Received: 1 October 2021 | Revised: 28 August 2022 | Accepted: 29 August 2022

DOI: 10.1111/dar.13549

ORIGINAL PAPER

Drug and Alcohol REVIEW APSAD WILEY

Beliefs and attitudes of drug and alcohol clinicians when considering referral of Aboriginal clients to involuntary drug and alcohol treatment: A qualitative study

K. S. Kylie Lee[1,2,3,4,5] | **Lynette M. Bullen**[6] | **Catherine Zheng**[1,2] | **Angela Dawson**[7] | **Alice Munro**[8] | **Katherine M. Conigrave**[9,1,2]

[1]NHMRC Centre of Research Excellence in Indigenous Health and Alcohol, Faculty of Medicine and Health, The University of Sydney, Sydney, Australia

[2]The Edith Collins Centre (Translational Research in Alcohol Drugs and Toxicology), Sydney Local Health District, Sydney, Australia

[3]National Drug Research Institute, Faculty of Health Sciences, Curtin University, Perth, Australia

[4]Burnet Institute, Melbourne, Australia

[5]Centre for Alcohol Policy Research, La Trobe University, Melbourne, Australia

[6]Involuntary Drug and Alcohol Treatment Unit, Western NSW Local Health District, Orange, Australia

[7]Australian Centre for Public and Population Health Research, Faculty of Health, University of Technology Sydney, Sydney, Australia

[8]Research Office, Western NSW Local Health District, Orange, Australia

[9]Drug Health Services, Royal Prince Alfred Hospital, Sydney, Australia

Correspondence

K. S. Kylie Lee, NHMRC Centre of Research Excellence in Indigenous Health and Alcohol, Faculty of Medicine and Health, The University of Sydney, Sydney, Australia.
Email: kylie.lee@sydney.edu.au

Lynette M. Bullen, Involuntary Drug and Alcohol Treatment Unit, Western NSW Local Health District, Orange, Australia.
Email: lynette.bullen@health.nsw.gov.au

Abstract

Introduction: Involuntary drug and alcohol treatment occurs in many countries and its role is often controversial. This can be a particular concern in relation to First Nations or other culturally distinct populations. This study explores beliefs and attitudes of drug and alcohol clinicians when considering referral of Aboriginal Australians to involuntary drug and alcohol treatment in New South Wales (NSW), Australia.

Methods: The Involuntary Drug and Alcohol Treatment program (IDAT) is legislated by the NSW *Drug and Alcohol Treatment Act* 2007. There are two IDAT units—in urban (Sydney, four beds) and regional NSW (Orange, eight beds). NSW Health drug and alcohol clinicians who had referred clients to IDAT between 2016 and 2018 were invited to participate in a semi-structured 1:1 interview. Eleven clinicians ($n = 2$, male) from six local health districts (urban through to remote) agreed to participate. A descriptive qualitative analysis of responses was conducted.

Results: Two key themes summarised the beliefs and attitudes that clinicians reported influencing them when considering referral of Aboriginal Australians to involuntary drug and alcohol treatment in NSW: (i) dilemma between saving someone's life and being culturally safe; and (ii) need for holistic wrap-around care.

Discussion and Conclusions: Almost all clinicians were worried that being in IDAT would further erode their Aboriginal client's autonomy and be retraumatising. Strategies are needed to support the involvement of Aboriginal-specific services in IDAT processes and ensure local support options for clients on discharge. Future research should examine the effectiveness, acceptability and feasibility of involuntary drug and alcohol treatment programs.

KEYWORDS

alcohol, dependence, drugs, involuntary, treatment

Funding information
National Health and Medical Research Council, Grant/Award Numbers: 1117198, 1117582; NSW Health

1 | INTRODUCTION

Alcohol and illicit drug use disorders contribute 6.7% to the burden of disease and injury experienced in Australia [1]. This burden increases in younger adults (aged 15–49 years) [2], in rural and remote communities, and in those with lower socio-economic status [1]. Aboriginal and Torres Strait Islander (First Nations) Australians are disproportionately affected by the harms from alcohol and illicit drug use, with associated burden 3.1 and 4.2 times higher, respectively, than among their non-First Nations counterparts [1]. This is comparable to First Nations peoples in similarly colonised countries (e.g., Aotearoa New Zealand [3], Canada [4], United States [5]). For these First Nations peoples, experience of intergenerational trauma, and past or ongoing experience of discrimination, racism [6] and child removal policies can increase the risk of physical and mental health conditions, including substance use disorders [7].

In any setting, people with severe alcohol or other drug dependence are vulnerable, and may have multiple health conditions [8, 9]. Medically supported withdrawal may be required, along with comprehensive assessment, treatment and support (e.g., relapse prevention medicines, counselling, residential programs) [8]. A subset of individuals with severe substance use disorders are either unable or unwilling to seek treatment voluntarily [9]. In such complex cases, compulsory drug and alcohol treatment, where available, may be an option of 'last resort' [10].

Compulsory or involuntary drug and alcohol treatment programs are offered in over 80% of countries worldwide [11]. In some programs, referrals are invoked because of law-and-order concerns [12], such as those linked to the criminal justice system [13]. Other countries provide involuntary treatment that is initiated because of health concerns (and is typically connected to the health system). In this scenario, involuntary care is provided for under mental health or drug- and/or alcohol-related legislation [14].

In Australia, compulsory drug and alcohol treatment options, initiated because of health concerns, are provided for by legislation in three states: New South Wales (NSW), Victoria and Tasmania (Table 1). Program models vary Australia-wide [15–17]. As well as these three health-focused models, in the Northern Territory of Australia, a mandatory alcohol treatment program existed for several years where individuals were sent for treatment based on law-and-order concerns. However, that program was repealed in 2017 over concerns of lack of efficacy and excessive referrals of First Nations Australians compared with other Australians (97% vs. 3%; 2014–2015) [15].

TABLE 1 Compulsory in-patient drug and alcohol treatment legislation in Australia (current/most recent in past 5 years)[a]

Jurisdiction	Legislation	Length of stay (up to)	Model used	Key features	Reviewed
New South Wales	*Drug and Alcohol Treatment Act* 2007	84 days	Health	• 2 sites (urban; regional). • No charge.	2019
Victoria	*Severe Substance Dependence Treatment Act* 2010	14 days	Health	• 2 sites (urban). • No charge.	2015
Tasmania	*Alcohol and Drug Dependency Act* 1968	6 months	Health	• 4 sites (2 urban, 2 regional). • No charge.	2012[e]
Northern Territory	*Alcohol Mandatory Treatment Act* 2013	3 months	Criminal justice	• 3 sites[b] (Darwin, Katherine, Alice Springs). • Can be charged if abscond.[c] • Treatment provider can recover costs.[d]	Repealed 1 September 2017

[a]There are no similar legislated options for compulsory treatment in Queensland or the Australian Capital Territory. Western Australia has a draft bill that was never enacted (Compulsory Treatment [Alcohol and Other Drugs] Bill 2016).
[b]Nhulunbuy and Tennant Creek were additional sites, which were later disbanded.
[c]Charge for absconding was repealed in October 2014.
[d]Costs can be recovered from the government for food, medicines, other consumables.
[e]At the time of writing, this Act was being repealed under the Alcohol and Drug Dependency Repeal Bill 2019.

Around the world, evidence on the effectiveness of involuntary drug and alcohol treatment is limited [18]. A recent systematic review found that 78% of included studies showed no significant impact of involuntary treatment on drug use or criminal recidivism compared with voluntary treatment [14]. Moreover, these studies are heterogeneous in design (e.g., prospective, longitudinal observational), program length (days to years) and location (inpatient vs. prison vs. outpatient) [14]. There are no existing randomised controlled trials and only limited evidence in case series based on small numbers of patients [18, 19]. In Australia (NSW), a study using a retrospective matched cohort found that both voluntary and involuntary drug and alcohol treatment were associated with reduced health service utilisation in the year following treatment, with no significant difference between the two groups [20]. In another NSW study, clinicians and some clients report clear benefits across a range of domains for some individuals with severe substance use disorders [17], and the program continues to operate.

Although the NSW Involuntary Drug and Alcohol Treatment program (IDAT) is open to all residents of the state, between 2016–2018, referrals of Aboriginal Australians to that program significantly decreased compared to referrals of non-First Nations Australians (data not published; personal communication with a recent IDAT medical director, Lee Nixon). Note, that the term 'Aboriginal' is used in this report to refer to First Nations Australians residing in NSW in accordance with direction from the Aboriginal Health and Medical Research Council of NSW [21], and because the majority of First Nations individuals in that state are Aboriginal rather than Torres Strait Islander. Despite this falling referral rate, over the same period the rate of alcohol-related hospitalisations among Aboriginal Australians in NSW was eight times higher than in their non-First Nations counterparts [22].

Previous studies have described the ethical dilemmas of providing involuntary treatment [23–25]. For example, clinicians may find referring individuals to involuntary care difficult because of the conflict between paternalism and promoting self-determination [26]. These issues are amplified in a First Nations context, given ongoing disempowerment, trauma and loss of culture, due to the forced removal of First Nations peoples from their land and often removal of their children [27–29]. However, to our knowledge, no previous studies have focused on beliefs and attitudes of clinicians when considering referrals of First Nations peoples to involuntary drug and alcohol treatment. Therefore, this study explores the beliefs and attitudes of drug and alcohol clinicians when considering the referral of Aboriginal Australians to IDAT in NSW, Australia.

2 | METHODS

2.1 | Aboriginal leadership

This study was conceived and led by Lynette M. Bullen, a Wiradjuri woman with over 25 years of experience as a drug and alcohol clinician in remote, regional and urban NSW. An Aboriginal Advisory Committee ($n = 6$), with expertise in Aboriginal health, clinical workforce development and research, guided the study. This group consisted of Aboriginal leaders employed within NSW Health ($n = 5$) and a representative of the Aboriginal Corporation Drug and Alcohol Network (the body representing Aboriginal drug and alcohol workers in government and non-government sectors in NSW).

2.2 | Setting

2.2.1 | Involuntary drug and alcohol treatment program in NSW

IDAT in NSW is covered by legislation in the NSW *Drug and Alcohol Treatment Act* 2007 [30]. It provides medical treatment and respite as a last course of action for individuals with severe alcohol or other drug dependence [30]. There are two secure IDAT units for individuals who meet the essential criteria for admission—in urban (Sydney, four beds) and regional NSW (Orange, eight beds). There are four eligibility criteria for involuntary treatment: (i) the individual must have a severe substance use dependence; (ii) care or treatment of the individual is deemed necessary to protect that person from serious harm; (iii) refusal of treatment for substance use dependence but would likely benefit from receiving this treatment; and (iv) no other appropriate or less restrictive means are reasonably available.

Referrals to IDAT are made by government-run local health districts across NSW and (less commonly) from community-based medical practitioners (i.e., with no involvement from NSW Health). To enter an IDAT program, an initial 28-day 'Dependency Certificate' is required from one of two medical practitioners in NSW specially accredited to do this. This certificate is then presented to a magistrate within 7 days. An involuntary stay can be extended by up to an additional 56 days (total of 84 days) if a patient is identified as having a substance use-related brain injury.

2.2.2 | Participants

Drug and alcohol clinicians employed by NSW Health were invited to participate in the study if they had

referred an individual (Aboriginal or non-Aboriginal) to an IDAT Unit between September 2016 and December 2018. That study period was chosen to allow the findings of this study to relate to an independent evaluation conducted of IDAT over that same period [31].

2.2.3 | Recruitment

The lead investigator (LMB) works as a senior drug and alcohol clinician in an IDAT unit in NSW. To ensure participant comfort and openness in the interviews, an independent researcher (AM), with no role in the operations of IDAT, conducted recruitment (assisted by KMC and KSKL) and interviews in 2019. Lynette M. Bullen had no access to the names of clinicians invited to interview or to those who consented to take part.

Permission was sought from the medical director of each IDAT Unit to access the names of referring drug and alcohol clinicians who met the study criteria ($n = 54$). Clinical nurse consultants in each IDAT unit then provided a list of potential interviewees (to AM). Eligible clinicians were emailed an invitation to take part in the study by a senior addiction medicine physician employed by NSW Health (KMC). Clinicians were asked to register their interest in participating by email or phone (with AM; $n = 11$). For those who did not respond ($n = 43$), a follow-up invitation was emailed approximately 2 weeks later (by KMC). A final email was sent to non-responders ($n = 43$) by an IDAT clinical nurse consultant approximately 1 week later again. No further contact was made after the third email.

2.2.4 | Data collection

Semi-structured interviews were conducted (by AM) with each clinician between October and November 2019 by secure NSW Health video conferencing. The interview schedule was organised into four domains, focusing on: (i) the clinician and where they worked; (ii) referring Aboriginal clients to IDAT; (iii) advantages and disadvantages of an involuntary treatment admission; and (iv) support to assist with admissions and discharges (Table 2). Interview questions were piloted with two NSW Health clinicians (a male Aboriginal mental health worker; a female clinical nurse consultant). Average interview

TABLE 2 Semi-structured interview schedule used in a study of clinicians who refer clients to the involuntary drug and alcohol treatment program in New South Wales, Australia

Themes	Questions
About you and where you work	1. What is your role designation? 2. How long have you been employed in the drug and alcohol sector? 3. Do you identify as being from an Aboriginal or Torres Strait Islander background? 4. What NSW Local Health District do you cover? 5. Have you completed the Involuntary Treatment Liaison Officers' training?
About referring Aboriginal clients to an Involuntary Drug and Alcohol Treatment Unit	6. Can you please tell me about the last time you referred an Aboriginal person to IDAT? 7. In what circumstances would you refer an Aboriginal person to IDAT? 8. What would stop you from referring an Aboriginal person to IDAT? 9. Can you tell me about a time when you were asked to refer an Aboriginal person to IDAT by their family member or friend?
Advantages and disadvantages of an involuntary treatment admission	10. What do you see as the advantages of referring an Aboriginal person to IDAT? 11. What do you see as the disadvantages of referring an Aboriginal person to IDAT?
Supports to assist with admissions and discharges	12. What things would support you to refer an Aboriginal person to IDAT? 13. How would you go about informing an Aboriginal person that you are preparing to refer them to IDAT? 14. If you have previously referred a client to IDAT (and they were accepted into the program), when the client returned to their community, what supports were available to help them remain abstinent? 15. What services/programs do you think are needed to support an Aboriginal person who has been discharged from IDAT? 16. What do you think would help you to refer an Aboriginal person to IDAT?

Abbreviation: IDAT, Involuntary Drug and Alcohol Treatment.

duration was 38 min (range: 19–61 min). Each interview was recorded and professionally transcribed.

2.2.5 | Data analysis

The analysis was conducted independently by two researchers (LMB, by hand; CZ, using NVivo version 12). Guidance was provided by K. S. Kylie Lee and Katherine M. Conigrave. A descriptive qualitative research study was conducted to offer a comprehensive summary of beliefs and attitudes of clinicians who have referred patients to IDAT. This approach allowed us to draw upon theories and methods across qualitative research [32]. The lens of naturalism was applied [33] to study this phenomenon in a manner free of artifice. We used conventional qualitative content analysis [34] and drew upon the constant comparison technique that is associated with Grounded Theory [35]. This involved independent inductive category coding by two researchers to describe and tabulate the data as per the study aims alongside a simultaneous comparison of experiences across all the transcripts. An analysis meeting was convened by video conference to discuss category coding and to compare and refine categories until consensus was reached on key themes and subthemes (LMB, CZ, AD, KMC and KSKL). The informational contents of the data were then summarised in a manner that best fitted the data.

3 | RESULTS

Of the 54 clinicians who met the study criteria and were invited to participate, 11 agreed to take part ($n = 2/11$ male). For the remaining 43 clinicians, no response was received to any of the three invitations made. No clinician directly declined participation.

Of the clinicians who were interviewed, six local health districts across NSW were represented (urban through to remote; Table 3). No interviewees were Aboriginal and/or Torres Strait Islander. Together, the interviewees had more than 220 years of clinical experience in the drug and alcohol sector. Just over half ($n = 6/11$) had referred an Aboriginal person to IDAT during that time. Nearly three-quarters of interviewees ($n = 8/11$) had completed Involuntary Treatment Liaison Officer (ITLO) training, which is non-mandatory training for clinicians on the process for referring clients to IDAT.

Two key themes summarised the beliefs and attitudes that clinicians reported influencing them when considering referral of Aboriginal Australians to involuntary drug and alcohol treatment in NSW: (i) dilemma between savings someone's life and being culturally safe; and (ii) need for holistic wrap-around care. There were no differences noted between clinicians who had previously referred an Aboriginal client to IDAT versus those who had not, or those who had completed ITLO training or not (non-mandatory training for clinicians on the process for referring clients to IDAT).

TABLE 3 Participant characteristics of NSW health drug and alcohol clinicians who referred a patient to the involuntary drug and alcohol treatment program between September 2016 and December 2018

Characteristic	($n = 11$)
Sex	
Female	9
Male	2
Geographical locality	
Urban	3
Regional, rural or remote[a]	8
Years working in drug and alcohol sector	
1–10	2
11–20	4
21+	5
Job title[b]	
Clinical liaison	1
Clinical nurse consultant	11
Nurse practitioner, nurse unit manager	3
Social worker	1
Relevant professional experience[c]	
Drug and alcohol: government only[d]	5
Drug and alcohol: government and non-government[e]	6
Drug and alcohol and mental health	2

[a]Categories were collapsed to ensure anonymity of drug and alcohol clinicians who were interviewed.
[b]$n > 11$, some clinicians have more than one job title.
[c]$n > 11$, some clinicians have worked in a range of settings.
[d]Includes prisoner health, corrections, involuntary drug and alcohol treatment.
[e]Includes community-based outpatient, temporary accommodation.

3.1 | Dilemma between savings someone's life and being culturally safe

Clinicians saw a tension between their goals to save someone's life and practising in a culturally safe way. Clinicians used the term cultural safety in keeping with the following definition, or spoke about this concept without using the term:

> '*Respecting the cultural identity of Aboriginal and Torres Strait Islander Australians to empower them in decision-making about their healthcare*.' [36]

Examples of culturally safe practice include: a bicultural approach to care provided by service staff, an individual being welcomed to the health facility; family involvement in service interactions; and understanding and empathy from service staff of cultural priorities, and of past or current traumas that might affect an individual's interactions with an involuntary health service.

Nearly three-quarters of interviewees ($n = 8/11$) said they would make a referral for an Aboriginal person to IDAT as a 'last resort' (when all other options were exhausted). Of those interviewees who did not mention IDAT as a last resort ($n = 3/11$), one had not referred an Aboriginal client to IDAT and very few Aboriginal clients attended their service. For nearly all interviewees ($n = 9/11$), ethnicity did not play a role when making a referral:

> '*I wouldn't ever question their ethnicity or Aboriginal status as an option for sending them. For me, it's just life or death decision, duty of care*.' (ID01)

> '*I don't want to be sort of like the reverse racism and think that because – how we've treated Aboriginal people, that they should never be involuntarily detained because of course sometimes that's* [a referral to IDAT is] *in everybody's interest*.' (ID10)

> '*I think if they've met the criteria. I don't really look whether they're Aboriginal or non-Aboriginal. If they meet those requirements, then they need the service*.' (ID02)

However, at the same time, nearly all clinicians ($n = 10/11$; including those who had referred an Aboriginal client to IDAT, $n = 6/11$) were worried that a referral of an Aboriginal person could be culturally unsafe. This was linked to clinicians' understanding of current and past experience of discrimination and racism by Aboriginal peoples, including from Australian government policies, such as child removal ('Stolen Generation'):

> '*We probably – by virtue of doing what we try to do* [in relation to considering a referral to IDAT], *we probably create more trauma*.' (ID06)

> '[...] *the last thing we want to do is superimpose ideas that will bring back traumatic memories for people of white fellas just making decisions for* [Aboriginal peoples]. *I weigh up the clinical risk and the balance of probability that this person was on a fatal trajectory ... always wrestling with those two sides. If we do nothing, the person is probably going to die*.' (ID08)

> '[...] *if the client is impacted on as part of the Stolen Generation ... you do have to tread a little bit differently* [when considering a referral to IDAT].' (ID04)

The requirement for a client to go 'off country' (i.e., away from traditional homelands) to attend IDAT was also viewed as culturally unsafe by half of the interviewees ($n = 6/11$; for clients not residing in Orange or northern Sydney):

> '*Obviously, it is taking them out of country, but again, as a last resort, if you have to take someone out of country, you do, because you've already, obviously, tried on country in some form already, if you're doing an IDAT referral*.' (ID01)

> '*One of the concerns I have with referring some of the patients, Aboriginal patients, was taking them off country*.' (ID04)

In keeping with these concerns about taking clients 'off country', the location of the two IDAT units (in regional and urban NSW) was described as being too far away for many clients and their families ($n = 8/11$):

> '*It definitely is a disadvantage for regional communities to try and visit, even call, like to have the credit – the money to be able to ring, to have a phone to ring if they're on remote country*.' (ID01)

The physical layout of IDAT was also described as being restrictive or 'sterile' ($n = 2/11$):

> '*They can't get away from each other, there's nowhere to have a quiet space*.' (ID02)

In relation to cultural supports available during an IDAT stay, more than half of the interviewees were unsure of what support was provided ($n = 6/11$). This knowledge was important to increase the comfort of their Aboriginal Australian clients and families in the lead up to going into an involuntary service:

> '*I guess having an understanding of how the service equips itself for cultural competence, what kind of avenues there might be for either Aboriginal-specific health workers there, or people who will act as a kind of liaison to the service*.' (ID05)

> '... [it is so important to let the client and family know] *what sort of cultural awareness they have* [in IDAT]. *... is there an Aboriginal worker there? What sort of cultural support are they going to get?*' (ID01)

For two clinicians, strong reservations were voiced about using IDAT as a treatment option for Aboriginal Australians, due to the potential damage that could be caused to relationships between the referring clinician, client and their family:

> '*I do have reservations because I think – I'm not sure of the model, if it actually makes enough of a difference and I think sometimes, it could set us back in terms of our engagement with people. You definitely don't want to be the person or the service that takes people away*.' (ID09)

3.2 | Need for holistic 'wrap-around' care

The capacity of IDAT to provide comprehensive, multidisciplinary 'wrap around' care was seen as a significant advantage of making a referral for more than half of the clinicians interviewed (n = 6/11), especially given the multiple health conditions often experienced by their Aboriginal clients:

> '[Holistic and comprehensive care is] *one of the selling factors I think for my clients*.' (ID01)

> '*Yeah, the teams there, in my experience, they are very good at dealing with complex medical, social, psychological and psychiatric problems*.' (ID05)

> '*If we got you a referral to [see someone] about your sore hip, which is half the reason you're drinking because you're in pain and you can talk to somebody about your early trauma – all in an integrated fashion*.' (ID08)

> '*I've found, with Aboriginal clients, they'd have huge dental issues, so it was a really good opportunity to get all those things sorted as well*.' (ID02)

Nonetheless, a range of suggestions were made to enhance the 'wrap-around' care provided during and after referral to IDAT: (i) enhancing local service provider involvement in the referral process; (ii) ensuring appropriate client transport to IDAT; (iii) weekly case review meetings that are inclusive of the referring clinician; and (iv) more local aftercare options on discharge from IDAT.

3.2.1 | Enhancing local service provider involvement

Involvement of local Aboriginal services in the referral process was suggested by more than one-third of clinicians interviewed (n = 4/11):

> '*It would be great to invite our Indigenous partners to that* [ITLO] *training. I think that would be a really big buy-in for referral in the future because they'll understand the act, they'll understand where we're coming from, and they might even say you know, yes, this is a great thing or, no, we need to point our nose in a different direction for this patient*.' (ID03)

> '*I'd like an Indigenous health worker that had spent some time* [doing ITLO training] – *perhaps even done IDAT training online. Somebody who could appreciate and analyse* [the appropriateness of a referral], *look, if we have to do this* [make a referral] *how could we make it better?*' (ID08)

These same interviewees (n = 4/11) perceived that Aboriginal-specific services or Aboriginal staff were reluctant to get involved. Reasons for this included, worries about being seen perceived to be colluding with government to 'take someone away' for involuntary care, and the flow-on effect that this could have on the client/clinician and client/family relationship, and on the clinician's standing in the service provider sector and/or community (particularly in isolated communities):

> '*Tried to get the Aboriginal liaison officer that works at these sites to get involved ...* [they] *were happy to be involved – to initiate it but then drop back was considerable. Just couldn't*

get the buy in. So, I tried [again] *... But just couldn't get the buy in. Wasn't interested in at that point. I think it – not wanting to be seen to be involved with the* [IDAT] *program or possibly an incarceration-type program.*' (ID04)

'*Obviously buy-in from the patients makes it easier and their family and the local services. The local Aboriginal services if they're involved with the patients, if they could be on the same page on the same treatment goals for the patients would be helpful. So, them being aware of IDAT and its value.*' (ID11)

3.2.2 | Appropriate client transport

Transport options to and from involuntary treatment were a major barrier mentioned by just over half of the interviewees ($n = 6/11$):

'*... we cannot transport them unless they agree to take sedative medication* [for alcohol or benzodiazepine withdrawal].' (ID04)

'*Well, if they're going to be discharged from* [IDAT] *it's again, we have to look at transport home. Are we able to broker for a family member to go down and meet them there to bring them back, or an Indigenous worker of some sort if that's what the patient wants?*' (ID03)

3.2.3 | Case review meetings

Involvement of the referring clinician in weekly clinical case reviews (during an IDAT stay) including discharge planning meetings, was suggested by interviewees to help provide more seamless care ($n = 3/11$):

'*I think it's good if you're part of the clinical review ... sometimes I was invited.*' (ID06)

3.2.4 | More local aftercare options on discharge from IDAT

At referral stage, clinicians are required to provide a detailed discharge plan that includes a range of aftercare options (e.g., housing, group work, 1:1 counselling, support from an addiction medicine specialist). However, nearly all of the interviewees described a lack of local aftercare options, particularly for their Aboriginal clients, which made it difficult to provide the detailed discharge plan required ($n = 9/11$):

'*... there's these barriers because they* [IDAT] *look at all that stuff* [discharge plan] *before they go in. You're got to be able to pretty much write what is their aftercare plan. If you don't have housing and various other people that are going to wrap services around them, sometimes it's difficult and they quite often baulk at some of those* [referrals].' (ID04)

'*It's really hard when they're returning back to the community because they're going back to the same environment* [with little or no available aftercare support/care options], *back to the same stresses. Quite often they'll just go back to drinking or using.*' (ID02)

In that same group of interviewees that mentioned a lack of local aftercare options, nearly three-quarters suggested that culturally-specific options were also needed ($n = 8/11$). This was more of an issue in isolated regions:

'*If you could actually have an Indigenous-specific drug and alcohol worker to cover certain areas ... keep connected with them and keep supporting them. Maybe some more Aboriginal-type groups* [like men's or women's groups] *that they can access to be supportive of each other.*' (ID02)

4 | DISCUSSION

To our knowledge, this is the first study worldwide to examine the beliefs and attitudes of drug and alcohol clinicians when considering referral of First Nations peoples to involuntary drug and alcohol treatment. Some clinicians questioned their ability to make a difference for their Aboriginal clients because of limited aftercare options available on discharge from IDAT, and the perceived normalisation of drinking or drug use in the individuals' home environment. However, the majority of clinicians recognised the likely benefits gained for clients from the highly specialised, comprehensive and multidisciplinary care provided by this service. Despite the dilemmas for service providers, when faced with a 'life or death' decision related to a client's substance use dependence, the client's ethnicity itself was not perceived as a barrier to referral for the majority clinicians interviewed.

A key strength of the study is that it was led by an Aboriginal woman of the Wiradjuri nation (LMB) who is also a senior drug and alcohol clinician in NSW Health.

Almost all clinicians were worried that being forced to attend IDAT would further erode their client's autonomy and be retraumatising [29]. This is especially relevant for Aboriginal Australian clients given their past and current experience of discriminatory policies [37, 38], and higher rates of imprisonment (of themselves or loved ones) [39]. These negative past experiences also likely place Aboriginal clients at greater risk of distressed or angry responses [40], as a result of being compelled to attend involuntary treatment.

While removing people from country was primarily seen by clinicians as a traumatic thing, there are cultural parallels to this, when enforced by First Nations Australian communities themselves. In one such community in remote Northern Territory, young people who were sniffing petrol were moved away from the community for a period of healing 'on country' [41]. While we could not find formal documentation of this type of community-driven approach being used for adults, anecdotally, in many parts of Australia, older relatives will tell an Aboriginal adult they must come away with them, to move away from substance-using associates or away from supply of the substance.

Once in IDAT, having a more culturally appropriate and less 'sterile' environment was identified as important for Aboriginal Australian clients by a couple of clinicians [42]. It is likely to be particularly important for Aboriginal clients given the cultural connection to outdoor spaces and the land, and also because of history of lack of control when interacting with non-Indigenous services [43, 44].

Referrals are made to IDAT based on health needs [45] and treatment is offered based on a holistic approach. This differs from a crime prevention focus, as of the former Alcohol Mandatory Treatment Program in the Northern Territory [24]. While NSW's IDAT clients are not free to discharge themselves, they have access to 'gate leave' once deemed to be sufficiently stable [45]. A similar program to the NSW IDAT operates in the state of Victoria. However, it offers a shorter stay (maximum duration 14 vs. 84 days) [10, 16]. The longer duration in NSW's IDAT can allow more time for holistic care, such as neuro-psychiatric assessment, and linking to integrated aftercare, such as housing and disability support. This includes preparations for aftercare support to gain employment, education or training where appropriate, and other needs such as parenting support and building social connections. Previous studies have demonstrated the importance of care that is informed by the social determinants of health [46]. In addition to this, ensuring continuity of care with local services [47] during an IDAT stay could help support optimal outcomes for the client and their family on discharge.

A lack of available culturally appropriate aftercare options for Aboriginal clients was a limiting factor for the majority of clinicians when considering referral to IDAT. Limited availability of such programs or supports on discharge might mean that any gains made while in IDAT may not be built on when the client returns to the community (e.g., via culturally tailored mutual support groups [48], men's or women's groups [49], residential programs [50]). Addressing this limitation is especially challenging in the current climate of dwindling resources for Aboriginal drug and alcohol programs or services [51].

The holistic model of care offered by IDAT is designed to cater to individuals with a range of complex psychosocial and medical issues [31]; for example, a person with alcohol-related brain damage who cannot get to the point of stopping drinking, or a person with recurrent or prolonged stimulant-induced psychosis who cannot get their thoughts clear enough to decide if they want to stop or continue using methamphetamine. However, while referring clinicians (and local services who support the referral) saw the advantages of IDAT, some remained reluctant to refer Aboriginal clients because of potentially damaging impacts on their relationships with the client, their family, and the broader community. It is worth considering what mechanisms could be implemented to support these delicate relationships and to foster trust in local services [47], while still providing access to 'last resort' involuntary care if needed. Where appropriate, working with the client's family in preparation for an IDAT referral could assist with understanding of the process and build, rather than detract from relationships between clinician and client.

Some clinicians highlighted that the low number of Aboriginal ITLOs in NSW could also be impeding awareness of IDAT in Aboriginal communities. They suggested that making this training available to the Aboriginal drug and alcohol workforce, in government and non-government sectors, could enhance awareness of IDAT in Aboriginal communities across NSW. However, this goal will be in tension with the reluctance of Aboriginal staff or organisations to be involved in a referral to IDAT, as reported by interviewees. Early discussions are underway in NSW Health to enable staff from Aboriginal Community Controlled Health Services to participate in ITLO training. This could also provide an opportunity for Aboriginal service providers to have input into the suitability of IDAT for a range of contexts [47].

In any case, a stronger link with Aboriginal health services before and after an IDAT treatment episode would increase clinicians' comfort when referring Aboriginal clients to IDAT. Regardless of staff efforts in

relation to cultural safety, the trauma some staff and Aboriginal clients feel, when a client is forced to attend treatment against their will, is likely to remain. Efforts to empower the person are likely to be particularly important for Aboriginal clients, given the history of disempowerment. For example, explaining their right to appeal to the magistrate, and asking about anything staff could provide for their travel to an IDAT unit, such as nicotine replacement therapy or food.

4.1 | Implications

Findings from this study could inform policymakers in their efforts to enhance access to IDAT for Aboriginal clients. An opportunity exists for IDAT units to examine what could be done to increase cultural safety and comfort of IDAT facilities—particularly for clients who need to be 'off country' and away from family to attend one of the two units. Ongoing research is needed to examine effectiveness, acceptability and feasibility of involuntary drug and alcohol treatment offered in Australia [18]. Research is also required to understand the experiences and needs of Aboriginal peoples referred to IDAT, and of their families—to better tailor IDAT for their needs. Such studies should be led by Aboriginal researchers and communities and designed to suit diverse local contexts.

4.2 | Limitations

Only 20% of clinicians who were invited agreed to take part in the study ($n = 11/54$). Clinicians who took part may have had different views from those who did not. Just over half of the clinicians who took part ($n = 6/11$) had referred an Aboriginal person to IDAT. As this study was concerned with reasons for referring or not referring an Aboriginal client, this balance was seen as useful. Eligible participants had to have made a referral to IDAT between 2016 and 2018. It is likely that some clinicians who were approached for interview no longer worked in their drug and alcohol role or for NSW Health. It is also possible that clinician perspectives of IDAT from referrals made in 2016–2018 may differ from those of clinicians who had referred more recently. The findings cannot be generalised to the experiences of other NSW Health clinicians or those interacting with other compulsory care programs across Australia or internationally.

5 | CONCLUSION

This study describes the beliefs and attitudes of drug and alcohol clinicians when considering the referral of Aboriginal clients to involuntary drug and alcohol treatment in NSW. Most clinicians interviewed were concerned that such a referral could retraumatise Aboriginal clients. For clinicians who had referred Aboriginal clients to IDAT, the likely benefits outweighed these concerns. Strategies are needed to support greater involvement of Aboriginal-specific services in IDAT and to ensure adequate local culturally appropriate support options for clients on discharge. Future research should examine effectiveness, acceptability and feasibility of involuntary drug and alcohol programs for First Nations clients, including in similarly colonised countries.

AUTHOR CONTRIBUTIONS

Each author certifies that their contribution to this work meets the standards of the International Committee of Medical Journal Editors. K. S. Kylie Lee: Mentored Bullen in each stage of study from conception and design, obtaining ethical approvals, through to write up. Assisted Munro and Conigrave with recruitment. Assisted in analysis by mentoring Bullen and taking part in group analysis meeting. Did first draft of paper. Consolidated co-author and reviewer comments. Responsible for overall scientific integrity. Lynette M. Bullen: Conceived the idea for this study. Led the development of study design, protocol, interview schedules and obtained ethical approvals. Conducted independent analysis of data. Conducted literature review. Responsible for overall cultural integrity. Edited several drafts of manuscript, and approved final manuscript. Catherine Zheng: Conducted literature review and assisted with writing introduction. Conducted independent analysis of data. Attended analysis meetings that achieved consensus on write up. Edited several drafts of manuscript, and approved final manuscript. Angela Dawson: Provided qualitative advice throughout the study from writing of the study protocol, design of interview schedule and recruitment. Convened analysis meetings and read a proportion of transcripts. Edited several drafts of manuscript, and approved final manuscript. Alice Munro: Led recruitment including liaison with study participants. Assisted Bullen with early readings of transcripts. Edited a draft of the manuscript and approved final manuscript. Katherine M. Conigrave: Sent out 2 email invitations to each clinician to invite them to take part in the study. Assisted in analysis by mentoring Zheng and taking part in group analysis meeting. Responsible for overall clinical integrity. Edited several drafts of manuscript, and approved final manuscript.

ACKNOWLEDGEMENTS

The authors are grateful to the interviewees who took part (and the Local Health Districts where they are

employed), and to the Aboriginal Advisory Group who guided this study. The authors would like to acknowledge help from: Lee Nixon (former Medical Director, IDAT Unit, Orange); Mark Montebello and Stan Theodorou (Medical Directors, IDAT Units, Sydney and Orange); Melissa Delaney (Clinical Nurse Consultant, IDAT Unit, Orange); Emily Walker (Clinical Nurse Consultant, Drug Health Service, Royal Prince Alfred Hospital); Taleah Reynolds, Dr Monika Dzidowska and Dr Mustafa Al Ansari (research support, The University of Sydney); Annalee Stearne (Research Associate/PhD candidate, National Drug Research Institute, Curtin University) and Mira Branezac (Drug and Alcohol Health Services Library, Sydney Local Health District). Open access publishing facilitated by The University of Sydney, as part of the Wiley - The University of Sydney agreement via the Council of Australian University Librarians.

CONFLICT OF INTEREST

Lynette M. Bullen is employed by NSW in an Involuntary Drug and Alcohol Treatment Program. However, this author did not take part in recruitment or data collection, and all data were de-identified prior to analysis. The other authors have no conflicts to declare.

FUNDING INFORMATION

This research was supported by NSW Health (Health Education Training Institute) and by the National Health and Medical Research Council (NHMRC) Centre of Research Excellence in Indigenous Health and Alcohol (#1117198). Katherine M. Conigrave was supported by a NHMRC Practitioner Fellowship (#1117582).

ETHICAL STATEMENT

Ethical approvals were obtained from NSW Health Greater Western Human Research Ethics Committee (ref: 2019/ETH13587) and the Aboriginal Health and Medical Research Council of NSW (ref: 1598/19).

ORCID

K. S. Kylie Lee https://orcid.org/0000-0001-5410-9464
Catherine Zheng https://orcid.org/0000-0003-1612-8466
Alice Munro https://orcid.org/0000-0002-8914-3504
Katherine M. Conigrave https://orcid.org/0000-0002-6428-1441

REFERENCES

1. Australian Institute of Health and Welfare, Impact of alcohol and illicit drug use on the burden of disease and injury in Australia: Australian Burden of Disease Study 2011, in Australian Burden of Disease Study series no. 17. Cat. no. BOD 19. 2018: Canberra.
2. GBD. Alcohol collaborators, alcohol use and burden for 195 countries and territories, 1990–2016: a systematic analysis for the global burden of disease study 2016. Lancet. 2016;2018:1015–35.
3. Bramley D, Broad J, Harris R, Reid P, Jackson R, Alcohol Burden of Disease and Disability Group. Differences in patterns of alcohol consumption between Maori and non-Maori in Aotearoa (New Zealand). N Z Med J. 2003;116:U645.
4. Tjepkema M, Wilkins R, Senécal S, Guimond E, Penney C. Mortality of urban Aboriginal adults in Canada, 1991-2001. Prev Chronic Dis. 2011;8:A06.
5. Shield KD, Gmel G, Kehoe-Chan T, Dawson DA, Grant BF, Rehm J. Mortality and potential years of life lost attributable to alcohol consumption by race and sex in the United States in 2005. PLoS One. 2013;8:e51923.
6. Gracey M, King M. Indigenous health part 1: determinants and disease patterns. Lancet. 2009;374:65–75.
7. Gone JP, Hartmann WE, Pomerville A, Wendt DC, Klem SH, Burrage RL. The impact of historical trauma on health outcomes for Indigenous populations in the USA and Canada: A systematic review. Am Psychol. 2019;74:20–35.
8. NSW Department of Health. NSW clinical guidelines - for the care of persons with comorbid mental illness and substance use disorders in acute care settings. North Sydney: NSW Department of Health; 2009.
9. Saunders JB, Conigrave KM, Latt NC, Nutt DJ, Marshall EJ, Ling W, et al. Addiction medicine. Oxford specialist handbooks. 2nd ed. Oxford: Oxford University Press; 2016.
10. Screening for drugs of abuse [editorial]. Lancet. 1987;1:365–6.
11. Israelsson M, Gerdner A. Compulsory commitment to care of substance misusers: international trends during 25 years. Eur Addict Res. 2012;18:302–21.
12. Lunze K, Lermet O, Andreeva V, Hariga F. Compulsory treatment of drug use in southeast Asian countries. Int J Drug Policy. 2018;59:10–5.
13. Passey M, Bolitho J, Scantleton J, Flaherty B. The magistrates early referral into treatment (MERIT) pilot program: court outcomes and recidivism. Aust NZ J Criminol. 2007;40:199–217.
14. Werb D, Kamarulzaman A, Meacham MC, Rafful C, Fischer B, Strathdee SA, et al. The effectiveness of compulsory drug treatment: A systematic review. Int J Drug Policy. 2016;28:1–9.
15. PricewaterhouseCoopers Indigenous Consulting. Evaluation of the Alcohol Mandatory Treatment program. Darwin: Northern Territory Department of Health; 2017.
16. Piper DLA. Review of the severe substance dependence treatment act 2014 (Vic). Melbourne: Victorian Department of Health; 2014.
17. Dore G, Sinclair B, Murray R. Treatment resistant and resistant to treatment? Evaluation of 40 alcohol dependent patients admitted for involuntary treatment. Alcohol Alcohol. 2016;51:291–5.
18. Hall W, Farrell M, Carter A. Compulsory treatment of addiction in the patient's best interests: more rigorous evaluations are essential. Drug Alcohol Rev. 2014;33:268–71.
19. Broadstock M, Brinson D, Weston A. The effectiveness of compulsory, residential treatment of chronic alcohol or drug addiction in non-offenders. Christchurch: Health Services Assessment Collaboration; 2008.
20. Vuong T, Gillies M, Larney S, Montebello M, Ritter A. The association between involuntary alcohol treatment and subsequent emergency department visits and hospitalizations: a

Bayesian analysis of treated patients and matched controls. Addiction. 2022;117:1589–97.
21. Aboriginal Health & Medical Research Council, Aboriginal communities improving Aboriginal health: An evidence review on the contribution of Aboriginal Community controlled Health Services to improving Aboriginal health; 2015.
22. Australian Institute of Health and Welfare. Substance use among Aboriginal and Torres Strait Islander people. Canberra: AIHW; 2011.
23. Klag S, O'Callaghan F, Creed P. The use of legal coercion in the treatment of substance abusers: an overview and critical analysis of thirty years of research. Subst Use Misuse. 2005;40:1777–95.
24. Lander F, Gray D, Wilkes E. The alcohol mandatory treatment act: evidence, ethics and the law. Med J Aust. 2015;203:47–9.
25. Walton MT, Hall MT. Involuntary civil commitment for substance use disorder: legal precedents and ethical considerations for social workers. Soc Work Public Health. 2017;32:382–93.
26. Slonim-Nevo V. Clinical practice: treating the non-voluntary client. Int Soc Work. 1996;39:117–29.
27. King M, Smith A, Gracey M. Indigenous health part 2: the underlying causes of the health gap. Lancet. 2009;374:76–85.
28. Pulver L, Haswell MR, Ring I, Waldon J, Clark W, Whetung V, et al. Indigenous health - Australia, Canada, Aotearoa New Zealand and the United States - laying claim to a future that embraces health for us all. World health report (2010). Background paper 33. Geneva: World Health Organization; 2010.
29. Sherwood J. Colonisation - it's bad for your health: the context of Aboriginal health. Contemp Nurse. 2013;46:28–40.
30. New South Wales Ministry of Health, *Drug and Alcohol Treatment Act* 2007 No 7. Sydney: NSW Government; 2018.
31. Vuong T, Sotade O, Beadman K, Ritter A. An evaluation of outcomes in the NSW involuntary drug and alcohol treatment (IDAT) program. Sydney: University of New South Wales; 2019.
32. Sandelowski M. What's in a name? Qualitative description revisited. Res Nurs Health. 2010;33:77–84.
33. Lincoln Y, Guba E. Naturalistic inquiry. California: Sage Publications; 1985.
34. Hsieh H, Shannon S. Three approaches to qualitative content analysis. Qual Health Res. 2005;15:1277–88.
35. Glaser BG, Strauss AL. The discovery of grounded theory: strategies for qualitative research. Chicago: Aldine Publishing Company; 1967.
36. Australian Institute of Health and Welfare. Cultural safety in health care for Indigenous Australians: monitoring framework. Canberra: AIHW; 2022.
37. Wilson R. Bringing them home. National inquiry into the separation of Aboriginal and Torres Strait Islander children from their families. Canberra, Australia: Human Rights and Equal Opportunity Commission; 1997.
38. Jones C. Levels of racism: a theoretic framework and a gardener's tale. Am J Public Health. 2000;90:1212–5.
39. Doyle MF, Guthrie J, Butler T, Shakeshaft A, Conigrave K, Williams M. Onset and trajectory of alcohol and other drug use among Aboriginal men entering a prison treatment program: A qualitative study. Drug Alcohol Rev. 2020;39:704–12.
40. Evans A. Transference in the nurse–patient relationship. J Psychiatr Ment Health Nurs. 2007;14:189–95.
41. Preuss K, Napanangka BJ. Stopping petrol sniffing in remote Aboriginal Australia: Key elements of the Mt Theo program. Drug Alcohol Rev. 2006;25:189–93.
42. Teasdale KE, Conigrave KM, Kiel KA, Freeburn B, Long G, Becker K. Improving services for prevention and treatment of substance misuse for Aboriginal communities in a Sydney Area Health Service. Drug Alcohol Rev. 2008;27:152–9.
43. Brady M. Indigenous and government attempts to control alcohol use among Australian Aborigines. Contemp Drug Probl. 1990;17:195–200.
44. Grant E. Approaches to the design and provision of prison accommodation and facilities for Australian Indigenous prisoners after the Royal Commission into Aboriginal deaths in custody. Aust Indig Law Rev. 2013;17:41.
45. Dore GM, Batey RG, Smyth DJ. Involuntary treatment of drug and alcohol dependence in New South Wales: an old act and a new direction. Med J Aust. 2013;198:583–5.
46. Marmot M, Allen J, Bell R, Bloomer E, Goldblatt P, Consortium for the European Review of Social Determinants of Health and the Health Divide. WHO European review of social determinants of health and the health divide. Lancet. 2012;380:1011–29.
47. Nolan-Isles D, Macniven R, Hunter K, Gwynn J, Lincoln M, Moir R, et al. Enablers and barriers to accessing healthcare services for Aboriginal people in New South Wales, Australia. Int J Environ Res Public Health. 2021;18:3014.
48. Dale E, Conigrave KM, Kelly PJ, Ivers R, Clapham K, Lee KSK. A Delphi yarn: applying Indigenous knowledges to enhance the cultural utility of SMART Recovery Australia. Addict Sci Clin Pract. 2020;16:2.
49. Lee KSK, Dawson A, Conigrave KM. The role of an Aboriginal women's group in meeting the high needs of clients attending outpatient alcohol and other drug treatment. Drug Alcohol Review. 2013;32:616–26.
50. James DB, Lee KSK, Patrao T, Courtney RJ, Conigrave KM, Shakeshaft A. Understanding the client characteristics of Aboriginal residential alcohol and other drug rehabilitation services in New South Wales. Australia. Addict Sci Clin Pract. 2020;15:27.
51. Australian Broadcasting Corporation (ABC) News, Health workers on front line in fight against drugs 'shocked' by $200m funding cut, in ABC Online; 2015.

How to cite this article: Lee KSK, Bullen LM, Zheng C, Dawson A, Munro A, Conigrave KM. Beliefs and attitudes of drug and alcohol clinicians when considering referral of Aboriginal clients to involuntary drug and alcohol treatment: A qualitative study. Drug Alcohol Rev. 2022. https://doi.org/10.1111/dar.13549