

Telling Another Story: Looking for Ways of Working in Partnership with Indigenous
Australian People Seeking Help for Alcohol and Other Drug Problems from Mainstream
Services

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Preamble

For thousands of years, over 500 indigenous language groups have lived on what is now known as the 'Australian continent'. It is not my intention to create an impression of one homogenous indigenous culture in talking about indigenous Australian society or culture.

Story, language, customs, kinship practices/relationships, laws, art, music, rituals and other cultural practices vary throughout this continent and the islands of the Torres Strait.

I wish to therefore acknowledge the diversity of indigenous Aboriginal and Torres Strait Islander beliefs, culture and practice. As a non-indigenous Australian, I also wish to acknowledge that this country is not the birthplace of my ancestors. Yet, I live on Wurundjeri land and pay respect to the traditional custodians of both the land and of the stories that have been so generously shared with me.

Abstract

This thesis examines a case for the inclusion of narrative therapy by mainstream alcohol and other drug (AOD) services in counselling Australian indigenous people. Narrative therapy and narrative practices emerged from work developed in partnership with indigenous practitioners in the 1980s in Australia, and although little research has been done on these methods, they are generally regarded as being culturally acceptable to indigenous people.

Currently, the interventions most commonly used in mainstream AOD counselling are generally short term and focus on changing behaviour. The argument of this thesis is not that mainstream AOD interventions are without value, but rather that some reductionist methods of counselling may not constitute the most culturally appropriate approach for working with indigenous clients, many of whom continue to be affected by trauma related to colonisation and its practices and experiences of ongoing racism and social disadvantage. This thesis also concerns itself with issues of language and power and proposes that these are of great significance in counselling indigenous AOD clients.

Declaration

I, Anni Hine Moana, declare that the Master of Counselling minor thesis entitled *Telling Another Story: Looking For Ways of Working In Partnership With Australian Indigenous People Seeking Help For Alcohol and Other Drug Problems From Mainstream Services* (12,971 words) is no more than 14,000 words in length, exclusive of tables, figures, appendices, references and footnotes. I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material that to a substantial extent has been accepted for the award of any other degree or diploma at Victoria University or any other educational institution, except where due acknowledgment is made in the thesis. Any contribution made to the research by colleagues with whom I have worked at Victoria University or elsewhere during my candidature is fully acknowledged.

I agree that this thesis be accessible for the purpose of study and research in accordance with the normal conditions established by the Executive Director, Library Services or nominee, for the care, loan and reproduction of theses.

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Dedication

This thesis has been a labour of love and is dedicated to my sons Scott, Gabriel and Raphael to my granddaughter Trinh and my grandson Harry and all future grandchildren.

It is also dedicated to all of those who have so generously shared their stories and journeys of recovery and to Australian indigenous peoples whose lives continue to be affected by the practices of colonisation and racism.

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This work has developed over time and I owe a deep debt of gratitude to Dr. Anita Milicevic, my thesis supervisor for most of this journey, who encouraged me to read widely, to trust myself, to discover my own voice and to write with courage. Her indescribable generosity, warmth, feedback and support have been invaluable. I am also indebted to Kim Shearson for her enthusiasm and support of my proposal. Thanks are also due also to Dr. Glen Hosking, my 2011 supervisor, for his feedback and to Rebecca Gerrett- Magee and Gary Foley from Moondani Balluk Academic Unit, Victoria University, for their rich contributions to my understanding of indigenous Australian history. Thanks also to Aunty Mehealani Kuamo'o Henry, Maui Loa and all of the other people who have contributed so generously to my knowledge of indigenous Australian, Polynesian and Maori cultural ways and talk story.

Most of all, I am indebted to my family: Scott, Gabriel, Raphael, Phuong, Debbie and Nina for providing me with inspiration and to my grandchildren, Trinh and Harry, who bring so much joy and wonder to my life. Thanks also to Bruce Sandell, my husband, who has always given me the space in which I could nurture my own work, a beautiful garden to sit in and music. I would also like to thank the late Arthur Sandell for his encouragement and my dear neighbour Helen Bowman for her friendship.

I am deeply indebted to Raphael Crickmay for his patient technical support, Nina Burstal for her loving kindness and to Phuong Dang for providing readings, comments and thought provoking reflections. Thanks to Dr. Scott Brook for his wonderful assistance and suggestions and thanks to Dr. Debbie and Gabriel Warren for their thoughtfulness, love and encouragement and for bringing Harry into the world in 2011. For accompanying me on this journey, teaching me much about courage and working from the heart, thanks are also due to my beautiful friend and colleague Elham Tawfiq.

Chapter 1: An Orientation to the Research: Taking another Track

The architect of mandatory sentencing, Stone, ran the 1997 election campaign on the need to crack down on Aboriginal drunkenness and anti-social behaviour in Darwin. It included a call for Territorians to monster and stomp on Aboriginal itinerants...and Stone—who once referred to Australian of the Year and respected Aboriginal leader Galarrawuy Yunupingu as ‘just another whingeing, whining carping black’—lead the CLP back into office.

‘Coalition Dirty 30: Part 1’ (Graham & McQuire, 2007)

1.1 Introduction

This chapter is an open invitation to courage and hope. It asks the reader to travel throughout relevant literature and to follow a less familiar track of my reflections and ideas, away from much of what is commonly heard and read on the prevalence of alcohol and other drug (AOD) problems among indigenous Australians. The reader is invited to consider and reflect upon the prevalence of these AOD issues among indigenous people in the light of a blood soaked history of invasion, colonisation, genocide and the traumas that have occurred throughout many generations. For some readers, this may be difficult as so often we hear the same refrain of, ‘really, the problems of Aboriginal people with drugs and alcohol...It is just too hard...The problem is overwhelming...You could throw money at it, but would that change anything? What can you do?’ (Anonymous personal communication, 10 December 2008).

This work is an attempt to find a way through the overgrowth of dominant discourse to the sites of both historic and contemporary processes of oppression and to also reveal the powerful layers of narrative approach to life and therapy, which have been laid down over time. For the purpose of this study, oppression refers to the state or process described by

Mar'i (1998) and quoted by Prilleltensky that involves 'institutionalised collective and individual modes of behaviour through which one group attempts to dominate and control another in order to secure political, economic, and/or socio-psychological advantage' (Prilleltensky, 2008, p. 6).

In Australia, problems associated with AOD use are widespread, and most people experience the effects of this prevalence whether it is directly or indirectly. The use of alcohol is enshrined in Australian culture (Lewis, 1997), and other drugs, legal and illegal, are also used widely (Loxley, Toumbourou & Stockwell, 2004; National Health and Medical Research Council [NHMRC], 2010). Alcohol is commonly used both as a part of everyday life and as a part of celebrations (Brady, 2005). As a consequence of the very high rates of use, the community bears witness to a range of harms such as increased rates of violence and suicide, health issues and accident trauma. According to NHMRC (2010), over half of the alcohol consumed in Australia is done so in a manner that poses short-term health risks to the drinker with nearly 40% of the alcohol consumed posing long-term health risks. The AOD problem among indigenous Australians is even more serious (Australian Government Department of Health and Ageing [DHA], 2007; Wilson, Stearne, Gray & Sagers, 2010). This situation has developed over time and can be linked to a range of historical, social, personal and cultural factors that will be explored in this thesis. Despite the widespread damage related to this high prevalence of AOD-related problems among indigenous people, many common contemporary models of AOD treatment do not address the underlying issues that may contribute to an individual or many individuals from within any particular population group to seek relief in substance use. It is a matter of public health to address and seek to eliminate racial and/or ethnic disparities (Sotero, 2006). In order to do so, the social and historical climate in which people live must be acknowledged. Thus, the scope of this thesis considered in light of research literature is to examine how mainstream services may

find pathways towards working appropriately with indigenous people who are seeking help with AOD issues. The emphasis is not only on AOD treatment. A holistic approach to healing is proposed in order to empower people to recover and to develop a greater sense of autonomy in the journey away from addiction. Therefore, the aim of this thesis is twofold: i) to further explore the connection between AOD problems among indigenous Australians and historical and current trauma-related issues to colonial practices (Brady, 2005; Gray, Pulver, Siggers & Waldon 2006; Human Rights and Equal Opportunity Commission [HREOC], 1997), and ii) to emphasise the need for mainstream AOD services to use practices that are holistic, culturally relevant and acceptable to indigenous clients (Gray, Stearne, Wilson & Doyle, 2010; National Indigenous Drug and Alcohol Committee [NIDAC], 2010).

I have chosen to explore the potential of narrative therapy (Freedman & Combs, 1996; White, 2000; White & Epston, 1990) because narration is the primary means by which human beings construct meaning out of experience, and, as Bacon (2007) so eloquently pointed out, it has an implicit cultural connection to indigenous ways. This process is informed both by social constructionist theory and a sincere desire that indigenous Australians receive culturally safe counselling that does not re-victimise the person seeking help.

The constructionist theory argues that reality is created and experienced individually and, thus, acknowledges the possibility of multiple, equally valid realities that are contextually obtained (Patton, 2002). A social constructionist/narrative-counselling position is concerned with which stories serve to support the existence of problems, which narratives demonstrate exceptions to the problem, what type of language is privileged and how an individual's experience of reality is socially constructed (Freedman & Combs, 1996). I have been driven in this venture by an acute sense of social justice and compassion that challenges the very existence of the *too hard* refrain and the reductionist interventions.

1.2 Revisiting the Site of History

The losses experienced by indigenous Australians due to colonisation, such as the taking away of land, culture and freedom (Maynard, 2003; Reynolds, 1999), make indigenous people the most disadvantaged of all peoples who live in Australia (HREOC, 1997).

Following the forced removal of the traditional owners of the land, many of whom were incarcerated, white Australia has prospered on what has been extracted from the soil, sand, rock, rivers and ocean. In the process, the country and its owners have grown rich. For many years, particularly between the First and Second World Wars, there was an assumption that the first nation people would either die out or assimilate, biologically and culturally.

Whiteness of skin was viewed as a signifier of racial superiority, and efforts were made through social control to encourage unions between *half caste* women and white men aimed at eradicating blackness (McGregor, 2002). In order to pursue the goal of ensuring that, over time, Aboriginality would disappear, new racial theories of white supremacy were created and reproduced, such as those espoused by the Adelaide anthropologist Basedow (1925).

During the eighteenth (Blumenbach, 1775) and nineteenth (Linnaeus, 1806) centuries, racial theories had emerged in Europe, and the notion of race was constructed, arguably, as a result of colonisation and its practices. In Australia, the program aimed at breeding out colour, combined with the labelling of indigenous people as morally and mentally deficient, paved the way for dictating whom one could marry and where one may live. Indigenous Australians often had jobs for which they received little or no pay, a practice that provided great economic benefit to the colonisers (Branford, 2004; Haskins, 2005).

It can be argued that although some of the particular forms of oppression may have changed, social control of indigenous populations continues, and it does so with the development of many practices including that of humanistic colonisation (Bowers, 2008).

Indeed, according to some authors, psychology and its practices have produced new forms of

social control through abnormalising difference (Prilleltensky, 2008; Sonn, 2004). New discourses now articulate the perceived deficiencies of indigenous people.

1.3 Background to the Study

Much of what has been written on indigenous people, their health and life expectancy is deeply disturbing. For example, according to the DHA (2007), the life expectancy for indigenous people is 20 years lower than for non-indigenous people and it has been estimated that alcohol is a factor in 50 per cent of early deaths. Depression, anxiety and suicide are reported as being highly prevalent and although, as Tatz (2001) argues, the real numbers are probably unknown, suicide rates for young indigenous males aged between 15 and 24 in Queensland are reported as being three and a half times higher than that of non-indigenous males in the same age group. Despite the vast amount of evidence that has been gathered that overwhelmingly supports the need for a range of culturally acceptable services to indigenous people with AOD issues, very little is being done. Findings from a Royal Commission (HREOC, 1997) and numerous reports (Gray et al., 2010; Loxley et al., 2004; NIDAC, 2010) point to the urgent need for more services and long-term planning, which would include longer term funding of programs, more staff and the introduction of culturally safe and relevant practices. Clearly, priority must be given to funding community-initiated and community-run indigenous AOD services as recommended by HREOC in 1997 and by NIDAC in 2010. The aim of this thesis is not to argue that an increase in funds be given to mainstream services at the expense of indigenous community-initiated and community-run services, rather the concern is simply that as mainstream AOD services exist in order to provide services to all people in the Australian community, and as some indigenous Australians use them, consideration must be given as to what type of counselling may be appropriate for each individual.

Counselling theories have generally been regarded as offering a true picture of both the clients' problems and the appropriate therapeutic responses (Hansen, 2006). Citing Bhatia (2002), Davidson (2000), Misra and Gergen (1993), Mogghadam (1987) and Sinha (1997), Sonn (2004) has noted that as psychology is rooted in Western culture, that the transportation of its theories and practices to other cultures without critiquing its constructions is problematic. It has been argued that when working with clients from minority or culturally diverse backgrounds, the provision of counselling services that assume the correctness of Western theories and practices over any other can be damaging to the individual's sense of identity (Sue & Sue, 2008). Further, in relation to working with indigenous clients, Sonn states that 'generally, people would say that the individualism that underpins much of Western psychology is in conflict with Aboriginal and Torres Strait Islander worldviews and cultural frames of reference, which include different understandings of "personhood"' (Sonn, 2004, p. 307).

With this in mind, this thesis aims to explore the literature and propose the inclusion of practices into mainstream AOD counselling that are culturally appropriate for indigenous Australians and neither pathologise nor ascribe deficit to the client (Gergen, 1990).

1.4 Motivation for Choosing this Topic

The decision to follow this topic of investigation arises from personal experience, as I have worked with indigenous and non-indigenous people in a counselling capacity, and from a desire to find better ways of working with not only indigenous clients, but all clients that truly respects cultural differences. My values and motivations are deliberately transparent and evident in this work.

1.4.1 Statement of Personal Experience as Background to the Research.

The desire to do this research has come from my own experiences as a woman, as a counsellor and as a client. I was born in Melbourne and grew up in a sometimes spiritual and

emotionally warm and sometimes volatile environment that was due to my parents' problem use of alcohol and prescription drugs. From the age of 11, I regularly found myself calling ambulances to the house I shared with my parents, and a number of Sunday mornings were spent sitting alone in the emergency department where I awaited the outcome of my mother's latest overdose. On these occasions, my father would be at home, unable to get out of bed.

One day, when I was 12, an elderly woman with a loud laugh and a broad Cockney accent asked me what I was doing there, in the hospital waiting room, alone. For some reason, I did not feel ashamed and simply told her that my mother had taken a large overdose of sleeping pills and that I was waiting to see if she would recover. The woman then told me a story, of a childhood much like my own, and described her feelings of anger and sadness at having to shoulder adult responsibilities at an early age, which included feeling responsible for her parents who were both frequently drunk and abusive. As she rose to leave, she bent over me and said, 'Never mind dear, in a few years you will be able to escape it. I did; just don't you start drinking because that'll only lead you to more heartache' (Personal communication, August, 1967).

I dwelled upon those words for days and made a decision that I would seek a different life for myself, away from alcohol problems and despair, as soon as I was able.

The story that the woman in the hospital waiting room told me was an invitation to use the knowledge that I had gained of what I did not want in my life to choose a different life for myself. Exposed to chaos and growing up quickly, I believe that in my formative years I developed both strengths and vulnerabilities that have contributed to my understanding of human suffering and some of the paths of migration that lead away from it. My brother's life ended tragically at 33 owing to AOD issues.

All of these events have expanded my understanding of and my ability to sit with human suffering, and they also led to my interest in working with those whose lives are

affected by AOD use and other problems. My early adult years were difficult and not without cost to myself and others because it took some years for me to accept myself and to feel whole. I am not an indigenous Australian woman, but I am of mixed blood having some maternal Maori ancestry. I have always felt a connection to Maori culture and to what could be described as an indigenous aesthetic (Bowers, 2008).

I took a Maori name as an adult after being told that I was no longer entitled to use my birth (father's) name, which was Italian. Searching for a suitable surname and trying to construct an identity that would not involve taking on the name of a former male partner, I decided to go to the mitochondrial DNA line, and with the help of a Maori mentor, I chose something that spoke to me: *Hine Moana*. It means 'ocean woman', and to take this name seemed fitting. The other suggestion that my mentor proffered was *Hine Ngaro*, which means 'lost woman'. The latter may have more accurately reflected my ancestral history of migration, adoption, illegitimacy and shame, and I have no ancestry to recall, no *whakapapa*, which is a major personal shortcoming in terms of Maori culture. I have seen the faces of racism and witnessed indigenous people's struggle for land rights and acknowledgement of past wrongs in New Zealand and in Australia. I have visited sacred sites and felt welcomed, and I have visited sites of suffering and despair where the darkness has seemed impenetrable. Having experienced such darkness, I have found healing in sitting with myself and others, witnessing, and working towards positive change. I have learned the value of not feeding the dominant story of deficit and instead tease out the golden threads of the implicit story, the hidden one that tells of heroism and compassion and soulfulness. I have heard many problem-laden stories from clients and witnessed their sighs of relief and the beginnings of hope to appear when using narrative, even if tentatively at first. I can also suggest that there are other ways of looking at the story.

1.4.2 Motivating Social and General Factors.

Indigenous Australians are much more likely to be poor, unhealthy, unemployed, scantily educated and addicted to alcohol or other drugs than any other cultural group in Australia (HREOC, 1997). Much is written and said about this population, and like many other indigenous peoples they have been the subject of a great deal of research (Smith, 1999). That AOD use is a problem for many indigenous people is well documented (Loxley et al., 2004; NIDAC, 2010; Wilson et al., 2010), as are the devastating effects that this problem frequently has on health, life expectancy and on every other aspect of psychological, social and cultural life (Catto & Thomson, 2008). It is also reported that there are multiple barriers to indigenous people both seeking and accessing AOD treatment (Catto & Thomson, 2008; McKelvie & Cameron, 2000; NIDAC, 2010).

Despite the development of cross-cultural competence (Sue & Sue, 2008) being described as an important part of counsellor education at universities (Baird, 2008), many AOD services offer treatment and practices based on reductionist approaches, which do not necessarily address a client's experiences of racial or cultural identity. Many current AOD interventions do not address critical psychosocial and historical factors that have contributed to the prevalence and severity of AOD problems among indigenous people (HREOC, 1997). In addition, interventions that may be seen as helpful in reducing AOD harm in the general Australian population cannot be assumed to be either as effective or even appropriate in working with indigenous clients (Gray et al., 2010). Prilleltensky and Nelson (2002) have argued that psychology and its practices, based on a Western construct of individual agency, may at times, have the potential to blame the victim. Further, both Bowers (2008) and Akinyela (2002) emphasise the importance of working with indigenous peoples in a manner that is empowering and does not contribute further to experiences of colonial oppression. The

aim of this paper is to highlight the inadequacies of current responses to the AOD problems of indigenous Australia and identify a more effective and culturally relevant path forward.

1.5 Why Choose Narrative Therapy?

Narrative therapies is a form of counselling or talk therapy that, although generally credited to White and Epston (1990), is acknowledged as having been derived from collaborative work done by non-indigenous and indigenous practitioners. Perhaps due to its engagement with power, language, culture and context (Freedman & Combs, 1996), it has been described as offering a culturally acceptable form of counselling that can be used with Australian indigenous people (Bacon, 2007; DHA, 2007; Towney, 2005; Wingard & Lester, 2001). Essentially regarded as a postmodern (Corey, 2005) or post-structuralist therapy (Akinyela, 2002), narrative practices avoid the use of language that may attribute deficits to the individual with the problem or contribute to the client's problem narrative. As an example, the use of common terms such as addict or alcoholic may effectively support the construction and the maintenance of a problem infused identity in the individual seeking help (Winslade & Smith, 1997).

In narrative therapy, the avoidance of such language creates a shift in how problems are thought about and responded to and therefore opens up the possibility that clients need not define themselves by their problems. Narrative therapy is concerned with how stories and identities are constructed, how dominant discourses or the problem story come into being and how the problem story is maintained (Freedman & Combs, 1996). In narrative therapeutic practice, stories that are exceptions to the problem narrative are sought in order to highlight the possibility of outcomes in which the client may experience freedom from the problem (White & Epston, 1990). These exceptions are frequently used to acknowledge the individual's own strength and resilience and to talk about the times when the problem did not seem to have so much of an effect. Both in theory and practice, narrative therapy is concerned

with the role of power and examines problems in a social, cultural and political context, factors considered by both Lamerton (2006) and Prilleltensky (2008) to be of critical relevance to counselling practice. Further, narrative therapy uses clients' stories (Bacon, 2007) and recognises the central role that these play in constructing and interpreting experience. This is highly relevant to working with indigenous clients, and in indigenous Australian culture, the role of the storyteller and the place of the narrative is not only central it is all pervasive (Hume, 2002). For human beings, story is essential for context, for identity and for culture. In a culture that has suffered the effects of genocidal policies for decades (Foley, 2008), the role of the story is of particular significance, for as long as there have been survivors to pass on the story to, the culture cannot be extinguished. Towney wrote of there being 'healing in the yarn' (Towney, 2005, p. 39) and many other indigenous workers and counsellors are using and developing narrative ways of addressing AOD problems (Bacon, 2007; Wingard & Lester, 2001). Narrative work in indigenous contexts has been developed in partnerships with indigenous counsellors and health workers as it not only intersects with existing indigenous healing practices but is a way by which people can examine their own lives and experiences in such a way as to strengthen the threads of stories of resilience and courage. According to Freedman and Combs (1996, p. 43), 'discourses powerfully shape a person's choices about what life events can be storied and how they should be storied. This is as true for therapists as it is for the people who consult them'.

Chapter 2

2.0 An Overview of the Severity and Depth of the AOD Problem among Australian Indigenous People

2.1 The Prevalence of AOD Problems amongst Indigenous People

As mentioned in the previous chapter, AOD-related harm is a cause of significant concern in Australia and is an issue of particular and critical concern in relation to Australian indigenous peoples (Loxley et al., 2004). There is a substantial body of evidence to support the view that socioeconomic and cultural factors play a significant role in how, when and why AOD use problems develop, and studies have demonstrated that patterns of use as well as the extent and range of harms experienced have been shown to vary significantly between indigenous and non-indigenous Australians (Brady, 2005; DHA, 2007; NIDAC, 2010; Wilson et al., 2010). Overall, more harm is caused by the use of licit drugs, such as alcohol and tobacco, than from the use of illicit drugs, but illicit drugs contribute significantly to injury, poor health and violence. In addition, illegal drug use is also frequently connected to a range of illegal behaviours and subsequently to a range of associated negative consequences both for the user and for others in society. Both licit and illicit drugs have been found to negatively impact work, interpersonal relationships and community (Catto & Thomson, 2008).

NIDAC (2010) has reported that although indigenous people drink less often (that is, on fewer occasions or on a less regular basis) than other Australians, over 60% of indigenous people drink alcohol at either long-term or short-term harmful levels. This is around twice the rate of harmful drinking rates of non-indigenous Australians. NIDAC (2010) has also reported that indigenous Australians have been found to use drugs and alcohol in what may be described as a harmful manner more frequently than non-indigenous Australians. As discussed by Wilson et al. (2010), although reports of alcohol-attributed deaths among

indigenous people appear to have varied according to geographical location, in Central Australia the rate is more than triple the overall rate of such deaths across Australia. Illicit drug use has also been related to significant levels of mortality and morbidity, and among indigenous Australians the rates for illicit drug use have been shown to be twice that of the non-indigenous Australian community. It has been reported that the most common illicit drug used by both indigenous and non-indigenous Australians is cannabis (Catto & Thomson, 2008).

According to Brady (2005), the majority of people in indigenous communities cite alcohol use as a problem and this problem is reported to be a factor in high imprisonment rates, most events of violence in families and in 75% of homicide. However, according to the DHA (2010), contrary to what is often assumed, more indigenous Australians than non-indigenous Australians actually abstain from alcohol. This suggests a further cultural difference in how alcohol is used by non-indigenous and indigenous Australians (Brady, 2005; Catto & Thomson, 2008; DHA, 2007). In addition to alcohol problems, reports have suggested that the problem use of prescription drugs, illicit drugs, volatile substances and kava have all been higher for indigenous Australians than for non-indigenous Australians and that illegal drugs are used even more frequently by indigenous Australians living in urban areas. In relation to the use of volatile substances such as glue, gases and aerosols, the NHMRC (2010) has reported that the prevalence of use has been difficult to determine as these substances (petrol, solvents, lighter fluids and glues that can be inhaled to give an effect) are used predominately by juveniles, many under the age of fourteen who may, therefore, not be recorded in national drug surveys. Evidence of prevalent use of volatile substances has been reported to be scarce as its use does not constitute an offence, although it is seen as antisocial and users generally make attempts to conceal this behaviour. Nevertheless, the use of volatile substances causes sufficient concern in some indigenous

community as it can injure the brain and lead to death. Due to the risks, in some communities only avgas and diesel fuels are sold (Bartlett, 1995).

2.2 AOD-Related Harm and Imprisonment

On working in Australian prisons, Denborough reports that ‘the first crucial learning was that men like me—white, middle class men—are generally not found in the prison system’ (Denborough, 2001, p. 73).

White people, or non-indigenous Australians, are far less likely to be incarcerated than indigenous Australians. It has been reported that rate of imprisonment for indigenous people is thirteen times that of the rate for the wider community and that indigenous prisoners are more likely to have used alcohol, cannabis or amphetamines prior to the offending behaviour (Catto & Thomson, 2008). Higher rates have also been reported for alcohol and cannabis dependence among indigenous prisoners. NIDAC (2009, 2010) has repeatedly expressed concern over the high rates of imprisonment of indigenous Australians and has described the high imprisonment rates of juveniles as alarming. The strong connection between the complex issues faced by indigenous people, AOD issues and incarceration rates have been, and continue to be of great concern to NIDAC, who has argued repeatedly that this is an area requiring urgent action from the government.

Once in prison, people face significant risks. Violence is widespread as are conditions that produce and reproduce despair (Denborough, 2001). Psychosocial factors bear a strong relationship to indigenous problem drug use in Australia (HREOC, 1997) and around 60% of indigenous prisoners reportedly use drugs on at least one occasion during their time in prison. On the subject of minimising harm in prisons through the introduction of controlled needle and syringe programs in Australia, Anex (2010, p. 3) reports that it is ‘an indisputable fact that illicit drugs enter correctional facilities regardless of the level and sophistication of security measures’. What is also of grave concern to many is the reported high prevalence of

syringe sharing among prisoners, and this practice has been found to be even more common among indigenous prisoners (Hepatitis Australia, 2010; Victorian Alcohol and Drug Association [VAADA], 2010). While other practices such as tattooing, piercing, unsafe sex and acts of physical violence also pose significant risks in terms of the spread of blood-borne virus (BBV) infections like HIV/AIDS and hepatitis C, it is possible to reduce the spread of BBV risks through the provision of needle and syringe programs (NSPs), which have been shown to be an effective measure in reducing the spread of BBVs (Hepatitis Australia, 2010; Loxley et al., 2004). This option has not been made available to prisoners despite VAADA (2010) reporting that drugs including those used intravenously, have been found to be readily available and used widely in Victorian prisons. The predominant view of those with the power to change this situation has been that prisoners should not have access to illegal drugs; yet, as mentioned earlier, there has been substantial evidence from both European (Stover & Nelles, 2003) and Australian (Anex, 2010) studies that drugs and injecting equipment are commonly used by people in prison. According to a report commissioned specifically to review the evidence on preventing substance use, risk and harm in Australia (Loxley et al., 2004), an NSP should be trialled in Australian prisons. The World Health Organization (WHO) has been recommending the introduction of such programs for the past twenty years. WHO has made this recommendation in respect of the principle of equality of health care for prisoners (WHO, 1993). Anex (2010) has argued that Australian prisons in five states and territories effectively acknowledge that illicit drug injecting in prisons does occur, as many provide the prisoners with bleach so that an attempt may be made to clean a syringe before or after injecting. The issue of BBV being spread in prisons has been an expressed concern of many involved with AOD, indigenous and prisoner health. In June 2010, this issue was raised by a delegate during a panel discussion at the inaugural NIDAC Conference (2010) in Adelaide. When asked to make a response to the evidence supporting the introduction of

NSPs in prisons the Chief Executive Officer of Correctional Services in South Australia, Peter Severin stated that as any prisoners using illicit drugs during their incarceration was engaging in an illegal activity that there was no plan to introduce needle and syringe exchange programs.

The governments of some countries have accepted WHO's recommendation. For instance, after evaluating the benefits of NSPs in prisons in Europe and the social costs of not providing such services, the Swiss Federal Ministry for Justice has officially confirmed the legality and necessity of such practices (Stover & Nelles, 2003).

2.3 A Historical Overview: Past and Present Factors that Contribute to the Problem

The reported prevalence of harmful use of alcohol and other drugs among Australian indigenous peoples may be attributed to multiple and complex factors that include the effects of colonisation on traditional values, historical trauma and the breaking down of cultural ways. The following paragraphs will address these issues.

2.3.1 Prior to Colonisation.

Prior to colonisation in some areas of Australia, indigenous peoples sometimes used intoxicating or mind-altering substances. As with some European practices such as the social and ritual use of alcohol, psychoactive substances made from plants were used in a social context, and tribal law protected the community by controlling the use of such substances. Using them was a part of cultural life for some peoples, and there is no evidence that their use was experienced as problematic (Brady, 2005). Indigenous people living in traditional societies lived in social and cultural climate that has been described as *optimal* for the maintenance of mental health (Purdie, Dudgeon & Walker, 2010).

Harm associated with drugs and alcohol came to indigenous people through the introduction to communities of new substances, the subsequent enculturation of very dangerous practices associated with these, modelled on the behaviour of hard-drinking

Europeans (Brady, 2005; Lewis, 1997), the breakdown and destruction of culture, the forced breaking apart of families and the subsequent widespread effects of loss and trauma (HREOC, 1997; McKelvie & Cameron, 2000; O'Shane, 1995; Reynolds, 1989). Prior to the white invasion, everything had a story (Brady, 2005), and in indigenous cultures, knowledge of how to live and how to engage with all that is around was traditionally passed down through narrative. According to Brady, many indigenous people have spoken about how the Whites never taught indigenous people how to drink safely and that the story for grog was not given.

2.3.2 Worldview: Values and Ethics.

There is no attempt here to explicitly convey the values and ethics of individual or of particular groups of indigenous people, but it is an attempt to highlight some of the differences between values and ethics found among many indigenous people and the colonisers. Prior to the arrival of Europeans, indigenous people in this country had a holistic worldview. In this view, everything was connected and dreaming was not just an event in the past, but a dimension of ever present reality, a spiritual realm that played an important role in the construction of the very fabric of existence. There were ways of doing things and ways of not doing things, and certain things were forbidden and many things valued. The values and the ethics of these traditional peoples were based on knowledge and powerful understandings of experience (Hume, 2002).

Fundamentally, the invasion and subsequent colonisation of this country not only involved loss of land, culture and liberty but also involved systemic genocide, which has affected every aspect of life for indigenous people (Maynard, 2003; Ranzijn, McConnachie & Nolan, 2009; Tatz, 1999). Among indigenous people, well-being has continued to be profoundly affected by ongoing anger, grief and loss that began with the dispossession of land and is perpetuated through ongoing trauma and loss (Adermann & Campbell, 2007).

Hunter (1993) examining the prevalence of harmful behaviours in an indigenous community eloquently described the relationship between powerlessness, substance abuse and violence. In addition to these factors, social disadvantage has been found to have directly affected social, emotional and physical health (HREOC, 2006).

2.3.3 Historical Trauma.

As with many other indigenous or first nation peoples worldwide, the effects of colonisation and the subsequent experiences of racism and oppression have continued to affect psychological, physical and social health. These experiences, both past and present, have combined to support the construction of a psychosocial environment in which AOD problems have become widespread (Brave Heart, 2004; Carvajal & Young, 2009; HREOC, 1997). This paper will now examine the role that historical trauma may have played in contributing to problem substance use among indigenous Australians.

Citing Yellow Horse Brave Heart, Denham (2008) defines historical trauma as ‘Cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences’ (p. 7). Denham also states that it must be made explicit that there is a difference between historical trauma and a historical trauma response.

According to Denham (2008), historical trauma is a construct used to describe the suffering of many peoples who have experienced directly or trans generationally the effects of such events as genocide, war, enslavement or colonisation. This author defines historical trauma response as referring to the emotional and psychological effects of the historical trauma on groups of people or on individuals, such as depression, anxiety, suicidal ideation, anger, violence, and AOD use. According to Denham (2008), these effects of trauma may also be pathologised, and according to the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000), used by many mental health clinicians,

they may be regarded as constituting evidence of mental illness or a disorder. Denham (2008) emphasises that understanding that resilience and resistance can equally be regarded as historical trauma responses can widen understanding and increase the potential for healing emotional and psychological wounds. In addition, by not requiring that an individual manifest what is commonly described the pathology of historical trauma response in order for it to be recognised that this trauma has occurred, individuals, groups and families who have experienced the historical conditions of war, genocide, enslavement or colonisation of their people may have the historical trauma acknowledged.

The intergenerational transmission of trauma described by Blanco (Levine &Kline, 2007) describes a cycle of violence and substance abuse amongst colonised peoples in South America that can be mapped onto the history of post- invasion Australian indigenous societies. Atkinson ((2008) reporting on the relationship between the historical events of colonisation and the social breakdown of indigenous societies, cited problems with violence, mental health issues, suicide and substance abuse issues as occurring across generations.

Although there has been substantial evidence to support the view that historical trauma and trans- generational trauma (Atkinson, 2008) is a part of the lives of many indigenous Australians, at the same time, for many, resilience and resistance have been and continue to be part of the story. Strong narratives of indigenous people fighting to defend their land, rights and freedom abound, yet many Australians have been unaware of many aspects of their own history including indigenous resistance movements (Reynolds, 1989).

In order for the disparity in health and well-being between indigenous and non-indigenous Australians to be addressed, service providers must have sufficient insight into how this disparity came into being (Sotero, 2006). Once it is seen that there is historical trauma at the root of many of the problems that come about in the lives of colonised native populations, a case can be made for the inclusion of responses to these problems that directly

address the effects of trauma and support indigenous people to reconnect in a positive manner with cultural identity. These factors are reported as being critical factors in facilitating healing (Brave Heart, 2004; Hunter, 1995; Whitbeck, Chen, Hoyt & Adams, 2004).

In the Americas, some practitioners who work with indigenous peoples struggling with AOD issues have examined some of what has been learned about historical trauma therapy from Holocaust research and considered how this may be of relevance to colonised indigenous peoples. Recognition that genocide has occurred has been found to be an important part of the healing process as has been emphasising the strengths of those who have suffered (Brave Heart, 2004; Carvajal & Young, 2009; Duran & Duran, 1995).

2.3.4 Further Traumas: Removal of Children and Forced Separation.

In the *Bringing Them Home Report*, the HREOC (1997) stated that the well-being of indigenous Australians today still suffers from the effects of trauma brought about by the breaking apart of families, the forced removal of children, and the subsequent fostering out and institutionalisation of children. This was occurring in Australia until the 1970s. It was found that these events were linked to a range of harms. As stated previously, indigenous Australians have been, and remain, the most disadvantaged of all people in Australia, and the report stated that this disadvantage and the AOD problem *are* both consequences of the loss and trauma suffered by families whose children were taken away. Many authors have asserted that the reported AOD problem among many colonised indigenous peoples in Australia and elsewhere is a political and social issue and that the reported high prevalence of AOD harm among indigenous people bears a relationship to historical trauma grief (Brady, 2005; Brave Heart, 2004; Carvajal & Young, 2009; Duran & Duran, 1995; McCabe, 2007; McKelvie & Cameron, 2000; Ranzijn et al., 2009). The use of alcohol and drugs to cope with emotional and social stressors has been widely documented and in the case of licit drugs,

their capacity to affect feelings, thoughts and behaviour has been a factor widely promoted by legal drug producers to advertise the benefits of use of tobacco and alcohol (Raven, 1997).

Further, it has been reported that high levels of shame, low self-esteem and poor self-image have been found to be commonly experienced by colonised indigenous peoples and that these factors have been reinforced and amplified by exposure to ongoing discrimination, racism and prejudice (Carvajal & Young, 2009). These conditions, toxic to individuals and communities, have been found to be commonly associated with AOD use problems (Brady, 2005; Foley, 1997; Foley, 2008; HREOC, 1997). Cultural messages that have lead indigenous people to have regarded themselves as different to, and indeed less than non-indigenous Australians have taken many forms, some of which have been insidious, such as the type of humanistic colonialism enacted through counselling practices, as described by Bowers (2008).

2.3.5 Socioeconomic Factors.

Problematic drug use in any community bears a relationship to socioeconomic factors such as education, income and levels of employment (Catto & Thomson, 2008; Loxley et al., 2004), and the link between disadvantage and problematic AOD issues within the Australian indigenous community has been widely reported (Australian Bureau of Statistics, 2008; Wilson et al., 2010). The Steering Committee for the Review of Government Service Provision, (2009), claimed that over recent decades, employment and educational outcomes have been improving for indigenous people, yet by every measurable social indicator of advantage the economic and social capital in Australia has continued to be held by the non-indigenous community and the gap remains vast. As a result, colonised indigenous people in Australia and elsewhere have been suffering physical, emotional and social harm including high mortality rates and lower life expectancy related to AOD use. For indigenous males, suicide has been the number one cause of alcohol-attributed death, with liver disease, stroke,

road accidents and violence also reported as common causes for both genders (Wilson et al., 2010).

2.4 Response

Counsellors have a critical role to play in affecting better outcomes, but in order to work effectively with diverse populations, and specifically with indigenous people, they must first examine their own values and sense of ethnicity (Corey, 2005; Sonn, 2004; Sue & Sue, 2008) and examine the discourse on what it may mean to be white (Green & Sonn, 2005). In addition to such self-reflective practices, there is a need for AOD counsellors to investigate and adopt counselling interventions with indigenous clients that support recovery from historical trauma in addition to responding to the presenting AOD problems (HREOC, 1997).

Government, apart from providing sufficient ongoing funding for an expansion of indigenous-run AOD services must ensure that mainstream AOD services are in a position to provide holistic, timely and appropriate treatment and support to indigenous clients (NIDAC, 2010). By working in partnership with indigenous stakeholders, not only may more culturally relevant responses be developed by mainstream AOD services, but further damage can be avoided. What is not needed is another enactment of colonialism through therapy as described by Bowers (2008), but strategies that are well funded, long term and holistic (Catto & Thomson, 2008).

The following lyrics, written by Archie Roach, describe his own experience of being taken away from his mother. This event, one of many such kidnappings, occurred in Australia in the late 1950s. 'Told us all the white man's ways/Then they split us up again/and gave us gifts to ease the pain/Sent us off to foster homes/ as we grew up we felt alone/Cause we were acting white/But feeling black' (Roach, 2000).

Chapter 3 Exploring Barriers Experienced by Indigenous People Seeking to Change Harmful Substance Use

3.1 Barriers to Using Indigenous-Run Services

It has been widely reported that indigenous Australians experience significant barriers in accessing appropriate AOD treatment (Catto & Thomson, 2008). Many reasons may be cited for this, some of them complex and some simply a matter of insufficient resources being made available (Gray et al., 2010). There have been a diverse range of services and programs initiated and run by the indigenous communities, which have come about in response to the prevalence of AOD use problems within these communities. Initiatives have included night patrols, sobering up centres and various forms of recovery and healing work (McKelvie & Cameron, 2000). As will be discussed, not all indigenous people have been able to access these services and some have not wanted to use indigenous services due to personal, social or cultural reasons. Admitting to having a problem with alcohol or other drugs has often been associated with feelings of shame and some individuals, indigenous and non-indigenous have preferred the anonymity of using a service not connected to their own community or group (Teasdale et al., 2008).

An enormous barrier to treatment has been, and remains, a critical lack of services in many geographic locations. In addition to this, where they do exist, Aboriginal community-controlled services have been severely hampered by insufficient resources and short-term funding cycles (Catto & Thomson, 2008; NIDAC, 2010). Supporting the long-term growth of indigenous community-controlled AOD services as recommended by HREOC (1997) and NIDAC (2010) is a matter of great urgency as is an increase in the indigenous AOD workforce at all levels (Robertson, Haitana, Pitama & Huriwai, 2006). In addition to providing adequate and culturally appropriate services, there is also a critical need for an

increase AOD research using indigenous methodologies (Gray, Pulver, Saggors & Waldon, 2006; Smith, 1999).

3.2 Barriers to Using Mainstream Services

Although in theory available to indigenous people, many mainstream AOD services have been found to be not readily accessible, affordable or seen as culturally safe by indigenous people and little is done to address this issue (Loxley et al., 2004). According to NIDAC (2010), there has been a failure of mainstream AOD treatments to address indigenous needs and this view is supported by Wilson et al. (2010). Further, according to McKelvie and Cameron (2000), the history of patronising, controlling and authoritarian attitudes of white health workers over a long period combined with the lack of respect demonstrated for cultural beliefs and history has impacted heavily on how services have been regarded by indigenous people. Some AOD agencies have been described as demonstrating cultural values and practices that not only fail to support an individual's positive sense of cultural identity but may be experienced by some as threatening (Curtis & Harrison, 2001; McKenzie, 1997).

The Aboriginal Council of South Australia in conjunction with the Dulwich Centre in the *Reclaiming our stories, reclaiming our lives* project (1995) made some recommendations as to how some improvement may be made. They reported in 1995 that in order for AOD services to understand the barriers that exist for indigenous people seeking treatment there needed to be an enhanced understanding of how many indigenous people regard or experience AOD services.

3.3 Lack of Services

Overall, it has been widely demonstrated that there have been simply insufficient culturally appropriate services available for indigenous people (Catto & Thomson, 2008; NIDAC, 2010). Despite the evidence of AOD use among indigenous people being a critical

health issue (Brady, 2005; Catto & Thomson, 2008; HREOC, 1997), it has been noted by NIDAC (2010) that Public Health Campaigns have rarely targeted this population.

3.4 Cultural Safety

A lack of consultation with indigenous people that has inevitably lead to a subsequent lack of appropriate service provision is also cited as having been a major barrier for indigenous people accessing a range of health services. When services have not had links with the indigenous community and the workers have not been culturally competent, these services may have been experienced as culturally unsafe. Poor cross-cultural communications, including practices such as culturally insensitive questioning, have been reported as a major barrier to treatment for many indigenous people. Overall, the relationship between indigenous people and mainstream health services has been reported to be poor (DHA, 2007; Wilson et al., 2010).

An individual's sense of self-agency is an essential factor when effecting and maintaining change and this is developed through personal empowerment (Hook, 2007). A study of an urban AOD program reported that clients often felt disempowered by the strict rules and objectified by the categorisations made between licit and illicit drug users and by the subsequent moral encoding that occurred (Curtis & Harrison, 2001). Reporting on working with indigenous people in Aotearoa, New Zealand, McKenzie (1997) described Maori as sometimes having felt blamed by health workers for their AOD problems.

Further, McKenzie stated that the type of language frequently used in AOD services may be experienced as alienating and further argued that an effect of using medical and diagnostic language may lead to a loss of an individual's sense of their own power, or *rangatiratanga*, (sovereignty). Culturally insensitive styles of assessment were reported to have been counterproductive. Many clients, McKenzie reports, have been reluctant to engage with services as the demands of the intake process alone have been experienced as intrusive

and many indigenous people have reported feeling worried about telling anyone much about their AOD use. Given the incarceration rates for indigenous AOD users, both in Australia (NIDAC, 2010) and in New Zealand, it is understandable that many potential clients have expressed concerns about the possible negative consequences of seeking help. In addition, it has been reported that many indigenous people have felt quite suspicious of welfare, health and social workers who over many decades have played a major role in the enactment of oppressive government policies (Foley, 1997; Tatz, 1999). It therefore must be emphasised (Bacon, 2007) that in order to work with indigenous people, counsellors and social workers must be aware of the history of indigenous people, including the role that government authorities have played in the genocide. It is reported that for many reasons, including some related to fear, indigenous people have frequently sought help for AOD problems at a much later stage than the non-indigenous community and often at a stage where significant co-morbidities had developed (Wilson et al., 2010).

3.5 Feeling Blamed and Shamed: Issues of Power

Generally, AOD interventions have enacted the common dominant discourse that has situated problem use of substances in moral failures, or lack of will power. Additionally, many treatment discourses have emphasised that a form of submission is required from the user, such as an admission of alcoholism or addiction (Smith & Winslade, 1997). People with AOD problems may have frequently been treated by a professional who uses language that Gergen (1990) described as attributing deficits to people. Using a social constructionist framework, Gergen described the accumulation of different technologies throughout the twentieth century that have resulted in psychology, at times, attributing qualities to individuals that could be described as inadequacies.

Arguably, in psychology, the standards and values of the white middle class have become the standards against which an individual's healthy development or mental state has

been measured (Fox & Prilleltensky, 1997). It can be said that until recently little consideration has been given to how indigenous peoples may have viewed the world, what may have constituted their experience of life and how that may have differed from that of a white person (Sue & Sue, 2008).

Examining the relevant literature, there is significant evidence to support the view that in order to provide culturally safe AOD services, mainstream services must work in partnership with indigenous Australians (HREOC, 1997; NIDAC, 2010; Wilson et al., 2010) and adopt appropriate holistic theory and practices. Without cultural relevance and without the understanding that many minority clients, including many indigenous Australians, have a non-mainstream or non-Western worldview, any AOD program will not only compromise its capacity to be effective (Carvajal & Young, 2009), but fail to address the person-related and treatment-related barriers faced by indigenous people seeking help in order to address harmful AOD use.

In addition, it has been reported that those in society who have less power and advantage have frequently experienced re-victimisation and that an emphasis on individual agency while not examining socio-political context may, in effect, blame the victim (Fox & Prilleltensky, 1997; Hook, 2007). Power has been defined as ‘the capacity and opportunity to fulfil or obstruct personal, relational or collective needs’ (Prilleltensky, 2008, p. 119). The relationships explored by Prilleltensky between power, wellness, oppression and liberation are critically relevant factors when considering problems experienced by indigenous populations. The importance of empowerment and mindfulness of power and psycho-political validity (Prilleltensky, 2008) will be further addressed in the following chapter that examines the relevance of mainstream AOD models to indigenous populations.

Edward Said (1993) eloquently described the embedded assumption of superiority of the colonisers over the colonised and the role that this plays in serving the ongoing success of

those with power. For non-indigenous counsellors working with indigenous people, the privilege of whiteness and embedded assumptions, values and practices are matters that require careful reflection (Sonn, 2004). In order for counsellors to achieve any level of cultural competency, openness to other worldviews and other ways of interpreting experience is needed.

It is said to be of great importance that counsellors can listen attentively to every person's experience of cultural and racial identity (Sue & Sue, 2008). Listening provides a counsellor with information about how an individual may see him- or herself (culture) and also how he or she experiences what others tell him or her about who he or she is based on their perceptions and categorisations (race). In order to work with clients from diverse backgrounds, counsellors need, in addition to examining their own attitudes, confront their own racism and work towards a high level of self-awareness (Corvin & Wiggins, 1989; Kiselica, 1991).

In examining methodology with an aim towards the decolonisation of theories and practice, Smith (1999) critiqued the privileged position that Western ways of knowing occupy and the way by which the language and culture of colonised indigenous peoples are devalued and invalidated; arguing that in order for inclusive practices to be enacted, indigenous methodologies must be used.

Chapter 4

4.0 How Appropriate are Mainstream AOD Counselling Interventions when Working with Indigenous People?

4.1 Relevance

In this chapter, consideration will be given to the relevance of mainstream AOD counselling in dealing with indigenous clients. Many of the issues raised made could be of wider relevance, particularly in relation to counselling clients from diverse backgrounds, but the analysis of mainstream AOD interventions will be specifically in relation to working with indigenous Australian clients using mainstream AOD services.

According to Ranzijn et al. (2009), indigenous Australian society, diverse as it, constitutes a separate, third-world society that exists alongside of the Australian diaspora. In this post-colonial social climate of dispossession and loss, high rates of violence, unemployment, incarceration and youth suicide compound existing conditions of despair, hopelessness and powerlessness, which in turn increase the use of alcohol and other drugs (Berends, 2003; Brady, 2005; Lamerton, 2006). In the previous chapter, some of the barriers experienced by indigenous people seeking support with AOD issues were examined. In addressing the need for safe and relevant support to help individuals with AOD problems, there is a profound need to examine current mainstream counselling interventions and analyse their cultural appropriateness for working with indigenous people.

4.2 Abnormalising

Psychology has emerged over the past century as both a new science and as a helping profession. Developing primarily in a modernist context, it contains beliefs, values and assumptions derived from a Western worldview (Sonn, 2005; Sue & Sue, 2008). Some writers (Bowers, 2008; Ranzijn et al., 2009) have noted that psychology can be seen to have practiced a form of neo-colonialism on indigenous people. Further, Lawson Te-Aho (1994)

has described the manner by which the application of psychological ideas and therapeutic styles developed from Western cultural perspectives has had a tendency to abnormalise indigenous cultures.

4.3 Positioning Authority

Modernist post-colonial discourse can be read as supporting the view that Western understandings of human behaviour were scientifically accurate (Fox & Prilleltensky, 1997) and therefore could offer objective interpretations of human behaviour. This has resulted in the development of counselling theory and practice aimed at treating various human problems including AOD issues.

The literature on the effectiveness of traditional AOD interventions with indigenous clients is scarce and writing on alcohol-related harm, Wilson et al. (2010) report that culturally sensitive or alternative treatment options for indigenous clients have not drawn consideration until recently. Given the prevalence of AOD related harm amongst Indigenous peoples, this would seem to be an area requiring urgent attention.

Mainstream AOD interventions focus on behaviour change and commonly use cognitive behavioural therapy (CBT) (Beck, 1993), motivational interviewing (MI) (Miller & Rollnick, 2002) and solution-focused brief therapy (SFBT) (De Shazer et al., 1986). Brief intervention therapies such as these, widely used in AOD treatment to support the recovery of many clients, are reported as unlikely to help indigenous people who have complex health issues, a high level of dependency or feel powerless due to complex social and/or family problems (DHA, 2007).

4.4 Cognitive Behavioural Therapy

CBT (Beck, 1993) is a therapist-centred form of counselling and psycho-education that is used widely to assist clients. The basic premise of CBT is that problem behaviour can be changed by addressing the thoughts and feelings that may be experienced before any

particular behaviour is enacted. In CBT, emotional distress is described as being alleviated by correcting the irrational beliefs, attitudes, and thoughts that, unchallenged, may support a client's negative view of self or of the world or lead towards the enactment of unwanted behaviours. Counselling interventions are highly structured and frequently may challenge the client's underlying belief system that may be viewed as supporting particular behaviours. The underlying beliefs that are considered unhelpful are sometimes described as irrational or superstitious. Essentially, CBT targets behaviour change through changes in thinking that will in turn affect emotions or mood and behaviour. CBT is usually a short intervention frequently used in AOD treatment (Marsh, Dale & Willis, 2007).

4.5 Solution-Focused Brief Therapy

SFBT (De Shazer et al., 1986) focuses on the desired positive outcome, therefore on the changes that a client may want to make, rather than focusing on the factors that may have led to the problem developing. It is not concerned with history, or what the client has experienced in the past, but encourages the client to think about future goals. The counsellor may explore with the client the necessary steps that can be taken towards the goal of change and assist the client to construct a plan of action towards that change. It is a brief intervention, designed to facilitate finding solutions, particularly in relation to a specific issue (Corey, 2005).

4.6 Motivational Interviewing

MI (Miller & Rollnick, 2002) invites the client to examine the benefits of maintaining the (unwanted or harmful) behaviour, and the benefits of change. It works with the client's own stated motivations towards the desired outcome. In working with AOD use problems, typically the counsellor would explore with the client what has been experienced as pleasurable in drug using behaviour, and then invite the client to examine what has not been pleasurable, and what the costs of using have been. MI aims lead the client to recognise and

to clarify what motivation he has towards making the desired changes that lead to issues being resolved. MI highlights ambivalence and emphasises discrepancies between thoughts, feelings and actions. It is sometimes described as semi-directive counselling and is used by coaches as well as counsellors. It is also widely used in addictions treatment (DHA, 2007).

4.7 The Locus of Problems and the Place of Power in Discourse

A problem with the widespread application of these models is that when used in AOD treatment, all are focused on changing the client's behaviour in relation to substance use only and do not address issues of trauma, marginalisation, power, history and the social context in which the AOD problems have arisen. Without addressing these issues, it can be argued that the AOD therapies can become another avenue by which the client is invited to experience evidence of his own inadequacy to deal with problems (Winslade & Smith, 1997). White (2007) emphasises the importance to recovery of any client is that the problem is not seen by the client as a definitive reflection of his or her identity. Therapies that are regularly used in AOD treatment are usually brief interventions, aimed at positive behaviour change and may work for many people. The problem that arises with using these indiscriminately is that in locating the source of the problem within the client without paying attention to psychosocial as well as socio-political factors the counsellor may serve to reinforce the sense of deficit in the client (Prilleltensky & Nelson, 2002). In the case of indigenous peoples, who of all groups in Australian society suffer from the highest rates of AOD problem use (Catto & Thomson, 2008), that deficit is frequently seen to be great, and the locus of the problem as being in the individual may compound rather than alleviate the distress that has led to the development of AOD problems (Winslade & Smith, 1997). Sue and Sue (2008) assert that many problems, including drug and alcohol issues, are often the result of systemic external situations such as social injustice, discrimination and prejudice and they also state that if ethnic identity and cultural considerations are not taken into account then counselling may be detrimental—both

in theory and practice. It is highlighted that this is of particular concern when a counsellor is attempting to work with clients who have suffered directly from racism and oppression. Baird (2008) also reports that counsellors who do not sufficiently attend to issues of culture and identity may inadvertently provide interventions that are antagonistic to clients' own experiences and values. These arguments are of particular relevance to counsellors who work with Australian indigenous people who have experienced social and political oppression as well as ongoing trauma from generations of loss (Brady, 1991; Foley, 2008; HREOC, 1997; Wilson et al., 2010). Additionally, the DHA (2007) has recommended that such short-term interventions may not adequately support indigenous AOD clients with significant other risk factors or who had complex social and/or family problems. These risk factors have been reported to be widespread among indigenous Australians.

Adermann and Campbell (2007), writing on the effects of colonisation on indigenous well-being, referred to a range of negative psychosocial and health consequences of forced separation of families and the removal of children. The *Bringing Them Home* report (HREOC, 1997) describes indigenous people as being vulnerable to a range of behavioural and environmental health risks and emphasises the psychosocial effects that generations of indigenous Australians have suffered. Effects of historical trauma on following generations can include poor physical health and impairments in the capacity for parenting (Sotero, 2006); an area often further upon impacted negatively when AOD problems are present.

4.8 A Review of Tools that Change Behaviour

The commonly used interventions used in mainstream AOD treatment each offer counsellors a framework that can be used either alone or in conjunction with other methods to facilitate positive behavioural change in clients. Many counsellors use a range of interventions and styles and regard these counselling theories and practices as tools that can

be used in conjunction with the basic counselling skills of acceptance, empathy and congruence (Corey, 2005).

CBT and MI, in conjunction with relapse prevention strategies are all derived from learning theory, and are the counselling interventions most used by AOD clinicians (McGovern, Fox, Xie & Drake, 2004). They offer clients tools for change. Great insight may be gained through examination of the thoughts that may lead a client, despite the costs, towards, for example, obtaining and injecting heroin. Insight and motivation to change may also be gained from reflecting on what may be gained through sobriety and what steps can be taken to minimise the risk of going back to harmful drug use or harmful behaviours such as the sharing of syringes.

The point being made here is that to focus only on changing behaviour is insufficient and that in attempting to assist clients to change behaviour, attention must be paid to cultural considerations, social context and every individual's unique story. For healing to occur for indigenous people, there needs to be an acknowledgement of the wounds that have been inflicted (Brave Heart, 2004) and an understanding that ongoing exposure to injustice, racism and disadvantage play a major role in the development of, and the maintenance of AOD problems (Bacon, 2007).

4.9 Re-Storying Strength

As has been established, for clients suffering from historical trauma and from historical trauma responses of all types, acknowledgement of their stories is an essential part of the pathway towards healing.

It has been reported that for Australian indigenous peoples, story is central to well-being, cultural and spiritual life (Bacon, 2007; Hume, 2002). Through paying attention to the client's own cultural traditions of narrative practices and working in cooperation with community members to develop acceptable practices counsellors may develop more effective

approaches to working with non-dominant cultures (Nwachuku & Ivey, 1991). Indigenous psychologies exist worldwide and these understandings of human beings have worked for many people over a long time and some of these ways may be drawn upon re-story strength (Ranzijn et al., 2009).

Chapter 5

5.0 The Potential of Narrative Therapy to Provide a Culturally Acceptable and Safe Response to Australian Indigenous People Seeking Help with AOD Issues from Mainstream Services

5.1 Postmodernism and the Development of Narrative Ideas

Postmodernist scholarship and social constructionist discourse have profound implications for counselling theory and practice (Gergen, 2001; Hansen, 2006). Fundamentally, these ideas challenge assumptions of truth, objectivity and individual knowledge and emphasise the importance of language as a medium through which local truths are constructed. Postmodern discourse has proposed that objectivity is a relational achievement and emphasise the communal construction of knowledge. These ideas offer new understandings and have the potential to change how counselling is performed, (Corey, 2005; Gergen, 2001). Postmodern therapies generally have been concerned with contextualising details with and the specifics of each unique story rather than with making generalisations. In order to do this the postmodern counsellor may pay attention to difference and not merely look for similarities in stories or circumstances (Freedman & Combs, 1996).

Concerned by the practice of positioning clients as unknowing, passive and *powerless* in relationship to counsellors whose assessment skills, knowledge and experience are highly regarded, Gergen (1994) argues that the postmodern argument was against the posture of authoritative truth rather than against the various schools of therapy.

According to Freedman and Combs (1996), in order for counsellors to work with narrative therapy, it is important that they have a postmodern worldview, or a social constructionist understanding of lived experience. It is emphasised by these writers that narrative therapy has been informed by postmodernist ideas that potentially change how counselling is understood and enacted (Corey, 2005). These ideas are that there are no

essential truths, that realities are socially constructed, that these realities are constituted through language and organised and maintained through narrative. In addition, according to postmodernist discourse, addressing issues of power and understanding its effects on individuals, families and communities is an integral part of the work of the counsellor or community worker.

Narrative therapy first emerged in an environment of social change in the 1980s. Issues of gender, social justice and the politics of experience were being explored and debated by many counsellors, social workers and community workers, some of whom were involved in Family Therapy, The Dulwich Centre, in Adelaide and its newsletter *The Family Therapy Networker*. Michael White and David Epston are credited with the originating of narrative practices (Denborough, 2009) and Michael White had been working in partnerships with Aboriginal colleagues from the mid-1980s. Indigenous Australian practitioners have been involved since the inception of narrative therapy and the work of both Barbara Wingard and Tim Agius have been acknowledged by Denborough (2009) as playing a central role in the development of narrative practices. The earliest collaborations between Michael White and indigenous practitioners occurred during the development of healing work in communities with families of indigenous people who had died in while in custody.

In furthering the case for providing appropriate ways of working with indigenous people experiencing problems with AOD use, it can be argued the inclusion of theories that recognise the power of language, the relativity of truth and the relational nature of objectivity is self-evident. In a report prepared for NIDAC and the Australian National Council on Drugs, Gray et al. (2010) described the findings of a report commissioned by WHO on the link between the social determinants of health such as socioeconomic disadvantage and AOD use (Wilkinson & Marmot, 2003).

Of particular interest to this thesis is that this report stated that not only must the AOD issue be met with appropriate support and treatment but that any intervention must also address the roots of the problems, which are often embedded in social patterns of deprivation. What may be extrapolated from this report from WHO is that AOD work in general would be more effective should it include conversations with the client that acknowledge the social, political and cultural factors that contribute to the development of a range of problems including those associated with AOD use problems. These conversations that acknowledge the role of social context as well as the politics of lived experience within these contexts are important aspects of narrative therapy.

5.2 The Locus of the Problem

From a narrative therapy perspective, locating and naming the problem is an important part of the counselling process (White, 2007). Many indigenous people seeking support with AOD issues may have experienced that the problem story has become the dominant story and frequently people will have subsequently formed a belief that the problem is that they are the problem. This is not surprising, given that much Western psychological and counselling discourse describes problems as being the result of some type of individual deficit and, as was mentioned in Chapter 4, this can lead to blaming the victim (Pedersen, Fukuyama & Heath, 1989; Prilleltensky & Nelson, 2002; Ryan, 1971).

Prilleltensky and Nelson (2002) have argued that mainstream counselling approaches may have effectively blamed victims of oppression for their oppression while ignoring the social and political ideology and practice that have both created and maintained the context in which oppression has been exercised. For indigenous clients, the issues of power and oppression are ever present, yet psychological practices have been frequently enacted that ascribe pathology to clients while ignoring the pathology in the society in which the individual lives (Pedersen et al., 1989). As discussed in Chapter 3, consideration needs to be

given to language used to describe both people with AOD problems and the problems themselves, as it is through language and the meanings that the locus of the problem can be identified. This process can then place an individual in a situation of social subjugation through the attribution of deficit (Winslade & Smith, 1997). From a narrative therapy perspective, the labelling of people as ‘patients’ and their problems as ‘disorders’ may only serve to reinforce the deficit or problem story and further entrench a problem-laden self-image (McKenzie, 1997).

5.3 Changing the Locus of the Problem

Narrative therapy offers people with AOD problems the potential of locating the problem externally, which is, extrinsic to their identity, through creating a conversation that externalises the problem (White, 2007). This is described by White (2007) as a conversation that leads away from the process of objectifying the person, towards objectifying the problem. As the problem becomes the problem and the person’s identity is experienced as being separate from the problem, the problem itself no longer represents the truth about the person’s identity. It is just a problem. This is described by White (2007) as a conversation that leads away from the process of objectifying the person, towards objectifying the problem. As the problem becomes the problem and the person’s identity is experienced as being separate from the problem, the problem itself no longer represents the truth about the person’s identity. It is just a problem. Narrative practitioners sometimes use letters, songs and other documents in helping people to move away from AOD problems. Metaphors, such as those used by White involving migration, may be used frequently, and these can serve to both externalise the problem and assist the individual to discover ways of dealing with the problem (Hegarty, Smith & Hammersley, 2010).

5.4 Alternative Stories

Central to narrative therapy is the acknowledgement of ethical, social, political, historical and cultural factors that powerfully affect stories. Some stories that may have supported a person's low self-esteem may come to be named differently, perhaps as stories of injustice (Boje, 2005). The naming of injustice and oppressions serves to witness the client's experience of historical trauma and further shores up the externalisation of the problem. The individualised stories of despair and grief brought about by historical events and no longer privatised can be seen as part of a collective experience. Towney (2005) writing on working with indigenous men with AOD issues describes the role that colonisation, trauma and racism have played in demoralising indigenous people. He describes his own experiences of racism, such as having to live on the outer fringes of town as a child, and explores how such structural degradation may serve to create an environment that is highly toxic to individual, family and community. According to Towney, the narrative of indigenous deficit, embedded as truth in the dominant Australian cultural narrative, has become the one by which indigenous people have frequently defined themselves. This particular form of oppression supports an internalised discourse of self-blame. This internalisation of blame feeds despair and depression, which in turn exacerbate the existing problems. Working with indigenous people (including many with AOD problems) through narrative to address the traumas and losses that they have experienced and using narrative ways, Towney describes a path to re-story pride and cultural identity.

5.5 Telling Stories in Ways that Support a Positive Construct of Self

By deconstructing the problem stories and creating a preferred reality (Freedman & Combs, 1996), an individual is offered an alternative story in which the problem may be seen differently. The AOD narrative may be newly experienced as having arisen out of a dynamic interplay between complex forces that include social and political issues of power and

privilege and the enculturation of styles of substance use (White, 1997). Man-Kwong (2004), writing on working with clients who are experiencing drug problems, described the critical importance of counsellors avoiding conversations that may invite shame into the counselling space and also discussed some uses of metaphor in externalising conversations when addressing the issue of dealing with urges or cravings. Referring to uses of metaphor in AOD counselling, Man-Kwong (2004) described how by utilising an appropriate cultural context, unique or generic names can be given to these cravings or urges that may place them firmly outside of an individual's identity and reposition them in the realm of the lived experience.

5.6 Using Narrative Therapy with Indigenous People Seeking Help from Mainstream AOD Services

Narrative practices create new possibilities and alternative stories of events. In practice, many individuals, suffering from the effects of AOD problems may change how they think of and experience problems. To use a narrative metaphor, the client, as a narrator, changes the stories that they tell about themselves and their lives (Bacon, 2007; Freedman & Combs, 1996; Wingard & Lester, 2001). In the construction of the problem-saturated story, so familiar to indigenous people (Towney, 2005), alternative stories, have often become submerged, which makes an alternative version of events increasingly difficult to summon.

Describing unique outcomes, a term credited (White, 2007) to Erving Goffman (1961), White and Epston (1990) refer to the importance of discussing with clients the exceptions to the problem. These unique outcomes may occur frequently but are often overlooked or trivialised. Narrative therapy aims to make these visible. In the case of an AOD client, the unique outcome may be when the individual experienced stress but chose not to drink alcohol or times in an individual's life when drugs were not so much a problem. A client may also be invited to consider what was felt, thought and done in times when life events or daily life encroached on the time and space commonly occupied in seeking and

using substances, and what made the using of substances seem less relevant at that time (Freedman & Combs, 1996; White, 2007; White & Epston, 1990).

Although not primarily developed for AOD work, narrative therapy is now gaining acceptance and is being used as a therapeutic response to people seeking help with AOD problems (Bacon, 2007; Hegarty et al., 2010; Ikin, 2008; Man-Kwong, 2004; Raven, 1997), and there are initiatives to both work with indigenous people individually and in communities to develop culturally appropriate narrative therapy practices for assisting with AOD problems (Bacon, 2007; Towney, 2005; Winslade & Lester, 2001). On the subject of using narrative therapy as a culturally acceptable intervention by counsellors working with indigenous Australians, Bacon states 'The telling of stories to inform, educate and learn draws on rich traditional Aboriginal oral ways, indicating a strong cultural connection already exists between narrative therapy practice and indigenous Australians' (Bacon, 2007, p. 77). Additionally, the Alcohol Treatment Guidelines for indigenous Australians (2010) describe narrative therapy as being culturally acceptable to most indigenous healthcare providers and communities and highlight the narrative practices of situating the client as expert on themselves and also the locus of the problem as separate to the individual seeking help for the problem.

In exploring the potential of narrative therapy in working with indigenous people, the cultural relevance of narrative practices and storytelling is compelling. Stories are central to meaning making for all peoples (Pinkola Estes, 1992) and have a particularly significant place in Australian indigenous cultures (Bacon, 2007).

5.7 Conclusion

Bacon (2007) highlights the pivotal role of storytelling in indigenous communities and connects this with the inclusion of the client's story in narrative practices. Narrative therapy is also described by Bacon as strengthening the preferred narrative of an individual,

in addition to authenticating the voices of groups so that a preferred story that may emerge. The many narratives of deficit or moral failings that are common in AOD discourse (Winslade & Smith, 1997) are replaced with new understandings of cultural, social and personal contexts in which AOD use problems develop (White, 2002). Although narrative therapy has as yet been employed to a limited extent in working among indigenous Australians with AOD problems, what may be emphasised is that from reviewing the available literature and anecdotal evidence, narrative therapy appears to offer a culturally acceptable response that can be utilised by counsellors in mainstream AOD agencies when working with indigenous Australians seeking help with AOD-related problems (Bacon, 2007; Brady, 1991; Brady, 2005; Gray et al., 2010). The Alcohol Treatment Guidelines for indigenous Australians (DHA, 2007) describe narrative therapy as respectful practice in working with indigenous Australians. It would therefore seem timely that mainstream AOD agencies actively work with indigenous practitioners towards the inclusion of narrative therapy as a culturally acceptable therapeutic option that may be used when working with indigenous Australians.

‘For the past two hundred years, Aboriginal people’s stories about ourselves have been shaped by what others have said about us. When the mainstream culture describes you in negative ways, this dominant narrative becomes highly destructive to individual lives, families and communities’ (Towney, 2005, p. 40).

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