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A review of engagement of Indigenous Australians within mental health and substance abuse services.

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Abstract

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Keywords

within, australians, services, indigenous, abuse, engagement, review, substance, health, mental

Disciplines

Arts and Humanities | Life Sciences | Medicine and Health Sciences | Social and Behavioral Sciences

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A review of engagement of Indigenous Australians within mental health and substance abuse services

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Abstract

Substance misuse is a significant issue in Australia, and a large proportion of individuals with substance misuse disorders have co-existing mental health disorders. There is evidence that Indigenous Australians are more likely than non-Indigenous Australians to experience the adverse effects of alcohol consumption, and that mental health disorders are more prevalent in Indigenous communities than non-Indigenous communities. Indigenous Australians currently do not access mental health and substance abuse services at a level which is consistent with their level of need, and this is largely due to inconsistent or insufficient culturally respectful mental health services. This paper provides a review of relevant literature, which indicates an increasing need for mental health and substance abuse services that are sensitive to the needs of Indigenous Australians, and discusses engagement challenges and what is needed to increase engagement and improve outcomes for these clients. Future research should aim to identify which approaches to mental health and substance abuse service provision are associated with better outcomes for Indigenous clients, and ways of increasing the cultural respectfulness of these services.

Keywords

Indigenous mental health, Aboriginal mental health, substance abuse, dual diagnosis, engagement, mental health services

The state of Indigenous health

Since colonisation Indigenous Australians have experienced extreme levels of loss, grief, disempowerment, cultural alienation, and loss of identity (Australian Institute of Health and Welfare, 2002, 2003; Hunter, 1993). This is considered to be the result of the three layers of colonisation: the physical violence of the frontier; the structural institutional violence perpetrated by the state; and the psychosocial dominance of another culture (Atkinson, 2006). The associated decline in physical health (e.g., dietary changes and exposure to foreign diseases) and mental health (e.g., exposure to

psychoactive substances, social trauma) identifies the health status of Indigenous Australians as being far below the Australian average. This is evident through significantly poorer physical health profiles, as well as higher prevalence rates of suicide, domestic violence, substance abuse, and unemployment (Cleworth, Smith & Sealey, 2006). Indigenous people are also disadvantaged when compared with the general Australian population on other social indicators such as poverty, mortality rates, average rates of pay, standards of housing, and educational outcomes (Roxbee & Wallace, 2003; Swan & Raphael, 1995).

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Violence in Indigenous communities is increasing, and Swan and Raphael (1995) report that much of this violence is directed towards women. Atkinson (2006) states that a primary contributing factor to inter-generational abuse is unhealed trauma reaching across generations, resulting from the psychological and physical suffering experienced by Indigenous Australians in the colonising process. It is suggested that because Indigenous people have needed to suppress their feelings of distress to survive over the years, their pain has become internalised within the family, and is associated with domestic violence (Atkinson, 1994). The Department of Health and Ageing (2007) reports a high correlation between domestic violence and alcohol use in Indigenous communities, with 70 to 90 percent of incidents being committed when under the influence of alcohol and/or other substances. Due to factors such as violence and substance misuse, Indigenous people have been found to be over-represented in prisons by a factor of 14, and over-represented in police custody by a factor of 26 (Kosky & Goldney, 1994). In addition, Dodson (1991) found that in Western Australia, 44 percent of children in foster care were Indigenous, despite the fact that Indigenous people only make up 2.5 percent of the population. These statistics all indicate the vast disparity between the health and wellbeing of Indigenous and non-Indigenous Australians.

Alcohol and substance use in the Indigenous population

Concern over the use of alcohol and other drugs by Indigenous people is expressed by Indigenous and non-Indigenous people alike (Langton, 1991). Research has shown that although there are proportionately more Indigenous people than non-Indigenous people who refrain from drinking (Perkins, Sanson-Fisher, Blunden et al., 1994), Indigenous people who do drink are more likely to do so at high-risk levels (Brady, 2004; Department of Health and Ageing, 2007). High-risk alcohol consumption was reported in 15 percent of Indigenous people over 15 years of age in 2002 (Australian Bureau of Statistics, 2002). It has also been found that binge drinking and episodic heavy drinking are common among Indigenous drinkers (Lake, 1989; Perkins et al., 1994). The Department of Health and Ageing (2007) reports that between 2000 and 2004

Indigenous men and Indigenous women died from alcohol-related causes at a rate seven times higher and ten times higher than their non-Indigenous counterparts respectively. This illustrates the reality that Indigenous Australians are more likely than non-Indigenous Australians to experience the adverse effects of alcohol consumption (Department of Health and Ageing, 2007).

Alcohol is not the only substance which is being misused in Indigenous communities. Sheldon (2001) highlights the devastating effects of petrol-sniffing among adolescent males in the remote areas of Central Australia being a significant source of shame and distress for many Indigenous communities. Although the roll-out of non-sniffable Opal fuel to 74 communities has been associated with a dramatic decrease in petrol sniffing in those communities, it has not addressed the reasons this behaviour exists, nor the fact that poly-substance abuse is commonplace within this group (Nicholas, 2007). Brady (2002) discusses the changing face of substance use within the Indigenous population, stating that over the last ten years alcohol use has been declining, with the use of other substances on the increase. These substances include opiates (found by the 2001 census to be the second most highly used drug among Indigenous people seeking treatment), cannabis, amphetamines, injecting drugs, and poly-drug use (Brady, 2002). Therefore, there is an increasing trend for drug and alcohol services to provide intervention for Indigenous drug users rather than Indigenous drinkers alone.

The rise of cannabis use is especially troubling considering the link between the catechol-O-methyltransferase (COMT) gene and a higher risk of psychosis resulting from adolescent cannabis use. Caspi and colleagues (2005) found that a genetic variation in the COMT gene moderated the influence of adolescent cannabis use on the development of psychosis in adulthood. This provides evidence of a distinct process by which early substance use may lead to mental illness later in life. Cohen, Solowij and Carr (2008) state that the association between cannabis use and the risk of developing schizophrenia is found consistently across studies, and that this risk increases with higher doses and earlier onset of cannabis use.

Mental health issues in Indigenous communities

Rickwood (2004) states that 'the social and emotional wellbeing of Aboriginal and Torres Strait Islanders remains a source of national shame' (p. 2). The available evidence, although limited, suggests that mental health disorders are more prevalent in Indigenous communities than non-Indigenous communities, and that Indigenous people are over-represented in inpatient mental health care (Roxbee & Wallace, 2003). Nagel (2006) reports that, in the Top End during 2002-2003, 84 percent of Indigenous mental health admissions indicated psychosis, depression, and substance-related disorders. She suggests that Indigenous people are vulnerable to poor mental health treatment outcomes due to poor physical health, social disadvantage, co-morbid substance misuse, and a burden of grief through suicide, homicide and incarceration. There is also evidence that substance use and self-harm behaviour are rising in the Indigenous community (Clough Cairney, D'abbs et al., 2004; Li, Measey & Parker, 2004). Hunter (1993) and O'Shane (1995) suggest that the factors which contribute to increasing rates of psychiatric morbidity in Indigenous communities include destruction of social infrastructure, rapid urbanisation and poverty, cultural alienation, loss of identity, family dislocation, and increased drug and alcohol consumption.

The trauma suffered by the stolen generations as a result of the assimilation policies of the Australian government has direct relevance to the psychological adjustment of Indigenous Australians when considered within the framework of attachment theory. Attachment theory posits that the quality of early parent-child bonding, as well as the infant's actual experience of the relationship with their parents, has important implications for psychological and emotional adjustment later in life (Strahan, 1995). Many studies have found evidence of a direct link between the quality of early relationships and the development of depression in adulthood (Armsden, McCauley, Greenburg & Burke, 1990; Parker, 1983; Parker & Barnett, 1988), and there is evidence that individuals who report that they had conflictual or rejecting parents in childhood have difficulties forming

healthy interpersonal relationships in adulthood (Hazan & Shaver, 1987; Strahan, 1991). Thus, it has been shown that poor attachment during childhood can have long lasting and detrimental effects on the psychological and emotional adjustment of individuals. A high level of stress during infancy, such as resulting from forcible and permanent removal of a child from their parents, cannot be ignored when considering the aetiology of mental health issues in Australian Indigenous populations.

Co-existing substance misuse and mental health disorders

A large proportion of individuals, both Indigenous and non-Indigenous, who have substance misuse disorders have co-existing mental health disorders (Blankertz & Cnaan, 1994), also known as co-morbidity (Drake, Mueser, Brunette & McHugo, 2004) or dual diagnosis (NSW Office of Drug and Alcohol Policy, 2006). It has been estimated that in Australia the proportion of people engaged by mental health services who experience concurrent substance abuse issues ranges from 30 to 90 percent (Davis, 2003). Along with other accumulating data from the 1980s and 1990s (Kessler, Nelson, McGonagle et al., 1996; Regier, Farmer, Rae et al., 1990), this indicates that co-existing disorders are so common that it might be considered the expectation rather than the exception (Minkoff, 2001). Roxbee and Wallace (2003) report that there are high rates of co-morbidity, as well as complex patterns in causality and treatment, which are unique to Australian Indigenous populations. Thus, service providers not only need to be sensitive and responsive to cultural and identity trauma and disempowerment, particularly for Indigenous clients, but also to needs, stigmas and engagement issues associated with each of the co-existing disorders.

The treatment of people with co-existing disorders is more complex than treating people with a single diagnosis. Clients with co-existing disorders tend to have significantly poorer social functioning, more severe psychiatric symptoms, higher levels of need (Weaver, Stimson, Tyrer et al., 2004), higher severity of substance misuse (Brooner, King, Kidorf et al., 1997; Driessen, Veltrup, Weber et al., 1998), less compliance

with treatment, poorer treatment outcomes (Chen, Collie, Donald et al., 2003; Hunter, Watkins, Wenzel et al., 2005), higher rates of suicide and self-harm (Chen et al., 2003; Drake et al., 2004), and higher treatment costs, including criminal justice involvement and hospitalisation (Brunette, Mueser & Drake, 2004; Chen et al., 2003; Szirom, King & Desmond, 2004; Teeson, 2001). Research has also shown that individuals with co-existing disorders who are in substance abuse programs have lower rates of program completion, shorter stays in treatment, and higher rates of relapse and rehospitalisation following treatment (Compton, Cottler, Jacobs et al., 2003; Weisner, Matzger & Kaskutas, 2003).

Co-existing substance misuse and mental health disorders represent significant challenges in terms of engagement, resources and skills to meet complex needs, and treatment retention. Drake, O'Neal and Wallach (2008) state that historically, even in cases where clients have received simultaneous treatments for both mental illness and substance abuse from different services (commonly referred to as parallel treatment approaches) the interventions were often inconsistent or incompatible. Treatment in parallel mental health and substance abuse treatment programs has been shown to be largely ineffective (Brunette et al., 2004), often due to non-adherence to interventions, drop-out, and inability of the client to make sense of the disparate messages they receive from the two services (Ridgely, Goldman & Willenbring, 1990). Sequentially treating one disorder before another, usually in different services, has also been found to be ineffective for similar reasons (Donald, Dower & Kavanagh, 2005; Ridgely et al., 1990). Thus, it has been increasingly recognised that an integrated service is necessary for people with co-existing disorders (Minkoff, 2001).

Residential treatment versus outpatient treatment programs

Residential treatment programs have some advantages for clients with substance misuse disorders, as well as clients with co-morbid substance misuse and mental health disorders. Such programs provide intensive therapeutic services as well as offering safe housing,

assistance with daily living (Brunette, Drake, Woods & Hartnett, 2001), and the opportunity to develop the skills necessary for recovery (Brunette et al., 2004). Therapeutic communities have been the standard therapeutic approach for many years for clients with primary substance misuse disorders. Many residential programs today are combining the therapeutic community model, traditionally used solely to treat substance misuse disorders, with mental health interventions (Brunette et al., 2004).

It has been found that there is little difference in outcome between inpatient or outpatient treatment programs for clients who are eligible for either service (Drake et al., 2008; Finney & Moos, 2002). However, not all clients will be eligible for either service, as outpatient programs are not well suited for clients with more severe drug and alcohol history (Finney & Moos, 2002; Prendergast, Podus, Chang & Urada, 2002), or significant detoxification needs (Brady, 2002).

There are many advantages of residential treatment programs over outpatient treatment programs, and these are applicable to all clients regardless of the severity and duration of their dependence. One of these advantages is the capacity of residential programs to buffer clients from their substance-abusing environments (Brunette et al., 2004). A strong relationship has been found between the presence of co-existing disorders and homelessness (Caton, Shrout, Dominguez et al., 1995; Leal, Galanter, Dermatis & Westreich, 1998), and clients who are not homeless are likely to live in marginal situations in which they have limited control over their environment, or in neighbourhoods that are pervasively affected by substance abuse (Quimby, 1995). Therefore, a residential program that offers relatively safer and supportive housing will increase the likelihood of positive outcomes for these clients. Additional difficulties for clients, especially those with co-existing disorders, can include unavailability of a positive peer support, lack of internal controls and refusal skills (particularly in the early stages of recovery), as well as problems with maintaining a connection to treatment (Brunette et al., 2004). Residential programs have the potential to assist with these difficulties by offering an alternative to high relapse-risk environments and placing clients within a

relatively supportive network where their connection to treatment is consistently maintained.

It has been found that longer stays in residential treatment, as well as participation in aftercare programs and outpatient mental health treatment, are associated with better post-treatment outcomes for clients with co-existing disorders for up to five years following treatment (Ray, Weisner & Mertens, 2005; Ritsher, Moos & Finney, 2002). It may be the case, therefore, that both residential treatment and outpatient care is needed for clients with co-existing disorders at different stages of the recovery process, with residential treatment comprising the initial stage of rehabilitation.

Given the high rates of poverty, unemployment, and low socio-economic status within the Indigenous population, residential programs are likely to be especially advantageous for Indigenous clients. However, these services need to be appropriately managed and staffed to ensure maximum engagement, cultural safety and appropriate responsiveness to the complexity of needs of disempowered people.

Issues in treatment for Indigenous clients

A literature review was conducted using the following databases and consultation with Indigenous research colleagues: PsycINFO, PsycArticles, Cochrane Library, Sociological Abstracts, Indigenous Australia, Indigenous Studies Bibliography, Aboriginal and Torres Strait Islander Health Bibliography, and Health and Society Database. The search terms used include Indigenous, services, treatment outcomes, residential programs, outpatient programs, recovery, dual diagnosis, alcoholism, substance abuse, and substance misuse. No other limits were placed on the database search.

Challenges in engaging and retaining Indigenous clients

Australian Indigenous people are not accessing mental health services at a level consistent with their level of need (Garvey, 2000; Westerman, 2004). It is often challenging to engage clients in mental health services and substance abuse services, especially clients with co-existing disorders. In addition, it is often more difficult to engage Indigenous clients than non-Indigenous

clients due to limited access to services and a lack of cultural respectfulness (cultural safety) of those services, evident in such things as preparedness to engage family and Indigenous workers beyond tokenism (e.g., three-way talking, as explained later) (Department of Health and Ageing, 2007). Further, research has shown a failure of mental health services to embrace an understanding of Indigenous conceptualisations of mental health (Dudgeon, 2000; Garvey, 2000; Mehl-Madrona, 2009). Westerman (2004) suggests that this lack of cultural respectfulness may include such things as: introductions between clinicians and clients which do not incorporate understandings of the land and familial relationships; the assessment of Indigenous clients outside of their own cultural context; a failure to acknowledge Indigenous concepts of mental health as holistic; the failure to use cultural consultants as a first step in engaging Indigenous clients; and a communication style which tends to put pressure on people by demanding a direct answer.

The psychotherapy process has been found to be problematic when working in Indigenous communities due to the high level of self-disclosure required, and the intrusive nature of the therapeutic experience (Krawitz & Watson, 1997; Vargas & Koss-Chioino, 1992). Vicary and Westerman (2004) found that participants communicated a preference for a therapist to develop a broader relationship with them, rather than the traditional separation of the professional and personal domains. It has also been recognised that a person's gender can influence the exchange of sensitive information, with Indigenous clients commonly feeling offended at being asked questions of a sensitive nature by a clinician of the opposite sex (Department of Health and Ageing, 2007). Additionally, Dudgeon and Pickett (2000) suggest that the individualistic focus of psychotherapy conflicts with systems of social support and cohesion which are important for Indigenous Australians.

Improving mental health and substance abuse services for Indigenous clients

Conceptions of mental health

There is great disparity between Indigenous and non-Indigenous conceptions of mental health, and this must be considered by clinicians when

working with Indigenous clients. Within the numerous attempts to define Indigenous mental health concepts, the common theme has consistently been the holistic nature of health and wellbeing (Roxbee & Wallace, 2003; Swan & Raphael, 1995; Vicary & Westerman, 2004; Ypinazar, Margolis, Haswell-Elkins & Tsey, 2007). The word *punyu*, from the language of the Ngarlingman of the Northern Territory, explains that health encompasses both *person* and *country* (Atkinson, Graham, Pettit & Lewis, 2002). *Punyu* is associated with being strong, happy, knowledgeable, beautiful, clean, socially responsible and safe (i.e., being within the law and also being cared for by others) (Mobbs, 1991). In fact caring for country has been associated with improvements in wellbeing (Burgess, Berry, Gunthorpe & Bailie, 2008; Kingsley, Townsend, Phillips & Aldous, 2009), with Anderson (1995) suggesting that for Indigenous people 'our identity as human beings remains tied to our land, to our cultural practices, our systems of authority and social control, our intellectual traditions, our concepts of spirituality, and to our systems of resource ownership and exchange. Destroy this relationship and you damage – sometimes irrevocably – individual human beings and their health' (cited in Burgess et al., 2008, p. 2).

The National Aboriginal Community Controlled Health Organisation (NACCHO, 1993) states that mental health must be considered in a social and emotional context that encompasses oppression, racism, environment, economical factors, stress, trauma, grief, cultural genocide, psychological processes and ill health. Much of this has been linked to the effects of colonisation and points to the failure of the assimilation policies of the late 19th and early 20th centuries (Department of Health and Ageing, 2007). Slattery (1994) states that the health of Indigenous people may not be considered in terms of a mind/body dichotomy, as it is generally viewed in a western model of health and illness. A possibility for future research is the collaboration of Indigenous mental health workers and Indigenous community members to develop a model of Indigenous mental health that may be understood by clinicians and clients alike. Such a model may help to operationalise Indigenous understanding of mental health and

guide clinicians in their approach. For example, Mehl-Madrona (2009) progressed this type of work in North America by recording discussions with traditional healers to develop a set of twelve 'guideposts' to direct training of mental health workers wishing to work with Aboriginal people. These guideposts include adopting beliefs that healing 'solutions must be internally derived,' requires a 'relational model of self,' and that 'empowerment is different from treatment,' to name a few.

Cultural respect

It is considered important to assess Indigenous clients within the context of their own culture (and even further in terms of family/community), which may include investigating how an individual's behaviour is viewed by members of their cultural group, and questioning whether a client's symptoms result in an impairment in their usual environment (Westerman, 2004). This process of culturally sensitive assessment is important, as Hunter (1988) found that Indigenous people who were assessed in a foreign environment often presented as significantly more distressed than usual.

It has been argued that the use of cultural consultants should become standard practice for clinicians working with Indigenous populations. Broadly defined, a cultural consultant is an Indigenous person who is willing to vouch for the non-Indigenous practitioner, and to act as the first point of contact between the clinician and the client (Westerman, 2004). Westerman (2004) states that cultural consultants should be of the same gender and from the same language group or tribal group as the client. Vicary and Westerman (2004) found that Indigenous clients communicated a preference to engage in services provided by Indigenous practitioners. Clients articulated that, considering the small number of such professionals, services for Indigenous clients could be improved through the use of cultural consultants as co-therapists.

Communication style has been found to be very important when engaging Indigenous clients. Direct questioning is considered by many Indigenous people to be an ill-mannered and inappropriate way to begin a relationship, and the older and more respected the person is, the more inappropriate direct questioning may be

(Department of Health and Ageing, 2007). For this reason a method of three-way talking may often be used, in which a client uses a third person (such as a family member) as a mediator to exchange information with the service provider (Department of Health and Ageing, 2007). This form of communication can be very valuable as it allows for effective exchange of information with minimal embarrassment for the client.

Therapeutic approaches

With regards to therapy, it has been consistently cited that the best approach involves a narrative style of communication, including open-ended questions which are positively-phrased (Harris, 1977; Malin, 1997; Vicary & Westerman, 2004). Vicary and Westerman (2004) refer to this as 'yarning about my problem' (p. 8). Chenhall (2006) conducted a study of the treatment at Benelong's Haven (Kinchela Creek, New South Wales), the first Indigenous-run Australian residential alcohol and drug treatment centre, established in 1974. Benelong's Haven combines a number of therapeutic approaches, including group psychotherapy, which is said to be related to the Indigenous tradition of sharing stories (Chenhall, 2006). Termed 'psych groups,' these facilitated psychotherapy groups are intended to provide a culturally appropriate forum in which clients may explore their negative and destructive thoughts, while also receiving a non-intrusive element of psychoeducation. This study provides an example of how traditional psychotherapy can be adapted and modified to be more culturally appropriate to Indigenous clients.

Cultural and clinical competencies

To increase engagement with Indigenous clients in mental health and substance abuse services, it is necessary for practitioners to have both cultural competencies and clinical competencies (Westerman, 2004). Cultural competencies, or the provision of culturally respectful services, involve the ability to identify and treat mental health issues in a way that accepts culture as having a central role in mental illness (Cross, 1995; Dana, 2000). It involves an integration of the practitioner's cultural awareness and knowledge into the clinical context, so that better health outcomes might be achieved for their

clients (Department of Health and Ageing, 2007). Cross, Bazron, Dennis and Isaacs (1989) have suggested that the elements of cultural competence may be organised under the concepts of cultural awareness, cultural knowledge, and flexibility. The Royal Australian College of Physicians (2004) has outlined five guiding principles for cultural competence: value diversity, maintain capacity for cultural self-assessment, remain aware of the dynamics which are inherent in the interaction of cultures, institutionalise cultural knowledge, and adapt service delivery to reflect an understanding of the diversity of cultures. These aspects of cultural competence could be increased in practising clinicians by a period of immersion within the Indigenous culture. By living and operating daily within an Indigenous community, clinicians may gain a greater knowledge of the language and customs of the people with whom they are working, leading ultimately to greater cultural knowledge and competence. There is evidence that increasing the cultural competence of clinicians results in increases in the utilisation of services, and the positive outcomes for Indigenous clients (Vicary, 2002).

Clinical competence involves the use of certain therapeutic techniques which are shown to be useful treatments for particular disorders (National Aboriginal and Torres Strait Islander Health Council, 2003). For example, it is important that clinicians working with people with co-existing disorders show clinical knowledge and capabilities relating to the treatment of both substance misuse disorders and mental health disorders. In short, clinicians must be competent to effectively treat given disorders, and competent to relate in a culturally respectful way to Indigenous clients, if mental health and substance abuse services are to achieve the aim of improving engagement and outcome for Indigenous clients.

More generally, Indigenous clients have identified that the core components necessary in non-Indigenous service providers are a non-racist attitude and a sound knowledge of Aboriginality (Vicary & Westerman, 2004). Vicary and Westerman (2004) found that 'non-Indigenous people who were cognisant of the issues confronting Indigenous people, who were

willing to listen and learn, and who were willing to apply a blend of western and Indigenous psychology using Indigenous advisors were more likely to be successful in their work with Indigenous clients' (p. 9). However, to date there is little empirical research that identifies the effectiveness of such approaches, nor what is the optimal 'blend' of western and Indigenous psychological, interpersonal, and communal recovery supports.

Residential treatment programs

With particular regard to residential treatment programs for Indigenous clients, Brady (2002) states that the programs must be flexible, so that they may cater for clients from a wide variety of backgrounds. She suggests the structure of the program should incorporate rigorous initial assessment, planning around discharge, and a wide range of treatment and counselling styles, rather than using AA meetings as their sole treatment. She further proposes that there are numerous substance misuse and behaviour change models that could be used and adapted for Indigenous-specific residential programs, such as social learning, motivational interviewing, cognitive behavioural interventions and family therapy. Brady, Dawe and Richmond (1998) reiterate the lack of organised counselling in existing residential rehabilitation services for Indigenous clients. They state that the term 'alcohol counsellor' is often used with no real understanding of its meaning, and that these counsellors are often ex-drinkers who have undertaken a short training course. It is becoming increasingly inappropriate for residential services to employ ex-drinkers for the purposes of counselling, as the complexities of clients' presenting problems are increasing due to poly-drug use and co-morbidity (Brady et al., 1998). Therefore, residential treatment programs should employ professional counselling staff trained in a diverse range of therapeutic approaches.

Conclusion

There is great disparity between the health of Indigenous and non-Indigenous Australians. Colonisation has been associated with a devastating impact on the health and wellbeing of Indigenous Australians, with persistent effects evidenced in elevated rates of suicide,

unemployment, imprisonment, and drug and alcohol abuse. Indigenous people have been disempowered by decades of racism, social disablement, rapid urbanisation, poverty, cultural alienation, and loss of identity. The Indigenous people of Australia represent a high need population, and the current system is not providing them with the level of service they require. The low level of engagement in treatment by Indigenous clients is likely to be related to the poor cultural respectfulness of many mental health and substance abuse services.

Despite a widely held belief that Indigenous clients are not receiving the mental health services they require, there is only a meagre body of published works that examine therapeutic interventions for Indigenous people (Westerman, 2004). Westerman (2004) states that although examples of good practice do exist, knowledge is not being shared between psychologists within the profession, and as a result practising clinicians do not know what works and what does not work for Indigenous clients. Brady (2002) argues that 'effective programs need to engage in an open-minded search for intervention and counselling strategies that meet the needs of [Indigenous] clients' (p. 5). The present paper is an attempt to begin such an open-minded search for effective interventions, and a communication of knowledge between researchers and practitioners. The paper presents the difficulties inherent in treating mental health and substance abuse within Indigenous populations, and draws together recommendations for how these difficulties may be approached.

Atkinson and colleagues (2002) state that for research to be of benefit, it is necessary to find out whether existing interventions are working, and determine which factors are contributing to positive outcomes. Clearly, more empirical research is needed to examine which approaches of mental health and substance abuse services are related to the best outcomes for Indigenous clients. Further empirical research should ultimately aim to increase the cultural respectfulness of mental health and substance abuse services, and to improve engagement, retention and outcomes for Indigenous clients.

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