*(1), 2. https://doi.org/10.1186/s13722-020-00212-8

Department of the Prime Minister and Cabinet. (2020). *Closing the gap: Report 2020.* https://ctgreport.niaa.gov.au/

Deroy, S., & Schütze, H. (2019). Factors supporting retention of Aboriginal health and wellbeing staff in Aboriginal health services: A comprehensive review of the literature. *International Journal of Equity Health, 18*(1), 70. https://doi.org/10.1186/s12939-019-0968-4

DeVerteuil, G., & Wilson, K. (2010). Reconciling Indigenous needs with the urban welfare state? Evidence of culturally-appropriate services and spaces for Aboriginals in Winnipeg, Canada. *Geoforum, 41*(3), 498-507. https://doi.org/10.1016/j.geoforum.2010.01.004

Dudgeon, P., Darlaston-Jones, D., Nikora, L. W., Waitoki, W., Pe-Pua, R., Tran, L. N., & Rouhani, L. (2016). Changing the acculturation conversation: Indigenous cultural reclamation in Australia and Aotearoa/New Zealand. In D. L. Sam & J. W. Berry (Eds.), *The Cambridge Handbook of Acculturation Psychology* (2nd ed., pp. 115-133). Cambridge University Press. https://doi.org/10.1017/CBO9781316219218.009

Dzidowska, M., Lee, K. S. K., Conigrave, J. H., Dobbins, T. A., Hummerston, B., Wilson, S., Haber, P.S., Gray, D., & Conigrave, K. M. (2021). Support for Aboriginal health services in reducing harms from alcohol: 2-year service provision outcomes in a cluster randomized trial. *Addiction, 117*(3), 796-803. https://doi.org/10.1111/add.15712

Epstein, R. M., & Street, R. L., Jr. (2011). The values and value of patient-centered care. *Annals of Family Medicine, 9*(2), 100-103. https://doi.org/10.1370/afm.1239

Fredericks, B. L., Adams, K., Finlay, S., Fletcher, G., Andy, S., Briggs, L., & Hall, R. (2011). Engaging the practice of Indigenous yarning in action research *ALAR: Action Learning and Action Research Journal, 17*(2), 8-20. https://research.monash.edu/en/publications/engaging-the-practice-of-yarning-in-action-research

Fredericks, B. L., Daniels, C., Judd, J., Bainbridge, R., Clapham, K., Longbottom, M., . . . Andersen, C. (2017). *Gendered Indigenous health and wellbeing within the Australian health system: A review of the literature*. CQUniversity https://eprints.qut.edu.au/115966/1/Gendered%20Indigenous%20Health%20and%20Wellbeing%20within%20the%20Australian%20Health%20System.%20A%20Review%20of%20the%20Literature.pdf%20%281%29.pdf

Gibson, C., Crockett, J., Dudgeon, P., Bernoth, M., & Lincoln, M. (2020). Sharing and valuing older Aboriginal people's voices about social and emotional wellbeing services: A strength-based approach for service providers. *Aging & Mental Health, 24*(3), 481-488. https://doi.org/10.1080/13607863.2018.1544220

Gone, J. (2011). The red road to wellness: Cultural reclamation in a Native First Nations community treatment center. *American Journal of Community Psychology, 47*(1-2), 187-202. https://doi.org/10.1007/s10464-010-9373-2

Gone, J. (2012). Indigenous traditional knowledge and substance abuse treatment outcomes: The problem of efficacy evaluation. *American Journal of Drug and Alcohol Abuse, 38*(5), 493-497. https://doi.org/10.3109/00952990.2012.694528

Gracey, M., & King, M. (2009). Indigenous health part 1: Determinants and disease patterns. *The Lancet, 374*(9683), 65-75. https://doi.org/10.1016/S0140-6736(09)60914-4

Gray, D., Cartwright, K., Stearne, A., Saggers, S., Wilkes, E., & Wilson, M. (2018). Review of the harmful use of alcohol among Aboriginal and Torres Strait Islander people. *Australian Indigenous Health Bulletin, 18*(1). https://aodknowledgecentre.ecu.edu.au/healthinfonet/getContent.php?linkid=590984&title=Review+of+the+harmful+use+of+alcohol+among+Aboriginal+and+Torres+Strait+Islander+people

Harrison, Lee, K. K., Dobbins, T., Wilson, S., Hayman, N., Ivers, R., Haber, P. S., Conigrave, J. H., Johnson, D., Hummerston, B., Gray, D., & Conigrave, K. (2019). Supporting Aboriginal Community Controlled Health Services to deliver alcohol care: Protocol for a cluster randomised controlled trial. *9*(11), e030909. https://doi.org/10.1136/bmjopen-2019-030909

Health Canada. (2014). *A statistical profile on the health of First Nations in Canada - determinants of health, 2006 to 2010*. http://publications.gc.ca/site/eng/9.699551/publication.html

Health Canada. (2015). *A statistical profile on the health of First Nations in Canada - determinants of health, 2006-2010*. https://www.sac-isc.gc.ca/eng/1585414580249/1585414609942

Health Promotion Agency. (2017). Research and data: Hazardous and risky drinking - Differences among past-year drinkers. *Alcohol NZ, 7*(1), 21-23. https://www.alcohol.org.nz/sites/default/files/field/file_attachment/AlcoholNZ-Magazine-June-2017.pdf

Hirchak, K. A., Leickly, E., Herron, J., Shaw, J., Skalisky, J., Dirks, L. G., Avey, J. P., McPherson, S., Nepom, J., Donovan, D., Buchwald, D., McDonell, M. G., & HONOR Study Team (2018). Focus groups to increase the cultural acceptability of a contingency management intervention for American Indian and Alaska Native Communities. *Journal of Substance Abuse Treatment, 90*, 57-63. https://doi.org/10.1016/j.jsat.2018.04.014

Huriwai, T., Sellman, D. J., Sullivan, P., & Potiki, T. L. (2000a). Optimal treatment for Māori with alcohol and drug-use-related problems: An investigation of cultural factors in treatment. *Substance Use and Misuse, 35*(3), 281-300. https://doi.org/10.3109/10826080009147697

Huriwai, T., Sellman, D. J., Sullivan, P., & Potiki, T. L. (2000b). Optimal treatment for Māori with alcohol and drug-use-related problems: An investigation of cultural factors in treatment. *Substance Use and Misuse, 35*(3), 281-300. https://doi.org/10.3109/10826080009147697

James, D. B., Shakeshaft, A., Munro, A., & Courtney, R. J. (2018). A move from describing to evaluating the effectiveness of Indigenous drug and alcohol residential rehabilitation services: A systematic review. *Current. Drug Abuse Review, 11:*, 52-67. https://doi.org/10.2174/1874473711666180404123904

Kaba, R., & Sooriakumaran, P. (2007). The evolution of the doctor-patient relationship. *International Journal of Surgery (London, England), 5*(1), 57-65. https://doi.org/10.1016/j.ijsu.2006.01.005

King, M., Smith, A., & Gracey, M. (2009). Indigenous health part 2: The underlying causes of the health gap. *The Lancet, 374*(9683), 76-85. https://doi.org/10.1016/S0140-6736(09)60827-8

Legha, R. K., & Novins, D. (2012). The role of culture in substance abuse treatment programs for American Indian and Alaska Native communities. *Psychiatric Services, 63*(7), 686-692. https://doi.org/10.1176/appi.ps.201100399

Lin, I., Green, C., & Bessarab, D. (2016). 'Yarn with me': Applying clinical yarning to improve clinician-patient communication in Aboriginal health care. *Australian Journal of Primary Health, 22*(5), 377-382. https://doi.org/10.1071/PY16051

Lovett, R., Dance, P., Guthrie, J., Brown, R., & Tongs, J. (2014). Walan Girri: Developing a culturally mediated case management model for problematic alcohol use among urban Indigenous people. *Australian Health Review, 38*(4), 440-446. https://doi.org/10.1071/AH13148

Munro, A., Allan, J., Shakeshaft, A., & Breen, C. (2017). "I just feel comfortable out here, there's something about the place": Staff and client perceptions of a remote Australian Aboriginal drug and alcohol rehabilitation service. *Substance Abuse Treatment, Prevention, and Policy, 12*(1), 1-14. https://doi.org/10.1186/s13011-017-0135-0

National Aboriginal Community Controlled Health Organisation. (2020). *About NACCHO*. https://www.naccho.org.au/about/

Pelzang, R. (2010). Time to learn: Understanding patient-centred care. *British Journal of Nursing, 19*(14), 912-917. https://doi.org/10.12968/bjon.2010.19.14.49050

Purcell-Khodr, G. C., Lee, K. S. K., Conigrave, J. H., Webster, E., & Conigrave, K. M. (2020). What can primary care services do to help First Nations people with unhealthy alcohol use? A systematic review: Australia, New Zealand, USA and Canada. *Addiction Science & Clinical Practice, 15*(1), 31. https://doi.org/10.1186/s13722-020-00204-8

Robertson, P. J., Futterman-Collier, A., Sellman, J. D., Adamson, S. J., Todd, F. C., Deering, D. E., & Huriwai, T. (2001). Clinician beliefs and practices related to increasing responsivity to the needs of Māori with alcohol and drug problems. *Substance Use and Misuse, 36*(8), 1015-1032. https://doi.org/10.1081/JA-100104487

Roche, A. M., Duraisingam, V., Trifonoff, A., Battams, S., Freeman, T., Tovell, A., Weetra, D., & Bates, N. (2013). Sharing stories: Indigenous alcohol and other drug workers' well-being, stress and burnout. *Drug and Alcohol Review, 32*(5), 527-535. https://doi.org/10.1111/dar.12053

Roche, A. M., Duraisingam, V., Trifonoff, A., & Tovell, A. (2013). The health and well-being of Indigenous drug and alcohol workers: Results from a national Australian survey. *Journal of Substance Abuse Treatment, 44*(1), 17-26. https://doi.org/10.1016/j.jsat.2012.01.009

Rocque, R., & Leanza, Y. (2015). A systematic review of patients' experiences in communicating with primary care physicians: Intercultural encounters and a balance between vulnerability and integrity. *PloS One, 10*(10), e0139577-e0139577. https://doi.org/10.1371/journal.pone.0139577

Rombouts, S. A., Conigrave, J. H., Saitz, R., Louie, E., Haber, P., & Morley, K. C. (2020). Evidence based models of care for the treatment of alcohol use disorder in primary health care settings: A systematic review. *BMC Primary Care, 21*(1), 1-17. https://doi.org/10.1186/s12875-020-01288-6

Schlesinger, C., Ober, C., McCarthy, M., Watson, J., & Seinen, A. (2007). The development and validation of the Indigenous Risk Impact Screen (IRIS): A 13-item screening instrument for alcohol and drug and mental health risk. *Drug and Alcohol Review, 26*, 109 - 117. https://doi.org/10.1080/09595230601146611

Shore, J. H., Beals, J., Orton, H., Buchwald, D., & AI-SUPERPFP Team. (2006). Comorbidity of alcohol abuse and dependence with medical conditions in 2 American Indian reservation communities. *Alcoholism: Clinical and Experimental Research, 30*(4), 649-655. https://doi.org/10.1111/j.1530-0277.2006.00076.x

Stewart, M. (2001). Towards a global definition of patient centred care: The patient should be the judge of patient centred care. *BMJ, 322*(444), 444-445. https://doi.org/10.1136/bmj.322.7284.444

Substance Abuse and Mental Health Services Administration. (2019). *2018 National Survey on Drug Use and Health Detailed Tables.* https://www.samhsa.gov/data/report/2018-nsduh-detailed-tables

Taylor, K., & Guerin, P. (2019*). Health care and Indigenous Australians: Cultural safety in practice* (3rd ed.). Red Globe Press.

Teffo, L. (2011). Epistemic pluralism for knowledge transformation. *International Journal of African Renaissance Studies - Multi-, Inter- and Transdisciplinarity, 6*(1), 24-34. https://doi.org/10.1080/18186874.2011.592388

Webster, E., Johnson, C., Kemp, B., Smith, V., Johnson, M., & Townsend, B. (2017). Theory that explains an Aboriginal perspective of learning to understand and manage diabetes. *Australian and New Zealand Journal of Public Health, 41*(1), 27-31. https://doi.org/10.1111/1753-6405.12605

World Health Organisation. (2018). *Global status report on alcohol and health.* https://apps.who.int/iris/bitstream/handle/10665/274603/9789241565639-eng.pdf?ua=1

World Health Organization. (2013). *WHO traditional medicine strategy: 2014-2023* (9241506091). https://www.who.int/medicines/publications/traditional/trm_strategy14_23/en/

Wynne-Jones M, Hillin A, Byers D, & Stanley D. (2016). Aboriginal grief and loss: A review of the literature. *Australian Indigenous HealthBulletin, 16*(3), 1-9. https://apo.org.au/node/67488

Yunkaporta, T. (2009). *Aboriginal pedagogies at the cultural interface* [Doctoral dissertation, James Cook University]. https://researchonline.jcu.edu.au/10974/2/01thesis.pdf

Yunkaporta, T., & McGinty, S. (2009). Reclaiming Aboriginal knowledge at the cultural interface. *The Australian Educational Researcher, 36*(2), 55-72. https://doi.org/10.1007/BF03216899

Zhang, X., & World Health Organization. (2002). *Traditional medicine strategy 2002-2005*. https://apps.who.int/iris/handle/10665/67163

Zheng, C., Conigrave, J. H., Conigrave, K. M., Wilson, S., Perry, J., Chikritzhs, T. N., Fitts, M. S., & Lee, K. (2022). Patterns of drinking in Aboriginal and Torres Strait Islander peoples as self-reported on the Grog Survey App: A representative urban and remote sample. *Drug and Alcohol Review, 41*(1), 114-124. https://doi.org/10.1111/dar.13333