



Jonathan Brett
Leanne Lawrence
Rowena Ivers
Katherine Conigrave

Outpatient alcohol withdrawal management for Aboriginal and Torres Strait Islander peoples

Background

There is concern from within Aboriginal and Torres Strait Islander communities about the lack of access to alcohol withdrawal management ('detox') services. Outpatient detox is described within national Australian guidelines as a safe option for selected drinkers. However, uncertainty exists as to how suited Aboriginal and Torres Strait Islander peoples are to this approach.

Methods

Consultations were conducted with stakeholders of four health services providing outpatient detox for Aboriginal and Torres Strait Islander peoples in NSW. Thematic analysis was performed to determine elements perceived as important for success.

Results

Key themes that emerged were individual engagement, flexibility, assessment of suitability, Aboriginal staff and community engagement, practical support, counselling, staff education and support, coping with relapse and contingency planning.

Discussion

There is a need to improve access to alcohol detox services for Aboriginal and Torres Strait Islander peoples. The outpatient setting seems to be a feasible and safe environment to provide this kind of service for selected drinkers.

Keywords

population groups; alcohol drinking; outpatients

There is significant concern from within Aboriginal and Torres Strait Islander communities about the harms associated with alcohol consumption. Although more Aboriginal and Torres Strait Islander peoples abstain from alcohol, compared with non-indigenous Australians, those who do drink are twice as likely to have consumed alcohol at levels that place them at risk of harm.¹ In keeping with this, Aboriginal and Torres Strait Islander peoples experience alcohol-related harms at 2–3 times the rate of that for non-Indigenous Australians.² Factors that contribute to this situation include stress, disadvantage and ongoing trauma. Despite this increased risk, however, reportedly there is a significant gap between service need and its provision and accessibility.³ This means that many Aboriginal and Torres Strait Islander peoples who are alcohol-dependent are unlikely to receive treatment.

Withdrawal management can be an essential step on the path to abstinence but may also help to interrupt a pattern of heavy and dependent use, and facilitate engagement in further treatment. Medical management of withdrawal involves assessing the severity of alcohol dependence, other drug use, medical and mental health problems and social problems, and determining the appropriate environment for withdrawal to occur. Management of withdrawal includes prescribing short-course diazepam where indicated to reduce withdrawal severity, and thiamine to reduce the risk of the Wernicke-Korsakoff syndrome. This approach reduces the risk of serious complications such as withdrawal seizures and

severe, complicated withdrawal including alcohol withdrawal delirium (delirium tremens).

Outpatient alcohol withdrawal is a treatment approach used around the world. It is included in Australian national treatment guidelines⁴ and *Alcohol Treatment Guidelines for Indigenous Australians*.⁵ Criteria must be met to be eligible for this (Table 1). At conferences, clinicians have expressed concerns about the safety of outpatient withdrawal management for Aboriginal and Torres Strait Islanders who consume alcohol. These concerns are likely to have arisen from observations of disadvantaged areas with large, crowded households containing multiple drinkers. However, Aboriginal community members in one urban region have expressed an interest in outpatient withdrawal management⁶ and a number of urban and regional services anecdotally occasionally provide this service to Aboriginal patients with successful outcomes. Here we discuss the potential role of outpatient withdrawal management services for Aboriginal and Torres Strait Islander peoples. Mainstream models of outpatient withdrawal management services are examined. We then describe selected services with experience in providing outpatient alcohol withdrawal for Aboriginal and Torres Strait Islander peoples, and highlight elements perceived by service providers as important for success.

Alcohol withdrawal management: current services and barriers

At present, alcohol withdrawal management often occurs in a residential setting (in a general hospital or a specialist withdrawal management facility). These expensive beds are in high demand,⁷ leading to long waiting lists. Some people who are alcohol-dependent may prefer residential care as a 'time

out' from challenging circumstances, or a setting in which it is easier to avoid alcohol; in other cases they simply may not know that outpatient treatment options exist.⁶

There are many barriers to accessing residential treatment services, including distance from the nearest service, transport difficulties, childcare,⁶ language, and shame and fear of stigmatisation. There is also a dearth of easily accessible, culturally secure services.

A recent national report identified a deficiency in the availability of withdrawal management services for Aboriginal and Torres Strait Islander peoples, and prioritised this as a key area for development.⁹ It also recognised the role of outpatient withdrawal management from mainstream literature.⁹ To our knowledge, however, there are no formal residential withdrawal management programs currently operating within NSW specifically for Aboriginal and Torres Strait Islander peoples.

Outpatient withdrawal management: likely applicability to Aboriginal and Torres Strait Islander peoples

A variety of models for mainstream non-residential alcohol withdrawal management services have been evaluated. Ambulatory withdrawal management involves patients visiting appropriately trained staff at a local clinic daily.¹⁰ Home withdrawal management involves health professionals travelling regularly to patients' homes after an initial assessment.¹¹ Home withdrawal management has the advantage of optimising engagement, particularly for individuals who are less able to attend the clinic daily. The disadvantage of this approach is the cost and additional risk to staff. Models include those which are nurse led and involve partnerships with primary healthcare providers.^{11,12}

Current mainstream literature supports many individuals being suitable for outpatient management.¹¹ Australian guidelines provide clear selection criteria for this pathway.⁴ Individuals meeting these criteria include those who are alcohol-dependent, have a predicted mild-to-moderate withdrawal, a safe, alcohol-free 'home' environment and a reliable support person. In Aboriginal and Torres Strait Islander communities, relatives can often provide such a safe environment even if a person's primary residence is overcrowded or contains drinkers. However, significant medical or psychiatric comorbidities and unstable social environments may exclude some Aboriginal and Torres Strait Islander peoples from outpatient management.

Not all Aboriginal and Torres Strait Islander peoples will experience withdrawal symptoms when they stop consuming alcohol. The episodic drinking patterns observed in Aboriginal communities¹ often mean that risk of tolerance, and hence withdrawal, is lower.¹³ However, those who do experience withdrawal symptoms may be more at risk of complications due to higher rates of medical and psychiatric comorbidities.

There is a dearth of research examining which alcohol interventions or models of care work best for Aboriginal and Torres Strait Islander peoples.¹⁴ Consequently, it is not known which outpatient withdrawal management model would best suit Aboriginal and Torres Strait Islander peoples.

Health services specifically for Aboriginal and Torres Strait Islander peoples, which are community controlled and include trained Aboriginal alcohol workers, may be well placed to provide outpatient withdrawal management. On the other hand, some patients prefer the anonymity of a mainstream service where they are less likely to meet friends or relatives.¹⁵ It may be important to have a range of options.

Anecdotally, community controlled Aboriginal health services and mainstream services have

provided outpatient withdrawal safely and effectively for carefully selected Aboriginal and Torres Strait Islander peoples. To our knowledge, however, there are no formal outpatient withdrawal management programs specific for Aboriginal and Torres Strait Islander peoples. The aim of this paper is to determine the successful components of a selection of urban and regional services that provide outpatient alcohol withdrawal management to Aboriginal and Torres Strait Islander peoples on an ad hoc basis.

Methods

Service providers' experiences

As part of the consultation to inform the design of an outpatient withdrawal management service specific for Aboriginal and Torres Strait Islander peoples, one author (JB) contacted five services that had been identified by colleagues as sporadically providing outpatient alcohol withdrawal management to Aboriginal and Torres Strait Islander peoples. These services, which are urban or regional, include Illawarra Aboriginal Medical Service (AMS), La Perouse Aboriginal Community Health Centre, Bowral Community Health Centre, Wyong Hospital and Canterbury Hospital. The Aboriginal Health & Medical Research Council (AH&MRC) ethics committee granted approval for this project (Approval number 965/13).

Semi-structured interviews were performed in person or by telephone with 1–3 key staff members involved with delivering outpatient withdrawal management (doctors, nurses and Aboriginal alcohol and/or drug workers) at each site. Participants were asked how their service was delivered, about any problems they had encountered and features they considered important for successful delivery. Notes were taken during the consultations and thematic analysis of these notes was conducted by one investigator (JB). Resulting themes were checked by two other authors (KC and LL), one of whom is an Aboriginal health professional.

Results

Several key themes were identified

Initial individual engagement

Staff of all services stressed the importance of patient engagement. Staff described the

Table 1. Eligibility criteria for outpatient alcohol withdrawal management

- No previous severe withdrawal including seizures or delirium tremens
- No concurrent acute medical illness
- No evidence of suicidal thoughts, severe depression or psychosis
- No evidence of other drug use (except cannabis)
- Supportive, stable and drug- and alcohol-free home environment (this could be a friend or relative's home temporarily)

development of rapport and trust, which may take several consultations, before the discussion of withdrawal management. This process involves listening to the individual's issues and story as the patient wants to tell it, as well as helping with practical problem-solving, for example linking to social services, financial supports and other health services specific for Aboriginal and Torres Strait Islanders. A feeling of trust and commitment can then lead to better program completion rates and a longer lasting therapeutic relationship.

Flexibility

Most services felt that being able to facilitate assessment for withdrawal management as soon as the patient is ready (without waiting lists) was important. Flexibility can reduce the chance of a window of opportunity being missed and the patient disengaging. On the other hand, all services aimed to start withdrawal management at the beginning of the working week so that early monitoring would be possible. This also avoids the risk of complications arising over the weekend when staff are not available. Staff encourage patients to use the gap between assessment and initiation for preparation.

Initial assessment of suitability

Australian national guidelines for alcohol treatment⁴ were used as a basis for deciding suitability for outpatient withdrawal at all centres and service-specific guidelines were also created. Of particular importance was ensuring the patient was staying at a safe, 'dry' house with a responsible person during the program. This may have been at their home or with a relative.

Services indicated that sometimes the risk of undertaking outpatient withdrawal in an individual with chronic disease had to be balanced against the risk of continued drinking if no inpatient services were available; it is often a case of choosing the 'least worst' option. They also indicated that patients with stable chronic diseases had successfully completed outpatient withdrawal.

Aboriginal staff and community engagement

Staff reported that some patients prefer to see Aboriginal alcohol and other drug (AOD) workers who understand culture and community. However, other patients may prefer to keep some distance

from Aboriginal staff members whom they know personally. Staff at most services identified a community ownership of the service as being important and that this empowers the community to prioritise and tailor treatment approaches on the basis of their values and so improve acceptability and engagement. One service felt strongly that ongoing community involvement and feedback are important to maintain, as any negative experiences could otherwise threaten the continuity of the program.

Practical support, transport and medicines

It was reported that many patients do not have access to private vehicles and so rely on public transport, which can be costly, time-consuming or simply unavailable. Staff at most services stated that either offering a transport service or reimbursement for travel improves engagement. Free access to medicines used during the withdrawal process and free or concessional access to relapse prevention medicines such as naltrexone and acamprosate was also reported to help engagement. Access to programs such as the Close the Gap Medicare co-payment scheme has helped with this.

One service observed that having medicines available on site removes the barrier of the need to travel to a pharmacy. However, as only doctors, pharmacists or nurse practitioners are able to dispense prescription medicines in most Australian states, this can pose a practical challenge. At one service, doctors or a pharmacist prepackage medicines in envelopes for nurses to hand out daily. Another option is for patients to pick up medicines daily from a local pharmacist. One service emphasised the importance of engaging with local pharmacies regularly to receive feedback on patient progress and provide advice and support.

Counselling

Counseling was seen as important for patient engagement and program completion at most services and was delivered on either a formal or informal basis. Counselling often included practical and supportive elements, and was not confined to one modality (eg cognitive behavioral or motivational) but tailored to the needs of the patient by drug and alcohol workers, nurses or counsellors. One service also provided formal counselling

before the program to improve engagement and motivation.

Staff education and support

All services commented that cultural awareness of non-Indigenous staff is important to reduce barriers to treatment access. In non-community controlled services this was typically achieved through the involvement of Aboriginal health staff and partnership with community. It was observed that appropriate professional development or continuing education for Aboriginal Alcohol and other drugs (AOD) workers, and their having a sense of being supported by medical staff and of program ownership were important for program success and sustainability.

Coping with relapse

When an individual slips back to drinking they often experience shame that can itself increase the risk of a full relapse. Accordingly, a non-judgmental, accepting approach should be used to sustain patient engagement. For example, one service described that if a patient reported having had two or three drinks during the program, the patient's honesty was applauded, and motivation and commitment to the program encouraged. In the event of a relapse to heavy drinking, the program could be postponed to a later date to maintain patient engagement.

Planning for when things go wrong

Through careful patient selection, medical emergencies such as unanticipated severe withdrawal or seizures were very rare. However, staff typically felt it was important for community-based services to be supported by a 24-hour hospital inpatient service in the case of emergencies. A clear plan was also provided to patients in case of deterioration or emergency.

Discussion

There is a great need to improve access to alcohol treatment services for Aboriginal and Torres Strait Islander peoples. Current inpatient withdrawal management services have many barriers to accessibility. Outpatient withdrawal management seems to be a safe and feasible treatment option for a selected group of urban and regional Aboriginal and Torres Strait Islander peoples

in NSW and is sporadically being successfully provided by a range of community-based services. A range of models have been used, all involving a team approach where, often, GPs play a key part, either within AMSs or in partnership with nurses in community health centres and pharmacists. Key principles for effective delivery of such services are presented in this paper.

This study is limited by the non-random selection of services and so generalisability of these approaches to other services and regions cannot be assumed. Remote areas may pose particular challenges, including crowded housing, cultural and language differences, lack of specialist or inpatient services for backup and, in some cases, a whole community affected by alcohol. There are anecdotal reports, however, of successful management by GPs of outpatient withdrawal, even in remote settings.

In general practice, cultural appropriateness and accessibility of services can be improved by partnerships with Aboriginal and Torres Strait Islander staff, or consultation with local Aboriginal controlled community health services.¹⁶ To support delivery of alcohol services, health professionals in all states and territories have access to 24-hour phone support services such as the Drug and Alcohol Specialist Advisory Service.¹⁷ We hope this work will assist the further development and evaluation of outpatient alcohol withdrawal management services for Aboriginal and Torres Strait Islander peoples.

Implications for general practice

- Outpatient alcohol withdrawal is a safe and feasible option for a selected group of Aboriginal and Torres Strait Islander peoples in urban and regional NSW.
- Accessibility to such programs can be improved by working in partnership with Aboriginal staff and community.
- Principles of these programs may be used to adapt similar models of care for Aboriginal and Torres Strait Islander peoples in other areas of Australia.

Authors

Jonathan Brett MBBS (Hons), BMedSci (Hons), DMM, Advanced Trainee Addiction Medicine, Drug Health Services, Royal Prince Alfred Hospital, Sydney, NSW. jonathan.brett2005@gmail.com

Leanne Lawrence DipComServices, Cert III Health Office Procedures, Illawarra AMS Community Services Team Manager, Drug and Alcohol Program, Illawarra Aboriginal Medical Service, Wollongong, NSW

Rowena Ivers MBBS, FRACGP, FAFPHM, PhD MPH, general practitioner, Illawarra Aboriginal Medical Service, Wollongong, Associate Professor, Graduate School of Medicine, University of Wollongong, NSW

Katherine Conigrave FACHAM, FAFPHM, PhD Senior Staff Specialist, Drug Health Services, Royal Prince Alfred Hospital, Sydney, Professor, Faculty of Medicine, University of Sydney, NSW

Acknowledgements

We are grateful to the staff of the services that were consulted and to the AH&MRC for checking a draft of this paper. Funding for this project was provided by the Foundation for Alcohol Research and Education (FARE).

Competing interests: None.

Provenance and peer review: Not commissioned; externally peer reviewed.

References

1. Chikritzhs T, Brady M. Fact or fiction? A critique of the National Aboriginal and Torres Strait Islander Social Survey 2002. *Drug Alcohol Rev* 2006;25:277–87.
2. MacRae A, Thomson N, Burns J, et al. Overview of Australian Indigenous health status, 2012. Australian Indigenous HealthInfoNet, 2013. Available at www.healthinfonet.edu.au/overview_2013.pdf [Accessed March 2014].
3. Wilkes E, Gray D, Siggers S, Casey W, Stearne A. Substance misuse and mental health among Aboriginal Australians. In: Purdie N, Dudgeon P, Walker R (eds.) *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. 2nd edn. Canberra: Australian Government Department of Health and Ageing, 2010;117–34.
4. Guidelines for the Treatment of Alcohol Problems. Canberra: Australian Government Department of Health and Ageing, 2009. Available at www.drugsandalcohol.ie/20201/1/Guidelines_for_treatment_of_alcohol_problems.pdf [Accessed March 2014].
5. Alcohol Treatment Guidelines for Indigenous Australians. Canberra: Australian Government Department of Health and Ageing. Last updated: 3 February, 2014. Available at www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/AGIO2 [Accessed March 2014].
6. Conigrave K, Freeman B, Carroll T, et al. The Alcohol Awareness project: community education and brief intervention in an urban Aboriginal setting. *Health Promot J Austr* 2012;23:219–25.
7. Australian Institute of Health and Welfare. Substance use among Aboriginal and Torres Strait Islander people. AIHW, 2011. Available at www.aihw.gov.au/publication-detail/?id=10737418268 [Accessed March 2014].
8. Gray D, Stearne A, Wilson M, Doyle M. Indigenous-

- specific alcohol and other drug interventions: continuities, changes and areas of greatest need. Report prepared for National Indigenous Drug and Alcohol Council, Australian National Council on Drugs, 2010. Available at www.nidac.org.au/images/PDFs/rp20_indigenous.pdf [Accessed March 2014].
9. Hayashida M, Alterman AI, McLellan AT, et al. Comparative effectiveness and costs of inpatient and outpatient detoxification of patients with mild-to-moderate alcohol withdrawal syndrome. *N Engl J Med* 1989;320:358–65.
 10. Blondell RD. Ambulatory detoxification of patients with alcohol dependence. *Am Fam Physician* 2005;71:495–502.
 11. Carlebach S, Wake D, Hamilton S. Experiences of home detoxification for alcohol dependency. *Nurs Stand* 2011;26:41–47.
 12. Sannibale C, Fucito L, O'Connor D, Curry K. Process evaluation of an out-patient detoxification service. *Drug Alcohol Rev* 2005;24:475–81.
 13. Margolis SA, Ypinazar VA, Clough AR, Hunter E. Absence of alcohol withdrawal syndrome in a remote Indigenous community. *Med J Aust* 2008;189:596.
 14. Gray D, Siggers S, Sputore B, Bourbon D. What works? A review of evaluated alcohol misuse interventions among Aboriginal Australians. *Addiction* 2000;95:11–22.
 15. Taylor K, Thompson S, Davis R. Delivering culturally appropriate residential rehabilitation for urban Indigenous Australians: a review of the challenges and opportunities. *Aust N Z J Public Health* 2010;34:S36–40.
 16. 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;27:152–59.
 17. Australian National Council on Drugs. Information services for professionals. Available at www.ncnd.org.au/aod-sector/health-professionals [Accessed March 2014].

correspondence afp@racgp.org.au