Review of the Aboriginal and Torres Strait Islander Community-controlled Alcohol and other Drugs Sector in Queensland

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QAIHC
Queensland Aboriginal and Islander Health Council

Review of the Aboriginal and Torres Strait Islander Community-controlled Alcohol and other Drugs Sector in Queensland

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Acknowledgements

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Recommendations

Some of the recommendations made in this report can be implemented by QISMC, QAIHC and particular organisations within the Indigenous AOD sector. Implementation of many others ultimately requires actions and the commitment of resources by government agencies. We are acutely aware, however, that this report has no official standing with those agencies and they are not in any way obligated to act upon them. For this reason we have framed many of the recommendations as actions to be pursued by QISMC – as it is only through such action that they will have a life beyond this report. In this regard, the objectives (and the categories under which they are grouped) also provide a strategic framework for action by QISMC as an organisation. It is also important to note that some of the recommendations (6, 9, 10, 12, 13, 15, 20, 21, 22, 23) require action at the national level, as well as the state level, and it is important that QAIHC pursue them with government agencies at that level and that they also seek the assistance of the National Aboriginal Community Controlled Health Organisation in pursuing their implementation.

Recommendations

QISMC

1. While it is ultimately a decision to be made by the members of both QISMC and QAIHC, we recommend that – rather than becoming a separate incorporated body – QISMC should become a discrete organisational unit within QAIHC (page 107).
2. QISMC should develop a clear vision statement and practical strategies by which these can be pursued as an organisation, by its individual members, and in partnership with other key stakeholders (page 107).
3. When its organisational status is resolved and it has developed a strategic plan, QISMC should seek from key stakeholders additional resources for agreed upon outcomes within the framework of the strategic plan (page 107).

Member support

4. QISMC should seek resources to expand its capacity to support member organisations to access a wider range of funding sources (page 99).
5. QISMC should seek additional funds from OATSIH to expand its role in supporting member organisations to develop competitive tender and grant applications (page 104).

Indigenous capacity

6. QISMC and QAIHC should seek a long-term commitment from funding bodies to resource additional capacity within the sector – including within Indigenous community-controlled health services (page 92).

7. The creation of Indigenous capacity for service delivery should be incorporated as an objective in government requests for tenders and in service delivery contracts in addition to specific services *per se* (page 104).

8. To further develop Indigenous capacity, government agencies should specify that, in assessing tender applications, if no suitable applications are received from Indigenous applicants, preference will be given to those non-Indigenous applicants tendering in partnership with Indigenous community-controlled organisations (page 104).

Service provision and standards of care

9. To address gaps in the provision of services, QISMC and QAIHC should seek a long-term commitment from funding bodies to increasing allocations to the Indigenous AOD sector to provide for an expansion of tobacco control interventions, on-going care services (see also recommendation 10), and alcohol and illicit drug prevention projects (page 93).

10. QISMC – in collaboration with other key stakeholders – should benchmark standards for the provision of on-going care and their cost, and also explore options for residential services (where they are not able to provide such services themselves) to contract the provision of on-going care to third parties (page 105).

11. Once benchmarks for the provision of on-going care have been established, QISMC should enter into negotiations with relevant funding bodies for the long-term expansion of on-going care services (page 105).

12. QISMC should seek the collaboration of relevant stakeholders – including OATSIH and Queensland Corrective Services – to benchmark the level of support needed to meet the additional needs of mandated clients and clients with complex AOD and/or comorbid mental health problems and the workforce, training, and resource levels necessary to meet those needs (page 100).

13. As essential elements of 'best practice', coordination and service integration functions should be part of service provision benchmarks and should be adequately resourced (page 106).

14. Those Indigenous AOD treatment services with high proportions of non-Indigenous clients should develop two to three year strategies to ensure that no more than 10 per cent of client places are occupied by them (page 101).

Staffing

15. As a matter of priority, staffing benchmarks for Indigenous AOD residential treatment services should be developed by QISMC in consultation with mainstream AOD agencies and agreed upon by all key stakeholders (page 101).

16. QISMC should continue with efforts to ensure that disparities in Indigenous AOD treatment service salary levels are addressed in the development of service benchmarks (page 101).

Training

17. QISMC–QAIHC should seek resources to expand the governance training currently provided by QAIHC, and members of the Boards of affiliated organisations should be encouraged to undertake such training (page 97).

18. QISMC should seek resources to conduct AOD training seminars and workshops itself, or to contract third parties to do so, and that Board and staff members of affiliated organisations should be encouraged to undertake such training (page 97).
19. QISMC should seek to enter into negotiations with relevant agencies to negotiate levels of funding which adequately compensate AOD services for the costs associated with training that are additional to the costs of training itself and the payments to which individual trainees are entitled under Abstudy (page 103).
20. QISMC and QAIHC should lobby relevant Australian and Queensland Government agencies to allocate additional funding to increase the numbers of Indigenous people directly entering AOD vocational and tertiary training (page 103).

Reporting

21. Activities already under way in the development of appropriate monitoring and evaluation measures should be given high priority. However, specific measures need to be negotiated with, and developed with regard to, the objectives of particular organisations (page 94).
22. QISMC should convene a meeting of all stakeholders to develop a set of recommendations for reducing the burden of reporting requirements (page 98).
23. Any benchmarking of organisational staffing levels should include specification of reporting skills requirements and needs (page 97).

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1. Introduction

In July 2004, Queensland Aboriginal and Islander Health Council (QAIHC), the peak body for 21 Indigenous community-controlled health services and the Queensland Indigenous Substance Misuse Council (QISMC), the peak body for 14 Indigenous substance misuse services formed a partnership aimed at improving the health, safety and well-being of Indigenous people through enhanced cooperation and collaboration. The partnership was based on a deep understanding of the harm alcohol, tobacco and other drugs have on physical, mental and social well-being of Indigenous people in Queensland. A memorandum of understanding between the organisations aims to:

> ... strengthen the comprehensive approach to Aboriginal and Torres Strait Islander health by incorporating a strong focus on Aboriginal and Torres Strait Islander substance use, especially through health promotion, education and prevention initiatives, into the broader holistic health approach.

This entails the understanding that more activity is necessary across the spectrum of AOD services and that the scope and quality of AOD services for Aboriginal and Torres Strait Islander peoples across Queensland can be improved.

As an initial step towards implementing the aim of the MOU, QAIHC and QISMC agreed to commission a review of the alcohol and other drugs sector in Queensland. A project plan for the review was developed by QAIHC, and the National Drug Research Institute was contracted to undertake the review. As set out in the project plan and contract, the aims of the review were to:

1. map, analyse, plan and report on alcohol and other drugs (AOD) services in a sample of Indigenous community-controlled AOD agencies across Queensland;
2. examine how the local community-controlled AOD services interact with local Indigenous community-controlled primary health care services and with other local services providers; and,
3. make recommendations on sector reform and development that will improve the scope and quality of AOD services for Aboriginal and Torres Strait Islander peoples across Queensland.[1]

The rationale for the review was also set out in the QAIHC project plan. This included:

- acknowledgement by both QISMC and QAIHC of the principle of harm minimisation and the requirement for a comprehensive and balanced approach to addressing substance misuse;
- agreement that more activity is necessary across the spectrum of AOD services, particularly in relation to education, prevention and early intervention and that more activity needs to be targeted towards the use of illicit drugs and volatile substances;
- the partnership arrangement between QAIHC and QISMC which provides for a coordinated approach to addressing substance misuse in Aboriginal and Torres Strait Islander communities; and,

- as a first step, the need to map the sector to clearly identify the range and scope of the Aboriginal and Torres Strait Islander community-controlled AOD sector in Queensland.[1]

As discussed in the following chapter, the scope of the review had to be curtailed. Rather than focusing on each of the QISMC member organisations as originally planned, case studies of five organisations were conducted and reviewed in the light of the relevant literature. This report on the project includes chapters on: the methodology used to undertake the review; a review of the relevant literature; an overview of QISMC, its membership, objectives, and the issues it faces; an overview of Indigenous-specific AOD services in Queensland, their distribution, and funding for them; case studies of five QISMC member organisations; key issues identified in the case studies and literature; and, recommendations for future action.

The findings and recommendations made in the report focus on four key areas. The first of these is the services themselves, identification of their outcomes and impact on substance misuse. This includes consideration of relevant contextual variables, such as current levels of funding, clinical and operational policies and practices, and staff training and development. Recommendations focus on models of best practice for the provision of AOD services in Aboriginal and Torres Strait Islander community-controlled agencies.

The second area is the degree of collaboration between AOD specific service providers with local and regional agencies providing complimentary services – in particular Indigenous community-controlled health services. A particular issue here is the fact that only a small proportion of those Indigenous people who use alcohol and other drugs in a harmful manner come into contact with specialist substance misuse services. Those with substance misuse problems are much more likely to come into contact with primary health care providers (both Indigenous and non-Indigenous). However, in such settings their problems are often not recognised or not adequately addressed. Strategies for how Indigenous community-controlled AOD agencies can work more effectively with primary health care service providers are thus a key consideration.

The third area relates to the partnership between QAIHC and QISMC. This encompasses both: the current nature and purpose of the partnership; and the relationship between QISMC and its member organisations and the roles QISMC needs to fulfil on behalf of those organisations. Consideration is given to the future direction of the partnership and more broadly how substance misuse services can exert a greater influence on the AOD sector and national health agenda. Recommendations on how member organisations can be supported better and what resources are required to enable this are also provided.

The final area refers to the relationship AOD services have with funding bodies. This includes a range of issues including; arrangements for the provision of funding by government agencies and to Indigenous and non-Indigenous NGOs, reporting requirements, and governance and administrative matters. More broadly this includes

the issue of the relationship between Indigenous community control and the control exerted by funding agencies.

2. Methodology

As well as establishing the aims and rationale for the review, the project plan developed by QAIHC also included a set of specific objectives. These were as follows.

- To document the AOD services provided by each of the Aboriginal and Torres Strait Islander community-controlled agencies in Queensland.
- To analyse the evidence of outcomes associated with AOD services in each of the agencies.
- To identify relevant context variables that influence such activities and associated outcomes, including but not limited to:
  - existing and potential links and networks;
  - current levels of funding;
  - clinical and operations policies and practices; and,
  - staff training and development and other HR issues.
- To identify models of best practice for alcohol and other drugs services in Aboriginal and Torres Strait Islander community-controlled agencies.
- To identify strategies for Aboriginal and Torres Strait Islander community-controlled AOD agencies to improve outcomes including options for linking with and utilising the broader health sector.[1]

In addition, the QAIHC project plan specified a three part methodology to be employed. This included:

- a literature review;
- a review of relevant documentary data from each of the 14 QISMC organisations; and,
- qualitative data collection – including visits to each of the 14 sites, where interviews were to be conducted with key informants – to expand upon the documentary review and to elicit detailed information in relation to current activity, barriers and opportunities to improve outcomes.

The plan also specified that, in addition to general reviews of each of the 14 organisations, two were to be selected to be the subject of more detailed case studies. Together, the project objectives and the broad methodology specified by QAIHC provided the methodological framework for the project as it was originally planned.

In response to the project plan developed by QAIHC, Professor Dennis Gray prepared a written submission and made a presentation to a QISMC meeting convened in Brisbane on 12th December 2006. In the submission and presentation, he proposed an overlapping six stage plan and timetable for the conduct of the review. This was considered by QAIHC and QISMC and a contract between QAIHC and the National Drug Research Institute was signed on 4th April 2007.

2.1 Project plan

The project was originally scheduled to be conducted in the following stages over a 13-week period commencing at the time of the signing of the contract.

Stage 1: Project Establishment (weeks 1–2)

In Stage 1 of the project, establishment tasks such as making contact with participating organisations and making formal requests for the submission of documentary data pertaining to the substance misuse activities of each of the participating organisations were scheduled.

Stage 2: Literature Review (weeks 1–4)

The literature review was originally scheduled to commence at the outset of the project and to be conducted over a four-week period. As specified in the draft Project Plan developed by QAIHC, this was to include:

> An analysis of relevant literature in relation to AOD services in Aboriginal and Torres Strait Islander communities ... This will include consideration of successful outcomes in this regard, related policy and program development and implementation, and models of services delivery linked to successful outcomes.

Stage 3: Documentary Review (weeks 3–5)

Documents on the substance misuse programs conducted by each of the participating organisations were to be reviewed and summaries entered into a Microsoft Access Database. The database was to be based on those previously developed for the mapping of Indigenous substance misuse services and for the identification of elements of best practice in Indigenous substance misuse interventions.

Items to be included in the database were:

- program/project type
- program/project setting
- target populations
- target substances
- program/project governance and management structures
- health information and client record systems
- program/project staffing levels and needs
- staff qualifications and experience
- staff development activities
- internal service linkages
- external service linkages
- program/project funding sources and levels
- program/project outcomes

On the basis of the documentary data provided, draft summary case studies of each organisation were to be prepared. These were to be reviewed to identify any missing information or additional information that would be sought during site visits to each of the participating organisations. Analysis of this information was also be used to develop checklists for use in key informant interviews and focus groups to be conducted during the site visits.

In addition, we obtained from the key funding agencies, and verified with service providers, data on all Indigenous AOD projects conducted in the 2006–2007 financial year. These data included information on the types of organisations providing services, type of services provided, target drugs, locations in which services were provided, and supporting grants.

Stage 4: Site Visits (3 weeks)

Over a three week period, visits to each of the 14 QISMC member organisations were scheduled to be made by Professor Gray and Dr Meredith Green (who was employed as a Research Fellow on the project). A meeting with QAIHC and QISMC staff was scheduled to be held, at the commencement of this stage of the project, for the purpose of mutual briefings. It was proposed that a one-day visit be made to each of the sites and that an additional two days would be spent in two key sites – Cairns and Rockhampton – to gather further information for more detailed case studies in which a particular focus was to be upon linkages between services. To ensure standardisation of interview and other data collection procedures, both Gray and Green were to jointly visit the first two sites in Brisbane. Thereafter, they were to divide visits to the other sites between them.

At each of the sites, interviews and/or focus groups were to be conducted with staff and board members and other key stakeholders (identified beforehand in consultation with service staff). The purpose of the interviews and focus groups was to:

- fill in and gaps identified in the documentary review;
- identify perceptions of current program/project strengths, weaknesses, opportunities and threats to the delivery and outcome of services to client groups; and,
- in the case of the key sites, to gather additional information about service coordination and elements of good/best practice in regard to this.

Stage 5: Data Analysis (4 weeks)

Data analysis was to be conducted over a four-week period – commencing in the last week of site visits and continuing into the second week of the report writing stage. Transcripts of interviews and focus groups conducted in Stage 4 were to be entered into a textual database and, with qualitative data from the documentary review, were to be analysed thematically. Analysis was to focus upon meeting the key objectives of the project. It was to include analysis of material from both the documentary review and the interviews and focus groups – both of which were to be considered in the light of the findings of the literature review.

Stage 6: Report Writing (4 weeks)

The final report was to include:

- the literature review – identifying lessons to be learnt from successful interventions elsewhere as a basis for comparison with the activities of the services under review;
- a brief case study of the each of the current services highlighting strengths, weaknesses, opportunities and threats;
- more detailed case studies of the interaction and coordination of services in the two key sites; and,
- conclusions and recommendations for future directions.

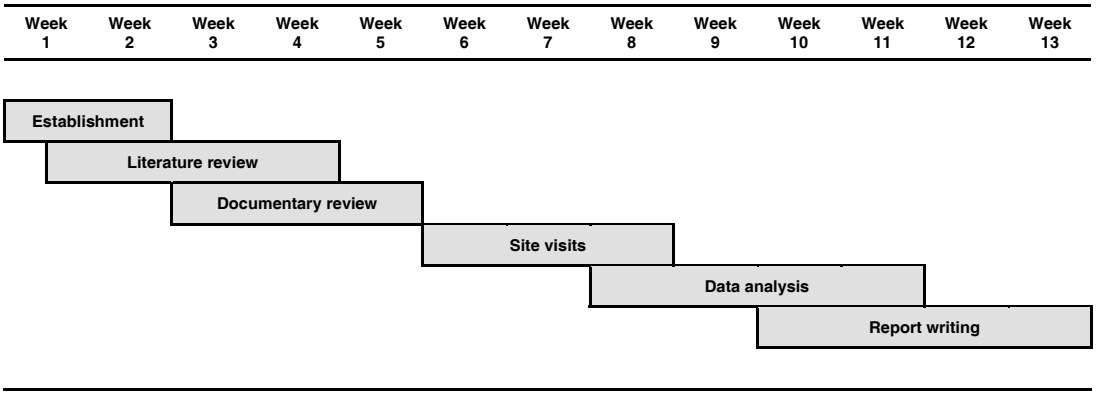
It was proposed that a draft report and presentation of the findings would be made to the QAIHC Board and QISMC Executive Committee by Professors Gray and Wilkes at a meeting to be held in Brisbane during week 12 of the project. No material on particular services was to be included in the report without the expressed consent of

those services. The report was be finalised in the light of feed-back from the particular services and the QAIHC Board and QISMC Executive Committee.

Project timetable

As indicated above, the project was to commence upon the signing of the contract (on the 4th April 2007) and be completed over a 13 week period as scheduled in Table 1. As noted above, the project extended considerably beyond this timeframe. The reasons for this are indicated in following sections of this chapter.

Table 1: Project timetable



Budget

The total estimated cost of conducting the project, $68,210, was considerably in excess of the QAIHC-QISMC budget for it. However – as it was deemed to be a worthwhile project and in accordance with NDRI's commitment to providing support to Indigenous community-controlled organisations within the AOD sector – NDRI agreed to contribute to the project the cost of salaries for the time allocated to the project by Professors Gray, Saggers and Wilkes. This reduced the cost of the project to QAIHC to a total of $47,744.

2.2 Ethical issues and project establishment

The project was conducted within the framework of the NHMRC's *Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research.*[2] NDRI's project proposal was approved by the QAIHC Board and the QISMC Executive Committee. In addition to complying the with NHMRC *Guidelines*, as specified in the QAIHC Project Plan:

- individual client records would not be accessed in any of the agencies visited;
- information obtained during interviews and focus groups discussions was to be de-identified unless approved by the organisations;
- a project advisory group was to be established in consultation with QAIHC and QISMC to advise on implementation and provide project feedback;
- each agency visited was be provided with a draft of their case study, and the opportunity to make corrections and comment, prior to inclusion in the final report; and,

- data analysis in relation to written documentation was to include only sources of publicly available information.

In anticipation of the signing of the research contract, an application to conduct the project was submitted to Curtin University of Technology's Human Research Ethics Committee in early January 2007. Approval was given by the Committee on 7th February 2007 (Protocol Approval NDRI-01-2007).

As scheduled, the project commenced on the signing of the project on the 4th April 2007. In anticipation of this, NDRI had prepared in advance a list of items required from each participating organisation for the documentary review. A letter of request for these documents was sent by the Chief Executive Officer of QAIHC on the 12th April 2007.

2.3 Literature review

At the time this project was being undertaken, the National Drug Research Institute was also undertaking a project to identify areas of greatest need in Indigenous substance misuse interventions for the National Indigenous Drug and Alcohol Committee (a committee of the Australian National Council on Drugs). As there was some overlap in the requirements for literature reviews for each project, a decision was made to combine them to bring more resources to bear and to provide a more detailed review for both projects.

The *Indigenous Australian Alcohol and Other Drugs Bibliographic Database* is a comprehensive database maintained by the National Drug Research Institute.[3] This database – which includes records on over 1300 items – was used as the primary source for the identification of literature pertaining specifically to alcohol and other drug use among Indigenous Australians. The database was searched using the key words 'intervention', 'recommendations for intervention', 'primary research' (including 'evaluation') and 'reviews and secondary research' and their various sub-categories. The search of the *Indigenous Australian Alcohol and Other Drugs Bibliographic Database* was supplemented by searches of 'Google Scholar', and 'Medline' and by reviewing the bibliographies and reference lists of items identified and selected from the electronic searches.

The literature on interventions for the harmful use of alcohol and other drugs among non-Indigenous populations is extensive and various aspects of this have been comprehensively reviewed by others. Thus, rather than seeking to review individual items from the general literature, we relied on the extant reviews.

2.4 Documentary review

The purpose of the review of documentation was to identify, in as much detail as possible: the objectives of the intervention strategies being undertaken by the organisations; the activities being conducted in furtherance of the those objectives; the resources (human, financial and capital) available for those activities, and their adequacy; and, the outcomes of the interventions.

Given the resources available to conduct the project, and the length of time that could be spent visiting each organisation, this component of the project was considered crucial as it would provide project staff with an overview of the organisations before they visited, preclude the collection of data that was already available, enable a more targeted approach to data collection at the time of site visits, and, reduce the amount of time that organisation staff would have to take from their normal duties.

As indicated previously, an initial request for documentary data was sent by the CEO of QAIHC to the individual organisations on the 12th April 2007. The documents requested were:

- completed Drug and Alcohol Service Report questionnaires for 2005–2006;
- 2005–2006 financial statements identifying sources of funding and components of expenditure;
- 2006–2007 budgets;
- the last three annual reports;
- any other reports on the organisations (e.g. reviews of programs or organisational activities); and,
- minutes of executive committee meetings from the previous 12 months (*where these did not contain confidential information*).

By the end of June, none of the documentary data had been received (thus putting the project considerably behind schedule). Thus, in early July, the CEO sent out a follow-up request and in late July QAIHC staff followed-up this request. However, by mid-August documents had been provided by only two organisations and by mid-October no additional documentation had been forthcoming. It was agreed by both the research project staff and staff from QAIHC and QISMC, that this in itself was a pointer to the limited capacity of many organisations to respond to requests for information over and above their normal activities.

Following discussions between research project and QAIHC staff, it was agreed that Professor Gray should make another presentation to QISMC representatives and seek their re-endorsement, or otherwise, for continuation of the project. This presentation took place on the 6th November 2007. It was subsequently decided by QISMC that: the project be re-endorsed and should continue whether or not all organisations were able to participate; a new deadline for the receipt of documentary data be set (21st December 2007); the documents be reviewed in the month of February 2008; and, site visits commence in March 2008. Accordingly, the research team developed a revised project plan with a completion date of 20th June 2008.

No additional documentary data were provided by other organisations until mid-February, when data – or subsets of them – were then available from five organisations:

- Gindaja Aboriginal Substance Misuse Corporation, Yarrabah;
- Gumbi Gumbi Aboriginal and Torres Strait Corporation, Rockhampton;
- Yaamba Recovery & Skills Training Centre, Bundaberg;
- Queensland Aboriginal and Islander Alcohol Services (QAIAS), Brisbane; and,

- one other (not named because it is not the subject of separate review and analysis in this report).

At this stage, further discussions were held again between research team members and QAIHC staff about the desirability, or otherwise of continuing the project. As a result of these discussions, it was agree that the project would continue but the focus would be upon the five QISMC member organisations that had provided documentary data. In addition to the data those organisations provided, we also accessed data from a complementary project being conducted for the National Indigenous Drug and Alcohol Committee which provided information on the broader range of Indigenous-specific AOD projects that were conducted in Queensland in 2006–2007.

2.5 Site visits: interviews and discussions

Following preliminary review of the documentary data, an interview checklist was developed to guide interviews and discussions during the site visits. Prior to the site visits – which were facilitated by Charmaine Jackson-Yeatman from QISMC – a meeting was held in Brisbane between Professor Gray and Dr Green and staff from QAIHC to clarify mutual expectations regarding the visits.

The first of the site visits – to QAIAS – was conducted by both Professor Gray and Dr Green, and the others by Dr Green in early to mid-April 2008. The focus of the interviews and discussions held at each site was upon:

- clarification of issues arising from the preliminary documentary review;
- the histories of the organisations;
- their perceptions of program strengths, weaknesses, opportunities and threats;
- partnerships and collaboration with other agencies in the area, particularly Indigenous community-controlled health organisations;
- participation in lobbying and policy development for the sector; and
- their views on the role of QISMC and its relationship to QAIHC.

Some interviews were also conducted with key stakeholders, who were identified in consultation with AOD service staff. These included representatives of other agencies providing services to the QISMC organisations, and agencies that worked in partnership with the organisations (including, other Indigenous community-controlled AOD organisations, Indigenous community-controlled health organisations, and Alcohol, Tobacco and Other Drug Services [ATODS]).

2.6 Data analysis

On the basis of available documentary and interview data, draft case studies of each organisation were prepared. Follow-up telephone interviews were then conducted with staff members from the organisation to collect missing or additional information. Follow-up telephone interviews were also conducted with key stakeholders not available at the time of the site visits, with staff from the Office of Aboriginal and Torres Strait Islander Health (OATSIH) and Aboriginal Hostels Ltd (AHL), and with QISMC/QAIHC staff to clarify information provided by the organisations. The draft case studies were then sent to each of the organisations for review.

While the drafts were with the individual organisations for review, each of the case studies was analysed thematically by members of the research team.[4] To begin, each member of the research team independently read the case studies and identified emerging themes. This process of open coding involved identifying differences and similarities within and between the case studies. The members of the research team then met to discuss and debate the different themes. Some themes were subsumed in other thematic categories and others were separated into multiple themes. Following this process of axial coding, the research team selectively coded each of the themes and agreed upon the key issues. The themes and key issues identified in this process were then presented to QISMC members at a meeting held on the Gold Coast in June 2008. At this meeting, QISMC members informally endorsed the key findings and provided additional information in regard to them.

In this report, case studies of only four of the participating organisations are presented. The fifth is not included as the Board of the organisation was not able to provide final endorsement of the case study before the deadline for presenting the final report. However, as participation in the project was approved by the Board, data collected from the organisation has been de-identified and included as a basis for discussion and recommendations (Chapter 10).

Analyses of the broader data set on Queensland AOD projects included: an overall summary of projects; identification of the types of organisations providing services; classification of projects by region and in accord with a model of service provision developed the United Kingdom's National Treatment Agency (see Chapter 3[5, 6]) in order to identify gaps in provision; and funding allocations and sources. In addition a comparison of projects and funding in 2006–2007 was made with data from 1999–2000 to identify changes in service provision.[7]

Finally, the results of both the qualitative and quantitative analyses were considered in relation to the review of literature, key policy documents, and the specific objectives of the overall project (page 4). On the basis of this, a set of recommendations was developed for the enhancement of the delivery of AOD services to Aboriginal and Islander peoples in Queensland.

3. Literature Review

As indicated in the previous chapter, the project plan developed by QAIHC included the undertaking of a literature review. As specified in the plan, this was to provide an analysis of relevant literature in relation to AOD services in Aboriginal and Torres Strait Islander communities and which was to include:

- consideration of successful outcomes in … regard (to the provision of services);
- related policy and program development and implementation; and,
- models of services delivery linked to successful outcomes.[1]

In this chapter, we have re-ordered consideration of these issues. We commence with a review of 'models of service delivery linked to successful outcomes'. We have done this because – to be effective – policy and practice must be consistent with an evidence-based understanding of those factors which facilitate or protect against the harmful misuse of alcohol and other drugs. Thus, the first section of the review provides a theoretical framework for intervention. The second section – 'consideration of successful outcomes' – focuses on the evidence for the efficacy of particular interventions. This enables consideration of these interventions in their broader contextual framework. Review of 'related policy and program development and implementation' in the third section enables consideration of these in the light of the evidence presented in the previous sections and assessment of the extent to which they are likely to be efficacious.

3.1 Models of service delivery linked to successful outcomes

The causes and consequences of harmful alcohol and other drug use are complex and strategies to address them must be multi-dimensional. 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.[8] This basic model was adapted by Zinberg who argued that to understand and address patterns of substance misuse 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).[9]

This basic conceptual framework underlies more complex models such as Lynch's model of structural determinants of health.[10] This model (Figure 1) highlights the complex set of relationships which determine both the health status of individuals (including their use or otherwise of psychoactive substances) and the social response to it. It 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.

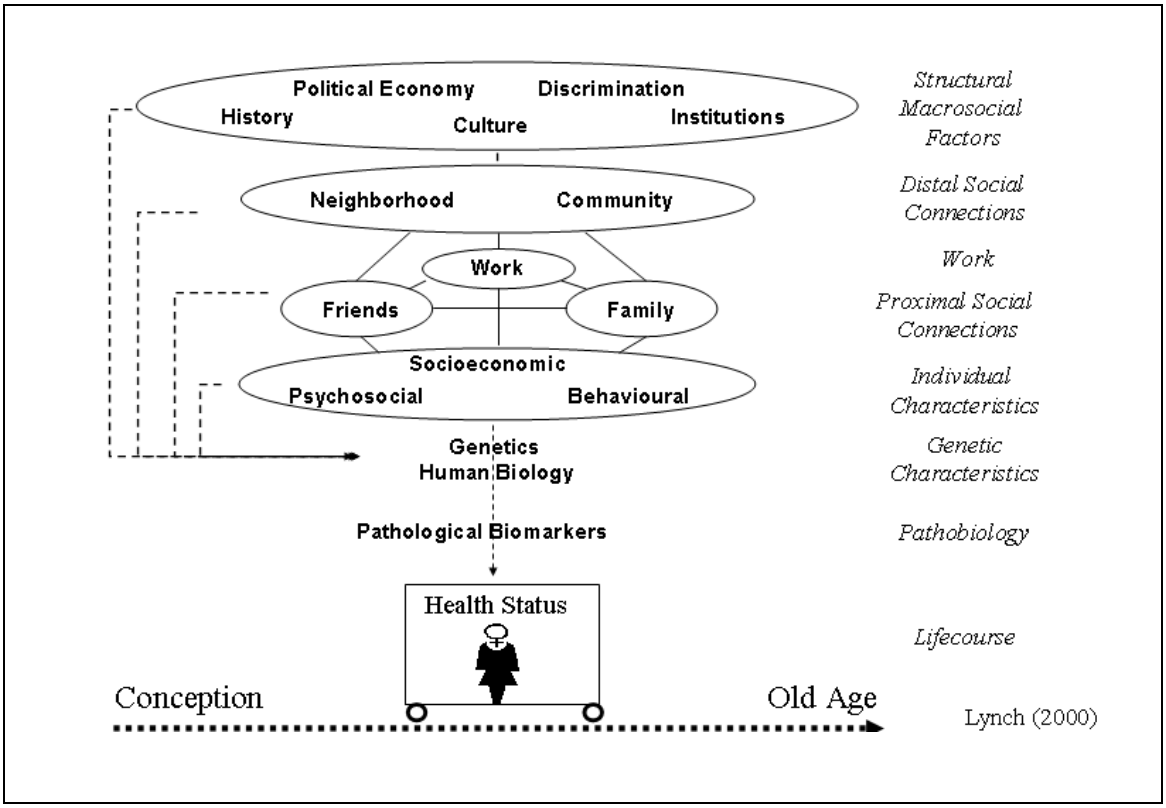


Figure 1: A multi-level and multi-time approach to social epidemiology

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.[11, 12, 13] However, over the past two decades, following the publication of the 'Whitehall studies' which demonstrated a clear inverse relationship between rankings in the public service and mortality rates,[14] there has been a resurgence of interest in this area. International evidence demonstrating the link between health status and 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 the World Health Organisation.[15, 16] Similar evidence from Australia has been presented in a book edited by Eckersley and others.[17]

With regard to Indigenous Australians, the link between social conditions and health status has been drawn by a 1979 House of Representative Standing Committee Report on Aboriginal Health, the Aboriginal Health Strategy Working Party, the Royal Commission into Aboriginal Deaths in Custody and a textbook on Aboriginal Health, among other publications.[18, 19, 20, 21] More recently, the evidence for such links has been set out in a book edited by Carson and others.[22] 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 (p. 25).[16]

A common model for categorising the range of interventions for addressing alcohol and other drugs is that used by Hamilton. This identifies opportunities for the prevention of substance misuse at primary, secondary and tertiary levels – including the prevention of harm to people other than users.[23]

Table 2: 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 (p. 163)[23]

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 the National Drug Research Institute (NDRI) for the Australian Government Department of Health and Ageing.[24] In the latter 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,[16] and a report prepared on the prevention of alcohol-related harm,[25] 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 (p. 70).[24]

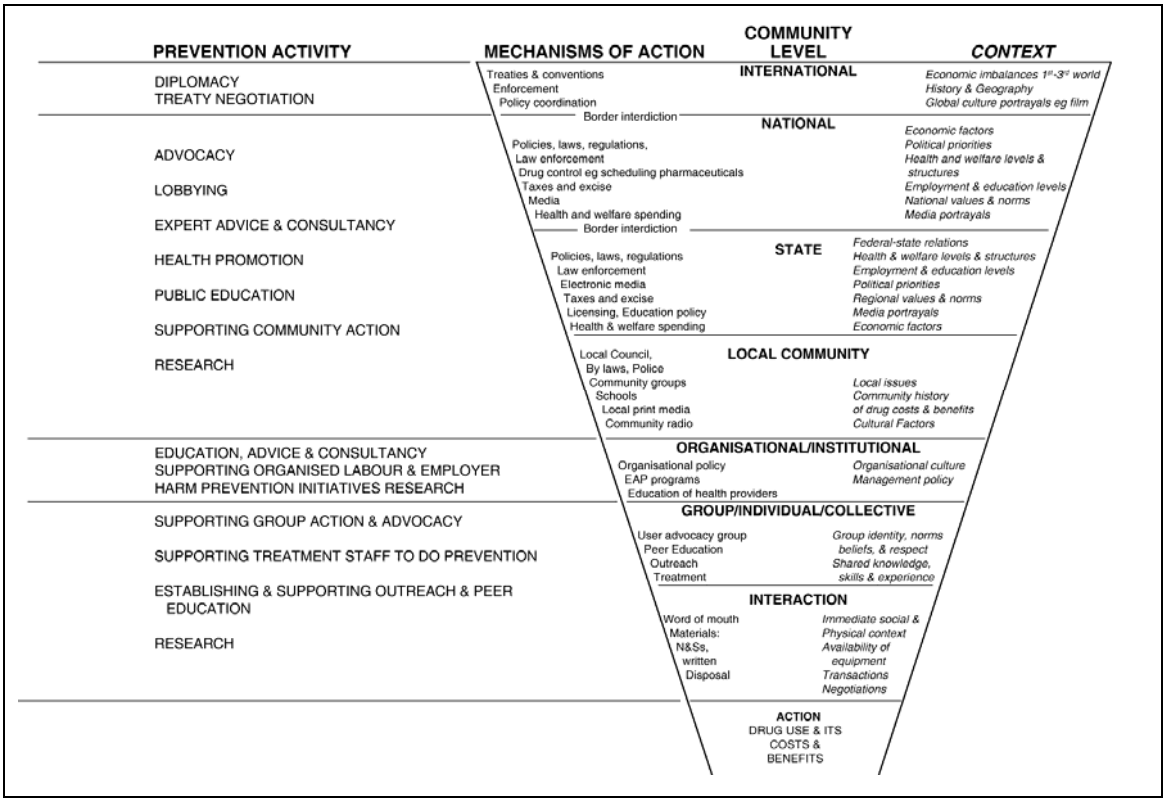


Figure 2: Systems model for the prevention of alcohol and other drug problems

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[26] – 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 substance misuse must be multi-faceted, include interventions at

all levels of the hierarchy of determinants, and should seek to enhance protective factors as well simply targeting the harmful aspects of use.

Table 3: 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
3	Structured community-based specialist drug misuse services	Drug specialist care planning and co-ordination Structured care planned counselling and therapy options Structured day programmes (urban and semi-urban) Community-based detoxification services Community-based prescribing stabilisation and maintenance prescribing Community-based drug treatment for offenders on DTTOs Other structured community-based drug treatment services targeting specific groups Structured aftercare programmes Liaison with drug treatment services
4a	Residential substance misuse specific services	Inpatient drug detoxification and stabilisation services Drug and alcohol residential rehabilitation services Residential drug and alcohol crisis centres Residential co-morbidity 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 to 21 years) HIV specialist units

Source: National Treatment Agency for Substance Misuse (p. 25) [5]

Table 4: 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
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 PHC 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	Inpatient detoxification Residential rehabilitation		
4b. Highly specialist non-substance misuse specific services	Specialist hospitals and hospital units		

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 – who have used the model in an Indigenous Queensland context – point out, it is applicable to the broad spectrum of alcohol and other drug treatment.[27] The NTA model identifies four tiers of intervention (Table 3) 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 on-going care), standards of care, and the provision of evidence-based interventions.

The NTA model focuses upon treatment of those already experiencing problems related to substance misuse: that is, upon those interventions classified as tertiary prevention by Hamilton. However, the model can be readily modified to include the other levels of prevention identified by Hamilton and to address the 'mechanisms of action' included in the NDRI model. 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 4). This includes demand, supply, and harm reduction strategies.

There are a number of points to be made about this expanded model. First, in Tier 1, it identifies services which are not primarily targeted at substance misuse but which include a range of primary prevention services which build upon factors which 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 have substance misuse problems with support which complements treatment *per se*. In this regard the expanded model is congruent with those reviews which 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 substance misuse services from Tiers 1, 2 and 3; or, as well as providing Tier 4 residential care, a substance misuse 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 Inter-departmental Committee which reviewed the Australian Government's Aboriginal and Torres Strait Islander Primary Health Care Program.[28] The number of Indigenous community-controlled health service (CCHS) providers is considerably greater than the number of community-controlled organisations providing substance misuse 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 someone else's) use of alcohol and other drugs. Given this, there is clearly a distinct role for CCHSs in the provision of substance misuse services. This is not, however, an argument against the resourcing of organisations that have been established specifically to provide substance misuse 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.[29, 30] 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 (p. 91).[31]

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 only provides a broad blue-print 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.

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 Australian National Council on Drugs commissioned a team from NDRI to identify elements of best practice in the provision of substance misuse services.[32] The project was based on a review of five Indigenous community-controlled organisations widely acknowledged to be successfully providing a broad spectrum of services. These 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 (p. 74).[32]

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 (p.75).[32]

These elements are similar to those identified in a review of Indigenous Canadian intervention projects.[33]

The Siggins Miller 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]' (p.49).[27] Based on community consultations, Siggins Miller 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 tolerance of violence and the misuse of alcohol and drugs and the supply of substances from the community, parents and other adults to young people; and,
- effective evidence-based services (p.49).[27]

As a starting point for enhancing Indigenous 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 for the development of measures for the process evaluation of Indigenous intervention projects.

3.2 Successful outcomes

There have been several reviews – both nationally and internationally – of the effectiveness of interventions for substance misuse in general and alcohol in particular. As indicated previously, in 2004, the NDRI published a report, commissioned by the Australian Government Department of Health and Ageing, which reviewed the evidence for the prevention of harmful substance use.[24] The review clearly placed harmful substance 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 which 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).[34]

Thomas Babor headed a team of international experts who wrote a book – sponsored by the World Health Organisation – reviewing the evidence for the efficacy of a 'toolkit' of strategies and interventions aimed at reducing alcohol-related harm.[25] 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 that 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 (p. 213).[25]

Although not specifically concerned with Indigenous people, 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.[25]

The evidence for the effectiveness of treatment for alcohol problems has been reviewed by Shand and her colleagues.[35] 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 National Health and Medical Research Council.[36] 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 (p.103).[35]

On the basis of their review, Shand and her colleagues developed a comprehensive set of guidelines for the treatment of alcohol problems. These guidelines are wide-ranging and include recommendations with regard to: screening, assessment, patient-treatment matching, withdrawal management, post-withdrawal treatment settings, brief interventions, psychosocial interventions, relapse prevention, extended care, and treatment issues for specific groups (pp. 1–10).[37] Importantly, they recommended that treatment include a range of elements including counselling, skills training and behavioural management.

A similar review to that undertaken by Shand *et al.* was undertaken in regard to treatment of illicit drug problems by Gowing and her colleagues.[38] Also using the NHRMC 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.

3.2.1 Outcomes among Indigenous Australians

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 people as being forced upon them by the non-Indigenous community; more frequent occurrence of co-morbid mental health problems; the settings in which they are offered; and, individual or social barriers to 'compliance'.

A comparative review of substance misuse interventions among Indigenous peoples in Australia, New Zealand, Canada and the United States was undertaken by Gray and Saggers.[39] They pointed out that, in each of these countries, the evidence base for addressing substance misuse 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 (p.382).[39]

The review undertaken by NDRI on behalf of the Department of Health and Ageing 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 which 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 substance misuse;
- adequate resourcing; and,
- a holistic and coordinated approach that includes Indigenous community-controlled organisations, all levels of government and all sectors (pp. 248–9).[24]

Gray and others also conducted an earlier review of alcohol-specific interventions for Indigenous Australians.[40] 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 that 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.[41] 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 have been predominantly Indigenous. The report included review of work done previously by

d'Abbs and Togni on restrictions in regional and remote Australia.[42] 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 that 'Evidence for the effectiveness of treatment specific to Indigenous clients is scant' (p. 93).[35] This reflected the findings of: the review by Gray and others; Hunter and Brady when developing an earlier set of treatment guidelines for Indigenous people; and those of a team contracted by the Department of Health and Ageing which developed a more recent set of treatment guidelines.[40, 30, 29] 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 (p.10)[37] – a recommendation reflecting a similar call made earlier by Brady.[43]

Alcohol has been, by far, the major focus in the literature in Indigenous substance misuse. In mid-2008, of 1303 items in the National Drug Research Institute's *Indigenous Australian Alcohol and Other Drugs Bibliographic Database*, 58 per cent dealt specifically with alcohol.[44] However, 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 people but found '… only three tobacco interventions have been formally evaluated in Indigenous communities with only one being able to conclusively show a positive effect' (p. xiv).[45] 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 the latter three: two reported on the same evaluation of a training program; and only one 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' (p. 486).[46]

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 people.[38] They commented on the absence of work in this area and highlighted the need for research among Indigenous people 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 people.

It is important to recognise that the paucity of published evaluation studies does not mean that alcohol and other drug interventions for Indigenous people are not effective. 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 people themselves which can be added to the range of strategies shown to be effective in other populations.

3.3 Policy and program development and implementation

There is a range of strategies and programs in place to address alcohol and other drug related harms. At the national level, these are encompassed by the *National Drug Strategy 2004–2009*.[47] Like earlier versions covering previous time periods, this strategy was agreed upon by the Ministerial Council on Drug Strategy (comprised of Australian and state and territory ministers of health and police as well as Australian Customs). The Strategy includes subsidiary strategies on alcohol, tobacco, and cannabis.[48, 49, 50] The Strategy has the overall objective of minimising the harm caused by alcohol and other drugs and includes supply, demand and harm reduction strategies.

An earlier version of the *National Drug Strategy* did not specifically address Indigenous issues.[51] However, in response to Indigenous concerns, the Ministerial Council on Drug Strategy established a National Drug Strategy Reference Group for Aboriginal and Torres Strait Islander Peoples (of which one of us, Wilkes, was the chair). This Group produced the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan.*[52] The Plan initially covered the period 2003–2006, but was subsequently amended to cover the period 2003–2009 to bring it into line with the *National Drug Strategy Framework 2004–2009*.[47]

The *Complementary Action Plan* includes 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 continually improve comprehensive approaches to reduce alcohol, tobacco and other drugs related harm;

3. substantially improved access for Aboriginal and Torres Strait Islander peoples to the range of services, programs and interventions that play a role in addressing alcohol, tobacco and other drugs issues;
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 capacity of community-controlled and mainstream organisations to provide quality services; and,
6. sustainable partnerships among Aboriginal and Torres Strait Islander communities, government and non-government agencies in developing and managing research, monitoring, evaluation and dissemination of information.

At the national level, the *Complementary Action Plan* is paralleled by the *National Strategic Framework for Aboriginal and Torres Strait Islander Health.*[53] Under this Framework – committed to by the Australian Health Ministers Conference – nine key result areas are identified. Among these is a focus on social and emotional well-being which includes a strong emphasis on addressing substance misuse. It also includes substance misuse interventions among areas of action to strengthen comprehensive primary health care services and, among other objectives, includes increased Indigenous participation in planning and managing health services and developing and retaining a competent health workforce. Importantly, the *Strategic Framework for Health* also recognised the need to link with wider strategies that impact on health – i.e. those that address the social determinants of Indigenous health (and substance use).

The health workforce issues identified in the *Complementary Action Plan* and the *Strategic Framework for Health* had previously been identified more broadly in the *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework.*[54] This was developed by the Commonwealth, State and Territory Standing Committee on Aboriginal and Torres Strait Islander Health for the Australian Health Ministers' Advisory Committee. This document recognised that a competent health workforce was integral to addressing the health needs of Indigenous Australians and that:

> … action is now required on specific strategies to improve the training, supply, recruitment and retention of appropriately skilled health professionals, health service managers and health policy officers in both mainstream and Aboriginal and Torres Strait Islander specific health services (p. 1).[54]

To this end, the *Workforce Framework* had five objectives:

1. increase the number of Aboriginal and Torres Strait Islander people working across all the health professions;
2. improve the clarity of roles, regulation and recognition of Aboriginal and Torres Strait Islander Health Workers as a key component of the health workforce, and improve vocational education and training sector support for training for Aboriginal and Torres Strait Islander Health Workers;
3. address the role and development needs of other health workforce groups contributing to Aboriginal and Torres Strait Islander health;
4. improve the effectiveness of training, recruitment and retention measures targeting both non-Indigenous Australian and Indigenous Australian health staff working within Aboriginal primary health services; and,

5. include clear accountability for government programs to quantify and achieve these objectives and support for Aboriginal and Torres Strait Islander organisations and people to drive the process (p.3).[54]

With regard to each of these four nationally agreed upon strategic frameworks – the National Drug Strategy, the *Complementary Action Plan*, the *Framework for Aboriginal and Torres Strait Islander Health* and the *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework* – implementation at the national level was to be the responsibility of the Australian Government, and the state and territory governments were to develop their own implementation plans and timetables according to jurisdictional priorities. This approach is summarised in the *Framework for Aboriginal and Torres Strait Islander Health* which states:

> This National Strategic Framework sets agreed directions for reform in Aboriginal and Torres Strait Islander health without imposing specific targets or benchmarks on the Commonwealth, State and Territory governments in recognition of the different histories circumstances and priorities of each jurisdiction. Therefore, reporting will record progress in areas consistent with the action areas detailed in each key result area and against the stated aims and, over time, chart each government's progress against their own baselines. Provision of financial resources to implement the Strategic Framework will depend on fiscal management strategies and competing funding priorities as determined by each jurisdiction's budget processes (pp. 39–40).[53]

Complementing the National Drug Strategy, is the *Queensland Drug Strategy 2006–1010*.[55] The goal of the Strategy is 'To improve health, social and economic outcomes by preventing and reducing the harmful effects of drug use in Queensland (p.2)' – both licit and illicit – and is based on the supply, demand and harm reduction strategies embodied in the National Drug Strategy. As well as being linked specifically to *Partnerships Queensland: Future Directions Framework for Aboriginal and Torres Strait Islander Health in Queensland 2005–10*,[56] the Queensland Drug Strategy also includes 'Indigenous alcohol and drug use' among seven priority areas and identifies a number of key areas for action. These are:

- expand the reach of community-based initiatives and programs under the *Meeting the Challenges of Substance Misuse* strategy to address alcohol and drug use and related problems (including underlying causes), among adults and young people in Indigenous communities;
- continue to work collaboratively with relevant Community Justice Groups and Councils to develop and implement improved alcohol management arrangements;
- develop and implement a multi-faceted awareness raising and community development program aimed at reducing the demand for alcohol in Indigenous communities;
- provide community-based programs, e.g. the *Indigenous Event Support Program*, to promote culturally appropriate anti-smoking messages at community sporting and cultural events;
- support the *Rio Tinto Child Health Partnership* to enhance existing health promotion and prevention programs for Fœtal Alcohol Syndrome, and prevent drinking and smoking during pregnancy;
- investigate the factors that influence young urban Indigenous women to initiate, maintain or stop smoking and drinking while pregnant and while caring for young

children. Using this research, work in partnership with urban communities to encourage and support positive behaviour change;

- implement the *Champions' Program and Negotiation Tables* process with a focus on alcohol demand reduction and child safety initiatives, and ensuring that outcomes from negotiation tables are actioned in a timely and effective manner;
- implement the *Indigenous Risk Impact Screen and Brief Intervention* (IRIS), to enable alcohol and drug workers and community workers to screen Indigenous clients for risks associated with drug use, provide assistance and make appropriate referrals;
- continue to implement the *Enhanced Model of Primary Health Care* for remote communities to promote health through a person's life, and to prevent and detect the main risk factors which lead to chronic diseases, in particular alcohol consumption and smoking; and,
- implement workforce enhancements for the delivery of alcohol and drug prevention and treatment services for *Meeting Challenges Making Choices* communities and other Indigenous communities (pp. 10–11).[55]

As indicated in the areas for action, the Indigenous component of the Queensland Drug Strategy builds on an earlier initiative, *Meeting Challenges Making Choices*, which was introduced in 2002. This strategy applied to 19 discrete 'Deed of Grant in Trust' communities – 17 of which are in the Cape York and Gulf area of the Mt Isa Region. The focus of the initiative was to reduce violence in those communities by placing restrictions on the supply and consumption of alcohol and by introducing alcohol management plans.

Partnerships Queensland: Future Directions Framework for Aboriginal and Torres Strait Islander Policy in Queensland 2005–10 is an attempt to integrate all aspects of Queensland Indigenous policy and practice. The policy has four goals: strong families; strong cultures safe places; and, skilled and prosperous people and communities (p.2).[56] Under the healthy living goal, alcohol and drug abuse are identified as a focus for action. Like the Queensland Drug Strategy, the Partnerships Framework builds on *Meeting Challenges Making Choices* and complementary initiatives – including addressing volatile substance misuse. The 'skilled and prosperous people and communities' goal includes a capacity building and leadership component which identified the need for investment in education and training.

To complement the initial supply reduction focus of *Meeting Challenges Making Choices*, in 2005 the Queensland Government introduced the 'Alcohol and Other Substances Demand Reduction Program' – to which it committed $12 million over four years. Like *Meeting Challenges Making Choices* it applied to the 19 discrete communities, and it had three foci: family and youth support; service enhancement and workforce development; and planning and partnerships. Incorporated bodies were invited to apply for program funding on a 'performance and service delivery contract basis'.

As part of the Partnerships Queensland initiative, in 2007, the pilot *Indigenous Alcohol Diversion Program: Your Health, Your Future* was introduced in Townsville,

Cairns and Rockhampton and the neighbouring 'Deed of Grant in Trust' communities of Palm Island, Yarrabah and Woorabinda.[57] The program aims to divert into treatment Indigenous people who are alcohol-dependent or high-risk drinkers. The program has two streams:

- the criminal justice stream targets defendants charged with offences where liquor is a factor … ; and,
- the child safety stream targets Indigenous parents involved in the child protection system who also have an alcohol problem.[57]

Under the pilot program $36.4 million was allocated to provide:

- 32 treatment places in Cairns and Rockhampton and 40 in Townsville for criminal justice participants;
- eight treatment place in Cairns and Rockhampton and ten in Townsville for child safety participants; and,
- 15 supported accommodation bed in each location.[58]

In 2008, based on a review of *Meeting Challenges Making Choices,* the Queensland Government introduced its 'Alcohol Reforms' package aimed at further reducing alcohol-related harm in the 19 'Deed of Grant in Trust' communities and two others.[59] As part of this package, the *Liquor Act 1992*, the *Aboriginal and Torres Strait Islander Communities (Justice, Land and Other Matters) Act 1984* and the *Police Powers and Responsibilities Act 2000* were each amended to facilitate greater control over the availability of alcohol. In addition $102 million of Australian and Queensland Government funding was committed to provide:

- new detoxification and rehabilitation programs;
- new programs like 'Cell Watch', sobering up facilities and support for community patrols;
- greater enforcement of alcohol restrictions with additional support from police and officers from Liquor Licensing Division;
- support programs including an increased focus on literacy, before and after school activities, more PCYC programs, help for families to manage their own homes and incomes, better parenting programs and targeted support for vulnerable families; and,
- support for community-run activities such as men's and women's groups.[59]

Clearly, there is a comprehensive AOD policy framework in place at both the national and State level. However, the extent to which these are effectively implemented and their outcomes is a matter for empirical investigation.

4. Indigenous specific AOD services in Queensland

4.1 Service provision

In 2006–2007, 43 organisations provided alcohol and other drug intervention services specifically for Indigenous people in Queensland. Between them, these organisations conducted a total of 54 projects (Table 5 and Appendix [page 111]). The majority of organisations providing those services were either Indigenous community-controlled organisations (ICCOs) (28 or 65 per cent) or Indigenous local governments (four or nine per cent) and between them they conducted 68 per cent of all projects. The Queensland Government Departments of Health, Communities, and Police (nine percent of agencies) conducted 15 percent of projects, non-Indigenous non-government organisations (16 per cent of agencies) conducted 15 percent of projects, and one non-Indigenous local government conducted one project.

Table 5: Types of organisations providing Indigenous AOD services by numbers of projects conducted, Queensland, 2006–2007

Organisation type	No. of orgs.	No. of projects conducted by individual organisations				No. of projects	% of projects
		1	2	3	5		
Indigenous CCO	28	25	2	1	-	32	59
Indigenous Local Govt.	4	3	1	-	-	5	9
Local Govt.	1	1	-	-	-	1	2
Queensland Govt.	4	3		-	1	8	15
Non-Indigenous NGO	7	6	1	-	-	8	15
	43	38	4	1	1	54	100

In Table 6 the distribution of projects by Australian Bureau of Statistics' Indigenous Regions by NTA model service tiers is presented. When considering these data, it is important to bear in mind that – while the *Complementary Action Plan* calls for a range of services to be available at the local level – the data only tell us about availability at the regional level. Within regions, many services are not available locally.

Eight (15 per cent) of the 54 intervention projects fell into the 'Non-substance misuse specific services' category. These were prevention projects which primarily aimed to provide diversionary activities for young people – such as the Wet Season Projects – and most were conducted in the Cairns Region (including for the purposes of this report the Cape York and the Torres Strait Islands Indigenous Regions). Four of these were conducted by Indigenous local governments, one by a non-Indigenous local government, and one each by an ICCO and a non-Indigenous NGO. It is important to

note that this does not exhaust the range of 'non-substance misuse specific services', as it includes only those projects conducted with funding *specifically* to address AOD misuse. In all regions, there are agencies which provide services that are important for preventing AOD misuse, or supporting those who have AOD-related problems, but which are not funded directly to do so. Organisations providing Tier 2, 3 and 4 services do utilise the supports provided by non-substance misuse services. However, from discussions with providers from the upper Tiers, there is some variation in the strengths of these collaborative relationships and some providers are constrained by staffing and resource factors in their ability to make and utilise such linkages.

Table 6: Indigenous AOD projects by tier by Indigenous region, 2006–2007

Tier	Region							Total
	Cairns	Towns-ville	Rock-hampton	Mount Isa	Roma	Brisbane	Qld wide	
1. Non-substance misuse specific services	5	1	-	1	-	1	-	8
2. Open access services	8	5	4	5	-	4	4	30
3. Structured community-based services	1	-	-	1	-	2	-	4
4a. Residential services	2	2	3	1	1	2	1	12
Total	16	8	7	8	1	9	5	54

The majority of projects (30 or 56 per cent) were Tier 2 interventions. Twenty (66 per cent) of these were harm reduction initiatives such as the provision of safe places, night patrols or 'cell watch' projects. These were conducted in all regions except Roma; and in Mt Isa they included a focus on young people and volatile substance use. The other ten projects in this category were demand reduction interventions. Of these, seven provided various health promotional interventions and three were capacity building projects – training in the use of the Indigenous Risk Impact Screen, development of a program to address fœtal alcohol spectrum disorder in Cape communities, and health worker conference attendance. Of the 20 harm reduction projects: 12 were conducted by ICCOs and one by an Indigenous local government; five by non-Indigenous NGOs; and two by the Department of Communities. Of the ten demand reduction projects, six were conducted by Queensland Government agencies (five by Queensland Health and one by Queensland Police), and four by ICCOs (three by one health service and one by a men's group).

Four projects focused on the provision of Tier 3 'Structured community-based services' – all of which were non-residential treatment or healing services. Three of these – conducted by two ICCOs in Brisbane and by one non-Indigenous NGO in Cairns – provided treatment for alcohol dependent persons. The fourth (conducted by a non-Indigenous NGO) provided healing services for the families of young people in

Mt Isa. Again it should be noted, that this does not exhaust the range of non-residential services as some projects which primarily provide residential services also provide non-residential treatment – including to clients diverted under QIADP. However, the capacity of most residential treatment services to provide non-residential treatment is circumscribed.

Of the 12 projects in Tier 4, 11 were residential treatment services and the other was a capacity building project conducted by the Queensland Aboriginal and Islander Health Council to provide support through QISMC to the treatment services. The residential treatment services were all conducted by ICCOs and were spread across all regions of the State. The Goori House project in Brisbane also included a half-way house. It was the only one to specifically do so – although some other services provided clients with the opportunity to stay for a post-treatment residential period to assist with their transition back into the community. As indicated above, some of the services in this Tier also provided non-residential treatment and some Tier 2 preventive services – however, as also indicated above, their capacity in this regard was limited.

Of the 54 projects, the primary focus of the majority (42 or 78 per cent) was upon alcohol-related problems. The primary foci of the others were volatile substances (6), tobacco (3), a multi-drug focus (2) and cannabis (1). Of those focused on alcohol 13 dealt with alcohol only – primarily Tier 2 harm reduction projects. The others had a secondary focus on some combination of illicit drugs (particularly cannabis and to a lesser extent amphetamine type stimulants) and/or tobacco.

4.2 Project funding

Details of funding expended upon Indigenous AOD projects conducted in Queensland in 2006–2007 are presented in Table 7. The data were provided by the funding agencies themselves and expenditures verified with the organisations providing the services. In all, a total of approximately $24.9 million was expended. This amount is an underestimate as some data on funding allocated by a major NGO were deemed 'commercial – in confidence'. Nevertheless – given the small proportion NGO funding overall – the under-estimate is also likely to be small.

The single largest amount of funds was provided by the Australian Government Department of Health and Ageing – with its Office of Aboriginal and Torres Strait Islander Health and Drug Strategy Branch together contributing 62 per cent of the total. In addition, the Australian Government contributed four per cent of funding through Aboriginal Hostels and one per cent through other agencies. The other major contributor was the Queensland Government which provided: 28 per cent of funds through the Department of Communities; three per cent through Queensland Health; and one percent through other departments. Non-government sources – the Alcohol Education and Rehabilitation Foundation and Beyond Blue – provided only one per cent of the funding we were able to identify. Of total expenditure, a little over $3.96 million (16 per cent) was for one-off capital expenses (including vehicles) – all of which was provided by OATSIH. Allocation of funds by these various agencies on a regional basis is summarised in Table 8.

Table 7: Funding for Indigenous AOD projects by funding agency, Queensland, 2006–2007

Funding agency	Funding $000	%age of funding
Australian Government Department of Health & Ageing – OATSIH	14,724	59
Australian Government Department of Health & Ageing – Other	627	3
Aboriginal Hostels	1,081	4
Australian Government – Other	226	1
Qld Department of Communities	6,864	28
Qld Health – ATODS	871	3
Qld Government – Other	296	1
NGOs	239	1
Totals	24,929	100

Table 8: Regional funding expenditure, Indigenous AOD projects, by agency, Queensland, 2006–2007

Agency	Cairns	Towns-ville	Rock-hampton	Region Mount Isa	Roma	Brisbane	Qld wide	Total $
OATSIH	5,969	3,026	1,467	1,384	317	2,562	-	14,724
DoHA Other	89	-	-	55	-	135	349	627
Aboriginal Hostels	389	181	105	167	97	143	-	1,081
Aust. Govt. – Other	29	-	-	-	-	198	-	226
DOCS	1,449	1,625	1,017	1,714	-	1,058	-	6,864
Qld Health	16	-	-	-	-	150	705	871
Qld Govt. – Other	6	125	-	-	-	165	-	296
NGOs	114	-	-	125	-	-	-	239
Total	8,060	4,957	2,589	3,445	414	4,410	1,054	24,929*

* Errors due to rounding.

As indicated above, a total of 43 service providers conducted 54 projects. For the purpose of the summary analysis in Table 9, one of these providers, the Queensland Department of Communities, which conducted separately administered projects in two regions, has been treated as a separate provider of each – bringing the total to 44 providers. For each of these projects, we endeavoured to identify the number of grants under which it was funded. However, this was not always possible because some data were provided to us in aggregated form. For example, we obtained summary information on five 'grants' for one residential treatment service, but one of those 'grants' was an aggregation of nine smaller grants. Thus, the number of discrete grants we have identified should be regarded as an underestimate. To the extent that we have been able to identify them, there was a total of at least 83 separate grants to

fund the projects. Of the 54 projects: 40 (74 per cent) were funded by one grant each; seven (13 per cent) by two grants; and seven (13 per cent) by three or more grants. As Table 9 also shows, there was considerable regional variation in funding on a per capita basis – ranging from a low of $58 per person aged ≥15 years in the Roma Region to $801 per person in the Mt Isa Region.

Table 9: Numbers of service providers, projects, and grants and total and per capita (Indigenous persons aged ≥15 years) funding by region, Queensland, 2006–2007

Region	No. providers	No. projects	No. grants	Total Funding $000	Indigenous Population ≥ 15 years	Per capita Funding $
Cairns	9	13	25	8,060	20,231	398
Townsville	7	8	14	4,957	11,644	426
Rockhampton	7	7	9	2,589	8,940	290
Mount Isa	9	10	15	3,455	4,302	801
Roma	1	1	2	414	7,077	58
Brisbane	10	14	17	4,410	25,372	174
Queensland-wide	1	1	1	1,054	77,566	14
Totals	44	54	83	24,929	77,566	321

In Table 10, we have broken down the funding on a per capita basis for each Tier of service provision and region. From this it can be seen that there was a disparity in the funds allocated to each Tier. In part, this reflects the higher cost of providing some services – for example the higher cost of providing Tier 4 residential treatment services vis-à-vis Tier 2 health promotion services. It might also be expected that a smaller proportion of AOD funding is allocated to the provision of Tier 1 services, which in many cases are more appropriately provided by agencies from other sectors. Despite this, there was an apparent imbalance which reflects the limited provision of Tier 3 services – particularly non-residential treatment and on-going care services. To a considerable extent the imbalance appears to reflect priorities of the funding agencies. In the case of OATSIH and other Australian Government agencies, the greatest proportion of the funds they provided went to Tier 4 residential services – this being in part historically determined by the number of established services. In the case of Queensland government agencies, most of the funding provided by the Department of Communities was allocated to Tier 2 harm reduction projects such as safe places and, to a lesser extent, the funding of treatment services by Indigenous NGOs as part of QIADP. Queensland Health's commitment of funds to Indigenous specific services was limited with most of its funds being allocated to Tier 2 demand reduction projects which it conducted itself and with relatively small allocations of funding to two Tier 4 Indigenous residential treatment services.

Again evident in Table 10 (as in Table 9) is the disparity between the funding of services on a regional basis. In part, this may reflect variation in the magnitude of AOD-related problems and the higher cost of service provision in more remote areas.

However, it also reflects the absence of particular types of service in some regions – as in the Roma Region for example. It may also reflect an assumption that there is a wider range of mainstream service providers in the south-east of the State which can be accessed by Indigenous people (although evidence from other sources suggests that, in fact, they are unlikely to do so).

Table 10: Per capita funding (persons aged ≥15 years) for Indigenous AOD projects by tier by Indigenous region, 2006–2007

Tier	Region							Total $
	Cairns	Towns-ville	Rock-hampton	Mount Isa	Roma	Brisbane	Qld wide	
1. Non-substance misuse specific services	30	4	-	13	-	8	-	12
2. Open access services	54	131	114	398	-	49	11	97
3. Structured community-based services	9	-	-	29	-	26	-	12
4a. Residential services	306	291	176	360	58	90	2	201
Total	398	426	290	801	58	174	14	321*

* Errors due to rounding

4.3 A longitudinal perspective

Comparative data on service provision and funding for the years 1999–2000 is available from a project conducted by Gray and others for the Australian National Council on Drugs.[7] In the seven year time period between then and 2006–2007 there was an increase of 60 per cent in the number of organisations providing services and an approximate increase of 64 per cent in the number of projects (Table 11). The latter number is approximate because of slight differences as a result of some projects being combined or split. Nevertheless, this was a significant increase.

The increases evident in Table 11 were not linear, in that there was considerable discontinuity in service provision. Of the 27 organisations providing services in 1999–2000, nine (33 per cent) were no longer doing so in 2006–2007. Of those nine organisations, seven were ICCOs, one was an Indigenous local government and one a non-Indigenous NGO. The discontinuity was even more marked with regard to particular intervention projects, with 13 (41 per cent) of those conducted in 1999–2000 having been discontinued by 2006–2007. Of those, eight had been conducted by ICCOs, three by Queensland Government agencies and one each by a non-Indigenous local government and a non-indigenous NGO. Of the 25 new projects operating in 2006–2007, a significant proportion were Tier 2 Harm reduction projects. These changes are in large part a reflection of the short-term nature of much funding in the sector – particularly with regard to Tier 2 services.

Table 11: Types of organisations providing Indigenous AOD services by numbers of projects conducted, Queensland, 1999–2000 and 2006–2007

Organisation type	1999–2000			2006–2007		
	No. of orgs.	No. of projects	% of projects	No. of orgs.	No. of projects	% of projects
Indigenous CCO	22	26	81	28	32	59
Indigenous Local Govt.	1	1	3	4	5	9
Local Govt.	-	-	-	1	1	2
Queensland Govt.	3	4	13	4	8	15
Non-Indigenous NGO	1	1	3	7	8	15
	27	32	100	44	54	100

There were increases in the numbers of Indigenous community controlled organisations (including Indigenous local governments) providing services and in the number of projects they conducted. However, as a proportion, they decreased from 85 per cent to 74 per cent of all providers and from 84 per cent to 69 per cent of all projects. On the other hand, the percentage of non-Indigenous NGOs providing services increased from four to 16 per cent and the number of projects they conducted from three to 15 per cent.

Table 12: Funding for Indigenous AOD projects by funding agency, Queensland, 1999–2000 and 2006–2007

Funding agency	1999–2000		2006–2007		Percent increase
	$000*	%	$000	%	
DoHA – OATSIH	3,707	46	10,767	43	190
DoHA – Other	391	5	627	3	60
Aboriginal Hostels	1,010	12	1,081	4	7
Australian Government – Other	120	1	226	1	88
Qld Department of Communities#	2,675	33	6,864	28	157
Qld Health – ATODS	214	3	871	3	307
Qld Government – Other	0	0	296	1	-
NGOs	0	0	239	1	-
Totals	8,117	100	20,971	100	158

* 2006–2007 dollars
# Previously Department of Aboriginal and Torres Strait Islander Policy

In 1999–2000, excluding capital expenditure, $6.75 million was expended on Indigenous specific AOD services in Queensland.[7] In Table 12 – using data obtained from the Reserve Bank of Australia (http://www.rba.gov.au/Statistics/historical_cpi_data.xls) – data from that year have been adjusted for consumer price inflation

and are presented in 2006–2007 dollars. These figures are then compared with expenditure in 2006–2007 minus the $3.96 million in capital expenditure contributed by OATSIH; that is, $20.97 million. In both periods, the Australian Government Department of Health and Ageing (OATSIH and the Drug Strategy Branch) provided the greatest percentage of funding – 51 and 46 per cent – and increased its overall contribution by 190 per cent. After the Department of Health and Ageing, the largest contributor of funds was the Queensland Department of Communities (in 1999–2000 this contribution was made by the then Department of Aboriginal and Torres Strait Islander Policy). In each period, it contributed 33 and 28 per cent of funds and over the period increased its contribution by 157 per cent. Although contributing three per cent of funds in each period, coming from a small base, Queensland Health's ATODS branch increased its overall contribution by over 300 per cent. Overall, there was an increase of 158 per cent in total expenditure. However this decreases to 125 per cent when adjusted for population increases. This represents a significant commitment of funds to addressing harmful AOD use among Indigenous people in Queensland. However, despite this commitment, there remain significant gaps in service provision.

5. Queensland Indigenous Substance Misuse Council

Discussions about establishing a peak body to represent residential rehabilitation services in Queensland started as early as the 1980s, but it was not until 2003 that representatives from those services got together and agreed to form the Queensland Indigenous Substance Misuse Council (QISMC). However, QISMC was not formally established until funded, through the Queensland Aboriginal and Islander Health Council (QAIHC), by the Office of Aboriginal and Torres Strait Islander Health in 2004, and the signing of an MoU between QISMC and QAIHC. However, QISMC remains unincorporated.

Under the 2004 MoU, QISMC and QAIHC aim to:

- build a sustainable united community voice to governments in relation to addressing the use of alcohol, tobacco and other drugs within a primary health care approach to enhance the health and wellbeing of Aboriginal and Torres Strait Islander people;
- improve the physical, social, emotional and cultural wellbeing of Aboriginal and Torres Strait Islander people … (by reducing) the harms of alcohol and other drug use;
- develop good practice in service delivery models for alcohol and other drugs work across the continuum of care; and,
- ensure member organisations are adequately resourced and supported to respond effectively to policy and program funding and accountability requirements.

OATSIH provides funding for the QISMC secretariat – a member support position and a substance misuse policy officer position (personal communication, QAIHC's Director of Policy and Advocacy and QISMC Secretariat). This secretariat is hosted by QAIHC in its Brisbane office. In addition, another four staff members were dedicated to the support of QISMC through the Queensland Indigenous Alcohol Diversionary Program (QIADP). However, the funding, provided by Queensland Health, for those positions ended on the 30th June 2008 and the positions were not be re-funded.

5.1 QISMC membership

As indicated in the previous chapter, of the 43 organisations which provided Indigenous specific AOD services in 2006–2007, 28 were ICCOs and four were Indigenous local government organisations. Of the former organisations 13 were members of QISMC (two of which were also associate members of QAIHC) and two were members of QAIHC. QISMC member organisations comprised forty per cent of Indigenous organisations providing AOD services, and thirty per cent of all organisations, providing AOD services in Queensland. In general, they provided Tier 3 and Tier 4 demand reduction services, while non-members mainly provided Tier 2

harm reduction services. Thus, QISMC represents a particular sub-set of those Indigenous organisations providing AOD services. Currently, it is made up of the following 14 ICCOs:

- Gindaja Rehabilitation Centre (Yarrabah);
- Congress Community Development and Education Unit (Stagpole Street Drug and Alcohol Rehabilitation Unit), Townsville;
- Palm Island Alcohol and Drug Rehabilitation Aboriginal Corporation (Ferdy's Haven), Palm Island;
- Aborigines and Islanders Alcohol Relief Service Ltd (AIARS), Cairns;
- Kalkadoon Aboriginal Sobriety House (KASH), Mt Isa;
- Yaamba Aboriginal and Torres Strait Islander Corporation for Men, Bundaberg;
- Gumbi Gumbi Aboriginal and Torres Strait Islanders Corporation, Rockhampton;
- Wunjuada Aboriginal Corporation for Alcoholism and Drug Dependence Service, Cherbourg;
- Milbi Incorporated, Rockhampton;
- Galangoor Duwalami Aboriginal and Torres Strait Islander Corporation, Hervey Bay (before its recent incorporation, AOD services provided by Galangoor Duwalami were provided out of Korrawinga Aboriginal Corporation);
- Queensland Aboriginal and Torres Strait Islander Corporation for Alcohol and Drug Dependence (QAIAS), New Farm, Brisbane;
- Meeanjin Treatment Association, Fortitude Valley, Brisbane.
- Krurungal Aboriginal and Torres Strait Islander Corporation for Welfare Resource and Housing, Gold Coast; and,
- Goori House Addiction Treatment Centre, Cleveland, Brisbane. [60, 61]

The majority of QISMC member organisations – including those which are the subject of case studies in the following chapters – provide residential treatment services. However, three services – Galangoor Duwalami, Meeanjin Treatment Association and Krurungal Corporation for Welfare Resource and Housing – provide non-residential assessment, counselling, referral, and advocacy services. Recently three services – Gumbi Gumbi, Milbi and Gindaja – have also become involved in the Queensland Indigenous Alcohol Diversionary Program (QIADP). As indicated in Chapter 3, this is a pilot program, to divert people facing the criminal justice system or whose children are assessed as needing protection by the Department of Child Protection into alcohol treatment programs.[57]

Of the organisations: three (Gindaja Rehabilitation Centre, Ferdy's Haven and Wunjuada Alcohol Services) are located in discrete Indigenous communities; three (Goori House, Queensland Aboriginal and Islander Alcohol Services and Meeanjin Treatment Association) are located in Brisbane; and the remaining eight are located in various regional cities and towns. These member organisations are clustered into three regional groupings:

- Northern – Gindaja, Stagpole St, Ferdy's Haven, AIARS, and KASH;
- Central – Yaamba, Gumbi Gumbi, Wunjuada, Milbi, and Galangoor Duwalami; and,

- Southern – QAIAS, Meanjin, Krurungal, and Goori House.

Each of the organisations sends delegates to QISMC annual general meetings. Delegates selected from each of the regional groupings, along with the QISMC policy officer, comprise the QISMC Executive Committee.

5.2 Purpose

Although not incorporated, QISMC has a draft mission statement and a draft constitution, and prepares annual work plans. According to the draft constitution, QISMC's mission is to:

> To advocate for member services to be adequately and equitably resourced to develop and deliver a range of services, in an effective and culturally appropriate manner, to holistically address the primary health care needs of their clients including drug and alcohol education, prevention and early intervention, treatment and rehabilitation, physical, social and emotional health, social and cultural integration and socio-economic issues.[62]

The aims and objectives set out in the draft constitution are broad. They include: amelioration of poverty; advancement of Aboriginal religion; education, training and research; and provision of holistic, culturally-appropriate, health and health-related services.[61] Similarly, the strategies to achieve these aims and objectives are broad and include: supporting members and other Indigenous community-controlled organisations; program implementation; policy and strategy development; establishing partnerships; employment and training of Indigenous people; and, representation and advocacy.

QISMC's 2006–2007 Draft Annual Work Plan identified the following six priority areas.

1. Relationship management – developing and participating in relationships with the community-controlled primary health care sector, Indigenous and mainstream services that have common or cross-over roles and responsibilities with AOD services, key national, state and local agencies and bodies, drug and alcohol research units, and philanthropic and aid agencies and organisations.
2. Policy and advocacy – development of strategies and policies which impact on Aboriginal and Torres Strait Islander people, particularly in relation to alcohol and drug issues.
3. Member support – writing funding proposals, developing policy and procedure manuals, developing individual business and strategic plans, establishing partnership with regional government and non-government agencies, and providing public relations support and advice.
4. QISMC corporate governance – developing culturally appropriate quality improvement standards, a governance procedures manual, and a human resources policy manual.
5. Drug and alcohol workforce and planning – identifying the skills and workforce needs of the sector, employment opportunities for Indigenous people in the sector, and training and staff development opportunities.
6. Drug and alcohol service information and data – development of an IT and communication strategy, analysis of Queensland Drug and Alcohol Service Report

(DASR) data, and development and implementation of a common Drug and Alcohol Client Management Systems. [63]

On behalf of QISMC, QAIHC has negotiated the inclusion of QISMC on the Queensland Aboriginal and Torres Strait Islander Health Partnership Forum.[60] The Forum is made up representatives of DoHA, Queensland Health, the Indigenous community-controlled sector (QAIHC, QISMIC), and the Northern Aboriginal and Torres Strait Islander Health Alliance (NATSIHA). It was established in 1996 as part of the Queensland Aboriginal and Torres Strait Islander Health Partnership to ensure implementation of the commitments to the Framework Agreement on Aboriginal and Torres Strait Islander Health which aim to improve the health status and wellbeing of Aboriginal and Torres Strait Islander peoples to a level at least commensurate with that of the wider Australian community. QISMC's participation in the Forum, and the roles of its member support and substance misuse officers in part address the first two priority areas of the work plan.

Progress in the fifth priority area – drug and alcohol workforce and planning – includes the implementation in 2006 of the Certificate III Community Services Work (Alcohol and Drugs) Training Program.[64] This two-year pilot program is being delivered to QISMC members and others (including ATODS staff) through a partnership arrangement between QAIHC, QISMC, the Queensland Alcohol and Drug Research and Education Centre (QADREC) and Western Australian Drug and Alcohol Office (DAO). The QISMC member support officer has been involved in delivering this training and the provision of support for it. The member support and substance misuse officers are also active in the implementation of strategies to implement QISMC's other priorities.

5.3 Future directions

There is continuing debate among members of QISMC as to the directions the organisation should take in the future and QISMC has convened several workshops to address the various issues it is confronting. One of these issues is organisational structure and role of QISMC itself. To assist members to address the issue, in 2007, the Substance Misuse Policy Officer developed a paper entitled 'Options for State-wide representation for the Aboriginal and Torres Strait Islander community controlled alcohol and other drugs sector'.[65] The paper canvassed three options. The first of these was for QISMC to incorporate as a discrete peak body. At a 2006 QISMC workshop, members expressed the view that – based on its strengths, including the unity amongst members and the quality of the executive committee – QISMC had an opportunity to become a leader within the AOD sector.[66] However, it was also agreed that QISMC's potential was limited by a lack of promotion, and the absence of a business plan, data systems, and documentation of program and services. As consequence of these limitations, it was felt that a considerable amount of funding would be required to establish and support a separate peak body. There was also concern that the amount of time and effort required to establish a peak body might overburden individual services.

The second option was that QISMC members become members of QAIHC. This would enable QISMC to draw on QAIHC's existing infrastructure, services and support –

which included, at the time, six QAIHC staff dedicated to substance misuse activities.[67] Under this option an arrangement might be negotiated to ensure there are designated positions for Indigenous AOD services on the QAIHC board. The third option was to maintain the current 'temporary' arrangement of QAIHC supporting QISMC. These various options were further discussed at workshops held in Brisbane in December 2007 and on the Gold Coast in June 2008. However, at the time of writing, no firm decision on these options or action towards implementing them has taken place.

According to QAIHC's Director of Policy and Advocacy, QAIHC is eager for QISMC to move ahead and is 'relaxed' about what direction that might take. QAIHC does not intend to lead QISMC in any particular direction and believes that that leadership must come from the member organisations. However, the (then) Director of QAIHC commented that QISMC members appeared to have difficulty in making a decision regarding QISMC's future and felt that this may be due to:

- limited funding for broader strategic management;
- unsustained motivation of member organisations;
- limited interest from the boards of AOD services in regards to sector issues; and,
- AOD services not recognising that they have leverage in Indigenous health.

At the time of writing, there was no clear resolution to the future directions or the structure that QISMC might take. However, we take these issues up in Chapter 10 in the light of the broader context of Indigenous AOD services in Queensland and the case studies presented in the following chapters.

6. Gindaja Substance Misuse Aboriginal Corporation

6.1 Introduction

Yarrabah – which means 'paradise by the sea'[68] – is an Indigenous community of about 2500 people,[84] located 37 kilometres south of Cairns. Yarrabah was established as a mission in 1892 by an Anglican missionary who used to visit the Indigenous people living in the area and was also the home of the first Aboriginal Anglican clergyman in Australia, James Noble. When the mission was closed in the 1960s, Yarrabah came under the control of the Queensland Government and Yarrabah Community Aboriginal Council was established. In 1986 Yarrabah Community received Deed Of Grant In Trust land tenure status and became self-governing under the *Community Services (Aborigines) Act 1984*. In 2006, under provisions of the *Local Government Act 1993*, Yarrabah Aboriginal Council became a 'mainstream' Shire Council.

As well as having a tea-tree plantation and its own museum, Yarrabah is serviced by: a hospital (for accidents and emergencies only); a Women's Resource Centre, which includes a domestic violence shelter; a state school (to Year 10); Bama Ngappi Ngappi Aboriginal Corporation; an aged care hostel; and Gurriny Yealamucka Health Service, which is currently in transition to becoming a community-controlled service. Gurriny Yealamucka provides men's and women's health programs, health promotion activities, suicide prevention, patient transport, and a pharmacy.

Gindaja was established in the early 1980s when the community highlighted the need to address alcohol and other drug misuse.[69] At that time, it operated under the auspices of Douglas House Rehabilitation Centre and Yarrabah Community Council, but in 1988 it separated from Douglas House and was incorporated under the *Aboriginal Corporations Act*. In 1992, land about five kilometres from the centre of Yarrabah was donated to the organisation by a local family; this is where Gindaja is now located. Until the mid-1990s Gindaja operated with three staff – a manager, cook and part-time book-keeper. Resources were stretched and staff were only able to manage the provision of basic accommodation and limited counselling. There were no additional activities for clients, detoxification services or after-care services. However, as reflected in Gindaja's Policy and Procedures Treatment Manual, in recent years the service has undergone significant development.

Originally, Gindaja's vision statement was to 'Increase community awareness of the effects of alcohol and drug misuse'. However this was changed and is now 'To eliminate drug and alcohol dependency problems for anyone accessing the Gindaja services, from both within and outside the Yarrabah Community'.[70] This is to be achieved by providing 'specialised care and support services for clients and families with alcohol, drug and substance dependencies'.

The main building at Gindaja consists of office space and reception, eight client bedrooms (two clients per room), a kitchen and dining room, and an outdoor living area connected by breezeways. There is also a caretaker's cottage and a large shed that is used for training and education sessions, arts and crafts and as a gymnasium. Gindaja also has two boats and seven vehicles, including two buses, two trucks and three cars.

In 2004 an Alcohol Management Plan (AMP) was introduced in Yarrabah. Restrictions under this were established by Yarrabah Community Council by-law and enforced by the Community Justice Group. The restrictions allow a person or vehicle entering the community to bring in no more than one carton of beer or pre-mixed spirits or two litres of wine. There was a canteen in Yarrabah where people could buy alcohol. However, it closed in February 2008 at the time Yarrabah became a Shire Council when its license expired and was not renewed. Following the closure of the canteen, Gindaja staff reported that there had been an increase in the number of people travelling to Cairns or Gordon Vale to buy alcohol to re-sell in the community. Staff were concerned that this might lead to an increased likelihood of motor vehicle crashes as people rushed to buy alcohol or drove home drunk. They also felt that the restrictions had led to a greater use of cannabis amongst young people. To address this, at the time of our visit there was some discussion in the community of applying for a club license and establishing a tavern.

In the latter half of 2007, Gindaja had an Acting CEO and was undergoing a restructuring. Prior to that time, the service was struggling with issues such as staff standards and staff 'working in silos'. However, the restructuring appears to have resulted in Gindaja becoming a more effective and efficient service better able to cater to diverse client and community needs.

6.2 Governance and planning

As of 2007, the Board of Gindaja Substance Misuse Aboriginal Corporation consists of eight members who are elected annually. Prior to this there were ten members, but two have resigned and the positions have not and will not be filled. The Board is mainly made up of local Indigenous people and includes people: employed in community management and alcohol and other drug services; experienced in rehabilitation services; studying theology; and, a number who hold a Certificate IV in Training and Assessment. There is an emphasis on the need for board members to be proficient – because of fears of Gindaja 'going up the creek' without sound management – and they receive generic corporate management training by a private company (MJ Smith) funded by OATSIH.

Board members attend bi-monthly meetings and receive reports from treatment and operational management staff. The meetings are opened to staff after Board members have read the reports. Staff are also able to communicate with Board members through the CEO or by requesting an opportunity to present at a Board meeting. According to staff interviewed, their voices are being heard at the Board level. In the period between the change in CEOS there were reports that Board members had been getting involved in the day-to-day management of the service and 'intimidating' staff. These issues have been addressed and there is a better relationship between the

current CEO and the Board, with the current Board seeing its focus as being the strategic management of Gindaja.

It is apparent that with a good working relationship between the CEO, the Board and staff, Gindaja has become a stronger organisation. The organisation is now able to meet reporting requirements and staff are comfortable speaking to funding body representatives. To date, targets in the business plan have been met and it is expected that Gindaja will achieve its goals for restructuring. At the time of the site visit Gindaja was in the process of developing a strategic plan for 2008–2010.

To facilitate staff development, there are plans for staff to be appraised every 12 months. Depending on the position of the staff member, these appraisals will be conducted by management staff, the CEO and/or Board members.

Staff meetings are held once a week to discuss client referrals and follow-ups, check the waiting list, delegate tasks to the treatment team, plan for community events (such as drug and alcohol week), receive and consider feedback on clients from medical practitioners, organise training, and receive feedback from the Board.

6.3 Clients and substances

As indicated above, Gindaja has 16 beds in 8 rooms. However, one of these rooms is currently being used for storage as the organisation cannot manage more than 14 residential clients at any one time without overloading staff. Gindaja caters for men and women over the age of 18 years and of the rooms used, five are reserved for men and two for women (as the majority of clients are male). While it does accept non-Indigenous clients, applications are rare, perhaps explained by the availability of mainstream services in Cairns through Ozcare and Australian Hostels Association. Gindaja caters for couples and, while it is not able to cater for families, it does help organise childcare with clients' families while they in rehabilitation. It is also not able to cater for people with disabilities.

According to the 2006–2007 DASR, in that financial year, residential treatment was provided to 67 clients. Of these, 50 were male, 17 female, and all were Indigenous.[71] In the same period, 68 clients (39 male and 29 female) – all of whom were again Indigenous – were provided with non-residential or follow-up care. The majority of clients are affected by alcohol, although cannabis, tobacco, volatile substances, and benzodiazepines are also listed as substances used by clients of Gindaja.[71]

Just over 60 per cent of Gindaja's clients come from outside Yarrabah, including the Torres Strait Islands and Mt Isa.[71] It also receives clients from Aborigines and Islanders Alcohol Rehabilitation Service (AIARS) in Cairns (although there is currently no other collaboration with that service). A number of clients on the waiting list are from other communities and have been referred by the Murri Court or their local health services. However, according to staff, when positions become available and people are contacted many are no longer interested in attending.

Staff at Gindaja recognise that many people with substance misuse problems have comorbid mental health problems. In such cases, it is the responsibility of referring

agencies to provide Gindaja with client histories so that staff can make decisions about their suitability for admission. Individuals with a dual diagnosis are admitted if they are stable with medication and counselling, and a Queensland Health psychologist visits Gindaja once a week to provide them with individual counselling. However, those whose mental health problems are deemed severe or people who are aggressive are not accepted into the program.

Prior to admission, people are required to have medical assessments, and to be detoxified and have a withdrawal assessment or, to have been sober for one week. Yarrabah Hospital does not provide a detoxification service but ATODS provides a program at the Cairns Base Hospital which clients attend between 8:30 am and 4:00 pm. However, ATODS reported that there was not a huge demand for the detoxification service. While they have had Indigenous clients detoxifying from cannabis, opiates and volatile substances, in the previous three years, they had no Indigenous clients using the service to detoxify from alcohol. The requirement that potential clients stay sober for a week before admission is a barrier for some as staff reported that most people wanted to be admitted at the time of first contact and are often unable to remain sober for the one week period.

Clients are referred to Gindaja by a range of health services, mainstream alcohol and other drug services such as ATODS, and the Women's Resource Centre in Yarrabah.[70] However, most local referrals are self-referrals or are made by family and friends.[72] While the 2006–07 DASR reported that only six clients were re-admitted during that period, staff reported that a small number clients from Yarrabah are re-admitted three or four times a year because they do not have stable homes and resume drinking once they return to the community. However, they also reported that many regular clients appear to be making small positive changes in their drinking patterns.

According to Gindaja's DASR, in 2006–07, 22 clients accessed the service as an alternative to going to prison or home detention. As indicated above, since August 2007 Gindaja has been part of the three-year pilot for QIADP. As part of this, Gindaja is now required to provide up to five beds for clients being referred through QIADP.

6.4 Staffing and training

Gindaja has recently undergone a reorganisation. This was, in part facilitated by a successful grant application (prepared with the assistance of the QAIDP State Coordinator) to OATSIH. The grant – under OATSIH's 'Improving Indigenous Health Worker Employment' program – provides recurrent funding of $290,000 per annum for five full-time positions and has enabled Gindaja to convert positions previously partially funded under the Community Developemnt Employment Progra, (CDEP).

Gindaja's staff are divided into operational and treatment groupings. At the time of our site visit, operational staff included: an operations manager, finance manager, receptionist, cleaner, groundsman, night-watchman, cook and a part-time weekend cook. The latter three positions are funded by AHL and the others are funded by OATSIH (including the operations manager position funded under the new grant).

Treatment staff included: a treatment program manager who manages client programs and supervises treatment staff; a male social worker, responsible for co-ordinating the men's program, including social and recreational activities and counselling; drop-in centre coordinator; demand reduction community coordinator; social worker; female health worker; weekend manager/counsellor; and weekend day care worker. These positions are funded by OATSIH (the first four of which are funded under the new grant). In addition to these positions – as part of QAIDP – Queensland Health funds a weekend recreation officer; and, in the near future will also fund a QIADP Coordinator position at Gindaja.

As well as funding the positions listed above, OATSIH also provides funding for an alcohol and other drug counsellor position, the duties of which include individual and follow-up counselling, facilitating various aspects of the program, and referral and re-admittance assessment. This position was vacant at the time of our visit and was being readvertised as no one in the community had the requisite counselling skills.

As well as its own staff, two people employed by external agencies work out of, and in conjunction with, Gindaja – a full-time ATODS worker who focuses on alcohol and other drug education and a psychologist for one day a week, funded by Queensland Health. The psychologist is part of Queensland Health's dual diagnosis program and works to link ATODS and mental health services. As a case co-ordinator for clients coming from either service who have both alcohol and other drug and mental health problems this position is crucial. The psychologist also provides individual counselling and training in dual diagnosis for the staff. Training in alcohol and other drug issues is also provided to staff by ATODS staff in Cairns, and Gindaja can now access training, supervision and debriefing from Queensland Health through the QIADP.

Currently, all the staff at Gindaja – except those from outside agencies – are Indigenous, most are long-term employees,[71] and most are members of the Yarrabah community. Like some of the other employees, the treatment program manager described feeling committed to the organisation because she was doing something for the community. The 2003 Business Plan states a preference for local employment and staff assert that local people best know local people.[73] However, it is recognised that – due to the specialised nature of some aspects of Gindaja's program – people with the necessary skills may need to come from outside the community and/or be non-Indigenous. However, to ensure that potential non-Indigenous employees are able to work with clients in culturally safe ways, they are asked to discuss their backgrounds, their experience in working with Indigenous people and their understanding of Indigenous issues, and are evaluated on how they present themselves to Indigenous people.

The objective is for all staff to be multi-skilled, to ensure that all components of the program can be undertaken in the absence of particular staff members. To facilitate this, as well as plans for the provision of training, there are also plans to develop a program manual to ensure that the program can be delivered in a consistent and timely manner. However, staff training is complicated by difficulties in being able to find suitably qualified relief staff to 'backfill' for those undergoing training.[71, 73]

6.5 Services and treatment

Gindaja provides a 12 week (20 week for QIADP clients) abstinence based program. However, those interviewed talked about 'grog' always being around and the difficulty of living without drinking excessively for clients who have to go back to old environments and face issues such as overcrowding. In this light, they talked about the need to focus on treating alcohol with respect rather than abstinence. Staff acknowledged that people relapse and that different approaches – such as controlled drinking – need to be considered.

Difficulties with the abstinence approach were also raised in Gindaja's recent Organisational Risk Assessment Profile and will be addressed in an updated treatment plan. While Board members – who are mostly non-drinkers – are in favour of the abstinence approach, staff believe they will be open to change.

Gindaja adopts treatment approaches from both Alcoholics Anonymous (AA) and the Holyoake program. Although AA is a spiritually-based treatment approach, neither Christianity nor other religious beliefs are promoted at Gindaja. While it is recognised that the AA approach is not appropriate for clients who are atheists, there are no particular provisions made for them. However, clients can choose not to attend those sessions. The Holyoake treatment approach is based on cognitive behavioural therapy and supportive expressive therapy.[69]

Gindaja also includes cultural and other activities as part of its rehabilitation program. Throughout the week, a variety of health, life skills and education programs is also conducted. These are outlined in Table 13. During the week, staff are also available to advocate for or represent clients with Centrelink, medical practitioners and the courts. On the weekends clients are taken for outings and shopping.

As indicated above, the program runs for 12 weeks. According to figures cited in Gindaja's Business Plan, 60 per cent of clients stay for 13 weeks or longer and another 13 per cent stayed for between nine and 12 weeks (which may include clients who have completed the program).[71] The 2006–07 DASR recorded six people on the waiting list on June 30th, 2007. However, as indicated previously, we were informed that when places become available, often people are no longer interested in entering the program.

At entry, care plans are developed for each client and are managed by the team. Between July and December 2007, 49 care plans for both residential and non-residential clients were developed, of which 35 were fully actioned.[72] There is a focus on ensuring clients do not become dependent and are ready to return to the community after the 12 weeks. However, if they have no accommodation or do not feel ready to leave, clients are able to stay until they have a safe place in which to stay. According to the 2006–07 DASR six clients were readmitted between July 2006 and June 2007.

Table 13: Gindaja Timetable, Monday to Friday

Time	Activity
6:30 am – 7:00 am	Clients out of bed
7:00 am – 7:45am	Breakfast
8:00 am – 8:30 am	AA Meeting
8:30 am – 9:30 am	Chores and clean up
9:30 am – 10:00 am	Health check
10:00 am – 12:00 pm	The following programs are delivered Monday to Thursday: • Family well being • Diversionary program • Alcohol and other drug education • Holyoake program On Fridays clients are taken to Cairns to go shopping.
12:00 pm – 1:00 pm	Lunch
1:00 pm – 3:00 pm	The following programs are delivered Monday to Thursday: • Men's and women's group • Cultural program • Life skills program • Health program
3:00 pm – 4:00 pm	Shopping, visiting hours or rest and relaxation.
4:00 pm – 5:00 pm	Fitness program or rest and relaxation
5:00 pm – 6:00 pm	Supper
6:00 pm – 10:30 pm	Rest and relaxation, including time to watch television or DVDs.
10:30 pm	Bedtime

Gindaja has an outreach program under which staff host community events and visit families and organisations (such as the council, CDEP, school, church) to talk about alcohol and other drug related issues. Five awareness sessions were held between July 2007 and December 2007.[72] Another aspect of outreach activities is the demand reduction program. This is funded by the Department of Community Services for three years to promote a decrease in demand for alcohol and other drugs in the community. The demand reduction coordinator is working with other organisations, such as the school, to do this and to promote Gindaja as a service. For example she assisted the Yarrabah Seahawks plan and organise a fun day for which it received Department of Communities' Demand Reduction funding.

Lack of a drop-in-centre had been identified as a gap in Gindaja's services – based on the DASR, community feedback, and the 2003 Business Plan. In response to this, as part of its outreach program, Gindaja is in the process of establishing such a centre. It is being designed as a one-stop-shop for people to get information, be referred to other services, and generally just 'chill out'. While funding for the centre has been obtained and the position of drop-in centre coordinator has been filled, at the time of

our site visit, Gindaja was still trying to locate suitable premises and the drop-in-centre coordinator was operating out of the residential rehabilitation premises.

Gindaja has the staff and resources to be able to provide on-going care and follow-up for clients returning to the local community. This includes assistance from the welfare officer in their dealings with Centrelink and in finding accommodation. The length of on-going care depends on the needs of individual clients. However, it does not usually extend beyond six months. According to the 2003 Business Plan the new drop-in-centre will also provide on-going care support and will give clients a 'chance to talk with a counsellor, to obtain peer support, and to obtain support from within their own community'.[73] There is also some discussion about establishing a residential hostel outside Yarrabah so clients are able to access the service and to work as well.

Follow-up with people living outside the community is difficult and staff refer clients to ATODS or a health centre in the client's area. These services usually provide Gindaja with a progress reports on clients. While staff are of the view that this is not necessarily the most effective follow-up, it is the only means possible given available resources.

6.6 Funding and contributions

Gindaja's main sources of funding are OATSIH and Aboriginal Hostels Limited (AHL). In the 2006–2007 financial year, Gindaja's funding from OATSIH increased from $513,080 to $794,171 – accounted for by funding for the five new positions – and AHL funding remained stable at $107,561.[74] AHL reported that it was pleased with Gindaja's performance, which has an occupancy rate of about 75 per cent.

OATSIH and AHL funding – as well as $50,958 from client tariffs – was expended on operating costs, including wages and salaries, food, car registration and fuel, insurance, telephone and internet costs, as well as hiring consultants. In addition, OATSIH funding was spent on accounting, the caretaker cottage, drug action week, kitchen improvements, and the purchase of two new vehicles.

Other funding received during the 2006–2007 financial year included:

- $6,402 from Alcohol Education and Rehabilitation Foundation for training and associated travel costs;
- a Centrelink Grant of $23,011, to provide assistance for people with Centrelink;
- $16,000 from Queensland Health; and,
- $3,164 from the Department of Education and Training.

In 2007 Gindaja also earned $1,363 in self generated funds from venue hire. However, it receives no significant funding donations. It's sewing and gardening programs are conducted by volunteers, it receives some donations of clothing, and last year received some furniture from the Kuiyam Hostel in Cairns after it was renovated.

At the time of our site visit, staff at Gindaja were happy with their level of funding and had sufficient funds to plan for additional allocation to the sewing and gardening program, a generator, air-conditioning the training building, and concrete pathways.

They also had had a roll-over of unspent funds, in part due to the previous CEO's frugality. They explained the increased level of funding from OATSIH as due to a perception within OATSIH that they were performing well and were therefore 'in the good books with OATSIH'. However, according to Gindaja's OATSIH Project Officer the increase in funding was largely accounted for by one-off funding, which fluctuates from year to year.

Gindaja's request in its 2007–08 Action Plan to OATSIH was for further funding to:

- establish a culturally appropriate meeting place in the Yarrabah community centre so that people could access services without being 'shamed' by going to Gindaja; and,
- develop a tailored family support program.[70]

The drop-in-centre, which has been funded, was also part of the 2007–08 Action Plan. To achieve this and the other requests, Gindaja estimated that $332,500 was needed.

6.7 Inter-agency cooperation

Gindaja has links to other organisations in Yarrabah, which reflect its holistic and community-based understanding of alcohol and other drug misuse. Table 14 provides an overview of the alcohol and other drug services provided in Yarrabah and describes Gindaja's relationships them. Formal and informal relationships are also maintained with a range of health, social, employment, housing, education and training, and other AOD services based in Cairns (including Aborigines and Islanders Alcohol Relief Service). These relationships include sharing information and resources, referrals, and provision of advocacy and support services.[71] However, staff also felt that, at times, Gindaja was treated by staff from some of those organisations as a 'dumping facility' for clients who are difficult to handle.

Gindaja conducts a family well-being program and cultural activities in collaboration with the Gurriny Yealamucka Health Service. However, a Board member of Gindaja, who is also a staff member at Gurriny Yealamucka felt this relationship could be enhanced by combined strategic planning around issues to do with alcohol and other drug use and the sharing of each service's client data. The CEO of Gurriny Yealamucka also reported that his organisation and Gindaja work together on governance reform and professional development to make this more cost-effective.

Elders from the Aged Care Hostel and clients from Gurriny Yealamucka attend Gindaja to participate in the men's and women's groups. Parenting programs, referral, and counselling are also undertaken with clients from the Women's Resource Centre and Gindaja provides alcohol and other drug education at the school. Education programs at the school and within the broader community were identified as an area of need in Gindaja's 2003 Business Plan and this has been addressed with the employment of a demand reduction coordinator.

Table 14: Alcohol and other drug services, Yarrabah

Tier	Service
1. Non-substance misuse specific service	• Aged Care Hostel* • Women's Resource Centre* ^ • Gurriny Yealamucka Health Service ~ # * • State school (up to year 10)* # • Bama Ngappi Ngappi Aboriginal Corporation
2. Open access substance misuse services	• Gindaja Substance Misuse Aboriginal Corporation
3. Structured community-based specialist substance misuse services	• Gindaja Substance Misuse Aboriginal Corporation
4. Residential substance misuse services	• Gindaja Substance Misuse Aboriginal Corporation

Notes
~ These organisations deliver aspects of Gindaja's rehabilitation program, including on-site and off-site delivery.
+ These organisations provide essential services to Gindaja clients (e.g., legal services, medical treatment).
^ These organisations refer clients to Gindaja.
# Gindaja attends meetings or is in collaborative forums with these organisations.
* Clients from these organisations receive services or participate in activities provided by Gindaja.

Gindaja provides information to the Yarrabah Aboriginal Shire Council about alcohol and other drug issues and policies in the community. For example, prior to establishment of the AMP and the closure of the canteen, Gindaja staff presented the Council with information about what the likely impact might be, the effect on people of not having ready access to alcohol, and what the community and Council could to do in preparation. To deal with possible issues, Gindaja also worked with Gurriny Yealamucka and ATODS to develop a five point assessment process and a referral flow chart for those going through withdrawal after the closure of the canteen. Gindaja also collaborated with Yarrabah's Community Justice Group on these issues and is referred clients through QAIDP.

Gindaja is also part of a Health Management Forum, which is led by Gurriny Yealamucka and includes the Yarrabah Aboriginal Shire Council, Queensland Health, Australian Government Department of Health and Aging, the Women's Resource Centre, and the state school. This Forum was established in 2002 in the context of the Queensland Aboriginal and Torres Strait Islander Health Partnership. The role of the Forum is to increase local capacity to develop new health service directions and coordinated planning under the Yarrabah Health Partnership which:

> … aims to ensure a balance and equitable approach for prioritising funding for the provision of Primary Health Care services, both clinical and non-clinical, health promotion/ prevention programs and Public Health Services.

The Forum meets once a month to discuss and plan implementation of the Yarrabah Health Framework Agreement. According to Gindaja staff, previously the Forum struggled with a lack of investment from partners and 'more rhetoric than action' from

those leading the Queensland Aboriginal and Torres Strait Islander Health Partnership. However, there has recently been renewed commitment and a Deed of Commitment to the Framework Agreement has been signed by partners. The current focus is on the transfer of services provided by Queensland Health (except acute care and accident and emergency services) to Gurriny Yealamucka – planned for completion by 2010. The CEO of Gurriny Yealamucka believes that this will place Gurriny Yealamucka in a better position to link with other services in Yarrabah, such as Gindaja, and thus enable them to jointly meet the needs of the community.

6.8 Reporting and evaluation

There are considerable reporting requirements to meet for OATSIH and AHL, and monthly reports for management staff to complete for the CEO and the Board. The strain of meeting these requirements has been identified within Gindaja as being an issue of staff time management. To address this, it is planned that the operations manager and CEO will provide staff with time management training. Templates provided by OATSIH for the Action Plan are reported as having been helpful in meeting the requirements for the Service Development and Reporting Framework. Staff also indicated that reporting would be more efficient if they had access to a data base similar to that developed by Goori House (another residential treatment service in Brisbane) which incorporates all the data required by AHL and OATSIH. However, it was reported to us that OATSIH had been interested in purchasing the database but it was too expensive and had high on-going costs.

Gindaja completed an Organisational Risk Assessment Profile (ORAP) conducted for OATSIH in February 2008. This covers the assessment of 'management structure and standards, control monitoring and reporting and accountability and financial management'.[75] The organisation was identified as being of 'medium risk' because of limitations in regards to procedure manuals, registers, delegation regulations, and client regulations. According to its OATSIH Project Officer, if Gindaja was re-assessed it would be identified as 'low risk', because of changes implemented by the new CEO, and that its performance in terms of administration has been excellent.

Gindaja management staff found the ORAP useful. As a result of it, they have developed a new client contact sheet, which the treatment team is responsible for completing, and have plans to implement a new treatment and program manual, as well as human resource and operational procedures manuals. The service is not accredited; however, management staff feel accreditation would be good process to go through to ensure the service is 'up to standard'.

Gindaja staff reported that they judge the success of the treatment program by whether alcohol use is reduced, whether people are able to apply for a work, and are controlling their drinking. Staff report observing such outcomes amongst clients living in Yarrabah. However, as indicated previously, they have way to measure such changes amongst clients living outside the community. The fact that people wish to undertake the treatment program is also regarded as an indicator of its success. Among other positive outcomes reported by the staff was a feeling of empowerment among clients – reflected in the fact that some wanted to 'run the place' or be on staff. Although success is not based on whether clients remain abstinent, nevertheless it is

reported that on follow-up of court-referred clients it was recorded that five per cent of court-referred clients had remained abstinent and were currently employed.[71] Gindaja's OATSIH Project Officer said it is difficult to measure treatment outcomes based on existing reports. The Project Officer said that, at the most fundamental level, Gindaja is funded to provide alcohol and other drug misuse services to Aboriginal and Torres Strait Islander people, which it does.

Clients also provide verbal feedback about the program and are asked to provide written comments when they leave; they are also provided with a suggestion box. Information from these sources is kept on file and used for reports. However, management staff are also considering other ways this feedback could be used, for example using it as supporting evidence in funding applications. Comments have been made by clients that they enjoy the services and 'love the environment created'.

6.9 Relationships with QISMC and QAIHC

While Gindaja management staff have not taken the opportunity to visit other Indigenous residential rehabilitation services, they have attended some of the QISMC meetings and workshops. This has involved discussing the direction of QISMC and participation workshops, such as that on developing generic policy and procedure templates for new organisations.

Those interviewed suggested that QISMC should play a more proactive role and saw QISMC as having a leading role in overseeing, supporting and advising residential rehabilitation services, and developing strategies for the future. They commented that Gindaja would like QISMC to provide information on what characterises an ideal program, including details about baseline training and wages. This sort of information could also be passed onto other residential rehabilitation services such as those being developed in Cape York.

7. Gumbi Gumbi Aboriginal and Torres Strait Islander Corporation

7.1 Introduction

Halo House Alcohol Support Awareness Centre is a nine bed residential rehabilitation service operated by Gumbi Gumbi Aboriginal and Torres Strait Islander Corporation. It is located in Rockhampton – a town with a population of nearly 6000 people, about six per cent of whom are Indigenous.

Halo House was established 17 years ago by Darryl and Hazel Kaur – who continue to manage it. They have put considerable time and effort into planning and creating a place where clients '… can feel calm and safe when they enter'. This includes renovating the rambling Queenslander to include a client lounge and deck area and spaces where clients can be alone, and the establishment of tropical gardens behind a high fence. Their contributions to the service have led the Kaurs to describe it as embodying who they are.

Their commitment can be explained in part by Hazel Kaur's own struggle with, and recovery from, alcohol misuse. In the late 1980s Hazel went into residential rehabilitation because her marriage to Darryl was at risk of breaking down. Residential rehabilitation combined with a spiritual experience led Hazel to stop drinking and, with Darryl's help, she learned how to live again without alcohol. After this experience Hazel said she '… wanted to share her experience, strength and hope with her people and support them to live their lives for their highest good'. After rehabilitation Hazel began working for an Anglican organisation that cared for people who drank at the riverbank, but wasn't allowed to run Alcoholics Anonymous (AA) meetings with the clients. This, and encouragement from her family, prompted her to apply for funding from the (then) Department of Aboriginal and Torres Strait Islander Policy to start her own service. Her submission was accepted and, in 1992, the premises for Halo House were purchased with initial operational funding of $30,000. To achieve what they wanted to with the service, Hazel and Darryl had to contribute much of their own money and have continued to do so.

Gumbi Gumbi's mission is to '… improve the health and well-being of individuals and the community by reducing the numbers of Aboriginal and Torres Strait Islander people misusing substances to their detriment'.[76] The managers believe that helping one person is better than helping none and they believe they have been successful if they have created awareness amongst clients about the harmful effects of substance misuse.

In addition to Halo House, Gumbi Gumbi has recently begun providing services next door at Lachlan House, as part of the Queensland Indigenous Alcohol Diversionary Program (QIADP). Five beds are funded as part of this program and there is funding for another four staff to be employed in addition to the existing nine at Halo House.

7.2 Governance and planning

Gumbi Gumbi Aboriginal and Torres Strait Islander Corporation has a membership of 25 people. However, we were told that many of the members do not attend meetings and there was a view among those interviewed that the number of members should be reduced to 10 or 12 and should include only those who regularly participate and take an interest in the organisation. The small membership of the organisation limits the number of people available to serve on the committee and, to accommodate this, the constitution was recently amended to reduce the number of board members to five. Three new Board members are elected each year at the AGM, with two members staying on for an additional term to ensure continuity.

In recent times, Gumbi Gumbi faced financial difficulties. To address this, an active campaign was conducted to recruit professional, as well as community-based, members to the Board. At the time of our site visit, all current Board members were Indigenous, all were women and included members who worked for other Indigenous community-controlled organisations and for Queensland Health. Governance training for all committee members is funded by OATSIH. However, some current members had such training in their roles on other committees.

Until now, Gumbi Gumbi has not had a strategic plan. Rather, planning has been informal – based on discussion between the managers and the Board and on consultations with professionals and clients. We were told that '… planning had not been a problem' but that '… finding money to turn visions into realities' was. Nevertheless, at the time of our site visit, Gumbi Gumbi was working with Future Dreaming – a non-profit organisation that provides mentoring and technical support to Indigenous organisations – to consult with the wider community to develop a three to five year strategic plan.

7.3 Clients and substances

In the 2006–2007 financial year, 565 clients were recorded as accessing the service, of whom 69 clients accessed the residential rehabilitation service.[77] The number of clients for whom residential care can be provided is a function of available beds at Halo House. However, we were told that the relatively small number of clients ensures that existing staff are able to spend quality time with each, and that existing human and other resources are not over-extended.

Clients are referred to Halo House by the Rockhampton Base Hospital, the Diversionary Centre, police, and the Bidgerdii Community Health Service. However, most clients are self-referred and there is a preference for such clients because of their higher level of motivation to address their substance-related problems

Alcohol, opiates, tobacco and cannabis were listed in the 2006–07 DASR as the substances that affected most clients. Gumbi Gumbi staff reported that there has been a change in patterns of substance misuse in the community and that whereas in the past alcohol misuse was the most common problem, now poly-drug use is common with larger numbers of people using cannabis and amphetamine type stimulants, and 'binge drinking' in combination with these. Gumbi Gumbi staff reported that, while they have had some success in the treatment of poly-drug users,

they limit the number admitted at any one time. They do so as such clients require higher levels of care and supervision and the organisation does not have the staffing and training levels to provide this. Accordingly, they refer those with more complex substance misuse problems to rehabilitation services managed by the Salvation Army on the Gold Coast and in Townsville that are better able to address the needs of those clients.

Staff also noted that those in the community with substance misuse problems were getting younger and were more likely to have mental health problems. However, in 2006–2007, 49 (70 per cent) of the 69 clients admitted to Halo House were aged 36 years or over. Halo House only provides services for those aged 18 years and over and, while Gumbi Gumbi has always desired to provide a family-based service, its staff do not have the training to provide care for young people. However, services for young people are provided in Rockhampton by Milbi (another Indigenous community-controlled organisation with which Gumbi Gumbi works very closely) and Darumbal Community Youth Service.

Many potential clients are identified as having mental health problems. Indeed, staff felt that other agencies often use Halo House as a dumping ground for those with mental illness and for whom no other services are available. In those instances where such problems are mild, individuals may be admitted and additional support for them provided by Community Mental Health Services. However, it has been found that those with severe mental health problems, such as schizophrenia, tend to disrupt other clients and – as with poly-drug users – require a level of intensive, specialised supervision and care which Gumbi Gumbi does not have the staff to provide. For this reason, such persons are not admitted

Most of those admitted to Halo House are men, with only two of the nine beds being available for women. This is a consequence of the structural layout of the premises. However, staff also noted that women clients often leave the program early because of concerns for their families – despite staff organising voluntary care for them through the Department of Communities.

Gumbi Gumbi is an Indigenous organisation and the service is designed to cater for Indigenous clients. Nevertheless, according to the 2006–07 DASR, it had twice as many non-Indigenous as Indigenous clients. Staff stated that if they were required to choose clients, Indigenous people would take priority. However, they have not been required to make such a choice and it has not been raised as an issue by funding bodies (a point which was confirmed by their OATSIH project officer). Nevertheless, according to the manager of Milbi Incorporated, with the introduction in July 2008 of a total alcohol ban at Woorabinda (an Indigenous community about 160 kilometres west of Rockhampton) there might be a greater demand for residential services by Indigenous people.

At the time of our site visit, Gumbi Gumbi had a current waiting list of 31 people. However, in the past, staff have found that many of those on the waiting list decline when offered a place. We were told that those who remained on the waiting list tended to be prisoners. However, prisoners are not accepted because they have been found to

be difficult to manage and supervise. Gumbi Gumbi's preference is to take offenders through the QAIDP before they are incarcerated.

7.4 Staffing and training

There are nine staff employed at Halo House all of whom are funded by OATSIH. The full-time positions include manager, assistant manager, administrative assistant, trainee Indigenous health worker, night-watchman, support worker, and cook. The part-time positions include a psychologist and weekend worker. At the time of our site visit, the administrative assistant had been dismissed and there was an OATSIH appointed funds administrator at Gumbi Gumbi. However, a new administrative assistant had been employed at the time of the follow-up interviews. There are also four new positions funded as part of QIADP. These include a cultural mentor, night-watchman, activities officer, and a weekend cook. At the time of follow-up interviews, the manager had retired and Gumbi Gumbi was in the process of appointing a new manager. In the interim, the assistant manager was managing the centre.

All the staff are Indigenous except the psychologist, funds administrator and the cook. There is no formal cultural safety training for the non-Indigenous staff. However, the managers feel that the psychologist has learnt a lot about Murri people and they have found him committed to the program and the organisation. He and the management would like to increase his two days a week to a full-time position.

While at Gumbi Gumbi all staff are considered part of the treatment team. The staff directly involved with the treatment program include the psychologist, the assistant manager, support worker and the trainee Indigenous health worker, as well as the cultural mentor. As well as the psychologist, the assistant manager is involved in counselling clients and running group sessions. The trainee Indigenous health worker and support worker are responsible for general case management, which includes arranging appointments (e.g., with medical practitioners) and organising documentation for clients (e.g., birth certificates). The cultural mentor will be required orientate new clients to the program, connect clients with people inside and outside of Gumbi Gumbi, including their family groups, and report back to the other staff about the clients.

Most of the staff are employed based on relevant work and life experiences. The registered psychologist has a Bachelor's Degree in Psychology and the trainee Indigenous health worker has a Certificate III in Community Services Work (Alcohol and Other Drugs) and intends to continue her training in the AOD area, health and hygiene, or psychology. The assistant manager has also started a psychology degree and a Certificate III in Community Services Work (Alcohol and Other Drugs), though has been unable to complete them due to illness and family commitments.

The psychologist at Gumbi Gumbi was of the view that the program would benefit by all staff having, at a minimum, a Certificate III in Community Services Work (Alcohol and Other Drugs) to complement existing expertise and experience and the philosophy of AA. This would provide all staff with up-to-date, evidence-based knowledge about alcohol and other drug misuse, such as motivational interviewing, the stages of change, and relapse prevention strategies. While the managers are

willing to increase staff training, further funding is required to backfill positions while people are away for training.

Management raised concerns over both the level of staffing and the level of staff salaries. With regard to the former they cited a need for clear benchmarks for staffing levels in residential rehabilitation programs. In particular, they noted that, in such settings, clients need care and support outside of 9:00 a.m. to 5:00 p.m. working hours and that this has to be resourced. While they felt that this need was not recognised by funding agencies, OATSIH's Project Officer said that OATSIH was open to any submissions relating to staffing requirements. With regard to salary levels, we were told that Gumbi Gumbi was not funded for increases in-line with increases in the consumer price index and that this was of concern. Management felt that the fact staff remained in spite of low wages testified to their passion and commitment. However, the issue of salary levels vis-à-vis those in other sectors needs to be addressed by funding agencies.

7.5 Services and treatment

Intake of clients to Halo House is based on informal assessment. Potential clients are shown through the centre and provided with information about the program. Staff interview them informally to determine whether they are ready to enter into rehabilitation and whether Halo House 'feels right for them'. If potential clients want to enter the program and staff assess them as being suitable, basic information – including personal details, likes and dislikes, previous admissions to mental health programs and drinking levels – is collected from them but no formal assessments are undertaken.

Before admission to Halo House, those with substance misuse problems need to be detoxified. However, based on the reports of those we interviewed, there is a paucity of detoxification services in Rockhampton. Rockhampton Base Hospital has no beds specifically allocated for detoxification and no one to whom we spoke at the hospital or ATODS was able to identify a particular staff member responsible for detoxification services, nor was able to report on the demand for such services. As a consequence, it was reported that considerable effort is required to get patients admitted for detoxification. At present, Gumbi Gumbi itself provides limited in-house detoxification services which are dependent upon the availability of a general medical practitioner as staff are qualified only to monitor medication, not to administer it. However, staff see this as an area in which Gumbi Gumbi could play a greater role, if resources were available.

To provide clients with an opportunity to distance themselves from associates who may encourage alcohol or other drug use, the Halo House guidelines state that clients are not allowed leave the premises or receive telephone calls during the first two weeks of their residence. During that period, clients are given rest, nutritious meals and dietary supplements to help them to adjust. After this two week period clients are able to leave and return as they please, except when compulsory program activities are being held. After the initial two week period, clients' families are permitted to visit, but visitors are confined to a garden area in the front of Halo House.

The program at Halo House is nominally a three month program. However, it is Gumbi Gumbi's philosophy that people need to go through rehabilitation at their own pace. Halo House guidelines state that it is up to clients to decide when they '… have healed enough to be able to live an independent healthy lifestyle'. According to management, most clients only stay for three months – although a number have stayed longer and some for up to two years. However, according to the 2006–07 DASR about 30 per cent of clients stayed for less than two weeks and only about 30 per cent stayed for nine weeks or longer. In relation to this, the part-time psychologist employed by Gumbi Gumbi felt that while some clients enter the program motivated to change, others' intentions to stop misusing alcohol or other drugs are superficial and they are motivated to enter Halo House for other reasons, such as obtaining food and shelter.

Gumbi Gumbi's approach to treatment is reflected in the Halo House guidelines which state:

> … we want you to relax and take time to heal your mind, body, and spirit. Only you can determine when this has occurred. So take your time, relax, and rediscover your true self.

The approach, which the managers see as 'Murri best practice', is described by them as drawing '70 per cent from mainstream, 25 per cent from Indigenous approaches and five per cent from Eastern approaches'. The latter elements include story telling, listening to music, tai chi, and reiki massage. This part of the program is delivered by the assistant manager whose focus is on '… re-educating people's minds about self and providing love and guidance'. According to the psychologist, the managers are seen as quasi-parents by clients, which greatly contributes to the success of the program.

The assistant manager also conducts groups based on *Dadirri*, which is described as '(a) special quality, a unique gift of the Aboriginal people, … an inner deep listening and quiet still awareness'.[78] It involves listening to one another, renewal of self, forgiveness and contemplation. A ritual circle including stones and candles is set up in the therapy room as part of *Dadirri*. The assistant manager believes that a spiritual element is required when dealing with Indigenous people, who are 'caught between Christianity and Dreamtime because of how they grew up'. As well as the *Dadirri* ritual circle, there is an allocated space in the back garden for smoking rituals.

The assistant manager also runs the morning AA meetings. However, the 12 steps are not strictly followed and clients do not have sponsors. Both the manager and assistant manager support the abstinence model and believe it is not possible to work with someone who is still drinking. They acknowledge that many clients return to drinking or using other substances, but feel that Gumbi Gumbi '… stays in people's heart' and there will always be the sense among clients that they are letting people down by drinking or using again. Although the psychologist supports the organisation's abstinence approach he feels that harm minimisation approaches may be more effective for those who do not intend, or find it too difficult, to stop drinking or using other substances.

The assistant manager's approaches are complemented by individual and group counselling sessions run by the psychologist. The group sessions draw on cognitive

behavioural approaches, relapse prevention, guided meditation, visualisation and deep muscle relaxation. While clients are required to have individual sessions with the psychologist at least once a month, most have weekly sessions with him. These individual sessions involve discussing the underlying reasons for clients' alcohol and other drug use and dealing with their mental health problems. Sand play therapy,[79] reality therapy,[80] and narrative therapy[81] are drawn on to conduct these sessions. The psychologist is also intending to complete a course in interpersonal therapy,[82] which will be introduced into the individual sessions.

The environment and living arrangements at Halo House are an integral component of Gumbi Gumbi's approach to treatment. Treatment is viewed as something that happens 'throughout the day and everyday' and, to facilitate this, the managers have purposely created a calm environment in which clients can read, think, reflect and meditate. However, while he agrees that rest and relaxation are an important part of treatment, the psychologist felt that more recreational and educational programs are required to prevent clients from becoming bored or 'stir crazy'.

To help them acquire the living skills, which the Halo House guidelines describe as part of a healthy lifestyle, clients are required to do daily chores and to contribute to cleaning the house on Tuesday mornings. To help them to 'learn care for something other than themselves' this includes caring for a dog, named 'Youfella'. In addition, Halo House staff provide a range of other supportive services to clients – including helping them with budgeting and facilitating contact with their children (where needed). Clients are also able to undertake part-time studies and staff register them with the Department of Housing and help them to establish networks to aid them in gaining employment on leaving the program. According to the psychologist, these services and the supportive environment at Halo House help clients to re-engage and ease their transition back into the community.

Table 15: Gumbi Gumbi Timetable, Monday to Friday

Time	Activity
7:00 am – 8:00 am	Guests out of bed
8:00 am – 9:00 am	Breakfast
10:00 am – 11:00 am	Morning meeting (individual counselling, group therapy, meditation, health and hygiene and drug education)
11:00 am – 12:00 pm	Personal development activities (quiet contemplation, counselling sessions, exercise)
12:00 pm – 1:00 pm	Lunch
1:00 pm – 5:00 pm	Personal development activities (clients can leave Halo House during this time)
5:00 pm – 7:00 pm	Dinner
7:00 pm – 10:00 pm	Rest and relaxation
10:00 pm	Guests to bed. Gates locked.

The program at Halo House also includes cultural activities, art and music. Previously, clients were taken on trips to the bush and Tablelands. However, at the

time of our site visit there was no vehicle available for this purpose. The weekly scheduling of activities is set out in Table 15. On Saturdays and Sundays clients are able to leave Halo House and it is suggested they use this time to reconnect with non-substance using friends.

Gumbi Gumbi staff are working to improve case management of clients. To this end, they have begun to use Voice CD – a program designed to assist organisations to develop policy and procedures and case management – and they have had assistance from case workers from organisations within the community. According to Gumbi Gumbi's Action Plan Report, between July and December 2007, 34 case management plans were developed. However, there was acknowledgement that more can be done in this area but that the paperwork involved is sometimes overwhelming. As part of the case management activities, the trainee counsellor arranges medical and other appointments and obtains documents such as birth certificates for clients. Staff are also working with staff from the Diversionary Centre, mental health and Bidgerdii Medical Centre to support clients.

Gumbi Gumbi staff reported that one of the impediments to the transition of clients back into the community is the shortage of public housing. This means that clients often have to move back into high risk environments. As a consequence of the shortage of public housing, at the time of our site visit, there were two long-term clients who – although ready for discharge – remained resident at Halo House.

As indicated above, prior to discharge, attempts are made to find housing and employment for clients. On discharge, they are provided with AA contacts and they are able to continue attending group sessions at Halo House and to meet with staff. Beyond this, however, on-going care is limited. Although there is a recognition that on-going care would be beneficial and that, as an Indigenous community-controlled organisation they could be effective in providing it, Gumbi Gumbi does not have the resources to do so, nor has it sought funds for this purpose.

Similarly, Gumbi Gumbi's outreach activities are limited but include networking with providers of other services, the promotion of Gumbi Gumbi's services, and the hosting of open days during NAIDOC Week and Drug Week.[83] In the past it was undertaking outreach work in the Woorabinda community in conjunction with the Sisters of Mercy. However, this was discontinued because of a lack of human and financial resources. The psychologist also feels that there are safety and staffing issues that would need to be addressed before outreach could recommence.

The managers of Gumbi Gumbi and Milbi told us that they had lobbied for some years to get an Indigenous diversionary program in place. However, they both felt that Queensland Health did not consult Indigenous controlled alcohol and other drug services about QAIDP and they suspect that the three year pilot program will face a number of challenges that will need to be addressed as a consequence. Nevertheless, the manager of Gumbi Gumbi feels that it will be effective in keeping Indigenous people out of prison.

7.6 Funding and contributions

Most of Gumbi Gumbi's income is provided by OATSIH, which in the 2006–07 financial year made a grant of $512,776.[77] This included expenditure of approximately $300,000 on salaries, as well as expenditure on operating costs, including accounting, running and maintenance of vehicles, insurance, electricity, rates stationary, and telephone costs. In that financial year, no income for capital works was received. However, in the previous year, Gumbi Gumbi received a one-off grant of $40,000 from Rio Tinto to build offices for the psychologist and trainee Indigenous health worker (although expenditure of this was delayed). Clients each pay $145 per week while resident at Halo House to cover the cost of board. In the 2006–07 financial year, these client contributions amounted to $8,000.[96] In addition, Darryl and Hazel Kaur reported expending an unspecified amount of their own money on the gardens and renovations at Halo House.

Unlike many residential rehabilitation services, Gumbi Gumbi does not access funding from Aboriginal Hostels Limited (AHL). The manager of Gumbi Gumbi cited several reasons for this, including complex reporting requirements and particularly inflexibility of the funding arrangements which he believes can place organisations at risk – an assessment with which the manager of Milbi agreed. As an example, the manager of Gumbi Gumbi said that if a service's occupancy rate fell below 70 per cent in any year, funding was reduced in the following year with adverse consequences for staffing levels and the provision of services. He also made the point that, no matter what the occupancy rate, some positions such as nightwatchman and cook were essential.

At the time of our site visit, Gumbi Gumbi was under funds administration and its quarterly funding payment from OATSIH was being withheld until the 2007–08 SDRF Action Plan had been approved. According to the managers and a board member interviewed, Gumbi Gumbi's financial management problems arose because of a lack of skilled administrative staff. This was, in part a consequence of a commitment to employing Indigenous staff, but lacking the resources and skilled staff to adequately train new employees. A board member said that the managers had always placed administration and financial management second to caring for individuals and the community but, unfortunately, this resulted in financial difficulties for the organisation. To address this, the managers are determined that the new administrative assistant (who may or may not be Indigenous) is well trained and experienced and will also be able to provide administrative training for younger Indigenous people.

According to Gumbi Gumbi's OATSIH Project Officer, Gumbi Gumbi has struggled to meet some the administrative requirements place upon it. However, she felt that the new administrative assistant and new manager will improve Gumbi Gumbi's capacity to meet these requirements. Despite the administrative problems, she also reported that OATSIH was pleased with the holistic service provided by Gumbi Gumbi and the caring and warm atmosphere at Halo House.

Gumbi Gumbi's 2007–08 SDRF Action Plan listed a number of strategies to improve the service (but did not include costing of them). The strategies included: increased

staff training; development of a recreational program in art and culture; liaison and development of MoUs relating to coordination of services with relevant Indigenous organisations (e.g., Murri Court, Milbi, ATODS); and vehicle upgrades. Commenting on the latter, the manager said that OATSIH requirements that organisations now accumulate funding for vehicles (rather than receiving it up-front) has been a problem for Gumbi Gumbi as it had not been able to accumulate such funds and as a consequence has only one ten year old vehicle and has to rely on the use of the managers' personal vehicle.

The managers at Gumbi Gumbi were positive about their relationship with OATSIH and the funding and support they have received. However, they raised a number of broad issues with regard to funding. First, the absence of benchmarks for the provision of services in the non-government sector means that they are often under-funded compared to the government sector, and that funding agencies use contracting to reduce costs. Second, the criteria attached to one-off funding grants – including provisions that they are only available for new initiatives – are not responsive to the needs of service providers. Third, they expressed concern that, as funding for alcohol and other drug services for Indigenous people has increased, large non-Indigenous NGOs – such as Red Cross, Ozcare, Centacare, Anglicare and St Vincent de Paul – are moving into the field. These organisations have an advantage in having expertise in writing funding submission and are able to employ Indigenous people. However, provision of services by these organisations does not build capacity within Indigenous communities.

7.7 Reporting and evaluation

The Gumbi Gumbi managers spoke positively about OATSIH's responsiveness to feedback from residential rehabilitation services on the appropriateness of reporting requirements – for example with regard to the modification of items such as 'episodes of care' which were designed for Indigenous primary health care services. They also reported that OATSIH staff are proactive in providing advice and assistance with regard to reporting requirements. However, they expressed disappointment that there is a general lack of response to Section B of the SDRF Action Plans in which organisations report on needs for additional services and support.

Individual client records are kept by the psychologist and Gumbi Gumbi's Action Plan Report for July to December 2007 reported that 35 clients had filled out session evaluation forms. In addition, the organisation receives some informal feedback in the form of comments from ex-clients and from the staff of other organisations. However, there is no formal evaluation of client outcomes. To address this and to meet the increasing demand from OATSIH for such data, at the time of our site visit, staff were considering the development of a questionnaire, to be administered on a monthly basis, to obtain feedback on the service from clients.

7.8 Inter-agency cooperation

Organisations which aim to addressing Indigenous social, health and substance misuse issues in Rockhampton are summarised in Table 16. The manager of Gumbi Gumbi works closely with the manager of Milbi and they provide mutual support. Milbi provides a range of services including a sobering up shelter, counselling,

accommodation for homeless people, and the Murri Court. The two services are not in competition but see each other as providing or building part of a range of necessary and complementary services. Both organisations have QIADP clients, and work with ATODS to plan and co-ordinate QIADP services and treatment of clients. Since the implementation of QIADP, staff at Gumbi Gumbi have had a greater opportunity to work with ATODS staff, who provide services at Lachlan House on a weekly basis. QIADP clients from Gumbi Gumbi will also go to Milbi for group counselling when the services are fully established.

Table 16: Alcohol and other drug services, Rockhampton

Tier	Service
1. Non-substance misuse specific services	
	• Aboriginal and Islander Community Resource Agency
	• Aboriginal and Torres Strait Islander Legal Services +
	• Ngua Gundi (mother and child) Program – Rockhampton Base Hospital
	• Rockhampton District Aboriginal and Islander Co-op Society (Housing) +
	• Milbi Incorporated Health #
	• Bidgerdii Community Health Service +
	• Aboriginal and Islander Community Resource Agency - HACC
	• Indigenous Housing Services CQ Ltd
	• Winna-Burra Aboriginal Community Centre @
	• Anglicare Central Queensland - Aboriginal and Islander Outreach @
	• Darumbal Community Youth Service #
	• G(h)in Gil Family Violence Prevention Legal Service
2. Open access substance misuse services	
	• Al Anon Family Group
	• ATODS + ~
	• Rockhampton District Aboriginal and Islander Co-op Society
	• Aboriginal & Islander Community Resource Agency – Management Of Public Intoxication Program #
	• Anglicare – Rockhampton Family & Adolescent Support Program
3. Structured community-based specialist substance misuse services	
	• Gumbi Gumbi – Halo House
	• ATODS + ~
	• Milbi Incorporated Health #
	• Juwarki Kapu Lug Aboriginal & Torres Strait Islander Corporation – Michael Hayes Diversionary Centre*
	• Juwarki Kapu Lug Aboriginal & Torres Strait Islander Corporation – in-home rehabilitation support service QIADP
	• Darumbal Community Youth Service #
4. Residential substance misuse services	
	• Gumbi Gumbi – Halo House

Notes
~ These organisations deliver aspects of Gumbi Gumbi's rehabilitation program, including on-site and off-site delivery.
+ These organisations provide essential services to Gumbi Gumbi's clients (e.g., legal services, medical treatment).
^ These organisations refer clients to Gumbi Gumbi.
# Gumbi Gumbi attends meetings, are in collaborative forums or have board membership with these organisations.
* Clients from these organisations receive services or participate in activities provided by Gumbi Gumbi.
@ Clients or staff from these organisations have visited or been invited to visit Gumbi Gumbi.

Gumbi Gumbi also works in conjunction with the Michael Hayes Diversionary Centre, which is managed by the Juwarki Kapu Lug Aboriginal and Torres Strait Islander Corporation. The Diversionary Centre is a sobering up shelter which aims to divert intoxicated Indigenous people from police custody. A number of clients from the Diversionary Centre are referred to Gumbi Gumbi and some attend group sessions held at Halo House. Consideration is also being given to expanding the service to allow young people at the Centre to take part in the groups. The CEO of the Diversionary Centre described the relationship between the two as 'sister services'. This relationship has been formalised now that both organisations are involved in the QIADP program. The Diversionary Centre also provides residential rehabilitation for homeless QIADP clients and refers other clients to Gumbi Gumbi.

Given their shared client base, at one stage, Gumbi Gumbi, Milbi and the Diversionary Centre considered centralising the operational aspects of their services and having a joint administration. The amalgamated organisation was to be named Murri Indigenous Drug and Alcohol Services (MIDAS). However, the amalgamation did not proceed because of the complexity of organisational funding arrangements. Nevertheless, the managers of the three organisations meet regularly to discuss issues facing their services.

Juwarki Kapu Lug also hosts quarterly 'Murri managers meetings' for all the Indigenous community-controlled organisations in the area (which Gumbi Gumbi attends) and hosts the 'CQ Murri e-mail list'. The meetings and e-mail list offer organisations informal ways of supporting each other and sharing information. Provision of these services is not part of Juwarki Kapu Lug's service agreement, but is provided as part of 'community business'.

Bidgerdii Community Health Service – a key Indigenous organisation in Rockhampton – is used by Halo House clients. However, although Bidgerdii has its own alcohol and other drugs counsellor, Gumbi Gumbi staff said that Bidgerdii does not refer potential clients to Halo House. About two years ago, the organisations discussed the development of an MOU to ensure that Halo House clients were seen quickly by Bidgerdii medical staff – especially when detoxifying. However, the MOU did not eventuate, and a local GP now supervises detoxification of Halo House clients.

Bidgerdii has been established for much longer than Gumbi Gumbi and is better resourced and Gumbi Gumbi staff expressed a reluctance to seek assistance from Bidgerdii lest they be seen as exploiting the relationship between the organisations. Gumbi Gumbi staff and one of its Board members also contrasted the more professional management approach at Bidgerdii with what they described as their own 'more caring' client centred approach. It seems that both organisations recognise the potential value of a stronger collaborative relationship but as a representative of Bidgerdii said, 'the connections haven't been made'.

As indicated, Gumbi Gumbi collaborates with a number of Indigenous community-based organisations. However, the manager expressed hesitancy about sharing information or ideas with staff from government agencies because he feels these organisations take such information and ideas without appropriate consultation or acknowledgement. He also described interagency meetings as '… like talking to a

wall', and mistrusts the professionalism of government staff members, feeling that because of their better education they ignore the experience of community-based members.

7.9 Relationships with QISMC and QAIHC

QISMC staff have assisted Gumbi Gumbi with writing job descriptions, establishing QIADP, tendering for services, developing their strategic plan, and completing the SDRF Action Plan. Such assistance was deemed by Gumbi Gumbi management as valuable – especially at the time of Gumbi Gumbi's audit. They are also pleased with, and supportive of, the unity QISMC has brought to the individual residential rehabilitation services which were previously working in isolation. They feel that QAIHC is the only group that has lobbied for the interests of residential rehabilitation services and that other state and national bodies tend to have agendas that are not in the interests of the Indigenous substance misuse services. However, the manager at Gumbi Gumbi felt that QISMC needs to be autonomous from QAIHC. He felt that progress towards such autonomy has been inhibited because alcohol and other drug services are seen as the poor cousin to health services, despite the two being intertwined. Gumbi Gumbi's manager believes that, in the future, a key role for QISMC, is the development of policies, procedures and benchmarks so as to standardise the services, and the quality of services, provided by residential treatment facilities.

As indicated above, there is considerable cooperation between Gumbi Gumbi and Milbi. Like the manager of Gumbi Gumbi, the manager of Milbi was very supportive of QISMC and the services it provides – particularly the provision of information and training. He also views QISMC as an important voice for the residential rehabilitation services and a vehicle for progressing their interests. He views this as particularly important with regard to OATSIH; which he said – as a consequence of QISMC's efforts – has provided them with various opportunities (such as finance workshops) that the services would not otherwise have received. Unlike the manager of Gumbi Gumbi, however, he does not think that QISMC should separate from QAIHC. He believes that, if it did so, QISMC would simply be 'another hand in the bucket' competing with other organisations. It was his view that QISMC would be better able to proved, and be more accountable for providing, better services by remaining connected to QAIHC, with QAIHC's strength and reputation.

8. Yaamba Drug and Alcohol Rehabilitation Centre

8.1 Introduction

The Yaamba Drug and Alcohol Rehabilitation Centre is located on a rural property 15 kilometres from Bundaberg – a town with a population of nearly 46,000 people of whom 3.5 per cent are Indigenous.[84] The main house on the property – decorated with Indigenous art and murals with slogans to motivate clients – includes: a large recreational area; an area for counselling sessions; three client bedrooms which can sleep up to four people each; a fourth bedroom for night-shift staff; and, the CEO's office. Other facilities include: the finance officer's office, including a meeting area; a new two-bedroom self-contained unit; a playground for visiting families; and, a greenhouse.

The idea to establish the service came from a non-Indigenous couple who spent time in Bundaberg in the 1980s and 1990s. They visited Indigenous people who were recovering from alcohol and drug misuse in hospital and they identified the need for a hostel for Indigenous people with alcohol and other drug related problems. The property was purchased in 1992, with funding from the now defunct Aboriginal and Torres Strait Islander Commission, and is owned by the Yaamba Aboriginal and Torres Strait Islander Corporation for Men.

Yaamba provides services for men only and aims to help them to regain '… confidence to enter the outside world again'.[85] According to the CEO, the service aims to: heal people; help families and individuals get back into the workforce; and, to help people control their drinking.

Prior to taking up his position the current CEO was – since its inception in 1992 – a member of the Yaamba Governing Committee, as a representative of the Bundaberg Aboriginal and Torres Strait Islander Men's Group. He has been CEO since being appointed in 1999 by the administrators after the service was placed under funds administration. For the first two years of his employment he ran the service himself, with the help of a cook and book-keeper. Since that time, Yaamba has received additional funding for staff and, at the time of our site visit, there were six full-time staff catering for up to 12 clients.

Yaamba's constitution was developed in 1993. At the time of our site visit, requirements relating to governance were being up-dated in response to provisions of the *Corporations Aboriginal and Torres Strait Islander (CATSI) Act 2006*. According to Yaamba's finance officer, among these:

- quorum requirements at an AGM have changed from 10 to 15 members to 10 per cent of membership (for Yaamba this would be five or six) ;
- if a quorum is not reached at a board meeting, another member can be temporarily appointed;

- the CEO can now be a committee member but not hold the Chair; and,
- non-Indigenous board members can be appointed based on their expertise but cannot hold the Chair.

The Yaamba Aboriginal and Torres Strait Islander Corporation for Men has 53 members and a Governing Committee of five members which meets monthly. Members of the Committee – who must be male (because it is an incorporated body for men), over the age of 18, and the majority of whom have to be Indigenous – are elected at the organisation's AGM.

The finance officer and CEO stated that it is difficult to get Yaamba members to nominate themselves for election because they are too busy, not interested, or unable to leave paid employment to attend the meetings. They also suspected that not being able to pay committee members – in accordance with the CATSI Act (and previously the Aboriginal Councils and Associations Act 1976) – is a disincentive to people nominating.

At the time of the site visit, only four positions on the Committee were filled. The members included: the CEO who returned as a committee member after this was permitted under the amended legislation; a member who has been involved in the Community Development Economic Program (CDEP) and the Jukanyula Aboriginal Corporation for Children's Enrichment; an Elder; and another long-term member. At the time of the visit, plans were afoot to appoint to the fifth position a local general medical practitioner with expertise in the area.

The finance officer has provided training to Committee members on how to read financial reports and the auditor has reviewed the auditing process with them. Last year Committee members also completed a governance course conducted by Office of the Registrar of Aboriginal and Torres Strait Islander Corporations (ORATSIC) – funding for which was provided by OATSIH.

Previously, where changes or additions to Yaamba's programs were deemed necessary and feasible, one-off submissions for funding for their implementation would be made to OATSIH or other funding bodies. However, the biannual Action Plans required under OATSIH's Service Development and Reporting Framework (SDRF) are now used to structure and formalise the planning process. Draft Action Plans and budgets are prepared for the Committee which reviews and amends them as appropriate before final approval.

Staff are given the opportunity to comment on Action Plans. At fortnightly meetings, they also have the opportunity to comment on, and suggest changes to, the day-to-day operations of the service (e.g., roster changes), and other matters such as the purchase of new equipment.

8.2 Clients and substances

While the service focuses on Indigenous men, it is open to both Indigenous and non-Indigenous males over 18 years of age. There are 12 beds available and to be viable the service needs to have nine people staying at the hostel at any one time.

Management therefore has a practice of not discriminating between Indigenous and non-Indigenous clients for the first nine clients, but after that threshold has been reached gives preference to Indigenous clients. Between July 2006 and June 2007, Yaamba staff provided care to a total of 72 clients (34 Indigenous and 38 non-Indigenous). The majority of these were between 19 and 35 years of age; and, 75 per cent came from outside of the Bundaberg area.[86] Clients come from nearby communities such as Charleville and Rockhampton but others have come from as far away as Tasmania and Western Australia. The recruitment of clients from such a widespread area is, in part, due to the distribution of promotional material by the CEO when travelling to other areas of the country. Clients from outside Bundaberg are encouraged because staff believe they are able to engage in the program more fully away from pressures of friends and family members. For similar reasons, the location of Yaamba, 15 kilometres outside of Bundaberg, is also viewed as a strength of the service.

Alcohol is the main substance of misuse among clients at Yaamba. However, staff also reported the misuse of cannabis and amphetamines and Yaamba's 2006–07 DASR reported the misuse of tobacco, volatile substances, and benzodiazepines among clients.[86]

Many clients enter the program voluntarily after they have been detoxified at Royal Brisbane Hospital or by Alcohol Tobacco and Other Drugs Service (ATODS) elsewhere in Queensland. According to the CEO, by the time such clients go to Yaamba they have often reached the 'end of their tether' and their families are breaking up. Yaamba also accepts some parolees on an early release program. However, Yaamba staff often find that such clients do not necessarily come with the intention of dealing with their harmful use of alcohol and other drugs. All prison applicants are reviewed by Corrective Services to determine if they are suitable, and only one parolee is admitted at a time because of staff concerns about 'gangs' forming.

In general, because of the extra stress on staff members, Yaamba tends not to admit clients who have mental health problems. In the past, the mental health service at Bundaberg Base Hospital was referring to Yaamba, clients who staff felt had greater mental health than substance misuse problems. As a consequence, clear parameters were set around the acceptance of clients referred by the mental health service. Now, only if Yaamba management is assured that potential clients will be stable when taking their medication are they accepted into the hostel.

Before they are admitted, potential clients are required to complete application forms, be detoxified, and need to agree to a luggage search on arrival and to regular drug testing during their stays. Local clients are required to detoxify as outpatients with ATODS because there is no in-patient detoxification unit at the Bundaberg Base Hospital. Once admitted, clients pay $140 per week in board for which they receive accommodation meals, regular transport to Bundaberg, alcohol and other drug education and counselling, and some assistance with finding post-treatment housing and employment.

Occasionally clients may infringe Yaamba's rules. For minor problems, they may be asked to leave for two weeks. However, if their behaviour is violent or difficult to manage they may be asked to leave permanently.

8.3 Staffing and training

As indicated above, at the time of our site visit, Yaamba employed six full-time time staff members. These included: the CEO, finance officer, and night manager, who were funded by OATSIH; and, a cook, weekend manager, and activities/support officer who were funded by AHL. In addition, one part-time relief position was funded by OATSIH. As part of a short-term trial, until mid-2006, Yaamba also employed a nurse. However, at the end of the trial, Yaamba felt that a nurse was not necessary for its operation and did not apply for recurrent funding for the position.[87] The longest serving staff member was the CEO, who had been there for nearly ten years, but staff usually stay for two to three years, and vacancies are generally quickly filled. The CEO and finance officer felt that staff numbers were adequate to operate the existing service.

While the organisation aims for all staff to be Indigenous, at the time of our site visit, there were two non-Indigenous employees. Employment of an Indigenous finance officer has been limited by applicants with necessary skills. According to the CEO, a well-functioning administration is essential to maintaining the service and the organisation does not want to compromise its service for the sake of Indigenous employment. The other non-Indigenous staff member was the cook who was previously a long-term client. Assessments as to whether or not non-Indigenous staff members are able to work in culturally safe ways are based on informal review by the CEO of a person's previous life experience and work in Indigenous communities.

The finance officer at Yaamba has a Diploma in Business Studies. The remaining staff are employed based on their relevant work or life experiences. However, the cook has completed a course in hygiene and dietetics, the activities/support officer has completed a first aid and CPR course, and most other staff members have had computer skills training. An ATODS Indigenous Health worker, who provides AOD counselling and education at Yaamba, has completed a Certificate III in Community Services Work (Alcohol and Other Drugs), a Certificate III in Aboriginal and Torres Strait Islander Primary Health Care, and an Associate Diploma in Aboriginal and Torres Strait Islander Human Services.

Yaamba was planning to adopt a computerised record system in late-2008 and all staff will complete further computer training. The CEO is also applying for entry to a management course being offered to OATSIH-funded Aboriginal and Torres Strait Islander community-controlled organisations to improve management capacity and performance.

The previous occupant of the activities/support officer position was supported by Yaamba to complete a Certificate III in Aboriginal and Torres Strait Islander Primary Health Care, but resigned soon after completing the training. The CEO was disheartened that the cost of this training – which included travel expenses to Brisbane – provided little return to Yaamba. It was his view that making such training

available at a local or nearby TAFE would make it more viable for Yaamba to train other staff members. As well as the lack of locally available training, the lack of funds to back-fill while staff attend courses was identified as another impediment to increasing staff training and skills.

The finance officer stated that the increased skills and qualifications staff gain through training requires an increase in wages and this places pressure on the budget. To address over-spending on increased wages, as well as on overtime and relief staff, OATSIH provided Yaamba with a one-off funding grant of $28,000. However, such increases are not covered by indexed increases in funding. Yaamba's OATSIH Project Officer said that organisations like Yaamba faced difficulties such as these because funding tends to be historically-based and there is no formula to determine funding levels.

Yaamba also recently requested funding from AHL for additional positions to cover overtime and relief hours. However, it was the view of the AHL regional manager that Yaamba had sufficient staff for a 24-hour service and, rather than employing more staff, needed to change its roster. Furthermore, AHL does not fund nightwatchmen in small services like Yaamba.

8.4 Services and treatment

Yaamba offers a three month program but clients are able to stay longer if they need more time before re-entering the community. One client had been at Yaamba for two years and became the assistant cook. However, between July 2006 and June 2007 only about 30 per cent of clients stayed for nine weeks or longer.[86] Forty six per cent of clients stayed for only four weeks or less, and another 22 per cent stayed for five to eight weeks. Three explanations were given by the finance officer for why many clients do not complete the three month program. The first was that many clients feel they are ready to leave before the three months are over and staff concurred that many clients seem ready to leave earlier. The second reason was that other clients are not ready to complete the program the first time they enter because they have been pressured to go to Yaamba by their families or referral sources. However, this explanation does not match the nil repeat clients reported in the 2006–07 DASR. The third explanation was that clients are required to attend AA meetings at least once a week and some feel uncomfortable doing this. Participating in this aspect of the program is not negotiable and, thus, some clients decide to leave. Given these reasons the finance officer felt that there was no need to specifically address why people leave before completing the program.

No Yaamba staff are trained as drug and alcohol counsellors and, appropriately, they are discouraged from informally counselling clients. Instead, alcohol and other drug counselling and education services at Yaamba are provided by external agencies. The CEO and finance officer feel this is more efficient given the availability of the services from other agencies and because of the greater cost of providing them in-house. However, this is disadvantageous in that staff from the outside agencies do not attend Yaamba staff meetings, nor specifically meet to discuss the rehabilitation program at Yaamba.

In addition to education and counselling, on most days clients are able to participate in recreational activities such as ten pin bowling, fishing, leatherwork, art, gymnastics, and aqua-aerobics with Bundaberg Aboriginal and Torres Strait Islander Men's Group. Clients are also taken into Bundaberg during the week to shop, for medical appointments and to attend training courses. The daily timetable at Yaamba is outlined in Table 17.

Table 17: Yaamba Timetable, Monday to Friday

Time	Activity
8:30 am – 9:00 am	Group meeting
9:00 am – 12:00 pm	Gardening and cleaning ATODS on Monday, Tuesday and Thursday. Lifeline counselling on Wednesday. Recreational activities or shopping on Friday and Saturday.
12:00 pm – 1:00 pm	Lunch
1:00 pm – 5:00 pm	Recreational activities or shopping. Visit to medical centre on Tuesday. AA meeting on Wednesday.
5:00 pm – 10:00 pm	Free time. AA or NA meeting on Tuesday, Wednesday and Thursday.

Yaamba promotes a total abstinence approach and requires clients to attend AA meetings on Thursday evenings at the Salvation Army Citadel. The option is also open to them to attend other AA meetings each week at various places in and around Bundaberg. Clients are also able to attend programs at the Salvation Army's Tom Quinn Centre – the manager of which was involved in the establishment of Yaamba. A counsellor from Lifeline, who is about to complete a Social Work degree, visits Yaamba once a week to provide individual counselling. This counsellor said that between one and three clients participate each week – the number depending upon who the clients themselves determine is most in need to his services. Clients are also able to attend anger management courses which the counsellor conducts as part of Lifeline's 'Men and Families' program. However, at this stage, only a few clients have actually participated.

An Indigenous health worker from ATODS visits Yaamba three times a week to provide alcohol and other drug education, as well as individual and group counselling. Monday sessions include a relapse prevention program, developed by Gold Coast ATODS, and alcohol and other drug education. Presentations are sometimes provided by guest speakers such as an ATODS clinician, a GP, or Hepatitis C worker. and representatives from CDEP Impact (employment, training and skills support centre). Male health workers or clinicians from ATODS also present sessions about 'men's business' because the Indigenous health worker is a female. Clients are encouraged to share their own experiences with the group after these sessions. Tuesday sessions involve either individual or group counselling and are voluntary. According to the ATODS health worker, between eight and 14 clients attend the group sessions and about four attend individual sessions. The counselling sessions are

designed to help clients deal with any mental health problems and to start planning for their transition out of Yaamba. Yaamba's SDRF Report from January 2007 to June 2007 stated that clients were showing a greater ability to participate in counselling sessions and were more willing to participate in activities in Yaamba.[88] The third weekly session, held on Thursdays, focuses on providing clients with information they request about issues such as the Stolen Generation, Centrelink, employment, and housing applications.

While there is no specific transitionary program provided for clients, staff do try and assist them to find housing and employment. Staff are also available to assist clients to write letters, deal with legal and taxation issues, provide information on setting up businesses, and apply for entry to TAFE courses. Clients are encouraged to enrol in training courses so that they are able to develop skills necessary to gain employment after they leave Yaamba. Between January 2007 and June 2007 three clients enrolled in literacy and numeracy courses, one enrolled in a small business course and another enrolled in a environmental Green Corp project.[88]

In 2007, with OATSIH funding, Yaamba built a two-bedroom self-contained accommodation unit. This used as a half-way house for long-term clients or for weekend family visits. Clients using the unit as a half-way house pay $100 week for board and are required to do their own cooking and cleaning. Clients are allowed to stay for up to three months, but must actively be looking for alternative accommodation. If a unit is vacant, after individual clients have been at Yaamba for a month, their families are allowed to stay for weekends. Clients are also able to leave Yaamba after a month to visit their families. This one month constraint is applied because the CEO believes that, in that period, clients still want to drink.

According to the CEO, because of the pressure to drink in the community (especially at events such as funerals), after leaving Yaamba only about ten per cent of clients are able to stop or control their drinking. However, he commented that there are very few repeat clients and the 2006–07 DASR reported that there were none.[86] The transient lifestyles of the clients and the fact that many clients come from outside Bundaberg were offered as reasons for this by the finance officer.

In the past, expansion of Yaamba was considered. To make this viable the service would have needed to double the number of clients to cover the cost of the infrastructure. However, the CEO had observed that other residential rehabilitation services had to reduce their size because the logistics of having more than 20 clients are unmanageable. In the light of this, expansion of Yaamba was deemed not viable.

At the time of our site visit, there were only short waiting lists for the service and management staff felt they have been able to meet demand. The focus of the organisation is to keep the existing services 'on track'. To facilitate this, Yaamba emphasises the need for promotion of its current services and pamphlets about them are distributed widely and a website is currently under construction.

Yaamba staff do recognise that there are gaps in alcohol and other services for the growing number of young people with substance problems. Drug Arm and the Salvation Army's Tom Quinn Centre target this age group, but they only provide a day

service, which focuses on keeping young people occupied with activities such as restoring furniture and bicycles, or on the provision of crisis accommodation. Again, however, there are no plans for Yaamba to provide services in this area.

8.5 Funding and contributions

In the 2006–2007 financial year, Yaamba received $223,370 from OATSIH and $104,783 from AHL. Additional funds were also self-generated by hiring out the finance officer's services to other local organisations. Approximately $2,500 was earned in this way in the 2006–2007 financial year. In the same period, client payments amounted to $55,143. Donations or contributions were limited to informal exchanges with community members – for example Yaamba provided land for grazing in exchange for back-hoe work and donations of produce by local farmers and machinery from the Salvation Army.

Both Yaamba's OATSIH Project Officer and the AHL Regional Manager agreed that Yaamba meets all its reporting requirements on time and is in regular communication, via newsletters and updates about the service. The CEO and finance officer believe that this and their close contact with the OATSIH project officer resulted in an additional $180,000 funding allocation to Yaamba, which was used for the self-contained units and a new tractor and refrigeration. In relation to this, the OATSIH Project Officer commented that prior to the SDRF Action Plans the relationship organisations had with OATSIH Project Officers and Project Officers' commitment to advocating for organisations in part determined one-off funding allocations, however, this is no longer the case.

Yaamba staff report that, compared to OATSIH, AHL is more difficult to negotiate with, as it has limited flexibility in its funding – which is provided primarily for accommodation and food, but not items such as vehicle and communications costs or client activities. In addition, AHL requires more detailed reporting of how funds are spent and how much Yaamba receives from OATSIH. Despite the burden this presents, Yaamba's finance officer believes that the latter requirement has worked in Yaamba's favour because they believe AHL provided additional funding for renovations in 2007 based on OATSIH's level of funding.

In its 2007–08 SDRF Action Plan to OATSIH, Yaamba was seeking additional funding to:

- up-grade non-clerical staff computer skills to enable them to operate the computerised client record system – $15,000;
- extend life skills programs for clients returning from Yaamba to the community – $20,000;
- improve staff first aid capabilities – $4,000;
- up-grade the existing truck for use in a greater variety of tasks, including community projects – $40,000;
- purchase two canoes for client use – $3,300; and,
- renovating the hostel – $13,720 in addition to $36,280 already funded by AHL.[89]

8.6 Inter-agency cooperation

Table 18 provides an overview of the alcohol and other drug services provided in Bundaberg as identified in the Bundaberg Community Directory.[90] The services are categorised according to the NTA's tiered model of AOD interventions. Services listed in the first tier – non-substance misuse specific services – only include Indigenous specific services or services with Indigenous specific programs or services that are directly aimed at reducing harmful substance use.

Table 18: Alcohol and other drug services, Bundaberg

Tier	Service
1. Non-substance misuse specific services	
	• Aboriginal and Torres Strait Islander Housing and Advancement Society +
	• Bundaberg Aboriginal Corporation for Women #
	• Bundaberg District Indigenous Health - Bundaberg Base Hospital +
	• Bundaberg Region Council for Elders - Woorabar Inc @
	• Coral Coast Indigenous Sport and Recreation Incorporated +
	• Indigenous Wellbeing Centre #
	• Jukanyula Aboriginal Corporation for Children's Enrichment
	• Nulloo Yumbah - Central Queensland University +
	• Together Women in Networking Services # >
	• Wandiny Home and Community Care >
	• Women's Legal Service Resource Advice Line
	• Bundaberg & Burnett Region Community Development Employment Program +
	• Murri Care (with Lifeline) ~
	• YAMMAD Youth Services
	• The Goori Jets (Alternative Education Program)
	• Aboriginal Legal Service+
	• Lifeline Coral Coast Capricorn ** ~
	• Impact (employment, training and skills support centre)*
	• Bundaberg Aboriginal and Torres Strait Islander Men's Group # >
2. Open access substance misuse services	
	• Al-Anon Family Groups
	• Alcohol, Tobacco and Other Drug Service** ^
	• Alcoholics Anonymous**
	• Drug Arm
	• Tom Quinn Centre – Salvation Army*
3. Structured community-based specialist substance misuse services	
	• Alcohol, Tobacco and Other Drug Service** ^
	• Bridges Drug & Alcohol Service – Bridges Aligned Services Inc
4. Residential substance misuse services	
	• Yaamba Rehabilitation Centre

Notes:
* Yaamba clients voluntarily attend programs delivered by these organisations.
~ These organisations deliver aspects of Yaamba's rehabilitation program, including on-site and off-site delivery.
\+ These organisations provide services to Yaamba clients (e.g., legal services, medical treatment).
^ These organisations refer clients to Yaamba.
\# Yaamba attends meetings held by these organisations.
\> Co-organises community events and activities.
@ Yaamba staff and board members are members of this group.

ATODS, the Salvation Army and Lifeline provide services directly to Yaamba, and Yaamba clients access services provided by the Aboriginal And Torres Strait Islander Housing And Advancement Society, Bundaberg District Indigenous Health at Bundaberg Base Hospital, Coral Coast Indigenous Sport And Recreation Incorporated, Nulloo Yumbah (Central Queensland University), Bundaberg & Burnett

Region Community Development Employment Program, and the Aboriginal Legal Service. Yaamba also refers clients to the mental health service at the Bundaberg Base Hospital.

There is no Indigenous community-controlled health service in Bundaberg. However, the Indigenous Wellbeing Centre, operated by the Bundaberg and Burnett Region Community Development Aboriginal Corporation, brokers medical services and facilitates medical appointments for Indigenous people. Yaamba has no direct relationship with this Centre. Instead, a local private medical practice conducts medical examinations of clients when they enter Yaamba. The same practice is also the only one used for prescription of client medication, to ensure that clients are not given, or do not obtain, double prescriptions.

Yaamba staff occasionally attend the meetings of the Bundaberg Aboriginal and Torres Strait Islander Advisory Group which meets bi-monthly to discuss health issues and coordinate the provision of health services. Yaamba staff also attend the infrequent community meetings held by Police, and the Police Aboriginal Liaison Officer (ALO) sometimes visits clients at Yaamba. To facilitate inter-agency cooperation, Yaamba also co-hosts an annual cricket game with the Police, and sporting events and a NAIDOC lunch with the Bundaberg Aboriginal and Torres Strait Islander Men's Group and Bundaberg Aboriginal Corporation for Women. Activities or events for clients are also organised with Together Women in Networking Services and Wandiny Home and Community Care.

8.7 Reporting and evaluation

Reporting is undertaken at Yaamba by the finance officer. Although this was not seen as a particular burden, in the future, it will be assisted by a computerised client record system. Yaamba hopes to sell this system – developed using a $20,000 grant from OATSIH – to other interested residential rehabilitation services in order to increase self-generated funds.

Yaamba has systems in place for any complaints by clients to be heard and addressed by the Governing Committee;[87] and the ATODS Indigenous Health Worker conducts random 'evaluations' of what the clients think of the service for use by ATODS administration. However, Yaamba itself conducts no formal evaluation of its services. The reason given for this is that it does not have the capacity or resources to follow-up clients after they have left Yaamba – many of whom lead a transitory lifestyle and/or live outside Bundaberg. Instead, Yaamba bases judgements about its success on the positive comments made about the service by the clients and received from the OATSIH Project Officer and Regional Manager of AHL. In this regard, the OATSIH Project Officer said that OATSIH was pleased with the holistic service Yaamba provides to its clients and its level of engagement with QAIHC and QISMC.

8.8 Relationship with QISMC

Both the CEO and finance officer have attended all QISMC training sessions and meetings. They said that having that forum in which to voice their opinions regarding the needs of, and problems within, the sector is not only good for staff development but is good for Yaamba. They also highlighted the way in which QISMC had brought

the different Indigenous residential rehabilitation services together and promoted interaction through meetings and workshops. Motivated by greater interaction at the QISMC meetings, Yaamba staff have visited and been visited by staff from other residential rehabilitation services, to share information about service operation. For example, Yaamba was recently visited by staff from the rehabilitation service in Cherbourg. During this visit, the two organisations negotiated the transfer of one of Cherbourg's clients to Yaamba because it was deemed a more suitable service for that particular client.

Arising from the increased interaction with other services through QISMC meetings and workshops, Yaamba's CEO and finance officer have identified gaps in the administrative aspects of residential rehabilitation services and they have been able to offer others solutions. One example is the computerised client record system that they have developed and intend to sell to other interested organisations. Yaamba has also provided policy and procedure templates to rehabilitation services in Palm Island and Rockhampton.

9. Queensland Aboriginal and Torres Strait Islanders Corporation for Alcohol and Drug Dependence Services

9.1 Introduction

The Queensland Aboriginal and Torres Strait Islanders Corporation for Alcohol and Drug Dependence Services (Queensland Aboriginal and Islander Alcohol Service or QAIAS) was established in 1977. It aims to 'provide culturally appropriate alcohol and other drug education, rehabilitation and treatment services for the indigenous community'.[91] Prior to 1994 the service operated out of various rented properties, but in 1994 a former private psychiatric hospital was purchased with funds provided by OATSIH. QAIAS is situated on Llewellyn Street in New Farm, an inner city suburb in Brisbane. The premises are named the Jesse Budby Healing Centre, after a long-term QAIAS supporter and Board member. As well as the Centre's close proximity to the city centre and accessibility to public transport, it is a short walk to the river and nearby parks, which are visited by QAIAS clients.

When it moved to the Llewellyn Street premises, QAIAS was challenged by neighbours who were concerned about 'criminals and alcoholics' entering the area to access the service. Despite community concern, state and federal politicians supported the service and QAIAS worked to educate and raise the awareness of the community. As a result of this, neighbours' concerns were addressed and a strong relationship between the service and the neighbours has grown. According to AHL's Regional Manager: QAIAS is well established; for a long time QAIAS was the only service of its kind in Brisbane; and, it provides a consistently good service.

Originally a ten bed service, QAIAS' capacity has grown to 35 beds. One dormitory has five beds and most of the other rooms sleep two people. There are also some private rooms available, but most clients prefer to share. All the women's rooms have en-suite bathroom facilities. Additional clients can be accommodated by using office space as bedrooms; the rationale for this being that if people are turned away, they may not return for treatment. At the time of our site visit, QAIAS was preparing a submission for funding for extensions to its premises to meet such additional demand for its services.

Despite a lingering atmosphere of being an old psychiatric hospital and the installation of security fences and cameras, efforts have been made to make the Healing Centre a pleasant environment for clients. A vegetable garden, outdoor area and smoking area have been established and, downstairs, there is a large open area that includes a gymnasium, computer room, client library, art room and music room.

In 1999, QAIAS rented an adjacent property which was used a halfway house with accommodation for ten clients. Funding for this pilot program was initially provided for three years as part of the National Illicit Drug Strategy. This was extended for a

further period. However, the property was sold in 2004, forcing the closure of the project. The halfway house was reported as having been successful and, at the time of our site visit, negotiations were underway to purchase three units in the same street in order to re-establish the service.

9.2 Governance and planning

QAIAS has a nine member elected board. To ensure continuity and to minimise the impact of strong disagreements over policy and directions, the current constitution provides for the retirement of three members at each annual general meeting and the election of three replacements. The constitution also stipulates that members must have been on the board for a period of at least two years before they are eligible to occupy the positions of president, vice-president or secretary. At the time our site visit, the chair was occupied by a person with experience in the Indigenous community-controlled health sector, justice and housing. Other members worked for the Police, welfare services, were business people or were studying.

On-going training is provided to Board members, including seminars, by invited speakers on their financial, legal and governance responsibilities. They also attend (and report back on) relevant conferences and they receive reports on conference attendance by staff members. Until recently, the senior drug and alcohol educator at QAIAS – who was previously a Board member – also acted as a special advisor to the Board.

9.3 Clients and substances

The service caters for males and females, including couples, over the age of 15 years (those under 15 who present to QAIAS are referred on to other services). Of those accepted as clients, 84 per cent come from the greater Brisbane area.[91] While it is an Indigenous service, QAIAS has a larger number of non-Indigenous than Indigenous clients. In the 2006–2007 financial year 156 non-Indigenous, compared to 70 Indigenous clients, accessed QAIAS' residential rehabilitation services,[92] a fact of which the Regional Manger of AHL was aware. In part, this was justified by staff in terms of QAIAS' anti-discrimination policy which, they said, means service cannot be refused to non-Indigenous people. In addition to its provision of residential care, QAIAS provided outreach services to a total of 2954 Indigenous clients.

QAIAS accepts clients who misuse alcohol and other drugs, including cannabis, amphetamine type stimulants and heroin. According to staff, forty years ago, alcohol was the only substance being used by clients. Now however – although the majority of clients are affected by alcohol – many are poly-drug users, and most staff time and resources are required to address problems associated with amphetamine and cannabis use.[92]

As well and the increase in poly-drug users, QAIAS has seen a steady increase in the number of clients with co-morbid mental health problems. According to both QAIAS' 2006–2007 Action Plan and the CEO, between 66 and 78 per cent of clients have a dual diagnosis – including schizophrenia, bipolar disorder, anxiety and depression.

The majority of QAIAS' clients are self-referred or referred by family members. The basis for such referrals was often familiarity or family connection with the service (with similar factors being responsible for self or family referrals to Goori House, another Brisbane facility). Clients are also referred through Department of Communities, Community Mental Health Service, medical centres, educational institutions, the Police, Centrelink and various metropolitan and regional hospitals.

If, on admission, clients are assessed as having severe mental health problems, they are referred on to Princess Alexandra Hospital, Prince Charles Hospital and Community Mental Service which provide a range of mental health services and have Indigenous workers. In the case of clients referred to QAIAS by Royal Brisbane Hospital's (RBH) detoxification unit, if they are assessed as having severe mental health problems, by agreement with RBH they are returned there.

As a consequence of the introduction of early release or diversionary programs, there has been an increase in the number of referrals to QAIAS from the Department of Justice through the Drug Court and prisons. Such referrals are accepted based upon QAIAS assessments of their suitability for its program including their motivation and readiness to change – screening out those who are only seeking to access the program to improve their legal outcomes. QAIAS staff find that among such referrals from the prison system, many need to be detoxified as they claim to have used alcohol or other drugs in prison. This poses difficult ethical questions for staff in relation to informing the Department about this.

9.4 Staffing and training

According to the 2006–07 DASR, 24 people were employed with QAIAS, of whom 18 were employed in full-time positions. QAIAS encourages Indigenous people to apply for positions and, at the time of our site visit, eleven staff were Indigenous, including the home supervisor, two welfare workers, a domestic worker, the cook, the receptionist, four counsellors, and a recreational activities officer. According to the CEO most non-Indigenous treatment staff had already received cultural safety training as part of their degrees, but cultural safety is addressed during staff orientation and at weekly in-service training.

Five positions are funded by Aboriginals Hostel Limited (AHL) including the home supervisor, welfare worker, domestic worker, and the cook and weekend cook. The other 19 positions are funded by OATSIH and include the CEO, psychologist, administrative assistant, senior project officer, five counsellors, recreational activities welfare officer, community counsellor, two nurses (agency), a welfare worker, security officer, yardman, receptionist, book keeper, and an accountant employed on a casual basis.

The security officer is employed on a needs basis, for instance during the hours a GP is at the Healing Centre or when the there are only one or two staff on during the weekend or at night. However, treatment staff are available 24 hours a day seven days a week, and the services they provide include telephone counselling for people not residing in the Healing Centre. Provision of service is more important to QAIAS than position duty statements and staff are able to fill the roles of others if necessary.

Most of the general staff and the two welfare workers are employed based on relevant work or life experience.[92] Amongst the treatment staff: the psychologist and two nurses have degrees in their respective disciplines; the CEO has a Post-graduate Diploma in Health Education; and, the senior project officer has a Diploma in Teaching. Three of the counsellors and the recreational activities officer have a Certificate in Drug and Alcohol Counselling and the other two counsellors and community counsellor have Diplomas of Welfare. In addition to the treatment staff at QAIAS, a GP visits three days a week or as needed, and a psychiatrist visits one day a week and has done so for the last 30 years. Clients are also taken to the GP's surgery for treatment.

All staff attend weekly in-service training, which focuses on updating skills and covers topics such as the social, physical and psychological effects of alcohol and other drugs and cultural issues. In-service training is conducted by the senior counsellor, the psychologist and CEO. Occasionally, professionals from outside QAIAS are invited to conduct sessions about other aspects of alcohol and other drug misuse.

As of June 2007, nine of the staff were long term employees – having worked at QAIAS for more than eight years. They included the home supervisor, domestic worker, administrative assistant, CEO, psychologist, two counsellors and the book keeper [92] The CEO has been at QAIAS for 23 years, the home supervisor for 18 years and one of the counsellors for 15 years. Six staff had been working at QAIAS for less than a year and the remaining nine had worked there between a year and eight years. The CEO reported no difficulty retaining staff, which is evidenced by the long term employment of some staff. Very few staff leave and positions are filled quickly by people on a waiting list. The CEO stated that all staff are considered part of the team, feel a responsibility to the service and are rewarded by its success. Staff are involved in making decisions about the organisation and have two weeks to comment on any changes or new plans proposed by the CEO. Staff needs for a healthy workplace and flexibility are also met, including provision of access to the gym equipment at QAIAS and being able to make changes to their rosters when required.

9.5 Services and treatment

Before entering QAIAS' treatment program clients must be detoxified. Individuals presenting to QAIAS receive an initial assessment. If they are intoxicated, they are taken by staff or by ambulance to the Hospital Alcohol and Drug Service (HADS) at Royal Brisbane Hospital (RBH) which has a 20 bed in-patient detoxification unit. If those presenting are not intoxicated and require only mild detoxification, this can be supervised by QAIAS staff and monitored by a visiting GP or nurses. However, most are referred to HADS, or to other detoxification services provided by Biala Acute Care Service (Alcohol and Drug Service), the Alcohol and Drug Assessment Unit at Princess Alexandra Hospital, the Alcohol and Drug Service at the Prince Charles Hospital Health Service District, and the Brisbane Recovery Services Centre – Moonyah (Salvation Army). In turn, many of those services refer their own clients, who have completed detoxification, to QAIAS for treatment.

Once detoxified, clients are medically and psychologically assessed and their needs identified using:

- motivational interviewing;
- QAIAS social assessment (personal details, marital status and number of children, family history, contact with family and friends, health problems, legal problems, reasons for wanting to address substance misuse);
- Alcohol Use Disorders Identification Test (AUDIT);
- Severity of Alcohol Dependence Questionnaire (SADQ);
- Readiness to Change Questionnaire (RTCQ);
- Diagnostic and Statistical Manual of Mental Disorders (DSM IV);
- medical assessment; and,
- blood alcohol level.[91, 93]

Following this assessment, individual care plans are developed based on: the needs of each client; the most appropriate treatment modality; and the staff members best suited working with particular clients. Between July 2006 and June 2007, 250 such case plans were developed – including new case plans for readmitted clients.[94, 95]

Once clients enter the Healing Centre they are not permitted to leave for 20 days unless accompanied by a staff member. After this period clients are allowed out between 11:00 am and midday Monday to Friday and, after two months, they are permitted to go out on Saturdays. If they are caught drinking, the restrictions are extended for further two weeks.

According to QAIAS staff, the program length is flexible. Clients may stay between three and nine months, but this can be extended up to twelve months after review. Staff said that this: gives people time to find accommodation and to complete any training they may have commenced at the Healing Centre; and, reduces readmissions. (In 2006–2007, 24 of a total of 226 clients were readmitted.[92]) Despite the option to stay for up to 12 months, the 2006–07 DASR reported that 34 per cent of clients stayed less than two weeks, 52 per cent stayed between two weeks and 12 weeks, and 14 percent stayed 13 weeks or longer.

If the criterion for completion is taken as being completion of a stay of between nine and twelve weeks, approximately 24 per cent of clients completed the program. However, the criterion used by QAIAS to measure completion is 'recovery from substance misuse'. This is assessed by a QAIAS clinical panel, consisting of a psychologist, GP and senior clinical staff. According to QAIAS staff, recovery is contingent on the degree of dependence and not simply the length of time in treatment. For example, clients admitted with a history of binge drinking can benefit from a reduced program because they receive the benefits of detoxification, a sustained period without substance misuse, and counselling without the need for an extended stay. Conversely, a strongly dependent user may not recover after six months in the treatment program. Furthermore, for some clients, recovery might require more than one admission and a program of community counselling and outpatient visits. Based on the criterion of recovery, the CEO claims that about 60 per cent of clients complete the program.

QAIAS' approach is based first and foremost on prevention and abstinence. Clients in community counselling and other outreach settings are informed about harm minimisation measures such as controlled drinking (which is recognised as being a suitable goal for some people in those settings). However, based on extensive experience and the AOD literature, QAIAS does not view controlled drinking as a suitable goal for those in residential treatment. Abstinence is seen as essential at this critical stage of treatment and, thus, the Healing Centre is an alcohol and other drug free environment in which the emphasis is upon achieving and maintaining total abstinence – while it is recognised that some clients will not achieve that goal.

At QAIAS substance misuse is understood in a holistic way and as damaging to all aspect of people's lives. Accordingly, a variety of treatment and rehabilitative approaches is employed, including:

- drug and alcohol education;
- group therapy and peer support;
- Alcoholics Anonymous (AA) meetings;
- individual counselling;
- anger management;
- relapse prevention;
- independent living skills;
- family involvement and reunification;
- cultural programs; and,
- religion.

The AOD education program includes a series of lectures about the health, social, and emotional effects of alcohol and other drugs. The content of the program is variable, depending on the needs of clients attending, their levels of knowledge about alcohol and other drugs, levels of education, areas of interest, and history substance use. A key focus of treatment is upon independent living skills – particularly the development of budgeting skills and management of personal finances. The QAIAS approach is based on the premise that the more that is done for clients, the more dependent they become. Accordingly, as part of the independent living program – while providing levels of assistance appropriate to individual client needs – staff encourage clients to do things for themselves, such as completing Centrelink forms and contacting the Department of Housing. QAIAS also places a strong emphasis on clients improving the quality of their lives through retraining and returning to work. Training is also conducted at TAFE, including certificates in Drug and Alcohol Education, Community Welfare, and Indigenous health. The option also exists for clients to undertake university studies. In 2006–2007, 92 clients (40 per cent) participated in various work or education programs.[94,95]

The daily program at the Healing Centre runs between 6:00 am and 8:00 pm and changes regularly. An example of the daily timetable is outlined in Table 19. During breaks in the program, clients have access to art and gym equipment, computers and QAIAS' library. Staff also regularly accompany clients to nearby parks for outdoor activities and QAIAS has a 23 and a 12 seater bus and three cars which can be used to take clients on excursions. On Saturdays, after the qualifying period, clients are

permitted to leave the Healing Centre and on Saturdays and Sundays visitors are allowed.

Table 19: QAIS Timetable, Monday to Friday

Time	Activity
5:30 am – 6:00 am	Wake up
6:00 am – 7:00 am	Educational group
7:00 am – 8:00 am	Breakfast and medication (GP visits on Monday and Wednesday)
8:00 am – 11:00 am	Different one hour sessions are scheduled. • Living skills • Drug and alcohol education • Cultural activities • Case or clinical management • Psychiatrist and GP visit (each Thursday) • Counselling • Support group • Shopping or field trip
11:00 am – 12:00 pm	Staff briefing and free time for clients.
12:00 pm – 1:00 pm	Lunch and medication
1:00 pm – 4:00 pm	Different one hour sessions are scheduled. • Drug and alcohol education • Counselling • Walking • Men's and Women's or Youth Group • Quit Smoking • Relapse Prevention • Spiritual Group • Psychological Assessment • NA and AA meetings
4:00 pm – 5:00 pm	Recreational activities, such as gym or sports
5:00 pm – 6:00 pm	Dinner and medication
6:00 pm – 7:00 pm	Free time, news or recreational activities
7:00 pm – 8:00 pm	Session on • Relapse Prevention • Drug and Alcohol Education • Quit Smoking Group Counselling
8:00 pm – 10:30 pm	Free time and medication

On completion of the residential treatment program, staff provide home-based counselling, clients are able to access QAIAS' services as outpatients or visit staff members, and some ex-clients are employed casually at the Centre. Telephone counselling and outreach services in parks and hospitals are also provided. In 2006–

2007, QAIAS reported providing 7224 clients with such services.[92] In addition, although it does not promote them widely, QAIAS' staff conduct education programs in school and hospital settings and have produced educational materials. In 2006–2007 QAIAS also conducted 22 training sessions for community organisations.[94, 95]

9.6 Funding and contributions

In 2006–2007, QAIAS' income totalled a little over $1.5 million (excluding GST). Most of this was provided by the Office of Aboriginal and Torres Strait Islander Health – the contribution of which included an operating grant of $944,000 and a non-recurrent grant of $189,000 to purchase a vehicle. In addition, DoHA's Drug Strategy Branch provided a non-recurrent grant of $135,000 for Drug Action Week activities and improvements to information and communication systems and substance use programs.[96] The CEO reported that he had found the Department to be cooperative and provided guidance in the areas in which funding was requested.

In the same period, Aboriginal Hostels Ltd provided funds totalling approximately $143,000, an amount supplemented by approximately $150,000 from client tariffs ($130 per person per week). These funds and the operating grant from OATSIH were expended on items including food, electricity and gas, rates, motor vehicle expenses, repairs and maintenance, insurance, telephone and internet costs, and consultant fees.[96]

In previous years, QAIAS also received one-off grants from other government agencies such as the Department of Justice. In addition government grants are supplemented by small donations of money, clothes and books by staff, neighbours and the Uniting Church.

The CEO reported that QAIAS' current level of funding was adequate to meet current levels of demand and to provide current levels of service. However, at the time of our site visit, it had recently been successful in an application for $550,000 over three years under the Improved Services Measure. This grant will be used to improve organisational capacity to serve clients with a dual diagnosis of mental health problems and substance misuse. The project will encompass: continuous quality improvement in the assessment and treatment of clients with a dual diagnosis; training and education; formalising agreements with other service providers; and, writing a dual diagnosis manual for use within QAIAS. QAIAS has also applied for a further $450,000 to expand the service.

9.7 Inter-agency cooperation

QAIAS has established a comprehensive set of collaborative arrangements, of varying intensity, with a wide range of organisations. These are summarised in Table 20. Organisations listed in Tier 1 of the table include only those providing Indigenous specific services and/or services aimed at people who are dealing with substance misuse. In addition, however, QAIAS has collaborative arrangements with various non-Indigenous and non-substance misuse specific services.

Table 20: Alcohol and other drug services, Brisbane

Tier	Service
1. Non-substance misuse specific services	• Aboriginal and Islander Community Health Service + ^ # • Aboriginal and Torres Strait Islander Women's Legal and Advocacy Service ^ • Aboriginal and Torres Strait Islanders Corporation For Legal Services + ^ # • Dundalli Youth Services + ^ • Gallang Place Aboriginal & Torres Strait Islander Counselling Service ^ • Indigenous Youth Health Service • Link-Up (Queensland) Aboriginal Corporation + ^ • Nalingu Aboriginal and Torres Strait Islanders Day Respite Centre + • Umpi Korumba Aboriginal & Torres Strait Islanders Corporation for Housing + • Winnam Aboriginal and Torres Strait Islanders Corporation • Jane Arnold Hostel + ^ • Elly Bennet Hostel + ^ • Yumba Hostel + ^ • 139 Club Drop-in Centre + ^
2, Open access substance misuse services	• Murri Watch Aboriginal & Torres Strait Islanders Corporation ^ • Drug Arm – outreach + ^ # • QAIAS
3. Structured community-based specialist substance misuse services	• Drug Arm – Personal Support Program + ^ • Drug Arm - Home Assessment and Response Team + ^ • Ozcare - Home-Based Detoxification and Rehabilitation Service + ^ • Holyoake - The Queensland Institute on Alcohol and Addictions • QAIAS
4. Residential substance misuse services	• Adolescent Drug and Alcohol Withdrawal Service • Ozcare - Illicit Drug Detoxification Services + ^ • Brisbane Recovery Services Centre (Moonyah) Salvation Army - + ^ • HADS Royal Brisbane Hospital + ^ • Brisbane Recovery Services Centre - Moonyah (Salvation Army) + ^ • Biala Acute Care Service (Alcohol and Drug Service) + ^ • Alcohol and Drug Assessment Unit at Princess Alexandra Hospital + ^ • Alcohol and Drug Service at the Prince Charles Hospital + ^ • QAIAS • Goori House ^

Notes
~ These organisations deliver aspects of QAIAS's rehabilitation program, including on-site and off-site delivery.
+ These organisations provide essential services to QAIAS clients (e.g., legal services, medical treatment, detoxification, housing).
^ These organisations refer clients to QAIAS.
# QAIAS attends meetings or is in collaborative forums with these organisations.
* Clients from these organisations receive services or participate in activities provided by QAIAS.

QAIAS has good links with other Indigenous AOD and primary health care services. For example, it receives referrals from Murri Watch, a diversionary centre in Brisbane. It is also part of a mutual referral network between Goori House and the Aboriginal and Islander Community Health Service (AICHS). QAIAS clients also receive kidney dialysis and medical transport from AICHS and a staff member from AICHS has conducted nutrition, cooking and shopping classes at the Centre.

As to be expected, QAIAS' closest relationships with non-Indigenous organisations are with those that provide services for QAIAS clients. For instance, QAIAS works with the Community Mental Health Service which provides services at the Centre for dual diagnosis clients. QAIAS also communicates with the Department of Housing regarding the provision of housing for clients who are approaching discharge from the Healing Centre. It also has an agreement with Centrelink, under which Centrelink staff visit the Healing Centre weekly in an attempt to reduce the risk of clients using alcohol or other drugs when off-site. Occasionally, inter-agency meetings are held to coordinate their delivery of services to particular clients and their families. Weekly programs are also conducted at the Centre by Alcoholics Anonymous and a local church.

9.8 Reporting and evaluation

The reporting requirements placed on Indigenous drug and alcohol services were of considerable concern to the CEO of QAIAS. QAIAS itself is required to complete 14 different reports for funding agencies, including:

- OATSIH Financial Reports (February and August);
- Service Development and Reporting Framework (SDRF) Reports (February and August);
- Audited Financial Report (September);
- Annual Report (September);
- Drug and Alcohol Strategy (DASR) (August);
- Draft SDRF Action Plan (May);
- Project budget (May);
- Quarterly reports to AHL (as well as monthly occupancy reports); and,
- Annual ORATSIC Report.

Residential rehabilitation services are now also required to complete the Organisational Risk Assessment Profile (ORAP) which was introduced by OATSIH in 2008 and which will be required annually. QAIAS has already participated in two Risk Assessments. As well, funding bodies require: additional information from organisations throughout the year; attendance at a range of meetings, conferences and seminars; and, involvement in research. Reporting demands are further exacerbated when organisations receive multiple, short-term grants to fund the same service provision. The timing of reporting requirements is also an issue, with many reports due at the time of the Annual Winter School in the Sun AOD conference – thus mitigating against staff attendance and potential benefits to clients.

Reporting demands also place considerable pressure on QAIAS staff (particularly as many are not trained in this area) and reduces the time they have available to spend directly with clients. The CEO argued that possible strategies to address this, such as employing staff with expertise in the area or out-sourcing are not feasible or appropriate because the they allocate resources away from service provision or undermine the philosophy of community control in favour of a business model.

While acknowledging the importance of reporting requirements in terms of accountability, maintenance of standards, and information sharing, the QAIAS CEO was of the view that they could be reduced without compromising accountability – including, for example, reducing requirements for organisations assessed as performing consistently well (a suggestion endorsed by the Regional Manager of AHL). Clearly, these are issues that need to be addressed at the national level and OATSIH is currently reviewing them.

To ensure best practice, QAIAS has introduced a clinical assessment and client satisfaction questionnaire for clients completing treatment.[91, 93] The clinical assessment, which is completed by a clinical panel, measures four components of treatment – general health, psychological health, social relationships and primary drug use on a five point scale from 'much improved' to 'much deteriorated'. For 100 clients accessing the service between 2006–2007: 86 per cent were assessed as improved or much improved in terms of general health; and 73 per cent were assessed as improved or much improved in terms of psychological health and social relationships. However, only 40 per cent were assessed as improved or much improved in terms of primary drug use. The client satisfaction questionnaire records clients' responses to the residential and outpatient treatment services. The 2006 Annual Report recorded that 53 per cent of residential rehabilitation clients were satisfied or very satisfied and 35 percent reported a neutral response – neither satisfied nor dissatisfied.

QAIAS acknowledges that some clients need to re-enter residential rehabilitation a number of times before they are successful in becoming abstinent.[91] QAIAS measures successful treatment in terms of:

- client abstinence during treatment;
- improvements in clients' physical and psychological health, and their social relationships;
- empowerment of clients to make changes in their lives (e.g., establishing support networks, accessing other services, improvements in communication and daily living skills); and,
- reduction in substance use related harms.

9.9 Relationships with QISMC and QAIHC

The CEO stated that QAIAS was supportive of collaboration with other residential rehabilitation services through QISMC and welcomed the workshops that they had conducted. However, he also noted that QAIAS had formed relationships and worked with other residential rehabilitation services before QISMC was established. For example the CEO from Yaamba had spent a number of weeks at QAIAS to learn about

their residential rehabilitation program and its operation. QAIAS has also had good working relationships with other substance misuse services including AIARS in Cairns and Wunjuada in Cherbourg.

10. Discussion and recommendations

A number of common themes are evident in the case studies we have presented in the previous chapters. These themes reflect areas of both strength and concern in regard to the provision of AOD services. In this chapter, we focus on those themes and consider them in the light of the wider literature and the data we presented in Chapter 4 on the broader provision of Indigenous AOD services. In addition, we make a number of recommendations for improving the delivery of services and their outcomes.

10.1 Indigenous community-controlled AOD agencies in Queensland.

The evidence reviewed in Chapter 3 indicates that, to be effective in the reduction of alcohol- and other drug-related harm, it is necessary to provide a comprehensive range of interventions. Furthermore, as specified in the *Complementary Action Plan*, the provision of services by Indigenous community-controlled organisations and enhancement of their capacity to do so are key elements in this. Here we briefly review the material presented in Chapter 4 on the services provided by Indigenous organisations to reduce Indigenous AOD-related harm and make recommendations to strengthen current responses.

The majority of organisations (74 per cent) providing Indigenous specific AOD services in Queensland in 2006–2007 were Indigenous community-controlled organisations (including four Indigenous local government organisations) and they conducted 69 per cent of all projects. However, between 1999–2000 and 2006–2007, while there were small increases in the numbers of Indigenous community-controlled organisations and the projects they provided, as percentage of total organisations and projects they declined (Table 11). This difference is accounted for by a larger number of non-Indigenous NGOs being funded to provide Indigenous specific services. In part, this appears to be due to a lack of Indigenous capacity to provide those services. At the 2006 QISMC Workshop members reported that they were so overwhelmed with the demand for treatment and rehabilitation services that their capacity to expand their services to include education, prevention and early intervention was limited. *We therefore recommend that QISMC and QAIHC should seek a long-term commitment from funding bodies to resource additional capacity within the sector – including within Indigenous community-controlled health services.*

Although they conducted a broad range of intervention projects, Indigenous service providers tended to fall into two groups: residential treatment services, which secondarily provided additional Tier 3 non-residential and other harm reduction services; and providers of Tier 2 demand reduction services such as safe shelters and community patrols. The primary focus of the majority services was alcohol-related problems – although many addressed cannabis and other illicit drugs in addition to alcohol-related problems.

There were a number of gaps evident in the services provided by Indigenous organisations. Tobacco is the largest single preventable cause of death among Indigenous Australians. However, tobacco was not the primary focus of any interventions conducted by Indigenous organisations – although it was a secondary focus of several (mainly treatment) projects. The second important gap in service provision was the lack of on-going care for those exiting treatment programs. Apart from one organisation, residential treatment services had limited capacity to provide such care and there was little evidence of these needs being systematically addressed by other services. Relative to Tier 2 harm reduction and Tier 4 residential treatment services there were few Tier 2 demand reduction projects (e.g. health promotion projects) and few Tier 3 non-residential treatment services (although these were sometimes provided by residential treatment services). On the surface, based on numbers of grants and/or funding allocations, there also appear to be gaps in service provision in some regions – particularly Roma and to a lesser extent Rockhampton. However, more detailed examination of needs in these areas should be undertaken. *To address gaps in the provision of services, we recommend that QISMC and QAIHC should seek a long-term commitment from funding bodies to increasing allocations to the Indigenous AOD sector to provide for an expansion of tobacco control interventions, on-going care services, and alcohol and illicit drug prevention projects.*

10.2 Indigenous community-controlled AOD agency outcomes

Clearly, in the interests of Indigenous communities, the organisations providing services, and the agencies funding them, there needs to be some measure of the efficacy of the services. However, we were not able to identify evaluation studies of any of the Indigenous intervention projects – either for the year under review or previous years.

Each of the organisations that were the subject of the case studies provided a range of services that included: counselling, AA programs, AOD education, life skills training, exercise and relaxation, recreation, health services, and cultural activities. Of these organisations only QAIAS had developed a clinical assessment and a client satisfaction questionnaire – each of which were to be filled out at the completion of treatment. Gindaja and another organisation, had developed client feedback forms – completion of which at the time was voluntary. However, both had plans to develop these into a more systematic feedback process. The other two organisations relied only on 'word of mouth' from clients as to the effectiveness of the services they provided.

Information currently gathered from the service providers by funding agencies essentially monitors activity rather than outcomes. That is, in large part, whether the organisations are providing the services they have been funded to provide. In the case of OATSIH, this information is gathered as part of the annual Drug and Alcohol Service Reports (DASR) and the Service Development and Reporting Framework (SDRF). Under the former, organisations report on topics including: project information and activities, client numbers, episodes and types of care, target drugs, staffing, and sources of funding. Under the latter:

> … services are required to prepare and implement an Action Plan describing their aims, strategies and measures, timeframes, management, community involvement and community linkages, and report against them at six monthly intervals.[97]

One measure that is sometimes used as an *indicator* of potentially improved client outcomes – in terms of reduction in both consumption and harms – is treatment program completion and this is collected as part of the DASRs. According to 2006–2007 DASRs, the proportion of clients completing a 12 week program of treatment at the five services ranged from a low 14 per cent to a high of 39 per cent with a median of 27 per cent. According to staff from two of the organisations, some clients feel that they are ready for discharge before the designated program length and that this is a positive outcome not captured in the DASR figures. On the other hand, the figures reflect the high levels of family and other problems many clients have and which result in their early withdrawal. An OATSIH staff member said they did not see these figures of particular concern, but said they would be concerned if some clients were simply using the services for short-term accommodation. Nevertheless, the figures do highlight the high levels of support that are needed to retain many clients in treatment and for which agencies are not well resourced.

As with the information collected by the funding agencies, the annual reports of service providers essentially provide information on activity and financial statements. They do not provide information that enables unambiguous assessment of outcomes.

Among those we interviewed, there was a general feeling that some services can be more effective. More specifically, concerns were expressed to us about the quality and effectiveness of two of the treatment programs. These concerns had to do with factors such as: the absence of a guiding philosophy; lack of structure in, and consistency in the application of, the programs; and, the lack of 'professional' skills among staff. It was beyond the scope of this study to assess claims such as these. Nevertheless, they do highlight the need for clearly articulated program objectives against which effectiveness can be measured. OATSIH has plans to provide for the accreditation of services and it is likely that as part of this process service providers will be required to report more detail on specific program outcomes. Stakeholders from the treatment services were supportive of the need for data which could demonstrate their effectiveness. However, they made the point that outcome measures need to be negotiated and developed in relation to their organisational objectives.

We are supportive of a requirement that service providers be required to report on program outcomes and *recommend that activities already under way in the development of appropriate monitoring and evaluation measures should be given high priority. However, specific measures need to be negotiated with, and developed with regard to, the objectives of particular organisations*. Care must be exercised that objectives and outcomes are not imposed, thus undermining the social responsibilities of organisations to their own communities. It is also important that the inherent difficulties of collecting data that can be used to assess outcomes are acknowledged and that the data collection process is realistic and is adequately resourced.

10.3 Contextual factors

Substance misuse intervention programs cannot be optimally effective if the organisational structures and procedures for their implementation – the key contextual factors – are not in place. As indicated in Chapter 3, a number of 'elements of best practice' in the implementation of substance misuse interventions have been identified,[32] and these can be measured in ways which reflect the characteristics of particular organisations. In this section, we canvas some of these contextual factors as they were identified in the case studies of residential treatment services – although the issues have wider relevance. It is important to note that many of the issues raised are not new and that attempts have been, and are being, made to address them. However, while they continue to be problematic it is unrealistic to expect better outcomes.

10.3.1 Approaches to the provision of treatment

It was beyond the scope of this project to review the clinical programs conducted by the participating service providers. However, we note that there is considerable variation in their structure and intensity of treatment. Embedded in these approaches are various tensions. These include those between: the passion of charismatic individuals who established services and the demands of professionalization; 12-step abstinence and broader harm minimisation approaches; and, demands for social accountability to Indigenous communities and financial accountability to government funding agencies. These tensions are not easily resolved but they need to be acknowledged and worked out over the longer term. In the short-term, however, it is important to note that while all treatment approaches should be available to Indigenous people, it is not necessary that all service providers provide all approaches.

The tensions identified above arose particularly around the issue of accreditation of services. OATSIH is developing an accreditation process that will apply to the range of services and programs it funds. It is anticipated that all services, including AOD services, will be accredited by June 2011. According to OATSIH representatives, with others, QAIHC will be involved in the development of an accreditation model which will draw on standards developed by the Quality Improvement Council and International Organisation for Standardization. Service providers were concerned that: the proposed standards take account of the diversity of approaches that have been decided upon by particular Indigenous community-controlled organisations and not impose approaches upon them; and, that adequate resources – including funding, training and equipment – be provided to enable organisations to meet those standards.

10.3.2 Governance and administration

There are three key dimensions to the role of board members of Indigenous substance misuse services:

- to represent the views and wishes of the wider Indigenous constituency which elected them to their positions;

- to be familiar with the range of substance misuse interventions and their effectiveness (especially in Indigenous contexts) and to use this information both to inform their constituency and their decisions as Board members; and,
- to provide oversight of the management and administration (including the financial management) of their respective organisations.

To be effective in serving the community, the organisation and its clients, board members must play an active role and they must be able to balance and address conflicting elements of their roles – for example if community perceptions of what constitutes effective treatment are at odds with the evidence or 'best practice'.

Without singling out particular organisations, among those which were included in the case studies, it was alleged that, in the past, some board members did not have the expertise to effectively manage an organisation, were not adequately aware of their responsibilities, and/or had exercised their roles in ways that were detrimental to their organisations or communities as a whole. That is they had suffered from poor corporate governance.

An important element of corporate governance is good financial management. However, with the exception of QAIAS, each of the five treatment services we reviewed had either been under 'funds administration' or had experienced difficulty in financial and administrative management. For Yaamba, these issues had been addressed and a full-time financial administrator has been appointed to the organisation. In the case of another organisation, these were reported to have been issues in the past but were being addressed under a new CEO. However, at the time of our site visits, two organisations were facing difficulties in this regard. OATSIH has been supportive of the organisations experiencing financial difficulties and the board members and staff members we interviewed were acutely aware of the threats to their organisations that these difficulties posed.

Enhancing the governance of Indigenous community organisations is of concern beyond the health and substance misuse sectors.[98] The Office of the Registrar of Indigenous Corporations has developed workshop and training programs for current or potential members of the boards of Indigenous corporations – including Certificate IV Business (Governance) and a Diploma in Business (Governance). Governance training is also provided to member organisations by QAIHC. Training covers topics such as policy development, planning, human resources and ethical issues. For its part, OATSIH provides support for participation in such training to the agencies to which it provides funding – in line with its commitment under the both the *Complementary Action Plan* and the *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework*.[52, 54] In 2007–2008, it provided support for: business and financial management training; Information Communication Technology and Information Management; the annual QISMC workshop; and, attendance at the Drug and Alcohol Nurses of Australasia Conference.

Representatives of all organisations included in the case studies reported that – either as members of their respective boards or as members of the boards of other organisations – their board members had received, or were receiving, governance training. They also reported that they attempted to ensure continuity and maintain governance expertise by introducing staggered terms for board members and/or

requiring that board members serve terms as ordinary members before taking executive positions. However, we were also told that – more broadly across the sector – governance training had not been provided systematically, that many members had pursued the training as individuals, and that it was not always easily accessible. Given the importance of such training, *we recommend that QISMC–QAIHC should seek resources to expand the governance training currently provided by QAIHC and that members of the Boards of affiliated organisations should be encouraged to undertake such training*.

As indicated above, it is important that members of the boards of AOD misuse services have a broad knowledge of interventions and the evidence for their efficacy – not only the principles of organisational and financial management – which they need to apply in the development of policy and planning. Furthermore, they need to play an active role, both formally and informally, in imparting that knowledge to their communities so that those communities can make informed decisions about the directions they wish their representatives on the boards to pursue. To address this, some organisations, such as Gumbi Gumbi, have actively sought to encourage professional people with appropriate qualifications to stand for board membership. Nevertheless, this is another area in which training could be profitably provided to board members (as well as some employees) and *we recommend that QISMC should seek resources to conduct AOD training seminars and workshops itself, or to contract third parties to do so, and that Board and staff members of affiliated organisations should be encouraged to undertake such training*.

10.3.3 Reporting requirements

Although the organisations reviewed reported positive relationships with funding bodies, and while they recognised the necessity of reporting, the number of reports they were required to prepare was experienced as a burden. Among these reports are annual reports required under corporations' legislation and organisational constitutions, activity reports such as DASR and SDRF (since 2008), an annual Organisational Risk Assessment Profile, quarterly financial reports, and in the case of those organisations receiving AHL funding, monthly occupancy reports. This burden is multiplied when organisations receive grants from more than one funding body and/or when they receive multiple grants. It is again further multiplied when organisations provide services other than AOD services, such as aged care. In addition to such formal reporting requirements, organisations are also subject to a variety of *ad hoc* requests for information.

Although services regard these reporting requirements as a burden, they are differentially placed to bear the burden – with some agencies able to meet the requirements, but with others (particularly, but not always, smaller organisations) struggling. In the case of smaller organisations when staff were primarily recruited for their clinical experience their ability to meet the demands of reporting were often limited; they did not perform those tasks well, and they became resentful. Given its importance, *we recommend that any benchmarking of organisational staffing levels should include specification of reporting skills requirements and needs*.

Several suggestion were made by organisational representatives as to how these issues could be addressed. The first of these was the pooling of funding by funding agencies (for example as proposed for the provision of primary health care in Cape York[99]), with service providers preparing a simplified set of reports on the one combined project. In the absence of this, it was suggested that service providers provide one report which was accepted as meeting the requirements of all funding bodies. To simplify the collection and collation of data for reporting, it was also suggested that common databases be developed – which meet the needs of both the service providers themselves and the funding bodies – from which information could be extracted as required by those with a need for it.

None of these concerns and proposed solutions are new. They are acknowledged at the regional and State level by representatives of the funding bodies and they themselves have lobbied to have them addressed. According to a representative of OATSIH, a project is currently underway to identify the elements of a reporting system that meets the needs of all the organisations to which it provides support. While this is important in its own right, the solution needs to be broader and to include other key stakeholders.

It is important that QISMC and its constituent members take a unified approach and play an active role in the development of solutions to this problem. However, ultimately the solution lies in the hands of the various funding bodies and the willingness of them, and their political masters, to cooperate. Nevertheless as a first step, *we recommend that QISMC should convene a meeting of all stakeholders to develop a set of recommendations for reducing the burden of reporting requirements*.

10.3.4 Funding levels and sources

As indicated in Chapter 4, between 1999–2000 and 2006–2007, in real terms, there was an increase of over 150 per cent in the level of funding provided to Indigenous-specific AOD services. In absolute terms, most of this increase was provided by OATSIH and the Queensland Department of Communities, both of which continued to be the greatest contributors of funds. A large proportion of funds provided by the former was allocated to Tier 4 residential services and a large proportion from the latter were allocated to Tier 2 harm reduction services or to treatment as part of QAIDP. For some organisations, existing funding levels were adequate to meet existing levels of service provision, but for most, relatively small amounts of additional funding were needed to consolidate existing service provision. Needs with regard to the latter included funds for salary increases, increased staffing levels and/or recruitment of more qualified staff, and support for training.

When considering the sector as a whole, there are clearly significant gaps in the types of services provided and in the regional provision of services. To fill these gaps will require a significant injection of funds. It will also entail both: the expansion of service provision by existing organisations, where they are interested in doing so and where they have the ability to do so; and/or the creation of new organisations where existing ones do not wish to expand their services.

It is likely that small increases in funding will be available to provide consolidation of existing treatment services and perhaps some modest expansion. However, it appears unrealistic to believe that there will be considerable injection of new funds by OATSIH – although there is an important role for QISMC in advocating for this. In the shorter term, for purposes of consolidation and expansion, services need to tap into existing mainstream AOD funding programs and have been encouraged to do so by OATSIH. Some organisations have done this – although as figures on the proportions of funds from the various funding bodies show, to date the impact has not been great – and QISMC has provided assistance with funding applications. In addition, as many AOD organisations provide a holistic range of services – such as child safety and crime prevention – there exists the potential to tap into funding programs for these other services. However, with existing resources, many organisations do not have the capacity to systematically explore the options and prepare funding submissions and *we recommend that QISMC should seek resources to expand its capacity to support member organisations to access a wider range of funding sources*.

Another source of funds for the expansion of service provision by Indigenous community-controlled organisations is contracting with government agencies for the provision of services – as with QIADP or with Corrective Services. For Indigenous organisations, however, this presents a dilemma. On the one hand, they recognise that services are needed but, on the other, they are concerned that the nature of the services to be provided is determined by the contracting agency – in some cases undermining the principle of community-control.

10.3.5 Client mix

Representatives of each of the services that participated in our review reported observing changing patterns of substance misuse with increases in amphetamine, cannabis and poly-drug use. They also noted that there have been significant increases in the numbers of clients presenting with comorbid mental health problems.

Despite these changes, the prime focus of the organisations has remained largely upon clients with alcohol-related problems (although to a lesser extent in the case of QAIAS). In fact, some organisations sought to restrict the numbers of clients with other drug-related problems. According to representatives of those organisations, there were several reasons for this, including: the more intensive level of management (and hence higher staff-client ratios) such clients required; and, the lack of expertise among staff members in dealing with clients with those problems.

Representatives of some of these organisations – and from the wider QISMC membership – felt that residential treatment services were often used by other agencies as a 'dumping ground' for people with mental health problems for whom substance misuse was secondary. Nevertheless, while they were willing to accept clients with mild comorbid mental health problems, services set parameters around the admission of those with more serious problems similar to the parameters they set around clients with more complex patterns of substance use. Again, the reasons cited were similar: the disruption that such clients often caused; inadequate staff levels to meet the increased demands such clients place upon services, including the time to adequately case manage them; and, the lack of staff (such as mental health workers

and psychologists) with the clinical training and experience to meet client needs. As was the case with regard to clients with complex substance misuse problems, service providers felt that there was a lack of understanding among the non-clinically trained staff of funding agencies and hence a lack of responsiveness to their needs for more adequate resourcing to address these increasing problems.

An emerging issue for the residential treatment services is the growing number of clients who are mandated into treatment as part of parole conditions or through the Queensland Indigenous Alcohol Diversion Program (QIADP). The service representatives saw QAIDP as a positive policy initiative and actively supported it. Indeed, two of those we interviewed claimed to have originated the idea which, they asserted, was taken up without acknowledgement. However, some organisations have found that mandated clients present additional challenges. First, unlike most voluntarily admitted clients, many are not motivated to change their substance use behaviour and are thus resistant to intervention. In addition, it has been found that some parolees bring with them the 'culture of the jail' which intimidates other clients and is disruptive. Again, services have found that they do not have the staff resources to adequately address the greater workload incurred – including the time to establish functional collaborative relationships with Queensland Corrective Services in order to provide better case management. Some services, such as Yaamba, have met this challenge by restricting the number of mandated clients accepted at any one time. However, there is a need to address this and the needs of other clients who need additional levels of care at a broader level. *We therefore recommend that QISMC should seek the collaboration of relevant stakeholders – including OATSIH and Queensland Corrective Services – to benchmark the level of support needed to meet the additional needs of mandated clients and clients with complex AOD and/or comorbid mental health problems and the workforce, training, and resource levels necessary to meet those needs.*

OATSIH provides funding for services for Aboriginal and Torres Strait Islander peoples and – although it has no specific guidelines in this regard – it is the expectation of OATSIH staff that Indigenous people will be primary recipients of those services. In the case of Aboriginal Hostels, staff advised us that AHL expects an Indigenous to non-Indigenous ratio of 60:40 among residents, but this is not formally monitored. However, despite the fact that all of the services we reviewed were established for Indigenous people, and that they have priority, we found that three of the services had a greater proportion of non-Indigenous than Indigenous clients and two of those services had more than double the proportion. (Although, it should be noted that data obtained from other services suggest that the figures for the organisations participating in our review may be atypical.)

In some cases, non-Indigenous clients are the partners of Indigenous clients and provision of treatment for them is entirely appropriate. However, most non-Indigenous clients are admitted to maintain occupancy rates (and in the case of those funded by AHL, to avoid a reduction in funding levels) in the absence of sufficient 'demand' for places from Indigenous people. Given the higher prevalence of harmful AOD use among Indigenous people, this raises the question of why there is insufficient 'demand' for those places. One answer to this appears to be that there is a lack of awareness of the AOD services, and a lack of expertise in making appropriate

referrals, among staff of other organisations. The lack of awareness is, in part, related to a lack of resources on the part of the AOD service providers to more actively promote their services. The lack of 'demand' also appears to be related to a passive rather than an active recruitment of potential Indigenous clients.

To simply require an immediate reduction in non-Indigenous client numbers, would have an adverse impact on the operation and/or viability of some services. Therefore, to address the problem and provide a greater level of service for Indigenous people, *we recommend that those Indigenous AOD treatment services with high proportions of non-Indigenous clients should develop two to three year strategies to ensure that no more than 10 per cent of client places are occupied by them*.

10.3.6 Workforce issues

The case studies and our more general discussions raised a number of workforce issues. These include specific concerns about staffing levels and salaries and more general issues regarding the limited pool of vocationally and professionally qualified personnel and the need for the training of such people.

Representatives of several of the organisations felt that they had inadequate staff numbers to provide appropriate levels of service and that there was insufficient recognition by funding agencies of the fact that a certain a level of staffing was required regardless of client numbers. Furthermore, there appeared to be differences of view between funding bodies and service providers, and between service providers themselves on the level of qualifications needed to provide services. Unfortunately, in the absence of agreed upon benchmarks there is no simple resolution to these issues and *we recommend that, as a matter of priority, staffing benchmarks for Indigenous AOD residential treatment services should be developed by QISMC in consultation with mainstream AOD agencies and agreed upon by all key stakeholders*.

Related to staffing levels and appropriate qualifications was the issue of salary levels and this was an issue of contention for each of the organisations we visited – as it was for organisational representatives attending the 2006 QISMC workshop. In particular, they cited the discrepancy in salary levels between staff working in the community-controlled sector vis-à-vis those in the government sector. Key issues here were the absence of any benchmarking of salaries, and historically-based funding arrangements which do not automatically provide increases above CPI increases to cover the employment of newer, more highly qualified staff members or to reward staff members who obtain higher qualifications.

In some cases, organisational representatives reported losing qualified staff to government agencies and to non-Indigenous NGOs which offered higher levels of remuneration. However, they also noted that, despite some dissatisfaction about salary levels, in general there was a strong commitment by staff to working in the sector and that dissatisfaction was offset by the efforts of agencies to provide workplace conditions that were attractive to staff. Nevertheless, the issue of salary levels is an ongoing one which is the source of some discontent. It is not an issue confined to Queensland and needs to be resolved at a national level, *we therefore recommend that QISMC should continue with efforts to ensure that disparities in*

Indigenous AOD treatment service salary levels are addressed in the development of service benchmarks.

Although the magnitude varied between service providers, the issue of recruitment of appropriately qualified staff was of concern. Representatives from the services that were reviewed estimated that the percentage of vocationally or professionally trained staff they employed ranged from a low of about ten per cent to a high of about 85 per cent, and most of them identified the need for more trained staff in the treatment and/or management of services. The shortage of trained clinical staff limited the types of clients some could accept, and the amount of support and the range of treatment options that could be provided to individual clients – especially in the light of the increasing numbers of clients, or potential clients, with comorbid mental health problems, complex patterns of AOD use and mandated clients.

It is important to note here that – although not discussed in as much detail as formal qualifications – for Indigenous board and staff members a desirable if not essential qualification for working in the clinical area was being an Indigenous person and having an understanding of the family, community and broader social worlds in which their clients lived; which provided both the context for their AOD problems and their solutions.

While indicating a preference for Indigenous workers in the clinical area, service providers and others cited the generally low numbers of Indigenous people who are trained in relevant disciplines as a key issue. This general shortage was exacerbated by other factors, relating to both Indigenous and non-Indigenous workers, and applying to different degrees in particular locations. These factors include: the difficulty of competing with organisations in the government and non-Indigenous NGO sectors in terms of salaries and conditions (cited above); difficulties of attracting qualified staff to small communities; and, the small scale of many services which do not have the resources nor the client base which would justify the appointment of more highly qualified staff members.

The shortage of qualified Indigenous staff in the AOD sector and the need for increased provision of staff training, as an element of Indigenous capacity building, has been highlighted in several evaluations of Indigenous AOD services.[40] As indicated in Chapter 3, such training is a key element in the *Complementary Action Plan* and more broadly is the subject of the *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework.* In line with this, there has been a significant increase in the provision of training opportunities – particularly at the Certificate III Community Services Work (Alcohol and Drugs) level. Since 2006 – in collaboration with QAIHC and QADREC and funded by DoHA and by Queensland Health's Alcohol, Tobacco and other Drug Services branch – QISMC has been offering such training to workers in residential treatment services. It also plans to extend this training to Certificate IV level in 2009.

Despite the increase in opportunities, however, to date few organisations have had staff complete training. Staff from the organisations we visited identified barriers to both access and completion of training. A key barrier to the former is the inability of organisations to release staff because of the lack of funding to backfill positions when

staff are training. Another factor is limited funding for travel and accommodation costs when trainees are required to travel outside their local areas to access training. Barriers to completion included: the family, community, and work commitments and circumstance of mature age students; frustration at inadequate recognition of experientially-based prior learning; and, the high levels of support many staff need because of the fears they face in relation to training and education. Given these barriers, *we recommend that QISMC should seek to enter into negotiations with relevant agencies to negotiate levels of funding which adequately compensate AOD services and individuals for the costs associated with training that are additional to the costs of training itself and the payments to which individual trainees are entitled under Abstudy.*

Training of existing members of the AOD workforce is clearly important. However, alone it is unlikely to meet the need for skilled workers – particularly at higher levels in occupations such as nursing and psychology. For this reason, *we recommend that, QISMC and QAIHC should lobby relevant Australian and Queensland Government agencies to allocate additional funding to increase the numbers of Indigenous people directly entering AOD vocational and tertiary training.*

10.4 Models of best practice

In Chapter 3, we reviewed the evidence in terms of models of service delivery that are linked to successful outcomes in the reduction of alcohol- and other drug-related harm. In this section, we examine three of those – Indigenous community-control (and capacity building), inter-agency collaboration, and on-going care – as areas in which outcomes in the AOD sector can be enhanced.

10.4.1 Indigenous community control

The Alma Ata Declaration – based on an extensive review conducted by the World Health Organisation – identified four key elements for the successful provision of primary health care.[100] These elements – which can be applied to the evaluation of all health services, including AOD services – were acceptability to clients, affordability, accessibility, and appropriateness in terms of technical response. An important aspect of acceptability is 'cultural appropriateness' or 'cultural safety' – which is more likely to be achieved when services are provided by members of the same cultural group as the clients – which results in increased willingness within communities to utilise services. This principle underlies the establishment of Indigenous community-controlled health services in Australia, it is the rationale for the provision of direct funding to ACCHSs by the Australian Government, and it is a key principle of the *Complementary Action Plan*.

Among those we interviewed from the Indigenous AOD sector, there was concern that the principle of community-control was being eroded by the process of tendering for the provision of services for Indigenous people by Queensland Government agencies. At a general level, on the one hand, increases in resources for the provision of services for Indigenous people was welcomed. On the other hand, however – because programs are developed externally to communities – in the execution of them, community organisations simply become extensions of the State government. At a more specific level, as evidence of erosion of the principle of community control they cited the

increasing tendering of services for Indigenous people by Queensland Government agencies to non-Indigenous NGOs.

In general, there was a feeling that Indigenous organisations are disadvantaged in the tendering process. Some organisations lack the skills and/or capacity to prepare tender applications and feel that they are not able to compete with large non-Indigenous NGOs which have the resources to employ skilled staff members to do this. To address this problem, QISMC has provided assistance to member organisations to prepare tender and grant applications. However, its capacity to do so is limited and *we recommend that QISMC should seek additional funds from OATSIH to expand its role in supporting member organisations to develop competitive tender and grant applications*.

As well as not having the capacity to prepare competitive applications, some organisations do not have the capacity to provide the services that are up for tender. This is a double edged sword, as without obtaining a tender an organisation is not able to build capacity within the community (again another important element in the *Complementary Action Plan*). To address this, *we recommend that the creation of Indigenous capacity for service delivery should be incorporated as an objective in government requests for tenders and in service delivery contracts in addition to specific services per se*. This will clearly increase total program costs, but this should be accounted as an investment in Indigenous capacity building, training and employment.

It was asserted that while large NGOs may employ Indigenous staff to enhance their apparent acceptability to Indigenous clients (and to the organisations calling for tenders), this was not a substitute for the broader understandings of communities and the experience of working with them that Indigenous organisations possessed. This is something that needs to be considered when tenders are awarded. However, to address this issue at a broader level, as a commitment to building capacity within the Indigenous AOD sector, *we recommend that, to further develop Indigenous capacity, government agencies should specify that, in assessing tender applications, if no suitable applications are received from Indigenous applicants, preference will be given to those non-Indigenous applicants tendering in partnership with Indigenous community-controlled organisations*.

10.4.2 On-going care

After-care, extended-care, continuing care, or what we refer to here as on-going care, is an essential component of any AOD treatment program. The *Guidelines for the Treatment of Alcohol Problems*, and the review of the evidence on which they are based, state 'Successful treatments of any condition which is subject to relapse, such as alcohol dependence, often requires ongoing and extended assistance'.[35, 37] To be effective, such care should: be assertive and structured; be provided by helpful and empathic agencies and practitioners; remove barriers to participation; and, provide social support (including AA meetings where appropriate).[37] The provision of 'structured aftercare programmes' is an essential element of Tier 3 interventions in the NTA model of service provision.[5, 6] The *Complementary Action Plan* also recognises the importance of on-going care. As indicated previously, Key Result Area 4 calls for

provision of: 'A range of holistic approaches, from prevention through to treatment and *continuing care*, that is locally available and accessible' (emphasis added).[52]

The need for on-going care is recognised by the broad QISMC membership and by QAIHC staff working in the AOD area. However – as the case studies show – while there is some variability in extent and quality, in general most services do not have the capacity to provide such care. Furthermore, the capacity they do have is taxed by the high mobility of many clients.

While some treatment services would like to expand service delivery in this area, if resources were available to do so, others were of the view that consolidation of current service provision was of higher priority. However, it is not necessary that, in all instances, on-going care be provided by the treatment services themselves. There is considerable room for shared-care arrangements to be put in place – particularly with community-controlled health services. *As a first step in the provision of enhanced on-going care, we recommend that QISMC – in collaboration with other key stakeholders – should benchmark standards for the provision of on-going care and their cost, and also explore options for residential services (where they are not able to provide such services themselves) to contract the provision of on-going care to third parties.*

Provision of more comprehensive on-going care has the potential to reduce the frequency of relapse among clients and to protect the investment of resources in treatment itself. Thus, *we recommend that once benchmarks for the provision of on-going care have been established, QISMC should enter into negotiations with relevant funding bodies for the long-term expansion of on-going care services.*

10.4.3 Integrated service delivery

As the models developed by Lynch and the National Drug Research Institute – among others – make clear, substance misuse is a complex problem which needs to be addressed at a number of levels and across a number of sectors.[5] Even within the health sector, no one agency can provide the range of responses required and, as the NTA model emphasises, an integrated response is needed between agencies and their program activities. The MOU between QISMC and QAIHC is a clear recognition of the need for shared goals and service integration. However, concern was expressed by the staff of both organisations and by some representatives of their member organisations, that this recognition was not always reflected at the local and regional level.

We observed some good examples of service integration – for example, the provision of psychological services by ATODS staff in some Indigenous residential facilities. However, in general, relationships appeared *ad hoc* and the strongest relationships between AOD treatment services and other organisations centred on the provision of services directly related to immediate client needs. These included, for example, detoxification, health care services, and income or other supports. We also identified a range of more general cooperative activities which included participation in inter-agency forums and special purpose committees, and contributions to activities in NAIDOC Week and Drug Action Week. However, while these are important, it was difficult to discern any overall strategic direction to the activities.

Beyond existing cooperative activities, the potential exists for putting in place a more structured set of arrangements which capitalise on the various skills within agencies and which have the potential to achieve enhanced client outcomes. These include, for example, provision of a broader range of services (particularly Tier 2 demand reduction services and Tier 3 non-residential treatment), integrated client case management and shared care, and the provision of on-going care.

The single largest barrier to better coordination of services is the current workloads of staff within organisations. In most organisations, staff appeared to be struggling to meet the immediate needs of clients. In these circumstances, integrated care was perceived as an 'optional extra' – not an essential element of care. Recognising this, some agencies have established MOUs which delineate the roles and obligations of the signatories. However, as the CEO of one organisation which was party to such an MOU said 'We signed an MOU with … (a particular service), but nothing's changed'. This comment underscores the fact that service integration will not take place simply on the basis of goodwill or signed agreements; it needs to be adequately resourced. To be effective, this resourcing should not be provided on an *ad hoc*, service-by-service basis. *As essential elements of 'best practice', we recommend that coordination and service integration functions should be part of service provision benchmarks and should be adequately resourced*. Within organisations, service coordination should be part of the specified role of a designated staff member or members.

In general discussion, several of those we interviewed raised the issues of intra-community political differences and personal differences between individuals on the boards or staffs of some organisations as barriers to service integration. These are a fact of life and must ultimately be resolved by those involved. However, they can be reduced by putting in place incentives to cooperation. The adequate provision of resources for service coordination is one such key incentive.

10.4.4 Strategic direction and participation in QISMC

The national and Queensland policy documents reviewed in Chapter 3 provide a broad framework for addressing the harmful use of alcohol and other drugs among Indigenous people in Queensland. However, their impact is dependent upon implementation, and Indigenous community-controlled organisations need to be actively involved in that implementation process and the monitoring of it.

The expansion and enhancement of service provision by Indigenous community controlled organisations – which is part of the *Complementary Action Plan* – is unlikely to take place without the active involvement of those organisations themselves. However, much of what is required to bring about positive change needs to take place at a broader structural level and requires changes to government policy, program development and funding levels. It is beyond the capacity of individual organisations to bring this about. For this reason alone it is important that they be represented by a strong umbrella organisation such as QISMC. Furthermore, many of the recommendations we have made in this report require such an organisation to pursue them.

In terms of bringing about better outcomes for Indigenous people whose lives are impacted upon by harmful AOD use, it is our view that a decision about the corporate status of QISMC is in need of swift resolution. *While it is ultimately a decision to be made by the members of both QISMC and QAIHC, we recommend that – rather than becoming a separate incorporated body – QISMC should become a discrete organisational unit within QAIHC*. There are many persuasive arguments for this: the current membership of QISMC is too small to effectively support a separately incorporated body; there are economies of scale to be had in sharing resources between QISMC and QAIHC; together the organisations can better provide the coordinated response that is needed to address harmful AOD use; and, they can provide a stronger representation of Indigenous community views in various Queensland and national forums.

To effectively pursue the interests of Indigenous people who are affected by harmful AOD use and the Indigenous community controlled organisations working to address those problems, QISMC needs a new, clearly articulated vision and a strategic direction – based on evidence. This exists in only rudimentary from at present and without it there is little basis for collaboration between services or for the negotiation of improved service delivery with governments and other key stakeholders. To be effective, QISMC must exist to actively pursue a shared vision of what is to be done. *We therefore recommend that QISMC should develop a clear vision statement and practical strategies by which these can be pursued as an organisation, by its individual members, and in partnership with other key stakeholders*.

In its present form QISMC does not have sufficient capacity or resources to adequately support its members, to engage in broader policy initiatives or to pursue implementation of the recommendations made in this report. Nor is it adequately resourced to play a strong role in the further development of the partnerships essential to effectively addressing harmful AOD use and which are in the interests of government as well as the sector itself. *We, therefore recommend that, when its organisational status is resolved and it has developed a strategic plan, QISMC should seek from key stakeholders additional resources for agreed upon outcomes within the framework of the strategic plan*.

As indicated in Chapter 5, many AOD services in Queensland are delivered by Indigenous organisations that are not members of either QISMC or QAIHC. While they first need to consolidate their own organisational arrangements, to effectively represent the sector as a whole, QISMC and QAIHC need to engage at some level with those other service providers.

10.5 Improving outcomes: recommendations

In previous sections of this chapter we have identified a number of key issues related to both the operation of AOD services and the delivery of programs to address substance misuse. Here we provide a summary of the recommendations we have made to improve outcomes in the Indigenous AOD sector.

Some of the recommendations made in this report can be implemented by QISMC, QAIHC and individual organisations within the Indigenous AOD sector.

Implementation of many others ultimately requires actions and the commitment of resources by government agencies. We are acutely aware, however, that this report has no official standing with those agencies and they are not in any way obligated to act upon them. For this reason we have framed many of the recommendations as actions to be pursued by QISMC – as it is only through such action that they will have a life beyond this report itself. In this regard, the objectives (and the categories under which they are grouped) also provide a strategic framework for action by QISMC as an organisation. It is also important to note that some of the recommendations (6, 9, 10, 12, 13, 15, 20, 21, 22, 23) require action at the national level, as well as the state level, and it is important that QAIHC pursue them with government agencies at that level and that they also seek the assistance of the National Aboriginal Community Controlled Health Organisation in pursuing their implementation.

Recommendations

QISMC

1. While it is ultimately a decision to be made by the members of both QISMC and QAIHC, we recommend that – rather than becoming a separate incorporated body – QISMC should become a discrete organisational unit within QAIHC (page 107).
2. QISMC should develop a clear vision statement and practical strategies by which these can be pursued as an organisation, by its individual members, and in partnership with other key stakeholders (page 107).
3. When its organisational status is resolved and it has developed a strategic plan, QISMC should seek from key stakeholders additional resources for agreed upon outcomes within the framework of the strategic plan (page 107).

Member support

4. QISMC should seek resources to expand its capacity to support member organisations to access a wider range of funding sources (page 99).
5. QISMC should seek additional funds from OATSIH to expand its role in supporting member organisations to develop competitive tender and grant applications (page 104).

Indigenous capacity

6. QISMC and QAIHC should seek a long-term commitment from funding bodies to resource additional capacity within the sector – including within Indigenous community-controlled health services (page 92).
7. The creation of Indigenous capacity for service delivery should be incorporated as an objective in government requests for tenders and in service delivery contracts in addition to specific services *per se* (page 104).
8. To further develop Indigenous capacity, government agencies should specify that, in assessing tender applications, if no suitable applications are received from Indigenous applicants, preference will be given to those non-Indigenous applicants tendering in partnership with Indigenous community-controlled organisations (page 104).

Service provision and standards of care

9. To address gaps in the provision of services, QISMC and QAIHC should seek a long-term commitment from funding bodies to increasing allocations to the Indigenous AOD sector to provide for an expansion of tobacco control interventions, on-going care services (see also recommendation 10), and alcohol and illicit drug prevention projects (page 93).
10. QISMC – in collaboration with other key stakeholders – should benchmark standards for the provision of on-going care and their cost, and also explore options for residential services (where they are not able to provide such services themselves) to contract the provision of on-going care to third parties (page 105).
11. Once benchmarks for the provision of on-going care have been established, QISMC should enter into negotiations with relevant funding bodies for the long-term expansion of on-going care services (page 105).
12. QISMC should seek the collaboration of relevant stakeholders – including OATSIH and Queensland Corrective Services – to benchmark the level of support needed to meet the additional needs of mandated clients and clients with complex AOD and/or comorbid mental health problems and the workforce, training, and resource levels necessary to meet those needs (page 100).
13. As essential elements of 'best practice', coordination and service integration functions should be part of service provision benchmarks and should be adequately resourced (page 106).
14. Those Indigenous AOD treatment services with high proportions of non-Indigenous clients should develop two to three year strategies to ensure that no more than 10 per cent of client places are occupied by them (page 101).

Staffing

15. As a matter of priority, staffing benchmarks for Indigenous AOD residential treatment services should be developed by QISMC in consultation with mainstream AOD agencies and agreed upon by all key stakeholders (page 101).
16. QISMC should continue with efforts to ensure that disparities in Indigenous AOD treatment service salary levels are addressed in the development of service benchmarks (page 101).

Training

17. QISMC–QAIHC should seek resources to expand the governance training currently provided by QAIHC, and members of the Boards of affiliated organisations should be encouraged to undertake such training (page 97).
18. QISMC should seek resources to conduct AOD training seminars and workshops itself, or to contract third parties to do so, and that Board and staff members of affiliated organisations should be encouraged to undertake such training (page 97).
19. QISMC should seek to enter into negotiations with relevant agencies to negotiate levels of funding which adequately compensate AOD services for the costs associated with training that are additional to the costs of training itself and the payments to which individual trainees are entitled under Abstudy (page 103).

20. QISMC and QAIHC should lobby relevant Australian and Queensland Government agencies to allocate additional funding to increase the numbers of Indigenous people directly entering AOD vocational and tertiary training (page 103).

Reporting

21. Activities already under way in the development of appropriate monitoring and evaluation measures should be given high priority. However, specific measures need to be negotiated with, and developed with regard to, the objectives of particular organisations (page 94).
22. QISMC should convene a meeting of all stakeholders to develop a set of recommendations for reducing the burden of reporting requirements (page 98).
23. Any benchmarking of organisational staffing levels should include specification of reporting skills requirements and needs (page 97).

11. Appendix: Service providers and projects by region, Queensland, 2006–2007

Cairns/ Cooktown	
Aborigines and Islanders Alcohol Relief Service Ltd	Douglas House & Rose Colless Haven
	Lyons Street Diversionary Centre
Addiction Health Agency Cairns	Queensland Indigenous Alcohol Diversion Program
Aurukun Shire Council	Aurukun Management of Public Intoxication Program
Gindaja Substance Misuse Aboriginal Corporation	Yarrabah Residential Rehabilitation
Hope Vale Aboriginal Shire Council	Hope Vale Wet Season Project
Lockhart River Aboriginal Shire Council	Lockhart River Community Partnerships
	Lockhart River Wet Season Project
Pormpur Paanth Aboriginal Corporation	Pormpuraaw Wet Season Project
Queensland Health	Policy Partnership Proposal – Foetal Alcohol Spectrum Disorder, Cape York
Queensland Police Service	Project MURUTU (Thursday Island)
WuChopperen Health Service	Conference attendance: Healing Our Spirit Worldwide
	Substance use services
	Tablelands Substance Misuse Program
Wujal Wujal Aboriginal Shire Council	Wujal Wujal Wet Season Project
Townsville	
Bwgcolman Future Inc	Diversion program - youth demand reduction project/workshops
Congress Community Development and Education Unit	Stagpole Street Detoxification & Withdrawal Services and Rehabilitation Centre
Palm Island Alcohol & Drug Rehabilitation Aboriginal Corporation	Ferdy's Haven Alcohol Rehabilitation Aboriginal Corporation
Palm Island Men's Business Group Inc	Palm Island Cell Visitor Service
	Workshops and counselling
Queensland Department of Communities	Reverend Charles Harris Diversionary Centre
Townsville Aboriginal and Islander Health Services Ltd	TAIHS House – Volatile Substance Misuse Initiative
Yuibera Aboriginal & Torres Strait Islander Corporation	Mackay Cell Visitor Service
Rockhampton	
Binda Waminda	Binda Waminda – Management of Public Intoxication
Darumbal Community Youth Service Inc	Addressing Volatile Substance Misuse
Gumbi-Gumbi Aboriginal and Torres Strait Islanders Corporation	The Halo-House Alcohol Support and Awareness Centre
Juwarki Kapu-Lug ATSI Corp	Michael Hayes Diversionary Centre
Milbi Incorporated	Milbi Farm Hostel
Rockhampton MPIP Aboriginal & Islander Community Resource Agency	Rockhampton Management of Public Intoxication Program
Yaamba Aboriginal & Torres Strait Islander Corporation for Men	Yaamba Hostel
Mount Isa	
Arthur Petersen Special Care Centre Inc.	Arthur Petersen Special Care Centre
Carpentaria Shire Council	Drug Action Project
Junkuri Laka Justice Association Inc	Mornington Island Management of Public Intoxication

Kalkadoon Aboriginal Sobriety House (KASH) Aboriginal Corporation	Kalkadoon Aboriginal Sobriety House
Mount Isa Youth Shelter Inc	Family Healing Project
	Mt Isa Youth Place of Safety
Queensland Department of Communities	Jimaylya Topsy Harry Wet Centre
Riverbed Action Group	Mt Isa Management of Public Intoxication Program

Roma

Wunjuada Aboriginal Corporation for Alcoholism and Drug Dependence Service	Wunjuada Hostel

Brisbane

Aboriginal & Islander Community Health Services Inc	Indigenous Youth Health Service - Places of Safety
Croc Festival Foundation	Sponsorship of Croc Festival
First Contact Aboriginal Corporation for Youth	Night Patrol (First Contact Urban Trax Prevention Program)
Goori House	Treatment program
Kidz Youth and Community Consultancy Pty Ltd	KYC Youth Reach – Addressing Volatile Substance Misuse
Krurungal Aboriginal and Torres Strait Islander Corporation for Welfare Resource and Housing	Substance use services
Meeanjin Treatment Association Inc.	Substance use services
Murrie Watch ATSI Corp	Murrie Watch Diversionary Centre
Queensland Aboriginal & Torres Strait Islander Corporation for Alcohol & Drug Dependence Services	Jesse Budby Healing Centre

Qld wide

Australian Red Cross	Save-A-Mate our way (SAM)
Queensland Aboriginal and Islander Health Council/ Queensland Indigenous Substance Misuse Council	Capacity building
Queensland Health	Event Support Program
Queensland Health	Indigenous Anti-smoking Radio Advertising
Queensland Health	Indigenous Risk Impact Screen (IRIS)
Queensland Health	Smoke Check Queensland

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