20

ANCD research paper

Indigenous-specific alcohol and other drug interventions

continuities, changes and areas of greatest need

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A report prepared for the
National Indigenous Drug and Alcohol Committee,
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The opinions expressed in this publication are those of the authors and are not necessarily those of NIDAC, the ANCD or the Australian Government.

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How to read this report

Ideally, a report such as this would be read from start to finish. However, recognising the requirements and time constraints of different reading audiences we have endeavoured to make the various chapters self-contained, and here we provide suggestions as to how the various audiences can take what they need from the report.

The executive summary provides an overview of the key findings. Chapter 8 ('Summary, discussion and recommendations') puts flesh on the bones of these findings, answers the key questions posed in the National Indigenous Drug and Alcohol Committee (NIDAC) project scoping document (see Appendix 9.5), and provides a rationale for the recommendations included in the executive summary.

The detailed findings of the project on service provision, and funding of it — summarised in Chapter 8 — are provided in Chapters 5 and 6. As well as providing a national overview, and information on changes over time, these chapters provide information at the State and Territory level and at Australian Bureau of Statistics (ABS) Indigenous region level on: types of interventions; the organisations providing them; the population groups and substances at which they are targeted; and the range of service coverage. Chapter 7 ('The view from the ground') builds on the quantitative data included in Chapters 5 and 6 by providing the views of service providers on the strengths of existing services and barriers to service provision, and contributes to the interpretations of the quantitative data that are presented in Chapter 8.

Chapters 3 and 4 provide a background to the study. Chapter 3 summarises data on the harms caused by alcohol and other drugs among Indigenous Australians, which the intervention projects described in Chapters 5 and 6 seek to address. Chapter 4 provides: the theoretical framework for intervention that informs this study; and an overview of the efficacy of interventions in both Indigenous and non-Indigenous populations against which the findings of the study can be considered.

Finally, Chapter 2 provides a description of the framework employed to answer the key questions posed in the NIDAC project brief. This includes the key definitions used in the study (which are also summarised in the glossary in Appendix 9.2), details of how data were collected and verified, and information on criteria for inclusion (and exclusion) of intervention projects in the study.

Acknowledgements

There are many people to whom we owe our gratitude for assistance provided in the completion of this project. First and foremost among these are the representatives of the various organisations providing alcohol and other drug intervention services for Indigenous Australians. They took time from busy schedules and put considerable effort into providing us with details of their projects. We also owe a considerable debt to the staff of various government and non-government agencies who provided us with details of the intervention projects they fund and who took the time to provide numerous points of clarification.

At the time this project was conducted, we also undertook a review of the Aboriginal and Torres Strait Islander community-controlled alcohol and other drugs sector in Queensland for the Queensland Aboriginal and Islander Health Council (QAIHC) and the Queensland Indigenous Substance Misuse Council (QISMC). The fact that for some tasks we were able to combine resources for both projects meant that we were able to contribute more to both than we would have been able to one alone. Thus, a considerable amount of the material included in Chapter 4 of this report was first published in the Queensland report. This material was largely prepared by Dennis Gray, but we must also acknowledge the contributions of our colleagues on that project: Dr Meredith Green, Professor Sherry Saggers and Associate Professor Ted Wilkes.

We also owe a debt to former colleagues from the National Drug Research Institute (NDRI) who worked with us on a previous project conducted for the Australian National Council on Drugs (ANCD): Brooke Sputoré, Deirdre Bourbon and Phillipa Strempel. Their work on that project contributed to the conceptualisation of the approach we have taken in the current study. The work involved in collecting and verifying data for this study was considerable and we want to thank our colleagues William Foster and Jenny Dodd who worked tirelessly at the task. Production of Maps 2 to 13 was undertaken for us on contract by the Australian Bureau of Statistics. However, we particularly want to thank Bev Fauntleroy who has patiently worked with us through numerous amendments to the maps.

The project was commissioned and funded by the National Indigenous Drug and Alcohol Committee (NIDAC). However, the salary costs of conducting the project far exceed the amount NIDAC was able to commit to the project. The additional costs were covered from a core grant to NDRI provided by the Australian Government Department of Health and Ageing and without that additional funding the project would not have been completed.

Lastly, we want to thank members of NIDAC and its secretariat for the faith and patience they have shown through what has been a long and difficult process.

Executive summary

In the body of the report, we provide considerable detail about the Indigenous-specific alcohol and other drug (AOD) intervention projects being undertaken in 2006–07 (including breakdowns at the State and Territory and regional levels) and the funding for them. It is not possible to briefly summarise those data and in this summary we present only information on the broad national picture with the caution that these conceal significant variation.

Alcohol and other drug services for Indigenous Australians

- This report deals only with Indigenous-specific AOD intervention 'projects' (discrete sets of activities aimed at minimising AOD-related harm among Indigenous Australians) funded in the 2006–07 financial year. It does not include projects aimed at making services provided by mainstream organisations more accessible or acceptable to Indigenous Australians, as such organisations have an obligation to provide appropriate services for all citizens.
- In the 2006–07 financial year there were 340 Indigenous-specific AOD intervention projects being conducted nationally.
- These projects were conducted by 224 organisations. The majority of projects (73 per cent) were conducted by 159 Indigenous community-controlled organisations.
- Between 1999–2000 and 2006–07, there was a 5 per cent increase in the number of organisations conducting Indigenous-specific AOD projects.
- Only 52 per cent of organisations conducting projects in 1999–2000 were doing so in 2006–07 and only 48 per cent of projects being conducted in 1999–2000 were being conducted in 2006–07.
- Of the projects conducted in 2006–07: 32 per cent primarily provided prevention services; 26 per cent provided harm reduction services; 15 per cent provided non-residential treatment services; 9 per cent provided residential treatment services; 8 per cent provided support, referral and ongoing care services; 7 per cent were workforce development projects; and 3 per cent were multi-service projects (largely based around the provision of residential treatment).
- There were considerable gaps in terms of the range of services provided at the regional level, with one group of eight regions having very limited service coverage.
- Alcohol was the prime focus of 72 per cent of projects: 13 per cent focusing solely on alcohol and 59 per cent having a secondary focus on other drugs, with another 10 per cent of projects having a multi-drug focus. The numbers of projects focusing specifically on other substances was small, with only 3 per cent targeting tobacco. When compared to the 1999–2000 period, this represents a focus away from alcohol alone to a focus on both alcohol and other substances.
- There were four broad population groups at which intervention projects were targeted: communities at large (34 per cent); intoxicated persons (23 per cent); 'dependent' persons or those with chronic problems (36 per cent); and those providing health workers with the skills to address alcohol- and other drug-related problems (6 per cent).

Funding of alcohol and other drug services for Indigenous Australians

- A total of $100.7 million (excluding GST) was expended on Indigenous-specific AOD intervention projects in 2006–07. This funding comprised 11 per cent capital expenditure, 74 per cent recurrent operational expenditure, and 15 per cent non-recurrent operational expenditure.
- Of this funding, 72 per cent was expended by Indigenous community-controlled organisations, 10 per cent by non-Indigenous non-government organisations, and almost all of the remainder by State and Territory governments and, in the case of the Petrol Sniffing Prevention Program, by the Australian Government.
- Between 1999–2000 and 2006–07, in real terms (2006–07 dollars) operational expenditure increased by 110 per cent from $42.6 million to $89.4 million. Within this, non-recurrent expenditure increased from $2.1 million (5 per cent) to $14.8 million (17 per cent).
- Operational expenditure by Indigenous community-controlled organisations increased by 61 per cent, between 1999–2000 and 2006–07, but as a percentage of total operational funding decreased from 90 to 69 per cent. Operational expenditure by non-Indigenous NGOs increased by 343 per cent, and as a percentage of total operational expenditure increased from 5 to 11 per cent. Expenditure by government agencies increased by 730 per cent and rose from 5 to 20 per cent of all operational expenditure (most of which was accounted for by the Australian Government's Petrol Sniffing Prevention Program).
- Forty-three per cent of all operational expenditure was on treatment projects (non-residential 10 per cent, residential 20 per cent and multi-service 13 per cent). Prevention projects accounted for 28 per cent and harm reduction projects 22 per cent of expenditure. Of the remainder, 5 per cent was spent on support, referral and ongoing care projects and 2 per cent on workforce development.
- The 340 projects were funded by a total of 494 separate grants. The average number of grants per project was 1.45, but in the case of residential treatment projects the average was 2.5 and in the case of multi-service projects the average was 4.1.
- Seventy-six per cent of all grants were less than $200 000. The distribution of operational grant amounts was extremely skewed — ranging from a low of $2300 to a high of $8.9 million for the Petrol Sniffing Prevention Program, with a median of $114 467.
- Of the 340 projects, 82 or 24 per cent were reliant totally on non-recurrent funding. Of these, 49 per cent were prevention projects, 23 per cent harm reduction projects, and 17 per cent workforce development projects. The median amount of grants for these projects was $34 250.
- Between 1999–2000 and 2006–07 there was a differential increase in operational expenditure across project types. The largest increase was on prevention projects, which rose by 459 per cent. Increases in funding for harm reduction (68 per cent), non-residential treatment (71 per cent) and residential treatment projects were less than the overall increase of 110 per cent.

- At the State and Territory level, operational expenditure ranged from a low $955 000 in the Australian Capital Territory to a high of $19.7 million in Queensland. On a per capita basis it ranged from $105 per person aged ≥15 years in Tasmania to $799 in South Australia.
- Between 1999–2000 and 2006–07 there were increases in total operational expenditure in all States and Territories. However, in two jurisdictions there was a decrease of 5 per cent in per capita expenditure.
- On a regional basis, operational expenditure ranged from a low of $59 000 to a high of $5.8 million. Median expenditure was $1.8 million with less than $1 million being expended in a third of all regions. On a per capita basis, operational expenditure ranged from a low $54 per person aged ≥15 years to a high of $1550, with a median of $282.
- Sixty-four per cent of all funding was provided by Australian Government agencies. Overall, State and Territory government agencies contributed 33 per cent of funding. However, there was considerable variation in the size of these contributions, ranging from 3 to 76 per cent.
- Operational funding of projects by the Australian Government increased from $24.6 million in 1999–2000 to $54 million in 2006–07, an increase of 119 per cent. The contribution of State and Territory governments rose from $17.8 million in 1999–2000 to $32.8 million in 2006–07, an 84 per cent increase. In percentage terms, the largest increase in contributions (1572 per cent) was made by NGOs, an increase from $155 000 in 1999–2000 to $2.6 million in 2006–07.

The appropriateness of current services and their funding

- Positive responses to the level of alcohol- and other drug-related harms include:
  - an increase of 110 per cent in total and an increase of 34 per cent in per capita expenditure between 1999–2000 and 2006–07
  - further significant increases in funding in the 2007–08 and 2008–09 financial years
  - positive responses to continuing and emerging problems, including: the Australian Government's Petrol Sniffing Prevention Program; a broadening of intervention services to address illicit drug use; drug diversion programs for offenders; increases in community patrol and sobering-up shelters in the Northern Territory and the north of Queensland and Western Australia; and a significant increase in the number of prevention projects.
- Lack of correlation between indicators of harm and the numbers of, and funding for, intervention projects indicate that need has not been an important factor in service planning.
- Despite its impact on morbidity and mortality, there was a paucity of projects specifically targeting a reduction in tobacco use.
- There was no correlation between the size of regional populations and the provision of services, indicating that this also has not been a factor in service planning.

- There were few community-based or residential treatment projects addressing the needs of women, families, young people and those suffering from comorbid mental health problems.
- The funding of treatment services did not reflect the need to address the complex needs of clients with comorbid mental health problems, polydrug users, and offenders.
- There was a significant discontinuity in the provision of Indigenous alcohol and other drug services which was reflected in the high turnover of organisations providing alcohol and other drug services and in the projects conducted by them. This is a consequence of relatively high levels of non-recurrent funding.
- There was little evidence of service planning at the regional level.
- As with the provision of individual projects, there was no correlation between the range of services provided and either levels of alcohol-caused mortality or population size.
- One of the most obvious gaps in provision of a comprehensive range of services was in the limited number of ongoing care projects. Failure to provide and adequately resource ongoing care is both a failure to clients and a failure to protect the investment made in the provision of treatment services.
- There was a shortage of detoxification services catering to the needs of Indigenous Australians.
- The lack of night patrols and sobering-up shelters was identified as a gap in the range of available services by service providers in some regions other than those in the Northern Territory and the north of Queensland and Western Australia where they were most commonly provided.
- The provision of a broad range of services at the regional level did not necessarily provide equal access to services for all people within a region.
- In some regions services provision was poorly coordinated.
- There is evidence that there has been movement away from commitment by governments to resourcing Indigenous community-controlled services and hence a limiting of the capacity of Indigenous Australians to address harmful AOD use.
- The capacity of some organisations to provide additional services for which there was a need was constrained by funding which has only kept pace with rises in the Consumer Price Index and which did not enable them to provide services outside 'normal' hours.
- Staff members from many of the organisations who participated in this study identified inadequate staff training as a barrier to effective service provision — a view supported by the evidence on the limited number of, and funding for, workforce development projects.
- Service providers highlighted a number of broader staffing issues which impose barriers to more effective service provision, including heavy workloads, poor remuneration vis-à-vis the government sector, lack of career paths and consequent high staff turnover rates.

- Lack of flexibility in funding guidelines and government tendering processes was identified by service providers as constraining their ability to adequately respond to local or regional needs and priorities.
- Considerable concern was expressed by Indigenous service providers that tendering of services for Indigenous Australians to non-Indigenous NGOs undermined the principle of Indigenous capacity building.
- Service providers reported that the outcomes of intervention projects are compromised by short-term non-recurrent funding.
- The onerous requirements of producing quarterly and sometimes monthly reports on multiple funding grants, as well as additional reporting requirements, were raised as a significant issue by many of those interviewed for this project.
- It is important to note that, in the financial years following that on which this report is based, the Australian and State and Territory governments made significant increases in expenditure on Indigenous-specific AOD interventions. We do not have data on this for all jurisdictions but expenditure by the Australian Government Department of Health and Ageing increased by $14.5 million in 2007–08, and by a further $4.5 million in 2008–09. Some of this funding was targeted at gaps identified in this report, including $2.7 million for capacity building, $2.5 million for people with comorbid AOD and mental health problems, and $1.5 million for tobacco control.

Recommendations

1. Given the evidence that there have been no significant reductions in the prevalence of harmful alcohol and other drug use among Indigenous Australians over the past decade, all levels of government should enhance their efforts to develop more effective policies and strategies to address the structural inequalities that underlie such prevalence, as well as the specific needs for service provision identified below.
2. The framework provided by the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan* provides a comprehensive basis for reducing harmful levels of alcohol and other drug use and has widespread support within the sector. As the peak policy and decision-making body in relation to licit and illicit drugs in Australia, the Ministerial Council on Drug Strategy should make a renewed commitment to the action plan.

Targeting gaps in service provision

3. Given the disproportionate negative impact of tobacco smoking on the health of Indigenous Australians, far greater emphasis should be put on the provision of appropriate interventions to reduce its prevalence.
4. Given the paucity of community and residentially based treatment services for women, families, young people and those suffering from comorbid mental illness, there should be a significant increase in the provision of such services.

5. To address the significant gap in the provision of ongoing care services, to minimise relapse among those who have undergone treatment and to protect the investment made in treatment services, priority should be given to the provision of community-based ongoing care services for those who have completed treatment.

6. Where a need is identified by Indigenous communities, and where justified by numbers of potential clients, there should be an expansion of detoxification services catering to the needs of Indigenous Australians.

7. There are several regions identified in Chapter 5 of this report which appear to be under-serviced. These regions should be targeted with regard to the provision of a wider range of Indigenous-specific alcohol and other drug services.

Capacity building

8. In the interest of providing more appropriate services, better client outcomes, and building capacity, all levels of government should re-commit themselves to the principle of Indigenous community control of service provision.

9. To develop the capacity of Indigenous communities to address alcohol- and other drug-related harms, it should be a requirement of tendering conditions that non-Indigenous NGOs tendering for the provision of services to Indigenous Australians make all endeavours to tender in partnership with Indigenous community-controlled organisations and put in place strategies and timeframes for handover of services to those organisations.

10. Given the gaps in the capacity of some providers either to effectively deliver existing services or to meet other community needs, consideration of current capacity and any need to enhance it should be part of service contract negotiations and funding should be provided accordingly.

Workforce issues

11. Given the shortages of skilled alcohol and other drug staff (and the constraints on service provision and expansion of capacity that such shortages impose) and the low levels of investment in staff development and training, funding and other resourcing for skilled staff should be substantially increased.

12. Given the high turnover of staff within the community-controlled alcohol and other drugs sector (as a consequence of heavy workloads, poor remuneration vis-à-vis the government sector, and lack of career paths), staffing benchmarks — including remuneration and conditions of employment — should be negotiated between funding agencies and service provider representatives, and should be implemented.

13. Given that the demand for qualified Indigenous staff members cannot be adequately met within the alcohol and other drugs sector, the Australian Government Department of Health and Ageing (as the most important of the funding agencies) should enter into discussion with the Department of Education, Employment and Workplace Relations to explore ways of facilitating increased direct entry of Indigenous Australians into vocational and tertiary education programs of relevance within the sector.

Funding

14. Given the evidence of significant gaps in the provision of alcohol and other drug services for Indigenous Australians, detailed costing of the services necessary to address those gaps should be developed in collaboration by the various funding agencies and service providers, and funding allocations should be increased accordingly.

15. Given the variation in need between regions and in community priorities, funding program guidelines and contractual arrangements for the provision of alcohol and other drug services to Indigenous Australians should be sufficiently broad to allow service providers to meet community needs within their particular regions.

16. Given the uncertainty of service delivery, the compromising of outcomes and the additional reporting requirements entailed in dependence upon non-recurrent funding, strategies should be put in place by governments to increase the proportion of funding allocated on a non-recurrent basis for the provision of alcohol and other drug services.

17. Benchmarks should be negotiated between funding agencies and service providers for the provision of treatment services – including provision for clients with special needs such as those with comorbid mental health problems, poly-drug users, and offenders – and services should be funded with regard to client needs and client mix.

18. Coordination of care within and between the government and non-government sectors should be part of treatment service benchmarking, and its provision should be appropriately funded.

19. Given the administrative burden of reporting requirements, steps should be taken by funding agencies to reduce such requirements – including the rationalisation of grant provision and the simplification and standardisation of reporting requirements – while at the same time upgrading the capacity of Indigenous organisations to meet them.

Planning

20. Given the evidence of limited planning of service provision, regional alcohol and other drug planning committees, made up of a broad range of stakeholders and including all community-controlled AOD and health services, should be established to facilitate provision of a 'range of holistic services from prevention through to treatment and continuing care', and to contribute to their evaluation and continuous improvement.

21. Agencies charged with collecting data on the prevalence of alcohol and other drug use and related harms should work together to provide such data at a regional level, and in a timely manner, to ensure that services are planned jointly by key stakeholders and funded in response to need.

22. Service provision at the regional level should be reviewed to ensure that a complete range of community-based services – and, where feasible, residential services – is available.

23. Where provision of services is not feasible at the local level, regional service providers should be resourced to provide reasonable region-wide access to their services.

1. Introduction

The Australian National Council on Drugs (ANCD) is the principal advisory body to the Australian Government on alcohol and other drug issues and plays a critical role in ensuring that the voices of the alcohol and other drugs (AOD) sector and the broader community are heard. As part of its commitment to providing high-level advice to government, the ANCD established the National Indigenous Drug and Alcohol Committee (NIDAC) in 2004 to specifically identify the most appropriate and effective approach for the ANCD to contribute to addressing Indigenous drug and alcohol issues within Australia.[1]

It is a commonly held view among those working in the AOD sector that there is a significant, but unquantified, level of unmet need for services for Indigenous Australians. To assess this and to identify 'areas of greatest need', at the request of the then Prime Minister, in late 2006 NIDAC called for tenders to conduct the project on which this report is based. As summarised in NIDAC's call for tenders, the aim of the project was to provide an in-depth report on:

- current alcohol and other drug services for Indigenous Australians
- funding of current alcohol and other drug services for Indigenous Australians
- the appropriateness of current services and funding for them, and
- the identification and assessment of unmet needs.[1]

Some members of our team had been part of a group which conducted an earlier study, on behalf of the ANCD, that mapped the distribution of Indigenous-specific AOD services in 1999–2000.[2] As much of the data collected for that study was directly comparable to the data needed for the current project, it was agreed with NIDAC that we would enhance this study by comparing the data on projects and funding for 1999–2000 with those for the current project to assess what changes had taken place in the intervening period.

Identification of the appropriateness of services and assessment of unmet needs require:

- information on the level of AOD consumption and variation in it among Indigenous Australians
- information on the harms associated with the consumption of various psychoactive substances and the relative magnitude of those harms
- Indigenous and government responses to AOD-related harms
- an understanding of the factors underlying or determining the patterns of observed consumption and harm
- a framework or model that identifies the range of interventions which should, ideally, be in place to address the underlying causes of AOD-related harm and its manifestation
- a knowledge of the efficacy of specific interventions, and
- information on what interventions are currently in place.

We examine these factors and, to the extent possible, put them in the context of the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009* (the CAP).[3] This document — which was agreed upon by the Ministerial Council on Drug Strategy (MCDS), the peak policy and decision-making body in relation to licit and illicit drugs — has six key result areas and provided the policy framework at the national and State and Territory levels within which the interventions reviewed in this report were implemented.

In Chapter 2 we outline the methods used in conducting this project. In Chapter 3 we summarise the data available on AOD consumption and related harms (as well as the problematic nature of some of the data) and provide an overview of the health-related harms associated with that consumption. Chapter 4 is also based on a review of the literature and provides: background information on the factors underlying the greater prevalence of AOD use among Indigenous Australians; the range of interventions available to minimise AOD-related harms and their application among Indigenous Australians; and a framework for assessing the coverage, or range, of interventions available at a local or regional level. In Chapter 5, we summarise the AOD intervention projects specifically targeted at Indigenous Australians in the 2006–07 financial year; and in Chapter 6 we provide data on expenditure on those projects. Chapter 7 provides a qualitative dimension to the material presented in Chapters 5 and 6 and reports on what service providers themselves saw as the strengths and weaknesses of the services they provided and gaps in AOD services in their regions. Finally, in Chapter 8 we provide a summary of current interventions, changes that took place between 1999–2000 and 2006–07, and gaps in service provision at that time, and we make recommendations for enhancing the response to harmful AOD use and related harms.

At this point, it is apposite to comment on the requirement in the original NIDAC call for tenders to report on 'current alcohol and other drug (AOD) services for Indigenous Australians'. As discussed in the Methods chapter of this report, there is no single repository of data on the many AOD intervention projects targeted at Indigenous Australians which are conducted and/or funded by a wide range of Indigenous community-controlled organisations, non-government organisations and government agencies. The largest funder of Indigenous AOD interventions is the Australian Government Department of Health and Ageing (DoHA)'s Office of Aboriginal and Torres Strait Islander Health (OATSIH). OATSIH produces an annual report — *Drug and Alcohol Services Report* (DASR) — summarising the activities of the AOD-specific organisations that it funds to provide services to Indigenous Australians.[4] This report is based on routine administrative data collection and does not include information on non- AOD-specific organisations (such as community-controlled primary health care services) funded to provide AOD services. Given the time it takes to collect, collate and analyse these data the DASRs are typically published 18 months to two years after the close of the financial year they cover. Thus, even the largest funder of services is not able to provide comprehensive information on 'current' service provision.

The difficulties inherent in compiling each DASR are compounded for the production of a report such as this which attempts to collate and verify data from multiple sources. The 'current' data on which this report is based are for the 2006–07 financial year – the last completed financial year prior to commencement of the project. While the data presented in the report are no longer 'current', this does not render them irrelevant to the planning and implementation of interventions in the present. The data provide a baseline against which changes in the provision of services and funding since that year can be compared and against which progress in addressing Indigenous AOD-related harms can be assessed. We do not have detailed data on the provision of services, and funding for them, post-2006–07. However in Chapter 8, we provide brief information on significant new commitments made by the Australian Government in that period. It should be noted, however, that this is not directly comparable to that provided in this report for 2006–07.

2. Research methods

As indicated previously, this project was commissioned by the National Indigenous Drug and Alcohol Committee (NIDAC). As specified in NIDAC's call for expressions of interest, the aims of the project were to report on:

- current alcohol and other drug services for Indigenous Australians
- funding of current alcohol and other drug services for Indigenous Australians
- the appropriateness of current services and funding for them, and
- the identification and assessment of unmet needs.[1]

In addition to these aims, as we had access to data from an earlier study conducted for the ANCD for the 1999-2000 financial year,[2] we also undertook to describe changes in the provision of services between that period and 2006–07 (the period covered by the current study).

2.1 Literature review

The NIDAC call for tenders specified that the report on the project should include 'a summary and critical analysis of the literature'.[1] In conducting this review, which is presented in two parts (Chapters 3 and 4), we have tried to make the report as a whole accessible to as wide a range of readers as possible and have therefore provided an extensive background to the data on 'current' intervention projects and their funding which comprise subsequent chapters.

Whether or not current AOD interventions for Indigenous Australians are appropriate is dependent upon levels of AOD consumption and related harms. In Chapter 3 we provide an overview of some of the difficulties in accurately measuring the prevalence and levels of AOD consumption among Indigenous Australians; we review the findings of several key surveys; and we assess those findings. The harms associated with AOD use are extensive and include social, economic and health costs. It was beyond the scope of this project to review these in detail and we have confined ourselves to providing an overview of harms to health. The latter have been summarised in several key publications and we have relied upon the work undertaken for them.

Chapter 4 provides: a review of the rationale for Indigenous-specific interventions; a consideration of the social factors underlying the greater prevalence of harmful AOD use among Indigenous Australians; a framework for situating the range of interventions in relation to the underlying social determinants; and a review of the evidence for the efficacy of specific interventions and their application in Indigenous contexts. The literature on these topics is quite extensive and there are several reviews of them. Where they are available, we have relied on those reviews, rather than upon undertaking new reviews of our own (a task well beyond the resources available for this project).

2.2 Indigenous-specific alcohol and other drug intervention 'projects'

The approach taken to the study was similar to that employed in the earlier study for the ANCD, which reported on the provision of AOD services for Indigenous Australians and their funding. As in the earlier study, the key unit of analysis for this report was an intervention 'project'. For our purposes we defined Indigenous-specific intervention projects as discrete sets of *services* (including the organisational framework for delivering those services) directly aimed at reducing the harms associated with AOD use among Indigenous Australians. There are several elements to this definition.

First, for inclusion, an intervention had to be targeted specifically at Indigenous Australians. That is, it must be part of a broader strategy to reduce harmful AOD use over and above those interventions that are provided for the broader Australian community. Thus, we do not include within our definition activities within 'mainstream' organisations (government or non-government) that are aimed at making their services more accessible and acceptable — or 'culturally secure' — for Indigenous Australians.

Second, for inclusion, intervention services must have *directly* targeted harmful AOD use. As we discuss in Chapter 4 — like health more broadly — patterns of AOD use are socially determined and there is a broad range of activities or interventions that can influence those patterns. However, to include interventions, such as the provision of employment opportunities or youth services, that might reduce harmful AOD use as a by-product, but which are not directly aimed at doing so, has the effect of expanding the potential range of projects to a wide range of services not normally considered as AOD interventions and expanding the study beyond manageable limits. Thus, for example, if a service for young people had an explicitly stated direct objective of reducing harmful AOD use, it was included; if it did not, it was excluded.

Third, an intervention project is not synonymous with an organisation. Many organisations provide discrete sets of services. These may be AOD services only (for example, a sobering-up shelter and a treatment program which are managed and financed as separate entities) or a combination of AOD services and non-AOD services (such as health or community development services). Fourth, a project is not synonymous with a funding grant or allocation, as many intervention services are funded from multiple sources.

Finally, as our concern is with the provision of services per se, projects as we have defined them are not synonymous with the intervention programs implemented by governments, although they are the practical expression of such programs. For example, while a State or Territory government agency might have a large program to divert Indigenous offenders into AOD treatment, we do not examine the program as such. Rather, we document the services provided to that target group by particular projects 'on the ground'. Another implication of this is that the funds expended on projects 'on the ground' (i.e. the funds that are actually expended on service provision) total less than funding program totals as the latter may include the administrative costs incurred by the funding agencies.

2.3 Data collection

Stage 1: Collection of basic data

The data necessary to conduct a study such as this are not readily accessible and, to obtain them, we followed a stepwise procedure. The most comprehensive data sets are the records of the Australian and State and Territory government agencies that provide funding for AOD intervention services, and it is from these records that the majority of intervention projects can be identified. However, many agencies do not have reporting mechanisms that routinely capture the necessary information on funding for Indigenous-specific intervention programs and the allocation of resources within those programs to specific projects. In many cases, compilation of the data by funding agencies entails the commitment of considerable human resources. Thus, to undertake the project, it was essential to obtain the commitment of those agencies to provide the necessary data.

The major agencies funding AOD interventions are the Australian and State and Territory health and/or AOD departments. These, along with police services and the Australian Customs Service, are members of the Intergovernmental Committee on Drugs (IGCD). As a first step to obtaining the cooperation needed, NIDAC approached the IGCD to request member support and, in July 2007, one of our team members and the chair of NIDAC (Associate Professor Ted Wilkes) attended an IGCD meeting at which the Committee agreed to support the project.

In the second step, in September 2007, NIDAC wrote to IGCD members formally requesting the following information:

- the names of organisations they had funded to conduct Indigenous-specific AOD interventions in the most recently completed financial year (i.e. 2006–07)
- the names and brief descriptions of funded projects (including any projects directly conducted by the funding bodies themselves) — including services provided, settings in which services were provided, substances and populations targeted, and geographical locations in which projects were conducted
- the discrete amounts and types of funding (operational or capital), whether they were inclusive or exclusive of GST, and the period over which they were allocated (these amounts are referred to as grants in this report and include internal allocations of project funding within agencies in cases where an agency was both a funder and provider of an intervention project)
- the program under which the project was funded, and
- contact details for the organisations providing services.

At the same time, a similar request was also made by NIDAC to government agencies not represented on the IGCD and to other organisations known to be, or possibly, funding or conducting Indigenous-specific AOD interventions. These included Indigenous affairs,

Attorney-General, corrections and education departments, Aboriginal Hostels Ltd and large NGOs such as the Alcohol Education and Rehabilitation Foundation.

As well as those major agencies, some local government councils and private foundations were also likely to conduct projects or provide funding for Indigenous-specific AOD interventions. These were not easily identifiable and it was decided that, to do so, we would seek information from service providers on any funding received from them and back-check that information with any organisations thus identified.

While some funding bodies responded relatively promptly to these requests, others were slower, and in some instances NIDAC had to make up to three requests before the information was provided. In part the delays were caused by: a change in the Australian Government; the shortage of resources to compile the data; and, in some instances, the low priority assigned to the request. However, by March 2008, 41 agencies had responded with information on 324 service providers conducting 551 projects.

In addition to the 41 agencies that provided information, we attempted to make contact with another 18 which had not. A small number of these did not respond, but the majority reported they had not funded any Indigenous-specific AOD interventions. In one case, an agency identified service providers to which it provided funding, but chose not to identify the amounts of funding provided. However, in this case, most of the service providers themselves provided this information, and it was verified against the agencies' annual reports.

At this time, an internet search was also conducted to identify any projects that were not reported by the funding agencies, but no additional projects were thus identified. However, as project team members have extensive knowledge of the field, they were able to identify additional projects not reported by the funding agencies. This and questions put to service providers (see below) led to the identification of an additional nine service providers conducting 30 projects.

As data from these various sources came to hand, details were entered into a Microsoft Access database designed for the project. By the means described above we identified a total of 333 organisations that were reported to have been conducting 581 AOD projects specifically for Indigenous Australians.

Stage 2: Service provider data verification

In the second stage, commencing in April 2008, an attempt was made to contact (by email and telephone) the organisations conducting the projects identified in Stage 1. The objective was to verify that the organisations conducted those projects in the 2006–07 financial year and to verify and expand upon the information provided by the funding bodies. In addition to verifying the data, representatives of the service provider organisations were to be asked for:

- information on the numbers of clients participating in projects, and numbers of staff members employed on the projects, their qualifications and Indigenous status, and

- whether their organisations provided any Indigenous-specific AOD services that we had not identified and whether they were aware of any other Indigenous-specific AOD services operating in their localities or regions.

They were also to be asked three broad, open-ended questions designed to elicit some qualitative data to illuminate the quantitative data we collected.

- What do you perceive as the current strengths of your service?
- What do you perceive as current barriers to the provision of your services?
- What other services are needed within your town or region to meet the needs of your community?

An introductory email was sent to the contact persons of the organisations conducting the projects. These emails explained the purpose of the study and informed them that they would soon be contacted about it. Following the email contact, commencing in April 2008, follow-up telephone calls were made to the service providers to provide additional information on the projects and to request interviews to enable us to verify the information on our database and to seek answers to the additional questions listed above.

The telephone calls and interviews were conducted by a team of four Indigenous and two non-Indigenous interviewers based in NDRI's Perth and Alice Springs offices. Some interviews were conducted immediately over the telephone and others were arranged for a later date. A small number of interviews were conducted face-to-face in Perth, Alice Springs and five locations in Queensland.

Where contact was not made on the first telephone call, interviewees made up to five follow-up calls, until either contact was made or attempts to make contact ceased.

By December 2008, this second stage of data collection had reached the point of diminishing returns and was terminated. Despite the persistence of the interviewers, we were not able to interview representatives from all the service provision organisations. Reasons for this included: loss from the organisations of staff who had detailed knowledge of the projects (especially in the case of 'one-off' projects); and the fact that staff were extremely busy and did not have the capacity to respond to non-urgent requests such as ours. In addition to some interviews not being conducted, 11 were incomplete due to: staff turnover which resulted in a loss of corporate knowledge regarding the project; staff being unable to answer questions at the time and not getting back to the interviewers; and, in some cases, with regard to the open-ended questions, non-Indigenous employees feeling that they were unable to answer because they were not Indigenous.

As indicated in the previous section, in the first stage of data collection we identified a total 333 service providers reported to be conducting 581 projects. Interviews were conducted with representatives of 240 organisations and, on the basis of these, 92 organisations conducting 180 projects were excluded from the study as they did not meet the inclusion criteria.

After completion of the interviews, and inclusion or exclusion of providers and projects, we were left with a total of 93 organisations reported to have conducted 168 projects requiring verification. In the absence of confirmatory interviews to verify the data, in

these cases we relied on the original information supplied to us by the funding agencies, electronic resources such as websites, documentary data such as annual reports and, in some instances, first-hand knowledge of organisations and projects. On the basis of this secondary verification process, we excluded a further 17 organisations conducting 61 projects. The main reasons for exclusion in both verification processes (by service provider) were as follows (with some providers being excluded for multiple reasons):

- duplicate or incorrect information (n=48)
- not AOD use-specific (n=55)
- not Indigenous-specific (n=46)
- not providing a service, for example, scoping projects (n=19), and
- not actually funded in the 2006–07 financial year (n=15).

The verification process was important as there were often discrepancies between the data provided by the funding agencies and those obtained from service providers. A major source of discrepancy was in the amount of funding reported as being allocated to projects. Amounts reported as being received by service providers for the 525 grants that funded the 340 projects included in the study matched the amounts reported by the funding agencies in only 111 instances (21 per cent). Among the reasons for this were: inclusion or exclusion of GST in one report and not another; reporting of budgeted expenditures over longer time periods rather that the actual expenditure in the 2006–07 financial year; non-expenditure of funds within the financial year; and variations to grants.

Other sources of discrepancies included project details, such as substances and populations targeted, and the locations in which the projects were conducted (as opposed to the locations in which service providers' business offices were located). Some of these discrepancies were able to be resolved at the time of the interviews; others required additional follow-up over several months. However, despite attempts at verification (particularly in the case of organisations that could not be contacted and, in some cases, with regard to the inclusion or exclusion of GST in grants) discrepancies in a number of cases could not be resolved directly and we were required to make decisions to resolve them indirectly on the basis of information to hand and our collective knowledge of the area.

Following the review process, we were left with information on 224 service providers operating 340 Indigenous-specific AOD intervention projects in 2006–07. The main implication of the fact that we were not able to interview representatives from all of the organisations is that there is probably a small under-estimation of total expenditure on projects, as we were not able to identify sources of project funding in addition to those notified to us by the major funding bodies.

2.4 Data analysis

Current alcohol and other drug services for Indigenous Australians

The first aim of the study was to report on 'current alcohol and other drug services for Indigenous Australians' (as indicated above, 'current' was for the most recently completed financial year at the commencement of the study, i.e. 2006-07). This element of the study was largely descriptive. Using the data collected from funding agencies and service providers, we described the organisations conducting projects, the types of services provided as part of those projects, the drugs and populations targeted, and their distribution by Australian Bureau of Statistics (ABS) Indigenous regions. These regions are based on the aggregation of statistical local areas (SLAs), and reflect a range of geographic, demographic and cultural similarities and differences.

To illustrate the descriptive data, we contracted the ABS to prepare national maps (using data provided by us) of the regional distribution of projects by main project type and the Indigenous residential population aged ≥15 years at the time of the 2006 Census (downloaded from the ABS website <http://www.abs.gov.au/>). In addition, the ABS also prepared State and Territory maps in which project types were overlaid on regional population distributions (these are included in the appendices).

The ABS regions used in this study parallel the former Aboriginal and Torres Strait Islander Commission (ATSIC) regions used in the 1999–2000 study of Indigenous interventions.[2] Prior to the abolition of ATSIC, these latter regions were the basis of much Indigenous administration and service provision. However, they are now of little practical significance and hence not used in this study. The two systems are similar and generally no significant problems arise in comparing data based on them between the 1999–2000 and 2006–07 periods. However, there are some key differences in the ABS classification — the partitioning of the State of Victoria in two markedly different ways; the splitting of the Wagga Wagga region in two (Wagga Wagga and Dubbo); splitting the Australian Capital Territory from Queanbeyan; and the absorption of the Western Desert Region of Western Australia into three adjoining regions. In these cases, where the differences result in only minor distortions we have made temporal comparisons. However, where they are of major significance — as in the Victorian case — we have not made regional comparisons or we have provided explanations of their effect.

Bearing these differences in mind, data on the provision of services were cross-tabulated and compared to those from 1999-2000, and changes in frequency and distribution were identified. Due to the small numbers in many cells of the cross-tabulations, not all of these data were amenable to testing of statistical significance. However, using the PASW® Statistics 17 (formerly SPSS) chi-square procedure, we were able to test the significance of changes in the numbers and types of organisations providing projects and the numbers of projects conducted by those organisations.

Data on the staffing of services and client numbers were of variable quality and/or not ascertainable and for this reason were excluded from analysis.

Funding of current alcohol and other drug services for Indigenous Australians

The second aim of the project was to report on 'funding of current alcohol and other drug services for Indigenous Australians' – all of which is reported here as GST-exclusive. In addressing this aim, we initially distinguished between capital and operational expenditure. Although we do report on total levels of expenditure, funds for capital investment are not made in all regions at all points in time and inclusion of them distorts comparisons. Thus, for most comparative purposes, we report only on operational expenditure.

As various reports have raised issues surrounding the provision of short-term funding for intervention projects, we have further broken down operational expenditure into 'recurrent' and 'non-recurrent' components. This classification is somewhat arbitrary as no governments provide an open-ended commitment to fund organisations to provide services. Funding contracts are for specified periods – even though many contracts have been renewed over considerable periods of time in the past and there is an expectation that they will be renewed in the future. Given this we defined non-recurrent operational funding, as for the 1999–2000 study, as funds provided on a 'one-off' basis for a period of 12 months or less.

In describing the provision of funding, we identified: the total amount expended by service provider type (i.e. types of Indigenous organisations, government and non-government organisations); the type of intervention projects on which funds were expended; the geographical distribution of expenditures; and the sources of funds expended (i.e. funding agencies). Expenditures were described in both absolute and per capita amounts. The latter were calculated using 2006 ABS Census data on Indigenous residential populations aged ≥15 years for ABS Indigenous regions and States and Territories. To illustrate this, at our request the ABS prepared maps on the regional distribution of operational and per capita expenditures.

As with data on projects, the funding data were compared with those for the 1999-2000 financial year. Data on capital expenditure were not available to us for the 1999-2000 period, so these comparisons were confined to recurrent and non-recurrent operational expenditure. Per capita expenditures in the report on 1999-2000 projects were calculated on the basis of total population numbers.[2] To enable comparison with data from the current project, these were recalculated based on the Indigenous population aged ≥15 years at the time of the 2001 Census (<http://www.abs.gov.au/websitedbs/D3310114.nsf/home/census+data?opendocument?utm_id=LN>). Also to facilitate comparison, expenditures for 1999-2000 were converted to 2006-07 dollars using data on annual increases in the Consumer Price Index obtained from the website of the Reserve Bank of Australia (<http://www.rba.gov.au/statistics/by-subject.html>).

The appropriateness of current services and funding for them

To address the appropriateness of services provided in the 2006–07 financial year and funding for them, we asked a number of key questions of the data.

To what extent did the services provided reflect need?

As indicated previously, there is a paucity of information at the regional level on patterns of substance use. Thus, we examined the frequency and percentage of projects targeting particular categories of drugs and compared those to what is known about the prevalence of use of those drugs at the national level. The frequencies and percentages of projects targeting particular drugs were also compared to those for the 1999–2000 period to assess to what extent changes in them reflected what is known about changes in the prevalence of drug use.

As with patterns of the prevalence of AOD use, there is a paucity of data on related harms at the regional level. In the absence of such data and given what is known about high levels of alcohol consumption and about variation in rates of alcohol-attributable mortality by the former ATSIC zones, we used the latter as a broad indicator of harm and assigned to each ABS Indigenous region the mortality rate of the ATSIC zone in which it was located. To test the relationship between this broad indicator of harm and both the number of projects and service coverage by region, we used Kendall's *tau-b* rank order correlation analysis. Pearson's R was used to test the relationship between alcohol-attributable mortality and total operational expenditure.

An important element of need — especially in the absence of epidemiological data — is population size. The relationship between the size of residential population aged ≥15 years, and the number and coverage or range of projects in each region was tested using Kendall's *tau-b* rank order correlation analysis. The relationship between population size and level of operational funding was tested using Pearson's R.

A third element to be considered in terms of need is the needs of particular groups within the larger population. Based on the data available for each of the projects, four major target groups were identified (the general community, intoxicated persons, dependent persons, and health workers) and these were further divided into sub-groups. The coverage of these target groups by intervention projects was assessed based on the distribution of their frequencies and percentages and what is known about their needs from the broader literature.

Was there 'A range of holistic approaches from prevention through to treatment and continuing care that is locally available and accessible' (CAP Key Result Area 4[3])?

To answer this question, we first identified the numbers of projects in each ABS Indigenous region in each of the following five sub-categories of the British National Treatment Agency model of AOD service provision (see Chapter 4):[5, 6] Tier 1 demand reduction; Tier 2 demand and supply reduction; Tier 2 harm reduction; Tier 3 demand reduction; and Tier 4 demand reduction (see Chapter 4 for more detail). As a proxy measure of 'service coverage' (or the range of available services), we allocated each region a score of one for each of the Tier sub-categories

in which there was one or more projects and totalled those scores. On this basis, regions were ranked into one of four groups based on the summary scores (5, 4, 3, and 2 and 1 combined), with those in the lower category (those with a score of 2 or 1) being classified as likely to be under-serviced. We also compared funding allocations between different project types.

As it is reasonable to expect that the provision of services might be dependent upon the remoteness or otherwise of a region, we tested the relationship between this variable and service coverage. The Accessibility/Remoteness Index of Australia (ARIA) provides a method for calculating the remoteness of a locality.[7] For the purposes of this study, the degree of remoteness of the ABS Indigenous regions was calculated by averaging the remoteness scores of SLAs within regions to provide a five-category ranking (highly accessible, accessible, moderately accessible, remote, and very remote). The relationship between the level of remoteness and the number and coverage of projects and the degree of regional remoteness was tested using Kendall's *tau-b* rank order correlation analysis.

To what extent did the provision of services enhance the capacity of Aboriginal and Torres Strait Islander individuals, families and communities to address current and future issues in the use of alcohol, tobacco and other drugs and promote their own health and wellbeing (CAP Key Result Area 1[3])?

To assess this, we examined the number of Indigenous organisations providing services, the percentage of projects conducted by Indigenous organisations, the percentage of operational funding expended by Indigenous community-controlled organisations, and the results of interviews with service providers.

To what extent did workforce initiatives enhance the capacity of Aboriginal and Torres Strait Islander community-controlled and mainstream organisations to provide quality services (CAP Key Result Area 5[3])?

To assess this, we examined the numbers and type of workforce development projects and expenditures on them and the results of service provider interviews.

Are there any administrative issues which affect the efficient delivery of effective AOD services to Indigenous Australians?

This was assessed based on the results of interviews with service providers and a review of the quantitative data to determine what evidence was available to support the interview results.

In the views of service providers, what are the strengths of current service provision and what are the barriers to more effective service provision?

It was beyond the scope of this project to conduct a comprehensive survey to supplement the data provided in Chapters 5 and 6. However, we offered representatives of participating organisations the opportunity to express their views on what they felt were the strengths of their organisation, the barriers they faced in the provision of services, and the areas of greatest need in their community.

Representatives of 129 organisations addressed one, two or all of the additional questions; the responses were entered into a Microsoft Access database and were manually coded by a non-Indigenous and an Indigenous member of the team. From the answers to the three additional questions, 137 themes emerged and these themes were organised into 'key' areas as summarised in Chapter 7. There were significantly more responses from representatives of Indigenous

community-controlled organisations (89) than non-Indigenous organisations (40), of which only 10 were representatives of State or Territory government organisations and two from local government organisations. Positions occupied by the interviewees included Chief Executive Officer, President, Manager, Project or Development Officer, Sports Recreation Officer and Youth Officer.

It is important to note that responses came from across regions. Overall, the number of responses from particular regions tended to be small and, when we examined responses to themes across regions, there were not enough data to make comments as to what issues were most pressing to, for example, organisations that were operating in rural areas. For this reason we have not provided the specific number of responses by location or drawn generalisations particular to region. However, the key areas we coded and present in Chapter 7 were those identified by a significant number of participants, indicating that there are issues common to those working in this area. We have indicated when an obvious majority of responses to a theme came from representatives of Indigenous and/or from non-Indigenous organisations.

Identification and assessment of unmet needs

Identification and assessment of unmet needs were based on our review of the appropriateness of services and their funding, and on data from the interviews with service providers. On the basis of this process, we make a number of recommendations to address those needs.

2.5 Ethical issues

The project was undertaken within the framework of the National Health and Medical Research Council (NHMRC) *Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health Research*.[8] Approval for the project was sought and granted by Curtin University of Technology's Human Research Ethics Committee (Approval no. NDRI-03-2007). To protect the privacy of particular organisations, we did not utilise any service provision or funding data that were not already in the public domain. However, in two regions there was only one provider of services in each and they could be easily identified. Thus, despite the fact that the information was publicly available, we obtained permission from service representatives to include the data they had provided and that we had collected on their organisations. No data were collected on any clients or employees of the organisations providing services. Consent to participate in the telephone interviews was obtained either prior to or at the time of those interviews and all responses have been reported anonymously to protect those interviewed.

3. Indigenous AOD use and related harms

Ascertainment of alcohol and other drug consumption levels and related harms is not a straightforward matter. Sales data, which provide a proxy measure of consumption, are available on licit drugs such as alcohol, tobacco and pharmaceuticals. However, no such data are available on the importation and production of illicit drugs. Furthermore, the data that are available cannot be disaggregated to provide information on levels of consumption by individuals or population sub-groups such as women or Indigenous Australians.

To overcome such difficulties it is necessary to rely on population surveys in which individuals are asked about their consumption. However, the results of such surveys vary and are dependent upon sampling methods, the questions asked, the way in which they are asked, and the way in which they are interpreted by respondents. Where direct data on consumption are available for comparison (such as alcohol sales data), surveys have been shown to always underestimate actual consumption – and the World Health Organization (WHO) has developed a set of survey guidelines which aim to reduce such discrepancies.[9, 10] For this reason, those survey methods that yield the highest estimates of consumption are to be preferred to those that yield lower estimates.[11]

Where survey data are not available, estimates of consumption can also be made by extrapolating from the frequency of health problems known to be associated with particular drugs. However, such estimates are dependent upon accurate diagnoses and, where the conditions being considered are not wholly caused by alcohol consumption, the estimates are themselves based on estimated levels of consumption; if they are inaccurate, then so also are the derived estimates of consumption.[11, 12]

These problems are exacerbated when attempting to estimate AOD consumption and related harms among Indigenous Australians. Of the various surveys undertaken, the triennial National Drug Strategy Household Surveys (NDSHSs) utilise the most sophisticated set of questions for ascertaining both the prevalence of use and, for alcohol and tobacco, levels of use.[13] In 1994, a supplementary NDSHS was undertaken among Aboriginal and Torres Strait Islander people living in 'urban' areas (i.e. areas with populations of more that 1000 people).[14] This remains the most comprehensive AOD-specific survey undertaken among Indigenous Australians and provides valuable baseline data. Although there have been many calls for this special survey to be repeated, these have not been heeded. In subsequent regular NDSHSs, the small size of the Indigenous samples within them and the methodology employed mean that estimates of Indigenous prevalence and consumption levels are more likely to be underestimates of actual rates than are those for the non-Indigenous population.

There are two regular, but infrequent, large-scale surveys of Australia's Indigenous population: the National Aboriginal and Torres Strait Islander Social Survey (NATSISS) and the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS).[15, 16] However, those surveys were not designed specifically to ascertain levels of AOD consumption and, particularly because of the time periods for which respondents to the surveys were required to recall consumption, both are likely to have produced significant underestimates of both the prevalence of recent consumption and levels of consumption.[9, 11]

3.1 Tobacco

There have been substantial declines in the number of non-Indigenous Australians who are recent tobacco smokers (i.e. had smoked in the previous 12 months) – from 29 per cent in 1993 to 19 per cent in 2007.[13, 17] However, these declines have not been replicated among the Indigenous population.

In the 1994 Aboriginal and Torres Strait Islander NDSHS, 54 per cent of Indigenous Australians surveyed reported being current smokers.[14] In the 2002 NATSISS 51 per cent of Indigenous Australians reported being recent smokers and in the 2004 NATSIHS 52 per cent reported being so.[15, 16] In comparison, the 2004 NDSHS reported that 39 per cent of Indigenous Australians were smokers.[18] Given the similarities of the questions asked and the smaller Indigenous sample in the latter survey, the results are likely to be a significant underestimate and (specifically with regard to smoking) the NATSISS and NATSIHS results are likely to be more accurate. The 2007 NDSHS reported that 34 per cent of Indigenous Australians were current smokers. As with the 2004 NDSHS we regard this as likely to be a significant underestimate. Furthermore, even if only the change in proportions is considered, this represents a decline of 13 per cent over three years. This is twice the annual rate of decline observed in the non-Indigenous population between 1993 and 2007,[13, 17] and should be regarded with some scepticism. In light of this, it is likely that current prevalence remains in excess of 45 per cent – a rate 2.4 times that in the non-Indigenous population. Thus, while there is likely to have been a small decline in the percentage of current smokers in the Indigenous population, the difference in the proportion compared to the non-Indigenous population has widened since 1993–94 when it was 1.9 times.

The prevalence rates cited above are national rates. However, a study from the Northern Territory, covering the years 1986–95 and utilising data from a number of sources, found that Indigenous Australians in the Top End (Darwin, East Arnhem and Katherine) smoked at twice the rate of those in 'the Centre' (Alice Springs and Barkly) – 70 per cent compared to 33 per cent.[19] Unfortunately, direct data on regional variation for other areas of the country are not available. However, State and Territory hospital admission rates for tobacco-related conditions (Table 1) suggest that there is considerable variation in prevalence.

The high prevalence of smoking continues to have a devastating effect on the health of, and burden of disease among, Indigenous Australians. They experience higher rates of tobacco-related diseases – including, for example, cardiovascular disease, stroke and chronic respiratory tract diseases – than non-Indigenous Australians and are hospitalised for smoking-related conditions at consistently higher rates than other Australians.[20, 21]

In New South Wales, Victoria, Queensland, Western Australia, South Australia and public hospitals in the Northern Territory, Indigenous Australians were hospitalised at 3.6 times the rate of non-Indigenous Australians for tobacco-related conditions.[21] This is despite likely under-reporting of Indigenous status in hospital separations. As Table 1 shows, there was considerable variation in rates among both Indigenous males and females and among Indigenous Australians as a whole – with the lowest estimates being for Queensland and the highest for the Northern Territory.

Table 1: Age-standardised hospitalisations related to tobacco use in NSW, VIC, QLD, WA, SA and public hospitals in the NT, 2006–07 (per 1000 population)

	Males		Females		People	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
NSW	4.3	1.4	4.2	0.8	4.2	1.1
VIC	1.4	1.2	6.8	0.7	4.1	0.9
QLD	2.1	0.7	1.1	0.4	1.6	0.5
WA	2.8	1.3	2.7	0.7	2.7	1.0
SA	4.0	1.1	7.6	1.7	5.7	1.4
NT (public hospitals)	8.2	5.7	4.6	1.1	6.2	3.3
Total	**3.7**	**1.2**	**3.5**	**0.8**	**3.6**	**1.0**

Source: Steering Committee for the Review of Government Service Provision (2009)[21]

It is difficult to provide an accurate assessment of mortality among Indigenous Australians nationally as routine data collection has not always accurately identified Indigenous status.[22] However, a study specifically measuring the burden of disease and injury among Indigenous Australians estimated that, in 2003, tobacco smoking accounted for 12 per cent of the total burden of disease and 20 per cent of total Indigenous Australian deaths — compared to about 8 and 12 per cent in the general population — and is thus the single most preventable cause of death among Indigenous Australians.[23]

3.2 Alcohol

Among non-Indigenous Australians, the percentage reporting no recent consumption of alcohol declined from 28 per cent in 1993 to 17 per cent in 2007.[13, 17, 18] Among Indigenous Australians, 38 per cent reported not having recently consumed alcohol in the 1994 NDS Aboriginal and Torres Strait Islander Survey, 31 per cent in the 2002 NATSISS, 24 per cent in the 2004–05 NATSIHS, 21 per cent in the 2004 NDSHS, and 23 per cent in the 2007 NDSHS.[13, 15, 16, 17, 18] Although the percentage of abstainers remains higher than in the non-Indigenous population, it is important to note that in the two populations the percentage of people who have *never*

consumed alcohol is similar and much of the difference in current abstention rates is due to the higher proportion of Indigenous Australians who used to drink but no longer do so – often because of the adverse consequences of previous heavy drinking.[17, 24] Thus, overall, although the percentage of people who have recently consumed alcohol has increased in both the Indigenous and non-Indigenous populations, it has increased to a greater extent in the former.

More important than the proportion of people who drink in a population is the extent to which they drink that constitutes a risk to their health or contributes to social disruption. Assessing this on the basis of existing data collections is more problematic and is complicated by the fact that definitions of risky and high-risk drinking and the timeframe for which risk is calculated have changed over time in the light of better evidence.[25, 26, 27]

As indicated above, based on critical review of the literature, WHO has published a set of guidelines for measuring alcohol consumption which aims to reduce the discrepancy between survey results and known levels of aggregate consumption based on alcohol sales data.[9] However, the questions asked in the NATSISS and the NASTIHS only partially comply with those recommended guidelines. As a consequence, the percentages of Indigenous Australians estimated to consume alcohol in a risky or high-risk manner – 15 per cent in the former and 16 per cent in the latter – significantly underestimate the true level of harmful consumption.[11]

The 1994 National Drug Strategy (NDS) Aboriginal and Torres Strait Islander Survey reported that 68 per cent of Indigenous Australians consumed alcohol in a 'high risk manner' – compared to 11 per cent of the non-Indigenous population.[14] The 2004 and 2007 NDSHSs used a different method for estimating risk and calculated the percentages of the population drinking at levels which posed both short- and long-term high-risk levels. In the 2004 survey these were 39 and 23 per cent for the Indigenous population, and 21 and 10 per cent for the non-Indigenous population – percentages at least 1.8 times greater.[18] In the 2007 survey the respective percentages were 27 and 13 per cent for Indigenous Australians, and 20 and 10 per cent for non-Indigenous Australians.[13] While these percentages were stable for the non-Indigenous population, they represent declines of 46 and 57 per cent in the proportions of short- and long-term high risk among Indigenous Australians. If they reflected the true population percentages, these would be significant decreases over a three-year period. However, a reduction of such magnitude in such a short period of time is unlikely, is not reflected in a similar decline in hospital admissions for short-term harms, and is thus likely to be a methodological artefact. Given this, it is not possible to estimate with any degree of confidence what the true differences are. However, for the Indigenous population they are *at least* likely to be twice the percentages for the non-Indigenous population.

Table 2: Indigenous to non-Indigenous hospitalisation rate ratios for conditions in which alcohol is a significant contributing factor, 2005–06*

Condition	Males	Females
Mental disorders due to psychoactive substance use (F10–F19)	4.5	3.3
Cerebrovascular disease (I60–I69)	2.4	2.5
Hypertensive disease (I10–I15)	4.2	5.6
Transport accidents (V01–V99)	1.2	1.3
Intentional self-harm (X60–X84)	2.9	1.9
Assault (X85–Y09)	6.2	33.0

* Data for NSW, VIC, QLD, WA, SA and NT combined

Source: Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008)[22]

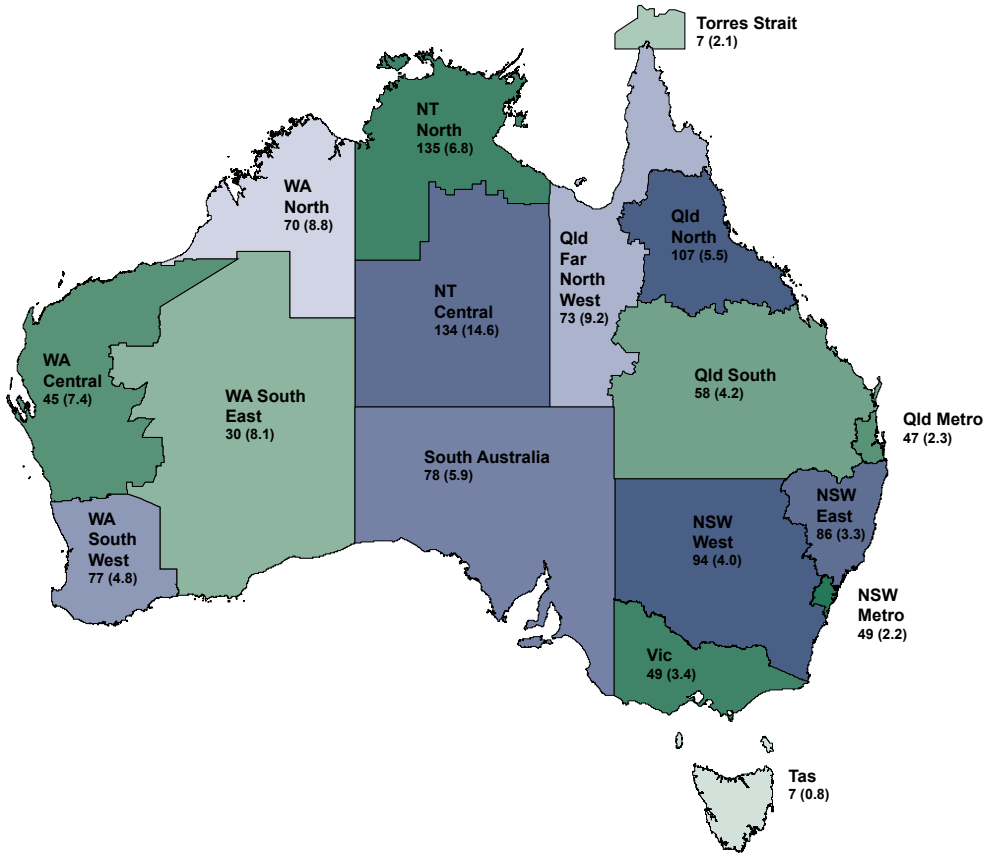
The higher rates of risky and high-risk consumption of alcohol are reflected in hospital admissions. No published data are available specifically on alcohol-caused admissions. However, in Table 2 we present data for 2005–06 on the ratio of Indigenous to non-Indigenous hospital admission rates — in New South Wales, Victoria, Queensland, Western Australia and the Northern Territory combined — for conditions to which alcohol is a significant contributing factor. At the lower end, admissions for injuries sustained in traffic accidents were 20 per cent higher for Indigenous males and 30 per cent higher for Indigenous females. At the higher end, for assault injuries (almost 50 per cent of which are alcohol-caused)[28] the rate ratios were 6.2 for males and a staggering 33.0 for Indigenous women.[29] The contribution of alcohol to higher hospital admission rates is also reflected in general practice data. It has been reported that problems associated with 'alcohol abuse' were managed in GP encounters with Indigenous patients at 2.7 times the rate among non-Indigenous patients.[22]

In 2003–07 in Queensland, Western Australia, South Australia and the Northern Territory, alcohol-related death rates were five to 19 times higher for Indigenous than for non-Indigenous Australians.[21] In the period 1998–2004, the leading alcohol-attributable causes of Indigenous Australian deaths were: suicide, alcoholic liver cirrhosis, road traffic injury, assault injury, and haemorrhagic stroke among males; and alcoholic liver cirrhosis, haemorrhagic stroke, assault injury, suicide, and road traffic injury among females (Table 3).[30] Importantly there was considerable regional variation in crude population rates of Indigenous alcohol-attributable mortality. In the former ATSIC zones these ranged from a low of 0.8 per 10 000 Indigenous residents in Tasmania to a high of 14.6 in the Northern Territory Central (Map 1).

Table 3: Five most common causes of alcohol-attributable death among Indigenous males and females (based on aggregates from 1998–2004)

	Condition	Number	Percentage	Mean age at death
	Males			
1	Suicide	222	19	29
2	Alcoholic liver cirrhosis	210	18	56
3	Road traffic injury	87	7	30
4	Assault injury	70	6	34
5	Haemorrhagic stroke	60	5	27
	Total	**649**	**56**	**35**
	Females			
1	Alcoholic liver cirrhosis	136	28	51
2	Haemorrhagic stroke	78	16	25
3	Assault injury	48	10	32
4	Suicide	33	7	27
5	Road traffic injury	18	4	36
	Total	**313**	**65**	**34**

Source: Chikritzhs, Pascal, Gray, Stearne, Saggers & Jones (2006)[30]



Map 1: Estimated numbers and crude population rates (per 10 000 Indigenous residents) of alcohol-attributable deaths by (former) ATSIC zones, 2000–04

Source: Chikritzhs, Pascal, Gray, Stearne, Saggers & Jones (2006)[30]

3.3 Illicit drugs

In Table 4 we present the findings of various surveys of illicit drug use. It should be noted that the 2002 NATSISS and the 2004–05 NATSIH report data on illicit drug use for residents of non-remote areas only. Due to its illegal nature, reports of illicit drug use in all these surveys are likely to be underestimates. Furthermore, because of the use of computer-assisted telephone interviewing to collect some data in the 2004 and 2007 NDSHSs, the reported results are likely to further underestimate true prevalence. Also, as a consequence of the small Indigenous sample sizes in each of those surveys (463 and 372 respectively), the estimates of the prevalence of use of particular substances are too unreliable to be published and made available for comparison. For these reasons, care must be taken when interpreting the results of the surveys and changes in the reported results through time.

The first thing to note is that, overall, among non-Indigenous Australians between 1993 and 2007 there were increases in the percentage of people who reported never having used illicit drugs and significant decreases in the proportion who reported current use of any illicit drug. However, the percentage of people reporting use of illicit drugs other than cannabis increased from 5 per cent in 1993 to 8.1 per cent in 2004 and decreased to 7.6 per cent in 2007.[13, 17, 18]

In contrast, among Indigenous Australians, there was an apparent increase in the percentage reporting never having used from 1994 to 2002, but subsequent apparent declines in the following surveys. There was a converse pattern in the reporting of recent drug use. However, whereas the percentages of Indigenous and non-Indigenous Australians reporting recent drug use were similar in 1993 and 1994, the percentage of Indigenous Australians reporting recent use was 1.8 times greater in 2002 and 1.9 times greater in 2007 than among non-Indigenous Australians. Similarly, the percentages of Indigenous and non-Indigenous Australians reporting use of drugs other than cannabis were about the same. However, in 2004 and 2007, the Indigenous percentages were 1.4 and 1.5 times higher.[13–18]

As indicated above, the 2004 and 2007 NDSHSs did not report on the use of particular illicit drugs among Indigenous Australians. However, between the 1994 NDS Aboriginal and Torres Strait Islander Survey and the 2004–05 NATSIHS — although there was little change apparent in the prevalence of cannabis use — the percentages of non-remote dwelling people reporting recent use of analgesics and sedatives for non-medical purposes, amphetamines, and ecstasy or 'designer drugs' increased 1.9, 4.1 and 7.5 times respectively.[14, 16] In the 2004–05 NATSIHS, the percentages of Indigenous Australians reporting recent use of cannabis (22.6) and amphetamines (6.9) were twice those in the non-Indigenous population (11.3 and 3.2) in the 2004 NDSHS.[16, 18]

As indicated above, the data reported on illicit drug use in the 2002 NATSISS and the 2004–05 NATSIHS do not include remote areas. However, on the basis of work carried out in those areas, Putt and Delahunty suggest that cannabis use is more extensive there, especially among young people.[31]

In the period 2004–06, in New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory, 4214 Indigenous Australians were hospitalised with principal diagnoses related to the use of drugs other than alcohol and tobacco.[22] The most common diagnoses were for mental and/or behavioural disorders (50 per cent), most frequently related to cannabis use (15 per cent) or multiple drug use (11 per cent). Closely following mental/behavioural diagnoses were diagnoses for various kinds of drug poisoning (47 per cent). The rate of admission for these problems among Indigenous Australians (4.4) was over twice that among non-Indigenous people. It is important to note that these diagnoses are for conditions directly caused by drug use and do not include hospitalisations for diagnoses to which drug use was a contributing factor.

It has been estimated that, in 2003, illicit drug use was responsible for 3.4 per cent of the total burden of disease among Indigenous Australians compared to 2 per cent in the non-Indigenous population.[20, 23] It has also been estimated that deaths among Indigenous Australians directly attributable to illicit drug use contributed 2.8 per cent of the burden as opposed to 1.3 per cent in the non-Indigenous population.[23]

Apart from the 1994 NDS Aboriginal and Torres Strait Islander Survey, none of the surveys reports on the level of injecting drug use among Indigenous Australians. However, in the former survey, 2 per cent of Indigenous participants reported recently injecting illicit drugs compared to 0.5 per cent of non-Indigenous participants – four times the rate.[18]

As a result of concerns about increases in hepatitis C notifications – of which 80 per cent of new infections are related to injecting drug use[32] – an attempt was made to estimate any likely changes in the prevalence of injecting in Western Australia. On the basis of increases in hospital admissions for all drug-related conditions except alcohol and tobacco, hospital admissions potentially related to injecting drug use, hepatitis C notifications and all police-reported drug-related offences, it was estimated that, between 1994 and 2000, the prevalence of recent injecting drug use had increased between 50 and 100 per cent and that the percentage of Indigenous Australians who recently injected drugs was between 3 and 4 per cent.[33] It is not clear how this relates to prevalence in other jurisdictions and what changes have take place since. However, while not quantifying the frequency of injecting drug use at the population level, a number of other studies have reported concerns about apparent increases in prevalence.[34, 35, 36]

As indicated above, of particular concern with regard to injecting drug use is the transmission of hepatitis C through the sharing of contaminated injecting equipment, its long-term health effects, and the cost of providing treatment. Reliable data on hepatitis C notifications are available only for Western Australia, South Australia and the Northern Territory. Although there was some variation between them, in those jurisdictions in each year between 2003 to 2007, the combined notification rates were 2.3, 3.8, 2.9, 3.0 and 2.7 times higher among Indigenous than among non-Indigenous Australians[37] – a fact consistent with higher injecting rates, particularly in Western Australia and South Australia.

The overall prevalence of HIV infection among Indigenous Australians is about 1 per cent – the same as in the non-Indigenous population. Among Indigenous Australians newly diagnosed with the infection between 2003 and 2007, about 18 per cent reported a history of injecting drug use.[37]

Table 4: Illicit drug use survey results, 1993–2007

	1993 NDSHS[17]	1994 NDSHS ATSI Survey[14]	2002 NATSISS[15]
Illicit drug use	**Non-Indigenous**	**Indigenous**	**Indigenous**
Any illicit drug use			
Recent users	24.0	25.0	23.5
Ex-users	18.0	29.0	16.1
Never used	58.0	46.0	51.4
Any illicit drug use except cannabis			
Recent users	5.0	6.0	–
Ex-users	16.0	19.0	–
Never used	79.0	75.0	–
Recent use of particular drugs			
Analgesics/sedatives	2.9	2.9	4.4
Amphetamines	1.4	1.7	4.7
Ecstasy/'designer' drugs	1.5	0.6	1.9
Cannabis	13.0	22.0	19.1

Sources: as referenced in the table[13–18]

3.4 Polydrug use

For many people use of psychoactive substances is not confined to one substance alone. Although it did not provide any figures, the 1994 NDS Aboriginal and Torres Strait Islander Survey noted: 'There is some evidence that smoking and drinking are correlated, with heavier smokers also more likely to be heavy drinkers.'[14] As reported in the 2008 *Aboriginal and Torres Strait Islander Health Performance Framework*, the 2004–05 NASTIHS found that, among people aged 18 years and over, the 67 per cent who drank at short-term and the 66 per cent who drank at long-term risky/high-risk levels were more likely to be smokers (49 and 47 per cent respectively) than those who did not drink at those levels.[22]

As illustrated by the data in Table 4, most Indigenous Australians reporting any illicit drug use report use of cannabis only; for many, any recent polydrug use is confined to use of tobacco, alcohol and cannabis. For example, the 1994 NDS Aboriginal and Torres Strait Islander Survey found that, among those reporting recent cannabis use, less than a quarter reported currently using any other illicit drug.[14]

	2004–05 NATSIHS[16]	2004 NDSHS[18]		2007 NDSHS[13]	
	Indigenous	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
	28.2	26.9	15.0	24.2	13.0
	20.3	22.9	22.9	29.0	24.8
	49.1	50.1	62.1	46.8	62.2
	–	11.6	8.1	12.1	7.6
	–	14.2	10.3	14.0	10.3
	–	74.2	81.5	73.9	82.1
	5.5	–	–	–	–
	6.9	–	–	–	–
	4.5	–	–	–	–
	22.6	–	–	–	–

Again, as reported in the 2008 *Aboriginal and Torres Strait Islander Health Performance Framework*, the 2004–05 NATSIHS found that approximately 20 per cent of Indigenous males and 17 per cent of Indigenous females aged 15 years and over had used one 'substance' (i.e. one illicit drug) in the previous 12 months. In addition, 12 per cent of males and 7 per cent of females reported having used 'two or more substances' in the same period.[22]

According to an ABS–AIHW publication, the 2004–05 NATSIHS also found that:

> Indigenous young people aged 18–34 years who had recently used illicit substances were around twice as likely as those who had never used substances [i.e. illicit drugs] to regularly smoke (66% compared with 34%) and to binge drink on a weekly basis (28% compared with 13%).[29]

While it is difficult to estimate the level of harm related to polydrug use, available data suggest that the prevalence of harm is greater among Indigenous Australians. For

example, hospitalisations for mental health disorders related to illicit drug use occur more frequently among Indigenous Australians and, as reported in the 2008 *Aboriginal and Torres Strait Islander Health Performance Framework*, mental health issues associated with polydrug use contributed to approximately 11 per cent of these substance use-related hospitalisations.[22] This is four times greater than for the general population. Vos and colleagues have estimated that, of the total burden of disease experienced by Indigenous Australians, illicit drug use contributes 3.4 per cent; 37 per cent of this is due to polydrug use or heroin.[23]

In a population experiencing an overburden of cardiovascular and respiratory disease, as well as greater levels of short-term harms associated with substance use than the non-Indigenous population, the patterns of use reported in these studies are a major concern. Consumption of tobacco and alcohol increases the risk of many diseases, and when used in combination, such use is often more regular and heavier.[20, 23] It is estimated that illicit and injecting drug use is occurring with greater frequency among Indigenous Australians, and there is evidence that the consequent harms are experienced at disproportionate levels. It is reasonable to assume that most of this use involves the combination of various substances and it can be concluded that polydrug use puts users, and those around them, at even greater risk of short-term and long-term harms.

The use of multiple drugs in combination has implications for interventions specifically targeting Indigenous Australians.[38, 39] Interventions need to account for patterns of drug use among Indigenous Australians – where polydrug use appears to be the norm rather than the exception – and aim for multifaceted approaches that reach further than simply targeting the 'primary drug'.[40]

3.5 AOD use and mental health

In 2007, the Australian Bureau of Statistics conducted the second National Survey of Mental Health and Wellbeing (NSMHW).[41] This study found that, during the previous 12 months, at least 20 per cent of Australians aged 16–85 years exhibited a mental health disorder. Of those people: 75 per cent had an anxiety disorder; 31 per cent had an affective disorder; and 26 per cent had a substance use disorder. Here, it is important to note that the first two categories exclude those whose symptoms can be attributed to AOD use. This study did not report on the prevalence of psychotic illness. However, an earlier study found the prevalence to be between 0.4 and 0.7 per cent.[42]

The NSMHW did not provide any indication of the prevalence of mental health disorders among Indigenous Australians. However, the 2004–05 NATSIHS (reported in the *Aboriginal and Torres Strait Islander Health Performance Framework*, 2008) found that Indigenous Australians experienced 'high or very high levels of psychological distress' at a rate double that among non-Indigenous Australians and this ratio increased to 2.3 for those residing in outer regional areas.[22]

Population-based estimates of the prevalence of mental illness are reflected in hospitalisation data. In 2005–07 Indigenous Australians were hospitalised for mental and behavioural disorders at 1.8 times the rate among non-Indigenous Australians.[21] The most common categories of such illnesses were: 'mental

disorders due to psychoactive substance use', 'schizophrenia, schizotypal and delusional disorders' (psychotic disorders); and 'mood and neurotic disorders' (including the anxiety and affective categories of the NSMHW). In 2005–06, Indigenous males and females were hospitalised for these categories of illness at rates 4.4, 2.7 and 1.2 and 3.3, 2.5 and 1.0 times greater respectively than their non-Indigenous counterparts.[29]

In 2003, mental disorders accounted for 15.5 per cent of the total disease burden among Indigenous Australians. Of this, the burden from alcohol dependence and harmful use was 4.5 times that of the non-Indigenous population, with a significantly larger fatal component.[23] At the same time, 11 per cent of substance use hospitalisations of Indigenous Australians were for mental and behavioural disorders caused by polydrug and psychoactive substance use — this is a rate 3.5 times higher than among non-Indigenous Australians.[22] The rate of hospitalisation among Indigenous Australians for volatile solvent-caused mental and behavioural disorders is 32 times that of non-Indigenous Australians.[22]

Intentional harm causing injury and death to self also occurs at greater rates among Indigenous Australians. During 2004–06, hospitalisations for self-harm were three times as high for Indigenous males and twice as high for Indigenous females than for other Australian males and females.[22] Suicide rates for both Indigenous males and females are significantly higher than among non-Indigenous Australians and it has been estimated that, in the Indigenous population, alcohol is a contributing factor in 40 per cent of male suicides and 30 per cent of female suicides.[12, 21] Pascal and colleagues estimated that between 2000 and 2004 there were 186 Indigenous Australian alcohol-attributable deaths from suicide — 159 males and 27 female deaths, compared to 123 male and 27 female deaths among non-Indigenous Australians.[12] Relative to the size of the Indigenous Australian population, this is clearly disproportionate. The increase in the frequency of suicide among Indigenous Australians over the last two decades is startling, particularly among Indigenous Australian males. During the period from 1981 to 2002, suicide among Indigenous Australian males increased by 800 per cent, compared to 30 per cent among non-Indigenous males.[21]

There are various reports on the co-occurrence of mental and behavioural health problems within the non-Indigenous population. Such comorbidity is most commonly found within disease categories — for example, the co-occurrence of particular anxiety disorders.[43] However, a significant degree of co-occurrence of substance misuse disorders and other categories of mental health problems has been documented. Analysis of data from the 1997 NSMHW by Teesson and colleagues showed that about 4 per cent of females and 9 per cent of males met the ICD-10 criteria for an alcohol use disorder. Among these people, 48 per cent of females and 34 per cent of males also met the criteria for an anxiety, affective or drug use disorder — compared to 15 and 9 per cent among those who did not have an alcohol use disorder. They also found that about 3 per cent of males and 1 per cent of females met the criteria for a drug use disorder (primarily related to cannabis) and that, among these, 65 per cent of females and 64 per cent of males met the criteria for an anxiety, affective or alcohol use disorder — compared to 12 and 11 per cent of those who did not have a drug use disorder.[44]

In 2003, Hunter reported that there were no studies among Indigenous Australians comparable to that of Teesson and her colleagues. However, he summarised studies he and his colleagues conducted in the late 1980s in which:

> associations were found between alcohol use and a range of psychiatric symptoms including anxiety and depression, disorders of ideation and perception, and acting on impulses to self-harm.[45, 46, 47]

Apart from a study of 106 Indigenous Australians aged 13 to 42 years in the Northern Territory which reported that heavy users of cannabis were four times more likely to report moderate to severe depressive symptoms,[48] little research has been conducted in this area. Nevertheless, given the statistical data on the higher prevalence rates of AOD use and hospital admissions for mental and behavioural disorders among Indigenous Australians, it is reasonable to surmise that levels of comorbidity are also commensurately higher than those reported among non-Indigenous Australians. As among the non-Indigenous population, the co-occurrence of such problems results in higher levels of disability, often it is not recognised, and it presents complications for the provision of effective treatment.[49, 50]

3.6 AOD use and offending

In this chapter, the focus has been on Indigenous AOD use and related health harms. In this section, however, we briefly turn attention to the relationship between AOD use and its implications for offending and imprisonment, and the provision of AOD services for Indigenous Australian offenders. Indigenous Australians are approximately 2.6 per cent of the population; however, in 2008, Indigenous Australian adults were 17.2 times more likely than non-Indigenous Australians to be imprisoned.[51, 52] During 2004–06, the percentage of Indigenous Australians in the total prison population was 23.6 per cent. Table 5 shows variations by State and Territory. The table also highlights the over-representation of young Indigenous Australians in juvenile detention – a staggering 54.3 per cent in the 2004–06 period.[52]

Compared to non-Indigenous offenders, Indigenous Australian offenders are not only over-represented in the criminal justice system, they also start offending at an earlier age; offend more frequently; are more likely to receive custodial sentences for property and violent offences; and have continued contact with the system.[52] Alcohol and other drug use is a significant factor in this. For example, 69 per cent of Indigenous Australian men in prison reported that they were under the influence of alcohol at the time of arrest compared with 27 per cent of non-Indigenous prisoners.[53] The role of alcohol and other drugs in offending and imprisonment has long been a concern,[54] and yet strategies for addressing this relationship have been found wanting. A recent report from the Australian Institute of Criminology

Table 5: Indigenous over-representation in the criminal justice system, 2004-06

State or Territory	Per cent Indigenous of total population	Per cent Indigenous of total police custody	Per cent Indigenous of total juvenile detention population	Per cent Indigenous of total prison population
Queensland	3.7	24.4	60.4	27.1
New South Wales	2.4	16.3	55.6	19.9
Australian Capital Territory	1.6	19.3	31.3	11.9
Victoria	0.7	8.2	19.4	5.5
Tasmania	3.9	11.6	22.2	10.4
Northern Territory	29.9	81.6	80.0	82.4
South Australia	1.9	27.6	41.2	19.1
Western Australia	3.8	45.9	77.1	39.7
Australia	2.6	26.3	54.3	23.6

Source: Joudo (2009)[52]

points out that criminal sanction of those who commit drug-related offences has done little to reduce Indigenous Australian offending and imprisonment rates.[51]

The consequences for the health of Indigenous Australians are stark. A recent NIDAC report has summarised issues associated with incarceration and health of Indigenous Australians.[55] The key identified health risks included transmission of blood-borne viruses, and comorbidity of mental health and substance use issues. According to the National Corrections Drug Strategy (2006–09), in one jurisdiction 66 per cent of females and 50 per cent of males in custody with an AOD problem were also suffering from a mental disorder.[56]

Australian governments have responded positively with a number of options to assist offenders with AOD problems to accessing treatment. For example, since 1999–2000 the Council of Australian Governments (COAG) has funded the Illicit Drug Diversion Initiative (IDDI). However, according to reports from the Australian Institute of Health and Welfare and the Australian Institute of Criminology, Indigenous Australians have difficulty accessing criminal diversion and treatment options through the IDDI because those who are primarily affected by alcohol are generally excluded, as are those whose offences were violent.[51, 52, 55, 57]

Given the younger demographic profile of the Indigenous Australian population, and their over-representation for AOD-related offences within the criminal justice system, diversion into treatment opportunities is required at many levels. At a State and Territory level, a number of police and court diversion programs for alcohol-related offences have now been established. NIDAC, however, argues that more needs to be done and recommended that access to such opportunities be expanded to increase opportunities for Indigenous Australians within the system to access treatment options at all levels including: pre-arrest; pre-trial; pre-sentence; within prisons and detention centres; and post-release.[55]

3.7 Summary

As illustrated above, various data sources indicate that levels of consumption of alcohol and other drugs among Indigenous Australians are alarmingly high in comparison to the general population. On a national level there have been considerable reductions in the use of most alcohol and other drugs among non-Indigenous Australians. However, this has not been matched in the Indigenous population. There has been little change in the prevalence of smoking among Indigenous Australians since 1994 with around 50 per cent reporting current smoking status, compared to approximately 19 per cent among non-Indigenous Australians.

Indigenous Australians are also more likely to have recently consumed alcohol and to have done so at levels which put them, and those around them, at increased risk of harm. While an accurate picture of the level of consumption and harm is difficult to establish, due largely to data quality and availability, preventable harms attributed to tobacco and alcohol comprise a significantly larger burden of disease and mortality among Indigenous Australians.

As illustrated in this chapter, the increasing use of illicit drugs and the high level of poly-drug use among Indigenous Australians are similarly of concern. Such usage contributes to increased rates of hospitalisations, mental health disorders, physical and social harms, and contact with the criminal justice system. Across all indicators presented above, Indigenous Australians are disproportionately affected.

4. Background to the provision of Indigenous AOD services

4.1 The rationale for Indigenous-specific services

In this report, we are concerned with Indigenous-specific alcohol and other drug interventions. By this we mean interventions specifically provided to address AOD-related harms among Indigenous Australians – whether provided by Indigenous or non-Indigenous organisations – *in addition* to those 'mainstream' services that are provided for all Australian citizens. As indicated previously, we do not include in our definition of Indigenous-specific services any attempts by mainstream providers to make their services more acceptable to, appropriate for or culturally secure for Indigenous clients.[58] We regard those activities as being part of the responsibilities of organisations to make their services accessible and acceptable to clients from whichever population groups they are drawn. In this section, we provide a brief overview of the rationale for the provision of Indigenous-specific services.

The high levels of AOD-related harms among Indigenous Australians have long been of concern – not least to Indigenous Australians themselves – and both they and the Australian and State and Territory governments have responded to them. In considering these responses, however, it is important that they be seen in the broader context of Indigenous affairs.

The disparities between Indigenous and non-Indigenous Australians do not need to be brought to the attention of the Indigenous Australians who experience them as an everyday fact of life. They have long struggled against them.[59] This struggle gained increasing momentum in the 1960s with calls for 'self-determination' and for a key role for Indigenous Australians in the making of decisions that affected their lives. In the early 1970s it also led to the establishment of a range of Indigenous community-controlled service organisations including housing associations, and legal, medical and AOD services. The first health service was established (without government funding) in 1971 in Redfern and the first AOD service, Benelong's Haven, was established in 1974.[60, 61, 62]

Hunter and others have defined community control as: 'the local community having control of issues that directly affect their community'. They go on to write, 'Aboriginal people must determine and control the pace, shape and manner of change and decision-making at local, regional, state and national levels'.[61] Although the literature is not extensive, it shows that, although it is not sufficient to do so, community control provides better access to and more appropriate health care and contributes to better health outcomes.[63, 64]

By the mid-1960s – as the Aboriginal rights struggle grew – it had become increasingly evident that government policy aimed at assimilating Indigenous Australians into the wider society was a failure.[65, 66] As a result of the 1967 Referendum, the Australian Government was given the constitutional power to make legislation with regard to Indigenous Australians. In 1968, the Gorton Liberal–Country Party government established an Office of Aboriginal Affairs. Following its election in December 1972 the Whitlam Labor government proclaimed a policy of Aboriginal Self-Determination, upgraded the Office of Aboriginal Affairs to a government department and established various programs aimed at reducing Indigenous inequalities.

A key element in the self-determination policy was the recognition that, in order to reduce Indigenous inequalities, special programs were needed over and above those that governments were obliged to provide for all citizens. To give effect to the policy, the Australian Government provided increasing levels of funding for Indigenous-specific programs and this was allocated to both Indigenous community-controlled organisations and to State and Territory governments. With some modification, under the Fraser Liberal–Country Party government, the policy of self-determination became the Aboriginal Self-Management Policy and continued with bipartisan support.

Under the Hawke Labor government the Department of Aboriginal Affairs became the Aboriginal and Torres Strait Islander Commission, governed by a board of elected Indigenous commissioners. Through the 1980s and early 1990s, under ATSIC the policy of self-management essentially remained in place. However, in 1995 because of their specialised nature, the health programs administered by ATSIC were transferred to what is now the Office of Aboriginal and Torres Strait Islander Health (OATSIH) within the Australian Government Department of Health and Ageing (DoHA).

In late 2004 the Howard Liberal–National government abolished ATSIC and introduced 'shared responsibility agreements' for the provision of services to Indigenous communities — an approach based on a policy of 'mutual obligation'.[67] Under this policy, programs formerly administered by ATSIC were transferred to various other Australian government departments, including the Department of Families, Community Services and Indigenous Affairs (FaCSIA). Nevertheless, funding for Indigenous-specific programs continued.

At the time of writing, the administrative changes introduced by the Howard government remain in place. However, on coming into office the new Prime Minister, Kevin Rudd, pledged to establish a 'new partnership between Indigenous and non-Indigenous Australians' at the core of which was the closing of the gap between them in areas of literacy, numeracy, employment outcomes and opportunities, infant mortality, and life expectancy.[68]

This overview hides some very real differences in both policy and practice among successive Australian governments. Nevertheless, it shows that the current policy of 'closing the gap' between Indigenous and non-Indigenous Australians is not in itself new. It also shows that, despite the differences between governments, the provision of Indigenous-specific services has been and continues to be an important part of strategies to reduce the disparities.

The harmful use of alcohol and other drugs makes a significant contribution to the gap between Indigenous and non-Indigenous Australians and, as indicated above, the funding of Indigenous-specific services has been a component of Australian government policies since the early 1970s. Although the Indigenous affairs policies of State and Territory governments have not generally aligned closely with those of Australian governments, in the *National Drug Strategy* and *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan* they do share a common framework for addressing AOD-related harms.[3, 69]

The *Complementary Action Plan* (CAP) has six key result areas:

1. Enhanced capacity of Aboriginal and Torres Strait Islander individuals, families and communities to address current and future issues in the use of alcohol, tobacco and other drugs and promote their own health and wellbeing.
2. Whole-of-government effort and commitment, in collaboration with community-controlled services and other non-government organisations, to implement, evaluate and continuously improve comprehensive approaches to reduce drug-related harm among Aboriginal and Torres Strait Islander peoples.
3. Substantially improved access for Aboriginal and Torres Strait Islander Peoples to the appropriate range of health and wellbeing services that play a role in addressing the use of alcohol, tobacco and other drugs.
4. A range of holistic approaches from prevention through to treatment and continuing care that is locally available and accessible.
5. Workforce initiatives to enhance the capacity of Aboriginal and Torres Strait Islander community-controlled and mainstream organisations to provide quality services.
6. Substantial partnerships between Aboriginal and Torres Strait Islander communities, government and non-government agencies in developing and managing research, monitoring, evaluation and dissemination of information.[3]

Under the CAP, the activities to be undertaken by particular governments to achieve these results are to be determined themselves, in response to problems and priorities within their own jurisdictions, and they have developed their own implementation plans. However, in all jurisdictions the funding and/or provision of Indigenous-specific services form part of their strategies to reduce AOD-related harm. This shared policy framework — along with consideration of AOD-related harms themselves, an understanding of the determinants of those harms, and knowledge of the range of effective interventions — is important when considering the appropriateness of current services and gaps in service provision.

4.2 The structural determinants of alcohol and other drug use

The causes and consequences of harmful alcohol and other drug use are complex and strategies to address them must be multidimensional. Whether an individual is healthy or ill is not a random phenomenon. Most simply conceived, this is summed up in the model known as the 'epidemiological triangle'. This model – developed initially to explain the occurrence of communicable diseases – postulates that the occurrence of disease is the result of interactions between the host (the individual), the agent (the pathogen) and the environment.[70] This basic model was adapted by Zinberg who argued that, to understand and address patterns of substance use, it is necessary to understand the interaction between the drug (its physiological effects), the set (the state of mind of the user) and the setting (the environment in which the drug is used).[71]

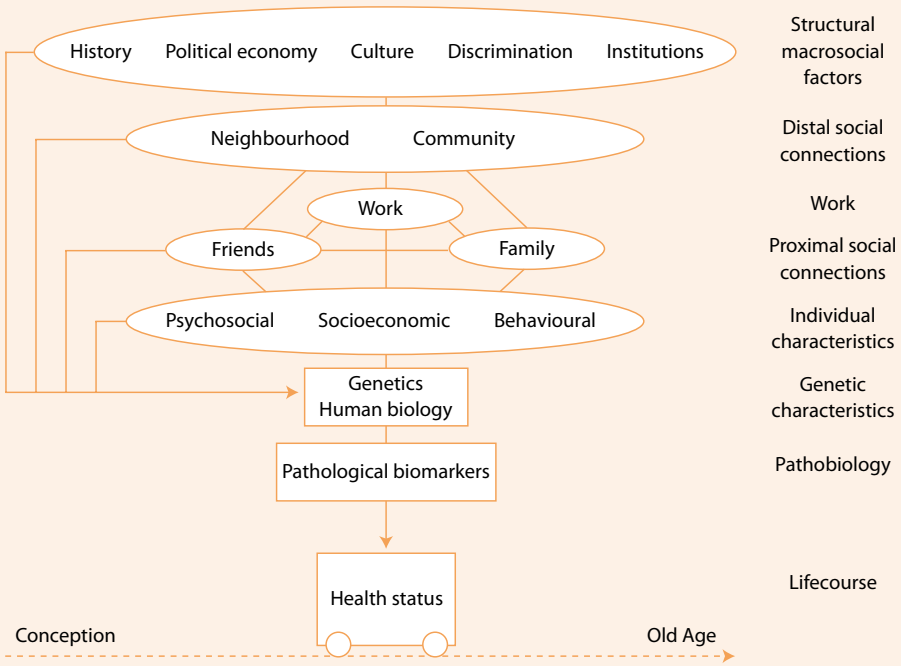


Figure 1: A multi-level and multi-time approach to social epidemiology

Source: Lynch (2000)[72]

This basic conceptual framework underlies more complex models such as Lynch's model of structural determinants of health.[72] This model (Figure 1) highlights the complex set of relationships that determines both the health status of individuals (including their use or otherwise of psychoactive substances) and the social response to it. This approach shifts the focus from disease agents or the behaviour of individuals to the broader set of factors that cause or protect against ill-health and its patterning.

Interest in the social or structural determinants of health is not new. In particular, there has been a long history of interest in the relationship between political and economic factors and health status.[73, 74, 75] However, over the past two decades, following the publication of the 'Whitehall studies' which demonstrated a clear inverse relationship between rankings in the British public service and mortality rates,[76] there has been a resurgence of interest in this area. International evidence demonstrating the link between health status and a range of factors – including social organisation, employment status, the psychosocial environment and social exclusion – has been presented in a book edited by Marmot and Wilkinson, and summarised by them and others for WHO.[77, 78] Similar evidence from Australia has been presented in a book edited by Eckersley and others.[79]

With regard to Indigenous Australians, the link between social conditions and health status has been drawn by a 1979 House of Representative Standing Committee on Aboriginal Health, the Aboriginal Health Strategy Working Party and the Royal Commission into Aboriginal Deaths in Custody among others.[54, 80, 81, 82] More recently, the evidence for such links has been set out in a book edited by Carson and others.[83] The clear lesson from this evidence – both international and national – is that to reduce the burden of Indigenous ill-health, it is necessary to focus upon its structural determinants not simply its manifestation among individuals.

The lessons from health in general apply to the harmful use of alcohol and other drugs in particular. The WHO summary of the evidence for the social determinants of health concluded that there is a clear link between socioeconomic deprivation and risk of dependence on alcohol, nicotine and other drugs, and that any intervention

> needs not only to support and treat people who have developed addictive patterns of use, but also to address the patterns of social deprivation in which the problems are rooted.[78]

The higher frequency of harmful AOD use among Indigenous Australians compared to non-Indigenous Australians and among segments within the Indigenous population (as well as protection from it) has been shown to be associated with factors such as income and education.[29, 84]

Table 6: Hierarchy of prevention opportunities

Primary prevention

preventing the uptake of drug use among non-users

- Preventing exposure and/or access to drugs
- Preventing initiation of drug use
- Delaying uptake of all drug use (later age of start decreases likelihood of problem use)
- Preventing regular use (beyond experimentation)

Secondary prevention

preventing risky or problematic use and preventing use progressing to dependency

(including preventing harm among early users)

- Preventing harm associated with a single episode of use (risky for short-term harm) which might be related to the amount used; the way in which the drug is used or its route of administration; the circumstances of use, including the location, social setting and related activities; and concurrent use of other drugs or other risky behaviours (e.g. driving while intoxicated, having unprotected sex)
- Preventing regular, heavy use (risky for long-term harm)

Tertiary prevention

reducing harm among problem users and helping to reduce or discontinue use

(includes treatment interventions)

- Preventing dependent use
- Preventing longer-term, drug-related illness; crime, social and behavioural problems; or death among those who continue to use

Preventing harm to others

- Preventing the drug use of a person causing harm to others, including partners, children, friends, colleagues and the broader community

Source: Hamilton (2004)[85]

4.3 A framework for intervention

A common model for categorising the range of interventions necessary to address AOD-related harms and their underlying causes is that provided by Hamilton (see Table 6). This model identifies opportunities for the prevention of harmful AOD use – including the prevention of harm to people other than users – at primary, secondary and tertiary levels.[85]

The classification of interventions used by Hamilton was also used in a review of the evidence for the prevention of harmful alcohol and other drug use conducted by NDRI for DoHA.[86] In the NDRI review, this classification was tied specifically to the structural determinants of health framework and more explicitly identified the loci for such interventions.

The NDRI review included a chapter on the social determinants of alcohol and other drug use. Like the WHO report on the social determinants of health,[78] and a report prepared on the prevention of alcohol-related harm,[87] it found that there is a clear relationship between alcohol and other drug use and various social factors – including unemployment, low income and insecure housing – and that these are mediated by individual and protective risk factors. The review concluded:

> The evidence base for the social determinants of drug use is such that researchers and policy makers need to plan and implement a wide range of interventions that acknowledge the social origins of poor health, and how poverty and associated disadvantage maintain this poor health and risky behaviours at all levels – from the macro-social to the individual.[86]

The NDRI review also provided a framework for such an approach to intervention – which, in part, reflects both Lynch's modelling of the structural determinants of health and the categorisation of interventions used by Hamilton. The model, based on the work of Lenton,[88] identified a number of loci of intervention from the individual to the international context (Figure 2). Within each of these loci, specific intervention strategies or 'mechanisms of action' and the context of intervention were identified. A clear message from this evidence-based review is that, to be effective, any strategy to address harmful AOD use must be multifaceted, include interventions at all levels of the hierarchy of determinants, and should seek to enhance protective factors as well as simply targeting the harmful aspects of use.

While not explicitly linked to either the structural determinants framework or the model employed in the NDRI review, a model of care for the 'treatment of adult drug misusers' developed by Britain's National Treatment Agency (NTA) for Substance Misuse, complements both and provides a framework for the provision of care at local or regional levels as well as the national level.[5, 6] The focus of this model was on the treatment of illicit drug use. However, as Siggins Miller Consultants – who were the first to use the model in an Australian context – point out, it is applicable to the broad spectrum of AOD treatment.[89] The NTA model identifies four tiers of intervention (Table 7) addressing four domains: drug and alcohol use; physical and psychological health; social functioning; and criminal involvement. It emphasises assessment, care planning, integrated care (including emphases on the provision of services in primary health care settings and upon ongoing care), standards of care, and the provision of evidence-based interventions.

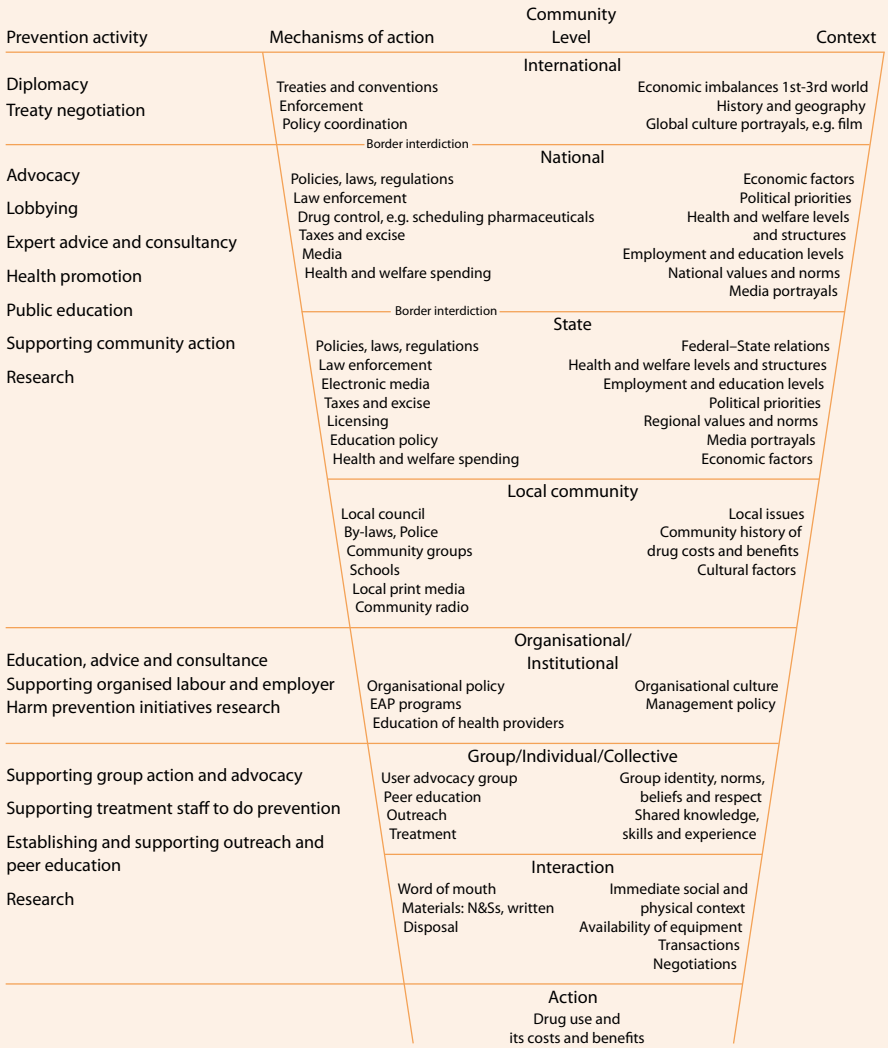


Figure 2: Systems model for the prevention of alcohol and other drug problems

Source: Loxley, Toumbourou, Stockwell et al. (2004)[86]

Table 7: Drug misuse treatment tiers

Tier	Tier title	Service modality
1	Non-substance misuse specific services	For example: Personal/general medical services (primary care) Non-drug misuse (DM) specific social services including children and family services; non-DM specific assessment and care management Housing and homelessness services Non-substance misuse (SM) specific probation services Vaccination/communicable diseases Sexual health/health promotion Accident and emergency services General psychiatric services Vocational services
2	Open access drug misuse services	Drug-related advice and information Open access or drop-in services Motivational interviewing/brief interventions Needle exchange (pharmacy/service/outreach) Outreach services (detached/domiciliary/peripatetic) Low-threshold prescribing Liaison with drug misuse services for acute medical and psychiatric sector DM specific assessment and care management

Tier	Tier title	Service modality
3	Structured community-based specialist drug misuse services	Drug specialist care planning and coordination Structured care planned counselling and therapy options Structured day programs (urban and semi-urban) Community-based detoxification services Community-based prescribing stabilisation and maintenance prescribing Community-based drug treatment for offenders Other structured community-based drug treatment services targeting specific groups Structured after-care programs Liaison with drug treatment services
4a	Residential substance misuse specific services	In-patient drug detoxification and stabilisation services Drug and alcohol residential rehabilitation services Residential drug and alcohol crisis centres Residential comorbidity services Specialist drug and alcohol residential units targeting specific groups, e.g. mother and child units services
4b	Highly specialist non-substance misuse specific services	For example: Specialist liver disease units Forensic services Specialist psychiatric units including: personality disorder units; eating disorders units Terminal care services Young people's hospital and residential services providing drug and alcohol treatment services (16–21 years) HIV specialist units

Source: National Treatment Agency for Substance Misuse (2002)[5]

The NTA model focuses on treatment of those already experiencing problems related to substance misuse: that is, upon those interventions classified as tertiary prevention by Hamilton. However, for this project and a parallel project conducted for QAIHC, we and our colleagues have modified the model to include the other levels of prevention identified by Hamilton and to address the 'mechanisms of action' included in the NDRI model.[90] In doing so, the expanded model has the advantage of operationalising the application of the complete range of intervention strategies to which populations should have access at the local and/or regional level (Table 8). This includes the demand, supply and harm reduction strategies of Australia's National Drug Strategy.[91]

There are a number of points to be made about this expanded model. First, in Tier 1, it identifies services that are not primarily targeted at harmful AOD use but which include a range of primary prevention services which build upon factors that enhance resilience and resistance to the harmful use of alcohol and other drugs. These include employment, education, youth, and community development programs. As well as having a role in primary prevention, services within this tier are essential in providing those who are using alcohol and other drugs in a harmful way with support that complements treatment per se. In this regard the expanded model is congruent with those studies that highlight the need to address the structural determinants of alcohol- and other drug-related harm.

It is important to note that, like the original NTA model, the expanded model focuses on intervention services per se, and not upon the organisations or community groups providing them. What is important is the provision of services, not necessarily the organisations providing them. Thus, for example, a primary health care service provider might provide AOD services from Tiers 1, 2 and 3; or, as

Table 8: Expanded tiered model of alcohol and other drug misuse intervention

Tier	Intervention		
	Demand reduction	Supply reduction	Harm reduction
1. Non-substance misuse specific services	Primary health care services Pre- and post-natal care programs Accident and emergency services Supported accommodation Employment programs Education programs Recreational programs Child care and support		Youth shelters Women's refuges Hepatitis B vaccination

Tier	Intervention		
	Demand reduction	Supply reduction	Harm reduction
2. Open access substance misuse services	Telephone information services – for users, the public and service providers School-based AOD education AOD-specific health promotion programs AOD-specific primary health care interventions Brief interventions AOD counselling services Assessment and referral services 12 Steps groups Education, training and support for AOD agencies and workers	Licensing accords Responsible server training Additional liquor licensing restrictions Enforcement of liquor licensing laws Limiting availability of volatile substances Supply-side drug law enforcement	Mobile assistance patrols Sobering-up shelters Needle exchange services
3. Structured community-based specialist substance misuse services	Diversion programs Behavioural family therapy Pharmacotherapies Community/home-based detoxification After-care services and support		
4a.Residential substance misuse services	In-patient detoxification Residential rehabilitation		
4b.Highly specialist non-substance misuse specific services	Specialist hospitals and hospital units		

well as providing Tier 4 residential care, an AOD service might also provide Tier 3 community-based treatment and operate a Tier 2 sobering-up shelter.

The emphasis on the provision of intervention services by primary health care providers in the NTA model is reflected in a paper prepared for an interdepartmental committee which reviewed the Australian Government's Aboriginal and Torres Strait Islander Primary Health Care Program.[92] The number of Indigenous community-controlled health service (CCHS) providers is considerably greater than the number of community-controlled organisations providing AOD-specific services. Furthermore, the number of clients seen by CCHSs is also considerably greater and many of those clients are likely to suffer problems caused by their own (or another person's) use of alcohol and other drugs. Given this, there is clearly a distinct role for CCHSs in the provision of AOD services. This is not, however, an argument against the resourcing of organisations that have been established specifically to provide AOD services. Collaboration and partnerships between organisations providing AOD services and CCHSs are crucial.

As in the original NTA model, a key emphasis in the expanded model is the integration of care and interventions from the various tiers. From a treatment perspective — as advocated in the most recent and previous sets of guidelines for managing alcohol in Indigenous settings — the focus is upon providing a holistic client-centred range of services.[93, 94] These are unlikely to be met by any one service provider. Hence, the need to ensure that: the services provided by particular agencies are linked; there is communication between agencies regarding what they are providing and what is needed in terms of client care; and that integrated case management plans are developed. In a non-Indigenous setting, clinical case management has been shown to improve outcomes in community treatment programs but:

> Essential elements for successful implementation included extensive training to foster collaboration; and pre-contracting of services to assure availability.[95]

Importantly, such service integration needs to go beyond the provision of individual client care to the integration of the wider range of preventive interventions.

The expanded NTA model provides only a broad blueprint for the range of services which should, ideally, be available. Application of the model, or parts of it, is dependent upon a number of other factors. These include: the size and structure of the population; patterns of alcohol and other drug use in a population; associated patterns of health and social harms; demand for particular services by a local or regional population; and the availability of human, capital and financial resources to implement the interventions. Of equal importance is the fact that implementation of specific interventions should be based on evidence for their efficacy.

4.4 Interventions to address harmful AOD use

There have been several reviews – both national and international – of the effectiveness of interventions for the harmful use of alcohol and other drugs. As indicated previously, in 2004, NDRI published a report, commissioned by DoHA, which reviewed the evidence for the prevention of harmful AOD use.[86] The review clearly placed harmful AOD use in its broad social context and emphasised the need for a systems approach to addressing the problem, taking into account both risk and protective factors. Within this broad framework, a range of interventions, at all levels of the hierarchy of social determinants, was reviewed. These interventions were considered under various categories including: interventions targeted at children and young people; broad-based prevention; demand reduction; regulation and law enforcement with regard to both licit and illicit drugs; judicial procedures; and harm reduction strategies. Within each of these categories, the strength of the evidence for the effectiveness of specific interventions was classified in terms of: limited investigation; evidence is contra-indicative; warrants further research; evidence for implementation; evidence for outcome effectiveness; and evidence for effective dissemination. On the basis of this review, recommendations were made for policy and future investment – aimed at increasing protection and reducing risk across the life course – in four broad areas:

- universal interventions to prevent tobacco use and risky alcohol use
- universal interventions to reduce the supply of, and demand for, illicit and illicit drugs
- targeted interventions to address vulnerable and disadvantaged groups with particular attention to Indigenous Australians, and
- treatment, brief intervention and harm reduction approaches for adolescents and adults with emerging or developed risky drug use patterns.

The NDRI study is complemented by a book on prevention edited by the lead authors of the NDRI report and one of their colleagues from the United States. The book consists of 36 chapters, by international experts, comprehensively reviewing the patterns of risk and related harms, and the range of interventions. It is beyond the scope of this review to consider each of these individually. Nevertheless, the authors identified a range of strategies for which there is good evidence for efficacy and others that warrant further investigation. In summarising the evidence presented in each of the chapters, the editors included among their recommendations that:

- existing tobacco control strategies should be maintained with an increased emphasis on youth
- prevention of alcohol-related harm should receive greater priority
- harm reduction (not just use reduction) should be a significant aspect of national drug policies, and
- policy should be developed to enable a coordinated prevention response *within local communities* (emphasis added).[96]

Thomas Babor headed a team of international experts who wrote a book, sponsored by WHO, reviewing the evidence for the efficacy of a 'toolkit' of strategies and interventions aimed at reducing alcohol-related harm.[87] This 'toolkit' included: pricing and taxation; regulating the physical availability

of alcohol; modifying the drinking context; drink-driving countermeasures; education and persuasion strategies; and treatment and early intervention services. The authors summarised the effectiveness of particular interventions in each category, the breadth of research support for them, whether they had been tested in cross-cultural contexts, the cost to implement them, and the target group for each. Generally, they found the most efficacious strategies were alcohol taxation, regulation of physical availability, drink-driving countermeasures, and treatment; and the least effective were those aimed at education and persuasion. Specifically with regard to treatment they noted that:

> In general, when patients enter treatment, exposure to any treatment is associated with significant reductions in alcohol use and related problems, regardless of the type of intervention used.[87]

Although not specifically concerned with Indigenous Australians, in a finding that is particularly relevant to them, the authors reported:

> There is no consistent evidence that intensive inpatient treatment provides more benefit than less intensive outpatient treatment. Nevertheless, residential treatment may be indicated for patients who:
>
> 1. are highly resistant to treatment;
> 2. have few financial resources;
> 3. come from environments that are not conducive to recovery; and,
> 4. have more serious, coexisting medical or psychiatric conditions.[87]

The evidence for the effectiveness of treatment for alcohol problems has been reviewed by Shand and her colleagues.[97] The review was comprehensive and included: assessment; patient–treatment matching; alcohol withdrawal management; post-withdrawal treatment setting; brief interventions; psychosocial interventions; relapse preventions; extended care; treatment issues for specific groups; and the economics of alcohol use. The strength of evidence for particular interventions was assessed using criteria developed by the NHMRC.[98] The authors highlighted the general effectiveness of treatment and, among their conclusions, they stated:

> To date it appears that day hospital or outpatient management services are cost-effective alternatives to inpatient management for many alcohol-dependent individuals, brief motivational counselling is both more effective and less costly than others [*sic*] psychological interventions and the use of pharmacotherapies in conjunction with psychological interventions is a cost-effective treatment option.[97]

On the basis of their review, Shand and her colleagues developed a comprehensive, wide-ranging set of guidelines for the treatment of alcohol problems.[99] Importantly, they recommended that treatment involve a range of elements including counselling, skills training and behavioural management.

A similar review to that by Shand and others was undertaken in regard to treatment of illicit drug problems by Gowing and her colleagues.[100] Also using the NHMRC criteria for assessing the strength of the evidence, they reviewed interventions specific to opioids, psychostimulants and cannabis, and

those relating to illicit drugs in general. They found that pharmacotherapies are effective in the treatment of opioid dependence and there is moderate evidence for the effectiveness of cognitive behavioural therapy in the treatment of psychostimulant and cannabis dependence. They noted high dropout rates from residential treatment for use of all illicit drugs but that there was moderate evidence for positive outcomes among those who completed treatment.

Interventions among Indigenous Australians and their efficacy

Interventions that are effective in reducing the harm caused by alcohol and other drugs in the wider population cannot simply be assumed to be likely to have the same impact among Indigenous Australians. Their efficacy may be circumscribed (or in some cases may be enhanced) by a range of factors including: the cultural appropriateness or otherwise of the interventions themselves; the extent to which interventions are perceived by Indigenous Australians as being forced upon them by the non-Indigenous community; more frequent occurrence of comorbid mental health problems; the settings in which they are offered; and individual or social barriers to 'compliance'.

A comparative review of AOD interventions among Indigenous peoples in Australia, New Zealand, Canada and the United States was undertaken by Gray and Saggers.[101] They pointed out that, in each of these countries, the evidence base for effectively addressing harmful AOD use is limited, and they identified a number of reasons for this:

- there are no publications that comprehensively document the range of interventions at national levels
- publications that describe particular interventions, or types of interventions, do not provide a representative picture of the range of interventions that are being, or have been, undertaken in any country
- of the interventions for which descriptive publications are available, few have been formally evaluated, and
- the evaluations that have been undertaken are extremely variable in quality – for a number of methodological, political and cultural reasons.[101]

The review undertaken by NDRI on behalf of DoHA included a section on interventions specifically targeted at Indigenous Australians and summarised those aimed at both prevention and treatment of alcohol-, tobacco- and petrol sniffing-related problems. The report noted that the evidence base for the efficacy of particular interventions was limited and that further research was warranted. However, on the basis of the studies reviewed, the authors identified several common themes in recommendations to enhance outcomes for Indigenous Australians. They included the need for:

- interventions that address the social determinants of Indigenous inequality
- involvement of Indigenous people as equal partners at all stages of the development and implementation of strategies to address harmful AOD use
- adequate resourcing, and
- a holistic and coordinated approach that includes Indigenous community-controlled organisations, all levels of government and all sectors.[86]

Gray and others also conducted an earlier review of alcohol-specific interventions for Indigenous Australians.[102] They reviewed 14 evaluation studies (two of which were themselves summaries of other reviews) which were grouped and reviewed under the broad categories of treatment, health promotion, acute interventions (harm reduction strategies) and supply reduction. Despite the limitations imposed by the small number of rigorous evaluations, they concluded: there was a need to employ a broader range of treatment models and complementary intervention strategies; interventions were generally inadequately resourced; and supply reduction strategies were effective in reducing harm.

NDRI has recently conducted a comprehensive review of additional restrictions on the sale and supply of alcohol.[103] The focus was on the application of restrictions in Australia but the report also included a review of international evidence. Although the review was not confined to Indigenous communities, the populations of most Australian locations where such restrictions have been applied are predominantly Indigenous. The report included a review of work done previously by d'Abbs and Togni on restrictions in regional and remote Australia.[104] Among other things, the NDRI review found:

- strong evidence for the effectiveness of restrictions on the economic availability of alcohol and on the hours and days of sale for licensed premises
- evidence of positive outcomes from restrictions on access to high-risk beverages, outlet density, mandatory packages of restrictions for remote and regional communities, and dry community declarations
- evidence of positive outcomes from restrictions on service to intoxicated patrons and liquor accords where they were enforced, but no evidence of positive outcomes where they were not enforced, and
- no evidence for the effectiveness of local 'dry area' bans (as opposed to community bans) such as those imposed in Port Augusta in South Australia.

The general review of the evidence for the efficacy of treatment for alcohol problems by Shand and others found: 'Evidence for the effectiveness of treatment specific to Indigenous clients is scant'.[97] This reflected the findings of the review by Gray and others; those of Hunter and Brady when developing an earlier set of treatment guidelines for Indigenous Australians; and those of a team contracted by DoHA which developed a more recent set of treatment guidelines.[102, 94, 93] Nevertheless, in their *Guidelines for the Treatment of Alcohol Problems*, Shand and her colleagues recommended that: 'The services available for Indigenous clients need to provide a greater quality and diversity of treatment options'[99] – a recommendation reflecting an earlier similar call by Brady.[105]

Alcohol has been, by far, the major focus in the literature on Indigenous AOD use. In mid-2008, of 1303 items in NDRI's Indigenous Australian Alcohol and Other Drugs Bibliographic Database, 58 per cent dealt specifically with alcohol.[106] However, as indicated previously, tobacco is the most preventable cause of Indigenous mortality and morbidity. A review of the literature by Ivers identified a range of interventions for Indigenous Australians but found 'only three tobacco interventions have been formally evaluated in Indigenous communities with

only one being able to conclusively show a positive effect'.[107] Although Ivers' review was published in 2001, little has changed since. Of 25 publications dealing with tobacco since that time, 13 were epidemiological studies, eight were program descriptions, and only three dealt with program evaluation. Of those three, two reported on the same evaluation of a training program, and only one dealt with the outcome of a particular intervention. The latter study examined the outcome of the use of free nicotine patches. It concluded that 'Free nicotine patches might benefit a small number of Indigenous smokers'.[108]

Of the 233 items reviewed by Gowing and others in their study of the efficacy of treatment for illicit drug use, none dealt with treatment of Indigenous Australians.[100] They commented on the absence of work in this area and highlighted the need for research among Indigenous Australians and other groups with particular needs. We have identified a total of 45 reports, of various types, dealing with illicit drug use among Indigenous Australians which have been published since the time of the report by Gowing and her colleagues. Of these, seven were summaries or letters to journal editors about more substantive issues reported in some of the remaining 37 reports. Of the 37, 11 dealt specifically with cannabis and the others with other illicit drugs or combinations of them; 25 were descriptions of patterns of drug use and/or their impact or about methods for ascertaining these; and 12 were descriptions of particular intervention services or their utilisation. None evaluated the outcomes of particular illicit drug interventions among Indigenous Australians.

It is important to recognise that the paucity of published evaluation studies does not mean that alcohol and other drug interventions for Indigenous Australians are not effective. Rather, it means that more research is needed in this area. However, the issue is not whether particular intervention strategies are effective but:

- whether they are, or can be made, culturally safe for implementation in particular Indigenous populations
- whether they are suitable for implementation given the social circumstances of particular communities, and
- whether there are particular intervention strategies, developed by Indigenous Australians themselves, which can be added to the range of strategies shown to be effective in other populations.

In successfully addressing alcohol- and other drug-related harm among Indigenous Australians, it is not enough to apply specific evidence-based interventions within a framework such as the expanded NTA model. The *process* of applying them is of equal importance. The ANCD commissioned a team from NDRI to identify elements of best practice in the provision of AOD services.[109] The project was based on a review of five Indigenous community-controlled organisations widely acknowledged to be successfully providing a broad spectrum of services.

The elements identified included:

- Indigenous community control
- clearly defined management structures and procedures
- trained staff and effective staff programs
- multi-strategy and collaborative approaches
- adequate funding, and
- clearly defined realistic objectives aimed at the provision of appropriate services that address community needs.[109]

The case studies also identified a number of other key factors in the success and endurance of the interventions. These included:

- the unique histories and contributions of individual services
- leadership by key individuals
- appropriate staff conditions, training and development
- cross-sectoral collaboration, particularly at the local level
- social accountability to the broader Indigenous community
- providing a multi-service operation
- sustainability of services and programs, and
- allowing Indigenous perspectives to direct services.[109]

These elements are similar to those identified in a review of Indigenous Canadian intervention projects.[110]

The Siggins Miller Consulting project on *Queensland Aboriginal and Torres Strait Islander Alcohol Service System Modelling and Investment Planning* 'confirmed the relevance of the elements of good practice identified in the [NDRI study]'.[89] Based on community consultations, Siggins Miller Consulting made slight modifications to this list and added:

- the capacity to address remoteness and isolation
- access to mentoring and practical learning through elders and other place-based Aboriginal and Torres Strait Islander drug and alcohol services in other communities
- networking across services in the community and the capacity to welcome services from outside the community, and professional support between organisations
- policy framework to reflect specific community needs and context, and long-term funding and resources that facilitate service system capacity and sustainability of programs
- increased capacity of families and communities to shift the social norms around the tolerance of violence and the misuse of alcohol and drugs, and the supply of substances to young people, and
- effective evidence-based services.[89]

As a starting point for enhancing Indigenous-specific AOD interventions, agencies need to ensure – and be supported to do so – that these elements are in place. Together, these key elements also provide a guide in the development of measures for the process evaluation of Indigenous intervention projects.

4.5 Indigenous-specific AOD interventions

As indicated in the Introduction to this report, there is no one source of information on Indigenous-specific AOD interventions. In an attempt to provide this, in 1997 — with a grant from the then Commonwealth Department of Health and Family Services — NDRI established a web-based National Database on Aboriginal and Torres Strait Islander Alcohol and other Drug Projects.[111] This database formed the basis for the NDRI project that documented Indigenous-specific interventions for the 1999–2000 financial year and it greatly facilitated the undertaking of that project.[2] However, maintenance of the database was labour-intensive and had to be discontinued due to lack of funding.

Importantly, since 1999–2000, DoHA has produced annually its *Drug and Alcohol Services Reporting* (DASR), the most recent being that for 2006–07.[4] These reports are based on the Department's records and questionnaires completed by the Indigenous-specific AOD services funded by DoHA. The reports provide information on the 'structure and activity' of the organisations providing services and, in addition to information on the funding provided by DoHA, include reporting of funds from other sources. However, as indicated previously, the limitation of these reports is that they are confined to those organisations that are funded by DoHA. Other sources of information on Indigenous projects are included in specific but not readily accessible reports such as those prepared by the Western Australian Department of Health's Drug and Alcohol Office, or in service directories which provide only partial information, such as that published by the Northern Territory Department of Health and Community Services.[112]

In part, it is because there is no one source of information on Indigenous-specific AOD intervention projects that this report was commissioned by NIDAC. However, the fact that the information is not readily accessible itself presents problems for the development of a report intended to provide an overview of 'current' services. That is, that it takes a considerable amount of time to collate and verify the data. DoHA's DASRs are typically published two years after the end of the financial year with which they are concerned; the NDRI report on Indigenous-specific projects for 1999–2000 was not finalised until 2002; and a report for the ANCD *Mapping National Drug Treatment Capacity* in the 2002–03 financial year was not completed until 2005.[2, 113] This fact should be borne in mind with regard to this report when considering the delay between the period reported upon and the time of publication. It is also a strong argument for cooperation between the Australian and State and Territory governments in developing a comprehensive and timely reporting system which could provide a basis for better targeting of intervention projects.

5. Indigenous-specific interventions

5.1 Providers of Indigenous-specific AOD intervention services

In 2006–07, 224 organisations were conducting a total of 340 alcohol and other drug intervention projects specifically for Indigenous Australians. In Table 9, these organisations are broken down by organisational type, and within those types the numbers of organisations and numbers of AOD projects they were conducting are summarised.

The majority of projects (248 or 73 per cent) were conducted by 159 Indigenous community-controlled non-government or Indigenous local government organisations. The largest of these groups were composed almost equally of: organisations established specifically to address AOD-related harm (48); community-controlled health services (46) – almost all of which were members or affiliates of the National Aboriginal Community Controlled Health Organisation (NACCHO); and organisations (45) that provided AOD services as part of a range of community support services – including employment, community development, legal, aged care, cultural activities and other services. The other 20 service providers were Indigenous local government organisations (Table 9).

Forty-four non-Indigenous NGOs (20 per cent) conducted 59 projects (17 per cent). These included national organisations such as Mission Australia and the Red Cross and a variety of regional and local organisations – about half of which were established specifically to address AOD-related harms. Four non-Indigenous local government agencies each conducted one Indigenous-specific AOD project, 16 State and Territory government agencies directly conducted 28 projects (8 per cent), and the Australian Government Department of Health and Ageing conducted one, the Petrol Sniffing Prevention Program. The latter replaced the old Comgas Scheme and rolled out the substitution of 'non-sniffable' Opal fuel for 'sniffable' petrol.[114, 115, 116]

The majority of organisations (158 or 71 per cent) conducted one AOD project each and a further 44 (20 per cent) conducted two projects each. Smaller numbers of organisations conducted three (11) or four (five) projects. Among those that conducted five or more projects, four conducted only five projects but two organisations, Tangentyere Council in Alice Springs and the Aboriginal Drug and Alcohol Council in Adelaide, conducted 10 and 11 projects respectively. In general, multiple projects were more likely to be conducted by Indigenous community-controlled organisations. It should be noted, however, that the projects were of differing size and complexity. It should also be noted that Table 9 includes only data on AOD projects. Many of the community-controlled health services and the community service organisations conducted various other projects associated with their broader objectives.

Between 1999–2000 and 2006–07, there was a 5 per cent increase in the number of *organisations* conducting Indigenous-specific projects and a 23 per cent increase in the number of projects (Table 10).[2] Despite the increase in service providers in general, there was a decline of 9 per cent in the number of Indigenous organisations providing services – down from 177 to 159. There was little change in the numbers of local and State/Territory government organisations

Table 9: Types of organisations providing Indigenous-specific AOD services by numbers of projects conducted, 2006–07

	No. of orgs	No. of projects conducted by individual organisations					No. of projects	% of projects
Organisation type		1	2	3	4	≥5		
Indigenous community-controlled organisation								
AOD service	48	34	8	2	2	2	80	24
Health service	46	30	8	6	1	1	73	21
Community service	45	30	12	2	–	1	70	21
Indigenous local government	20	15	5	–	–	–	25	7
Local government	4	4	–	–	–	–	4	1
State/Territory government	16	10	3	1	1	1	28	8
Australian Government	1	1	–	–	–	–	1	<1
Non-Indigenous NGO	44	34	8	–	1	1	59	17
Total	**224**	**158**	**44**	**11**	**5**	**6**	**340**	**100**

conducting projects, and most of the overall increase in the number of service providers was the result of a larger number of non-Indigenous NGOs entering the field – up from 16 to 44, or from 6 to 17 per cent of all service providers. This change is both practically and statistically significant ($\chi^2_{df\ 2}$ = 13.79 p = 0.001).

The total number of *projects* conducted in 2006–07 was 340 compared to 277 in 1999–2000. As indicated above, this represented an overall increase of 23 per cent. Although an additional 22 projects conducted by Indigenous organisations contributed to this increase, they declined from 82 to 73 per cent of all projects. However, the number and percentage of projects conducted by non-Indigenous NGOs increased significantly – from 17 to 59 projects and from 6 to 17 per cent ($\chi^2_{df\ 2}$ = 18.00 p = 0.001). In part, this increase in the number of non-Indigenous NGOs conducting projects was a function of State/Territory governments calling for competitive tenders to provide AOD services to Indigenous Australians. Evidence of this can be seen in Chapter 6 with regard to the sources of grants for Indigenous and non-Indigenous organisations.

Table 10: Types of organisations providing Indigenous-specific AOD services and projects conducted, 1999–2000 and 2006–07

	1999–2000			2006–07		
Organisation type	No. of orgs	No. of projects	% of projects	No. of orgs	No. of projects	% of projects
Indigenous organisation	177	226	82	159	248	73
Non-Indigenous NGO	16	17	6	44	59	17
Local government	2	2	<1	4	4	1
State/Territory government	18	32	12	16	28	8
Australian Government	–	–	–	1	1	<1
Total	**213**	**277**	**100**	**224**	**340**	**100**

Note: Errors due to rounding

The totals in Table 10 conceal some important underlying changes. Of the 213 organisations conducting projects in 1999–2000, only 52 per cent were doing so in 2006–07. Of those organisations, Indigenous community-controlled organisations were the most stable, with 76 per cent of AOD-specific organisations and 60 per cent of CCHSs continuing to provide AOD services. The percentage of non-Indigenous NGOs conducting projects in both time periods was 40 per cent. Of State/Territory providers conducting projects in 1999–2000, only 32 per cent were still doing so in 2006–07. Those that were not were primarily sections within larger government departments which had been funded to conduct one-off or short-term Indigenous-specific projects in the 1999–2000 period.

5.2 Intervention projects

The 340 intervention projects being conducted in 2006–07 fell into seven broad categories. In Table 11 these projects are categorised according to both the United Kingdom's NTA model of service provision and the demand, supply and harm reduction components of the National Drug Strategy.[69] The largest single category was prevention projects, of which there were 109, comprising 32 per cent of all projects. Within this category were 72 Tier 2 demand reduction projects, most of which (55) provided health promotion, education and information services. Another ten provided alternative activities to AOD use (mostly for adolescents and young people), six provided advocacy and one provided community support services.

Table 11: Indigenous-specific AOD intervention projects by project type, 2006–07

Project type	Intervention tier						Totals	Per cent
	Tier 1 Demand redn	Tier 2 Demand redn	Tier 2 Supply redn	Tier 2 Harm redn	Tier 3 Demand redn	Tier 4 Demand redn		
Prevention	33	72	3	1	–	–	109	32
Harm reduction	–	–	–	89	–	–	89	26
Support, referral, ongoing care	2	22	–	1	3	–	28	8
Treatment: non-residential	–	–	–	–	52	–	52	15
Treatment: residential	–	–	–	–	–	30	30	9
Multi-service	–	–	–	1	–	8	9	3
Workforce develop-ment	–	15	–	–	7	1	23	7
Totals	**35**	**109**	**3**	**92**	**62**	**39**	**340**	**100**

The prevention projects also included 33 Tier 1 demand reduction projects which provided broad primary prevention services not specifically targeted at alcohol and other drug use but funded through AOD programs. The majority of those projects (27) were conducted by Indigenous community-controlled organisations. They included a range of sporting, recreational and cultural activities which provided alternatives to AOD use, most (22) of which were targeted at adolescents and young adults. They included school holiday activities and the Croc Festival. The remaining three prevention projects included two supply reduction projects — a local project in Tennant Creek, and the Australian Government's Petrol Sniffing Prevention Program which operated in the Northern Territory, South Australia and Western Australia — and one which provided support for harm reduction activities.

The second-largest category (89 or 26 per cent) of interventions was harm reduction projects, all of which were Tier 2 services. The category included 47 community patrols — two of which, in the Northern Territory, were targeted specifically at adolescents. It should also be noted that an additional patrol was provided by one of the 'multi-service' projects (discussed below).

Map 2: Indigenous-specific alcohol and other drug intervention projects by ABS Indigenous region, 2006–07

This category also included 36 sobering-up shelters or safe places, four of which — three in Queensland and one in New South Wales — were for adolescents. Several of the sobering-up shelters also provided cell visitors' services. Of the remaining six projects, four provided various support services for intoxicated persons, one provided a safe designated drinking area, and one a needle and syringe program. It is important to note that there were other needle and syringe programs but they were conducted by community-controlled health services as part of their primary health care programs not as discretely funded AOD interventions.

Non-residential treatment services comprised the third-largest category of intervention projects. These 52 projects (15 per cent of the total) generally provided a range of services including assessment, counselling

for individual clients and/or their families, '12 Steps' meetings, case management, referrals to residential treatment and, in two cases, non-residential detoxification. Most of those projects also provided Tier 2 prevention services. Seventeen of the non-residential treatment projects specifically targeted offenders referred through various illicit drug and alcohol diversion programs. Another four were aimed specifically at adolescents and one targeted adult women.

Thirty projects (9 per cent) provided services in residential settings. In two cases (one in South Australia and one in Western Australia), the services were confined to residential detoxification. Another, in Western Australia, provided a two-week residential camp three times each year. Several of these projects also provided some non-residential treatment and community outreach services and limited ongoing care services. Of these, three in the Northern Territory were specifically targeted at volatile substance use and the remainder focused broadly on alcohol and other drugs. Four residential treatment projects – two in the Northern Territory and two in Victoria – were targeted at adolescents and young adults, five targeted families, and another four specifically identified offenders among their target groups (although others also accepted diversion clients).

The range of residential services was not exhausted by those discussed above. We have classified a total of nine projects (3 per cent) as 'multi-service' projects, eight of which provided residential treatment services. Four of those eight projects were conducted in Queensland, two in South Australia, and one each in the Northern Territory and Western Australia. As well as residential treatment they provided a range of other services which cannot be separated – in terms of administration, staffing and funding – from the residential treatment component. Such other services included: a range of non-residential and preventive services in all cases; residential detoxification in two; a half-way house in one; a community patrol in another; and other ongoing care services to varying degrees. The one multi-service project (located in South Australia) that did not provide residential treatment offered a comprehensive range of health and support services for illicit drug users, including drug substitution options. Given the number of both residential and non-residential treatment services, the small number of organisations providing detoxification services is noteworthy.

A group of 28 projects (8 per cent) provided a miscellany of services including support services (22), referral services (four) and ongoing care (two). Generally, the support and referral service projects did not stand alone but were conducted by organisations conducting other kinds of demand reduction projects. The fact that there were only three projects specifically targeting ongoing care (the two above and a half-way house that was part of a multi-service project) is a cause for concern. The provision of ongoing care is crucial to reducing relapse among those who have completed treatment.[117, 118] However, most such care was provided with limited resourcing by organisations primarily conducting residential and non-residential treatment projects, hence constraining their potential efficacy – an issue commented upon by service providers in Chapter 7.

There was a total of 23 (7 per cent) workforce development and capacity-building projects. Nine of the projects provided comprehensive training such as certificate or diploma training and/or workforce support. Seven were more limited in scope but aimed to provide workers with particular skills such as use of the Indigenous Risk Impact Screen (IRIS), brief intervention training and withdrawal management. Of the remainder, six small projects enabled staff members from various organisations to attend conferences; and the other provided

capacity-building support for Indigenous community-controlled residential treatment services in Queensland. Fifteen of these workforce development projects were linked to the provision of Tier 2 demand reduction services, seven to Tier 3 demand reduction services, and one to Tier 4 services.

At the organisational level, many staff development activities are not funded as particular projects. Rather, they are built into staffing arrangements and costs supplemented with funding under the Aboriginal Study Assistance Scheme (ABSTUDY) – an arrangement that is often difficult for organisations because of lack of funding for backfilling positions while staff members are attending courses and because of a shortage of available temporary staff if funding was available.[90] Nevertheless, given the need for workforce expansion and training – and despite an increase in projects in this area (see below) – there was a significant unmet need for training and workforce capacity development.

That there were only three supply reduction projects (less than 1 per cent) should not be surprising. Most supply reduction initiatives are not implemented as funded 'projects', but as changes to existing legislation or regulations controlling the availability of alcohol or other substances. Furthermore, most licensing restrictions are not – at least formally – targeted specifically at Indigenous Australians, but at all residents of the communities in which they are imposed.[103]

Table 12 presents a comparison of the number and types of projects conducted in 2006–07 with those conducted in 1999–2000. It is important to note that one of the most obvious differences – in the number of multi-service projects – is largely an artefact of classification and the funding of some intervention activities as discrete projects. Nevertheless, when multi-service projects, residential and non-residential treatment projects are considered as a group, there was a collective decline of about 15 per cent. The most significant difference between the two periods was in the number of prevention projects, which increased from 57 to 109, a rise of 86 per cent. This was an important change, as in 1999–2000 there was clearly a gap in the provision of such services.[2] The other significant difference was in the number of projects simply classified as 'other' in 1999–2000, an increase from 22 to 54. In part, this is due to the increase in the number of workforce development and capacity-building projects, which doubled. Nevertheless, this latter area remained under-resourced in terms of need within the sector.

Of the 277 projects conducted in 1999–2000, only 48 per cent were still being conducted in 2006–07. The most stable projects were those focused on aspects of treatment (including referral and support services and multi-service projects). About half of all harm reduction projects conducted in 1999–2000 were not operating in 2006–07 but – apart from small projects in areas such as staff and resource development, needs assessment and program development – prevention projects were those that were most reduced; with only 21 per cent of 57 projects in this area operating in both periods. This reflects the fact that, when short-term funding is available, prevention projects requiring little infrastructure are relatively easier to put in place and can often be taken up by organisations not primarily established to provide AOD intervention services. It also reflects the converse – that once they are established it is more difficult to withdraw funding for projects requiring considerable infrastructure, such as residential treatment services. In particular, however, the changes in numbers of both providers and projects highlight a lack of continuity of services in some areas.

Table 12: Indigenous-specific AOD intervention projects by project type, 1999–2000 and 2006–07

	1999–2000		2006–07			Per cent change
Project type	Total	Per cent	Sub-total	Total	Per cent	
Prevention	57	21		109	32	86
Harm reduction	91	33		89	26	–2
Treatment: non-residential	48	17		52	15	8
Treatment: residential	33	12		30	9	–9
Multi-service	26	9		9	3	–65
Other						
Support, referral, ongoing care			28 (8)			
Workforce development			23 (7)			
	22	8		51	15	132
Total	**277**	**100**		**340**	**100**	**23**

Table 13: Indigenous-specific AOD intervention projects by State and Territory, 1999–2000 and 2006–07

	No. of projects	No. of projects	Per cent change
State/Territory	1999–2000	2006–07	
Queensland	32	54	69
New South Wales	38	41	8
Australian Capital Territory	1	6	500
Victoria	31	40	29
Tasmania	1	7	600
Northern Territory	70	85	21
South Australia	30	37	23
Western Australia	74	68	–8
Multi-State/Territory	–	2	
Australia	277	340	23

When considering the data in Table 12 it is important to note that they refer to what we have defined as projects (not the organisations conducting them) and that they reflect both real changes in the provision of services and changes in the classification of projects. These points are of particular relevance to what we have classified as multi-service projects; that is, those under which more than one major intervention type is funded as one project and in which it is not possible to allocate funding to a particular intervention activity. In 2006–07 there were fewer intervention activities funded in this way, with funding more likely to be allocated for discrete interventions and hence for them to be classified as different projects although conducted by the same number of organisations. Of the 26 multi-service projects conducted in 1999–2000, five included residential treatment services, taking the total number of residential services in that year to 38. In 2006–07, the number of residential services included in the multi-service category was eight, bringing the total of residential services to 38 — the same as in the previous period.

5.3 Geographical distribution of Indigenous-specific AOD intervention projects

As indicated previously, the number of Indigenous-specific AOD projects was 23 per cent higher in 2006–07 than in 1999–2000 (see Table 13). In absolute terms, the greatest increases in the numbers of projects were in Queensland (22) and the Northern Territory (15). There were modest increases in numbers in the other jurisdictions, with the exception of Western Australia which saw a reduction of six projects. In percentage terms, the greatest increases were in the Australian Capital Territory (500 per cent) and Tasmania (600 per cent) — coming as they did from a small baseline number of projects. In the other jurisdictions, there were increases of between 8 per cent (New South Wales) and 69 per cent (Queensland), with a reduction of 8 per cent in Western Australia.

As discussed in Chapter 4, the NTA model of service provision provides a useful means of identifying the coverage of interventions and their potential integration. In Table 14 the distribution of projects by State and Territory jurisdiction is broken down by Tiers and their sub-categories. In comparing jurisdictions, caution must be exercised. First, the jurisdictions have Indigenous populations of markedly different size. To take account of this, we have calculated the number of projects serving every 1000 persons aged ≥15 years. Second, as indicated previously, not all projects were equivalent in scope. For example, one large project might have provided a wider range of services than two or three smaller ones. In this regard, knowledge of the amount of resources invested in projects is also important, and this is taken up in the following chapter of the report. Third, the small number of projects conducted in the Australian Capital Territory and Tasmania means that comparison of the breakdowns of projects by Tier precludes useful comparison of these jurisdictions with the others. Bearing these caveats in mind, the figures in the table nevertheless provide a broad basis for comparison.

There was no correlation between the size of the populations in the various jurisdictions and the number of projects conducted within them. This is reflected in the considerable variation in the number of projects for every 1000 Indigenous persons aged ≥15 years. Nationally, this averaged out to 1.2 projects, but ranged from a high of 2.4 in the Northern Territory to a low of 0.5 projects per 1000 persons in New South Wales.

Table 14: Indigenous-specific AOD intervention projects by State/Territory jurisdiction, 2006–07

State/ Territory	Intervention tier					No. of projects	Indigenous popn ≥15	Projects per 1000 popn ≥15
	1: Demand redn	2: Demand & supply redn	2: Harm redn	3: Demand redn	4: Demand redn			
QLD	8	10	20	4	12	54	77 616	0.7
NSW	4	18	1	11	7	41	85 125	0.5
ACT	–	3	–	3	–	6	2451	2.4
VIC	1	17	4	14	4	40	18 944	2.1
TAS	–	6	–	1	–	7	10 649	0.7
NT	12	27	30	6	10	85	34 876	2.4
SA	6	17	6	6	2	37	16 195	2.3
WA	3	13	31	17	4	68	36 849	1.8
Multi	1	1	–	–	–	2		
Australia	35	112	92	62	39	340	282 705	1.2

To some extent, the State and Territory jurisdictions fell into two broad groupings which reflected an important difference in the prevalence of alcohol-related problems. In Western Australia, Queensland and the Northern Territory with larger and more mobile fringe-dwelling populations, there was a larger proportion of Tier 2 harm reduction projects (mainly community patrols and shelters) and, in the case of Western Australia and Queensland, a lesser proportion of Tier 2 demand reduction projects. In addition to the reversal of this pattern in the other jurisdictions, in New South Wales, the Australian Capital Territory and Victoria there were greater proportions of Tier 3 and 4 demand reduction projects, that is those oriented towards treatment.

Earlier studies have found considerable variation in the distribution of projects on an intra-State/Territory basis.[2, 119] For this reason, the distribution of projects by ABS Indigenous regions within those jurisdictions is presented in Table 15.

Among the total of 340 projects there were two multi-State and Territory projects. One was a Tier 1 demand reduction project covering parts of Queensland, the Northern Territory and Western Australia; the other was the Tier 2 Petrol Sniffing Prevention Program (the Opal fuel roll-out) covering parts of the Northern Territory, South Australia and Western Australia. Another 17 projects were State- or Territory-wide projects. Among these were: one Tier 1 demand reduction

Table 15: Indigenous-specific AOD intervention projects for Indigenous Australians by intervention tier by ABS Indigenous region and State/Territory, 2006–07

ABS Indigenous region	Tier 1 Demand redn	Tier 2 Demand redn	Tier 2 Supply redn	Tier 2 Harm redn	Tier 3 Demand redn	Tier 4 Demand redn	Total
Cairns & District	5	5	–	3	1	2	16
Townsville	1	1	–	4	–	2	8
Rockhampton	–	–	–	4	–	3	7
Mount Isa	1	–	–	5	1	1	8
Roma	–	–	–	–	–	1	1
Brisbane	1	–	–	4	2	2	9
Queensland-wide	–	4	–	–	–	1	5
Queensland	**8**	**10**	**–**	**20**	**4**	**12**	**54**
Coffs Harbour	1	1	–	–	2	2	6
Tamworth	–	3	–	–	–	1	4
Dubbo	–	1	–	–	–	–	1
Bourke	1	3	–	–	–	1	5
Wagga Wagga	–	3	–	1	–	1	5
Sydney	–	1	–	–	6	1	8
Queanbeyan	2	4	–	–	2	1	9
NSW-wide	–	2	–	–	1	–	3
New South Wales	**4**	**18**	**–**	**1**	**11**	**7**	**41**
Australian Capital Territory	**–**	**3**	**–**	**–**	**3**	**–**	**6**
Non-metropolitan Victoria	1	9	–	3	10	2	25
Melbourne urban	–	7	–	1	4	2	14
Victoria-wide	–	1	–	–	–	–	1
Victoria	**1**	**17**	**–**	**4**	**14**	**4**	**40**

ABS Indigenous region	Tier 1 Demand redn	Tier 2 Demand redn	Tier 2 Supply redn	Tier 2 Harm redn	Tier 3 Demand redn	Tier 4 Demand redn	Total
Tasmania	**–**	**6**	**–**	**–**	**1**	**–**	**7**
Nhulunbuy	–	3	–	3	2	–	8
Jabiru	1	4	–	3	–	–	8
Darwin	2	2	–	2	2	3	11
Katherine	1	2	–	6	–	1	10
Tennant Creek	2	1	1	5	1	1	11
Apatula	4	4	–	6	–	2	16
Alice Springs	1	8	1	5	1	3	19
NT-wide	1	1	–	–	–	–	2
Northern Territory	**12**	**25**	**2**	**30**	**6**	**10**	**85**
Port Augusta	3	4	–	1	–	–	8
Ceduna	1	2	–	2	2	–	7
Adelaide	2	8	–	3	4	2	19
SA-wide	–	3	–	–	–	–	3
South Australia	**6**	**17**	**–**	**6**	**6**	**2**	**37**
Kununurra	2	–	–	6	2	2	12
Derby	–	–	–	3	1	–	4
Broome	–	2	–	2	2	1	7
South Hedland	–	2	–	4	2	–	8
Geraldton	1	1	–	8	1	–	11
Kalgoorlie	–	3	–	6	1	–	10
Narrogin	–	1	–	–	4	–	5
Perth	–	1	–	2	4	1	8
WA-wide	–	3	–	–	–	–	3
Western Australia	**3**	**13**	**–**	**31**	**17**	**4**	**68**
Multi-State	**1**	**–**	**1**	**–**	**–**	**–**	**2**
Australia	**35**	**109**	**3**	**92**	**62**	**39**	**340**

prevention project; seven Tier 2 demand reduction prevention projects; and nine workforce development projects, seven of which were associated with Tier 2 demand reduction projects, and one each with a Tier 3 and a Tier 4 demand reduction project.

As Table 15 illustrates, there was considerable variation in the number of projects conducted in particular regions, ranging from a low of one to a high of 25. However, the average number per region was nine with most (about 70 per cent) having between five and 12 projects. Ignoring the expected small number of Tier 2 supply reduction projects, it can also be seen from the table that many regions do not have Indigenous-specific services in particular Tiers or sub-categories of them.

The data presented in Table 15 for particular regions are presented in more detail in Table 16. In this table we have provided a measure of the 'coverage' of services within each region. This has been done by combining Tier 2 supply reduction projects with Tier 2 demand reduction projects (as there were so few of the former) and giving regions a score of one for each of the five resultant major Tier sub-categories in which there was a project. It should be noted, however, that this is a crude measure because of both the non-equivalence of some projects (noted previously) and because of variation in the geographical size of regions. The latter consideration means that in some regions there might have been a cluster of services in a regional centre but no reasonably accessible services for people in particular localities within the region (thus it should not be concluded that coverage was adequate). Nevertheless it provides a basis for judicious comparison. In Table 16, the regions are ranked in terms of this measure of service coverage and the number of projects per 1000 persons aged ≥15 years. In the table, we have also included the ARIA category of remoteness into which each region falls ('Very remote', 'Remote', 'Moderately accessible', 'Accessible' and 'Highly accessible').[7]

The group of regions with the broadest range of service coverage — that is, those with at least one project in each of the five Tier sub-categories — comprised Alice Springs, Tennant Creek, non-metropolitan Victoria, Adelaide, Darwin and Cairns. All had a relatively large number of projects — between 11 and 25 — but in relation to population size there was considerable variation, with those in the less populous 'remote' and 'very remote' regions of Alice Springs and Tennant Creek being better served. It should be noted, however, that while Tennant Creek is among this group by virtue of the fact that it has projects in each of these Tier sub-categories, it is more similar to the group of regions with projects in four of the Tier sub-categories — for while it has a 'half-way house', it does not have a residential treatment facility and half the projects in the region were community patrols or shelters.

A second group of 13 regions had projects in four of the five major Tier sub-categories of service. While these regions were located in most States or Territories, about half were located in Western Australia (four) and Queensland (three). Within those regions there was no consistent pattern with regard to the Tier sub-categories in which services were provided. However, in the 'very remote' regions of Kununurra, Katherine and Mount Isa, and the 'remote' region of Geraldton, over 50 per cent of all projects were community patrols and shelters and, in another 'very remote' region, Apatula, they comprised over a third of projects. While these harm reduction interventions are important, as they restrict the supply of alcohol in these regions, in some there is clearly a need for a wider range of demand reduction interventions.

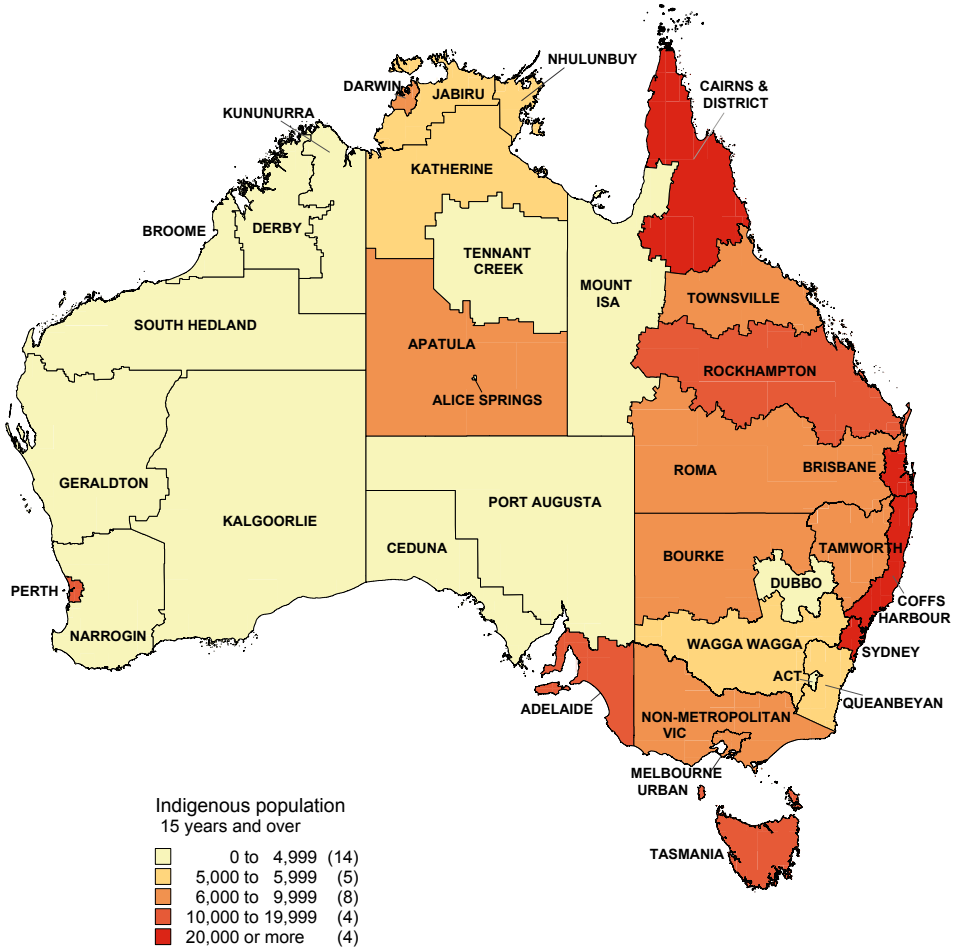
Table 16: Indigenous-specific AOD intervention projects by intervention tier by ABS Indigenous region

	Intervention tier			
Indigenous region	1: Demand reduction	2: Demand & supply reduction	2: Harm reduction	3: Demand reduction
Alice Springs	1	9	5	1
Tennant Creek	2	2	5	1
Non-metro Vic	1	9	3	10
Adelaide	2	8	3	4
Darwin	2	2	2	2
Cairns & District	5	5	3	1
Ceduna	1	2	2	2
Kununurra	2	–	6	2
Geraldton	1	1	8	1
Broome	–	2	2	2
Apatula	4	4	6	–
Katherine	1	2	6	–
Mount Isa	1	–	5	1
Queanbeyan	2	4	–	2
Melbourne urban	–	7	1	4
Townsville	1	1	4	–
Perth	–	1	2	4
Brisbane	1	–	4	2
Coffs Harbour	1	1	–	2
Kalgoorlie	–	3	6	1
South Hedland	–	2	4	2
Port Augusta	3	4	1	–
Nhulunbuy	–	3	3	2
Jabiru	1	4	3	–
Wagga Wagga	–	3	1	–
Bourke	1	3	–	–
Sydney	–	1	–	6
ACT	–	3	–	3
Narrogin	–	1	–	4

		No. of projects	AOD service coverage score	Indigenous popn ≥15 years	Projects per 1000 popn ≥15 years	ARIA category
	4: Demand reduction					
3		19	5	2984	6.4	Remote
1		11	5	2170	5.1	V. remote
2		25	5	9638	2.6	Mod. acc.
2		19	5	10 624	1.8	Access.
3		11	5	6818	1.6	Mod. acc.
2		16	5	20 281	0.8	Mod. acc.
–		7	4	1281	5.5	Remote
2		12	4	2745	4.4	V. remote
–		11	4	3424	3.2	Remote
1		7	4	2350	3.0	V. remote
2		16	4	6117	2.6	V. remote
1		10	4	5250	1.9	V. remote
1		8	4	4302	1.9	V. remote
1		9	4	5257	1.7	Access.
2		14	4	9306	1.5	High acc.
2		8	4	8940	0.9	Mod. acc.
1		8	4	13 349	0.6	High acc.
2		9	4	25 372	0.4	High acc.
2		6	4	24 331	0.2	Access.
–		10	3	3380	3.0	Remote
–		8	3	3759	2.1	V. remote
–		8	3	4290	1.9	Mod. acc.
–		8	3	5710	1.4	V. remote
–		8	3	5827	1.4	Remote
1		5	3	5343	0.9	Access.
1		5	3	9905	0.5	Remote
1		8	3	26 698	0.3	High acc.
–		6	2	2451	2.4	Access.
–		5	2	4988	1.0	Mod. acc.

	Intervention tier			
Indigenous region	1: Demand reduction	2: Demand & supply reduction	2: Harm reduction	3: Demand reduction
Tasmania	–	6	–	1
Derby	–	–	3	1
Rockhampton	–	–	4	–
Tamworth	–	3	–	–
Dubbo	–	1	–	–
Roma	–	–	–	–
State/ Territory-wide, Multi-State	**2**	**15**	**–**	**1**
Australia	**35**	**112**	**92**	**62**

		No. of projects	AOD service coverage score	Indigenous popn ≥15 years	Projects per 1000 popn ≥15 years	ARIA category
	4: Demand reduction					
	–	7	2	10 649	0.7	Access.
	–	4	2	2854	0.7	V. remote
	3	7	2	11 644	0.6	Mod. acc.
	1	4	2	8833	0.5	Access.
	–	1	1	4758	0.2	Remote
	1	1	1	7077	0.1	Mod. acc.
	1	**19**				
	39	**340**		**282 705**	**0.8**	



Map 3: Indigenous residential population aged ≥15 years
by ABS Indigenous region, 2006

Eight regions had projects in three of the Tier sub-categories. The number of projects in each of these regions ranged between five and ten; and the number per 1000 people aged ≥15 years was between 0.3 in Sydney and 3.0 in Kalgoorlie. Generally, these regions were less likely to have residential treatment facilities, but again there was no consistent pattern in the sub-categories in which projects were conducted. Five of the regions in this grouping were 'remote' or 'very remote'.

Of the remaining eight regions, six had projects in only two of the Tier sub-categories and two had a project in only one sub-category. Regions in this grouping had between one and seven projects and had between 0.1 and 2.4 projects per 1000 persons aged ≥15 years. In contrast to regions in the other groups, in these regions there was generally a larger proportion of Tier 2 demand reduction projects and an absence of Tier 1 demand reduction projects. In the group, the Rockhampton region was unusual in that there were two residential treatment facilities in different towns, and four Tier 2 harm reduction projects. Six of the eight regions were 'accessible' (four) or 'moderately accessible' (two), one was 'remote' and one was 'very remote'.

Given the environments in which they live, their personal circumstances, poor health and high levels of dependence, for many dependent Indigenous Australians residential treatment is likely to be the most efficacious form of intervention.[87] However, it is clear that there are many regions that do not have such services. Given small populations and resource constraints, it is not reasonable to expect that such services be available in all regions. However, the provision of residential services in adjacent regions occupied by culturally similar groups is a reasonable goal — if desired by Indigenous Australians themselves. This needs to be accompanied by structural changes such as the provision of transport to facilitate access and by the provision of services that cater for a wider range of clients including women and their families.

A first principle of intervention is that services should be provided in areas where most harm is occurring. However, published data on levels of AOD consumption and related harms are not available at the ABS Indigenous regional level. The best data we have in this regard are summarised in Chapter 3 and Map 1, which provides information only for alcohol-related mortality by the (former) ATSIC zones — areas of aggregation larger than both the old ATSIC regions and the ABS Indigenous regions.

We assigned to each of the ABS regions the rate of alcohol-attributable deaths for the ATSIC zone in which it was located. While the fit between them is not perfect, this provides the best estimate of the magnitude of alcohol-related problems at the regional level. We found that this rate was moderately well correlated with the number of projects in a region (Kendall's *tau-b* = 0.266 p = 0.033) but not with the regional coverage of intervention projects (Kendall's *tau-b* = 0.244 p = 0.065). This indicates that, generally, interventions were being targeted (by both the organisations conducting them and by the agencies directing funding to them) to the areas of greatest need — at least with regard to alcohol-related harms — but that provision of those projects was not necessarily balanced. Those areas with the highest alcohol-attributable mortality rates were generally in the north of the country and/or in remote regions. Importantly, some of those regions such as Alice Springs, Apatula and Mount Isa had, at the time, the highest frequency of volatile substance use (particularly petrol

sniffing) and interventions in those regions were also targeted at that. Notable exceptions to this pattern were the Derby region which was in a zone of high mortality but which was low in terms of the number of projects and coverage, and non-metropolitan Victoria which had relatively low mortality but a relatively high number of projects both in absolute terms and in terms of number of projects per Indigenous persons aged ≥15 years.

After considering need in terms of identifiable harms, it might be expected that there would be higher numbers of projects and levels of coverage in regions with larger populations. However, there was no correlation between these. This means that there are some regions of relatively high populations which appear to be under-served in terms of either numbers of projects and/or service coverage. These regions include Coffs Harbour, Rockhampton, Tasmania and Bourke.

It might also be expected either that there would have been a greater number of projects in more accessible regions (reflecting the distribution of services in general) or, alternatively, that there would have been a greater number of projects in less accessible regions (to compensate for the disadvantage posed by living in remote regions). However, there was neither a positive nor a negative correlation in this regard (Kendall's *tau-b* = 0.054 p = 0.681). Nevertheless, when the size of the population was statistically controlled, the number of projects per 1000 persons aged ≥15 years was positively correlated with the degree of remoteness (Kendall's *tau-b* = 0.401 p = 0.002). That is, remote and very remote regions were better served in terms of the number of projects per 1000 persons aged ≥15 years – a function of larger numbers of projects being conducted in response to higher levels of alcohol-attributable harm.

Overall, there was no correlation, either positive or negative, between the coverage of projects and their degree of remoteness (Kendall's *tau-b* = 0.047 p = 0.739). However, in terms of particular types of projects, there was a correlation between the number of Tier 2 harm reduction services and the degree of remoteness (Kendall's *tau-b* = 0.447 p = 0.001) – with most such services being located in 'remote' and 'very remote' regions in Queensland, the Northern Territory and Western Australia. Again, this is a function of both the higher levels of alcohol-related harm and the larger numbers of itinerant or transient people in those regions.

This information on the distribution of projects enables us to draw three broad conclusions. First, there are some regions that appear to be particularly poorly served in terms of both numbers and coverage of Indigenous-specific services. These include Roma and Rockhampton in Queensland, Wagga Wagga, Tamworth and Dubbo in New South Wales, the Australian Capital Territory, Tasmania, and Derby and Narrogin in Western Australia. Related to this is the fact that – with the exception of the provision of Tier 2 harm reduction projects – the coverage provided by projects was largely a random phenomenon. That is, projects have been established and undertaken in a manner that fails to provide many regions (and certainly more localities) with an integrated range of services. Second, there appear to be some regions with relatively large populations that were under-serviced in terms of the provision of Indigenous-specific services. In addition to those listed as poorly served above, these include Coffs Harbour and Bourke. Third, compensating for degree of remoteness has not been a consideration in the establishment of services.

An issue pertaining to the degree of service coverage is that of service integration. That is, within regions, to what extent were AOD projects linked to each other and to Tier 1 services provided outside the AOD sector? No

clear answer to this question can be provided here. The fact that 168 (largely Tier 1 and 2) projects were conducted by 111 Indigenous community-controlled health services, community support and local governments not established primarily to provide AOD services affords a basis for the integration of those AOD services with other services provided by the organisations. However, the degree to which many stand-alone projects (particularly Tier 3 and 4 treatment services) are integrated varies. Case studies from Queensland and a report from Central Australia indicate that, in at least some cases, there is little or no integration and hence limited coordination of care, especially for clients with comorbid mental health problems.[90] This is, in part, a resourcing issue. When organisations are working to capacity, achieving integration and coordination of services is difficult. Coordination of care within and between the government and non-government sectors is essential and, in such cases, needs to be resourced as such.

5.4 Drugs targeted by Indigenous-specific AOD intervention projects

Alcohol was the primary focus of 246 (72 per cent) of the 340 intervention projects (Table 17). Of these, the focus of 44 was on alcohol alone and, of the others, 151 had a secondary focus on illicit drugs (primarily cannabis and amphetamine-type stimulants), 33 on tobacco and 18 on volatile substances. It is important to note, however, that from our experience there is considerable variation in the degree of emphasis on these other substances. For some, there is an active attempt to address problems associated with their use; for others, the focus is squarely on alcohol with incidental engagement with clients who have other problems.

Thirty-three projects (10 per cent) had a multi-drug focus – primarily some combination of alcohol, cannabis and amphetamine-type stimulants. They differed from those in the 'alcohol and other drug' category in that there was no primary focus on alcohol. Of the other projects, 30 were targeted at volatile substance use (in 24 instances specifically on petrol), 20 had a focus on illicit drugs (again primarily cannabis and amphetamine-type stimulants, but in some cases with a secondary focus on alcohol), and 11 targeted cigarette smoking (in some cases also targeting cannabis use).

As Table 17 also shows, there were some minor differences of emphasis in target drugs across the intervention tier sub-categories. However, across all sub-categories, the emphasis was clearly upon 'alcohol and other drug' interventions. Secondary foci among Tier 1 harm reduction interventions were multi-drug interventions and volatile substances, and among Tier 2 demand reduction projects were multi-drug interventions. Among Tier 3 demand reduction projects there was also a secondary emphasis targeting illicit drug use and related harms.

In Table 18 the main substances targeted are presented by region. The table shows that, as might be expected, there were slightly more projects targeting volatile substances in 'remote' and 'very remote' regions. However, apart from this there was little difference in substances targeted by region.

Table 17: Indigenous-specific AOD intervention project type by main substances targeted, 2006–07

Project type	Alcohol	Alcohol & other	Multi-drug focus
Tier 1: Non AOD-specific services			
1.1 Demand reduction	1	20	6
Tier 2: Open access AOD services			
2.1 Demand reduction	7	58	21
2.2 Supply reduction	1	–	–
2.3 Harm reduction	31	49	–
Tier 3: Community-based specialist services			
3.1 Demand reduction	2	41	6
Tier 4: Residential AOD-specific services			
4.1 Demand reduction	2	34	–
Totals	**44**	**202**	**33**
Per cent	13	59	10

	Illicits	Volatile substances	Tobacco	Total	Per cent
	3	5	–	35	10
	4	10	9	109	32
	–	2	–	3	1
	3	9	–	92	27
	10	1	2	62	18
	–	3	–	39	11
	20	**30**	**11**	**340**	**100**
	6	9	3	100	

Table 18: Indigenous-specific AOD intervention project type by main substances targeted by ABS Indigenous region and State/Territory, 2006–07

Region	Alcohol	Alcohol & other	Illicits	Volatile substance	Tobacco	Multi-drug	Total
Cairns & District	4	10	1	–	–	1	16
Townsville	3	4	–	1	–	–	8
Rockhampton	2	4	–	1	–	–	7
Mount Isa	3	3	–	2	–	–	8
Roma	–	1	–	–	–	–	1
Brisbane	1	5	–	2	–	1	9
Queensland-wide	–	2	–	–	3	–	5
Queensland	**13**	**29**	**1**	**6**	**3**	**2**	**54**
Coffs Harbour	–	3	1	–	–	2	6
Tamworth	–	3	–	–	–	1	4
Dubbo	1	–	–	–	–	–	1
Bourke	–	4	–	1	–	–	5
Wagga Wagga	–	4	–	–	–	1	5
Sydney	–	6	1	–	1	–	8
Queanbeyan	1	5	–	–	2	1	9
NSW-wide	–	2	–	–	–	1	3
New South Wales	**2**	**27**	**2**	**1**	**3**	**6**	**41**
Australian Capital Territory	**–**	**4**	**1**	**–**	**–**	**1**	**6**
Non-metropolitan Victoria	2	21	–	–	–	2	25
Melbourne urban	–	11	–	–	–	3	14
Victoria-wide	–	–	–	–	–	1	1
Victoria	**2**	**32**	**–**	**–**	**–**	**6**	**40**

Region	Alcohol	Alcohol & other	Illicits	Volatile substance	Tobacco	Multi-drug	Total
Tasmania	**–**	**4**	**–**	**–**	**1**	**2**	**7**
Nhulunbuy	–	6	1	1	–	–	8
Jabiru	1	4	1	2	–	–	8
Darwin	–	8	1	–	–	2	11
Katherine	2	6	–	2	–	–	10
Tennant Creek	2	9	–	–	–	–	11
Apatula	1	8	1	6	–	–	16
Alice Springs	3	11	–	4	–	1	19
NT-wide	–	1	–	–	1	–	2
Northern Territory	**9**	**53**	**4**	**15**	**1**	**3**	**85**
Port Augusta	–	1	1	5	–	1	8
Ceduna	1	5	1	–	–	–	7
Adelaide	1	6	5	–	1	6	19
SA-wide	–	1	–	–	1	1	3
South Australia	**2**	**13**	**7**	**5**	**2**	**8**	**37**
Kununurra	5	5	1	–	–	1	12
Derby	1	3	–	–	–	–	4
Broome	1	6	–	–	–	–	7
South Hedland	4	2	1	–	1	–	8
Geraldton	1	10	–	–	–	–	11
Kalgoorlie	3	5	–	2	–	–	10
Narrogin	–	4	1	–	–	–	5
Perth	1	5	2	–	–	–	8
WA-wide	–	–	–	–	–	3	3
Western Australia	**16**	**40**	**5**	**2**	**1**	**4**	**68**
Multi-State	**–**	**–**	**–**	**1**	**–**	**1**	**2**
Australia	**44**	**202**	**20**	**30**	**11**	**33**	**340**

In Table 19 substances that were the target of intervention projects in 2006–07 are compared with those targeted in 1999–2000.[2] The table shows that there were some significant changes over the seven-year period. First, there was a reduction in both the number (143 to 44) and percentage (51 to 13) of projects focusing only on alcohol. Second, although there was a significant increase in the number (113 to 202) and percentage (41 to 59) focusing on alcohol and other drugs, overall the percentage of projects with a focus primarily on alcohol (i.e. alcohol only, and alcohol and other drugs) was reduced from 92 to 72 per cent.

Most of the change is accounted for by the increasing salience of cannabis and amphetamine-type stimulant use. This is reflected in: the increase in the number of projects focusing on the use of other drugs secondarily to alcohol; a six-fold increase in the percentage of projects focusing specifically on illicit drugs (from 1 to 6 per cent); and projects with a specifically 'multi-drug' focus (10 per cent), a focus that was not evident in 1999–2000. While there was an increase in the percentage of projects targeting volatile substances (4 to 9 per cent), there was only a very small change in the number of projects specifically targeting tobacco smoking, despite the fact that tobacco is the single largest preventable cause of Indigenous deaths.

The change in the targets of the intervention projects represents an appropriate response to changing patterns of alcohol and other drug use and related harm. The increase in the use of illicit drugs and polydrug use had to be addressed. However, given that there are strong associations between the use of alcohol and illicit drugs (as well as with tobacco), it is not desirable to have a plethora of interventions targeting specific substances. Thus, there was a need for interventions initially targeting alcohol to expand their scope to address other forms of drug use. However, a problem for many services is that staff do not have the skills required to address the added complexity of problems.[90] Hence, the need for expanded workforce development and capacity-building activities is even more important.

Table 19: Drugs targeted by Indigenous-specific AOD intervention projects, 1999–2000 and 2006–07

	1999–2000		2006–07	
Target drug	No.	Per cent	No.	Per cent
Alcohol	143	51	44	13
Alcohol & other drugs	113	41	202	59
Illicits	3	1	20	6
Volatile substances	12	4	30	9
Tobacco	6	2	11	3
Multi-drug focus	–	–	33	10
Total	**277**	**100**	**340**	**100**

5.5 Population groups targeted by Indigenous-specific AOD intervention projects

The population targets of the various intervention projects (Table 20) fell into four broad categories: communities at large (113 or 34 per cent); intoxicated persons (80 or 23 per cent); 'dependent' persons or those with chronic problems (124 or 36 per cent); and those providing health workers with the skills to address alcohol- and other drug-related problems (23 or 7 per cent). Within each of these broad categories there were more specific foci.

The mainly preventive Tier 1 and Tier 2 demand reduction projects (Table 21) aimed at the broader community fell into two sub-groups, those aimed at the general community and those aimed at adolescents and young adults (i.e. those aged 15 to 24 years). The former group included 53 projects, three of which were targeted specifically at females and two at males. The remaining 60 projects, targeted at the community, were specifically for adolescents and young adults, one of which was targeted at adolescent females. Projects targeted at both sub-groups included alternatives to AOD use, community education and support services.

Table 20: Indigenous-specific AOD intervention projects by target group, 2006–07

Target group	Frequency	Per cent
Community		
General community	53	16
Adolescents & young adults	60	18
Intoxicated persons		
Intoxicated persons	73	21
Intoxicated adolescents & young adults	7	2
Dependent persons		
Dependent persons	93	27
Offenders	22	6
Dependent adolescents & young adults	9	3
Health workers		
AOD and other health workers	23	7
Total	**340**	**100**

Table 21: Indigenous-specific AOD intervention projects by target group by intervention tier, 2006–07

Service tier		General community	Adolescents	Intoxicated persons
Tier 1:	Non AOD-specific services			
1.1	Demand reduction	13	22	–
Tier 2:	Open access AOD services			
2.1	Demand reduction	30	28	1
2.2	Supply reduction	2	1	–
2.3	Harm reduction	4	5	72
Tier 3:	Structured community-based specialist services			
3.1	Demand reduction	4	4	–
Tier 4:	Residential AOD-specific services			
4.1	Demand reduction	–	–	–
Totals		**53**	**60**	**73**

Projects targeted at intoxicated persons were mainly Tier 2 harm reduction projects such as community patrols and shelters. However, they also included some referral and case management services. Of these 80 projects, one was targeted specifically at adult females and seven were targeted at adolescents.

One hundred and twenty-four projects provided services for dependent persons or those with chronic AOD-related problems. Most (85) of those projects provided Tier 3 and Tier 4 demand reduction services, particularly treatment services, but 35 projects also provided Tier 2 demand reduction services, largely support and referral services and, to a lesser degree, preventive services.

Of the 124 projects targeting dependent persons, 93 were for dependent persons in general — including nine specifically for males and four specifically for people who inject drugs (although many other projects in this category include those who inject drugs among their clients). Of the projects providing residential treatment, only five specifically targeted families. As reported in the interviews with service providers (Chapter 7), this is a barrier to entering treatment — especially for women — and presents a significant gap in service provision. Of the 93 projects targeting dependent persons in general, nine also provided services for offenders as part of their

Intoxicated adolescents	Dependent persons	Offenders	Dependent adolescents	AOD & other workers	Total
–	–	–	–	–	35
–	29	3	3	15	109
–	–	–	–	–	3
7	4	–	–	–	92
–	28	17	2	7	62
–	32	2	4	1	39
7	**93**	**22**	**9**	**23**	**340**

broad community focus. Of the remaining 31 projects targeting dependent persons, 22 were specifically targeted at offenders and nine were for dependent adolescents.

The final category of people at whom projects were targeted were AOD and other health workers. This category included a total of 23 workforce development projects associated with the provision of Tier 2 (15), Tier 3 (seven) and Tier 4 (one) demand reduction services.

Projects targeted at adolescents and young adults comprised 53 per cent (60 of 113) of those aimed at communities (primarily Tier 1 and 2 demand reduction projects) — well above their proportion (19 per cent) of the Indigenous population aged ≥15 years. Given the focus of those projects on early intervention and prevention, this is to be expected. However, among projects targeted at intoxicated and dependent persons, there was an under-representation of projects specifically for adolescents and young adults — seven of 80 or 9 per cent; and nine of 125 or 7 per cent, respectively.

Offenders — clients diverted into treatment under various State and Territory programs — were the specific target of 22 intervention projects (17 non-residential, two residential and three prevention/support projects). However, although not specifically targeted, offenders were among the clientele of many

other intervention projects, and the numbers of offenders diverted from the criminal justice to the health sector are likely to increase. Such diversion is a positive step and the research evidence shows that mandated treatment can be effective.[121] However, mandated clients often bring to the treatment setting an additional set of issues that need to be dealt with. These include issues around the motivation to change and what, in some instances, has been called the importation of a 'prison culture' to residential treatment settings.[90] As is the case with changing patterns of drug use, staff in many agencies do not have the skills to address these issues and, again, this highlights the need for expansion of workforce development initiatives.

Given increased awareness of the issue, interventions to meet the needs of clients with comorbid substance use and mental health problems were a notable absence from the list of population group targets. While a number of treatment projects addressed the needs of individual clients with such problems, little was being done in a systematic way. As indicated in Chapter 7, many staff members felt that they had neither the skills to address the needs of such clients (a finding also reported in a Queensland study[90]) nor access to services that could provide support and advice.

6. Indigenous-specific AOD intervention project funding

In 2006–07 a total of approximately $100.7 million (excluding GST) was expended on the provision of Indigenous-specific alcohol and other drug intervention services. As indicated previously, this amount was expended by 224 organisations on 340 projects (Table 9) and was funded from a total of 528 grants. Of the total, $89.4 million (89 per cent) was spent on the provision of services and the remaining $11.3 million (11 per cent) was expended on capital infrastructure. While obviously an important element in building capacity for service provision, the allocation of funds for capital projects is not recurrent and such funds are not allocated to all organisations providing services in any one year. Thus, when considering funding for service provision, inclusion of capital expenditure distorts the picture of resource allocation. For this reason, we treat capital expenditure separately and exclude it from some of the comparisons of service provision in the following sections. In comparing expenditures on service provision between 1999–2000 and 2006–07, figures for the former period have been adjusted for inflation and are presented in 2006–07 dollars.

6.1 Provider expenditures

In Table 22 the amounts of project expenditure are presented by provider organisation type by funding category on a State and Territory basis. As indicated above, in total $11.3 million was expended on capital infrastructure – including buildings, motor vehicles and equipment. With the exception of Western Australia, all capital expenditure was made by Indigenous community-controlled organisations. In the latter jurisdiction, the Western Australian Department of Health's Drug and Alcohol Office expended $25 000 on minor capital items. Of the remaining $89.4 million, $74.6 million (74 per cent) was recurrent operational funding and about $14.8 million (15 per cent) consisted of one-off, non-recurrent expenditure. The percentage of non-recurrent operational funding within each State ranged from a low of nil in the Australian Capital Territory to a high of 20 per cent in South Australia. These funds were expended across the range of project types but 27 per cent was spent on prevention projects, 25 per cent on residential treatment and 19 per cent on harm reduction projects.

Overall, 72 per cent of all funds was expended by Indigenous community-controlled organisations (47 per cent by AOD services, 12 per cent by health services, 11 per cent by community service organisations and 2 per cent by Indigenous local governments). Of the remainder, non-Indigenous NGOs expended 10 per cent, State and Territory government agencies 9 per cent, the Australian Government 9 per cent and local government agencies less than 1 per cent. Direct expenditure by the Australian Government was confined to the Petrol Sniffing Prevention Program in selected regions in the Northern Territory, South Australia and Western Australia. In the case of Indigenous organisations, the percentage of funds expended (72 per cent) was almost the same as the percentage of projects they conducted. However, the Australian Government's significant contribution to the Petrol Sniffing Prevention Program meant that the proportion of all government expenditures (18 per cent) was significantly greater than the proportion of projects they conducted (about 9 per cent).

When capital expenditure is excluded, in all jurisdictions the percentage of total funds expended by Indigenous community-controlled organisations was 69 per cent,

Table 22: Total expenditure on Indigenous-specific AOD intervention projects by provider organisation type, by State/Territory, 2006–07

Territory	Organisation type	Recurrent
Queensland	Indigenous CCO	
	AOD service	10 697
	CCHS	754
	Community service	686
	Indigenous local govt	256
	Non-Indigenous NGO	970
	Local government	50
	State/Territory government	2470
	Queensland total	**15 883**
	Per cent	68
New South Wales	Indigenous CCO	
	AOD Service	4914
	CCHS	3529
	Community service	60
	Non-Indigenous NGO	0
	Local government	0
	New South Wales total	**8502**
	Per cent	78

ranging from 64 per cent in South Australia to 100 per cent in Tasmania. The jurisdictions in which non-Indigenous NGOs expended the largest percentage of funds were the Northern Territory (33 per cent — 10 organisations, 19 projects) and Western Australia (17 per cent — 11 organisations, 14 projects). These were also the jurisdictions in which non-Indigenous NGOs expended the largest amount of funding and, in this regard, they were followed by Queensland (7 organisations, 8 projects). The jurisdictions in which State governments expended the largest percentages and amounts of operational funding were South Australia (30 per cent), Western Australia and Queensland (both 13 per cent).

Fifteen per cent of total expenditure was for non-recurrent operational projects (or 17 per cent of all operational expenditure). On a State and Territory basis, this was 20 per cent in South Australia, 18 per cent in the Northern Territory, 17 per cent in Queensland, 16 per cent in Victoria, 15 per cent in Western Australia, 10 per cent in New South Wales, 8 per cent in Tasmania, and nil in the Australian Capital Territory.

	Non-recurrent operational	Non-recurrent capital	Total	Per cent
	3085	3593	17 375	74
	87	0	841	4
	295	40	1021	4
	311	0	568	2
	45	0	1015	4
	0	0	50	<1
	40	0	2510	11
	3864	**3633**	**23 379**	
	17	16		
	733	1157	6804	62
	291	101	3920	36
	7	0	67	1
	101	0	101	1
	5	0	5	<1
	1137	**1258**	**10 897**	
	10	12		

Territory	Organisation type	Recurrent
Australian Capital Territory	Indigenous CCO	
	CCHS	565
	Community service	205
	Non-Indigenous NGO	124
	State/Territory government	61
	Australian Capital Territory total	**955**
	Per cent	100
Victoria	Indigenous CCO	
	AOD service	2681
	CCHS	856
	Community service	1426
	Non-Indigenous NGO	590
	State/Territory government	298
	Victoria total	**5851**
	Per cent	83
Tasmania	Indigenous CCO	
	Community service	1033
	Tasmania total	**1033**
	Per cent	92
Northern Territory	Indigenous CCO	
	AOD service	3874
	CCHS	429
	Community service	2218
	Indigenous local govt	671
	Non-Indigenous NGO	4878
	Local government	0
	State/Territory government	100
	Northern Territory total	**12 171**
	Per cent	64

	Non-recurrent operational	Non-recurrent capital	Total	Per cent
	0	0	565	59
	0	0	205	21
	0	0	124	13
	0	0	61	6
	0	**0**	**955**	**100**
	0	0		
	348	0	3029	43
	278	20	1155	16
	322	40	1788	25
	195	0	785	11
	0	0	298	4
	1143	**60**	**7054**	
	16	1		
	90	0	1123	100
	90	**0**	**1123**	
	8	0		
	495	2659	7028	37
	775	74	1278	7
	1418	380	4017	21
	415	0	1086	6
	324	268	5470	29
	40	0	40	<1
	0	0	100	<1
	3468	**3380**	**19 019**	
	18	18		

Territory	Organisation type	Recurrent
South Australia	Indigenous CCO	
	AOD service	4284
	CCHS	1739
	Community service	100
	Indigenous local govt	0
	Non-Indigenous NGO	336
	Local government	0
	State/Territory government	3532
	South Australia total	**9991**
	Per cent	75
Western Australia	Indigenous CCO	
	AOD service	5292
	CCHS	700
	Community service	1850
	Non-Indigenous NGO	1792
	State/Territory government	1663
	Western Australia total	**11 297**
	Per cent	70
Multi-State	Non-Indigenous NGO	0
	Australian Government	8924
	Multi-State total	**8924**
	Per cent	100
Australia	Indigenous CCO	
	AOD service	31 741
	CCHS	8572
	Community service	7578
	Indigenous local govt	928
	Non-Indigenous NGO	8690
	Local government	50
	State/Territory government	8123
	Australian Government	8924
	Australia total	**74 607**
	Per cent	74

Note: Errors due to rounding

	Non-recurrent operational	Non-recurrent capital	Total	Per cent
	209	540	5033	38
	1519	106	3363	25
	111	0	211	2
	100	0	100	1
	75	0	411	3
	377	0	377	3
	229	0	3761	28
	2619	**646**	**13 256**	
	20	5		
	1052	2211	8554	53
	369	0	1069	7
	316	100	2266	14
	541	0	2334	14
	188	25	1876	12
	2465	**2336**	**16 099**	
	15	15		
	18	0	18	<1
	0	0	8924	100
	18	**0**	**8942**	
	<1	0		
	5922	10 160	47 823	47
	3319	300	12 191	12
	2558	560	10 697	11
	826	0	1754	2
	1301	268	10 259	10
	422	0	472	<1
	457	25	8606	9
	0	0	8924	9
	14 805	**11 313**	**100 725**	
	15	11		

Table 23: Recurrent and non-recurrent operational expenditure on Indigenous-specific AOD intervention projects by provider organisation type, 1999–2000 and 2006–07

	1999–2000			
Organisation type	Recurrent $000*	Non-recurrent $000*	Total $000*	Per cent
Indigenous	36 818	1361	38 179	90
Non-Indigenous NGO	2110	144	2255	5
Government	1552	615	2167	5
Total	**40 481**	**2119**	**42 601**	
Per cent	95	5		

* In 2006–07 dollars

Note: Errors due to rounding

Table 23 provides a comparison of operational expenditure by service provider type for 1999–2000 and 2006–07. In real terms, expenditure increased from approximately $42.6 to $89.4 million, an increase of 110 per cent. Expenditure by Indigenous community-controlled organisations increased by 61 per cent. However, as a percentage of the total, expenditure by those organisations declined from 90 to 69 per cent. The largest increase in expenditure was by government organisations, rising 730 per cent from $2.2 to $18 million. However, over half that increase was accounted for by the Australian Government's Petrol Sniffing Prevention Program. Expenditure by non-Indigenous NGOs increased from approximately $2.3 to $9.9 million, an increase of 343 per cent. The other significant difference between the two periods was the increase in non-recurrent operational funding from 5 to 17 per cent.

6.2 Project expenditures

The largest amount of expenditure was for treatment services of various kinds. Together multi-service projects ($14.8 million), residential treatment services ($23.6 million) and non-residential services ($9.7 million) accounted for a total of $48.1 million or 48 per cent of all expenditure (Table 24). Even when capital expenditure is excluded (84 per cent of which was spent on these services), treatment projects still accounted for 43 per cent of all operational expenditure (Table 25).

Prevention projects (mostly Tier 1 and Tier 2 demand reduction projects) accounted for 25 per cent of total expenditure ($25.4 million) but 28 per cent ($25 million) when capital expenditure is excluded. Harm reduction projects (mainly patrols and shelters) were significant recipients of capital funding ($1.3 million or 11 per cent of all capital expenditure). When this funding is included, harm

	2006–07				Percentage change
	Recurrent $000	Non-recurrent $000	Total $000	Per cent	1999–2000 to 2006–2007
	48 819	12 625	61 444	69	61
	8690	1301	9991	11	343
	17 097	879	17 977	20	730
	74 607	**14 805**	**89 412**		**110**
	83	17			

reduction projects accounted for 20 per cent of total expenditure; and, when excluded, for 22 per cent of operational expenditure. Other project types received relatively small amounts of funding. When capital expenditure is excluded, support, referral and ongoing care services received $4.3 million (5 per cent), and workforce development $2.1 million (2 per cent). The most striking aspect of expenditure on these latter project types was the small amount for ongoing care (even when taking into account that some additional limited ongoing care services are provided as part of multi-service and residential projects) and workforce development.

In Table 25, operational expenditure is broken down by the number of organisations conducting projects of each type, the number of projects being conducted and the number of grants received for those projects. Overall, the 340 projects were funded by a total of 494 grants for operational expenditure – that is, a mean of 1.45 grants per project. With two exceptions all categories of projects were funded by an average of between 1.0 and 1.5 grants per project. The exceptions were residential and multi-service projects which were funded by an average of 2.5 and 4.1 grants per project respectively.

It is important to note that the number of grants for operational expenditure listed in Table 25 does not exhaust those managed by the organisations providing services. As noted in Chapter 5, the majority of organisations conducting AOD intervention projects were primarily established to provide a range of health, community support and local government services and they manage numerous other grants for those activities.

The distribution of the amount of funding per grant was extremely skewed. It ranged from a low of $909 to $8.9 million for the Petrol Sniffing Prevention Program (followed by $1.6 million for a multi-service project)

Table 24: Total expenditure on Indigenous-specific AOD intervention projects by project type, 2006–07

Project type	Recurrent $000	Non-recurrent $000	Capital works $000	Total $000	Per cent
Prevention	21 020	3969	442	25 432	25
Harm reduction	16 456	2853	1261	20 570	20
Treatment: non-residential	8347	823	575	9744	10
Treatment: residential	14 271	3635	5695	23 601	23
Multi-service	9075	2526	3200	14 801	15
Support referral, ongoing care	3817	489	140	4446	4
Workforce development	1620	510	–	2130	2
Total	**74 607**	**14 805**	**11 313**	**100 725**	**100**

Note: Errors due to rounding

with a median of $80 066, with 76 per cent of grants being for less than $200 000. Similarly, the amount of operational funding per project (i.e. the total of individual grants per project) was also skewed. This ranged from a low of $2300 to a high of $8.9 million, with median expenditure per project being $114 467.

Of the 340 projects, 82 (24 per cent) were reliant solely upon non-recurrent funding totalling $5.6 million (i.e. 6 per cent of total operational funding). Of these 82 projects, 49 per cent were prevention projects, 23 per cent were harm reduction projects and 17 per cent were workforce development projects. Almost two-thirds of the projects were conducted by community support service organisations (26 per cent), community-controlled health services (23 per cent) or Indigenous local government organisations (17 per cent). Of the others, 11 per cent were conducted by Indigenous AOD service providers and 15 per cent by non-Indigenous NGOs. The mean amount of these grants was skewed by a small number of large grants but they ranged from a low of $2273 to $521 675 with a median of $34 250.

The amount of operational expenditure was $46.8 million (110 per cent) greater in 2006–07 than in 1999–2000 (Table 26). The most significant increase was in expenditure on prevention projects, which rose from $4.5 million to $25 million — an increase of 459 per cent. This is an important change as this was an area identified as being under-resourced in 1999–2000.[2] The next greatest

Table 25: Operational expenditure on Indigenous-specific AOD intervention projects by project type, 2006–07

Project type	No. of orgs*	No. of projects	No. of grants	Median project $000	Total $000	Per cent	Per capita $
Prevention	87	109	148	60	24 989	28	88
Harm reduction	77	89	104	106	19 309	22	68
Treatment: non-residential	44	52	72	78	9169	10	32
Treatment: residential	29	30	74	159	17 906	20	63
Multi-service	9	9	37	124	11 601	13	41
Support, referral, ongoing care	24	28	32	83	4306	5	15
Workforce development	17	23	27	55	2130	2	8
Total	**287**	**340**	**494**	**80**	**89 412**	**100**	**316**

* Some organisations conducted more than one project type and are thus counted twice in the total.

increase was in those services grouped together as 'other' in 1999–2000 — that is, referral services, support services, ongoing care and workforce development. Together, expenditure on this group of services increased by 354 per cent to approximately $6.4 million in 2006–07. However, despite their importance, within this category there was only a 2 per cent increase in funding for workforce development projects.

Overall, although there were increases in the amount of expenditure on both residential and non-residential treatment services, their combined percentage of overall expenditure was reduced from 47 per cent in 1999–2000 to 30 per cent in 2006–07. This percentage change was largely a reflection of the greater increase in expenditure on prevention services rather than a decline in funding for treatment services. As indicated previously, all of the nine multi-service projects provided treatment (eight residential and one non-residential) among their other services. However, because of the way these projects were structured, it was not possible to allocate proportions of funding to particular intervention types.

It is important to note that the number of people aged ≥15 years identifying as Indigenous increased from 180 283 at the 2001 Census to 282 705 at the 2006 Census, an increase of 57 per cent. Thus, while there was an overall increase of 110 per cent in operational expenditure, expenditure on a per capita basis increased by only 34 per cent from $236 per person aged ≥15 years in 1999–2000 to $316 in 2006–07.

Table 26: Operational expenditure on Indigenous-specific AOD intervention projects by project type, 1999–2000 and 2006–07

	1999–2000		2006–07			
Project type	Total*	Per cent	Sub-total	Total	Per cent	Per cent change
Prevention	4474	11		24 989	28	459
Harm reduction	11 501	27		19 309	22	68
Treatment: non-residential	5377	13		9169	10	71
Treatment: residential	14 420	34		17 906	20	24
Multi-service	5409	13		11 601	13	114
Support, referral, ongoing care			4306 (5)			
Workforce development			2130 (2)			
Other	1419	3		6437	7	354
Total	**42 601**	**100**		**89 412**	**100**	**110**

* In 2006–07 dollars

Note: Errors due to rounding

6.3 Geographical distribution of expenditures

There was considerable variation in operational expenditure on intervention projects at both State and Territory and regional levels. On an absolute basis, expenditure ranged from a low of $955 000 in the Australian Capital Territory to a high of $19.7 million in Queensland (Table 27): with $1.1 and $7.0 million expended in Tasmania and Victoria; $9.6, $12.6 and $13.8 million in New South Wales, South Australia and Western Australia; and $15.6 million in the Northern Territory. These levels of expenditure were roughly proportional to the number of projects undertaken in each of the jurisdictions.

As indicated above, nationally, mean operational expenditure was $316 per person aged ≥15 years and by jurisdiction ranged from a low of $105 per person aged ≥15 years in Tasmania to a high of $779 in South Australia. In New South Wales and Queensland per capita expenditure was $113 and $254; in Victoria, Western Australia and the Australian Capital Territory it was $369, $373 and $390; and in the Northern Territory and South Australia it was $448 and $779.

A comparison of expenditures in 1999–2000 and 2006–07 on a State and Territory basis is presented in Table 27. The table shows – with the exception of New South Wales and the Australian Capital Territory (combined) – there were increases in operational expenditure in all jurisdictions. Those increases ranged from 47 per cent in Western Australia to 112 per cent in Queensland and most significantly to 2537

Table 27: Operational and per capita operational expenditure (2006–07 dollars) on Indigenous-specific AOD intervention projects, 1999–2000 and 2006–07

State/ Territory	1999–2000			2006–07			Per cent change per capita
	Popn ≥15 yrs	Total $000*	Per capita $	Popn ≥15 yrs	Total $000	Per capita $	
Queensland	67 544	8117	120	77 616	19 746	254	112
New South Wales	47 457	6049	127	85 125	9639	113	−5
Australian Capital Territory^				2451	955	390	
Victoria	15 335	4301	281	18 944	6994	369	31
Tasmania	9505	34	4	10 649	1123	105	2537
Northern Territory	32 453	8289	255	34 876	15 639	448	76
South Australia	14 404	6796	472	16 195	12 610	779	65
Western Australia	35 543	9015	254	36 849	13 763	373	47
Australia#	180 283	42 601	236	282 705	89 412	316	34

* Based on Gray et al. (2002) adjusted to 2006–07 dollars

^ Australian Capital Territory figures were included in New South Wales in 1999–2000

\# The total includes multi-State projects not included in State/Territory figures

per cent in Tasmania. Tasmania was also the jurisdiction in which increased expenditure was greatest on a per capita basis. Increases in per capita expenditure in all other jurisdictions were greater than 31 per cent. The apparent 14 per cent reduction in per capita expenditure in New South Wales is a consequence of the fact that, in the 1999–2000 figures, the Australian Capital Territory was included with those for New South Wales. When expenditure for 2006–07 in these jurisdictions is combined, there was a 5 per cent decrease in per capita expenditure.

In Table 28, operational expenditure for 2006–07 is broken down by region and compared to expenditure in 1999–2000. In 2006–07, median operational expenditure per region was $1.8 million (mean = $2.2 million, SD = $1.6 million) with less than $1 million being expended in a third of all regions. As the size of the standard deviation (SD) indicates, there was considerable variation in the range of expenditure by region — from a low of $59 000 in the Dubbo region to a high of $5.8 million in the Port Augusta region of South Australia.

Nationally, per capita operational expenditure was $316 but median per capita expenditure per region was $282. As with total expenditure, there was considerable variation in this. In a group of 15 regions (Dubbo, Roma, Sydney, Tamworth, Jabiru, Bourke, Coffs Harbour, Tasmania, Nhulunbuy, Brisbane, Perth, Narrogin, Apatula, Wagga Wagga and Rockhampton) per capita funding was less than $200. At the other end of the spectrum, in one group of five regions (Mount Isa, Ceduna, Broome, Tennant Creek and Kununurra) per capita expenditure was between $732 and $938 and in another two regions (Port Augusta and Alice Springs) was $1353 and $1550.

Table 28: Operational and per capita (persons aged ≥15 years) expenditure (2006–07 dollars) on Indigenous-specific AOD intervention projects by ABS Indigenous region, 1999–2000 and 2006–07

	ARIA Index	1999–2000	
ABS Indigenous region		Popn ≥15 yrs	Expenditure $000*
Cairns & District	3	18 398	2506
Townsville	3	10 015	1326
Rockhampton	3	7541	1194
Mount Isa	5	4417	1335
Roma	3	6069	362
Brisbane	1	21 104	1395
Queensland°		**67 544**	**8117**
Coffs Harbour	2	19 706	1709
Tamworth	2	7569	533
Dubbo@			
Bourke	4	4599	648
Wagga Wagga	2	12 351	770
Sydney	1	23 821	1418
Queanbeyan (NSW)^	2	6686	972
New South Wales		**47 457**	**6049**
Australian Capital Territory	**1**		

At the 0.05 level, there was no significant correlation between regional levels of operational expenditure and either population levels (Pearson's R = 0.257 sig = 0.136) or rates of alcohol-attributable mortality (Pearson's R = 0.066 sig = 0.705). Similarly, there was no correlation between operational expenditure and ARIA scores (Kendall's tau-b = –0.162 sig = 0.205). These results indicate that none of these factors had a significant effect on the determination of funding allocations to intervention projects.

		2006–07		Per cent change per capita
Per capita expenditure $	Popn ≥15 yrs	Expenditure $000	Per capita expenditure $	
136	20 281	5307	262	92
132	8940	3759	421	219
158	11 644	2270	195	23
302	4302	3147	732	142
60	7077	385	54	–9
66	25 372	3839	151	129
120	**77 616**	**19 746**	**254**	**112**
87	24 331	2295	94	8
70	8833	733	83	19
	4758	59	12	
141	9905	895	90	–36
62	5343	983	184	197
60	26 698	1841	69	15
145	5257	2565	488	236
127	**85 125**	**9639**	**113**	**–5**
	2451	**955**	**390**	

	ARIA Index	1999–2000	
ABS Indigenous region		Popn ≥15 yrs	Expenditure $000*
Wangaratta (ATSIC region)+		7443	2818
Ballarat (ATSIC region)+		7892	1483
Non-metropolitan Victoria	2		
Melbourne urban	1		
Victoria		**15 335**	**4301**
Tasmania	**2**	**9505**	**34**
Nhulunbuy	5	5138	405
Jabiru	4	5322	718
Darwin	3	6323	2322
Katherine	5	4999	1220
Tennant Creek	5	2032	909
Apatula	5	5374	784
Alice Springs	4	3265	1930
Northern Territory		**32 453**	**8289**
Port Augusta	3	4140	1622
Ceduna	4	1204	654
Adelaide	2	9060	4520
South Australia		**14 404**	**6796**

		2006–07		Per cent change per capita
Per capita expenditure $	Popn ≥ 15 yrs	Expenditure $000	Per capita expenditure $	
379				
188				
	9638	2960	307	
	9306	3724	400	
280	**18 944**	**6994**	**369**	32
4	**10 649**	**1123**	**105**	**2537**
79	5710	771	135	71
135	5827	511	88	–35
367	6818	5280	774	111
244	5250	1480	282	16
447	2170	1838	847	90
146	6117	1004	164	12
591	2984	4625	1550	162
255	**34 876**	**15 639**	**448**	**76**
392	4290	5804	1353	245
543	1281	962	751	38
499	10 624	5165	486	–3
472	**16 195**	**12 610**	**779**	**65**

	ARIA Index	1999–2000	
ABS Indigenous region		Popn ≥15 yrs	Expenditure $000*
Kununurra	5	2903	1979
Derby	5	2924	809
Broome	5	2627	1554
South Hedland	5	3124	962
Geraldton	4	3330	391
Western Desert†	5	1924	649
Kalgoorlie	4	2184	1034
Narrogin	3	4091	156
Perth	1	12 436	1480
Western Australia		**35 543**	**9015**
Australia		**180 283**	**42 601**

* Based on Gray et al. (2002), adjusted to 2006–07 dollars

° State/Territory totals include State/Territory-wide project funding

@ In 1999–2000 Dubbo was part of the Wagga Wagga region

^ In 1999–2000 the Queanbeyan region included the Australian Capital Territory

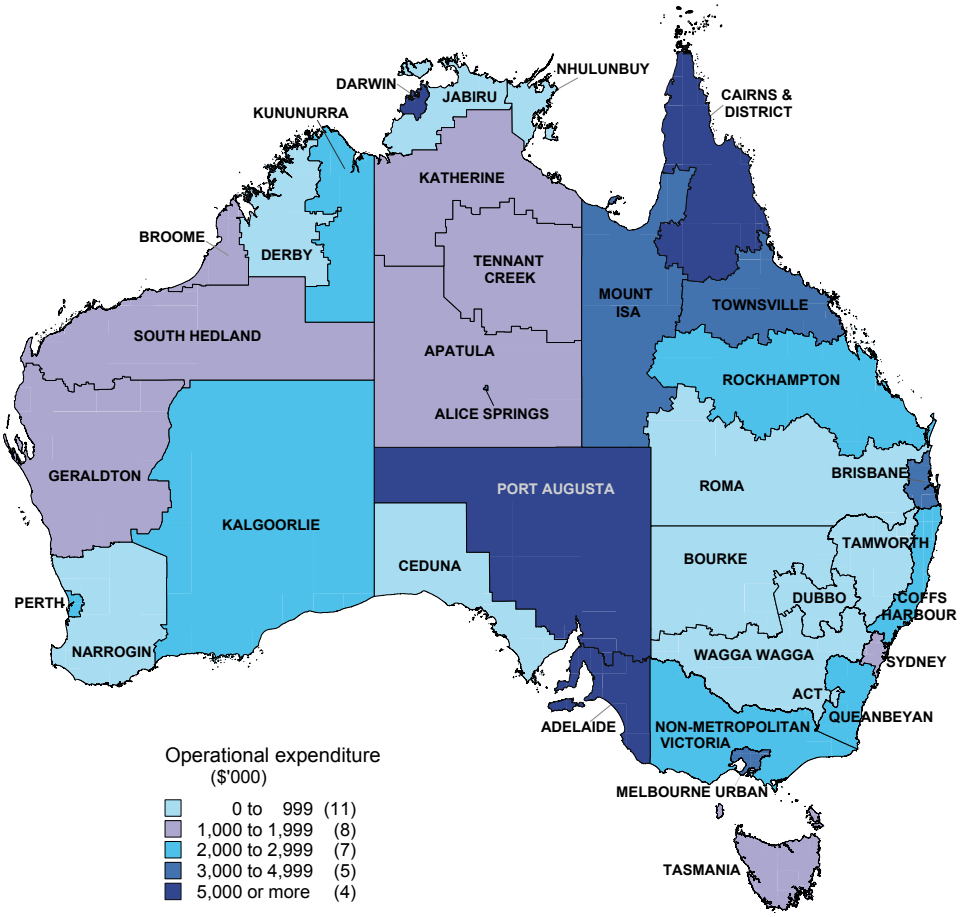
\+ Funding data for regional Victoria in 1999–2000 are available only for the old ATSIC regions which split the State in two and included part of Melbourne in each. These data are not comparable to the 20006–07 data for the ABS Indigenous regions

† The Western Desert region has been incorporated by the ABS into its Kalgoorlie region

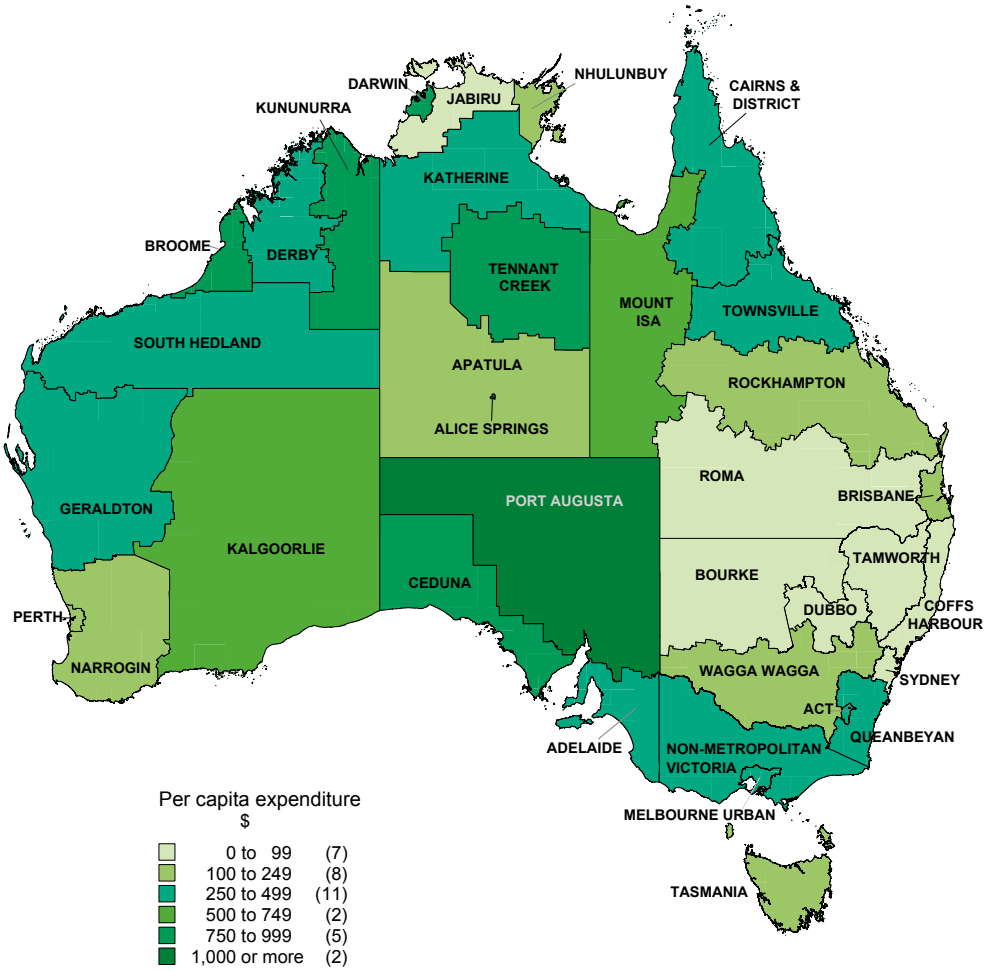
As indicated previously, in real terms, between 1999–2000 and 2006–07 there was an increase in operational expenditure of 110 per cent. In four regions (Geraldton, Port Augusta, Narrogin and Tasmania) expenditure increased by over 200 per cent and in another eight (Townsville, Brisbane, Queanbeyan, Alice Springs, Mount Isa, Darwin, Cairns & District, and Tennant Creek) it increased by between 102 and 184 per cent. Increases in the other regions were more modest with increases of between 52 and 94 per cent in Victoria as a whole, South Hedland, Kalgoorlie, Nhulunbuy, Rockhampton and Wagga Wagga, and between 6 and 47 per cent in Bourke, Tamworth, Perth, Coffs Harbour, Kununurra, Sydney, Apatula, Broome, Katherine, Adelaide, Roma and Ceduna. In two regions, Derby and Jabiru, there were decreases in expenditure of 7 and 29 per cent in real terms.

		2006–07		Per cent change per capita
Per capita expenditure $	Popn ≥15 yrs	Expenditure $000	Per capita expenditure $	
682	2745	2576	938	38
277	2854	750	263	–5
591	2350	1889	804	36
308	3759	1654	440	43
117	3424	1294	378	223
337				
473	3380	2006	594	25
38	4988	789	158	316
119	13 349	2021	151	27
254	**36 849**	**13 763**	**373**	**47**
236	**282 705**	**89 412**	**316**	**34**

On a per capita basis, nationally, in real terms there was a 34 per cent increase in expenditure. The median regional increase in expenditure was 38 per cent. Regional increases paralleled those in total regional expenditure with little overall differences in the ranking of regions on either measure. In six regions (Port Augusta, Townsville, Queanbeyan, Geraldton, Narrogin and Tasmania) per capita expenditure increased by over 200 per cent. A second group of regions (Nhulunbuy, Tennant Creek, Cairns, Darwin, Brisbane, Alice Springs, Mount Isa and Wagga Wagga) had per capita increases of between 71 and 197 per cent. The other regions had per capita increases of between 8 and 43 per cent with the exception of Roma, Derby, Adelaide, Bourke and Jabiru which experienced declines of between 3 and 36 per cent in real terms.



Map 4: Operational expenditure on Indigenous-specific alcohol and other drug intervention projects by ABS Indigenous region, 2006–07



Map 5: Per capita operational expenditure on Indigenous-specific alcohol and other drug intervention projects by ABS Indigenous region, 2006–07

Table 29: Operational expenditure ($000) on Indigenous-specific AOD intervention projects by project type by State and Territory, 2006–07

State/ Territory	Prevention	Harm reduction	Treatment: non-residential
Queensland	1953	5768	835
New South Wales	1583	54	1450
Australian Capital Territory	0	0	350
Victoria	1611	1371	905
Tasmania	1095	0	29
Northern Territory	3972	4030	1154
South Australia	4461	2387	323
Western Australia	1372	5700	4124
Multi-State	8942	0	0
Australia	**24 989**	**19 309**	**9169**
Per cent	28	22	10

Note: Errors due to rounding

In Table 29 operational expenditure by project type is broken down by State and Territory jurisdiction. The areas of expenditure largely reflect the distribution of project types with variation in foci within the jurisdictions. Nationally, prevention projects were the most common intervention (109 or 32 per cent) and the level of expenditure on them was similar (28 per cent). However, there was considerable variation at the State and Territory level. The largest amount expended on prevention projects was on two programs that operated in more than one region, the Australian Government's Petrol Sniffing Prevention Program and Croc Festival ($8.9 million). The largest amount expended on prevention projects in one State was in South Australia ($4.5 million), followed by the Northern Territory ($4.0 million) and Queensland ($2.0 million).

In terms of the percentage of funds expended on prevention projects, the jurisdictions in which most was spent were Tasmania (97 per cent), South Australia (35 per cent), the Northern Territory (25 per cent) and Victoria (23 per cent). Given the foci of particular projects and the way they have been classified for the purpose of this report, it should not be inferred that no preventive services are provided in the Australian Capital Territory. Rather, preventive activities are conducted as part of projects that focus on non-residential treatment. This is also the case in Queensland, Western Australia and New South Wales.

Treatment: residential	Multi-service	Support, referral, ongoing care	Workforce development	Total $000
5123	5432	46	591	19 746
5992	0	322	238	9639
0	0	605	0	955
655	1687	503	263	6994
0	0	0	0	1123
4381	1460	577	65	15 639
0	3022	2225	190	12 610
1755	0	29	783	13 763
0	0	0	0	8942
17 906	**11 601**	**4306**	**2130**	**89 412**
20	13	5	2	100

In some jurisdictions where expenditure on prevention projects was relatively low, there was a converse emphasis on treatment projects. The largest allocation of funding to non-residential treatment was in Western Australia ($4.1 million), New South Wales ($1.4 million) and the Northern Territory ($1.2 million). Reflecting a greater emphasis in those jurisdictions, the percentage of funds expended on non-residential treatment in the Australian Capital Territory (37 per cent) and Western Australia (30 per cent) was considerably greater than in other jurisdictions and the percentage nationally (10 per cent).

In New South Wales ($6.0 million), Queensland ($5.1 million) and the Northern Territory ($4.4 million) there was considerably greater expenditure on residential than non-residential projects. When expenditure on these projects is combined with that of multi-service projects (all but one of which, nationally, included a residential treatment component), the amount of expenditure on residential treatment is increased considerably in the case of Queensland ($10.6 million) and Victoria ($2.4 million). In percentage terms, New South Wales (62 per cent) and Queensland (53 per cent) were the jurisdictions in which most was expended on

residential and multi-service projects, followed by the Northern Territory (37 per cent), Victoria (33 per cent), South Australia (24 per cent) and Western Australia (13 per cent). The fact that residential treatment projects and multi-service projects combined accounted for 12 per cent of projects nationally but 33 per cent of operational expenditure reflects the higher costs involved in providing such services.

As indicated in Chapter 5, there was greater emphasis on the provision of harm reduction projects in Queensland, Western Australia and the Northern Territory. This was reflected in operational expenditure in those jurisdictions – $5.8, $5.7 and $4.0 million respectively. Nationally the expenditure on harm reduction projects as a percentage ranged from 1 per cent in New South Wales to 41 per cent in Western Australia, with no Indigenous-specific harm reduction projects being conducted in either the Australian Capital Territory or Tasmania.

With the exception of the Australian Capital Territory and South Australia where support, referral and ongoing care services accounted for 63 and 18 per cent of operational funding respectively, in no jurisdictions did expenditures on these other project types exceed 7 per cent. Expenditure on workforce development was highest in Western Australia ($783 000, 6 per cent) and in Queensland ($591 000, 3 per cent).

6.4 Sources of project funding

No matter which type of organisation conducted intervention projects, 97 per cent of all identified expenditure, both operational and capital, was provided by either the Australian or State and Territory governments. The amounts contributed by various types of organisations are presented in Table 30, broken down by State and Territory jurisdictions. Overall, approximately $64.3 million (64 per cent) was provided by Australian Government agencies. Of these, OATSIH made the largest contribution ($47.2 million or 47 per cent). It should be noted that the latter figure – based on information provided by OATSIH – exceeds the $23.5 million reported in the 2006–07 DASR,[4] as the DASR reports only on organisations funded primarily to provide AOD services and does not include primary health care service providers.

In addition to funds provided by OATSIH, DoHA's Drug Strategy Branch contributed a further 8 per cent. Aboriginal Hostels contributed 3 per cent (towards residential treatment projects), as did the Attorney-General's Department (primarily for harm reduction projects and mostly in the Northern Territory). Small amounts were also provided by the then Department of Families, Community Services and Indigenous Affairs (FaCSIA) and the Department of Education, Science and Training (DEST).

State and Territory government agencies provided a total of approximately $33.7 million (33 per cent). Most of this contribution was made by Departments of Health or AOD agencies within them. These are best considered together, as in some jurisdictions they are one. Overall, they contributed $23.2 million (23 per cent of all expenditure). In Queensland and Western Australia, Departments of Communities and Indigenous Affairs contributed approximately $8.2 million (8 per cent) – primarily for safe places in Queensland and for community patrols in Western Australia. A variety of other State and Territory agencies – such as Police, Justice, Family and Children's Services, and Premier and Cabinet – contributed about $2.3 million (2 per cent).

The remaining 3 per cent of funding was provided by local governments ($32 000 or less than 1 per cent) and non-government organisations ($2.6 million or 3 per cent). The largest contributor among the non-government agencies was the Alcohol Education and Rehabilitation Foundation, with smaller amounts being provided by organisations including Beyond Blue, the Fosters Group, the Foundation for Young Australians and St John of God Health Care.

Table 30: Total Indigenous-specific AOD project grant funding by funding agency source by State/Territory, 2006–07

	Qld	NSW	ACT	Vic	Tas
Funding agency	**$000**	**$000**	**$000**	**$000**	**$000**
Commonwealth					
DoHA – OATSIH	13 420	6960	226	2155	1095
DoHA – Drug Strategy	595	574	–	333	–
Aboriginal Hostels	1081	613	–	278	–
Attorney-General's	198	–	–	–	–
Other	29	54	–	–	–
	15 323	**8201**	**226**	**2767**	**1095**
State/Territory					
Health	–	1420	729	4194	–
AOD agencies	871	982	–	–	29
Indigenous affairs	6240	–	–	–	–
Other	295	265	–	–	–
	7406	**2667**	**729**	**4194**	**29**
Other					
Local government	–	–	–	–	–
NGO	650	29	–	93	–
	650	**29**	**–**	**93**	**–**
Total	**23 379**	**10–897**	**955**	**7054**	**1123**

Note: Errors due to rounding

	NT	SA	WA	Multi-State	Total	Per cent
	$000	$000	$000	$000	$000	
	6577	5812	2044	8924	47 213	47
	919	1945	3619	–	7985	8
	453	153	394	–	2973	3
	2014	251	887	–	3349	3
	1822	939	10	–	2853	3
	11 785	**9100**	**6954**	**8924**	**64 373**	**64**
	72	1453	554	–	8423	8
	6426	155	6317	–	14 780	15
	–	-	1993	–	8233	8
	34	1612	60	–	2267	2
	6533	**3220**	**8924**	**–**	**33 703**	**33**
	23	–	9	–	32	<1
	679	936	213	18	2617	3
	702	**936**	**221**	**18**	**2649**	**3**
	19 019	**13 256**	**16 099**	**8942**	**100 725**	**100**

The relative contributions of Australian and State and Territory agencies varied considerably. As indicated above, overall, Australian Government agencies contributed 64 per cent of total funding but this ranged from a high of 98 per cent in Tasmania through 75 per cent in New South Wales, 69 per cent in South Australia, 62 per cent in the Northern Territory, 43 per cent in Western Australia, 39 per cent in Victoria, to 24 per cent in the Australian Capital Territory. Conversely, State and Territory government contributions ranged from 3 per cent in Tasmania to 76 per cent in the Australian Capital Territory. The ranking of the States and Territories on the basis of their contribution to the funding of intervention projects in their jurisdictions was similar to their ranking on the basis of funding contributions per capita for persons aged ≥15 years: the Australian Capital Territory ($298), Western Australia ($242), Victoria ($221), South Australia ($199), the Northern Territory ($187), Queensland ($95), New South Wales ($31) and Tasmania ($2.70).

The 64 per cent of funding provided by Australian Government agencies comprised 51 per cent of the 494 grants under which total funding was distributed, reflecting the larger mean size of the Australian Government grants. However, of the 78 grants provided to non-Indigenous NGOs 22 (28 per cent) were provided by the Australian Government and 48 (62 per cent) by State or Territory governments. This is almost the reverse of the situation for Indigenous organisations which received 57 per cent of grants from the Australian Government and 37 per cent from State or Territory governments. This distribution reflects the increase in the award of tenders to non-Indigenous organisations to provide Indigenous-specific services highlighted in Chapter 5.

As indicated previously, in real terms, operational funding of Indigenous-specific intervention projects was 110 per cent higher in 2006–07 than in 1999–2000 (Table 31). The largest increase (1572 per cent) was in the combined contributions of non-government organisations and local government agencies – although funding by local government fell by 79 per cent and all the increase was provided by NGOs (2498 per cent), albeit with both coming from small baseline contributions. In total, the combined contributions by Australian Government agencies increased by 119 per cent and those by State and Territory agencies by 84 per cent. In dollar terms, the largest increase was provided by OATSIH ($20.9 million) and by the combined contributions of State and Territory health and AOD agencies ($8.9 million). As a consequence of the higher increases in the contributions by Australian Government agencies, their relative contributions to the funding of intervention projects were also higher.

A final word needs to be said about funding. The amounts of funding we have identified do not exhaust the resources that are put into many intervention projects. As we demonstrated in Chapter 5, a significant proportion of projects are conducted by Indigenous community-controlled organisations. Such organisations are dependent for their existence on the voluntary effort that community members devote to the establishment and continuing governance of those organisations. Although little has been written about it, this voluntary effort often extends to service provision activities and can be considerable.[122]

Table 31: Indigenous-specific AOD intervention project operational grant funding by source, 1999–2000 and 2006–07

	1999–2000		2006–07		Per cent change: total contrib'n	Per cent change: relative contrib'n
Funding agency	$000*	Per cent	$000	Per cent		
Commonwealth						
DoHA – OATSIH	18 168	43	39 040	44	115	2
DoHA – Drug Strategy	2236	5	6535	7	192	46
Aboriginal Hostels	3013	7	2973	3	–1	–53
Attorney-General's			2969	3		
Other	1210	3	2515	3	108	–6
	24 627	58	54 032	60	119	4
State/Territory						
Health/AOD	13 379	31	22 288	25	67	–20
Indigenous affairs	3845	9	8233	9	114	2
Other	595	1	2267	3	281	154
	17 819	42	32 788	37	84	–13
Other						
Local government	71	<1	32	<1	–55	–79
NGO	84	<1	2560	3	2948	1352
	155	<1	2592	3	1572	697
Total	**42 601**		**89 412**		**110**	

* Based on Gray et al. (2002) adjusted to 2006–07 dollars

7. The view from the ground

In this chapter, we provide an overview of the experiences of service providers delivering Indigenous-specific AOD services. Those interviewed were asked to comment generally on the strengths of their organisations, the barriers they experienced providing services and what they perceived to be the gaps in services in their regions.

Below we outline the key themes that emerged: firstly, in relation to strengths; and secondly, in relation to barriers. We go on to outline the gaps in service provision identified by participants and, lastly, we provide a discussion of the significance of the key findings.

7.1 Organisational strengths

'Local solutions for local people'

Representatives of both Indigenous and non-Indigenous organisations providing Indigenous-specific AOD services highlighted the importance of providing 'culturally appropriate', 'culturally safe' or 'culturally secure' services for their clients. According to service providers, a culturally secure environment meant that programs were relevant to the populations they were serving and had the effect of breaking down barriers for Indigenous Australians seeking help for AOD-related problems. Responses from the staff of community-controlled organisations outlined the advantages for clients of being able to access services run largely by Indigenous workers in their own communities: 'for the community by the community'. While few defined what they meant by culturally secure services, a number of participants from non-Indigenous organisations recognised the importance of employing 'Aboriginal staff [who] are local community members'. Participants from non-Indigenous organisations also felt they were able to provide services in a culturally secure environment by conducting cultural awareness programs and delivering services in partnership with Indigenous AOD and other community-controlled health organisations, and in consultation with the members of local communities.

Innovative and holistic approaches

An 'innovative' approach to the delivery of services was felt to be important. A number of services provided by Indigenous organisations included input from local elders and a focus on strengthening Indigenous culture; others (both Indigenous and non-Indigenous) drew on music and art to reach their target audiences. The provision of a holistic service was also central in the dialogues, coming from both Indigenous and non-Indigenous organisations. As highlighted in Chapter 6, most organisations (71 per cent) were funded to conduct one Indigenous-specific AOD project. However, many participants recognised that harmful AOD use among clients could not be addressed in isolation from other issues in their lives. Therefore, an ability to provide a 'one-stop shop' where clients can 'follow a complete pathway through' was felt to be beneficial. The capacity to offer multiple services, a multi-pronged approach to substance use and a collection of specialists in the one location were believed to enhance the ability of organisations to promptly and easily respond to the multiple problems faced by many clients. Some participants reported that their organisation had managed to achieve this and listed these factors as strengths of their organisations. However, as discussed later, the majority of participants found it difficult to make this a reality due to financial, resource and locational restraints.

Ability to produce results

A number of participants believed that their organisations were producing results. Along with raising awareness of AOD issues, participants mentioned: seeing a reduction in harmful AOD use and associated harms such as violence; witnessing a reduction in the amount of alcohol consumed in their communities; assisting clients to achieve lifestyle changes; and helping community members avoid coming into contact with police and the courts. However, it was stressed that change did not occur overnight — as one participant commented, 'it's taken 20 years for us to achieve changes'.

'Commitment of workers to make a difference'

Many Indigenous participants emphasised the importance of their staff. They commented on admirable qualities of staff (both employed and voluntary) and spoke about cohesion between staff as being a key strength:

> A large proportion of staff are Aboriginal including the clinical team. There are enough Aboriginal staff to form a core group to support each other while working in such a challenging area.

Of primary importance for Indigenous organisations was that the majority of staff belonged to local communities. This meant that Indigenous Australians designed programs, provided services, managed projects and had 'life experiences that related to the clients'. A small number of non-Indigenous participants mentioned having staff who were well trained and qualified for the roles they undertook.

Relationships with others

Some participants reported that having and maintaining relationships with other service providers enabled them to better respond to client needs. These relationships created referral networks and meant — in the words of an Indigenous participant — 'we use the skills that we have, and then refer the clients to those with greater skills'. Links to the community were also highlighted by both Indigenous and non-Indigenous participants. Many described the ways in which communities supported, trusted and respected their organisations. They reported that their organisations were well known within their communities (and staff knew the communities) which meant clients were willing to access and support their services. A number made the point that they actively worked to consult and engage community members in the planning and coordinating of projects. Consultation enabled organisations to identify community needs and to respond accordingly. An Indigenous participant said, '[Our organisation] is a true grass-roots organisation; it means that there's feedback very quickly and we can respond to the needs of the community very promptly'. Most importantly, a high number of service providers felt that it was important that their communities were part of the solution to the problems of harmful AOD use.

Other issues

In addition to the key responses outlined above, participants also spoke about the importance of providing reliable consistent services for their clients. A number also mentioned that their organisations benefited from internal stability and staff cohesion.

7.2 Barriers to service provision

'We simply don't get enough'

The ability to produce results is 'a big thing in this industry', but the majority of participants from both Indigenous and non-Indigenous NGOs felt that their potential to deliver successful, holistic services was seriously constrained by lack of funding and inadequate resources; a finding also reflected in a recent report on the Aboriginal and Torres Strait Islander community-controlled AOD sector in Queensland and in the non-government sector more generally.[90, 123]

Many of those we interviewed described the visions they had for their particular organisations including, for example, the expansion of existing programs and the addition of new services such as a healing centre or a camp for young people. However, they reported that lack of funding and resources meant they were limited in their capacity to respond to client needs and often could provide only a 'band-aid' service. This frustration is reflected in the following comment from an Indigenous participant:

> Funding is a huge barrier, we run 13 programs and none of us are funded for more than 0.5 FTE [full-time employment]. It means that we have to do more than one job. At one stage I was involved in four different programs. If we had more funding we could be more proactive, get out into the community and prevent the problems occurring.

A key area of need identified by participants from both Indigenous and non-Indigenous NGOs was for the provision of ongoing care services. They were concerned that they failed their clients by not having the resources to provide much-needed follow-up. The paucity of such services and funding for them was highlighted in Chapters 5 and 6.

Some participants also commented that funding arrangements were not flexible enough to allow their organisations 'to do it our own way'. For example, an Indigenous participant explained that they were 'funded for a set number of clients, not to meet community needs of service'. In particular, a number of Indigenous participants believed that funding bodies do not acknowledge the way Aboriginal Australians do things or fail to listen to the ideas they have; and a small number attributed this to the reluctance of funding bodies to fund particular programs or approaches. One Indigenous participant explained:

> [Our organisation] concentrates efforts on rehabilitation. The program needs to address social issues but doesn't have the resources to do so. We'd like to provide a holistic service — more prevention and early intervention — but funding bodies won't fund this.

That is, the main funders of Tier 4 rehabilitation services do not generally provide funding for Tier 1 services. These restrictions, participants felt, did not allow organisations to 'work in an Aboriginal way to meet demand'.

Some participants believed that there were fundamental differences in the definitions of 'success' employed by funding bodies and the organisations delivering the services. It was felt that this restricted the ability of organisations to respond to client needs in an Aboriginal way. It was also felt that if organisations did not meet the definitions of success used by funding bodies, their ability to attract further funding was compromised.

Non-recurrent or short-term funding

The non-recurrent or short-term nature of much funding was reported as presenting a 'huge barrier'. For many, the future of projects was uncertain and there were calls for 'a continuing commitment from the government' to fund interventions. Participants stressed that results take time and many found it hard to maintain and develop programs without the certainty of longer-term funding. As one said:

> Funding ... it's not there for a complete service. So many programs have to go unfunded, or it's only for a year and then it's finished.

This was felt to have an impact on the ability of organisations to attract and retain staff, and to earn the trust of community members.

For some Indigenous organisations the funding application processes and reporting requirements were also considered problematic and time-consuming. Aboriginal staff did not always have the high levels of numeracy and literacy required or were not trained in report writing. In addition, many organisations were already understaffed and stretched to their limits. Furthermore, they did not see the results of such reporting. 'The reporting requirements are very heavy – every three months reports are needed. What's being done with this information?' Added to this burden, organisations funded by a number of different bodies were required to complete reports for each, often requiring the same information but in different formats – a finding of other studies.[90, 109]

Staffing issues

A high proportion of both Indigenous participants and those from the non-Indigenous NGO sector felt that staffing issues were a major barrier to service provision, a barrier also identified in previous studies.[90, 109] Limited funding meant that organisations were often understaffed and that existing staff were over-stretched and were forced to 'multi-task'. Indigenous Australians represent only about 1 per cent of the health workforce in Australia[124] and many participants stated they had difficulty recruiting staff, especially Indigenous and local Indigenous staff. Positions in some organisations had been vacant for a number of months and, in one case, for years.

> The coordinator's position has been unfilled for two years as the service can't attract a person to run the program due to low wages and housing. Program officer positions have had a high turnover rate due to [lack of] access to housing, and poor wages. Skilled Indigenous workers can get jobs in government departments that pay a lot more.

For this reason, some organisations funded in the 2006–07 period to deliver Indigenous-specific AOD interventions had been unable to do so.

Retention of staff was also a problem. The smaller NGOs and Indigenous organisations stated they could not match the remuneration offered by government organisations – 'we pay the lowest wages in town' – and short-term and non-recurrent funding meant that security of employment was tenuous. The lack of career opportunities was another factor that was seen as impacting on the ability of organisations to retain staff. In the words of a participant from an Indigenous community-controlled organisation, 'When we get the staff, we have trouble keeping

them because there's no clear career path working from here.' Another issue seen as an inhibiting factor for recruiting and retaining staff included the personal safety issues of working with a difficult population. This was captured in the following comment from an Indigenous participant:

> At present we have to get people to Sydney for detox, which is at least a three-hour drive. Doing that drive with someone who's withdrawing from alcohol and amphetamines is a challenge for staff.

Another major issue for participants was the lack of qualified staff (especially in AOD service provision), together with the difficulty in accessing training. Participants stressed the need for staff training. A number of specialist training programs for Indigenous AOD workers do exist. For example, the Western Australian Department of Health's Drug and Alcohol Office offers a number of workforce development initiatives for both the Aboriginal workforce and the broader human services sector.[125] However, the location of many organisations means that if they want to access training for staff, they have to send them to programs in metropolitan areas. In organisations already understaffed the loss of a worker, even for a short period, poses a serious challenge:

> The training that's available is in Sydney, and that means that while the staff are being trained, there are no workers here for the service.

Additionally, a number of participants commented that it was necessary to 'train up' staff – as 'they usually have no experience in the field' – only to then 'lose them to the government sector which pays more. The award we are on doesn't match the government'. A small number of participants also questioned the appropriateness of available training, with one Indigenous service provider commenting, 'most of it is too academic-based for health workers. The course in comorbidity was aimed at psychologists, not on-the-ground workers'. Another Indigenous participant was concerned that Indigenous-specific AOD courses are created from 'above' without consultation with those delivering the services and therefore were not always appropriate for addressing issues in local contexts. Many of these barriers to service provision have also been identified in other reports into the Indigenous community-controlled and non-Indigenous NGO sectors.[126, 127]

Some participants felt that staff were not equipped to deal with the rise in polydrug use among clients and believed that training should focus on all drugs, not only alcohol. As highlighted in Chapter 5, despite an increase in projects directed at workforce development, there remains significant unmet need in relation to training and staffing, a point emphasised by participants.

Relationships with others

For at least some State and Territory government agencies, it seemed that engaging local communities was a challenge. Participants reported that referrals to their services were low, and they had difficulty attracting Indigenous clients because there was a perception among Indigenous people that the services lacked cultural awareness or that they were only for non-Indigenous people. Similar beliefs were voiced in interviews with government service providers in a study from Western Australia.[126]

Other issues

A small number of participants drew attention to wider socio-structural barriers such as a lack of housing, limited employment options for Indigenous Australians, the high school truancy rate among Indigenous children, racism and negative community attitudes, and the overall level of disadvantage experienced by Indigenous Australians compared to their non-Indigenous counterparts: 'Our people are just so disadvantaged'.

7.3 Gaps in service provision

Service providers identified what they felt were the areas of greatest need in and around their communities, and four key themes emerged:

- the need for more services
- the lack of ongoing and acute services
- the need for increased access and availability, and
- the need to address the social determinants of health.

The need for more services

More treatment services

There was consensus among representatives from a large number of Indigenous and non-Indigenous organisations about the pressing need for more AOD and general health services, an issue highlighted elsewhere.[29, 90] Participants in our study frequently highlighted the lack of local Indigenous-specific detoxification and rehabilitation services. A key concern among Indigenous participants was that people seeking detoxification and rehabilitation needed to leave their home communities to access such services and the barrier this can present. Some felt that the need to leave communities to access mainstream detoxification and rehabilitation services provided a further disincentive to entering treatment, and stressed the need for more Indigenous-specific detoxification and rehabilitation services in local communities:

> This region needs its own residential AOD treatment centre. [We have] the capacity, knowledge, skills and experience to do this. The idea of our people having to leave their families and communities to get residential treatment is a huge barrier.

In addition, long waiting lists for the limited places in some detoxification and residential rehabilitation facilities often resulted in potential clients losing their resolve to undertake treatment: 'There's no local detox, there's a two-month waiting list for the service, by then the opportunity has passed'.

Services for particular groups

Participants from both Indigenous and non-Indigenous organisations felt that programs and/or services targeting groups with specific needs were lacking. As reported in Chapter 5, there was a scarcity of AOD services targeting Indigenous Australians with comorbid mental health problems. Participants pointed to an increase in dual diagnosis among those presenting with substance use issues, but said services to deal with this 'hardly exist on the ground in communities'.

Participants also felt that there was a need for gender-specific Indigenous services and programs, and for inclusive services that cater for families, a gap also highlighted in a Western Australian study.[126] As was the case with regard to detoxification services, a number of Indigenous participants stressed that having to leave family behind presented a major barrier to seeking treatment, especially for women. The words of one Indigenous participant reflected the views of a significant number of other service providers:

> At a regional level we only have a men's Aboriginal-specific residential treatment facility. There's a need for a women's facility. There is a women's rehab ... but that's a two-day drive away. It's not Aboriginal-specific, and the women can't take their children in with them. Also, the women that we work with seem to prefer an Indigenous-specific service.

As already mentioned, several participants spoke about their desires to provide more holistic services for clients. Of these, a number of Indigenous participants expressed the wish to provide services that also catered for members of clients' families, as indicated in the following comment: 'We'd like to make the program a family program but can only take single people as we don't have the resources to take families.'

The lack of services for young people was especially emphasised, and participants felt that intervention needs to begin prior to the emergence of problematic drug use. As a participant from a remote Indigenous organisation explained (a comment mirrored in those of many other participants):

> Young people need more education around drug and alcohol issues. They need fun stuff to do that's not drug- and alcohol-related. More cultural-type activities — learning about the old ways — old people teach them about country, camping out, values.

As seen in Chapter 5, there was a significant number of projects targeting adolescents and young adults at the community level (primarily Tier 1 and 2 demand reduction projects). However, there is not equal access to such services across all regions and it cannot be assumed that there is equal access to those services within particular regions. In addition, many of these interventions occurred infrequently or only during school holidays. Furthermore, over one-third of such projects identified in Chapter 5 received only non-recurrent funding; that is, they were largely 'one-off' projects. Participants felt there was a need for services for adolescents and young adults that were regularly available;

in particular, after-school activities and safe spaces for young people to go at night:

> We need a hostel or place to go for young people. When parents get drunk, there's nowhere for young people to go and be safe, so they walk around the streets.

Participants felt that young people had very limited access to youth workers if they were not in a major regional centre and believed young people need to 'be able to talk in a safe place to counsellors that are full-time'. In addition, as identified in Chapter 5, in 2006–07 across Australia there were only four Tier 4 residential services catering specifically for young people, a shortage noted by participants.

> There are five or six young people in town with comorbid issues and one suicided last year. They have problems with marijuana. Rehabs in the region are for alcohol only and they vary in quality. There's one rehab for young people but it's very expensive. We sent one young man there for three months and it cost $30 000. While it was successful, it was very expensive. We desperately need funding for diversionary programs for the young people. We have a farmstead which is over 33 000 acres and want to run a diversionary program there including things like youth challenges, get them working on the farm, but we haven't been able to get any funding.

On a broader level, participants stressed that not enough was being done to keep young people engaged at school: '[We need a] youth and children program to boost school attendance and encourage them to go to school.'

Programs to address other issues

The need for more programs to address specific issues was also highlighted. A number of participants believed there was a need for the integration of cultural programs into substance use interventions. In addition, support programs addressing issues such as violence, grief and loss and relationship counselling were felt to be lacking. Others called for increased education on injecting drug use and blood-borne viruses and parenting classes for young parents.

The lack of ongoing care and harm reduction services

Ongoing care and outreach services

A large number of both Indigenous and non-Indigenous responses pointed to the desperate need for outreach and ongoing care services:

> There's nothing for people after they leave rehab – they go back into their homes and camps and end up in the same place. After-care programs are needed and a proper exit strategy for clients.

As indicated in Chapter 5, there were only two projects specifically funded to provide ongoing care and a small number of other organisations providing such services on an ad hoc basis. Participants from both Indigenous and non-Indigenous organisations stated that, while they wanted to provide ongoing care, limited funding and resources restricted their capacity to provide those services.

Participants also highlighted the need for after-hours care for intoxicated people and also those seeking refuge from the effects of alcohol in their communities. As a participant from an Indigenous organisation

commented, 'We need more sobering-up shelters and dry-out centres so that people don't go home and cause fights et cetera while they're drying out.' Participants also highlighted the need for: safe houses for women escaping domestic violence; shelters for intoxicated people to go during the day; and drug-free and safe spaces for young people to go to at night.

Access and availability of appropriate services

Access to services on a regional basis

Some participants felt that it was of little use to increase the number of services, if access to services was not also improved. As indicated in Chapter 5, the presence of services in a region does not necessarily equate with equal access for those in particular localities within it. Additionally, survey results have found that geographical distance and lack of transport (in both urban and non-urban regions) are two significant barriers to Indigenous Australians accessing healthcare services in Australia.[125] Many participants in this study cited a need for improved transport within their regions and to other regions to facilitate access to AOD services 'out of town'. A significant number of participants felt their hands were tied in regard to servicing outlying areas within their regions: 'The program is not large enough to service the 44 outlying communities.' As indicated in Chapter 6, compensating for the degree of remoteness has not been a significant consideration in the funding of services. The capacity to respond to demand is often restricted by the size of organisations, small numbers of staff, and lack of funds and resources, which mean that some outlying communities are not visited as often as they should be: 'the large service area doesn't allow for adequate service provision for the whole of [the region]'.

Access to harm reduction services

Access to after-hours harm reduction services such as patrols and sobering-up shelters was felt to be critical. However, as shown in Chapter 5, they are not available at all in many regions; while in others, although they are available, access is often limited due to restricted operating hours (often the result of understaffing). With regard to this, participants expressed concerns about the safety of intoxicated people on the street and attributed at least some violence and fighting in the home to lack of access to such services.

Indigenous services

While there was a blanket call for more AOD services in general, a significant number of Indigenous participants felt that increasing the number of Indigenous-specific services should be a priority. They stated that mainstream services are not always appropriate options for Indigenous Australians, and felt that Indigenous-specific services are better placed to understand and respond to client needs. Commitment to increasing the number of Indigenous-specific services, participants suggested, also presented an opportunity to empower an Indigenous workforce by providing capacity-building opportunities.

Integrated services

While collaborative relationships were felt by some participants to be a strength of their organisations, others identified the need for increased dialogue between service providers and between service providers and government: 'we need a system to enable greater networking across all services. The services are there, but they aren't linked'. It was felt that inefficient communication saw 'reinvention of the wheel' and led to a duplication of services. Both Indigenous and non-Indigenous participants expressed the view that increased

communication could contribute to the provision of more appropriate services that better respond to the needs of communities, and to the provision of continuity of care for clients:

> If government were to work in partnership with the Aboriginal community-controlled sector, we'd be in a much better position to provide an even more effective ATODs [alcohol, tobacco and other drugs] service to the Aboriginal community.

The need to address social determinants of health

A large number of participants commented on the urgent need to address underlying social and structural issues in their communities. While participants recognised the need to 'get people well' in the short term, the future health and wellbeing of Indigenous Australians constituted a central issue. As outlined above, grave concern was expressed about young people in communities. School attendance is low and 'young people have nothing to do'. Responses also emphasised the need to address the shortage of adequate housing, the lack of employment opportunities for adults and young people, the limited transport and the poor state of infrastructure. A participant from an Indigenous community-controlled organisation in a regional area summed up this cycle:

> Housing is the number one issue. People do the program and go back to the same problems with housing in the community. This causes depression and people drink to feel better. No employment opportunities in community, people have to leave to get a job.

Other issues

In addition to the key areas identified above, a small number of participants highlighted the need for improved and more appropriate funding. They felt that this would enable organisations to extend the breadth of their services to outlying areas, to provide on-site training and to offer other services such as detoxification and residential rehabilitation. Others highlighted the need for continuous staff development and training, for continuing programs, and to find ways to engage communities and families in the process of addressing harmful AOD use.

7.4 Discussion

Those interviewed provided greater description of barriers to service provision than strengths. While they were committed to producing 'local solutions for local people' and while a number reported they had 'successes', the barriers they faced frequently frustrated their ability to address AOD-related harms in a holistic manner. They believed that they were managing to address the immediate aspects of AOD use, but did not have the resources to tackle the broader range of problems clients faced and the underlying causes. The major barrier was felt to be the provision of low levels of short-term funding which restricts the services that organisations can provide. Short-term funding leads to uncertainty about the future of programs (impacting both staff and clients) and leaves many Indigenous organisations feeling that funding bodies do not understand the unique way they operate, including the need to respond flexibly to the requests of their communities. Many organisations reported that they were also under- or inadequately staffed. The majority of participants who contributed to this study stated that they struggled to meet the longer-term needs of their clients and communities under current conditions.

The extensive barriers experienced by many of the Indigenous organisations are a concern. Reliable data on patterns of general mainstream health service utilisation among Indigenous Australians are limited. However, it appears that Indigenous Australians are more likely to attend Indigenous-specific than mainstream services or to use a mixture of both, as evident among patterns of use among Victorian Kooris.[128, 129]

The potential these organisations have to provide 'local solutions for local people' needs to be enhanced. However, community control in and of itself does not ensure effectiveness if an organisation is not adequately funded, resourced and staffed. Partnerships between Indigenous and non-Indigenous service providers are imperative to ensure that the design and delivery of programs and services are professional, competent, holistic and culturally appropriate. Underpinning this is the need for services to be equitably resourced, implemented, evaluated and monitored. This will ensure that Indigenous community-controlled organisations are supported to play a lead role in implementing the *Complementary Action Plan*.[3]

Representatives from both Indigenous and non-Indigenous organisations were able to identify the service gaps in their communities, and it was clear from responses that they felt the solution was not simply a matter of increasing the number of AOD services. It is the case that more services are urgently required to cope with the number of Indigenous Australians experiencing alcohol- and other drug-related harms; existing services are over-stretched. However, participants' comments highlighted the fact that Indigenous health status is linked to other continuing social and structural inequalities and that provision of AOD intervention services alone is insufficient to remove the health and other disparities between Indigenous Australians and their non-Indigenous counterparts.

8. Summary, discussion and recommendations

There is an extensive literature on the prevention (in its broadest sense) of AOD-related harm and this has been reviewed and summarised in a number of publications. This literature shows that, like other health problems, harmful AOD use is socially determined and, to reduce that harm, policy and practice need to be broad-based and to address the full range of determinants, not just their manifestations. The literature identifies a range of preventive strategies and the evidence for their efficacy. It also highlights the need for interventions to be coordinated.

While there may be issues with the way in which they are measured, it is clear that among Indigenous Australians rates of AOD use and related harms are significantly higher than in the non-Indigenous population. To address these and the broader range of social inequalities of which they are a part — to 'close the gap', it has long been recognised that, over and above the range of health, educational and welfare services that are provided for all Australians, there is a need for the provision of additional special services for targeting Indigenous Australians. Such special services have been provided by government agencies and to a lesser extent by non-Indigenous NGOs. However, particularly in the health arena, Indigenous community-controlled organisations have been funded to provide such services to their communities.

8.1 Alcohol and other drug services for Indigenous Australians

In the 2006–07 financial year there were 340 Indigenous-specific AOD intervention projects being conducted nationally. These projects were conducted by 224 organisations. The majority of projects (248 or 73 per cent) were conducted by 159 Indigenous community-controlled organisations: AOD-specific organisations (48); community-controlled health services (46); general community service organisations (45); and Indigenous local government organisations (20).

Other providers of Indigenous-specific AOD services included: non-government organisations (44 or 20 per cent); State and Territory government agencies (16 or 7 per cent); local government organisations (four or 2 per cent); and one Australian Government agency.

Between 1999–2000 and 2006–07, there was a 5 per cent increase in the number of organisations conducting Indigenous-specific AOD projects. There was a small decline in the number of Indigenous community-controlled organisations conducting projects and a significant increase in the number of non-Indigenous organisations providing services.

Only 52 per cent of organisations conducting projects in 1999–2000 were doing so in 2006–07. The most stable of these organisations were Indigenous community-controlled AOD services and health services — with 76 per cent of the former and 60 per cent of the latter still providing services, compared to 40 per cent of non-Indigenous NGOs and 32 per cent of State and Territory agencies.

Thirty-two per cent of all projects conducted in 2006–07 were prevention projects including health promotion, education and information services, alternative activities to AOD use, and advocacy and community support services. The second-largest category of interventions was harm reduction projects (26 per cent), primarily community patrols and sobering-up shelters.

Non-residential treatment services constituted the third-largest category of projects (15 per cent), although it is important to note that many of these projects also conducted a range of other services in addition to their main role. Nine per cent of projects provided treatment in residential settings (28 projects) or residential detoxification services. In addition, eight of the nine projects we have classified as 'multi-service' also provided residential treatment and the other provided non-residential treatment among other services.

Eight per cent of projects provided a variety of services including client support services, referral services and ongoing care. Another 7 per cent of projects focused on workforce development and organisational capacity building.

As with the organisations providing services, there was a large turnover in the projects being conducted, with only 48 per cent being conducted in both 1999–2000 and 2006–07. This represents a significant discontinuity in service provision. The most stable were treatment projects, and the greatest turnover was in prevention projects. There was an overall increase of 23 per cent in the number of projects being conducted between the two periods and, despite the turnover, the most significant increase was in the number of prevention projects (an increase of 86 per cent).

Although the numbers were small, the greatest increases in Indigenous-specific AOD services in percentage terms were in the Australian Capital Territory and Tasmania, with the greatest increases in numerical terms being in Queensland and Victoria. There were some differences in the distribution of project types. There was a larger proportion of harm reduction projects (mostly community patrols and sobering-up shelters) in Western Australia, Queensland and the Northern Territory and a correspondingly lower proportion of preventive projects in Western Australia and Queensland. In contrast, there was a larger percentage of treatment-oriented projects in New South Wales, the Australian Capital Territory and Victoria.

When projects were cross-classified in terms of the intervention tiers of the British NTA's model of service provision and the demand and harm reduction components of the National Drug Strategy, and scored on the basis of service coverage, there were considerable gaps in service provision at a regional level. In these terms, the Rockhampton, Roma, Tamworth, Dubbo, Australian Capital Territory, Tasmania, Derby and Narrogin regions in particular were poorly covered. However, as indicated in Chapter 5, even where coverage is 'good' at a regional level, services are not always accessible to people living in different localities within regions.

Alcohol was the prime focus of 72 per cent of projects – 13 per cent focusing solely on alcohol and 59 per cent having a secondary focus on other drugs – with another 10 per cent of projects having a multi-drug focus. The number of projects focusing specifically on other substances was small, with only 11 (3 per cent) targeting tobacco. When compared to the 1999–2000 period, this represents a focus away from alcohol alone to focusing on it in conjunction with other substances (although there is some variation in the extent of that broader focus).

There were four broad population groups at which intervention projects were targeted: communities at large (113 or 34 per cent); intoxicated persons (80 or 23 per cent); 'dependent' persons or those with chronic problems (125 or 37 per cent); and those providing health workers with the skills to address alcohol and other drug-related problems (22 or 6 per cent).

8.2 Funding of alcohol and other drug services for Indigenous Australians

A total of $100.7 million (excluding GST) was expended on Indigenous-specific AOD intervention projects in 2006–07. This funding comprised 11 per cent capital expenditure, 74 per cent recurrent operational expenditure and 15 per cent non-recurrent operational expenditure. Of this funding, 74 per cent was expended by Indigenous community-controlled organisations, 10 per cent by non-Indigenous organisations, and almost all of the remainder by State and Territory governments and, in the case of the Petrol Sniffing Prevention Program, by the Australian Government.

Between 1999–2000 and 2006–07, in real terms (2006–07 dollars) operational expenditure increased by 110 per cent from $42.6 million to $89.4 million. Within this, non-recurrent expenditure increased from $2.1 million (5 per cent) to $14.8 million (17 per cent).

Operational expenditure by Indigenous community-controlled organisations increased by 61 per cent, between 1999–2000 and 2006–07, but as a percentage of total operational funding it decreased from 90 to 61 per cent. On the other hand, operational expenditure by non-Indigenous NGOs increased by 343 per cent, and as a percentage of total operational expenditure increased from 5 to 11 per cent.

In percentage terms the largest increase in expenditure was by government organisations (most of which was accounted for by the Australian Government's Petrol Sniffing Prevention Program). This increased by 730 per cent and rose from 5 to 20 per cent of all operational expenditure.

Forty-three per cent of all operational expenditure was on treatment projects (non-residential 10 per cent, residential 20 per cent and multi-service 13 per cent). Prevention projects accounted for 28 per cent and harm reduction projects 22 per cent of expenditure. Of the remainder, 5 per cent was spent on support, referral and ongoing care projects and 2 per cent on workforce development.

The 340 projects were funded by a total of 494 separate grants. The average number of grants per project was 1.45, but in the case of residential treatment projects the average was 2.5 and in the case of multi-service projects it was 4.1.

Seventy-six per cent of all grants were less than $200 000. The distribution of operational grant amounts was extremely skewed — ranging from a low of $2300 to a high of $8.9 million for the Petrol Sniffing Prevention Program with a median of $114 467.

Of the 340 projects, 82 or 24 per cent were reliant totally on non-recurrent funding. Of these 49 per cent were prevention projects, 23 per cent harm reduction projects and 17 per cent workforce development projects. The median amount of grants for these projects was $34 250.

Between 1999–2000 and 2006–07 there was a differential increase in operational expenditure across project types. The largest increase was in funding for prevention projects which rose by 459 per cent. These were followed by support, referral, ongoing care and workforce development projects. Expenditure on these projects rose by 354 per cent. However, this was an increase from a small baseline of $1.4 million to $6.4 million. Increases in funding for harm reduction (68 per cent), non-residential treatment (71 per cent) and residential treatment (24 per cent) projects were less than the overall increase of 110 per cent.

Operational expenditure ranged from a low of $955 000 in the Australian Capital Territory to a high of $19.7 million in Queensland. On a per capita basis it ranged from $105 per person aged ≥15 years in Tasmania to $799 in South Australia. Between 1999–2000 and 2006–07 expenditures increased in all jurisdictions. Both the percentage and per capita increases were greatest in Tasmania, coming as they did from a small baseline. In the other jurisdictions, increases in operational expenditure ranged from 53 per cent in Western Australia to 143 per cent in Queensland. The increase on a per capita basis was greatest in the Northern Territory (76 per cent) but in New South Wales and the Australian Capital Territory combined per capita expenditure decreased by 5 per cent.

On a regional basis, operational expenditure ranged from a low of $59 000 to a high of $5.8 million. Median expenditure was $1.8 million with less than $1 million being expended in a third of all regions. On a per capita basis operational expenditure ranged from a low $53 per person aged ≥15 years in Roma in Queensland to a high of $1353 in the Port Augusta region in South Australia, with a median of $282. Operational expenditure by project type by State and Territory largely reflected differences in the distribution of project types.

Ninety-seven per cent of all funding for Indigenous-specific projects was provided by the Australian and State and Territory governments. Of this, 64 per cent was provided directly by Australian Government agencies. The largest contributor among these was DoHA which contributed 47 per cent through OATSIH and 8 per cent through the Drug Strategy Branch. Overall, State and Territory government agencies contributed 33 per cent of funding. However, there was considerable variation in the size of these contributions, ranging from 3 to 76 per cent. Within the States and Territories, health and/or AOD agencies provided most funding.

Operational funding of projects by the Australian Government increased from $24.6 million in 1999–2000 to $54 million in 2006–07, an increase of 119 per cent. The contribution of State and Territory governments rose from $17.8 million in 1999–2000 to $32.8 million in 2006–07, an 84 per cent increase. In percentage terms, the largest increase in contributions (1572 per cent) was made by NGOs – an increase from $155 000 in 1999–2000 to $2.6 million in 2006–07.

8.3 The appropriateness of current services and their funding

The title of the NIDAC scoping document for this project was 'Identifying Areas of Greatest Need' and this has been a focus of this report. However, it is important to note that there have been a number of positive responses to AOD-related harms by both funding agencies and service providers.

The high levels of harmful use of alcohol and other drugs among some sections of the Indigenous population remain a major health and social problem and in some areas have actually worsened. In recognition of this, the various jurisdictional governments have significantly increased funding for Indigenous-specific AOD interventions. As indicated previously, between 1999–2000 and 2006–07 in real terms operational expenditure increased by 110 per cent in total and by 34 per cent on a per capita basis. A key element in this regard is the Australian Government's Petrol Sniffing Prevention Program, introduced in 2005, under which Opal fuel was introduced to replace 'sniffable' fuel. This program has had a significant impact in reducing the prevalence of petrol sniffing across Central Australia.[115, 116]

As indicated in Chapter 3, there have been increases in the prevalence of use of illicit drugs other than cannabis and in polydrug use. Evidence of the positive response of service providers to this problem can be seen in the increase between 1999–2000 and 2006–07 in the number of service provider organisations established primarily to target alcohol-related problems but which now also target other drugs, and in the increase in the number of projects specifically targeting illicit drugs.

There has long been concern about the high rates of imprisonment among Indigenous Australians.[54, 55] A positive means of addressing this has been the National Illicit Drug Diversion Initiative which aims to divert illicit drug users from the criminal justice system into treatment and education programs. The practical expression of this and similar State and Territory initiatives, and programs for the early release of prisoners into treatment, can be seen in the number of projects that either specifically target offenders (22) or include offenders among their wider target population.

Another positive response to need can be seen in the targeting of intervention projects in some regions with high rates of alcohol-related harms (as evidenced by alcohol-related mortality rates). Among these responses are the greater numbers of community patrols and sobering-up shelters in the Northern Territory and the north of Queensland and Western Australia.

One of the most positive changes in the provision of services has been the significant increase in the number of prevention projects. In 1999–2000 such projects comprised 21 per cent of the total but in 2006–07 this had increased to 32 per cent. Even more positive was the increase in the percentage of funds expended on these projects – from 11 to 28 per cent and an overall increase of 459 per cent.

Since the period covered by this report, there have been increases in funding for Indigenous-specific AOD interventions by the Australian and State and Territory governments. We do not have details of this funding and its breakdown for all jurisdictions but Table 32 provides an indication of increases by DoHA. It is important to note that this provides an indication only as the data provided by the DoHA for 2007–08 and 2008–09 were not ascertained and verified in the same way as the data presented in this report for 2006–07 and, unlike the data presented in the table for 2006–07, may include capital allocations. Nevertheless, bearing these caveats in mind, increases by DoHA have been significant. Operational expenditure for 2006–07 was approximately $45.6 million (Tables 31 and 32). In 2007–08 this increased by $14.5 million to $60.1 million, and in 2008–09 by a further $4.5 million to $64.6 million (Table 32) – increases of 32 and 42 per cent respectively over 2006–07 levels.

Most of the increase in funding allocations over the two-year period 2007–09 was made by OATSIH under COAG 'Drug and Alcohol' and 'Indigenous Drug and Alcohol' measures. Of this increase, $2.7 million was allocated specifically to the Northern Territory, as was another $7.8 million as part of the Northern Territory 'Emergency Response'. New funding by the Drug Strategy Branch included $2.5 million under the 'Improved Services for People with Drug and Alcohol and Mental Health Problems' program and $1.5 million under the 'Indigenous Tobacco Control Initiative'. The Branch also increased expenditure under existing programs including: $2.7 million under the 'Capacity Building in Indigenous Communities Initiative' and an additional $1.7 million under the 'Non-Government Treatment Grants Program'. As can be seen, these increases target some of the gaps in service provision identified in this report.

Table 32: Australian Government Department of Health and Ageing, Indigenous AOD-specific, verified operational expenditure 2006–07 and funding allocations 2007–08 and 2008–09

	2006–07	2007–08	2008–09
Area	$000	$000	$000
OATSIH	39 040	51 435	50 044
Drug Strategy Branch	6535	9427	14 576
Totals	45 575	60 862	64 620

Source: Australian Government Department of Health and Ageing

To what extent did the services provided reflect need?

A key consideration in the rational planning of health service provision is the magnitude of particular health problems. As highlighted in Chapter 3, there is little information available either on consumption of alcohol and other drugs at the regional level or on related harms. Nevertheless, in the case of petrol sniffing, although prevalence data are not good, it has long been obvious that its occurrence is concentrated in a number of regions in central and northern Australia. In a positive response to this, the Australian Government introduced its Petrol Sniffing Prevention Program which replaced the old Comgas Scheme and substituted non-sniffable Opal fuel for regular petrol.

One indicator of harm which can be broadly extrapolated to the ABS Indigenous regions is data on alcohol mortality rates derived for the old ATSIC zones (comprised of groupings of ATSIC regions). As outlined above, there has been an increase in the number of harm reduction projects being conducted in some areas where rates of alcohol-related harms are especially high. However, statistical analyses of the relationship (at the regional level) between this indicator and the numbers of projects and funding for them demonstrated no significant correlation between them — indicating that, overall, this was not an important factor in determining what services were provided and that some regions were under-served in relation to this particular indicator of need.

As discussed in Chapter 3, any decline in the prevalence of tobacco smoking among Indigenous Australians has been small and it is still likely that in excess of 45 per cent of Indigenous adults are recent smokers. Furthermore, the gap between smoking prevalence in Indigenous and non-Indigenous communities is widening. This continues to have a significant impact on both morbidity and mortality. While considerable activity is being undertaken within primary health care settings to address this on an individual level, and while smoking cessation is part of a number of general health promotion activities, in 2006–07 only 11 of the 340 AOD intervention projects were targeted specifically at tobacco. As noted above, a small step in increasing interventions in this area has been taken by DoHA's Drug Strategy Branch which committed $1.5 million for an Indigenous Tobacco Initiative in the 2008–09 financial

year. However, given the magnitude of the problem and the small number of initiatives specifically to address it, there is clearly a need for more investment in this area.

Ideally, another key consideration in health service planning should be the size of the populations for which services are provided – especially when data on rates of particular health problems are not available and the limited data point to generally high rates of prevalence across-the-board. However, there was no significant correlation between the size of regional populations and numbers of projects or funding for them. This indicates that there were large Indigenous populations in some regions that were under-serviced in terms of the provision of particular services and the coverage of Indigenous-specific AOD intervention projects.

The lack of services targeting particular groups of people is a concern. Women, families, young people and those suffering from mental illness are particularly under-serviced. While there are a number of Tier 1 and 2 services for young people, women and families, the paucity of Tier 3 and 4 community-based and residential treatment projects for these groups was a significant gap in service provision. People with co-occurring mental illness were notably absent among targeted populations in all tiers of service provision. As shown in Chapter 3, Indigenous Australians are hospitalised at far greater rates than non-Indigenous people both for mental health problems associated with alcohol and other drug use and for mental health problems due to other causes. However, responses to, and treatment for, these problems largely remain the domain of separate, non-integrated mental health services – services which providers reported as often being not readily accessible.

As well as those with comorbid mental health problems, other client groups with complex needs are illicit and/or polydrug users and offenders who are either diverted into treatment or who are released early into treatment programs. As indicated above, the expansion of existing treatment services to include such clients in their target groups is a positive response to the changing nature of AOD-related problems in the community. However, as with clients with comorbid mental health problems, many services are not adequately resourced to meet their needs.[90] Recognition should be given to this changing mix of clients and its consequences when service providers and funding agencies are negotiating funding agreements. These clients require additional levels of care and the degree of funding provided to organisations that target these individuals should take into account the extra human and financial resourcing needed to provide such care. To facilitate this, there is a need for benchmarking of service provision requirements to help ensure that services are appropriately resourced.

As the data in Chapters 5 and 6 show, only 52 per cent of organisations conducting projects in 1999–2000 were doing so in 2006–07, and only 48 per cent of projects being conducted in 1999–2000 were being conducted in 2006–07. This represents a significant discontinuity in the provision of AOD services for Indigenous Australians, and undermines the attempts of Indigenous community-controlled organisations to provide employment and build the capacity to address AOD problems. A key reason for this discontinuity is the budgetary allocation by governments to short-term funding programs and the consequent provision of non-recurrent funding to service providers. As the data in Chapter 6 show,

the percentage of non-recurrent funding increased from 5 per cent in 1999–2000 to 15 per cent in 2006–07 and in the latter year 24 per cent of all intervention projects were totally reliant on non-recurrent funding.

The general absence of good quality data on the prevalence of AOD use and related harms at the regional level, the lack of correlation between the limited prevalence data that are available and population levels with the provision and funding of services, as well as the gaps in the provision of services for significant population sub-groups, all attest to the limited planning of services at the regional level. They also attest to the fact that there remains a considerable way to go in achieving Key Result Area 6 of the CAP which calls for:

> Substantial partnerships between Aboriginal and Torres Strait Islander communities, government and non-government agencies in developing and managing research, monitoring, evaluation and dissemination of information.[3]

This information is crucial to improved planning of AOD service provision.

Was there 'a range of holistic approaches from prevention through to treatment and continuing care that is locally available and accessible'?[3]

As discussed in Chapter 4, a comprehensive integrated range of services is required to effectively address AOD-related harms. As seen in Chapter 5, to assess this we calculated summary scores to measure the coverage, or range of services, in each region. When these were ranked, it was clear that there were considerable discrepancies by region in the range of services available; one group of eight regions, on the face of the available evidence, were most clearly under-serviced in terms of the range of services needed to provide comprehensive care. As with the provision of individual projects, there was no correlation between the range of services provided and either levels of alcohol-caused mortality or population size. Furthermore, there was no observable pattern in terms of gaps in service coverage across regions. That is, where there were gaps, there was not one particular type of service, or types of services, that were not provided.

The literature indicates that, given their personal and environmental circumstances, residential treatment is a desirable option for many Indigenous Australians with AOD-related problems. However, such services were unavailable in about one-third of regions. In some of those regions, the size of the Indigenous population is too small to justify the provision of a residential service and the cost of providing such services in all regions in which they are needed is prohibitive in the short term. However, there are clearly some groups of regions — such as those in the south of Western Australia — which are noticeably under-served and there is a case for establishing such services to serve clusters of adjacent regions.

One of the most obvious gaps in provision of a comprehensive range of services was in the limited number of ongoing care projects. The literature demonstrates the importance of ongoing care in reducing rates of relapse and/or reversion to harmful patterns of AOD use. Several treatment projects provided ongoing care as part of their services. However, they were not funded specifically to provide such care and often found it difficult to do so. In fact, there were only three projects specifically funded to provide ongoing care. Failure to provide and adequately resource ongoing care is both a failure to clients and a failure to protect the investment made in the

provision of treatment services. For some clients, residentially based ongoing care might be the preferred option. However, given the need, it is our view that a greater number of clients can be supported if priority is given to providing community-based care.

Another gap in the provision of particular types of services was the shortage of detoxification services catering specifically to the needs of Indigenous Australians. There were only six projects nationally that provided such services and this shortage was highlighted by some service providers. Among the non-Indigenous population, the provision of home detoxification services is often advocated on the ground of cost-effectiveness and it has been successfully undertaken in some Indigenous primary health care settings. However, for many dependent Indigenous Australians, home settings in which AOD use might be rife are not conducive to effective outcomes and provision of residential services may be preferable.

As the data in Chapter 5 show, most harm reduction, or acute, services such as night patrols and sobering-up shelters were provided in regions in the Northern Territory and in the north of Queensland and Western Australia. However, several service providers in other regions identified the absence of such services as a significant gap in the range of services within their particular regions.

It is important to note that the provision of a broad range of services at the regional level does not necessarily provide equal access to services for all people within a region. While in some regions populations are clustered in regional centres, in others the populations are dispersed and, especially in geographically large regions, people in outlying areas are not able to access services. Providers explained that they struggled to service large areas and in some cases were able to visit outlying regions only once a fortnight or monthly. This points to the need to plan for the provision of improved access to services for dispersed local populations in some regions.

Provision of effective services to reduce AOD-related harms requires more than simply the provision of the services themselves. It also requires that those services be integrated and that they provide coordinated care for individuals, families and communities. We do not have quantitative data on this aspect of service provision. However, the qualitative data we collected, and other work, suggest that in some regions service provision is poorly coordinated.

Coordination of services best occurs when they are provided within one organisation.[109] At the inter-agency level, coordination is more likely to occur, the more closely related are the particular services provided. There was considerable variation in reports of the extent of service coordination, but it was less likely to occur when staff were fully occupied with day-to-day activities. In this regard, it is important to note that coordination and service integration will not occur when organisations are understaffed, when staff have otherwise full workloads, or simply as a result of agreements to cooperate.[90] Coordination and case management need to be resourced in terms of both infrastructure (records and communications) and staffing, and in some regions or localities a good case can be made for the establishment of case-coordinator positions within lead Indigenous organisations.

To what extent did the provision of services enhance the 'capacity of Aboriginal and Torres Strait Islander individuals, families and communities to address current and future issues in the use of alcohol, tobacco and other drugs and promote their own health and wellbeing'?[3]

In order to reduce the health and social disparities between Indigenous and non-Indigenous Australians, there is a need for Indigenous-specific services over and above those provided by mainstream agencies. Furthermore, the literature provides evidence that, other factors being equal, provision of health care services by Indigenous community-controlled organisations results in improved outcomes. In the AOD area, however, there is evidence that there has been movement away from commitment by governments to resourcing such services and hence a limiting of the capacity of Indigenous Australians to address harmful use. Evidence for this was provided in Chapters 5 and 6 in terms of reductions in the number of Indigenous organisations providing services, the percentage of projects conducted by Indigenous organisations, and the percentage of operational funding expended by Indigenous community-controlled organisations.

Indigenous community control over service provision is clearly important. However, it is not sufficient to provide improved health outcomes. Community-controlled organisations need the capacity both to effectively provide the services for which they were established and to meet changing needs and increasing demand. Representatives of several organisations complained that they had been funded at levels that kept pace only with increases in the Consumer Price Index. As a result, their services had remained static and were thus unable to address longstanding gaps in service provision, and were unable to meet increased demand for services due to population growth and changing patterns of AOD use.

A related concern was that often funding allocations did not provide organisations with the capacity to work outside of 'normal' working hours when many clients needed services at other times. Similarly, staff from some of the community patrols and sobering-up shelters reported that they were funded to operate only on the busiest days of the week, but that people are at risk on other days. In both cases, staff felt that they had the skills and commitment to provide needed services but were constrained in their capacity to do so.

The capacity of organisations to deliver services is also constrained by the availability of suitably qualified staff members and by the arrangements under which governments call for tenders to provide services to Indigenous Australians. These issues are discussed in the sections of this chapter below.

It is important to recognise that building the capacity of Indigenous organisations has wider ramifications than the provision of AOD services per se. It must also provide employment opportunities, broader social and economic development, and the capacity of community-controlled organisations to address a wider range of social issues.

The widening gap in the prevalence of AOD use between Indigenous and non-Indigenous Australians, constraints on the provision of services by Indigenous community-controlled organisations and the reports of service providers themselves indicate that attempts to build the capacity of Indigenous Australians to address AOD-related harms have been constrained and that further effort is needed to achieve this goal of the CAP.[3]

To what extent did 'workforce initiatives ... enhance the capacity of Aboriginal and Torres Strait Islander community-controlled and mainstream organisations to provide quality services'?[3]

A key element in building the capacity of both Indigenous community-controlled organisations and non-Indigenous service providers to provide effective services is workforce development. A recurrent theme in the evaluation literature has been the need for more investment in this area, and staff members from many of the organisations who participated in this study identified inadequate staff training as a barrier to effective service provision. In 1999-2000 there were only seven workforce development projects (3 per cent of the total). This had increased to 23 (7 per cent) in 2006-07. However, expenditure on these remained only 2 per cent of the total. Provision of workforce development projects on this small scale is barely likely to keep pace with staff turnover and is inadequate to meet the broader needs of the sector. Thus, there is a need to both expand the range of workforce development opportunities and to provide improved access to those opportunities. However, such measures alone are unlikely to meet the overall demand for trained staff. For this reason, as part of broader health workforce and educational programs, there is a need to actively recruit students into the range of occupational categories needed to provide AOD services, including counselling, psychology, AOD nursing and addiction medicine.

Workforce development is not the only workforce initiative that needs to be addressed if capacity to provide AOD services for Indigenous Australians is to be enhanced. While we did not collect quantitative data, interviews with service providers highlighted a number of broader staffing issues that impose barriers to more effective service provision in the community-controlled sector. These include heavy workloads, poor remuneration vis-à-vis the government sector, lack of career paths and consequent high staff turnover rates.

To address these issues, there is a need for development of staffing benchmarks — including remuneration levels for Indigenous AOD workers — and agreement among funding agencies to provide funds to enable service providers to comply with those benchmarks. Development of such benchmarks should be undertaken at a broad level, not simply on an agency-by-agency basis. As the major funder of Indigenous-specific AOD services, this is an area in which OATSIH is well placed to take a lead.

Are there any administrative and funding issues which affect the efficient delivery of effective AOD services to Indigenous Australians?

The heterogeneity of Indigenous communities has often been remarked upon, the limited epidemiological data suggest that there is significant regional variation in the prevalence of AOD use and related harms, and Indigenous Australians in situations of poverty and marginalisation often face competing priorities for action. These issues require that funding for intervention projects be flexible enough to accommodate these differences. However, many service providers commented that often the criteria attached to government funding programs were inflexible, particularly with short-term programs. This meant that organisations were faced with the choice of either not applying for funds

(a difficult option, given the scarcity of resources in many communities) or to apply for funds that had to be expended in ways that did not match local needs or community priorities. This issue has been raised elsewhere and various solutions to the problem proposed — including the pooling of government funding and providing more flexible core funding to service providers.[90, 130, 131] At the least, funding program guidelines and contractual arrangements need to be sufficiently broad to allow service providers to meet community needs within their particular regions.

A related issue of considerable concern to Indigenous service providers was the tendering by governments of the provision of services for Indigenous Australians to non-Indigenous NGOs. There are two elements to this: the provision of appropriate services; and the capacity, or lack of capacity, among many Indigenous community-controlled organisations. Many organisations, particularly small ones, do not have the capacity — in terms of personnel or time — to respond, or respond adequately, to calls for tenders to provide services. As a result, either they do not submit tenders or they submit tenders that are not competitive with those submitted by large non-Indigenous NGOs. Second, while they might have the capacity to prepare tenders, other community-controlled organisations do not have the capacity — in terms of trained personnel or infrastructure — to provide the services for which tenders have been called.

There are several solutions to this problem. However, beyond funding Indigenous community-controlled organisations to simply provide sets of defined services, they require clear commitments from governments to enhance the capacity of Indigenous community-controlled organisations to provide effective AOD services.

Given what is known about the magnitude of AOD-related problems in the Indigenous population, there is clearly a need for the services for which non-Indigenous NGOs are tendering — a need that often cannot be met by Indigenous community-controlled organisations. A solution to this problem is to require non-Indigenous NGOs (as some are doing voluntarily to an extent) to have Indigenous partner organisations and/or establish services that can be handed over to Indigenous organisations at the end of the tender period. This would require commitments by governments to fund capacity-building components over and above the cost of service provision and provide continuing funding for service provision.

A second strategy for building Indigenous AOD service provision capacity is the provision of specific capacity-building funding over and above the cost of providing the particular services for which tenders are called. In this regard, we again note that DoHA's Drug Strategy Branch has a small funding component for this and committed amounts of approximately $1 million, $2.5 million and $2.3 million in the 2006–07, 2007–08 and 2008–09 financial years. We do not have any data on the allocation of this funding, and while it is to be welcomed, this funding amounts to only about $71 000 per region or $10 000 per organisation per annum.

Related to both the inflexibility of some funding programs and government tendering processes is the issue of non-recurrent funding. In 1999-2000, non-recurrent funding

comprised 5 per cent of operational expenditure; in 2006-07 this had risen to 17 per cent. Provision of non-recurrent funding is a double-edged sword. On the one hand, the allocation of such funding gives opportunities to provide services that would not otherwise be provided. However, for many organisations this advantage is outweighed by several disadvantages. The first of these is lack of continuity in service provision, reflected in the large proportions of organisations and projects providing services in 1999-2000 that were no longer doing so in 2006-07 and vice versa. Projects established and funded because they are recognised as having some merit are simply discontinued and communities left without the services provided.

Non-recurrent funding also makes longer-term service provision planning difficult and creates uncertainties for service providers and the communities they serve. Particularly in more remote regions, where it is difficult to recruit and retain staff anyway, this difficulty is exacerbated when employment contracts are offered for short periods of time with little security of continuing employment. As well, it often takes time for organisations to gain the trust and respect of target populations and a lack of continuity of services does little to encourage confidence among community members, with the result that the services provided are less than optimally effective.

The outcomes of intervention projects are also compromised by short-term non-recurrent funding. The difficulty of recruiting and retaining appropriately qualified staff further compromises the outcomes of short-term intervention projects. This is exacerbated when projects are targeted at high-risk, marginalised clients with whom considerable periods of time must be spent in building rapport and trust before they are willing to engage effectively with project staff and activities.

As evidenced in Chapters 5 and 6, in 2006–07 over half the 224 organisations providing AOD services conducted more than one project and each project was funded by an average of 1.5 grants, with residential and multi-service projects being funded by an average of 2.4 and 4.1 grants respectively. Furthermore, of the 159 Indigenous community-controlled organisations, 70 per cent were primarily providers of other services (such as primary health care, general community services and local government services) and as such were funded from a larger number of grants, all of which have their own reporting requirements.

The onerous requirements of producing quarterly and sometimes monthly reports on these grants, as well as additional reporting requirements (such as for the DASR), were raised as a significant issue by many of those interviewed for this project. They have been commented upon for many years by service providers and, with regard to primary health care services, have been the subject of a recent report entitled *The Overburden Report: Contracting for Indigenous Health Services.*[131] In a model that can be applied to the provision of AOD services, among other things, this latter report suggested that government funding agencies should contract for services over longer time periods, provide core funding that allows flexibility of priority

setting, and introduce simplification of data collection and monitoring. In a similar vein, a report prepared for QAIHC recommended a trial of pooling funding for the provision of primary health care services in two areas of northern Queensland.[130] If the recommendations of these reports were taken up, not only would the burden of reporting be reduced, but services could be provided more efficiently and the issue of disjunction between government and community priorities would be addressed.

In this report, we have documented: the increasing gaps between Indigenous and non-Indigenous Australians in the prevalence of AOD use and related harms; gaps in provision of particular types of services in some regions; absence of a comprehensive range of services in some regions; under-provision of services for particular population subgroups; limited capacity to adequately address both existing and emerging demands; and a limited range of workforce development initiatives. All of these factors point to the fact that, in 2006–07, the overall level of funding for Indigenous AOD interventions was inadequate. However, estimating the magnitude of that shortfall was beyond the scope of this project.

As noted above, in subsequent years, there have been funding increases by the Australian and State and Territory governments, both unilaterally and as part of COAG agreements. The extent to which these increases have filled the shortfall is a matter for further empirical investigation. However, in our view, it is unlikely to have done so.

8.4 Unmet needs in the provision of Indigenous alcohol and other drug interventions

The evidence reviewed in Chapter 3 indicates that, since the mid-1990s, there has been an increase in the prevalence of recent alcohol use among Indigenous Australians; there has been only a slight reduction in the prevalence of tobacco smoking and the gap in prevalence between Indigenous and non-Indigenous Australians has increased; the gap in the prevalence of recent cannabis use between Indigenous and non-Indigenous Australians has widened; the prevalence of recent use of illicit drugs other that cannabis has increased among Indigenous Australians and the gap in prevalence between them and non-Indigenous Australians has increased; and there is evidence to suggest that injecting drug use has increased among Indigenous Australians.

Reductions in AOD use among the non-Indigenous population have been achieved. This together with the data on current levels of use among Indigenous Australians demonstrates that attempts to address these problems have been limited in their effectiveness, and indicate that more needs to be done. In general terms, we know what interventions work. The key is to deliver those interventions in a manner that is acceptable to, and appropriate for, Indigenous Australians.

The levels of harmful AOD use among Indigenous Australians are structurally determined and, while they can contribute to reductions in harm, AOD-specific interventions are limited in what they can achieve. Thus, to achieve further reductions in AOD-related harm among Indigenous Australians we need a two-pronged strategy.

First, there is a need to make a concerted effort to address the structural determinants of harmful AOD use. This is a point that has been made in the literature and was made by the service providers interviewed for this project. Among their priorities were the creation of culturally sensitive and supportive environments to keep children and adolescents at school, sustainable employment opportunities for people in their local communities and the provision of infrastructure such as transportation systems. However, apart from a broad recommendation to make further efforts to address the structural factors underlying harmful AOD use, it is beyond the scope of this project to make specific recommendations in this regard. We are aware of the commitment made by the present Australian Government to 'reduce the gap' in Indigenous life expectancy and other inequalities and the commitment of funds to that end (including funds to address AOD-related harm). Whether these measures are sufficient and effective is a matter for future research and we have open minds on the issue. However, our optimism is tempered by the observation that in the past no Australian Government has committed the resources sufficient to eliminate Indigenous inequalities; and that, despite numerous intervention programs over the past three decades, gains in this regard have been limited.[82, 132, 133]

The second prong to any strategy to reduce harmful AOD use should be a greater effort to implement the intervention framework provided by the *Complementary Action Plan*.[3] Development of the CAP was led by a team of Indigenous Australians with many years of experience in the health and AOD fields, and was based on a comprehensive review of the literature and extensive consultations with key stakeholders. It was introduced in 2003 for a period of three years, was subsequently extended to 2009 and, at the time of writing this report, it was being evaluated. It is our view that the CAP provides a sound basis for addressing AOD-related harms among Indigenous Australians. If it has not delivered optimal outcomes in some areas (as evidenced by some of the data presented in this report), we believe this is a function of the way in which it has been implemented. We therefore recommend that, as the peak policy and decision-making body in relation to licit and illicit drugs in Australia, the Ministerial Council on Drug Strategy make a renewed commitment to the CAP.

Within the framework of the CAP, we provide below a comprehensive list of recommendations. In doing so, we recognise that not all recommendations apply in all regions and that their implementation needs to considered in the context of effective regional planning. Key Result Area 4 of the CAP calls for 'A range of holistic approaches from prevention through to treatment and on-going care that is locally available and accessible'. Planning for these cannot effectively take place at the State level and we recommend that regional AOD planning committees, made up of a broad range of stakeholders and including all community-controlled AOD and health services, be established. The role of these committees should be to facilitate provision of a 'range of holistic services from prevention through to treatment and continuing care' and contribute to evaluation and continuous improvement of services — as recommended in Key Result Areas 2 and 4 of the CAP.

8.5 Recommendations

1. Given the evidence that there have been no significant reductions in the prevalence of harmful alcohol and other drug use among Indigenous Australians over the past decade, all levels of government should enhance their efforts to develop more effective policies and strategies to address the structural inequalities that underlie such prevalence, as well as the specific needs for service provision identified below.

2. The framework provided by the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan* provides a comprehensive basis for reducing harmful levels of alcohol and other drug use and has widespread support within the sector. As the peak policy and decision-making body in relation to licit and illicit drugs in Australia, the Ministerial Council on Drug Strategy should make a renewed commitment to the action plan.

Targeting gaps in service provision

3. Given the disproportionate negative impact of tobacco smoking on the health of Indigenous Australians, far greater emphasis should be put on the provision of appropriate interventions to reduce its prevalence.

4. Given the paucity of community and residentially based treatment services for women, families, young people and those suffering from comorbid mental illness, there should be a significant increase in the provision of such services.

5. To address the significant gap in the provision of ongoing care services, to minimise relapse among those who have undergone treatment, and to protect the investment made in treatment services, priority should be given to the provision of community-based ongoing care services for those who have completed treatment.

6. Where a need is identified by Indigenous communities, and where justified by numbers of potential clients, there should be an expansion of detoxification services catering to the needs of Indigenous Australians.

7. There are several regions identified in Chapter 5 of this report which appear to be under-serviced. These regions should be targeted with regard to the provision of a wider range of Indigenous-specific alcohol and other drug services.

Capacity building

8. In the interest of providing more appropriate services, better client outcomes, and building capacity, all levels of government should re-commit themselves to the principle of Indigenous community control of service provision.

9. To develop the capacity of Indigenous communities to address alcohol- and other drug-related harms, it should be a requirement of tendering conditions that non-Indigenous NGOs tendering for the provision of services to Indigenous Australians make all endeavours to tender in partnership with Indigenous community-controlled organisations and put in place strategies and timeframes for handover of services to those organisations.

10. Given the gaps in the capacity of some providers either to effectively deliver existing services or to meet other community needs, consideration of current capacity and any need to enhance it should be part of service contract negotiations, and funding should be provided accordingly.

Workforce issues

11. Given the shortages of skilled alcohol and other drug staff (and the constraints on service provision and expansion of capacity that such shortages impose) and the low levels of investment in staff development and training, funding and other resourcing for skilled staff should be substantially increased.

12. Given the high turnover of staff within the community-controlled alcohol and other drugs sector (as a consequence of heavy workloads, poor remuneration vis-à-vis the government sector, and lack of career paths), staffing benchmarks — including remuneration and conditions of employment — should be negotiated between funding agencies and service provider representatives and should be implemented.

13. Given that the demand for qualified Indigenous staff members cannot be adequately met within the alcohol and other drugs sector, the Australian Government Department of Health and Ageing (as the most important of the funding agencies) should enter into discussion with the Department of Education, Employment and Workplace Relations to explore ways of facilitating increased direct entry of Indigenous Australians into vocational and tertiary education programs of relevance within the sector.

Funding

14. Given the evidence of significant gaps in the provision of alcohol and other drug services for Indigenous Australians, detailed costing of the services necessary to address those gaps should be developed in collaboration by the various funding agencies and service providers, and funding allocations should be increased accordingly.

15. Given the variation in need between regions and in community priorities, funding program guidelines and contractual arrangements for the provision of alcohol and other drug services to Indigenous Australians should be sufficiently broad to allow service providers to meet community needs within their particular regions.

16. Given the uncertainty of service delivery, the compromising of outcomes and the additional reporting requirements entailed in dependence upon non-recurrent funding, strategies should be put in place by governments to increase the proportion of funding allocated on a non-recurrent basis for the provision of alcohol and other drug services.

17. Benchmarks should be negotiated between funding agencies and service providers for the provision of treatment services — including provision for clients with special needs such as those with comorbid mental health problems, polydrug users, and offenders — and services should be funded with regard to client needs and client mix.

18. Coordination of care within and between government and non-government sectors should be part of treatment service benchmarking, and its provision should be appropriately funded.

19. Given the administrative burden of reporting requirements, steps should be taken by funding agencies to reduce such requirements – including the rationalisation of grant provision and the simplification and standardisation of reporting requirements – while at the same time upgrading the capacity of Indigenous organisations to meet them.

Planning

20. Given the evidence of limited planning of service provision, regional alcohol and other drug planning committees, made up of a broad range of stakeholders and including all community-controlled AOD and health services, should be established to facilitate provision of a 'range of holistic services from prevention through to treatment and continuing care', and to contribute to their evaluation and continuous improvement.

21. Agencies charged with collecting data on the prevalence of alcohol and other drug use and related harms should work together to provide such data at a regional level, and in a timely manner, to ensure that services are planned jointly by key stakeholders and funded in response to need.

22. Service provision at the regional level should be reviewed to ensure that a complete range of community-based services – and, where feasible, residential services – is available.

23. Where provision of services is not feasible at the local level, regional service providers should be resourced to provide reasonable region-wide access to their services.

9. Appendices

9.1 Abbreviations

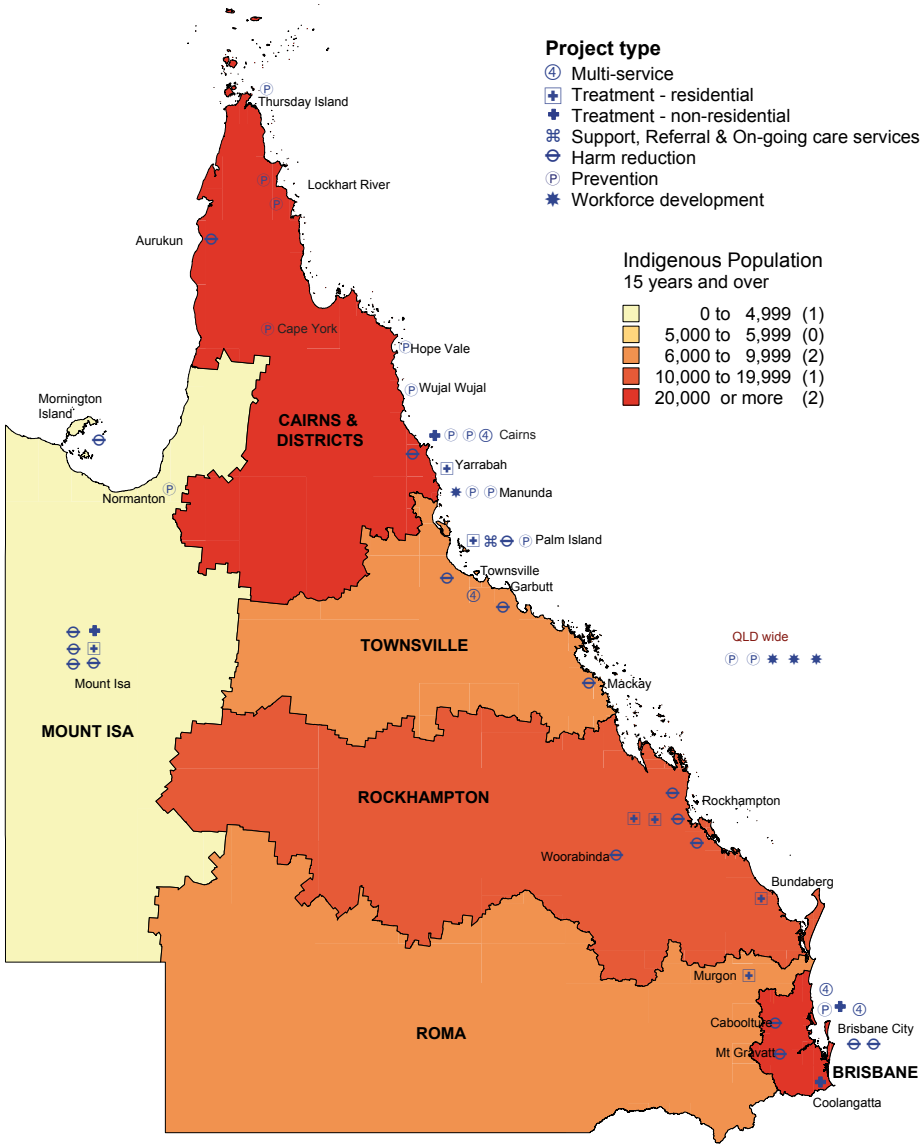
ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
ANCD	Australian National Council on drugs
AOD	Alcohol and other drugs
ARIA	Accessibility/Remoteness Index of Australia
ATSIC	Aboriginal and Torres Strait Islander Commission
CAP	*National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan*
CCHS	Community-controlled health service
COAG	Council of Australian Governments
DASR	*Drug and Alcohol Services Reporting*
DEST	Department of Education, Science and Training
DoHA	(Australian Government) Department of Health and Ageing
FACSIA	Department of Families, Community Services and Indigenous Affairs
GST	Goods and services tax
IGCD	Intergovernmental Committee on Drugs

IRIS	Indigenous Risk Impact Screen
MCDS	Ministerial Council on Drug Strategy
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NDRI	National Drug Research Institute
NDS	National Drug Strategy
NDSHS	National Drug Strategy Household Survey
NGO	Non-government organisation
NHMRC	National Health and Medical Research Council
NIDAC	National Indigenous Drug and Alcohol Committee
NSMHW	National Survey of Mental Health and Wellbeing
NTA	(United Kingdom) National Treatment Agency for Substance Misuse
OATSIH	Office of Aboriginal and Torres Strait Islander Health
QAIHC	Queensland Aboriginal and Islander Health Council
QISMC	Queensland Indigenous Substance Misuse Council
SLA	Statistical local area
WHO	World Health Organization

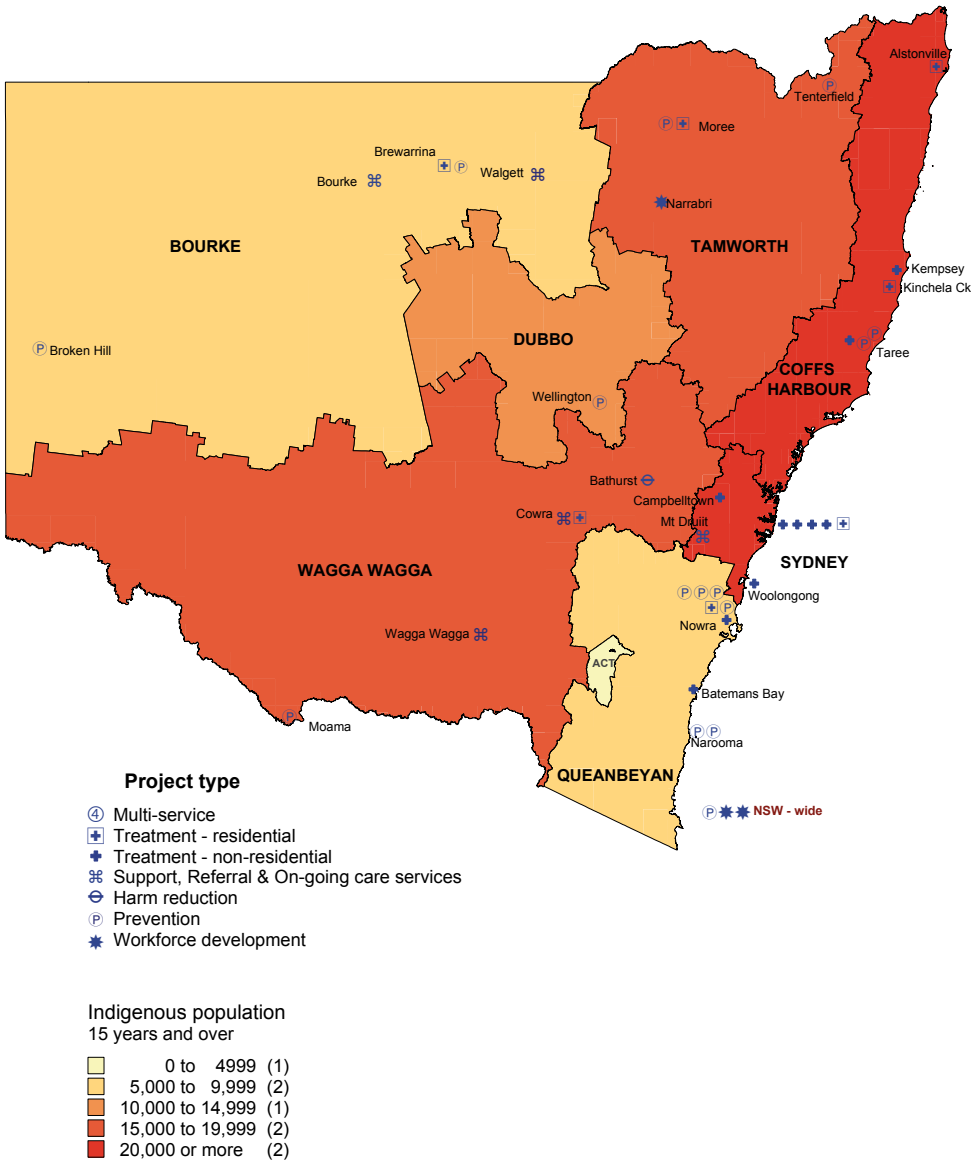
9.2 Glossary

Funding body	A government or non-government agency which funds the provision of alcohol and other drug services. (In some instances funding bodies may also be service providers – as when a government agency itself provides services and funds third parties to do so.)
Funding program	A discrete pool of funding allocated by a government or non-government agency for the provision of alcohol and other drug (or other) services from which specific intervention projects are funded.
Indigenous-specific	Projects or services provided specifically for Indigenous Australians over and above those provided by mainstream organisations for the population as a whole.
Intervention project	A discrete set of activities aimed at addressing a particular need, or needs, with a community or communities. (In practice funding bodies and/or service providers may refer to these as 'programs'. However, we use the more specific term 'project' to more clearly distinguish them from larger-scale funding programs.)
Multi-service project	Provide more than one main service. Funding for those services cannot be disaggregated – even though it might come from more than one funding source (e.g. OATSIH and Aboriginal Hostels).
Non-recurrent funding	Funds provided on a 'one-off' basis for a period of 12 months or less.
Project	A discrete set of *services* (including the organisational framework for delivering those services) directly aimed at reducing the harms associated with alcohol and other drug (AOD) use.
Service	A specific intervention – for example, a brief intervention or the administration of a pharmacotherapy.
Service provider	An agency or organisation that conducts intervention projects or provides alcohol and other drug services.

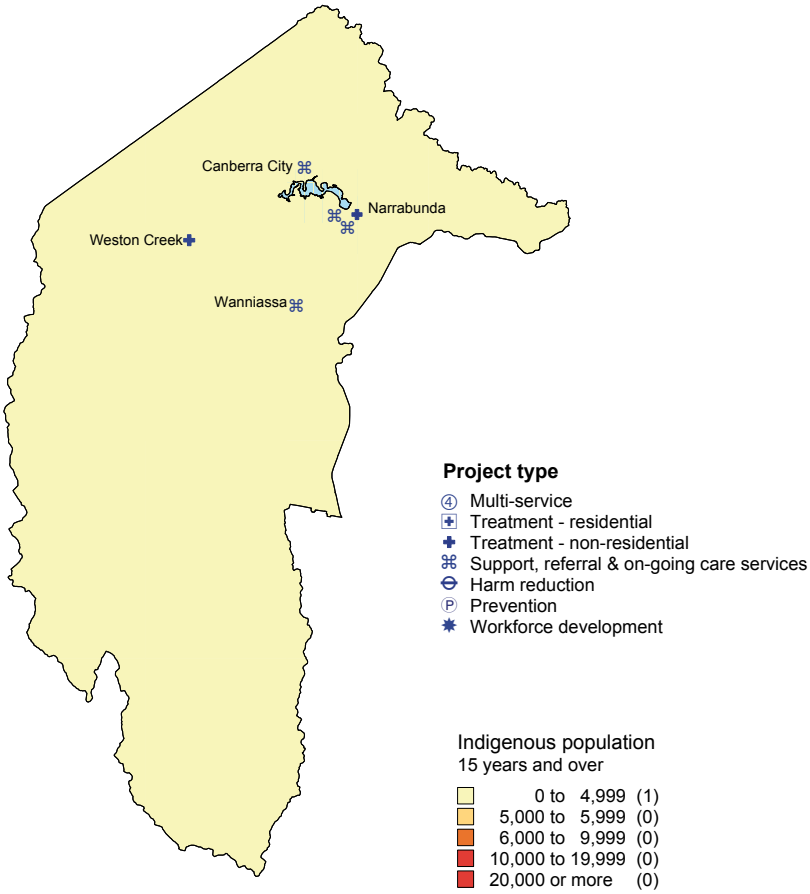
9.3 Supplementary maps



Map 6: Indigenous-specific alcohol and other drug intervention projects by ABS Indigenous region, Queensland, 2006–07

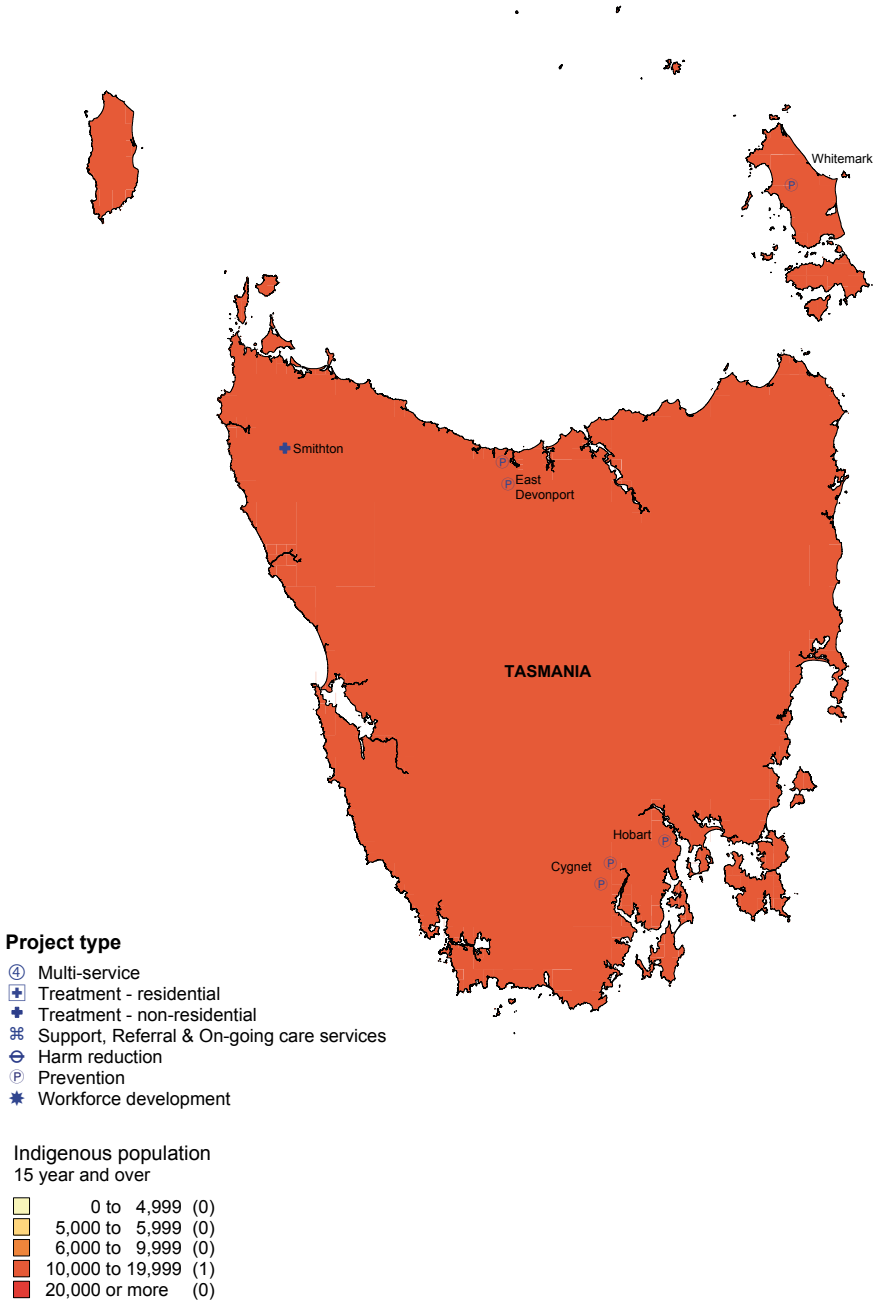


Map 7: Indigenous-specific alcohol and other drug intervention projects by ABS Indigenous region, New South Wales, 2006–07

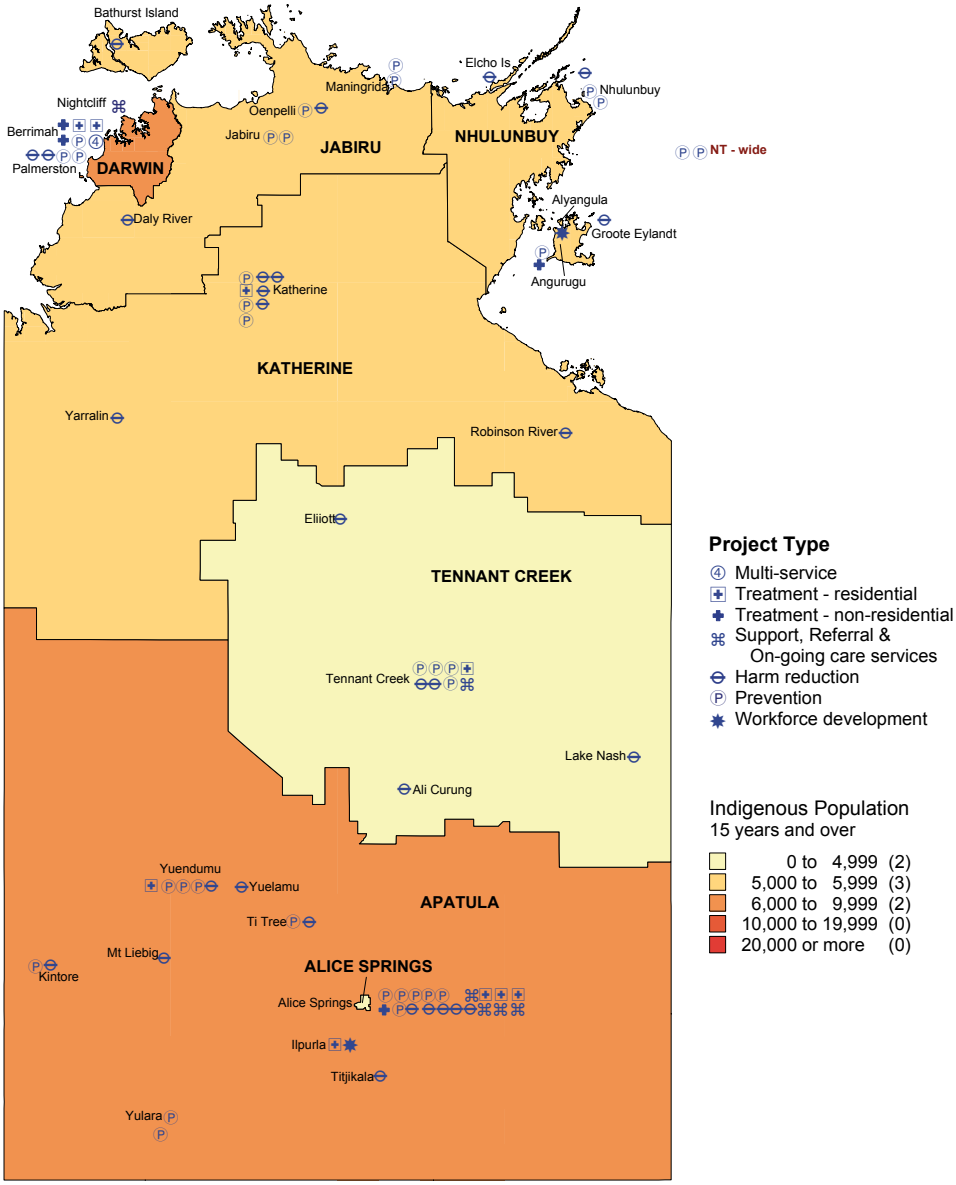


Map 8: Indigenous-specific alcohol and other drug intervention projects by ABS Indigenous region, Australian Capital Territory, 2006–07

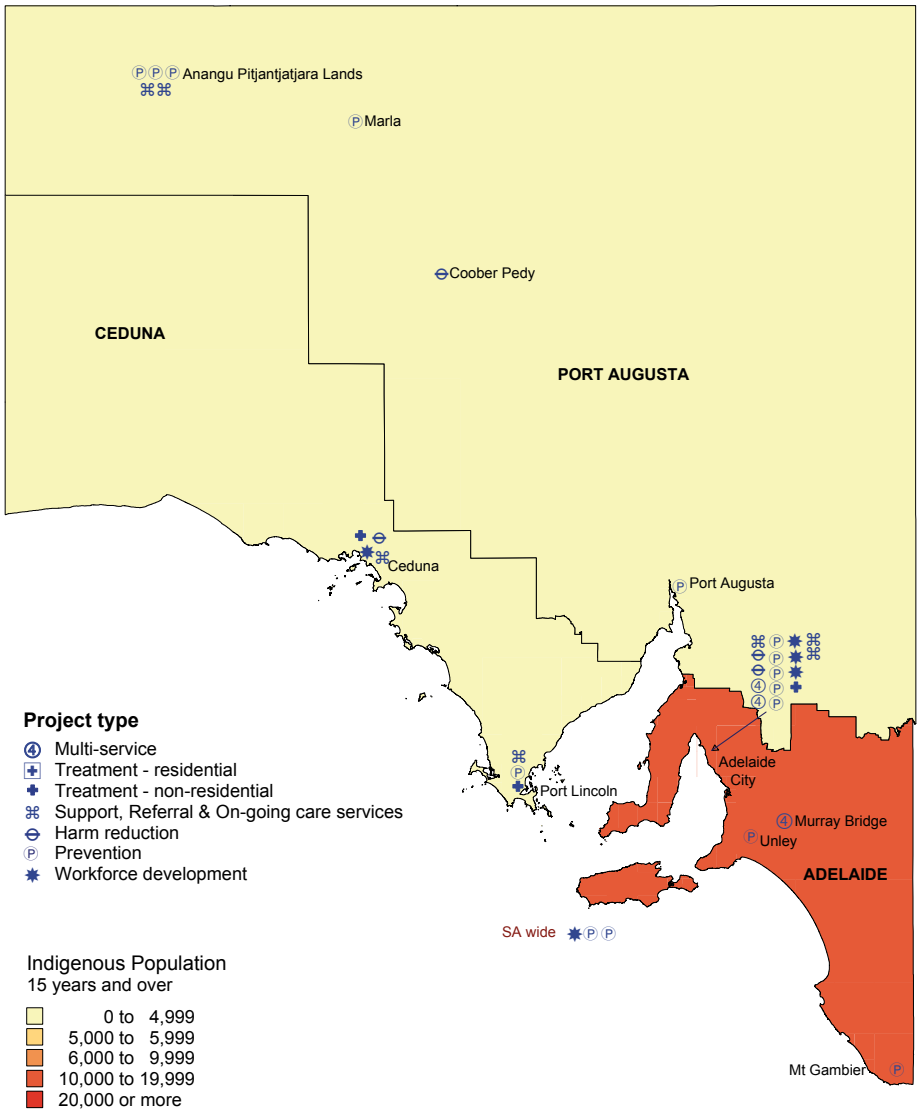
Map 9: Indigenous-specific alcohol and other drug intervention projects by ABS Indigenous region, Victoria, 2006–07



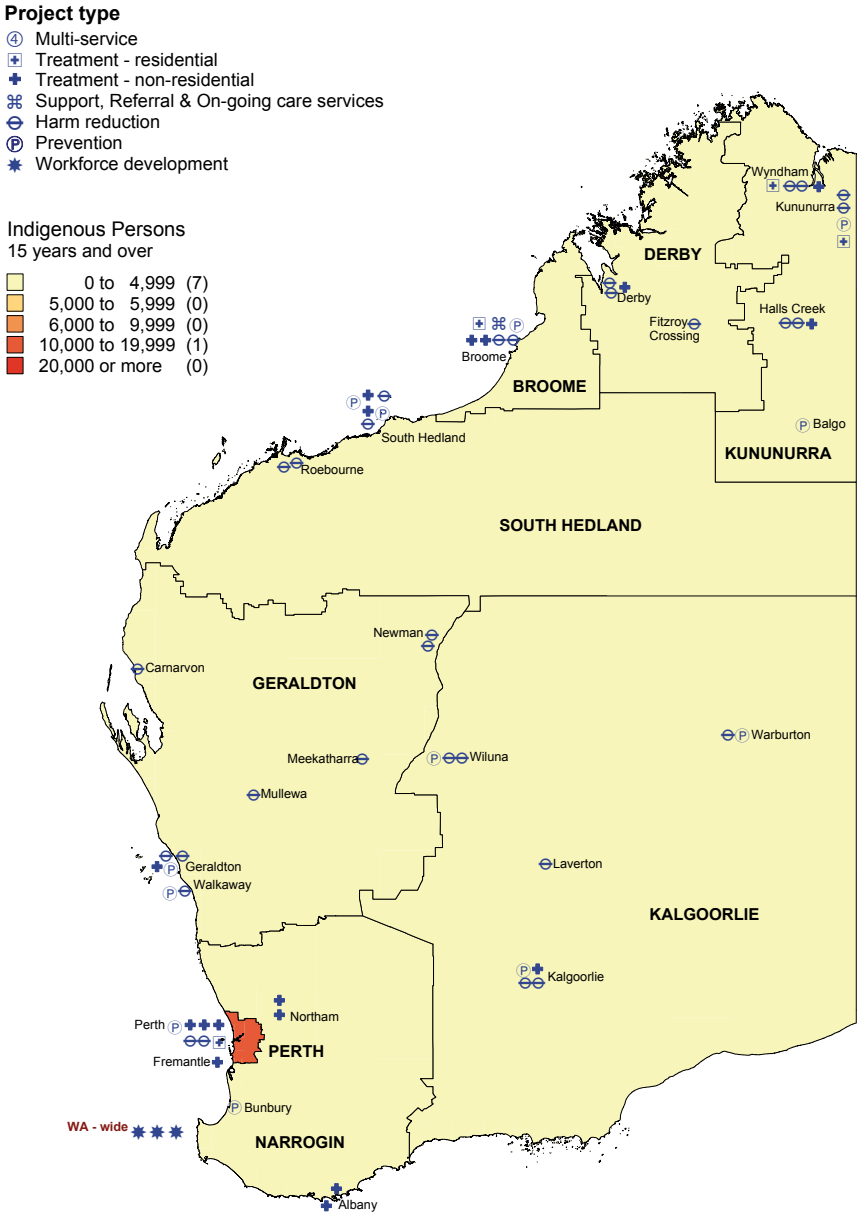
Map 10: Indigenous-specific alcohol and other drug intervention projects by ABS Indigenous region, Tasmania, 2006–07



Map 11: Indigenous-specific alcohol and other drug intervention projects by ABS Indigenous region, Northern Territory, 2006–07



Map 12: Indigenous-specific alcohol and other drug intervention projects by ABS Indigenous region, South Australia, 2006–07



Map 13: Indigenous-specific alcohol and other drug intervention projects by ABS Indigenous region, Western Australia, 2006–07

9.4 Service provider and project listing by ABS Indigenous region, 2006–07

Organisation	Project name	Organisation type
Queensland-wide		
Queensland Aboriginal & Islander Health Council/ Queensland Indigenous Substance Misuse Council	Capacity Building	Community-controlled health service
Queensland Health	Event Support Program	State/Territory government
	Indigenous Anti-Smoking Radio Advertising	State/Territory government
	Indigenous Risk Impact Screen (IRIS)	State/Territory government
	Smoke Check Queensland	State/Territory government
Cairns & District		
Aborigines & Islanders Alcohol Relief Service	Douglas House & Rose Colless Haven	AOD service
	Lyons Street Diversionary Centre	AOD service
Addiction Health Agency Cairns	Queensland Indigenous Alcohol Diversion Program — Cairns/Yarrabah	Non-Indigenous NGO
Aurukun Shire Council	Aurukun Management of Public Intoxication Program	Indigenous local government
Australian Red Cross	Save-a-Mate Our Way (SAM)	Non-Indigenous NGO
Gindaja Substance Misuse Aboriginal Corporation	Yarrabah Residential Rehabilitation	AOD service
Hope Vale Aboriginal Shire Council	Hope Vale Wet Season Project	Indigenous local government

Project type	Main services provided	Target drugs
Workforce development	Workforce development	Alcohol & others
Prevention	Health promotion & education	Tobacco
Prevention	Media campaign	Tobacco
Workforce development	Staff training	Alcohol & others
Workforce development	Brief intervention training	Tobacco
Multi-service	Residential rehabilitation & treatment	Alcohol & others
Harm reduction	Sobering-up shelter	Alcohol
Treatment: non-residential	Drug diversion to treatment	Alcohol
Harm reduction	Safe place/ Sobering-up shelter	Illicits
Prevention	Community education	Alcohol & others
Treatment: residential	Residential rehabilitation service	Alcohol & others
Prevention	Alternatives to drug use	Alcohol & others

Organisation	Project name	Organisation type
Lockhart River Aboriginal Shire Council	Lockhart River Community Partnerships	Indigenous local government
	Lockhart River Wet Season Project	Indigenous local government
Pormpur Paanth Aboriginal Corporation	Pormpuraaw Wet Season Project	Community support service
Queensland Health	Proposal for a Policy Partnership to Fund a Foetal Alcohol Syndrome Project in Indigenous Communities in Cape York	State/Territory government
Queensland Police Service	Project MURUTU	State/Territory government
Wuchopperen Health Service	Conference Attendance: Healing Our Spirit Worldwide	Community-controlled health service
	Substance Use Services	Community-controlled health service
	Tablelands Substance Misuse Program	Community-controlled health service
Wujal Wujal Aboriginal Shire Council	Wujal Wujal Wet Season Project	Indigenous local government
Townsville		
Bwgcolman Future	Diversion Program – Youth Demand Reduction Project/ Workshops	Community support service
Congress Community Development & Education Unit	Stagpole Street Detoxification & Withdrawal Services & Rehabilitation Centre	AOD service
Queensland Department of Communities	Reverend Charles Harris Diversionary Centre	State/Territory government

Project type	Main services provided	Target drugs
Prevention	Alternatives to drug use	Alcohol & others
Prevention	Alternatives to drug use	Alcohol & others
Prevention	Alternatives to drug use	Alcohol & others
Prevention	Health promotion	Alcohol
Prevention	Community development	Alcohol
Workforce development	Conference attendance	Alcohol & others
Prevention	Program development, Health promotion, Support & referral services, Community education	Alcohol & others
Prevention	Community education, Support & referral services	Multi-drug focus
Prevention	Alternatives to drug use	Alcohol & others
Prevention	Alternatives to drug use	Alcohol & others
Multi-service	Residential rehabilitation, Life-skills counselling, Detoxification & withdrawal	Alcohol & others
Harm reduction	Sobering-up shelter	Alcohol

Organisation	Project name	Organisation type
Palm Island Alcohol & Drug Rehabilitation Aboriginal Corporation	Ferdy's Haven	AOD service
Palm Island Men's Business Group	Palm Island Cell Visitor Service	Community support service
	Workshops & Counselling	Community support service
Townsville Aboriginal & Islander Health Services	TAIHS House	Community-controlled health service
Yuibera Aboriginal & Torres Strait Islander Corporation	Mackay Cell Visitor Service	AOD service
Rockhampton		
Binda Waminda	Management of Public Intoxication Service	Non-Indigenous NGO
Darumbal Community Youth Service	Addressing Volatile Substance Misuse	Community support service
Gumbi-Gumbi Aboriginal & Torres Strait Islander Corporation	The Halo-House Alcohol Support & Awareness Centre	AOD service
Juwarki Kapu-Lug Aboriginal & Torres Strait Islander Corporation	Michael Hayes Diversionary Centre	AOD service
Milbi	Milbi Farm Hostel	AOD service
Rockhampton Aboriginal & Islander Community Resource Agency	Rockhampton Management of Public Intoxication Program	AOD service
Yaamba Aboriginal & Torres Strait Islander Corporation for Men	Yaamba Hostel	AOD service

Project type	Main services provided	Target drugs
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Harm reduction	Sobering-up shelter	Alcohol
Support, referral and ongoing care service	Counselling & support	Alcohol & others
Harm reduction	Support services, Community education	Volatile substances
Harm reduction	Sobering-up shelter	Alcohol
Harm reduction	Community education, Alternatives to drug use, Referrals	Alcohol & others
Harm reduction	Community education, support & referral services	Volatile substances
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Harm reduction	Sobering-up shelter	Alcohol
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Harm reduction	Sobering-up shelter/ Safe place	Alcohol
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others

Organisation	Project name	Organisation type
Mount Isa		
Arthur Petersen Special Care Centre	Arthur Petersen Special Care Centre	AOD service
Carpentaria Shire Council	Drug Action Project	Local government
Queensland Department of Communities	Jimaylya Topsy Harry Wet Centre	State/Territory government
Junkuri Laka Justice Association	Management of Public Intoxication Program	Community support service
Kalkadoon Aboriginal Sobriety House Aboriginal Corporation	Kalkadoon Aboriginal Sobriety House	AOD service
Mount Isa Youth Shelter	Family Healing Project	Non-Indigenous NGO
	Mount Isa Youth Place of Safety	Non-Indigenous NGO
Riverbed Action Group	Management of Public Intoxication Program	Non-Indigenous NGO
Roma		
Wunjuada Aboriginal Corporation for Alcoholism & Drug Dependence Service	Wunjuada Hostel	AOD service
Brisbane		
Aboriginal & Islander Community Health Services	Indigenous Youth Health Service – Places of Safety	Community-controlled health service
Croc Festival Foundation	Sponsorship of Croc Festival	Non-Indigenous NGO
First Contact Aboriginal Corporation for Youth	First Contact Urban Trax Prevention Program	Community support service
Goori House	Treatment Program	AOD service

Project type	Main services provided	Target drugs
Harm reduction	Sobering-up shelter	Alcohol
Prevention	Alternatives to drug use	Alcohol & others
Harm reduction	Designated drinking area	Alcohol
Harm reduction	Sobering-up shelter/ Safe place	Alcohol
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Treatment: non-residential	Family counselling & treatment	Volatile substances
Harm reduction	Safe place	Volatile substances
Harm reduction	Sobering-up shelter/ Safe place	Alcohol & others
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Harm reduction	Safe place	Volatile substances
Prevention	Alternatives to drug use	Alcohol & others
Harm reduction	Night patrol	Alcohol
Multi-service	Residential treatment, After-care stabilisation services, Support & referral services	Alcohol & others

Organisation	Project name	Organisation type
Kidz Youth & Community Consultancy	KYC Youth Reach	Non-Indigenous NGO
Krurungal Aboriginal & Torres Strait Islander Corporation for Welfare Resource & Housing	Substance Use Services	Community support service
Meeanjin Treatment Association	Substance Use Services	AOD service
Murrie Watch Aboriginal and Torres Strait Islander Corporation	Murrie Watch Diversionary Centre	AOD service
Queensland Aboriginal and Torres Strait Islander Corporation for Alcohol & Drug Dependence Services	Jesse Budby Healing Centre	AOD service
New South Wales-wide		
Aboriginal Health & Medical Research Council of NSW	Aboriginal Drug & Alcohol Network	Community-controlled health service
	Ain't No Drugs in This Body – Be Proud, Strong, Black & Drug-Free	Community-controlled health service
	Diploma of Aboriginal & Torres Strait Islander Primary Health Care (Practice)	Community-controlled health service
Coffs Harbour		
Benelong's Haven Limited	Benelong's Haven	AOD service
Biripi Aboriginal Corporation Medical Centre	Aboriginal Drug & Alcohol Program	Community-controlled health service

Project type	Main services provided	Target drugs
Harm reduction	Support & referral services, Case management	Volatile substances
Treatment: non-residential	Non-residential treatment, Alternatives to drug use	Alcohol & others
Treatment: non-residential	Substance use services	Multi-drug focus
Harm reduction	Sobering-up shelter	Alcohol & others
Multi-service	Residential rehabilitation & treatment	Alcohol & others
Workforce development	Workforce support	Alcohol & others
Prevention	Peer education training	Multi-drug focus
Workforce development	Diploma course	Alcohol & others
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Treatment: non-residential	Therapeutic counselling, Community education, Support services	Alcohol & others

Organisation	Project name	Organisation type
Durri Aboriginal Corporation Medical Service	Merit Program	Community-controlled health service
Ghinni Ghinni Youth & Culture Aboriginal Corporation	Djabann Gorriman – Strong Koori Kids	Community support service
	Weekend Warriors Project: Taree Community Drug Action Team	Community support service
Namatjira Haven	Namatjira Haven Drug & Alcohol Healing Centre	AOD service
Tamworth		
Moree Community Drug Action Team	Rescue-a-Cuz Education (RACE)	Non-Indigenous NGO
New England/ Northwest Region Community Drug Action Team	Capacity Building & Networking Forum in Narrabri	AOD service
Roy Thorne Substance Misuse Rehabilitation Centre	Roy Thorne Centre	AOD service
Tenterfield Community Drug Action Team	Sista's in Unity	Non-Indigenous NGO
Dubbo		
Wellington Aboriginal Corporation Health Service	Aboriginal Drug & Alcohol Program	Community-controlled health service
Bourke		
Bourke Aboriginal Health Service	Aboriginal Drug & Alcohol Program	Community-controlled health service

Project type	Main services provided	Target drugs
Treatment: non-residential	Illicit drug diversion	Illicits
Prevention	Peer education training	Multi-drug focus
Prevention	Alternatives to drug use	Multi-drug focus
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Prevention	Peer education training	Multi-drug focus
Workforce development	Health promotion & education	Alcohol & others
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Prevention	Community education, Alternatives to drug use	Alcohol & others
Prevention	Prevention & community education	Alcohol
Referral services	Referral services, Community education	Alcohol & others

Organisation	Project name	Organisation type
Brewarrina Community Drug Action Team	Festival of the Fisheries	AOD service
Broken Hill City Council	Community Drug Action Team: Smart Choices	Local government
Orana Haven Aboriginal Corporation	Substance Use Service	AOD service
Walgett Aboriginal Medical Service Cooperative	Aboriginal Drug & Alcohol Program	Community-controlled health service
Wagga Wagga		
Bathurst – Shared Responsibility Agreement	Bathurst – Shared Responsibility Agreement	AOD service
Cummeragunja Housing & Development Aboriginal Corporation	Looking After Self, Looking After Country – Cummeragunja Community Drug Action Team	Community support service
Riverina Medical & Dental Aboriginal Corporation	Aboriginal Drug & Alcohol Program	Community-controlled health service
Weigelli Aboriginal Corporation	Residential Rehabilitation Service	Community-controlled health service
	Weigelli Centre Outreach	Community-controlled health service
Sydney		
Aboriginal Medical Service Cooperative	Aboriginal Drug & Alcohol Program	Community-controlled health service
	Outpatient Drug & Alcohol Service	Community-controlled health service
Awabakal Newcastle Aboriginal Cooperative Limited	Aboriginal Drug & Alcohol Program	Community-controlled health service

Project type	Main services provided	Target drugs
Prevention	Alternatives to drug use	Alcohol & others
Prevention	Health promotion & education	Volatile substances
Treatment: residential	Residential treatment, Sobering-up shelter	Alcohol & others
Support, referral and ongoing care service	Counselling, Community education, Support & referral services	Alcohol & others
Harm reduction	Safe place, Alternatives to drug use	Alcohol & others
Prevention	Community education, Alternatives to drug use	Multi-drug focus
Support, referral and ongoing care service	Support & referral services	Alcohol & others
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Support, referral and ongoing care service	Provides outreach	Alcohol & others
Treatment: non-residential	Prevention & treatment program	Illicits
Treatment: non-residential	Detoxification, pharmacotherapy & rehabilitation	Alcohol & others
Treatment: non-residential	Counselling, Community education, Support & referral services	Alcohol & others

Organisation	Project name	Organisation type
Illawarra Aboriginal Medical Service Aboriginal Corporation	Substance Use Services	Community-controlled health service
Marrin Weejali Aboriginal Corporation	Substance Use Services	AOD service
Ngaimpe Aboriginal Corporation	The Glen Centre	AOD service
Tharawal Aboriginal Corporation	Aboriginal Drug & Alcohol Program	Community-controlled health service
Western Sydney Aboriginal Medical Service Cooperative	Aboriginal Drug & Alcohol Program	Community-controlled health service
Queanbeyan		
Aboriginal Drug & Alcohol Committee Community Drug Action Team	Koori Youth Camp	AOD service
Campbell Page Employment & Training	Eden Drug & Alcohol Counsellor	Non-Indigenous NGO
Katungul Aboriginal Corporation Community & Medical Services	Substance Use Services	Community-controlled health service
Oolong House Aboriginal Corporation	Oolong House	AOD service
South Coast Medical Service Aboriginal Corporation	Clear Air Dreaming	Community-controlled health service
	It's Our Future – Let's Do It Right: Youth Performance Project	Community-controlled health service

Project type	Main services provided	Target drugs
Treatment: non-residential	Therapeutic counselling, Community education, Support services	Alcohol & others
Treatment: non-residential	Therapeutic counselling, Community education, Support services	Alcohol & others
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Treatment: non-residential	Support services, Assessment & treatment	Tobacco
Support, referral and ongoing care service	Referral services	Alcohol & others
Prevention	Alternatives to drug use	Multi-drug focus
Treatment: non-residential	Counselling & information workshops	Alcohol & others
Prevention	Support & referral services, Community education	Alcohol & others
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Prevention	QUIT program	Tobacco
Prevention	Alternatives to drug use	Alcohol & others

Organisation	Project name	Organisation type
	Local Substance Use Service	Community-controlled health service
	Regional Substance Use Service	Community-controlled health service
	Youth Drug & Alcohol Worker	Community-controlled health service
Australian Capital Territory		
ACT Health, Alcohol & Drug Program	Aboriginal Liaison Officer	State/Territory government
Gugan Gulwan Youth Aboriginal Corporation	Alcohol & Other Drug Outreach Service	Community support service
ACT Division of General Practice	The Opiate Program (TOP)	Non-Indigenous NGO
Winnunga Nimmityjah Aboriginal Health Service	Dual Diagnosis Program	Community-controlled health service
	Substance Misuse Service	Community-controlled health service
	Youth Detoxification Support Service	Community-controlled health service
Victoria-wide		
Victorian Aboriginal Child Care Agency	Koori Faces	Community support service
Melbourne Urban		
Isis Primary Care	Koori Alcohol & Other Drugs Worker	Non-Indigenous NGO
Ngwala Willumbong Cooperative	Aboriginal Diversion Unit (ADU)	AOD service

Project type	Main services provided	Target drugs
Treatment: non-residential	Counselling, Case management	Tobacco
Prevention	Community education, Staff training, Support services	Alcohol & others
Prevention	AOD worker	Alcohol
Support, referral and ongoing care service	Liaison & assessment, Referral services, Community education	Alcohol & others
Support, referral and ongoing care service	Support & referral services, Community education	Multi-drug focus
Treatment: non-residential	Support & referral services	Illicits
Support, referral and ongoing care service	Support services	Alcohol & others
Treatment: non-residential	Counselling, Support & referral services, Community education	Alcohol & others
Support, referral and ongoing care service	Support & referral services	Alcohol & others
Prevention	Prevention & community education	Multi-drug focus
Treatment: non-residential	Counselling, Community education	Alcohol & others
Treatment: non-residential	Drug diversion	Alcohol & others

Organisation	Project name	Organisation type
	Koori Community Alcohol & Drug Resource Centre	AOD service
	Koori Youth Alcohol & Other Drug Healing Service	AOD service
	Outreach Services	AOD service
	Substance Use Service (incl. Winja Ulupna, Galiamble Halfway House & Percy Green Memorial Centre)	AOD service
Peninsula Community Health Services	Peninsula Drug & Alcohol Program	State/Territory government
Seads Dandenong	Koori Alcohol & Other Drugs Worker	Non-Indigenous NGO
Unitingcare Moreland Hall	Koori Alcohol & Drug Diversion Worker	Non-Indigenous NGO
Victorian Aboriginal Health Service Cooperative	Koori Alcohol & Other Drugs Worker	Community-controlled health service
	VAHS Aboriginal Worker Drug & Alcohol Training Program	Community-controlled health service
Western Health: Drug & Alcohol Services	Koori Alcohol & Other Drugs Worker	State/Territory government
Youth Substance Abuse Service (YSAS)	Certificate IV in Alcohol & Other Drugs Work for Aboriginal Workers	Non-Indigenous NGO
	Conference Attendance: Healing Our Spirit Worldwide	Non-Indigenous NGO
Non-metropolitan Victoria		
Ballarat & District Aboriginal Cooperative	Substance Use Services	Community support service

Project type	Main services provided	Target drugs
Harm reduction	Sobering-up shelter	Alcohol & others
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Prevention	Outreach service	Alcohol & others
Multi-service	Residential treatment, Non-residential treatment, Conference attendance, Referral services	Alcohol & others
Support, referral and ongoing care service	Counselling, Support & referral services, Community education	Multi-drug focus
Prevention	Counselling, Community education, Support & referral services	Alcohol & others
Treatment: non-residential	AOD worker	Alcohol & others
Support, referral and ongoing care service	Support services, Community education	Alcohol & others
Workforce development	Workforce development	Alcohol & others
Support, referral and ongoing care service	Referral services	Multi-drug focus
Workforce development	Staff training	Multi-drug focus
Workforce development	Conference attendance	Alcohol & others
Prevention	Community education, Referral services	Alcohol & others

Organisation	Project name	Organisation type
Bendigo Community Health Service	Koori Alcohol & Other Drugs Worker	Non-Indigenous NGO
Gippsland & East Gippsland Aboriginal Cooperative	Alcohol & Drug Aboriginal Partnerships Project: Men's Group	Community support service
	Koori Alcohol & Other Drugs Worker	Community support service
	Koori Resource Centre Worker	Community support service
Goolum Goolum Aboriginal Cooperative	Substance Use Services	Community-controlled health service
Goulburn Valley Community Health Services	Koori Alcohol & Drug Diversion Worker	Non-Indigenous NGO
Gunditjmara Aboriginal Cooperative	Substance Use Services	Community support service
Latrobe CHS – Central Gippsland Alcohol & Drug Service	Koori Alcohol & Drug Diversion Worker	Non-Indigenous NGO
	Koori Alcohol & Other Drugs Worker	Non-Indigenous NGO
Mildura Aboriginal Corporation	Substance Use Services	Community-controlled health service
	Warrakoo Substance Use Program	Community-controlled health service
Murray Valley Aboriginal Cooperative	Substance Use Services	Community-controlled health service
Njernda Aboriginal Corporation	Baroona Farm – Healing the Spirit – Youth Healing Centre	Community-controlled health service

Project type	Main services provided	Target drugs
Treatment: non-residential	Counselling, Support, Community education	Alcohol & others
Prevention	Health promotion, Community development	Alcohol
Prevention	AOD worker	Alcohol & others
Harm reduction	Shelter worker	Alcohol & others
Support, referral and ongoing care service	Support & referral services, Community education	Alcohol & others
Treatment: non-residential	Drug diversion from the courts, Counselling & referrals	Alcohol & others
Treatment: non-residential	Counselling, Case management, Support & referral services	Alcohol & others
Treatment: non-residential	AOD worker	Alcohol & others
Prevention	Counselling, Community education, Support & referral services	Alcohol & others
Prevention	Prevention, Community education	Alcohol & others
Treatment: residential	Residential treatment, Drug diversion	Alcohol & others
Prevention	Community education, Therapeutic counselling	Alcohol & others
Treatment: residential	Development of residential treatment	Alcohol & others

Organisation	Project name	Organisation type
	Conference Attendance: Healing Our Spirit Worldwide	Community-controlled health service
	Enhanced Rural Withdrawal Capacity Building Project – Shire of Campaspe	Community-controlled health service
	Koori Alcohol & Other Drugs Worker	Community-controlled health service
Ramahyuck District Aboriginal Corporation	Substance Use Service	Community-controlled health service
Rumbalara Aboriginal Cooperative	Koori Resource Centre	Community support service
	Substance Use Services	Community support service
Sunraysia Community Health Service	Enhanced Rural Withdrawal Capacity Building Project	Non-Indigenous NGO
	Koori Alcohol & Drug Diversion Worker	Non-Indigenous NGO
Wathaurong Aboriginal Cooperative	Koori Alcohol & Other Drugs Worker	Community support service
Western Region Alcohol & Drug Centre	Koori Alcohol & Drug Diversion Worker	Non-Indigenous NGO
Winda Mara Aboriginal Corporation	Koori Resource Service	Community support service
Tasmania		
Circular Head Aboriginal Corporation	Illicit Drug Diversion Initiative	Community support service
Flinders Island Aboriginal Association (FIAA)	National Drug Action Week – Poster Competition	Community support service
Mersey Leven Aboriginal Corporation (MLAC)	Aboriginal Drug & Alcohol Worker	Community support service
	National Drug Action Week	Community support service

Project type	Main services provided	Target drugs
Workforce development	Conference attendance	Alcohol & others
Workforce development	Workforce development	Alcohol & others
Prevention	Support & referral services, Community education	Alcohol & others
Treatment: non-residential	Counselling, Support & referral services, Community education	Alcohol
Harm reduction	Sobering-up shelter	Alcohol & others
Treatment: non-residential	Substance use services	Alcohol & others
Workforce development	Staff training	Multi-drug focus
Treatment: non-residential	Drug diversion	Multi-drug focus
Prevention	AOD worker	Alcohol & others
Treatment: non-residential	Alcohol & drug diversion, Therapeutic counselling	Alcohol & others
Harm reduction	Sobering-up shelter	Alcohol & others
Treatment: non-residential	Illicit drug diversion	Alcohol & others
Prevention	Community education	Multi-drug focus
Prevention	AOD worker	Alcohol & others
Prevention	Community education	Alcohol & others

Organisation	Project name	Organisation type
South East Tasmanian Aboriginal Corporation (SETAC)	Counsellor	Community support service
	National Drug Action Week	Community support service
Tasmanian Aboriginal Centre	Holistic Primary Health Care	Community support service
Northern Territory-wide		
Northern Territory Department of Health & Community Services: Alcohol and Other Drugs Program	I'm Smarter than Smoking Campaign	State/Territory government
Red Dust Role Models	Health Promotion Program & Resources	Non-Indigenous NGO
Nhulunbuy		
Anglicare NT	*Nungu Malatjarryunnarawa* ... Your Choice	Non-Indigenous NGO
Angurugu Community Government Council	Substance Use Services	Indigenous local government
	Volatile Substance Abuse Outstation	Indigenous local government
Anindilyakwa Land Council & Numbulwar–Numburindi Community Government Council	Indigenous Cessation Workers' Project	Indigenous local government
Galiwin'ku Community	Community Patrol	Community support service
Mission Australia (NT)	Nhulunbuy Patrol	Non-Indigenous NGO

Project type	Main services provided	Target drugs
Prevention	Community education, Therapeutic counselling	Alcohol & others
Prevention	Community education	Multi-drug focus
Prevention	QUIT program, Substance misuse services through comprehensive & integrated Aboriginal primary health care	Tobacco
Prevention	Health promotion	Tobacco
Prevention	Alternatives to drug use	Alcohol & others
Prevention	Life skills	Alcohol & others
Treatment: non-residential	Substance use services	Alcohol & others
Prevention	Alternatives to drug use	Volatile substances
Workforce development	Staff training	Illicits
Harm reduction	Night patrol	Alcohol & others
Harm reduction	Night patrol	Alcohol & others

Organisation	Project name	Organisation type
Miwatj Health Aboriginal Corporation	Substance Use Services	Community-controlled health service
Umbakumba Community Council	Community Patrol	Indigenous local government
Jabiru		
Djabulukgu Association – Kakadu Health Service	Gunban An-Bang	Community-controlled health service
	Two Worlds Youth Life Project	Community-controlled health service
Kunbarllanjnja Community Government Council	Family Safety Program	Indigenous local government
	Night Patrol	Indigenous local government
Malabam Health Board Aboriginal Corporation	Maningrida Youth Centre	Community-controlled health service
	Substance Use Services	Community-controlled health service
Nauiyu Nambiyu Government Council	Night Patrol	Indigenous local government
Tiwi Islands Youth Diversion Development Unit	Tiwi Youth Diversion	Indigenous local government
Darwin		
Centacare NT	Aboriginal & Islander Alcohol Awareness & Family Recovery	Non-Indigenous NGO
	Outreach Program	Non-Indigenous NGO
Corrugated Iron Youth Arts	Urban Indigenous Performing Arts Project	Non-Indigenous NGO

Project type	Main services provided	Target drugs
Prevention	Substance use services	Alcohol & others
Harm reduction	Night patrol	Alcohol & others
Prevention	Community education	Alcohol
Prevention	Alternatives to drug use	Illicits
Prevention	Community education, Case management	Volatile substances
Harm reduction	Night patrol	Volatile substances
Prevention	Youth centre	Alcohol & others
Prevention	Substance use services	Alcohol & others
Harm reduction	Night patrol	Alcohol & others
Harm reduction	Night patrol, Prevention	Alcohol & others
Treatment: non-residential	Counselling, Community education, Support & referral services	Alcohol & others
Treatment: non-residential	Staff support, Alternatives to drugs use, Therapeutic counselling, Community education, Support services	Alcohol & others
Support, referral and ongoing care service	Alternatives to drug use	Multi-drug focus

Organisation	Project name	Organisation type
Council for Aboriginal Alcohol Program Services (CAAPS)	Dolly Garinyi Hostel & Other Services	AOD service
	Introduction to Prevention & Treatment of Substance Misuse	AOD service
Forster Foundation for Drug Rehabilitation (Banyan House)	Therapeutic Community Drug Rehabilitation	Non-Indigenous NGO
Foundation of Rehabilitation With Aboriginal Alcohol Related Difficulties (FORWAARD)	Substance Use Rehabilitation	AOD service
Mission Australia (NT)	Darwin Sobering-Up Shelter	Non-Indigenous NGO
	NT Integrated Youth Services Project	Non-Indigenous NGO
	Palmerston Youth Beat	Non-Indigenous NGO
Palmerston City Council	Youth Initiatives	Local government
Katherine		
Kalano Community Association	Community Patrol	Community support service
	Rockhole Rehabilitation	Community support service
Mission Australia (NT)	Katherine Sobering-Up Shelter	Non-Indigenous NGO
Mungoorbada Aboriginal Corporation	Night Patrol	Community support service
Ngaliwurru-Wuli Association	Night Patrol	Community support service
Nyirranggulung Mardrulk Ngadberre Regional Council	Night Patrol	Indigenous local government

Project type	Main services provided	Target drugs
Multi-service	Residential treatment, Withdrawal services, Staff development & training	Alcohol & others
Prevention	Education to the students at the Don Dale Juvenile Correctional Centre	Illicits
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Harm reduction	Sobering-up shelter	Alcohol & others
Prevention	Community education, Alternatives to drug use	Multi-drug focus
Harm reduction	Night patrol	Alcohol & others
Prevention	Alternatives to drug use	Alcohol & others
Harm reduction	Night patrol	Alcohol & others
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Harm reduction	Sobering-up shelter	Alcohol
Harm reduction	Night patrol	Volatile substances
Harm reduction	Night patrol	Alcohol & others
Harm reduction	Night patrol	Alcohol & others

Organisation	Project name	Organisation type
Sunrise Health Services Aboriginal Corporation	Beswick Community SRA – Youth at Risk (Petrol Sniffing)	Community-controlled health service
Walangeri Ngumpinku Community Government Council	Night Patrol	Indigenous local government
Wurli-Wurlinjang Aboriginal Corporation	Health Promotion / Substance Misuse Program	Community-controlled health service
YMCA Katherine	Katherine Community Alcohol & Drug Strategies for Youth	Non-Indigenous NGO
Tennant Creek		
Ali Curung Council Association	Night Patrol	Community support service
Alpurrurulam Community Government Council	Night Patrol	Indigenous local government
Anyinginyi Health Aboriginal Corporation	After-Care/ Case Management Coordinator	Community-controlled health service
	Substance Use Services	Community-controlled health service
Barkly Region Alcohol And Drug Abuse Advisory Group (BRAADAAG)	Residential Rehabilitation Service	Non-Indigenous NGO
	Sobering-Up Shelter	Non-Indigenous NGO
Elliot District Community Government Council	Night Patrol	Indigenous local government
Julalikari Council Aboriginal Corporation	Council of Elders & Respected Persons (CERP)	Community support service
	Night Patrol	Community support service
	Youth Development Unit	Community support service

Project type	Main services provided	Target drugs
Prevention	Alternatives to drug use	Volatile substances
Harm reduction	Night patrol	Alcohol
Prevention	Health promotion & education	Alcohol & others
Prevention	Alternatives to drug use	Alcohol & others
Harm reduction	Night patrol	Alcohol & others
Harm reduction	Night patrol	Alcohol & others
Support, referral and ongoing care service	After-care stabilisation services	Alcohol & others
Prevention	Substance use services	Alcohol & others
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Harm reduction	Sobering-up shelter	Alcohol
Harm reduction	Night patrol	Alcohol & others
Prevention	Community development	Alcohol
Harm reduction	Night patrol	Alcohol & others
Prevention	Alternatives to drug use, Support & referral services	Alcohol & others

Organisation	Project name	Organisation type
Papulu Apparr-Kari Aboriginal Corporation	Winanjjikari Music Centre	Community support service
Apatula		
Anmatjere Community Government Council	Night Patrol	Indigenous local government
	School Holidays Educational Activities Programs	Indigenous local government
Ilpurla Aboriginal Corporation	Conference Attendance: Healing Our Spirit Worldwide	AOD service
	Volatile Substance Abuse Rehabilitation Service	AOD service
Mount Theo Yuendumu Substance Misuse Aboriginal Corporation	*Jaru Pirrjirdi* (Strong Voices) Youth Development Program	AOD service
	Mt Theo Outstation	AOD service
	Wirliyajarrayi Pirrjirdi Nyiarniyi (Willowra Strong & Healthy)	AOD service
	Yuendumu Youth Program	AOD service
Mutitjulu Health Aboriginal Corporation	Substance Use Services	Community-controlled health service
Nyangatijatjara Aboriginal Corporation	Alternative Activities for Young People	Community support service
Tapatjatjaka Community Government Council	Night Patrol	Indigenous local government
Walungurru Aboriginal Community Council	Night Patrol	Indigenous local government
	Volatile Substance Abuse Rehabilitation Service	Indigenous local government

Project type	Main services provided	Target drugs
Prevention	Alternatives to drug use	Alcohol & others
Harm reduction	Night patrol	Alcohol & others
Prevention	Alternatives to drug use	Alcohol & others
Workforce development	Conference attendance	Alcohol & others
Treatment: residential	Residential treatment, Alternatives to drug use	Volatile substances
Prevention	Alternatives to drug use	Volatile substances
Treatment: residential	Residential diversion program, Alternatives to drug use	Volatile substances
Prevention	Alternatives to drug use	Volatile substances
Prevention	Alternatives to drug use	Volatile substances
Prevention	Substance use services	Alcohol & others
Prevention	Alternatives to drug use	Illicits
Harm reduction	Night patrol	Alcohol & others
Harm reduction	Night patrol	Alcohol & others
Prevention	Alternatives to drug use	Volatile substances

Organisation	Project name	Organisation type
Watiyawanu Community Government Council	Night Patrol	Indigenous local government
Yuelamu Community Council	Night Patrol	Indigenous local government
Yuendumu Women's Aboriginal Centre	Yuendumu Women's Community Patrol	AOD service
Alice Springs		
Bushmob	Bushmob Outreach Care Management & Treatment Service	Non-Indigenous NGO
Central Australian Aboriginal Alcohol Program Unit (CAAAPU)	Outreach Referral	AOD service
	Residential Treatment	AOD service
Drug & Alcohol Services Association (DASA)	Detoxification Program	Non-Indigenous NGO
	Indigenous Outreach Service	Non-Indigenous NGO
	Sobering-Up Shelter	Non-Indigenous NGO
	Volatile Substance Abuse Rehabilitation Service	Non-Indigenous NGO
Gap Youth Centre – Not Running at Present	Sport & Recreation	Community support service
Ngkarte Mikwekenhe Community (Irrkerlantye)	Substance Use Services	Community support service
Tangentyere Council	Central Australian Youth Link-Up Caseworker	Community support service
	Community Day Patrol	Community support service
	Hidden Valley Men's Project	Community support service

Project type	Main services provided	Target drugs
Harm reduction	Night patrol	Alcohol & others
Harm reduction	Night patrol	Alcohol
Harm reduction	Night patrol	Alcohol & others
Prevention	Support services, Community development, Alternatives to drug use	Alcohol
Treatment: non-residential	Support services, Community education	Alcohol & others
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Treatment: residential	Detoxification, counselling & support with withdrawal	Alcohol
Support, referral and ongoing care service	Support & referral services, Case management	Alcohol & others
Harm reduction	Sobering-up shelter	Alcohol
Treatment: residential	Detoxification & treatment	Volatile substances
Prevention	Alternatives to drug use	Alcohol & others
Prevention	Substance use services	Multi-drug focus
Support, referral and ongoing care service	Referral services, Case management	Volatile substances
Harm reduction	Night patrol	Alcohol & others
Support, referral and ongoing care service	Support services	Alcohol & others

Organisation	Project name	Organisation type
	Men's & Women's Caseworker at Larapinta	Community support service
	Night Patrol	Community support service
	Remote Area Night Patrol	Community support service
	School Holidays Educational Activities Programs (CAYLUS)	Community support service
	Sport & Recreation	Community support service
	Volatile Substance Abuse Supply Reduction Project	Community support service
	Youth Patrol	Community support service
South Australia-wide		
Aboriginal Drug & Alcohol Council of South Australia (ADAC)	Aboriginal Drug & Alcohol Council of South Australia	AOD service
	Makin' Tracks	AOD service
Cancer Council of South Australia	Smoke-Free Pregnancy Project: Stage 4	Non-Indigenous NGO
Port Augusta		
Aboriginal Legal Rights Movement of South Australia	APY Lands Restorative Justice Project	Community support service
Anangu Pitjantjatjara Services Aboriginal Corporation	APY Lands Sports League	Indigenous local government
Drug & Alcohol Services South Australia (DASSA)	APY Lands Substance Misuse Treatment Facility Outreach Program	State/ Territory government
Nganampa Health Council	Substance Use Services	Community-controlled health service

Project type	Main services provided	Target drugs
Support, referral and ongoing care service	Support services	Alcohol & others
Harm reduction	Night patrol	Alcohol & others
Harm reduction	Night patrol	Alcohol & others
Prevention	Alternatives to drug use	Alcohol & others
Prevention	Alternatives to drug use	Alcohol & others
Prevention	Supply reduction	Volatile substances
Harm reduction	Night patrol	Volatile substances
Prevention	Advocacy, Community education, Support services	Multi-drug focus
Prevention	Community education, Staff training, Alternatives to drug use	Alcohol & others
Workforce development	Health worker training	Tobacco
Support, referral and ongoing care service	Support & referral services	Volatile substances
Prevention	Alternatives to drug use	Volatile substances
Support, referral and ongoing care service	Mobile outreach & support service	Volatile substances
Prevention	Alternatives to drug use, Community education	Volatile substances

Organisation	Project name	Organisation type
South Australian Department of Families & Communities: Aboriginal & Torres Strait Islander Services	Motocross: Shared Responsibility Agreements (SRA)	State/Territory government
South Australian National Football League	APY Lands RPA: Sports Competition, Multi-Sports & Youth Activities	Non-Indigenous NGO
Corporation of the City of Port Augusta	National Drug Action Week	Local government
Umoona Tjutagku Health Service	Substance Use Services	Community-controlled health service
Ceduna		
Ceduna/ Koonibba Aboriginal Health Service	Conference Attendance: Healing Our Spirit Worldwide	Community-controlled health service
	Sobering-Up Shelter	Community-controlled health service
	Substance Misuse Program	Community-controlled health service
Port Lincoln Aboriginal Health Service	Port Lincoln Aboriginal Kinship Program	Community-controlled health service
	Port Lincoln Nunga Youth Project	Community-controlled health service
	Program	Community-controlled health service
Tullawon Health Service	Substance Use Services	Community-controlled health service

Project type	Main services provided	Target drugs
Prevention	Alternatives to drug use	Illicits
Prevention	Alternatives to drug use	Volatile substances
Prevention	Education	Multi-drug focus
Harm reduction	Sobering-up shelter, Mobile assistance patrol	Alcohol & others
Workforce development	Conference attendance	Alcohol & others
Harm reduction	Sobering-up shelter	Alcohol
Support, referral and ongoing care service	Support & referral services, Needle exchange, Mobile assistance patrol	Alcohol & others
Support, referral and ongoing care service	Support services	Alcohol & others
Prevention	Alternatives to drug use	Illicits
Treatment: non-residential	Counselling, Community education	Alcohol & others
Treatment: non-residential	Substance use services	Alcohol & others

Organisation	Project name	Organisation type
Adelaide		
Aboriginal Drug & Alcohol Council of South Australia (ADAC)	Indigenous Homeless Project	AOD service
	Conference Attendance: 2nd International Conference on Foetal Alcohol Spectrum Disorder, Research, Policy & Practice around the World	AOD service
	Mentor Project	AOD service
	National Indigenous AOD Training Project	AOD service
	Police Drug Diversion	AOD service
	SA Cultural & Sports Festival	AOD service
	Training & Assessment Certificate IV	AOD service
	Young Nunga Yarning Together	AOD service
	Young Aboriginal People & Hepatitis C	AOD service
Aboriginal Sobriety Group (ASG)	Cyril Lindsay House & Annie Koolmatrie House	AOD service
	Mobile Assistance Patrol	AOD service
	Substance Misuse Services	AOD service
Baptist Community Services	Brotherboy & Sistergirl: Schools Drug Prevention Program for Indigenous Youth	Non-Indigenous NGO

Project type	Main services provided	Target drugs
Support, referral and ongoing care service	Support services	Alcohol & others
Workforce development	Conference attendance	Alcohol
Support, referral and ongoing care service	Family support	Multi-drug focus
Workforce development	Workforce development	Multi-drug focus
Treatment: non-residential	Illicit drug diversion	Illicits
Prevention	Alternatives to drug use	Multi-drug focus
Workforce development	Workforce development	Multi-drug focus
Prevention	Community education, Alternatives to drug use	Alcohol & others
Prevention	Capacity building, Staff development	Illicits
Support, referral and ongoing care service	After-care stabilisation services	Alcohol & others
Harm reduction	Night patrol	Alcohol & others
Multi-service	Counselling, Education & support, Outreach services, Residential rehabilitation	Alcohol & others
Prevention	Community education, Alternatives to drug use	Illicits

Organisation	Project name	Organisation type
Drug & Alcohol Services South Australia (DASSA)	Wiltanendi	State/Territory government
Kalparrin	Substance Use Services	AOD service
Muna Paiendi, Central Northern Adelaide Health Service	Deadly Nungas Say No to Piuya	Community-controlled health service
Nunkuwarrin Yunti of South Australia	No Pulgi & Drug Substitution Options & Support	Community-controlled health service
	NU HIT	Community-controlled health service
Pangula Mannamurna	Substance Use Services	Community-controlled health service
Western Australia-wide		
Western Australian Drug & Alcohol Office (DAO)	WA Aboriginal Alcohol & Other Drugs Program Branch	State/Territory government
Western Australian Drug & Alcohol Office (DAO) & WA Office Aboriginal & Torres Strait Islander Health	WA Aboriginal Alcohol & Other Drug Workers Forum	State/Territory government
Western Australian Network of Alcohol & Other Drug Agencies	Statewide Substance Use Services	Non-Indigenous NGO

Project type	Main services provided	Target drugs
Prevention	Case management	Multi-drug focus
Multi-service	Mobile assistance patrol, Detoxification & stabilisation, Residential treatment, Life skills, Support services, Prevention & after-care support	Alcohol & others
Prevention	QUIT program & education	Tobacco
Multi-service	Needle exchange & harm reduction education, Drug substitution options & support	Illicits
Harm reduction	Needle exchange & harm reduction education	Illicits
Prevention	Alternatives to drug use	Multi-drug focus
Workforce development	Workforce development	Multi-drug focus
Workforce development	Workforce support	Multi-drug focus
Workforce development	Workforce development	Multi-drug focus

Organisation	Project name	Organisation type
Kununurra		
Halls Creek People's Church	Halls Creek Sobering-Up Shelter	Community support service
	Night Patrol	Community support service
Jungarni Jutiya Alcohol Action Council	Alcohol Centre	AOD service
Mirrilingki Spirituality Centre, Diocese of Broome	Community Support	Community support service
	Understand & Teach	Community support service
Ngnowar–Aerwah Aboriginal Corporation	7 Mile Rehabilitation Centre	AOD service
	Indigenous Diversion of Drug Offenders Program	AOD service
	Night Patrol	AOD service
	Wyndham Sobering-Up Centre	AOD service
Palyalatju Maparnpa Health Committee	Kutjungka Region Youth Services Program	Community-controlled health service
Waringarri Aboriginal Corporation	Moongoong Dawang	Community support service
	Night Patrol	Community support service
Derby		
Garl Garl Walbu Alcohol Association Aboriginal Corporation	Derby Sobering-Up Shelter	AOD service
	Numbud Patrol	AOD service
Nindilingarri Cultural Health Service	Fitzroy Crossing Sobering-Up Shelter	Community-controlled health service

Project type	Main services provided	Target drugs
Harm reduction	Sobering-up shelter	Alcohol
Harm reduction	Night patrol	Alcohol
Treatment: non-residential	Therapeutic counselling, Community education, Alternatives to drug use	Alcohol & others
Prevention	Alternatives to drug use	Alcohol & others
Treatment: residential	Short-term residential program	Alcohol
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Treatment: non-residential	Illicit drug diversion	Illicits
Harm reduction	Night patrol	Alcohol & others
Harm reduction	Sobering-up shelter	Alcohol
Prevention	Alternatives to drug use	Multi-drug focus
Harm reduction	Sobering-up shelter	Alcohol
Harm reduction	Night patrol	Alcohol & others
Harm reduction	Sobering-up shelter	Alcohol
Harm reduction	Night patrol	Alcohol & others
Harm reduction	Sobering-up shelter	Alcohol & others

Organisation	Project name	Organisation type
Northwest Mental Health Service/ Kimberley Community Drug Service Team	Aboriginal Alcohol & Drug Worker	State/ Territory government
Broome		
Mamabulanjin Aboriginal Corporation	Kullarri Patrol	Community support service
Milliya Rumurra Aboriginal Corporation	Broome Sobering-Up Shelter	AOD service
	Milliya Rumurra Hostel	AOD service
Nirrumbuk Aboriginal Corporation	Pinakarra – Prisoner Support & Rehabilitation	Community support service
Northwest Mental Health Service/ Kimberley Community Drug Service Team	Community Drug Service Team/ Aboriginal-Specific Non-Residential Treatment & Support Services	State/Territory government
	Dampier Peninsula Prevention Project	State/Territory government
	WA Diversion of Drug Offenders Program	State/Territory government
South Hedland		
Bloodwood Tree Association	Hedland Patrol	AOD service
	Substance Use Services	AOD service
Combined Universities Centre for Rural Health	Family Interventions to Reduce Tobacco Smoke Exposure of Pilbara Aboriginal Children	Non-Indigenous NGO
Pilbara Aboriginal Drug & Alcohol Program – WA Country Health Service	Indigenous Diversion of Drug Offenders Program	State/Territory government

Project type	Main services provided	Target drugs
Treatment: non-residential	Counselling, Health promotion, Community development	Alcohol & others
Harm reduction	Night patrol	Alcohol & others
Harm reduction	Sobering-up shelter	Alcohol
Treatment: residential	Residential rehabilitation & treatment	Alcohol & others
Support, referral and ongoing care service	Support services, Community education	Alcohol & others
Treatment: non-residential	Substance use services	Alcohol & others
Prevention	Community education, Referral services	Alcohol & others
Treatment: non-residential	Counselling, Support, Community education	Alcohol & others
Harm reduction	Night patrol	Alcohol
Prevention	Community education, Support services	Alcohol & others
Prevention	Community education	Tobacco
Treatment: non-residential	Illicit drug diversion	Illicits

Organisation	Project name	Organisation type
	Pilbara Aboriginal Drug & Alcohol Program	State/Territory government
Port Hedland Sobering-Up Centre Group	Port Hedland Sobering-Up Shelter	Non-Indigenous NGO
Roebourne Sobering-Up Shelter	Mingga Patrol	AOD service
	Roebourne Sobering-Up Shelter	AOD service
Kalgoorlie		
Bega Garnbirringu Health Services	Kalgoorlie Sobering-Up Shelter	Community-controlled health service
Centrecare – Goldfields Community Drug Service Team	Indigenous Substance Use Program	Non-Indigenous NGO
Ngangganawili Aboriginal Community Controlled Health & Medical Service	Substance Use Services	Community-controlled health service
	Wiluna Patrol	Community-controlled health service
	Wiluna Sobering-Up Shelter	Community-controlled health service
Nooda Ngulegoo Aboriginal Corporation	Kalgoorlie Street Patrol	Community support service
	Nooda Ngulegoo Aboriginal Corporation	Community support service
Warburton Community	Community Patrol	Community support service
	Warburton Youth Diversion Activity	Community support service
Wongatha Wonganarra Aboriginal Corporation	Night Patrol	Community support service

Project type	Main services provided	Target drugs
Treatment: non-residential	Counselling, Community education, Support & referral services	Alcohol & others
Harm reduction	Sobering-up shelter	Alcohol
Harm reduction	Night patrol	Alcohol
Harm reduction	Sobering-up shelter	Alcohol
Harm reduction	Sobering-up shelter	Alcohol
Treatment: non-residential	Counselling, Community education	Alcohol & others
Prevention	Substance use services	Alcohol & others
Harm reduction	Night patrol	Alcohol & others
Harm reduction	Sobering-up shelter	Alcohol
Harm reduction	Night patrol	Alcohol & others
Prevention	Substance use services	Alcohol & others
Harm reduction	Night patrol	Volatile substances
Prevention	Alternatives to drug use	Volatile substances
Harm reduction	Night patrol	Alcohol

Organisation	Project name	Organisation type
Geraldton		
Carnarvon Community Patrol	Night Patrol	AOD service
Geraldton Regional Aboriginal Medical Service	Substance Use Services Training	Community-controlled health service
	Youth Initiatives	Community support service
	Youth Outreach Shared Responsibility Agreement	Community support service
Geraldton Yamatji Patrol Aboriginal Corporation	Geraldton Yamatji Patrol	AOD service
Midwest Employment & Economic Development Aboriginal Corporation	Night Patrol	Community support service
Newman Police	Martu Elders Patrol	State/Territory government
Newman Sobering-Up Centre	Tartilla Patrol	Non-Indigenous NGO
WA Country Health Service – Midwest Community Drug Service Team	Geraldton Sobering-Up Shelter	State/Territory government
	Indigenous WA Diversion of Drug Offenders Program	State/Territory government
Yulella Aboriginal Corporation	Night Patrol	Community support service
Narrogin		
Holyoake Institute – Wheatbelt Community Drug Service Team	Community Drug Service Team Program/ Aboriginal-Specific Non-Residential Treatment & Support Services	Non-Indigenous NGO
	Indigenous Diversion Program	Non-Indigenous NGO

Project type	Main services provided	Target drugs
Harm reduction	Night patrol	Alcohol & others
Prevention	Staff training, Community education	Alcohol & others
Harm reduction	Night patrol	Alcohol & others
Prevention	Community education, Youth development	Alcohol & others
Harm reduction	Night patrol	Alcohol & others
Harm reduction	Night patrol	Alcohol & others
Harm reduction	Night patrol	Alcohol & others
Harm reduction	Night patrol	Alcohol & others
Harm reduction	Sobering-up shelter	Alcohol
Treatment: non-residential	Counselling, Community education, Needle exchange	Alcohol & others
Harm reduction	Night patrol	Alcohol & others
Treatment: non-residential	Counselling, Support & referral services, Community education	Alcohol & others
Treatment: non-residential	Illicit drug diversion	Alcohol & others

Organisation	Project name	Organisation type
Palmerston Association – Great Southern Community Drug Service Team	Community Drug Service Team Program/ Aboriginal-Specific Non-Residential Treatment & Support Services	Non-Indigenous NGO
	Community Drug Service Team & Young Adolescents Program	Non-Indigenous NGO
St John of God Healthcare/ South West Community Drug Service Team	Indigenous Program	Non-Indigenous NGO
Perth		
Aboriginal Alcohol & Drug Service (AADS)	Aboriginal Youth At Risk – Outreach Program	AOD service
	Substance Use Services	AOD service
	WA Diversion of Drug Offenders Program	AOD service
Daughters of Charity (Ruah Centre)	ANAWIM Sobering-Up Shelter	Non-Indigenous NGO
Nyoongar Patrol System	Night Patrol	AOD service
South Metro Community Drug Service Team & Palmerston Australia	WA Diversion of Drug Offenders Program	Non-Indigenous NGO
Western Australian Drug & Alcohol Office (DAO)	Aboriginal Youth Mentor, Next Step Youth Services	State/Territory government
	Next Step Withdrawal Unit, Aboriginal Drug & Alcohol Workers	State/Territory government

Project type	Main services provided	Target drugs
Treatment: non-residential	Counselling, Support services	Alcohol & others
Treatment: non-residential	Counselling	Illicits
Prevention	Support services, Community education	Alcohol & others
Prevention	Community education, Alternatives to drug use	Alcohol & others
Treatment: non-residential	Therapeutic counselling, Alternative therapies	Alcohol & others
Treatment: non-residential	Illicit drug diversion	Illicits
Harm reduction	Sobering-up shelter	Alcohol
Harm reduction	Night patrol	Alcohol & others
Treatment: non-residential	Illicit drug diversion	Illicits
Treatment: non-residential	Counselling	Alcohol & others
Treatment: residential	Detoxification	Alcohol & others

Organisation	Project name	Organisation type
Multi-State		
Australian Government Department of Health & Ageing: Office of Aboriginal & Torres Strait Islander Health (OATSIH)	Petrol Sniffing Prevention Program	Australian Government
Croc Festival Rock Challenge	Croc Festival	Non-Indigenous NGO

Project type	Main services provided	Target drugs
Prevention	Provision of a non-sniffable fuel, Prevention, Alternatives to drug use	Volatile substances
Prevention	Alternatives to drug use	Multi-drug focus

9.5 NIDAC Project Scoping Document

Australian National Council on Drugs

National Indigenous Drug & Alcohol Committee (NIDAC)

'Identifying Areas of Greatest Need' Project

Brief Background to the Project

The Australian National Council on Drugs (ANCD) is the principal advisory body to government on drug and alcohol issues and plays a critical role in ensuring that the voice of communities and all related sectors are heard.

As part of its commitment to provide high level advice to government, the ANCD established the National Indigenous Drug and Alcohol Committee (NIDAC) in 2004 to specifically identify the most appropriate and effective approach for the ANCD to contribute to addressing Indigenous drug and alcohol issues within Australia.

The committee comprises a range of members from government and non-government organisations, law enforcement with either specialist expertise or broad experience in dealing with Indigenous drug and alcohol issues.

NIDAC is committed to providing advice on ways of addressing the serious issues that exist for Indigenous Australians. In order to provide a foundation for this work, the Prime Minister has requested that the ANCD & NIDAC commission a project to determine the current Indigenous specific drug and alcohol funding available across all State, Territory and Federal jurisdictions; and the current distribution & appropriateness of AOD services across all sectors across these jurisdictions. Given that there is general agreement on a significant level of unmet need existing in Indigenous communities a particular goal of this project is to identify the areas of greatest need.

Outline

NIDAC calls for suitable individuals or groups to provide an in-depth report on the current Indigenous specific drug and alcohol funding which is available and also the current distribution & appropriateness of services across all sectors.

The report should provide a clear and concise analysis, outlining the funding and appropriateness of the current Indigenous services for drug and alcohol. In addition to this, an analysis is required in order to provide a complete report on the current situation of Australia's Indigenous drug and alcohol funding, services, appropriateness of those services and the identification and assessment of unmet needs.

Statement of Requirement

NIDAC expects that the individual or group appointed to undertake the project to undertake the following tasks:

1. With assistance from NIDAC consult with all major funding and administrative bodies to ensure co-operation, at the commencement of the project.

2. Collect the relevant information identifying the funding available for Indigenous drug and alcohol services in Australia. Indigenous drug and alcohol agencies include those providing specific drug and alcohol prevention, education, treatment, outreach and harm reduction services that are either/or:

   - Community controlled
   - Predominately providing services for Indigenous people
   - Located within Indigenous communities
   - Providing a specific service for Indigenous people

3. Collect the relevant information on the drug and alcohol services which are funded in Australia.

4. Analyse the drug and alcohol services which are funded in Australia, looking at the following areas:

   - Location in relation to Indigenous communities
   - Number of clients engaged in services who are Indigenous
   - Cost effectiveness
   - Source and nature (e.g. ongoing vs. pilot) of funding

   From the information above the appropriateness of the individual services can be analysed and reported on.

5. Engage in consultation with all the relevant stakeholders from both government and non-government organisations.

6. Provide a report including a summary and critical analysis of the literature, outlining the funding available for Indigenous AOD services, the appropriateness of the services provided and identifying and assessing areas of greatest unmet need. The report is to contain clear and concise recommendations.

Details Required

- Short statement of claims (addressing the 'Statement of Requirement' as above, maximum of 5 pages).
- Timeframe – anticipated commencement date and time required to complete each task (Please note that this initiative is expected to be completed within nine to twelve months of signing the contract).
- Indicative budget to a maximum of $100,000, including GST.
- Names and contact details of at least 3 referees.

Address your proposal to:

NIDAC Project Officer
ANCD Secretariat
PO Box 1552
CANBERRA ACT 2601
ancd@ancd.org.au
Ph: 02 6279 1650

NOTE: Proposals must be received by the ANCD Secretariat by close of business, Monday 29th January 2007

Submissions by email or fax are welcome; however, they must be followed by a hard copy.

9.6 NDRI Project Information Sheet

NDRI
national drug research institute

www.ndri.curtin.edu.au
Curtin University of Technology
Health Research Campus
GPO Box U1987 Perth WA 6845
telephone + 61 8 9266 1600
facsimile +61 8 9266 1611
enquiries@ndri.curtin.edu.au
CRICOS Provider Code 00301J
Preventing harmful drug use in Australia
Funded by the National Drug Strategy
Curtin
University of Technology

Identifying Areas of Greatest Need in Indigenous Substance Misuse Intervention

The National Drug Research Institute (NDRI), on behalf of the National Indigenous Drug and Alcohol Committee (NIDAC), is conducting a study to identify the areas of greatest need in Indigenous Australian substance misuse. For the financial year 2006–07, NDRI will identify the current Indigenous specific drug and alcohol interventions, the level of funding they receive, and examine the current distribution and appropriateness of services across all sectors. Ultimately the project will identify the areas of greatest need in Indigenous substance misuse interventions, providing the evidence for where further resources and programs are needed.

The aims of the study are to provide an in-depth report on:
- current alcohol and other drug services for Indigenous Australians;
- funding of current alcohol and other drug services for Indigenous Australians;
- the appropriateness of current services and funding for them; and,
- the identification and assessment of unmet needs.

The information required are:
- details and names of, and expenditure on, all *projects*, conducted by your agency in the 2006–2007 financial year which *directly targeted* at substance misuse among Indigenous people. That is, programs which have the reduction of substance misuse as a specific objective.
- information on each specific *project*, either funded by or conducted by your agency as part of the programs including (to the extent possible):
  - project name;
  - name of the organisation conducting the project;
  - number of clients (non-Indigenous verses Indigenous)
  - number of staff (Indigenous and non-Indigenous)
  - contact details of a responsible person within the organisation conducting the project;
  - main services provided – eg night patrol, non-residential treatment;
  - target group; and
  - target drugs; and
  - amount of funding.

The information provided by organisations will be reported on as follows:

- the numbers of projects by type by ICC region and state/territory;
- project types by the setting in which they are conducted; and
- project types by drugs and populations targeted.

Summary tables of financial information will include:

- expenditures by project type;
- total expenditures by ICC region, state/territory, and funding source; and
- recurrent versus non-recurrent expenditures by project type.

Identification of areas of need will be made by comparing the existing services to the ideal service model, and the range of existing services and expenditures within ICC regions with: regional population levels; the available (but limited) data on levels of substance misuse (including changing patterns of use such as increased in cannabis use and injecting drug use); indicators of harm (for example alcohol-related mortality and hospital morbidity data collected as part of NDRI's Indigenous Alcohol Indicators Project); and regional indices of remoteness.

Any queries regarding the project can be directed to:

Prof Dennis Gray
National Drug Research Institute
GPO Box U1987
Perth WA 6845
Phone: 08 9266 1624
Fax: 08 9266 1611
d.gray@curtin.edu.au

Ms Anna Stearne
National Drug Research Institute
C/ Research Unit
Tangentyere Council
PO Box 8070
Alice Springs NT 0871
Phone: 08 8951 4270
042 726 6641
a.stearne@curtin.edu.au

9.7 Funding Agency Project Data Collection Sheet

national drug research institute

Project Information Sheet
2006–2007

NDRI use only

Part A – to be completed for each project funded and/or conducted by your agency.

1.	Name of funding agency:[1]		
2.	Project name:		
3.	Name of service provider:[2]		
4.	Type of organisation providing service: (please circle)	1. Indigenous community 2. Non-Indigenous NGO	3. State/territory government 4. Local government
5.	Project funding 2006–07	$	
6.	Funding type: (please circle)	1. On-going	2. One-off – 2006–07 only
7.	Project description:[3]		

1. Your agency.
2. Your agency, if it provides the intervention project, or the name of the agency contracted to provide the service.
3. Two or three sentences describing the project.

Project Information Sheet

2006–2007

8.	Drug or drugs targeted: (circle one or more as appropriate)	1. Alcohol 2. Tobacco 3. Cannabis 4. Amphetamine type substances	5. Heroin/other opioids 6. Petrol 7. Other volatile substances 8. Other drugs	
9.	Target groups: (circle one or more as appropriate)	1. Substance dependent persons 2. Intoxicated persons 3. Injecting drug users 4. Offenders 5. Prisoners 6. Communities	7. Adult males only 8. Adult females only 9. Adolescents only 10. Families 11. Health workers 12. Other (specify)	
10.	Project setting:	1. Non-residential AOD facility 2. Residential facility 3. Primary health care 4. Home	5. Community 6. School 7. Custodial 8. Other (specify)	
11.	Indigenous Coordinating Centre Region in which project conducted:[4] (circle one or more as appropriate)	10. *Queensland-wide* 11. Brisbane urban 12. Cairns/Cape York 13. Mt Isa 14. Rockhampton 15. Roma 16. Townsville 30. *Victoria-wide* 31. Melbourne urban 31. Victoria regional 40. *Tasmania-wide* 41. Hobart urban 42. Tasmania regional	20. *NSW-wide* 21. Sydney urban 22. Bourke 23. Coffs Harbour 24. Dubbo 25. Queanbeyan 26. Tamworth 27. Wagga Wagga 60. *SA-wide* 61. Adelaide urban 62. Ceduna 63. Port Augusta	50. *NT-wide* 51. Darwin urban 52. Alice Springs 53. Katherine 55. Nhulunbuy 55. Tennant Creek 70. *WA-wide* 71. Perth urban 72. Broome 73. Derby 74. Geraldton 75. Kalgoorlie 76. Kununurra 77. South Hedland
12.	Service provider contact: Name, telephone, e-mail address			

4. See attached map.

Project Information Sheet

2006–2007

Part B – only to be completed if the project was conducted by your agency.

13. Project staffing:[5]

Position	Paid Indigenous FTE	Paid non-Indigenous FTE	CDEP Top-up	CDEP	Voluntary
E.g. Manager	0.25	0.5			
Psychologist					
AOD worker	2.0				

14. Number of clients : Indigenous Non-Indigenous

5. This applies only to persons working on this project *not* the number of persons employed by the service. If a worker has responsibility for other projects please estimate the time the person spends on *this project* – e.g. 0.5 FTE (full-time equivalent).

9.8 Service Provider Data Collection Sheet

national drug research institute

Data Collection Sheet
2006–2007

Service Provider: __ _____	SP	
Before we begin, did your organisation/ service provide any programs/ projects that address substance misuse during the financial year 2006/ 07?	YES	NO
Was this project Indigenous specific, or cater for a large number of Indigenous clients?	YES	NO
If yes to both of these, continue. If No, double check based on the information already provided by the funding agency. Thank them for their assistance, however they do not meet the criteria of the project, and thus are excluded.		

Part A – completed details for the entire organisation.		
1.	**Name of service provider:**	**What is the official name of your agency?** **Is it known by any other names?**
2.	**Type of organisation providing service:**	**What type of organisation is your agency?**
	1. Indigenous community Controlled (includes NGOs) 2. Non-Indigenous NGO 3. State/territory government 4. Local government 5. Other (specify) _____	
3.	**Service provider contact person and title:**	**Who is the best person to contact for information on this project?** ***Make note of who and when you spoke to each person, in case there is a need to recontact people.***
4.	**Location Address:**	
5.	**Postal Address:**	

Data Collection Sheet

2006–2007

6.	**Phone/ Fax:**		
7.	**Email:**		
8.	**Details of the services provided by the organisation**	**What does your organisation do?**	
9.	**In which ICC regions is the agency located?** **Which regions does the agency service?**		
	10. *Queensland-wide* 11. Brisbane urban 12. Cairns/Cape York 13. Mt Isa 14. Rockhampton 15. Roma 16. Townsville 30. *Victoria-wide* 31. Melbourne urban 31. Victoria regional 40. *Tasmania-wide* 41. Hobart urban 42. Tasmania regional	20. *NSW-wide* 21. Sydney urban 22. Bourke 23. Coffs Harbour 24. Dubbo 25. Queanbeyan 26. Tamworth 27. Wagga Wagga 60. *SA-wide* 61. Adelaide urban 62. Ceduna 63. Port Augusta	50. *NT-wide* 51. Darwin urban 52. Alice Springs 53. Katherine 55. Nhulunbuy 55. Tennant Creek 70. *WA-wide* 71. Perth urban 72. Broome 73. Derby 74. Geraldton 75. Kalgoorlie 76. Kununurra 77. South Hedland

Data Collection Sheet

2006–2007

Part B – completed one set for EACH individual project that was conducted by the organisation.		
10.	**Project name:**	
11.	**Project contact person and title:**	
12.	**Project description:**	**What does the project do (objectives and aims)?**
13.	**Drug or drugs targeted:**	**What drug does this project target? (please note the order of priority/ focus)**

	1. Alcohol		5. Heroin/other opioids		
	2. Tobacco		6. Petrol		
	3. Cannabis		7. Other volatile substances		
	4. Amphetamine type substances		8. Other drugs (specify) _____		

Data Collection Sheet

2006–2007

14.	**Target groups:**	**Who is the project targeted AT?** **(Up to three can be recorded, note the order of priority/ focus)** ***We are interested in who the project is targeted DIRECTLY towards.***		
	1. Substance dependent persons		7. Adult males only	
	2. Intoxicated persons		8. Adult females only	
	3. Injecting drug users		9. Adolescents only	
	4. Offenders		10. Families	
	5. Prisoners		11. Workforce/ capacity building	
	6. Communities		12. Other (specify) _____	
15.	**Project setting:**	**In what setting does the project operate?**		
	1. Non-residential AOD facility		5. Community	
	2. Residential facility		6. School	
	3. Primary health care		7. Custodial	
	4. Home		8. Other (specify) _____	

16.	**In which ICC regions is the project conducted? (we have space for two, but select more if necessary, and rank in order of priority if possible)**		
	10. *Queensland-wide* 11. Brisbane urban 12. Cairns/Cape York 13. Mt Isa 14. Rockhampton 15. Roma 16. Townsville 30. *Victoria-wide* 31. Melbourne urban 31. Victoria regional 40. *Tasmania-wide* 41. Hobart urban 42. Tasmania regional	20. *NSW-wide* 21. Sydney urban 22. Bourke 23. Coffs Harbour 24. Dubbo 25. Queanbeyan 26. Tamworth 27. Wagga Wagga 60. *SA-wide* 61. Adelaide urban 62. Ceduna 63. Port Augusta	50. *NT-wide* 51. Darwin urban 52. Alice Springs 53. Katherine 55. Nhulunbuy 55. Tennant Creek 70. *WA-wide* 71. Perth urban 72. Broome 73. Derby 74. Geraldton 75. Kalgoorlie 76. Kununurra 77. South Hedland

Data Collection Sheet

2006–2007

17. Project funding:

We are interested in if the resources provided are enough to meet the needs of the community. In particular, Is the funding for more than one year? if so how long.
Who provided funding during this period?
How much funding was provided?
For how long was the funding provided?
How long is the contract for?

	Funding Agency/ program	Amount received	Period funding received	Notes regarding this funding

18. Project Staffing

We are interested in whether the resources meet the staffing needs of the project (not the organisation).
How many staff directly involved in this project are Indigenous? What are there positions and how long are they employed for?
Which staff have formal qualifications in the drug and alcohol field? What is the level of qualification that they have?

Full-time equivalent positions

Position	Paid Indigenous FTE	Paid non-Indigenous FTE	CDEP Top-up	CDEP	Voluntary

19. Number of clients

How many clients (approximately) were seen/ assisted by this project in 2006–07?

Indigenous _____

Non-Indigenous _____

Data Collection Sheet

2006–2007

20. Other projects	**Does you service operate any other Indigenous-specific substance misuse programs/ projects?**
21. Other service providers:	**Are you aware of any other projects operating in your town/ region that address substance misuse issues?** **Are these Indigenous –specific? If so, get contact details**
22. Strengths	**What do you perceive as the current strengths of the program? (record examples/ evidence)**
23. Barriers	**What do you perceive as the current barriers of the program? (record examples/ evidence)**
24. Needs of community	**What other services programs are needed within your town and region to meet the needs of your community?**

10. References

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