

**Indigenous residential treatment programs
for drug and alcohol problems: Current status
and options for improvement**

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Abbreviations and acronyms

AA	Alcoholics Anonymous
ADAC	Aboriginal Drug and Alcohol Council (SA) Inc.
AGPS	Australian Government Publishing Service
AHL	Aboriginal Hostels Ltd
ANU	The Australian National University
AOD	alcohol and other drug
ATCA	Australian Therapeutic Communities Association
ATODS	Alcohol, Tobacco and Other Drug Services
ATSIC	Aboriginal and Torres Strait Islander Commission
CAAAPU	Central Australian Aboriginal Alcohol Program Unit
CAEPR	Centre for Aboriginal Economic Policy Research
COTSA	Clients of Treatment Services Agencies
DAA	(Commonwealth) Department of Aboriginal Affairs
DHFS	(Commonwealth) Department of Health and Family Services
DHSH	Department of Human Services and Health
FORWAARD	Foundation of Rehabilitation for Aborigines with Alcohol-Related Difficulties
GGT	Gamma-Glutamyl Transferase
GP	general practitioner
HRSCAA	House of Representatives Standing Committee on Aboriginal Affairs
MASH	Moree Aboriginal Sobriety House
NADA	Network of Alcohol and Drug Agencies
NARU	North Australia Research Unit
NASAS	Noongar Alcohol and Substance Abuse Service
NDARC	National Drug and Alcohol Research Centre
NDRI	National Drug Research Institute
NGO	non-government organisation
OATSIH	Office for Aboriginal and Torres Strait Islander Health
ORAC	Office of the Registrar of Aboriginal Corporations
PER	Program Effectiveness Review of Aboriginal Health
STD	sexually transmitted disease
TAFE	(College of) Technical and Further Education
TC	therapeutic community
UNSW	University of New South Wales
VADA	Victorian Alcohol and Drug Association

Summary

Commonwealth-funded residential rehabilitation programs for Indigenous problem drinkers or drug users were established in the 1970s as community-controlled organisations that were separate from Aboriginal Medical Services and independent of State drug and alcohol units. Structural and political factors during their development and growth have meant that many such programs are now poorly networked with sources of professional advice and other types of therapeutic community. They remain wedded to a single treatment regime and are insulated from change. On the other hand, some offer a range of vocational and skills-based activities as well as providing referrals for effective counselling. Trends in Indigenous drug and alcohol misuse are changing, with a decline in alcohol use and an increase in opiate use as the principal drug problem for those receiving services. Residential programs need to be informed and competent in order to respond to these changes. Fruitful avenues to pursue in order to improve their knowledge base and perspectives include providing better training for board members as well as facilitating exchanges with other, non-Indigenous therapeutic communities. Collaboration in quality improvement reviews, closer partnerships with local State drug and alcohol services and non-government organisation networks, and mandatory participation in the many available in-service training programs would contribute to achieving these goals.

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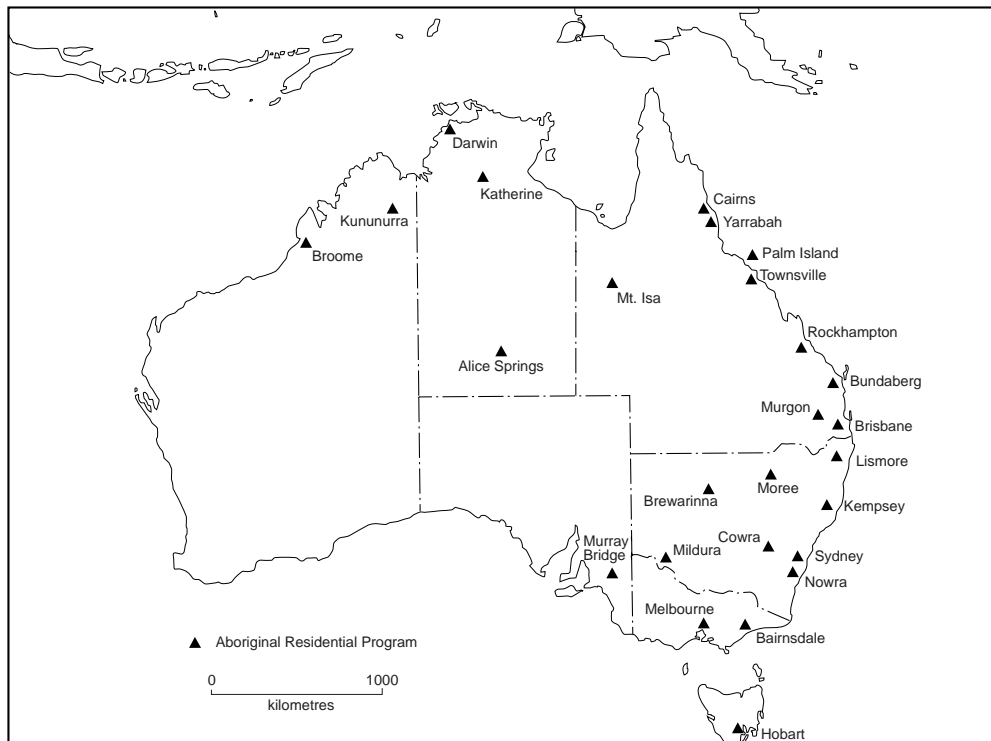
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Introduction

Through the Office for Aboriginal and Torres Strait Islander Health (OATSIH), the Commonwealth currently funds 26 residential rehabilitation programs in rural and urban areas for Aboriginal people with alcohol and/or other drug problems (see Fig. 1). These programs are designed for individuals with problems of dependence or long-term use, and provide stays of varying periods, from a few weeks to several months. There are three more OATSIH-funded programs, located in outback Central Australia. They are outstation-based, and target petrol sniffers. Out of the 26 OATSIH-funded residential programs, 18 also receive funding from Aboriginal Hostels Ltd. In addition, there are Indigenous residential programs which are primarily State-funded, and which may receive additional small grants from OATSIH. Altogether in Australia in 1999–2000 there were 33 residential facilities for Indigenous drug and alcohol treatment, according to Gray and colleagues (Gray et al. 2002: 26).

Fig. 1. Location of OATSIH-funded residential substance misuse programs, 2002



Residential alcohol programs usually employ Indigenous staff who are ex-drinkers themselves, with variable levels of training. These programs are non-government organisations (NGOs) and, because they are community-controlled, are run by Boards of Management or governing committees made up of members of the local Aboriginal community. Residential treatment is accepted as being the type of program most suitable for particular kinds of drinker. The literature on the general population suggests that residential programs are needed for those with few social supports, who are socially disintegrated as a result of their drinking, and who have severe dependency. They are particularly relevant for Aboriginal drinkers as they also provide time out and time away from the normal home environment which is frequently characterised by heavy drinking. Residential programs also have indirect functions, such as providing employment for, and maintaining the sobriety of, the ex-drinkers who work in them.

In 1999 a review of the Commonwealth's Aboriginal and Torres Strait Islander Substance Misuse Program noted that:

- services need to respond to changing trends in drug use (i.e. not just alcohol but polydrug use)
- the almost ubiquitous stress on abstinence goals deters a number of potential clients (particularly young people), from seeking treatment
- there is sometimes conflict between the approaches favoured by the boards of management of services, and those favoured by their staff
- there has been no attempt to provide boards of management with information about the variety of treatment options and available referrals.

In 2001 OATSIH commissioned the author, through the Centre for Aboriginal Economic Policy Research (CAEPR), to undertake research that would contribute to the resolution of these concerns. This Discussion Paper is based on selected research findings.

Cost and usage of residential programs

Usually known as 'rehab centres', the residential programs are a costly part of the overall OATSIH substance misuse budget. In 1996, 74 per cent of OATSIH's total Indigenous-specific drug and alcohol funding was directed into the residential treatment programs. This proportion has since diminished slightly, but in 1998 residential programs were still allocated about 50 per cent of the overall OATSIH substance misuse budget (Department of Health and Family Services (DHFS) 1998: 84,134). This totalled \$17.3 million in 1997–98. In 2002, Gray et al. reported on all expenditure on Indigenous drug and alcohol projects—that is, on Commonwealth, State and Territory-funded projects. They found that treatment projects accounted for the largest percentage of expenditure of all alcohol and other drug intervention projects, and that residential treatment accounted for 33.8 per cent of this total expenditure (2002: 30). Together the Commonwealth,

State and Territory expenditure on residential treatment totalled \$12 million in 1999–2000 (Gray et al. 2002: 37). A review by Ernst and Young (1996) of residential treatment across Australia found that the average annual expenditure per residential place was highest for Aboriginal programs.

The overall trend for the general population is to use non-residential services, which are now more prevalent than residential services. Aboriginal people are more likely to use residential forms of treatment than are non-Aboriginal Australians, according to a regular census of Clients of Treatment Service Agencies (COTSA) (Chen, Mattick & Baillie 1993; Shand & Mattick 2002a; Torres et al. 1995). The percentage of clients of treatment services who are Aboriginal or Torres Strait Islander has increased between 1990 and 2001, the date of the last national census. In 1990, 8.8 per cent of substance users in treatment in Australia were Indigenous, and in 2001, 11 per cent were Indigenous. As well as using Aboriginal-specific residential programs, Aboriginal clients are evidently accessing non-specific residential treatment services, although it is difficult to establish exactly how many of them do so. A 'Clients of Residential Agencies' database exists for 23 non-governmental residential treatment agencies funded by the New South Wales Drug and Alcohol Directorate. Only two of these have targeted Aboriginal clients. The database was examined for admissions between 1988 and 1992, including Aboriginal admissions (see Table 1).

Table 1. Clients of New South Wales non-governmental residential treatment agencies with alcohol as primary problem, 1988–92

	1988 (%)	1989 (%)	1990 (%)	1991 (%)	1992 (%)
Aboriginal	14.4	11.0	14.0	9.3	12.7
Non-Aboriginal	85.6	89.0	86.0	90.7	87.3
Total (no.)	423	1006	1030	1063	1168

Source: Kelaher et al. 1995: 4.

Although the actual numbers are quite small, the proportion of Aboriginal clients (about 13%) in these primarily mainstream residential programs is greater than the proportion of Aboriginal people in the general population (about 1.5% at 1991 Census). However, an evaluation by Turning Point of four residential programs in Victoria in 1998–99 found that participation of Aboriginal people in mainstream programs was 'minimal' (Berends et al. 1999: 68). Attempting to explain this minimal participation in mainstream 'therapeutic communities' (TCs), the evaluators suggested that the services had limited capacity to house family members, and one centre dealt with polydrug rather than alcohol misuse. It is also possible that Aboriginal services do not choose to refer their clients to mainstream programs. The Turning Point evaluators noted that TCs were attempting to increase the receptivity of their programs to Indigenous clients by training their staff, liaising with an Aboriginal service, and undertaking a cultural diversity audit.

Program content

It is now generally agreed that to be successful, treatment programs should assess the variety of client needs and provide services to meet those needs effectively. Several reviews have voiced concerns about whether this is occurring for Aboriginal clients. In 1993, a Quality Assurance Project which reviewed different forms of alcohol treatment for the majority population in Australia, observed that the Aboriginal residential programs needed to provide ‘a greater quality and diversity of treatment programs ... it appears that one model of treatment tends to dominate the current services’ (Mattick & Jarvis 1993: 222). This comment refers to services based on the Twelve Steps model (associated with Alcoholics Anonymous (AA)), or the Minnesota ‘chemical dependency’ approach. These models promote the goal of abstinence as being the only recourse for the problem drinker, and usually conceive of alcoholism as a disease.

Another study reinforces the findings of Mattick and Jarvis. In a survey of 178 drug and alcohol agencies Australia-wide, 29 were providing in- and out-patient services primarily for Aboriginal people. There were 11 State-run agencies, and 18 community-controlled agencies. Only five of the 18 Aboriginal community-controlled agencies were offering a broad range of approaches, while the others were based solely on the Minnesota model (Brady, Dawe & Richmond 1998). Most of the agencies that offered a range of treatment and counselling approaches to Aboriginal people were State alcohol and other drug services. However, there are examples of independent Aboriginal residential programs that are not solely abstinence-oriented such as Marralam and Milliya Rumurra in Western Australia, and Roy Thorne Centre in Moree, New South Wales (Ellis 1998; Sputore et al. 1998: 52).

Although when it comes to ‘treatment’ in its literal sense, the majority of Aboriginal-specific residential programs have a narrow focus, it must be said that these programs do offer variety in other ways. There are programs that offer their clients agriculture and horticulture experience, building and carpentry skills, permaculture training, healing circles, massage, Reiki therapy, and approaches identified by them as ‘cultural’, such as daily smoking ceremonies, Aboriginal art activities, collecting wood for carving, or visits to the bush. Other activities in different programs include line dancing, karaoke and sing-alongs. Residential program managers stress to varying degrees the special qualities of these centres as being that they are staffed by Indigenous people, are family oriented, have kinship links and are ‘like everyone’s auntie and uncle’.

The issues raised by the Quality Assurance Review—that Aboriginal programs tend to have a narrow treatment focus, and that Aboriginal people are more likely to use a residential program than non-Aborigines—are relevant for a number of reasons. The best advice of national and international drug and alcohol treatment expert reviews warns against a narrow focus on any single treatment approach. This limits the range of individuals who can receive help with their drinking, and is not scientifically justified. Results from the few randomised controlled trials of different forms of treatment suggest that AA-style approaches are no better than,

and may be inferior to, alternative therapies (Proudfoot & Teesson 2000). Indeed, the Quality Assurance Review stated unequivocally:

[T]here is currently no convincing evidence supporting the use of treatment based *solely* upon the 12-Step model ... and it is unacceptable that agencies or government bodies allow the continuance of interventions that are of unproven efficacy when there are interventions that have proven efficacy available (Mattick & Jarvis 1993: 220).

The fact that most residential programs offer few treatment options is of concern to government agencies that fund and support efforts to improve responses to alcohol-related problems among Aboriginal and Torres Strait Islander people. Concerns have been expressed in various forms for over 20 years about the limited range of approaches available to Aboriginal clients, the need for workers in such centres to have training, and the lack of evidence of effectiveness. The emphasis on alcoholism as a disease in AA, Minnesota and Co-dependency model programs is to be expected; however the disease model is one of several alternative explanations for a complex phenomenon. Whether it explains alcohol misuse in general, or among Aboriginal people in particular, is a matter of ongoing debate, doubt and research (Casey et al. 1998; d'Abbs 1990: 24–5). Effective programs need to engage in an open-minded search for intervention and counselling strategies that meet the needs of clients. D'Abbs considers that the residential programs are problematic not necessarily because they choose a particular model of treatment, but for 'the degree of rigidity, bordering on closed-mindedness' (1990: 25), that many of them demonstrate. Not all clients of residential programs fit the mould of the 'classic' alcoholic; many are episodic heavy drinkers, are young, and use alcohol in conjunction with other drugs. In short, there are strong indications that notwithstanding the 'cultural' and recreational programs on offer, residential programs should be encouraged to broaden the range of counselling and treatment approaches offered to clients while they are resident.

Substances used

A major argument for the need for a broader range of treatment approaches and a better mix of trained and untrained staff, is the changing face of substance use within the Indigenous population. Apart from anecdotal evidence for this change, the COTSA censuses provide us with more substantial evidence. COTSA is a national census conducted to identify the characteristics of clients attending drug and alcohol treatment services. Because it is conducted every few years (2001 was the fourth COTSA census), it allows for comparison over time. Participation in the census is voluntary and fewer Aboriginal than mainstream agencies responded to the survey, partly because they had drug and alcohol staff positions vacant on the day of the census (Fiona Shand, pers. comm. 12 November 2001). Nevertheless, the censuses show that over the last ten years, alcohol has been declining as the principal drug problem for Aboriginal people receiving services.

Other drug problems, particularly opiate use (including heroin) have been on the increase (see Table 2).

Table 2. Principal drug problems of Indigenous substance users in treatment, 1990, 1992, 1995, 2001^a

Drug problem	1990 (n=485)	1992 (n=520)	1995 (n=554)	2001 (n=544)
Alcohol	82.8%	81.8%	76.5%	57.1%
Opiates	7.9%	8.8%	12.5%	18.4%
Tobacco	8.5%	10.8%	5.4%	3.5%
Benzodiazepines	0.9%	1.3%	1.4%	0.9%
Cannabis	2.5%	8.5%	9.2%	9.0%
Amphetamines	1.4%	2.5%	2.7%	4.6% ^b
Polydrug (including opiates)	3.9%	3.3%	6.0%	19.2%
Injected drugs in past 12 months	8.0%	12.4%	16.2%	22.6%

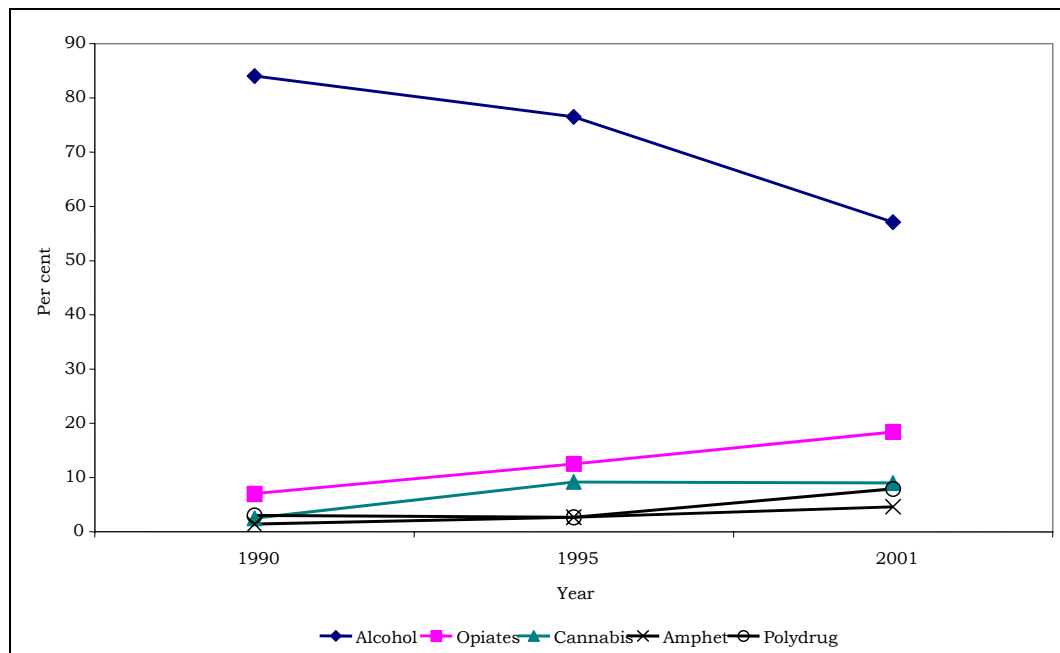
Notes: (a) Figures reflect more than one drug problem for some participants.

(b) The 2001 figure includes amphetamine-related substances (e.g. ecstasy).

Source: Shand and Mattick 2002b: 355, Table 4.

The trend downward for alcohol as the principal problem, and upward for other drugs as the principal problem shows more clearly in Fig. 2.

Fig. 2. Principal drug problem of Indigenous people receiving services, 1990, 1995, 2001



With the increased trend for drug and alcohol services (including residential programs) to be seeing Aboriginal drug users rather than people with alcohol problems, the reliance on untrained ex-drinkers as staff and counsellors becomes more and more inappropriate.

Development of residential program funding

The first 'independent' Aboriginal-run residential program was Benelong's Haven, started by Val Bryant, a long-term AA member, in 1974. In the following years, Bryant and co-workers travelled to Aboriginal settlements in Queensland and New South Wales, holding AA meetings and spreading the word about Benelong's. This process spawned several offshoots including Moree Aboriginal Sobriety House (MASH), the Foundation of Rehabilitation for Aborigines with Alcohol-Related Difficulties (FORWAARD) in Darwin, Wandering in Western Australia, Namatjira Haven in Lismore, and a centre for Palm Island. In this way, the Twelve Step model was disseminated to Aboriginal people across broad regions of the country (Brady 1999: 103; Carroll & Wilson 1984).

From the time of their inception in the early 1970s, the community-controlled alcohol programs found that they could attract separate funds from the Department of Aboriginal Affairs (DAA), and this provided them with independence from other Aboriginal organisations such as the Aboriginal Medical Services (which had been established around the same time). The two movements for community control—in alcohol rehabilitation and in primary health care—developed separately, and relationships between them have been fractious at times. The medical services and alcohol rehabilitation programs were established by different groups of activists, who took different approaches to problem drinking. The availability of funds from DAA had the effect of stimulating Aboriginal efforts to develop separate treatment facilities (House of Representatives Standing Committee on Aboriginal Affairs (HRSCAA) 1976-77: 2677), rather than the seeking of other ways of offering these services to dependent drinkers. The untied Commonwealth monies came without performance requirements, advice on best practice, or requirements to create partnerships with local health authorities.

In 1976 a HRSCAA subcommittee, chaired by Phillip Ruddock, was appointed to examine the 'Alcohol Problems of Aboriginals'. One outcome was that more residential programs received funding. By 1980 they accounted for 50 per cent of the DAA's allocation for alcohol problems (Wilson 1986). The 1980 *Program Effectiveness Review of Aboriginal Health* (PER) expressed scepticism about the programs (Department of Prime Minister and Cabinet 1980).

Once established, the residential programs continued to be funded and to receive the bulk of available funding, year after year. More than half of the existing residential alcohol programs (15 out of 26) have continued to be funded since before 1989 when DAA controlled Commonwealth funding of Aboriginal health (see Appendix A). To a large extent, this continued until the present day, although

in 1986 the DAA had attempted to redirect its policy approach (and its funds) away from residential rehabilitation and towards a greater emphasis on prevention and community education (Huddleston 1987a, 1987b). Such a shift in emphasis was in keeping with changing national policy directions; it offered an opportunity for the rationalisation of the residential programs and the institutionalisation of a wider range of approaches to problem drinking. This initiative was impeded by the formation of the Aboriginal and Torres Strait Islander Commission (ATSIC) in 1989 and the dissolution of the DAA as a distributor of Commonwealth funds, and also by a resurgence of emphasis on the importance of residential treatment as a result of the influence of visiting North American (primarily Canadian) Indigenous treatment activists (Brady 1995b). From 1989 onwards, following these visits, there was intensified pressure from Aboriginal collectivities for the Commonwealth to fund more residential centres. From 1990 to 1995 this funding was administered by ATSIC. In 1995 the responsibility for the funding for health and substance misuse passed to OATSIH in the Commonwealth Department of Health and Aged Care.

One outcome of these historical and structural influences has been that many residential programs are poorly networked with other agencies that could provide professional support and input. This became more and more crucial following the increasing sophistication and variety of treatment approaches available in Australia generally from the mid 1980s. In 1996, a review of long-term residential treatment programs observed:

there was little evidence of any effective links between Aboriginal treatment programs across Australia or between programs operated by Aboriginal councils/agencies and those operated by other organisations. There is a need to develop such a network to encourage the sharing of successful treatment strategies for Aboriginal people (Ernst & Young 1996: 82).

Administrative structures

In order to obtain DAA funding, the Aboriginal alcohol rehabilitation programs were required to have a primarily Aboriginal board of management or committee. These boards were composed of 'well-meaning people in the Aboriginal community' according to alcohol worker Cyril Hennessy. In 1981, he pointed out that in many cases the managing boards did not know what they were doing, that there was frequently confusion and conflict between them, and that there was no management training provided for any of them (Hennessy 1981). The federal government was unable to provide enough field staff to give them the ongoing support that could have helped to disentangle these problems (Wilson 1986). It appears that many of these problems of governance persist. Administrative and staff issues are frequently major barriers to success in residential programs (Sputore et al. 1998: 84; Dennis Gray pers. comm. 1998). These problems of governance are by no means restricted to residential alcohol programs. Mantziaris and Martin (2000: 277–80), discussing Native Title corporations, identify several sites of potential conflict within a range of Aboriginal corporations including

disputes within or between families, issues of representation, localism and competition for resources.

In many alcohol programs there is still an unresolved confusion about the roles of the boards and the managers. Their separate roles have been described in the following way: 'the directors are the mind of the organisation, managers are the hands' (Sharma 2001: 3). This 'separation of powers' is difficult to bring about or sustain in situations where there may be a relatively small group of interested and capable Indigenous people willing to devote time to drug and alcohol issues. In addition, as Mantziaris and Martin point out, notwithstanding the service delivery aspect of an organisation, the boards 'often comprise individuals associated with specific factions or families, rather than being drawn broadly from across the wider group or constituency' (2000: 280). Rowse notes the need for Aboriginal associations to transcend narrow personal, family and other social organisational interests (Rowse 1992: 89).

This research found instances in which the board members were all related to one another, board members were related to managers of programs, and membership had remained unchanged for many years (in one case 12 years). One manager had to ask the permission of his board to attend a local inter-agency networking meeting, and in another instance, board members negotiated special concessions for a relative who was a program client. Managers of programs observed that it was important that board members should have a commitment to the program rather than participating just to 'improve their résumé', and that younger people were needed on boards, which were usually composed of people over 50 years old. There is evidence that some boards are over-involved in the day-to-day management of programs.

Board members can also be influential in terms of the program content and philosophy. In some cases this has meant that the orientation of the program remains firmly embedded in a Twelve Steps or other abstinence framework, despite suggestions for a wider range of approaches and offers of help from local drug and alcohol professionals. In other cases, Board members have been open to the involvement of outside workers.

Strategies for program strengthening

There are a number of strategies and options to be considered that could help to improve the functioning of boards and managers, the quality of staff, linkages between Aboriginal and other programs, and program content in residential programs.

Boards of management

Boards of management and program managers should be expected to avail themselves of training in their respective roles and responsibilities. One mechanism for board-member management training is through the Office of the Registrar of Aboriginal Corporations (ORAC), in view of the fact that half (13) of

the OATSIH-funded residential programs are registered under the *Aboriginal Councils and Associations Act 1976* (see Appendix A). ORAC conducts information and training workshops for Aboriginal and Torres Strait Islander corporations to help them manage better their day-to-day affairs. The training sessions are specifically directed at corporation-governing committee members, other members and staff. In 2001 ORAC conducted nationwide workshops in the Northern Territory (5 locations); Queensland (11 locations); New South Wales (8 locations); Western Australia (6 locations); South Australia (2 locations); and the ACT (Canberra). Further workshops will be conducted in 2002. Workshops have between 10 and 50 participants. ORAC was not able to say how many of the substance misuse organisations that are registered with them had attended a training workshop. The Registrar's office has also produced a series of plain English pamphlets explaining different aspects of the rights and responsibilities of Aboriginal corporations.

Currently (in 2002) a review of the *Aboriginal Councils and Associations Act* is under way, instigated by the Registrar of Aboriginal Corporations. One of the key questions being considered in the review process is whether the role of ORAC should be extended to include a focus on organisational capacity-building.

Other residential programs are registered under State or Territory Associations Acts designed for non-Aboriginal organisations, which have no provision for training the managing boards of organisations. Aboriginal Hostels Ltd (AHL) also offers training to the organisations it funds, but very few take up the opportunity. AHL provides advice to boards and has criteria for funding. Boards report to it, and AHL will intervene if the funding guidelines and criteria are not met.

Apart from training for boards of management in the proper conduct of committees, drug and alcohol awareness training would be of benefit. As the body responsible for setting the overall policy directions of a program, the board members need to have a broad understanding of these issues, over and above their personal experience and histories. Inter-agency visits would assist boards to appreciate how other programs are run.

Providing skills for staff

It is clear that the narrow 'treatment' framework used in most residential programs persists partly because workers in these and other programs have simply never been exposed to other ideas. Training is a means of ensuring that both staff and managers of residential programs are exposed to a range of approaches to treatment. Training and formal tertiary education are also important as a means of opening up debate on models of addiction—indeed, as a way of spreading the word that there is a debate. It is only recently that residential program managers and boards have come to accept that training is required in order to work with problem drinkers. In the mid 1970s it was common for people to express views such as the following: '[A]part from the training, a lot of his [the counsellor's] effectiveness will come not so much from academic

qualifications as from understanding and sympathy, along with common sense and homespun aboriginal wisdom' (Leary et al. 1975: 40).

During the conduct of this research, in 2001, some Aboriginal workers still expressed views that were dismissive of trained counsellors, including the view that 'you can't talk academic way' with clients. Others relied on the jargon associated with AA ('one drink away from a drunk'). Life experiences were, and often still are, deemed more important than 'qualifications'. Of course staff with personal histories are highly valuable: not only are they aware of the self-deception that problem drinkers and drug users often show, but also they demonstrate by their example that recovery is possible.

However, it is becoming less appropriate for residential programs to employ untrained ex-drinkers as the sole providers of counselling. In the last ten years, the number of Indigenous clients in treatment for problems other than alcohol has almost tripled, from 78 in 1990 to 233 in 2001 (Shand & Mattick 2002a: 355). With the complexity of polydrug use and the severity of alcohol and other drug (AOD) problems within the Aboriginal community in the twenty-first century, having at least some staff with formal skills-based training in drug and alcohol work or counselling should be compulsory for all residential programs. Because the nature of the work is intense, complex and demanding, programs need staff with a mix of formal qualifications and relevant personal histories. Aboriginal AOD workers themselves identify the need for training (Brady, Dawe & Richmond 1998: 74; Carnegie & Patterson 1998; Sputore et al. 1998: 26). Most mainstream residential programs employ some staff who are ex-users or ex-drinkers, however there are usually rules accompanying their employment, such as a gap of 12 months between completion of treatment and employment in a treatment program. A guideline such as this could be of benefit to Aboriginal programs, and would circumvent the problem of barely-recovered individuals trying to counsel others. The emphasis on professional qualifications has now increased in the mainstream treatment sphere (Maree Teesson, pers. comm.). In some cases it appears Aboriginal workers in Sobering-up Shelters (Diversionary Centres) have had more training (for example in first aid, assessment and management of intoxication and fits, workplace health and safety) than have their counterparts working in residential programs.

Case studies of training

There are examples of skills-based training courses that are designed for Aboriginal AOD workers, which would equip them for work in a residential program. In-service training can be an alternative, or an adjunct, to this and there are examples of workable in-service and day-release courses in different regions.

In Victoria there is a Koori Alcohol and Drug Worker Training Program. Turning Point (Melbourne) was commissioned to develop, implement and evaluate this

program following a Victorian review that created a new worker category, the Koori Community Alcohol and Drug Worker. Before this, training for AOD workers had been ad hoc. The course content was aligned to the endorsed 1998 National Alcohol and Other Drugs Competency Standards and the 1996 Aboriginal Health Worker and Torres Strait Islander Health Worker National Competency Standards. The objectives of the project were as follows:

- introduce participants to the general concepts and principles underlying effective counselling interventions
- introduce participants to alcohol and drug specific counselling skills (motivational interviewing and relapse prevention)
- develop skills in providing brief interventions, especially harm reduction strategies
- provide an understanding of legal issues
- familiarise participants with the new specialist alcohol and drug assessment proforma and issues in conducting an effective assessment
- provide a framework for case management
- provide a safe and confidential environment for participants to practise these new skills.

The project provided 25 participants with six days in-service training with a follow-up day. There were two three-day residential workshops held three weeks apart. This allowed most workers from all areas of the State to be removed from their workplaces, in order to minimise possible interruptions to the training. Having a three-week interval between the two workshops allowed workers the opportunity to practice their new skills in the workplace. The proximity to other workers, which was deliberately engineered as part of the process, meant that group cohesion developed rapidly. The training was delivered by three highly experienced trainers, and there was no cost to participants. Evaluations were ongoing throughout the course and, through focus groups and feedback from the needs analysis (which preceded the course), Aboriginal participants provided input and commentary on making the course appropriate, non-threatening and positive for them.

Alcohol, Tobacco and Other Drug Services (ATODS), part of Queensland Health in Rockhampton, organise a variety of AOD training opportunities for Indigenous workers. This includes a course for volunteers (people who get called out at night in emergencies) and a course for community leaders. A one-week residential workshop was conducted for drug and alcohol workers. This was free, with accommodation provided. There is also a one-year day-release Certificate 3 in community services AOD course based on the Australian Remote and Rural Training System which includes the stages of change model, motivational interviewing and learning to distinguish between dependence, regular use and intoxication. This course also covers workplace health and safety issues, how to

keep records, and management of emergencies such as fits (learning the difference between epileptic and detoxification-induced fitting). All these issues are relevant to workers in residential programs, but despite this, staff from the local Aboriginal residential program had not attended any of the offered courses.

Wollongbar TAFE in Lismore offers a drug and alcohol course that provides skills to Aboriginal health workers. In order to cater for the needs of Aboriginal students it runs one day per fortnight over a year (excluding school holidays), and it was established in response to a need identified by Aboriginal workers themselves. It is designed to skill up generalist workers—people working in health, probation and parole, juvenile justice, family based services—so that they can respond better to drug and alcohol problems. It is an accredited course, with recognition of prior learning, and a certificate of attainment is awarded at the end. The course outline includes:

- perspectives on drug use including alcohol issues (models of drug use, personal values and beliefs and their influence on AOD work)
- drug actions and related issues (effect of drugs on body and brain, dependence, overdose, detoxification and withdrawal)
- assessment and referral (how to undertake an assessment, case management, referral, assessing local supports for clients)
- intervention strategies (motivational interviewing, responding to crises, programs incorporating Aboriginal cultural values, relapse prevention strategies).

Significantly, the course includes placements for students so that they have a chance to put into practice what they have learned. Such placements allow Aboriginal workers to have practical experience of other service agencies and how they operate. The success of this training venture (according to local informants) lies in the excellent partnership between the TAFE and the Northern Rivers Health Service Aboriginal health and drug and alcohol services.

These are just three examples of skills-based training which would be appropriate for and accessible to staff employed in residential programs. Most programs have difficulty in attracting qualified Indigenous workers.

Linkages

For a number of historical and structural reasons, residential programs are relatively insulated from outside influences, visiting professionals, and regular contact with similar non-Indigenous organisations. For many, their networks are made up of strong ties to a relatively narrow range of organisations and individuals, rather than loose ties to a wide range of outside bodies (Granovetter 1983). This form of ‘inward-looking’ networking tends to deprive the programs of information from a range of sources, and means that they become privy only to information of the kind they already have.

One means of improving networking would be for the Aboriginal programs to become associates of the drug and alcohol non-government (NGO) peak body in their State. As Appendix A shows, only five of the OATSIH-funded programs are associated with these useful NGOs, which act as advocates for the drug and alcohol sector, rather than for individual agencies. These bodies (affiliated to the AOD Council in Canberra) are: the Network of Alcohol and Drug Agencies (NADA); the Victorian Alcohol and Drug Association (VADA); and the Western Australian Network of Alcohol and Other Drug Agencies. Queensland, South Australia and the Northern Territory do not have peak bodies, although the Alice Springs NGO acts as an informal advisory body to other organisations including the local Aboriginal residential program, the Central Australian Aboriginal Alcohol Program Unit (CAAAPU). Aboriginal programs could also become associate members of the Australian Therapeutic Communities Association (ATCA)—a non-profit organisation representing TCs in Australia and New Zealand. ATCA members are actively encouraged to continually improve their services, to consult the research literature, and to organise forums for exchange. No Aboriginal residential program has joined ATCA either as a member or an associate.

These NGO peak bodies and associations arrange meetings, workshops and forums for their members. They have discussion groups, organise policy forums, keep members up to date with research and in touch with one another. They allow for workers in a range of services to get together and share ideas. All these organisations expressed a desire to have more involvement from Aboriginal organisations in the drug and alcohol area. NADA has an Aboriginal person on its board as a matter of policy.

Another means of improving networking for Aboriginal residential program staff and managers would be to arrange placements or staff exchanges with mainstream residential programs. Such arrangements would enable Aboriginal workers to see how another (usually larger) service operates, and would expose them to TC regimes that are not necessarily reliant on the Twelve Steps model but which use a combination of approaches. In general, TCs endorse harm minimisation programs. Some training courses allow for placements with services as part of the course; the Woolongbar TAFE course in Lismore is an example.

Not all Aboriginal residential programs have easy access to comparable mainstream residential programs, and an exchange strategy such as this may only suit programs in cities or large rural towns. Fig. 3 shows the proximity of the OATSIH-funded programs to mainstream TCs, giving an overall indication of the feasibility, in geographical terms, of this idea. Negotiation of placements and exchanges would have to be on a case-by-case basis, but a pilot project in an appropriate area would be fruitful. Aboriginal AOD workers in Victoria have raised the possibility of exchanges, and expressed the desire to learn from one another (Carnegie & Patterson 1998). Managers of several mainstream TCs, when asked, responded positively to the idea of having staff exchanges with Indigenous

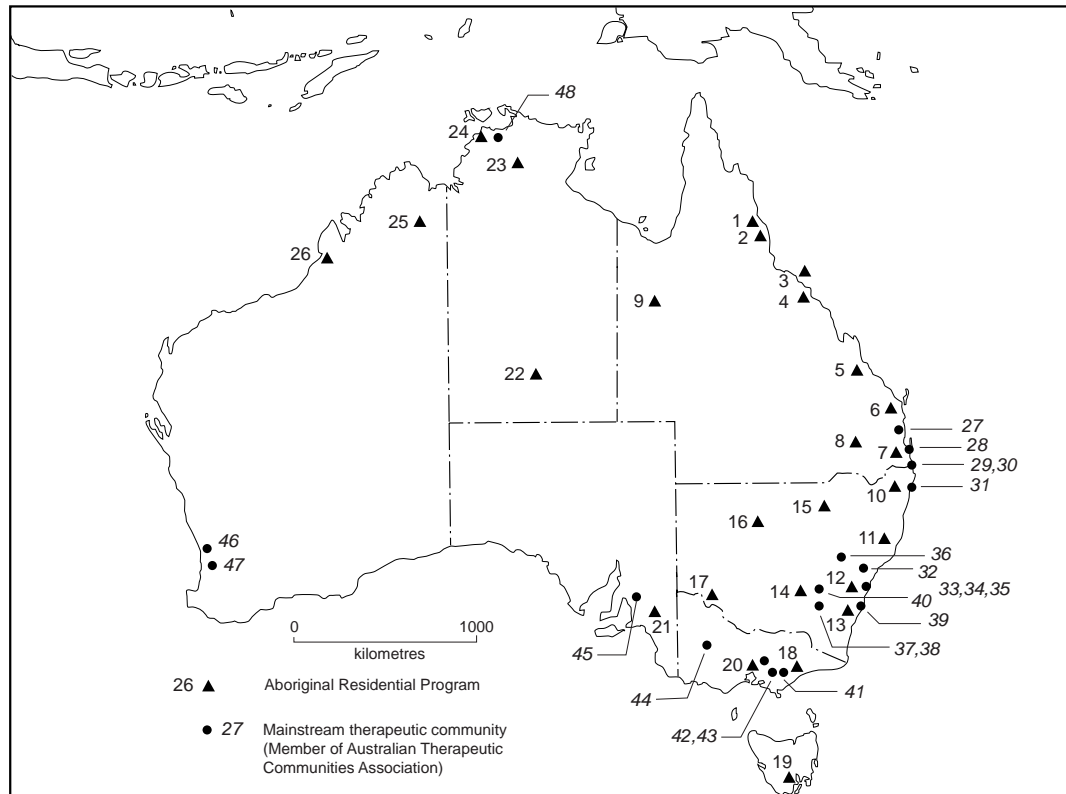
programs. Similarly, this research found examples of AOD organisations which were willing to participate in mentoring or 'buddy' relationships, and to cooperate with Aboriginal residential programs in every way.

All the indicators (particularly the changing patterns of drug use) point to the need for Aboriginal programs to be more closely monitored, influenced and supported by State AOD services. These are major sources of locally-available professional advice and help, but the fact that most residential programs are funded by the Commonwealth, and report to OATSIH, presents additional structural impediments to successful networking. As well as these 'top-down' impediments, this research identified residential programs which have isolated themselves from inter-agency meetings and workshops instigated by State agencies, and are resistant to outside influences. In their evaluation of Kimberley programs, Sputore and colleagues also found cases where some staff in residential programs thought that it was more important to build on links among their own services (rather than outside ones). Others in the same service felt that there should be regular meetings with other agencies 'because we are for the same cause' (Sputore et al. 1998: 136).

The significance of having linkages with State AOD agencies is that these agencies participate in ongoing quality improvement reviews. In New South Wales for example, all the health facilities are required to have a quality improvement agreement, and all State-funded NGOs are expected to be accredited with Quality Management Services (Quality Improvement Council 1999). Improved contact between Aboriginal residential programs and these agencies would help to normalise involvement with quality management, making it an acceptable and less threatening aspect of program procedures. Eventually all services, whether Aboriginal or not, will have to comply with these quality standards. Quality improvement reviews of programs can also occur in partnership with an Aboriginal umbrella organisation. OATSIH has funded a pilot project in South Australia, to ensure participation by substance misuse services such in reviews. The South Australian Aboriginal Drug and Alcohol Council has carriage of this project (Aboriginal Drug and Alcohol Council Inc. 2001: 13). Participants are hopeful that this process can be repeated in other locations with Aboriginal AOD programs.

State AOD agencies are usually staffed by health professionals with training and experience in issues such as detoxification, pharmacotherapies, counselling and motivational techniques and public health—all of which are relevant to the provision of services to clients in residential programs. State agencies obviously cannot help with micro-management issues in Indigenous residential programs, but they can assist with program planning, individual treatment plans, and training. Partnership agreements, memoranda of understanding or performance agreements should be utilised to facilitate a closer working relationship with public health professionals in the State and Territory agencies.

Fig. 3 Proximity of OATSIH-funded residential programs to mainstream therapeutic communities



Key: Indigenous programs

1. Cairns: Aborigines and Islanders Alcohol Relief Service
2. Yarrabah: Yarrabah Substance Misuse Aboriginal Corporation
3. Palm Island: Palm Island Alcohol and Drug Rehabilitation Aboriginal Corporation
4. Townsville: Congress Community Development and Education Unit
5. Rockhampton: Gumbi Gumbi Aboriginal and Torres Strait Islander Corporation
6. Bundaberg: Yaamba Aboriginal and Torres Strait Islander Corporation for Men
7. Brisbane: Queensland Aboriginal and Torres Strait Islander Corporation for Alcohol and Drug Dependence Services
8. Murgon: Wunjuada Aboriginal Corporation for Alcohol and Drug Dependence Service
9. Mt Isa: Kalkadoon Aboriginal Sobriety House Aboriginal Corporation
10. Lismore: Namatjira Haven
11. Kempsey: Benelong's Haven
12. Sydney: Eastern Zone Housing Aboriginal Corporation
13. Nowra: Oolong Aboriginal Corporation
14. Cowra: Weigelli Centre Aboriginal Corporation
15. Moree: Roy Thorne Substance Misuse Rehabilitation Centre
16. Brewarrina: Orana Haven Aboriginal Corporation
17. Mildura: Mildura Aboriginal Corporation
18. Bairnsdale: Gippsland and East Gippsland

19. Hobart: Tasmanian Aboriginal Centre
20. Melbourne: Ngwala Willumbong Cooperative
21. Murray Bridge: Kalparrin Inc.
22. Alice Springs: Central Australian Aboriginal Alcohol Program unit
23. Katherine: Kalano Community Association Inc.
24. Darwin: Council for Aboriginal Alcohol Program Services Inc.
25. Kununurra: Kununurra Waringgarri Aboriginal Corporation
26. Broome: Milliya Rumurra Aboriginal Corporation

Mainstream therapeutic communities (members of ATCA)

27. Nambour: Branchout Community
28. Brisbane: Logan House
29. Southport: Goldbridge
30. Burleigh Heads: Mirikari
31. Bangalow: The Buttery
32. Wyong: Kamira Farm
33. Sydney: Odyssey House
34. Sydney: Ted Noffs
35. Sydney: We Help Ourselves
36. Katoomba: Westmount Cooperative Society
37. Canberra: Karralika
38. Canberra: Canberra Rehabilitation Service
39. Wollongong: Wollongong Crisis Centre
40. Canowindra: The Lyndon Community
41. Warburton: Warburton Clinic
42. Melbourne: The Windana Society
43. Melbourne: Odyssey House
44. Horsham: Palm Lodge Rehabilitation Centre
45. Adelaide: Kuitpo Community
46. Perth: Cyrenian House
47. Wellard: Palmerston Farm
48. Darwin: Banyan House

Program content

Whether or not a residential centre has a ‘program’—a structured timetable of activities, and group or individual sessions—is a key issue. This research was not intended to be a review of all programs, but we already know that in some cases, activities at residential programs are so ad hoc that they do not constitute a ‘program’. The comment ‘it’s not a rehab, it’s a rest place’ could apply to several locations (see Hunter, Brady & Hall 1998, Appendix 2). The differing expectations of clients is an ongoing problem underlying the provision of formal (or semi-formal) regular activities, including counselling. In their evaluation of Kununurra-Waringgarri in the Kimberley, a team from the National Drug Research Institute found that clients of the residential program (Marralam) were divided. One group of clients wanted to take decisive action to change their drinking behaviour, and looked to the program to help them to do this. The other group wanted to have a break from drinking, improve their health, and get away from alcohol for a while. Sputore and colleagues suggested that having both client groups in the same program was problematic, as those individuals with no intention of taking long-term action about their drinking were not interested in counselling or in a structured program. Those clients who did want to change their behaviour were

frustrated by the lack of a program. They wanted more formal and structured counselling, and took the view that the existing 'counselling' was 'just gossiping' (Sputore et al. 1998: 39–40).

This raises the question of the purpose that a residential program does, or should, fulfil. In a review of Aboriginal rehabilitation programs in Western Australia, O'Connor found that many programs were using terms such as 'alcohol counsellor', 'rehabilitation' and 'detox' without really knowing what each of these mean (O'Connor & Associates 1998). He suggested making a distinction between three types of program: a rehabilitation program, a recuperative program, and a dry camp. He also proposed that a rehabilitation (or 'treatment') program should have most of the following features:

- detoxification (either under medical supervision or with access to such supervision)
- rest and recuperation
- individual counselling (motivating people to change, helping their commitment)
- group counselling
- therapeutic activities (art work, artefact making, gardening, bush trips)
- advice on employment and educational opportunities, job-finding
- follow-up (home visits by staff, a halfway house, aftercare).

If a program only has the first two features, then it is not strictly a 'treatment' or rehabilitation program.

Clearly Aboriginal programs need to be flexible to cater for clients from a wide range of backgrounds, and too much rigidity would be counterproductive. A quality management review process can provide assistance with structuring a program, and would involve boards of management in the process, as well as managers and staff. As discussed above, better partnerships with State AOD agencies would be a means of instigating more rigorous initial assessment, planning around discharge, and introducing a wider range of treatment and counselling styles to those organisations which at present offer only an AA meeting as their 'program'. AA is not in reality a treatment approach, but a self-help network with thousands of members and meeting places worldwide. There are numerous models—albeit non-Indigenous models—relating to substance misuse and behaviour change that could be used in, and adapted for, Aboriginal residential programs, including social learning, motivational interviewing, family therapy, and cognitive behavioural interventions. These approaches would vary in their applicability to Aboriginal clients in different regions. Motivational interviewing, for example, is being well used at Weigelli Centre near Cowra, New South Wales. The TC model itself is based primarily on the idea that the social environment within the facility is itself a major factor in the therapy. Both staff and other inmates are part of the process of assisting individuals to deal with their drug or alcohol problems. TCs use a wide range of counselling techniques

and treatment modalities. Aboriginal services could learn from them (see www.atca.com.au/docs/about.htm).

Residential programs need to have professional input when dealing with medical issues. These include detoxification, assessment procedures, and the use of pharmacotherapies. Although the programs seen on site visits for this research all had a relationship with a medical practitioner, much more needs to be done to improve, strengthen and formalise these links.

Detoxification is a widely misunderstood term (and not just in the Indigenous population), and is often confused with long-term residential treatment. It means *the process of reducing risks associated with withdrawal from any drug*. Detoxification alone is of benefit to the individual as it provides respite from physical damage, but in order to maintain the benefit it needs to be followed by treatment to prevent relapse (Proudfoot & Teesson 2000). Withdrawal from alcohol can be life-threatening, and the process can be managed on an in-patient or out-patient basis, but there are advantages and disadvantages attached to each of these and some special features that arise with Aboriginal clients. Out-patient detoxification can be much more difficult for Aboriginal people, primarily because their environment is often not safe, and not free from the drinking behaviour of others. A primary requirement for out-patient detoxification is safety. At issue, in the context of this research, are the rules applying to admission to a program, whether detoxification can be managed within a residential program, and whether emergency medical supervision is accessible.

According to Dr Tony Gill, Clinical Director of Drug Programs Bureau, New South Wales Health (pers. comm.), individuals ineligible for out-patient detoxification include:

- those with a history of complicated withdrawal (e.g. delirium tremens)
- those with evidence of severe withdrawal
- those with serious physical or psychiatric complications
- those using alcohol or benzodiazepines (tranquillisers) in large amounts or together
- those with uncondusive living situations (unsafe or unsupportive)
- those with poor access to medical assistance

Doctors, usually general practitioners (GPs), have important roles to play with clients of residential programs. They have an administrative role associated with Medicare and the payment of sickness benefits. The following roles are also of significance:

- professional—the GP may be the *only* qualified professional who sees clients before or during their residence because of the lack of qualified staff in programs
- medical—the GP can provide a thorough assessment, which can include alcohol history, level of dependence, mental health assessment for

co-morbidity problems, health check and vaccination, medications for withdrawal and relapse prevention, and monitoring detoxification

- evaluative—a pre-release medical assessment by a GP can provide data for monitoring the client's progress and also for measuring program outcomes
- advisory—ongoing discussions between a client and a doctor (during a program) can assist with motivation, and give positive feedback on progress (Brady 1995a).

For certain clients, the GP associated with a residential program may be the only point of contact with the health care system. These practitioners have the only available opportunity to assess whether psychiatric co-morbidity with harmful drinking is evident. If a doctor does not take advantage of this opportunity, it is unlikely that further treatment or specialist consultation will take place. Hunter, Brady and Hall (1999) have provided recommendations for clinical management of these issues.

Doctors could assist residential programs to provide care plans. They can undertake biological tests such as Gamma-Glutamyl-Transferase (GGT)¹ for liver damage and provide feedback; undertake routine screening for tuberculosis and sexually transmitted diseases; prescribe thiamine; and give vaccinations (for example pneumovax). Some services want urine tests done for cannabis and other drugs. There are also pharmacotherapies which can be used as part of the treatment and rehabilitation of alcohol or drug users; these are not to be confused with medications which treat the symptoms of withdrawal during detoxification. Pharmacotherapies can include medications such as Acamprosate, a promising anti-craving agent for dependent patients (Proudfoot & Teesson 2000: 25). Although the use of medication is often controversial in the context of residential programs (especially strictly Twelve Step programs), it could be argued that Aboriginal people have as much right to access new drug treatments for alcohol abuse as members of the majority population. Program managers should ideally be fully informed about advances in medical approaches.

Concluding remarks and issues for consideration

A major task at hand is to facilitate a broader range of treatment modalities, experiences and contacts for Indigenous residential programs, and to ensure that programs participate in quality management reviews.

Many programs suffer from a high degree of insularity. Their managers and boards tend to operate within a relatively small network of strong ties. In this way, the status quo is maintained, there are few challenges to it, and there is conscious resistance to the creation of outward-looking networks. Some of this may be explained by the history of the development of these programs, including their long association with the self-help approach of AA, the fierce competition for funds, and their separate development from both Aboriginal Medical Services and Aboriginal units in State AOD departments. Also implicated are the relatively low level of funding directed to them, and the lack of consistent monitoring and

guidance from the three different government bodies (DAA, ATSIC and OATSIH) that have been responsible for disbursing and administering Commonwealth funding over the last 25 years. The long history of separation between these residential programs and local health and AOD agencies (both Aboriginal and non-Aboriginal) means that it will not be easy to re-orient them. In addition, the fact that local AOD agencies are primarily State bodies, whereas community-controlled residential programs are primarily Commonwealth-funded, presents particular challenges. Ongoing collaboration at the federal level (between OATSIH and Aboriginal Hostels Ltd), and between OATSIH and State services, is crucial to the building of capacity among these often isolated programs.

With no decrease in the intensity of substance misuse problems in the Indigenous population, and the diversification in the substances used, residential facilities that describe themselves as 'programs' (rather than dry recuperation facilities), should now be under pressure to become more competent, in touch, and willing to provide alternatives to their clients. Increasingly, all forms of government funding will become 'outcome oriented', and Aboriginal rehabilitation programs will probably have no choice in the matter. The need to pay attention to these issues in no way detracts from the benefits of these centres as safe, alcohol-free and culturally respectful milieux for Indigenous people.

Cultural isolation, however, is no longer defensible if it means that treatment programs are isolated enclaves, out of touch with the activities taking place in the wider AOD and public health networks of services. This is not a call for mainstreaming, but for these programs to have embedded in them practices that have demonstrable benefit. Aboriginal treatment programs need to network and gain from the wider AOD treatment community, and in turn share their insights with it.

So what are the essential elements of a successful Indigenous residential treatment program? Based on this research, and the advice of others (Ernst & Young 1996; Hunter, Brady & Hall 1998; Sputore et al. 1998), the following is a guide.

Governance

- a good administrative and management base
- participation in regular quality improvement reviews by accredited reviewers
- a clear definition of the purpose of the program, either as a structured treatment program or a dry recuperative facility
- clear distinctions between the roles and responsibilities of boards and managers
- board members with knowledge and experience of mainstream residential programs
- participation by board members in training (both governance and AOD)
- rules to cover day release activities for clients, as well as rules of conduct within the program

- having the support of the local community or local population.

Training and networking

- counsellors who have training to increase their confidence and efficacy and to acquire new skills
- ongoing in-service training, staff exchanges and placements with larger organisations
- staff mentored by outside professionals
- close involvement with a local doctor to provide assessment before, during and after admission, supervision of detoxification, pharmacotherapy, assistance with care plans, advice to clients
- formal and informal partnerships with local public health professionals and State AOD services
- membership of, and participation in, relevant regional AOD NGO networks and TC associations.

Program content

- a safe drug/alcohol-free environment
- an environment that takes into account people's cultural, familial and social circumstances in an informed and respectful manner
- time and place for clients to withdraw from a high-risk lifestyle or situation
- peer support and encouragement to withdraw from use
- education regarding strategies for maintaining moderate drinking, or a lifestyle free of drugs and alcohol, to match client's needs
- encouragement of open reflection and discussion of personal issues related to use
- healthy lifestyle, structured activity, and balanced diet during residence
- assistance with a range of issues associated with community living and daily living skills
- providing vocational, recreational and 'cultural' activities
- providing practical skills through TAFE and other vocational training (literacy, carpentry, agriculture, permaculture, art production, etc.)
- planning for discharge, provision of after care and home visits after treatment, or referrals to achieve this.

Notes

1. Long-term excessive alcohol consumption causes GGT to be released from the liver to the bloodstream. Increased GGT levels therefore may be detected in the blood, making GGT a useful marker for early intervention.

Appendix A. Funding, legislative and network status of OATSIH-funded residential programs

Ref. no. ^a	Residential program organisation	Name and location
1	Aboriginal and Islanders Relief Services	Douglas House Cairns, Qld
11	Benelong's Haven	Benelong's, Kempsey, NSW
10	Bundjalung Tribal Society	Namatjira Haven, Lismore, NSW
22	Central Australian Aboriginal Alcohol Programs Unit	CAAAPU, Alice Springs, NT
4	Congress Community Development and Education Unit	Staggpole St Townsville, Qld
24	Council for Aboriginal Program Services Inc	CAAPS, Dolly Garinyi, Darwin, NT
12	Eastern Zone Housing Aboriginal Corporation	Sydney, NSW
18	Gippsland and East Gippsland	Jumbarra, Bairnsdale, Vic
5	Gumbi Gumbi Aboriginal and Torres Strait Islander Corporation	Gumbi Gumbi, Rockhampton, Qld
23	Kalano Community Association Inc	Rockhole, Katherine, NT
9	Kalkadoon Aboriginal Sobriety House Aboriginal Corporation	KASH, Mt. Isa, Qld
21	Kalparrin Inc	(Barry Wiegold) Murray Bridge, SA
25	Kununurra Waringgari Aboriginal Corporation	Marralam, Kununurra, WA
17	Mildura Aboriginal Corporation	Mildura, Vic
26	Milliya Rumurra Aboriginal Corporation	Milliya Rumurra Broome, WA
20	Ngwala Willumbong Cooperative	Galiamble, Winja Ulupna, Melbourne, Vic
13	Oolong Aboriginal Corporation	Oolong House, Nowra, NSW
16	Orana Haven Aboriginal Corporation	Orana Haven, Brewarinna, NSW
3	Palm Island Alcohol and Drug Aboriginal Corporation	Ferdy's Haven, Palm Island, Qld
7	Queensland Aboriginal and Torres Strait Islander Corporation for Alcohol and Drug Dependence Services	Jesse Budby, New Farm, Brisbane, Qld
15	Roy Thorne Substance Misuse Rehabilitation Centre	Ray Thorne Centre, Moree, NSW
19	Tasmanian Aboriginal Centre	Hobart, Tas
14	Weigelli Centre Aboriginal Corporation	Weigelli Centre, Cowra, NSW
8	Wunjuada Aboriginal Corporation for Alcohol and Drug Dependence	Wunjuanda, Cherbourg (Murgon), Qld
6	Yaamba Aboriginal and Torres Strait Islander Corporation for Men	Yaamba Bundaberg, Qld
2	Yarrabah Substance Misuse Aboriginal Corporation	Yarrabah, Qld

Note: (a) Reference numbers refer to the numbers assigned to the programs in Fig. 3.

Appendix A cont.

Ref. no. ^a	Funding:			Incorporated legislation	Member of State NGO AOD peak body?
	Pre-1990 DAA	1990–95 ATSIC	AHL		
1	Yes	Yes	Yes	Corporations Act	No
11	Yes	Yes	Yes	Corporate Affairs Commission, Sydney	Network of Alcohol & Drug Agencies
10	Yes	Yes	No	Corporate Affairs Commission, Sydney	No
22	No	No	Yes	?	No
4	No	No	Yes	Corporations Act	No
24	Yes	Yes	Yes	NT Associations Incorporations Act 1978	No
12	Yes	Yes	No	Aboriginal Councils & Assoc. Act 1976 (1990)	No
18	No	No	Yes	Victorian Cooperative Act 1996	No
5	No	No	No	Aboriginal Councils & Assoc. Act 1976 (1991)	No
23	Yes	Yes	Yes	NT Associations Incorporation Act 1978	No
9	Yes	Yes	Yes	Aboriginal Councils & Assoc. Act 1976 (1990)	No
21	Yes	Yes	Yes	SA Associations Incorporations Act 1985	No
25	No	No	No	Aboriginal Councils & Assoc. Act 1976 (1990)	No
17	No	No	No	Aboriginal Councils & Assoc. Act 1976 (1990)	No
13	Yes	Yes	Yes	Aboriginal Councils & Assoc. Act 1976 (1990)	No
20	Yes	Yes	Yes	Victorian Cooperative Act 1996	Associate of VADA
13	Yes	Yes	No	?	NADA
16	Yes	Yes	Yes	Aboriginal Councils & Assoc. Act 1976 (1990)	NADA
3	Yes	Yes	Yes	Aboriginal Councils & Assoc. Act 1976 (1990)	No
7	Yes	Yes	Yes	Aboriginal Councils & Assoc. Act 1976 (1990)	No
15	Yes	Yes	Yes	NSW Associations Incorporation Act 1984	No
19	No	No	No	?	No
14	No	Yes	No	Aboriginal Councils & Assoc. Act 1976 (1987)	NADA
8	No	No	Yes	Aboriginal Councils & Assoc. Act 1976 (1990)	No
6	No	No	Yes	Aboriginal Councils & Assoc. Act 1976 (1990)	No
2	No	Yes	Yes	Aboriginal Councils & Assoc. Act 1976 (1990)	No

Note: (a) Reference numbers refer to the numbers assigned to the programs in Fig. 3.

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