RESPONDING TO ABORIGINAL SUBSTANCE
MISUSE: A REVIEW OF PROGRAMS
CONDUCTED BY THE COUNCIL FOR
ABORIGINAL ALCOHOL PROGRAM SERVICES
(C.A.A.P.S.), NORTHERN TERRITORY

by Peter d'Abbs, Ph.D.
Senior Research Officer,
N.T. Drug and Alcohol Bureau,
Department of Health and Community Services

A review conducted on behalf of the N.T. Drug and Alcohol Bureau, Department of Health
Community Services, and the Aboriginal and Torres Strait Islander Commission
(ATSIC)

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I should like to thank all CAAPS staff with whom I spoke in the course of conducting this review. Without exception they have been friendly, co-operative and patient even while they knew that their activities were, to a degree, under scrutiny. I should also like to thank the Aboriginal and non-Aboriginal staff in Community Health Centres at Port Keats, Maningrida, Alyangula and Angurugu, firstly for their hospitality during my visits to these communities, and secondly, for their cooperation with my efforts to gather data for the review. It is appropriate to mention by name Sr Mary Stephens of Port Keats, Sr Helen Mathews and Mr Charlie Gunabarra at Maningrida, Sr Kay Chapman at Alyangula and Sr Joanne Walker at Angurugu. I would also like to thank the Aboriginal Health Workers at Port Keats, Maningrida and Angurugu who acted as 'key informants'; I am not sure, however, that they would wish to be identified. For their hospitality, too, thanks go to the Christian Brothers at Port Keats. For part of the review, I was also assisted by Ms Raelene Cummings, whose contribution as a Research Assistant I should also like to record with thanks.
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INTRODUCTION

The Council for Aboriginal Alcohol Program Services (CAAPS) is an organisation made up of a number of constituent bodies, the structure of which is outlined in Chapter One. Since its establishment in the Northern Territory in 1984, CAAPS has offered a variety of residential and non-residential programs and services for non-urban Aboriginal people experiencing problems associated with substance misuse, especially but not exclusively alcohol. CAAPS also provides, through its Training Unit, programs designed to promote community awareness of alcohol problems in Aboriginal communities, educational programs for professionals and others interested in Aboriginal substance misuse, and in-service training for CAAPS staff.

A comprehensive evaluation of CAAPS would have to address two broad sets of issues. The first are organisational issues, which include such matters as recruitment and staffing practices, funding mechanisms and relationships with funding bodies. The second set of issues has to do with effectiveness of the programs themselves: does CAAPS, through its various programs, achieve what it sets out to achieve? If not, why not? These two sets of issues are inter-related. Failure to achieve some objectives, for example, might be a result of inadequate or inappropriate-funding. Nonetheless the two sets are distinct in important ways, and impose quite different demands on an evaluator. For present purposes, the two have been separated.

This review is concerned with the effectiveness of CAAPS intervention programs. After presenting an overview of the organisational structure of CAAPS in Chapter One, I examine the theories, ideas and models governing the CAAPS approach to substance misuse. This examination takes up Chapter Two. The next few chapters examine individual components of the CAAPS service delivery system. Chapters Three and Four focus on the two major residential programs - The Daly River Five Mile Family Program and the Gordon Symons Centre residential programs respectively. Chapter Five looks at the non-residential programs offered at the Gordon Symons Centre between 1987 and 1989. In Chapter Six the focus is on CAAPS' community-based field workers. In the final Chapter, I attempt to draw together the threads of previous chapters into an overall assessment of the effectiveness of the CAAPS system.

Terms of reference

When the terms of reference for this review were drawn up following discussions between the NT Drug and Alcohol Bureau and the then Department of Aboriginal Affairs, it was agreed that the range of questions and topics to be addressed required a two stage approach. Stage one, of which this review is the product, was to examine program effectiveness. Stage two was to take up questions pertaining to organisational matters.
A number of important matters, therefore, are not addressed in this review, but rather belong to stage two. These include questions concerning:

- the administration of CAAPS and its constituent organisations;
- the funding mechanisms through which CAAPS obtains (or fails to obtain) funds;
- staff recruitment, development, and conditions of employment;
- the roles of Aboriginal and non-Aboriginal people respectively in the administration of CAAPS; and
- other aspects of relations between CAAPS and bodies such as the Aboriginal and Torres Strait Islander Commission (ATSIC) and the Northern Territory Department of Health and Community Services.

No attempt has been made here to evaluate the CAAPS Service Section, not because it is considered unimportant, but because its activities are essentially administrative. (Although one of its roles, as a national clearing-house for information about CAAPS programs, gives it in effect an educational role also.)

The Training Unit also receives no more than cursory attention. This is perhaps a less defensible omission, since the functions of the Unit can hardly be categorised as administrative only. In fact, had time permitted, I would have liked to include a detailed examination of the Unit's activities. In the event, the time required to deal with the priority questions - namely, those to do with the effectiveness of the residential and non-residential programs - left insufficient for such an examination. I would suggest that one of two alternative courses be adopted: either the Training Unit be reviewed as a supplement to the present review, or such a review be included within the scope of the proposed stage two review.

Because many of the matters not dealt with here have to do with relationships between CAAPS and government bodies, they tend to loom large in the day-to-day concerns of officers in these bodies. I hope, however, that these same officers will recognise that of no less importance - perhaps of even more importance - are the relationships that constitute the focus of this review, namely those between CAAPS and Aboriginal families struggling with problems of substance misuse.

Feedback of findings to CAAPS

A provisional first draft of this report was made available to CAAPS in October 1990 and circulated by the organisation to member agencies. Comments, both written and verbal, arising out of this process were then the subject of further discussions between myself and the CAAPS Council, which in turn led to a number of modifications to the text. The present
text, I trust, reflects this process of consultation, although
the responsibility for all views expressed in the review
remains mine.
EXECUTIVE SUMMARY

1. This report is an evaluation of the effectiveness of programs and services provided by the Council for Aboriginal Alcohol Program Services (CAAPS), a body established in Darwin in 1984 by the Anglican Diocese, Catholic Missions and the Uniting Church's Aboriginal Advisory and Development Services to integrate and rationalise Aboriginal substance misuse programs and services hitherto administered by each body separately. CAAPS defines itself as 'a co-operating group of agencies and individuals who are working with tribally oriented Aboriginal people on problems of substance misuse.'

2. The evaluation was conducted in 1990 on behalf of the Drug and Alcohol Bureau, NT Department of Health and Community Services and the Aboriginal and Torres Strait Islander Islander Commission (ATSIC). It is seen as stage one in a two stage process, the second stage involving an examination of organisational matters such as staffing, recruitment, funding and relationships with funding bodies.

3. Chapter One is an overview of CAAPS. It includes a brief description of programs and services, which are categorised as follows: residential recovery programs, non-residential recovery programs, family worker/field worker programs, a training unit, and a service section which exercises a coordinating function and provides information and other services to the public. The chapter also includes some historical background, and a brief overview of funding arrangements.

4. Chapter Two examines the treatment model used by CAAPS, and key assumptions underlying the model. The 'family disease' model is shown to be one of a number of competing explanations for substance misuse, each of which has distinctive implications for prevention and intervention strategies. It is argued in Chapter Two that it is not appropriate for funding agencies to insist upon the adoption or exclusion of particular models, particularly when no existing model can legitimately claim to be clearly superior to all of its rivals. However, CAAPS' manner of using its preferred model is criticised on two grounds: firstly, for an element of rigidity and resistance to alternative ideas, which is not conducive to maximising program effectiveness; secondly, for the use of key concepts, especially 'dependency' and 'codependency', without sufficient regard being given to the meanings of these concepts within Aboriginal frames of meaning. It is also argued that, when used as a basis for community-based field work, the 'family disease' model fails to provide an adequate framework for working at community levels other than that of the family.

5. Three recommendations arise out of Chapter Two:

   The CAAPS organisation should be urged to adopt, at the appropriate organisational levels (such as the Training Unit), a more open stance towards differing treatment approaches.
Greater consideration should be given to locating key treatment concepts within Aboriginal frames of meaning, even if this means radically changing these concepts.

In its model for community-level work, CAAPS should give greater consideration to developing linkages with social institutions other than the family (while not, thereby, neglecting the importance of family work).

6. Chapter Three focuses on the four-week residential recovery program conducted at Daly River Five Mile. It is noted that the professed aims of the program avoid any reference to altering clients' drinking behaviour, or to attaining readily measurable outcomes. It is also suggested that this strategy may have been used in the past by CAAPS representatives as a basis for the claim that the programs cannot be assessed in terms of measurable outcomes. Patterns of client contact are examined: between its commencement in May 1987 and the end of 1989, the program had 434 admissions, accounted for by 371 clients. Most clients came from communities linked historically with the Catholic Church, and were referred via an informal Catholic Missions network, rather than by government health, welfare or correctional agencies.

7. In order to gauge the impact of attendance at Daly River Family Programs on drinking behaviour, a random sample of 79 residents of Port Keats aged 15 and over, who had not attended any CAAPS courses, was selected and placed alongside the 82 residents who had attended one or more courses at Daly River (as well as 25 residents who had attended courses at Gordon Symons and another 10 who had attended courses at both Daly River and Gordon Symons.) The total sample thus created comprised 196 people. Two Aboriginal Health Workers were then asked, with respect to each member of the sample, whether the person was a non-drinker, moderate or heavy drinker; where applicable, the same question was asked with respect to the person's spouse.

8. Analysis of responses indicated that male clients who had attended Dependent Male courses at Daly River were more likely to be non-drinkers, and less likely to be heavy drinkers, than males who had not attended any CAAPS Courses. Those who had attended Daly River Family Program courses were also a little more likely than those who had not attended any CAAPS courses to belong to households in which neither the respondent nor his/her partner (where applicable) drank. None of these results however, were statistically significant. They constituted, in sum, a suggestion that attendance at Daly River Five Mile has a modest but real effect on drinking behaviour, such behaviour in turn constituting one of several relevant outcome criteria of the program.

9. Chapter Four comprises a similar examination of the Gordon Symons Centre Dependents' Education-Recovery Program for Men. (Prior to March 1990, Gordon Symons offered a residential program for 'dependent' men and a non-residential program for female 'codependents'. In March 1990 the structure was altered, with a single residential 'family program', similar
to that offered by Daly River, being provided. The present review covers the period ending 31 December 1989."

10. The structure of the dependents' program and patterns of client contact are both described. Between 1987 and 1989, the program catered for 475 admissions, 68.1 per cent of which were for alcohol abuse, and most of the remainder for petrol sniffing. Some 80 per cent of admissions for which relevant data are available were a result of referrals through the court system, in marked contrast to the Catholic Missions-based referral system serving the Daly River Family Program. The 475 admissions were accounted for by 331 clients, a third of whom attended more than one course.

11. In order to assess outcomes, treatment and non-treatment samples were obtained for Maningrida and Angurugu. In the Maningrida sample, those who had attended GSC courses were slightly less likely to be heavy drinkers than those who had not attended courses. The difference however was not statistically significant. Former GSC clients were significantly more likely to be current petrol sniffers than males who had not attended any courses, although 40 per cent of former clients were categorised as 'non-sniffers'. In the Angurugu sample, little difference was recorded in drinking behaviour between ex-clients and the non-treatment sample. As at Maningrida, however, ex-clients were significantly more likely than non-clients to be petrol sniffers, although once again, a majority of ex-clients were non-sniffers.

12. It is suggested that the data cast doubts on the adequacy of the GSC Dependent Males Program as a response to petrol-sniffing by Aboriginal youths. This may be because the Program has not been sufficiently attuned to client needs and perceptions, and/or because it has drawn on an intervention model based largely on crisis intervention, for another substance (alcohol) in a different cultural context. At the same time, attendance at the course may have other beneficial consequences, such as educational content which might be utilised at later stages of clients' lives.

13. Chapter Five examines the non-residential 'Recovery Program for Women'. Between 1987 and 1989 171 clients were admitted to the program, accounting between them for 227 admissions. It is not clear how many people admitted to the courses actually completed them. Indeed, a striking feature of the program is the paucity of client records, in the absence of which it is difficult to see how either the program organisers at the time, or an external evaluator in the present, could reach an informed judgement about the effectiveness of the program. A discussion with one group of former clients at Maningrida revealed difficulties on the part of the women concerned in understanding the course content. To what extent this problem was shared by other clients, and to what extent it was offset by other, more beneficial outcomes, is also not clear. The findings fail to provide a strong indication of either success or failure on the part of the Codependents' program.
14. In Chapter Six, CAAPS' community-based field workers (also called 'family workers' and 'co-ordinators') are examined. All three affiliated Church organisations have appointed field workers. Styles of work vary from field worker to field workers; all, share some common characteristics: all have both a preventative as well as an after-care function; all are working in the field, rather than an institution, and all work to a greater or lesser degree with a 'family sickness' model of substance misuse.

15. The analysis concludes that the community-based field workers constitute an essential complement to residential programs, and that individuals occupying these positions have pioneered a variety of effective styles of intervention. At the same time, a number of defects are identified. Firstly, field worker (or family worker) programs have suffered to date from inadequate, ad hoc funding arrangements. Insofar as the full potential of residential programs can only be realised if these programs are complemented by appropriate community based services, the CAAPS Field Worker/Family Worker Program should be recognised by funding agencies as an integral component of prevention and treatment, and funded accordingly.

16. Secondly, although individual field/family workers bring to their positions a wide range of relevant experience and training, the position itself is not institutionally supported at present by adequate training, especially in three key areas: Aboriginal kinship systems, basic counselling and referral skills, and community development. This observation should not be construed as a criticism of the CAAPS Training Unit, firstly because that unit has neither the funding nor other resources to provide training other than short, essentially in-service courses, and secondly, because the lack of suitable training in these areas is by no means a peculiar characteristic of CAAPS programs, but rather a problem affecting Aboriginal alcohol services throughout the Northern Territory as a whole. It is therefore recommended that attention be directed to meeting current deficiencies in the training of field workers.

17. As mentioned earlier, it is also argued in the review that the present training of field-workers fails to equip them adequately for working in the community at levels other than that of families.

18. One innovative field worker program is considered worthy of attention as a possible model for use (or adaptation) elsewhere. At Angurugu, two senior Aboriginal members of the local community work within their community, supported by a non-Aboriginal couple who have long been resident in the community. One of the Aboriginal workers concentrates on activating traditional lines of responsibility within his own extended family, in order (a) to assist young petrol sniffers within his family and (b) to demonstrate by his example a strategy open to other senior men in his community, in the hope that they too will follow his example. The other Aboriginal worker provides counselling and support both to sniffers and drinkers. The non-Aboriginal couple hold informal meetings with the Aboriginal workers and other
interested persons, sometimes showing videos or making
available other instructional materials, sometimes inviting
the workers to discuss problems or simply explore ideas.

19. Chapter Seven summarises the findings of the review and
concludes with eight recommendations, some of which were
foreshadowed earlier in the text (and have been included
already in this Executive Summary). The recommendations
arise, not out a perceived failure on the part of CAAPS
programs and services, but out of what are described as
indications of limited effectiveness, and out of a possibility
that effectiveness could be improved. Recommendations not
listed already are as follows:

(a) In its residential programs, CAAPS should consider, and
trial, alternatives in terms both of the duration and
content of courses. Is four weeks the optimum duration
for all clients? Perhaps it is longer than necessary for
some, and not long enough for others.

(b) Consideration should be given to shifting the emphasis in
funding, facilities and other aspects away from
centralised residential treatment as exemplified by Daly
River Five Mile and Gordon Symons Centre, towards smaller
more localised facilities, attached to but geographically
distinct from Aboriginal communities. In their staffing,
administration and intervention practices, such
facilities should have maximum Aboriginal involvement.
The outcomes of any such shift in emphasis should be
systematically monitored.

(c) In their present and any future activities,
administrators of CAAPS programs should maintain a
record-keeping system adequate for both internal
monitoring and external evaluation of both processes and
outcomes. Such a system will not necessarily be the same
as records required by funding bodies such as ATSIC,
although some overlap would be expected. If requested,
the NT Drug and Alcohol Bureau should provide assistance
in setting up a system.

20. Because the CAAPS Training Unit is not examined in this
review, no recommendations concerning its activities are made
here. However, the examination of residential and field
worker programs did bring to light a situation which calls for
comment, and that is the dearth of training facilities for
people - both Aboriginal and non-Aboriginal - working in the
area of Aboriginal substance misuse. This is not a need that
CAAPS should be called upon to fill, unless it is provided
with the necessary resources. Rather, organisations such as
CAAPS should be able to recruit staff from a pool of
appropriately trained people (who would then require further
in-service training from the Training Unit). The
recommendation, therefore, that urgent attention be given to
providing training for people working in the field of
Aboriginal substance misuse, is one that is properly addressed
to the NT Government.
21. A final recommendation is addressed to funding bodies: a period, suggested as two years, should be designated as a "transition period" during which the recommended changes would be pursued. During this period, provided CAAPS undertakes to address the issues and is observed to be doing so, it should be assured by both Commonwealth and NT Government agencies of adequate and regular funding.
CHAPTER ONE

THE COUNCIL FOR ABORIGINAL ALCOHOL PROGRAM SERVICES (CAAPS): AN OVERVIEW

The Council for Aboriginal Alcohol Program Services (CAAPS) was established in Darwin in September 1984 by three church-based bodies: the Anglican Diocese, Catholic Missions and the Uniting Church's Aboriginal Advisory and Development Services (AADS), which in 1985 became Aboriginal Resource and Development Services Inc. (ARDS). Essentially, CAAPS represents an attempt to integrate and rationalise the Aboriginal substance misuse programs and services hitherto administered by each body separately; it refers to itself as 'a co-operating group of agencies and individuals who are working with tribally oriented Aboriginal people on problems of substance misuse' (CAAPS 1990a, p.1).

Today, CAAPS administers the most extensive and comprehensive range of residential and non-residential Aboriginal substance-misuse programs in the Northern Territory. Although primarily serving "Top End" communities in the NT, it draws clients from as far away as central Australia, Queensland and Western Australia. Its funding comes from a complex amalgam of Commonwealth and Northern Territory Government grants as well as church sources and a little from clients themselves.

At the apex of this structure (as of July 1990) are two bodies: the CAAPS Council and the CAAPS Board. The former comprises 15 members, made up as follows:

- 3 heads of churches or their delegates;
- 3 agency directors or their proxies;
- 3 Aboriginal representatives;
- 3 agency accountants/administrators, and
- 3 other representatives, one appointed by each church.

The Council meets quarterly to consider and approve recommendations of the Board; it also acts as or appoints trustees for any property or assets jointly owned or used by CAAPS.

Membership of the CAAPS Board is made up of nine of the above Council members, namely the three agency directors, three agency accountants/administrators, and the three Aboriginal representatives. The Board meets at least once a month, has responsibility for management of CAAPS services and programs, and makes recommendations to the Council regarding policy matters. It ensures that all staff employed by CAAPS agencies adhere to CAAPS 'principles and philosophy', according to which chemical dependency is to be viewed as a 'family disease' and dealt with primarily through Aboriginal kinship systems (CAAPS 1990a; the 'principles and philosophy' are considered in more detail in Chapter Two). The Board oversees and approves any program changes, issues guidelines concerning matters such as recruitment to agencies and authorises and oversees training of agency staff. The Board also directs a CAAPS Service Co-ordinator.
Training itself is conducted by the CAAPS Training Unit, which currently employs two staff members and reports directly to the CAAPS Board.

(At the time of writing, the structure and functions of the Council and Board were being re-examined by CAAPS with a view to making any changes that may be necessitated to meet funding criteria set by the new Aboriginal and Torres Strait Islander Commission (ATSIC).)

Each of the three participating churches has its own agency for dealing with substance misuse, and each agency in turn operates a number of programs and services.

CATHOLIC MISSIONS

In the case of the Catholic Church, the agency was known prior to 19 June 1990 as Alcohol Awareness and Family Recovery (AAFR), an offshoot of the Darwin-based Catholic Missions. On 19 June 1990 AAFR was superseded by the Aboriginal and Islander Alcohol Awareness and Family Recovery Association (AIAAFR). AAFR was founded in 1983 by Brother Andrew Howley, M.S.C. Initially entitled the "Alcohol Awareness Sobriety Centre", it drew many of its guiding ideas from the Holyoake Institute in Perth, a family-oriented alcohol rehabilitation facility. Between 1984 and 1986 the Centre arranged for 140 Aboriginal people from various communities in the Northern Territory to attend residential courses at Holyoake. (In June 1990, as part of the restructuring referred to above, AAFR was renamed Aboriginal and Islander Alcohol Awareness and Family Recovery Association.)

In 1986 the Centre acquired its present name and in the following year opened a local residential facility at Wulk Wulbi, eight kilometres from Daly River Mission, and just over 200 kilometres south-west of Darwin. Known as the 'Daly River Alcohol Education and Awareness Institute', the Wulk Wulbi facility offers a 4-week residential program for Aboriginal drinkers (known in program terminology as 'dependents'), their spouses and other family members (dubbed 'codependents') and - since mid 1989 - their children. The program normally admits only families, not single individuals.

In addition to the Daly River family program, AIAAFR employs three Family Workers (or, as they are sometimes called, Field Workers or Co-ordinators) in the communities of Wadeye (Port Keats), Nguiu (Bathurst Island) and Pularumpi (Garden Point) respectively. The roles of these workers include fostering local AA (Alcoholics Anonymous) and Al-Anon groups; providing follow-up support counselling for ex-Daly River clients; arranging for new clients to attend Daly River, and acting as general resource persons in the community for chemical dependency matters. In some cases, and at various times, the Family Workers work closely with volunteer Aboriginal Field Workers in their communities.
Finally, AIAAFR also operates a Service Support Section to serve all of its programs. The program structure outlined above is summarised in Figure 1.1.

**Figure 1.1: CAAPS programs administered under Catholic Missions**

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CATHOLIC MISSIONS  CAAPS

ABORIGINAL & ISLANDER ALCOHOL AWARENESS & FAMILY RECOVERY

DALY RIVER ALCOHOL EDUCATION AND AWARENESS INSTITUTE

FIELD WORKERS:
- Wadeye
- Nguiu
- Pularumpi

SERVICE SUPPORT

FAMILY PROGRAM:
- Dependents
- Codependents
- Children
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**THE UNITING CHURCH: ABORIGINAL RESOURCE AND DEVELOPMENT SERVICES INC. (ARDIS)**

The Uniting Church agency which forms part of CAAPS is the Aboriginal Resource and Development Services Inc. (ARDIS), which in turn reports to an Aboriginal body of the Uniting Church, namely the Northern Regional Council of the Uniting Aboriginal and Islander Christian Congress).

ARDS's present mode of operation has grown largely out of activities initiated under its predecessor - the Aboriginal Advisory and Development Services (AADS) - in 1982. At that time AADS, in co-operation with the NT Department of Community Development, sponsored two community workers to work with traditional Aboriginal people who had come to Darwin, taken up residence in town camps, and were experiencing alcohol-related problems. The workers quickly concluded that the problems being experienced by these people could not be addressed unless (a) the issue of substance misuse was dealt with in conjunction with other problems, such as breakdowns in relationships, (b) the problem was located and interventions aimed not at the individual but at the level of the wider kinship network, at least part of which was located in communities away from Darwin, and therefore (c) an integrated system of programs was required which would include a residential rehabilitation facility in Darwin, a family worker based in Darwin, and one or more family workers located in Aboriginal communities (AADS, 1984).
In 1985 the Gordon Symons Centre, a facility located in Darwin and previously operated by the Uniting Church as an Aboriginal hostel, began offering 4-week residential courses to 'dependent' Aboriginal males from Northern Territory communities. Unlike the Daly River program, which has been dedicated almost entirely to alcohol-related problems, the Gordon Symons Centre has from the outset catered for a significant proportion of petrol-sniffers, as well as clients with alcohol problems (and some who both drink and sniff). Unlike Daly River Five Mile it did not, prior to March 1990, offer a residential program for female 'codependents'. However, between 1987 and 1989 the Centre conducted non-residential programs for women from outlying communities who were temporarily resident in Darwin. Since March 1990, the Gordon Symons Centre has modified its programs, bringing them more into line with the 'family' orientation of the Daly River program; only families are now admitted to the Centre, which offers a residential program for 'dependents' and 'codependents' alike.

ARDS also employs two non-Aboriginal Family Workers, one based in Darwin and one in Maningrida. The latter is expected to be replaced around the end of 1990 by an Aboriginal couple resident in Maningrida. Figure 1.2 portrays the ARDS/Uniting Church component of CAAPS.

**Figure 1.2: CAAPS programs administered by ARDS/Uniting Church**

<table>
<thead>
<tr>
<th>ABORIGINAL RESOURCE &amp; DEVELOPMENT SERVICES INC.</th>
<th>CAAPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>GORDON SYMONS CENTRE:</td>
<td>FAMILY WORKERS:</td>
</tr>
<tr>
<td>. Residential dependents' program</td>
<td>. Darwin</td>
</tr>
<tr>
<td>. Codependents' program (non-residential prior to March 1990)</td>
<td>. Maningrida</td>
</tr>
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</table>

THE ANGLICAN DIOCESE AND ANGLICARE

To date, the involvement of the Anglican Diocese in CAAPS has been on a smaller scale than that of either the Catholic or Uniting Churches, consisting mainly of employing two Family Workers to cover the areas of south-east Arnhem Land and south-west Arnhem Land respectively. In February 1989, the Diocese established 'Anglicare' to co-ordinate the welfare activities of the Diocese. Prior to 1990, both Family Workers were based in Darwin (unlike most of the other Family or Field Workers under the CAAPS umbrella), from where they made regular trips, one to the communities of Oenpelli, Goulburn Island and Jabiru, the other to Groote Eylandt, Numbulwar and Ngukurr. At present, one non-Aboriginal Family Worker continues to work in this manner, visiting Oenpelli, Goulburn Island and Jabiru. The second position, however, is currently shared by a non-Aboriginal couple living in Angurugu, Groote Eylandt, where they act as a support team for two Aboriginal men. The latter are, in effect, the 'front line' Family Workers in a new and experimental model of fieldwork with
substance misusers. The Anglican component of CAAPS is shown in Figure 1.3.

Figure 1.3: CAAPS programs administered by Anglican Diocese

CAAPS training unit

As mentioned above, a CAAPS Training Unit services staff in all of the CAAPS programs. In many ways, the Training Unit is the engine of the organisation. Through it, the CAAPS approach to intervention is promulgated - through courses, in-service training, and the production of program materials.

The Unit offers three main courses as well as workshops for treatment staff. The first of these are the Two Week Training Seminars, which is offered both for CAAPS' own staff and outsiders. The first week covers aspects of the family disease model of chemical dependency, codependency, and family dynamics, while the second week focuses on recovery programs and intervention techniques such as group discussion.

A second program is the Community Based Program, designed to be conducted in Aboriginal communities by facilitators chosen within the communities, who would normally have previously attended the Counsellor/Facilitator Course. The Training Unit's role here is essentially that of a resource provider, making available videos, information sheets, a workbook and other material.

A third type of course - Aboriginal Community Awareness - is also conducted in Aboriginal communities, but for a different purpose. Whereas the Community Based Program is, as the name implies, essentially an externally-supported, community-based intervention program, the Community Awareness course is often attended by non-Aboriginal residents of the communities. The courses normally run for two or three days, and are conducted by one of the two full-time staff members of the Training Unit. In 1988/89, 15 of these programs were conducted.

In addition to the organisations described above, CAAPS has a Service Section, responsible for disseminating information about substance misuse, CAAPS programs, and producing materials. The overall structure is summarised in Figure 1.4.
In sum, since 1984 CAAPS has provided three main kinds of prevention and treatment programs: residential and non-residential 'recovery programs'; community-based Family Workers, and training for CAAPS employees and others working in the field of Aboriginal substance-misuse. The location of these programs reflects to some extent the earlier missionary activities of the respective churches. Catholic Missions' AAFR-run programs mainly service Nguiu (Bathurst Island), Wadeye (Port Keats), Pularumpi (Garden Point), Nauiyu Nambiyi (Daly River) and, in Central Australia, Santa Teresa. Anglicare operates in areas where it has historical associations through the Anglican Church Missionary Society, although its Family Workers also serve Arnhem Land communities linked historically with forerunners of the Uniting Church. ARDS, the Uniting Church-linked body, draws many clients of its residential program from Arnhem Land.

The programs which are administered under the CAAPS umbrella, and with which the present review is concerned, are listed in Table 1.1.
### Table 1.1: CAAPS substance misuse programs

<table>
<thead>
<tr>
<th>Program type</th>
<th>Program</th>
<th>Agency</th>
</tr>
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<tbody>
<tr>
<td>Residential recovery</td>
<td>Daly River Five Mile Family Program</td>
<td>A.A.F.R.</td>
</tr>
<tr>
<td></td>
<td>Gordon Symons Centre Dependents' Program</td>
<td>Gordon Symons Centre</td>
</tr>
<tr>
<td>Non-residential recovery</td>
<td>(Prior to March 1990) Gordon Symons Centre Codependents' Program</td>
<td>Gordon Symons Centre</td>
</tr>
<tr>
<td>Family Work/Field Work</td>
<td>Groote Eylandt</td>
<td>Anglicare</td>
</tr>
<tr>
<td></td>
<td>South West Arnhem Land</td>
<td>Anglicare</td>
</tr>
<tr>
<td></td>
<td>Wadeye (Port Keats)</td>
<td>A.A.F.R.</td>
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<td>Information, etc.</td>
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* Because the Service Section is not directly involved in prevention and treatment activities, it is not covered in the review that follows.

**FUNDING CAAPS PROGRAMS AND SERVICES**

CAAPS programs have received funds from a variety of Commonwealth, N.T. Government and other sources, giving rise to a fairly intricate system of grants and payments. Since the focus of this review is on program outcomes and effectiveness, no attempt is made here to present more than an overview of these arrangements.

**Daly River Family Program**

Since the commencement of the Daly River Family Program in May 1987, its main source of funding has been the Commonwealth Department of Employment, Education and Training (DEET). Prior to June 1990 (at which time DEET policy changed), DEET made Abstudy grants and travelling assistance available to clients. For part of this period, these payments were made directly to the Family Program on behalf of the clients; subsequently, this practice was abandoned, responsibility for obtaining the payments being left to Catholic Missions Alcohol Awareness and Family Recovery (AAFR). In 1989/90, this assistance was valued by AAFR at approximately $100,000.
In the financial years ending 1988, 1989 and 1990, AAFR has also received an annual grant of $26,000 from Australian Catholic Relief which, while not being designated specifically for the Family Program, has been allocated to meeting that program's salary expenses.

Since 1988/89, the Program has also received financial support from the N.T. Department of Health and Community Services: $30,000 in 1988/89 for improvements to facilities, followed by $4,000 the following year for similar purposes. In addition, in 1989/90, the Department of Health and Community Services granted $54,548 for salaries and operational expenses associated with the Family Program and AAFR itself.

**Gordon Symons Centre Dependents' Program**

Prior to January 1989, the Gordon Symons Centre Dependents' Program received funds from the Department of Aboriginal Affairs and Aboriginal Hostels Limited. In addition, clients' Sickness Benefits were paid to the Gordon Symons Centre.

In January 1989, following discussions between DAA and the N.T. Department of Health and Community Services, the latter Department ceased funding Gordon Symons Centre courses and other ARDS programs, and transferred an equivalent funding allocation to a completely separate Aboriginal rehabilitation facility in Darwin, known as the Foundation of Rehabilitation With Aboriginal Alcohol Related Difficulties (FORWAARD). At the same time, ARDS-related funding responsibilities previously met by the Department of Health and Community Services were assumed by the Department of Aboriginal Affairs.

As a result, funding for the Dependents' Program is now provided by two sources: DAA/ATSIC, which funds a Counsellor/ Facilitator position, and Aboriginal Hostels Ltd., which funds three hostel-related positions at a cost of $138,000 per annum. The positions are: Hostel Manager, Assistant Manager and a part-time Domestic Advisor.

**Gordon Symons Centre Non-residential Codependents Program**

Prior to 1989/90, the Gordon Symons Centre Codependents Program was funded by ARDS; in that year it received a 12-month grant from DAA/ATSIC, which also provided the Program with $24,500 for a bus.

**Family Worker Positions**

Prior to January, 1989, the Darwin and Maningrida Family Worker positions were funded by the N.T. Department of Health and Community Services. Since then, under the DAA/Health and Community Services arrangements referred to above, salary and operational expenses for both positions have been met by DAA/ATSIC.

According to AAFR, the three Field Worker positions (or Coordinators, as AAFR prefers to call them nowadays) operating under the auspices of AAFR - namely those at Wadeye (Port Keats),
Nguiu (Bathurst Island) and Pularumpi (Garden Point) - receive no direct funding support from government or other non-government agencies, and at no stage have they done so.

The two Anglicare Family Worker positions, covering South West Arnhem Land and Angurugu (Groote Eylandt) respectively, are funded by DAA/ATSIC - the latter position being funded through the Nhulunbuy Office.

CAAPS Training Unit

The two Trainer/Co-ordinator positions at the CAAPS Training Unit are funded by DAA/ATSIC.

CAAPS Service Section

Prior to January 1989, the position of CAAPS Service Co-ordinator was funded by the Northern Territory Department of Health and Community Services. Since then, DAA/ATSIC has funded this position as well as that of a Secretary/Receptionist in the Service Section. An additional position, that of Administrative Officer, was funded by ARDS itself until early 1990.
CHAPTER TWO

MODELS AND CREEDS: THE CAAPS APPROACH TO ABORIGINAL SUBSTANCE MISUSE

As an organisation, CAAPS adheres strongly to a particular view of substance misuse and its treatment, and expects its staff to do likewise. This view is encompassed in the 'CAAPS Philosophy and Principles' (CAAPS 1990a). It is part of the responsibility of the CAAPS Board to see that current and new staff adhere to the CAAPS philosophy and principles. Although recruitment is the responsibility of individual agencies, all new staff are required to sign "a statement of adherence to CAAPS principles and philosophy, relating to their commitment to CAAPS chosen work model and methods" (CAAPS 1990a, Section 4.1.3). All program materials used in CAAPS work areas must have the approval of the CAAPS Board to ensure that they are consistent with the philosophy and principles, and staff must undertake to use only materials as approved by the CAAPS Board. Staff attendance at training courses other than courses conducted by the CAAPS Training Unit itself must be approved by the Agency Director in consultation with the CAAPS Board, and will be considered suitable "if the Board is satisfied that they offer a broader understanding of CAAPS philosophy and work model regarding service delivery and/or personal growth" (CAAPS 1990a, Section 5.1.2).

This stance raises questions as to CAAPS's openness to intellectual development and new initiatives in program development, both of which are essential preconditions of a scientifically-grounded approach to dealing with problems such as substance misuse. Before taking up these questions, the 'philosophy and principles' will be briefly outlined. These are set out formally in a CAAPS Policy Document (1990a); they are also discussed in several papers by people who are, or have been, associated with formulating the CAAPS approach (in particular, Gluck, 1985; Sigston, 1985; Murdock and Coster, 1988). The elements of the approach can usefully be considered in three groups:

1. propositions about the nature of societies in general and Aboriginal society in particular;
2. propositions about the nature and causes of substance misuse; and
3. propositions about appropriate methods and goals of prevention and treatment.

PROPOSITIONS ABOUT THE NATURE OF ABORIGINAL AND OTHER SOCIETIES

Most descriptions of the CAAPS philosophy begin with the assertion that:

Each person is a unique creation of God, and entitled to a quality of life, here and now. In the case of other faiths we may not use the word 'God' but nevertheless believe that each one is unique and entitled to a quality of life in their own right (CAAPS 1990a, Section 1.1).
Other propositions then advanced are:

People have the capacity to change and realize greater potential in their lives, but their capacity to do so is limited unless they are aware of other possibilities.

Aboriginal society has unique cultural characteristics which must be taken into account in any programs.

In all societies, some people experience 'personal and interpersonal problems through chemical dependency'.

Traditional Aboriginal society has no model for working with chemical dependency.

Presumably, few would wish to take issue with these propositions, although the last one warrants comment. While it is undoubtedly true that traditional Aboriginal society has no model for dealing with contemporary forms of chemical dependency, it does not follow that it has nothing to offer by way of cultural tools for dealing with chemical dependency. Indeed, a number of Aboriginal men and women working in the area of substance abuse, both inside and outside CAAPS, are committed to identifying and mobilising traditional social mechanisms and values in the belief that these have more to offer in the struggle against alcohol abuse than culturally alien models.

Several anthropologists have also questioned the widely-held view that Aborigines were ignorant of alcohol before the arrival of Europeans. O'Connor, for example, (1988, pp.19-21) cites instances of Aboriginal groups fermenting various fruits and nectars of flowers, the use of the leaves and twigs of the pituri plant in Central Australia, and fermentation by Tasmanian Aborigines of the sap of the ribbony gum (Eucalyptus gunnii). Moreover, Macassan trepanggers who regularly visited settlements along the Arnhem Land coast prior to European arrivals brought with them tobacco, arrack and other alcoholic drinks (Macknight 1976, pp.30-31). These substances, however, were almost certainly less strong and less widely available than alcohol today.

PROPOSITIONS ABOUT THE NATURE AND CAUSES OF SUBSTANCE MISUSE

According to the CAAPS philosophy as set out in its Policy Document (1990a):

Chemical dependency is recognized as a 'Family Disease' which can be treated.

The 'family disease' model has not always been the guiding frame of reference for CAAPS. When Gluck and Sigston began working with Aboriginal town campers in Darwin in the early 1980s under the auspices of the Unitig Church and the Department of Community Development, they adopted a 'community development' model which promoted a number of activities including bark painting, film making, hunting and health services. They abandoned this model when they concluded that their work "was always beaten by grog" (Gluck, 1985, p.156). Worse, they
concluded that the networks of which they were a part, and which they were helping to maintain in the course of their activities, were themselves a key part of the problem. These networks, Gluck and Sigston concluded, made up of family links, health and welfare agencies, social security and other government departments, all served one way or another to enable the drinkers to keep drinking. Close kin, for example, would send money and airfares from the community to their kinsmen in the town camps, and would take over essential roles back on the community which were being neglected by the drinkers; legal services would protect drinkers from the full consequences of their actions; welfare agencies provided money to enable families to survive while a breadwinner drank away the primary income; training schemes were used to finance drinking excursions, and so on. Virtually every person in the drinker's social environment, according to the Gluck-Sigston critique, whatever his or her ostensible purpose, served the latent function of enabling the drinker to keep drinking.

The critique was an important and thoughtful one, and had a major influence on subsequent developments. For that reason alone, it is perhaps a pity that at the time it was advanced it was not subjected to an equally thoughtful, critical appraisal by others.

Gluck, Sigston and others pursued two main implications of the critique. First, they made substance abuse their prime target of intervention; second, they adopted a framework which focused not only on the substance abuser but also on the network of 'enablers'.

At around the same time - between 1983 and 1985 - Brother Andrew Howley of Catholic Missions was establishing the Alcohol Awareness Sobriety Centre in Darwin, drawing many of his ideas from the Kakawis centre in Canada and the Holyoke Institute in Perth. The 'family disease' model of chemical dependency utilised by Holyoke as a basis for its programs was derived in part from the Hazelden and Johnson Institute in the U.S.A. It was also eminently suited to the perspective being formulated by Gluck and Sigston, offering at once an explanation for the corrosive effects of substance abuse and a strategy for targeting interventions on 'enablers' as well as 'substance abusers'.

Central to the notion of substance abuse as a family disease is the concept of 'chemical dependency'. According to this perspective, not all users of mind-altering substances (nor even all mis-users) become 'chemically dependent either physically or psychologically', but many do (CAAPS, 1990a, p.5). The model itself does not purport to explain why this should be so; theories and arguments about the influence of biological, psychological and sociological factors on addictive behaviour belong to a related, but separate, realm of inquiry. The model does, however, set out signs by which chemical dependency can be recognised. Johnson summarises these as a maladaptive lifestyle reflecting (1) a growing anticipation of the welcome effects of alcohol, (2) increasing rigidity about the expected time of consumption and (3) progressive ingenuity on the part of the individual directed towards obtaining ever larger amounts of alcohol (1980, p.26).
Chemical dependency is assumed to have a number of properties, which provide a rationale for intervention strategies.

Dependency:

- is a "primary, progressive, chronic, and fatal" disease which has definable signs and symptoms (Johnson, 1980, p. 1; Murdock and Coster, 1988, p.9);
- responds to treatment;
- can be arrested but not cured;
- adversely affects all members of the family, who as a result may become emotionally, spiritually and physically sick;
- is characterised by patterns of denial and delusion on the part both of the dependent person and those close to him or her, such as spouse, children, parents, employer (CAAPS, 1990a, p.5; Murdock and Coster, 1988).

The disease model of alcoholism is currently the dominant model among U.S. treatment agencies, as well as agencies elsewhere. The belief that alcoholism is a disease has been officially endorsed by the American Medical Association, the American Psychiatric Association, the National Association of Social Workers, and the American Public Health Association (Brower, Blow and Beresford, 1989, p.150). It is also a central component in Alcoholics Anonymous programs, and related programs such as Al Anon and Al Ateen, elements of all of which are incorporated into CAAPS courses.

According to the model, the etiology of chemical dependency is unknown; genetic factors are believed to play a part, but exactly what part is as yet not understood. There are several variants of the model, but common to all of them is the same defining characteristic of the disease - inability of users to control their use. Lack of control is due, not to moral weakness or a mental disorder, but to the presence of the disease of chemical dependency, one form of which is alcoholism.

Despite its widespread use, especially among treatment agencies in the U.S., the disease model does not enjoy uncontested supremacy as an explanation for substance misuse, nor as a basis for treatment. In both Britain and Australia, for example, it has been heavily criticised (Heather and Robertson, 1985; Krivanek, 1982). Brower, Blow and Beresford (1989) identify four other 'basic' models in current use - that is, models which are built on a single explanatory factor - as well as a number of models which seek to integrate more than one explanation. The first is the 'moral' model, according to which substance misuse is essentially a reflection of weakness of character. This, as they point out, is the oldest model of chemical dependency, and is no longer widely used, largely because some of its treatment implications run counter to modern principles of therapy. A second model is the 'learning' model, according to which chemical dependency, like many other forms of behaviour both adaptive and maladaptive, is learned as part of normal socialisation
processes. (Proponents of the social learning model would not deny that use of mind-altering substances can lead to physiological and psychological dependency; it is in accounting for the sources of that dependency, and in recommending what to do about it, that 'learning' theorists differ from proponents of the 'disease' model.) The major goal of intervention, in terms of this model, is to teach new behaviours and knowledge which will lead to more effective self-controls.

The third basic model identified by Brower, Blow and Beresford is the 'self-medication' model, according to which excessive use of chemicals is a mechanism by which the user seeks to alleviate the symptoms of some other mental disorder, such as depression. Intervention, according to this model, should be focused not on the substance misuse but on treating the underlying mental disorder.

The fourth model is the 'social' model, according to which chemical dependency is a result of "environmental, cultural, social, peer, or family influences" (Brower, Blow and Beresford, 1989, p.152). Interventions derived from this model aim either to alter those factors in the social environment which are seen to give rise to the problem, such as poverty or lack of jobs, or to teach more effective coping responses to that environment - or both.

As this cursory account should indicate, these models differ from each other not only in terms of causal factors emphasised, but also in their implications for treatment. The purpose of outlining them here is not to advocate one at the expense of the others, but rather to locate the explanation for chemical dependency used by CAAPS within a context of current thinking about substance misuse.

Studies of Aboriginal alcohol use by researchers working within a variety of disciplines do not, on the whole, support disease-based explanations. While some racial differences have been observed in the presence of two enzymes associated with the elimination of alcohol from the body - alcohol dehydrogenase and aldehyde dehydrogenase - there is no evidence to date suggesting that Caucasians differ from Aboriginal Australians in this respect (Greeley and McDonald, 1990, p.4). Anthropologists and other social scientists have attributed observed drinking behaviour to a number of historical and social factors (e.g. Brady and Palmer, 1984; Healy, Turpin and Hamilton, 1985; Hazlehurst, 1986; Barber, Punt and Albers, 1988). O'Connor (1984), an anthropologist who worked for some time as co-ordinator of an Aboriginal alcohol rehabilitation program in Alice Springs, is particularly critical of the disease model. He argues that, according to prevailing definitions of alcoholism, most adult Aboriginal residents of town-camps would qualify as alcoholics. Yet, once they were away from those camps, many of them showed themselves quite capable of drinking in moderation. The source of the compulsion to drink to excess, O'Connor claims, lies not in personal, disease-engendered lack of self-control, but in pressures generated in particular social settings. In the camps around Alice Springs, to belong to the group meant to drink with the group. Abstention was possible, but
at the price of social exclusion - a particularly harsh penalty for people who value interaction with family and friends.

One relevant criticism raised against the disease model as an explanation for substance misuse concerns the ambiguity surrounding its meaning. Shaffer and Gambino (1990), who suggest that the concept of disease itself has ambiguous connotations, distinguish those who assert that alcoholism is a disease from those who contend that it is like a disease. The former, suggest Shaffer and Gambino, have taken what might otherwise have been a useful metaphor beyond constructive use and, in so doing, 'have confused the map with the territory' (1990, p.352).

The assertion, embodied in CAAPS statements, that dependency is 'primary, progressive, chronic, and fatal' implies that it is a disease - a bit like AIDS. On the other hand, the claim that it adversely affects all family members, who as a result become 'emotionally, spiritually and physically sick' suggests that it is a social phenomenon with some disease-like properties; that is to say, it is not (presumably) contagious in the same way that influenza is, but nonetheless its effects extend beyond the immediate 'victim' to that person's network of social relationships.

The attempt to use this model, complete with its ambiguities, in treatment programs for tribally-oriented Aborigines raises additional problems, insofar as Aboriginal cultures employ very different frames of reference for the interpretation of health and ill-health (Reid and Mununggurr, 1977). If, as Shaffer and Gambino suggest, the interpretations that clients place on events are every bit as important as those of the treatment experts, then the use of such an alien set of concepts in such a central explanatory role raises important questions of cross-cultural communication. The remarks of one anthropologist, Grayson Gerrard (1989), are apposite:

Increasingly, Aborigines are coming to believe that there is something in what whites say about drugs, and that drugs aren't very good for you, but I have never met an Arnhem Lander who was able to fully embrace a European model of disease aetiology . . . . Apart from small children and those who have minor ailments such as coughs and headaches, all sick people are believed to be the victims of sorcerers (1989, p. 55).

For better or worse, the disease model as sometimes interpreted carries its own built-in justification for not heeding alternative cultural frameworks: being a disease, the signs and symptoms, in the words of two writers associated with CAAPS, 'cross cultural boundaries' (Murdock and Coster, 1988).

The 'disease' explanation, to summarise, is not a body of truth beyond question (which in any case would take it out of the realm of science and make it a dogma), but one of several alternative explanations for a complex phenomenon. Its adequacy as an explanation for substance misuse in general, and among Aboriginal people in particular, are matters of continuing doubt, debate and research. In these circumstances, the path to effective prevention and treatment lies not in demanding unquestioning
adherence to the model, and applying it to all clients who come through the doors, but in a continuing, open-minded search for intervention strategies that best match the needs of clients. This requires an openness to alternative, even competing, ideas and theories.

As the first paragraph of this chapter indicated, CAAPS is not geared as an organisation to openness of this kind, a fact which has not gone unnoticed among several CAAPS staff members with whom I spoke in the course of the review. The implied criticism of CAAPS here is deliberate: in my view, CAAPS is to be criticised, not for choosing a particular explanatory model as a base for intervention, but for the degree of rigidity, bordering on closed-mindedness, with which it has used the model.

This is not to call for wholesale abandonment of the model. Whatever its defects as an explanatory framework, the disease model may well be helpful under certain circumstances. Nor is it to invite conceptual anarchy. Programs must have guiding frameworks. What is being called for is a new openness to ideas and other approaches. As I shall suggest later, this should be done in a spirit of partnership and consultation with Aboriginal people.

PROPOSITIONS ABOUT APPROPRIATE METHODS AND GOALS OF PREVENTION AND TREATMENT

The goal of CAAPS treatment is 'a substance free lifestyle in order that a quality of life be attained' (CAAPS, 1990a, p.3). This does not mean that CAAPS enjoins total abstinence from alcohol upon all Aboriginal people; however, it is a sine qua non of treatment programs in which clients are defined as being victims of a disease of chemical dependency, that the only way of arresting the disease is through abstinence. CAAPS follows this principle.

Many of the elements underlying the approach to treatment (including those itemised earlier in this chapter) are derived from what is known as the 'Minnesota Model', a treatment model that originated in the United States in the late 1940s, from where it has spread to several other countries (Cook, 1988a). In Australia, the Minnesota Model has been adopted and further modified by the Holyoake Centre in Perth which, as mentioned in the previous chapter, was to provide many of the seminal ideas for the CAAPS program. Cook (1988a) defines the Minnesota Model in terms of four key elements: (1) a belief that chemically dependent people can change their beliefs, attitudes and behaviours; (2) adoption of the disease concept of chemical dependency; (3) treatment aimed at the twin goals of abstinence from mood altering chemicals, and an improvement of lifestyle, and (4) use of the principles of AA and NA. The Holyoake program, while broadly following this framework, makes extensive use of family systems concepts and emphasises the need to develop clients' sense of 'self-responsibility' (Binns, Dear, Knowles and Hall, 1990, p.4). It uses (as does CAAPS) the terms 'dependent' to refer to persons who are misusing substances and 'codependents' for key significant others in dependents' lives, who inadvertently assist dependents' continuing misuse.
In attempting to adapt this approach to working with tribally-oriented Aboriginal people, CAAPS has enunciated five intervention principles:

- intervene from kin group initiative and have extended kin group support;
- utilize the Aboriginal kinship system as an integral part of the program;
- take account of the total context in which substance misuse occurs;
- include a range of information which enables people to develop appropriate continuums of care;
- utilize a total environmental approach that is grounded in the realities of the kinship perspective (CAAPS, 1990a, p.4).

In reality, the most obvious reference to Aboriginal kinship takes the form of a focus on 'codependents', largely for pragmatic reasons. Because of the power of 'denial' and 'delusion' in chemical dependency, drinkers themselves are considered to be often the least aware of their true circumstances and the least willing to change their behaviour. Those most likely to want changes are the codependents: usually the spouse, sometimes also the children, sometimes friends. They therefore represent a potentially more productive point of intervention into the system in which the 'family disease' has taken hold.

From the outset, 'codependents' programs' have formed a major component of the residential treatment activities at Daly River Five Mile. Prior to March 1990, the Gordon Symons Centre did not offer a residential program for codependents, but since that time it, too, has followed an approach similar to that of Daly River, accepting families for residential treatment and offering a codependents' program alongside the dependents' course.

The extent to which a focus on codependency represents Aboriginal 'kin group initiative' and the use of Aboriginal kinship systems, however, is open to doubt. While there is no reason in principle why the concepts of 'codependency' and 'dependency' should not be applied to Aboriginal families, both concepts are derived from Western family systems which are governed by very different norms of responsibilities, rights and obligations to those underlying Aboriginal kinship systems.

At present, in my view, these concepts are applied to Aboriginal families with insufficient regard to how their meaning might be affected by the very different cultural context of Aboriginal kinship systems. An illustration of this is provided by the Daly River residential family program, which for the first two years of operation classified all male clients as 'dependents' and all
females as 'codependents'. Only in May 1989 was a 'female dependents' program inaugurated.

O'Connor has criticised a codependents' program for traditional Aboriginal people in Roebourne, Western Australia, on the grounds that it urged participants not to fulfil traditional kin-based obligations, thereby further undermining their own culture (O'Connor, 1988, p.119).

The third and fifth principles listed above emphasise the need to 'take account of the total context in which substance misuse occurs' and to 'utilise a total environmental approach'. Other statements of the CAAPS model, however, adopt a rather different stance. Writing in 1985, Roger Sigston, one of the founders of the model, dismissed what he calls "corporate community involvement" as a "foreign concept" for tribally oriented people, and went on to assert: "The concept of Aboriginal communities taking over family and individual welfare responsibilities should not be used" (1985, p.20). Sigston's then colleague, Russell Gluck, testifying before the Senate Select Committee on Volatile Substance Fumes, urged Committee members to "forget the business about councils; they are not relevant" (Commonwealth of Australia, Senate, 1985, p.1481). In the same testimony, he criticised community-based recreation programs on the grounds that they drew young people away from the proper focus of their activities - namely, their families.

One should not make too much of these statements, firstly, because they were made several years ago and, secondly, because what people actually do may or may not accord with principles as set forth in papers delivered to conferences or inquiries. Moreover, in some communities the availability and use made of "grog" is a highly charged political issue, dividing community members among themselves and making it difficult for any outsider to work with the community as a whole on alcohol-related matters.

At the same time, it is difficult to see how a program can take due account of the 'total context in which substance abuse occurs' and adopt a 'total environmental approach' if it does not incorporate constructive linkages with key institutions operating in that context. Whatever their weaknesses as governing institutions, community councils are key institutions, as are recreation officers, youth workers, and so on. Despite the commitment in principle to a 'total environmental approach', the potential effectiveness of the CAAPS approach is weakened by a failure, at the level of its guiding conceptual framework, to identify linkages between its own chosen sphere of activities - the family - and other social institutions in the community, or to spell out ways in which such linkages might be developed.

Later, I shall suggest that this conceptual failure has practical consequences, in that it leaves several family workers, for example, with poorly defined roles and more isolated than they need be within their communities.

The remaining intervention principle outlined above calls for "a range of information which enables people to develop appropriate continuums of care". The concept of a 'continuum of care' refers to an integrated set of activities and programs which range from
consciousness-raising to the provision of follow-up services, such as AA and Al-Anon self-help groups. Murdock and Coster (1988) identify eight elements in the continuum:

1. Community mobilisation: making the community aware of problems of substance abuse;
2. Information and related resources;
3. Intervention strategies;
4. Detoxification centres, both medical and non-medical;
5. Residential education/recovery programs for dependents;
6. Non-residential education/recovery programs for dependents;
7. Codependents' program;
8. Aftercare, e.g. AA and Al-Anon.

CAAPS is not involved in the provision of either medical or non-medical detoxification facilities, but it does endeavour to provide the remaining seven elements. In doing so, CAAPS staff are expected to adopt a characteristic method of work, of which two aspects are particularly important: first, keeping a lookout for situations, especially crises, that offer a point of entry for disseminating information, initiating counselling, or providing other services; second, assisting people to reflect objectively on their situations and their actions, and to help them to interpret these situations and actions in the light of new information, provided by CAAPS workers (CAAPS, 1990a, p.12). Intervention with dependents, which normally involves codependents as well, is aimed at recovery wherever possible. With codependents, it is aimed at imparting the increased awareness through which, it is hoped, the dependent will in turn become more likely to recover; it also seeks to give codependents greater capacity to cope in the event of the dependent not recovering.

The emphasis on crises reflects a belief that family crises such as domestic violence, injuries, alcohol-related evictions and school attendance problems provide a 'lever' or bargaining point for commencing intervention, the goal of which is entry into a structured treatment program (Murdock and Coster, 1988, p.15).

CONCLUSIONS

In the field of substance misuse treatment, as in many other areas, the programs and activities undertaken are shaped largely by ideas and beliefs concerning the nature and causes of substance misuse. It is for this reason that the present review has begun with a critical examination of these ideas and beliefs. The object has been, not to criticise for the sake of criticising, but to locate the ideas within a broader context of current thinking about substance misuse, and also to aid in understanding the structure and purposes of CAAPS programs.

The examination has brought to light three points on which, I have suggested, CAAPS stands to be criticised. Firstly, in pursuing its chosen approach to the treatment of chemical dependency, CAAPS has been unnecessarily rigid and resistant to alternative ideas. Such a stance, I have argued, is not compatible with maximising program effectiveness. This is not to pass judgement on the chosen model itself. It is not the business of funding agencies to insist that treatment agencies
adopt a particular treatment model, unless it can be shown that one model is clearly superior, and this is not the case in the field of substance misuse, partisan claims notwithstanding. As the author of a recent review of U.S. treatment services concluded: "... no single treatment approach can legitimately claim superiority to all others. No one treatment has been shown to work for all, or even most people who receive it. Rather than one treatment of choice, we have at our disposal a range of promising alternatives to try" (Miller, 1990, p.255). The findings to be reported later in this review will suggest that Miller's conclusions are very relevant to CAAPS.

Secondly, it has been suggested that in using concepts such as 'dependency' and 'co-dependency', CAAPS has given insufficient consideration to the meanings of these concepts within Aboriginal frames of reference. This observation raises an important issue which will be explored later in the review - namely, the degree of Aboriginal involvement in formulating the concepts, terminology and intervention methods in programs which are, after all, intended to alter the attitudes and behaviour of Aboriginal people. Again, this is not to call for the abandonment of concepts currently in use, but it does imply the need for changes in the ways in which they are adopted.

Thirdly, the CAAPS model has been criticised on the grounds that, while claiming to address the total context of substance misuse, it has in fact failed to develop a framework for working at community levels other than that of the family. Whatever the views of individual CAAPS staff about Aboriginal community councils (which indeed do represent the imposition of European political structures on Aboriginal societies), these councils are an important element in local community life, and a concerted community-based attack cannot be mounted against substance-misuse without some thought being given to their role.

Some recommendations arise out of these observations.

1. **The CAAPS organisation should be urged to adopt, at the appropriate organisational levels (such as the Training Unit), a more open stance towards differing treatment approaches.**

2. **Greater consideration should be given to locating key treatment concepts within Aboriginal frames of meaning, even if this means radically changing these concepts.**

3. **In its model for community-level work, CAAPS should give greater consideration to developing linkages with social institutions other than the family (while not, thereby, neglecting the importance of family work).**
CHAPTER THREE

RESIDENTIAL RECOVERY PROGRAMS I: DALY RIVER FIVE MILE FAMILY PROGRAM

This chapter examines the Daly River Five Mile Family Program in three sections:

1. structure and objectives of the program;
2. patterns of client contact; and
3. program outcomes.

THE STRUCTURE AND OBJECTIVES OF THE PROGRAM

As indicated in Chapter One, CAAPS has two residential facilities: Daly River Alcohol Education and Awareness Institute, operated by Catholic Missions and more commonly referred to as Daly River Five Mile, and the Gordon Symons Centre, located in Darwin and run by the Aboriginal Resource and Development Services Inc. The Daly River Institute is currently housed in a group of buildings known as Wulk Witbi, located 8 km from Daly River Mission and 210 km from Darwin. The buildings are rented from the Nauiyu Nambiyu (Daly River) Aboriginal community council, although the land itself is owned by the Catholic Church. The buildings also serve as emergency accommodation for the Nauiyu Nambiyu community in times of flooding, and Catholic Missions have made several representations to the NT Government, claiming that the buildings are inadequate as a residential treatment facility.

The 'Family Program' is an intensive four-week residential course based on the Minnesota model (see Chapter Two) and on Kakawis, a family residential program for people with alcohol problems located near Vancouver, Canada. It accepts families rather than individuals, and allocates individual family members to one of four courses:

. a Dependents' Program for male dependents;
. a women's Codependents Program for non-drinking spouses;
. a women's Dependents' Program (commenced May 1989), and
. a Children's Program (commenced August 1989).

(The Children's Program is being funded by the National Campaign Against Drug Abuse as a 18-month pilot program, and is subject to a separate evaluation as part of the funding conditions; for this reason, and because of its newness, it is not covered in the present review.)

The centre is designed to accept up to eight families at a time, each of which can be housed in a separate cottage; in practice, as is shown below, the number of families attending has generally been higher.

Like other 'education-recovery' programs offered by CAAPS, the courses have four main components, seeking to provide:

1. information about the effects of alcohol and other substances on individuals and families, with special
emphasis on self esteem, interpersonal relationships, the role of family and cultural perspectives;

2. a caring, safe environment in which people can learn to talk about their fears, guilt, anger, etc;

3. assistance in sorting out practical problems; and

4. one-to-one counselling (Murdock and Coster, 1988).

Each of the three adult courses follows a similar structure, again comprising four components:

1. a two-hour lecture/video session each week-day morning, often commencing with a 20 minute relaxation session;

2. two two-hour afternoon sessions each week, also involving lectures and videos;

3. two evening AA-type meetings, and two evening Al Anon-type meetings, each week; and

4. one 'one-to-one' counselling session per client per week – a target which program staff readily admit is not always met.

The remaining time is part structured, part free. For example, on afternoons when they are not attending lecture/sessions, clients are expected to attend to community chores such as rubbish disposal and wood collection, as well as household responsibilities such as shopping and visits to the bank, health clinic, etc. Lectures are also timed to ensure that one parent is available as necessary to look after children. Available recreational pursuits include hunting, football and swimming.

The instructional component of the course adds up to 20 hours per week, which happens to be the amount of time required in order for the program to receive funding from the Commonwealth Department of Employment, Education and Training (DEET).

The adult courses are described by Catholic Missions' Alcohol Awareness and Family Recovery agency as having five basic aims. As set out in submissions for funding, these are:

1. further education in awareness of substance abuse at personal, family and community level;

2. to create an awareness of choices with the use of 'substances';

3. further training of leaders and facilitators to work in traditionally oriented Aboriginal communities;

4. to create possibilities for a more thorough development of the ongoing group(s) at the community; and

5. to intervene in the intergenerational transfer of chemical dependency.
The aims as specified in the program's internal evaluation documents are slightly different. Again, there are five. Clients, it is hoped, will:

1. identify their alcohol use and recognise behaviour patterns associated with this;

2. recognise patterns of behaviour dysfunction in their community, family and personal level due to alcohol use;

3. comprehend the concept of alcoholism as a family disease and how this influences the family dynamics of given situations;

4. acknowledge orally and in written form that they contribute directly or indirectly to the dysfunction of their family network; and

5. identify and list choices each can make to assist in combating family dysfunction.

One interesting point about these aims is that none of them, from either list, specifies a behavioural outcome. They are all either 'process' goals; that is, they indicate what the program is designed to do - to train people, to 'create possibilities', to intervene, etc. - but not what is to be achieved by these actions. Or they specify non-behavioural, and sometimes extremely vague, outcomes, such as creating an 'awareness of choices'. In particular, there is virtually no reference in these aims to bringing about changes in people's drinking behaviour - again, the sole partial exception being the aim of 'intervening in the 'intergenerational transfer of chemical dependency', and even here no explicit desired outcome is attached to the intervention, although one is clearly implied.

Those involved in CAAPS programs have sometimes argued that their programs do not lend themselves to quantitative evaluation. There appears to be some slightly specious logic at work here: if one defines one's aims in terms that avoid any mention of measurable, behavioural outcomes, then of course one can argue that what one is trying to do cannot be quantitatively assessed in terms of outcomes. But are these the real aims? I would suggest that the justification for promoting a particular model of chemical dependency and mounting a publicly-funded four week residential program is that it will contribute to achieving two goals. These are:

1. to help drinkers or other drug-dependent persons break free of their dependency; and

2. to help family members who are not themselves substance-misusers either,
   (a) to exercise a positive influence on substance-misusers within the family and/or
   (b) to cope more effectively with the dependent person's continuing misuse, thereby reducing the damage done by substance misuse in the family and improving their own quality of life.
If these are the real aims, the programs should be assessed fairly but rigorously according to the relevant criteria - several of which are in principle measurable. If they are not the aims, one wonders on what basis CAAPS can claim that early intervention based on the family disease model stands a good chance of halting further progression of the disease, and that the treatment is cost effective (Murdock and Coster, 1988).

Some idea of how the aims are related to course content can be gained from the outline of the Codependents' program, which itemises the following topics for discussion:

WEEK 1
- Introduction to the Codependent Program
- Chemical dependency - the feelings sickness
- Cultural group activity
- Grog, petrol and kava and Aboriginal culture
- Saying things are OK when really they are not OK

WEEK 2
- Caretaking or enabling - how it makes the sickness worse
- Out of control - the mess our lives get into with the sickness
- Cultural group activity
- Letting go - getting well
- Introduction to Al-Anon

WEEK 3
- Family sickness - what happens to the family
- Video: 'Soft is the Heart of a Child'
- Cultural group activity
- Grief
- Al-Anon

WEEK 4
- Stress - what happens to us
- How we feel about ourselves
- Cultural group activity
- Tough Love - ABC's
- Al-Anon.

Course material consists of overseas-produced documentary videos such as 'For the Honour of All', instructional videos prepared by the CAAPS Training Unit, and written material, much of it also produced by the Training Unit. Posters and other displays, some bearing the stamp of approval of AA, are also used.

At the time of the review, the adult programs were being conducted by a staff of three people - all non-Aboriginal. They were:

- a Director/Program Co-ordinator, whose formal training had been obtained from the Sydney-based Australian Institute of Counselling Addictions and Holyoake, in Perth, where he completed a training school in chemical addictions and attended the dependents' and codependents' programs;
a Facilitator, Codependents' Program, similarly trained, who had additional experience and qualifications in teaching and librarianship; and

facilitator, Dependents' Program, whose background and qualifications were similar to those of the Codependents' Facilitator.

A fourth non-Aboriginal staff-member and an Aboriginal couple, each of whom was employed part-time, also worked at Daly River, but were fully engaged in the Children's Program. From time to time the centre has also employed a manager.

All three of the staff members listed above have many years experience working in Catholic mission communities both in and outside the Northern Territory. No doubt, this background imparts a certain style to staff members' view of their role and to their mode of interaction with Aboriginal clients. To explore these matters in any depth would take the review into the realm of speculation; nonetheless, a few observations are in order. On the one hand, people such as the staff listed bring to their tasks a long-term commitment to involvement with Aboriginal welfare which is conspicuously rare among non-Aboriginal people outside of a mission setting. At the same time, traces of the kinds of paternalistic control which were once the hallmark of administration are not easily discarded, and may be counter-productive. For instance, while at Daly River, Aboriginal people are subjected to a high degree of control in such day-to-day matters as use of the telephone and what they may buy on credit at the nearby store. As an outside observer, I found it difficult to reconcile the maintenance of these controls with programs which purported to enhance people's self-esteem and exhorted them to assume greater control over their own lives.

The issue of how much control should be exercised over clients in an institutional setting, and how that control should be exercised, is a vexed one at the best of times, made even more so when the clients are Aboriginal and the controllers are not. Those who have a long association with Daly River Five Mile contend that program organisers have tried a variety of approaches, but that more liberal measures have resulted in administrative headaches and a pile of bad debts at the store - which the organisers have had to honour. I do not doubt that this is so, nor do I doubt the complexity of the issue. My observation, therefore, should be taken as just that: the impression of one outside observer who has not had to wrestle with the problems in this setting for himself.

Admission of clients to the Family Program is co-ordinated through Alcohol Awareness and Family Recovery, to which all requests for admission are passed.

PATTERNS OF CLIENT CONTACT

J, a male, was a health worker for 20 years - his alcohol problem has prevented him working the last 2 years. J is desperate to stay sober as his health is not good. He is terrified of the alcoholic seizures etc. He says: I am going to walk away from teasers and drunken trouble makers.
I want to stay sober for me and my family. I feel low down like the gutter when my eldest daughter say this thing I do when I'm full drunk (From an internal course evaluation).

Several people and families have attended more than one course at Daly RiverFiveMile. Each time a person attends a course, he or she counts as an admission to the course. The number of admissions, therefore, is a quantitative indicator of the usage and popularity of the course. In order to see how extensive the impact of the course is, however, we need also to look at the number of individual clients who account for those admissions. The following analysis, therefore, looks at both admissions and numbers of clients attending the Family Program.

Information concerning client contact was gathered from the program's attendance register and intake interview forms. All admissions, except those of children accompanying their parents to the program, were examined from commencement of the program in May 1987 up until 31 December 1989.

During that time, the Daly River Family Program catered for 434 adult admissions. These were distributed as shown in Table 3.1:

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of courses</th>
<th>Admissions</th>
<th>Mean no. admissions/course</th>
</tr>
</thead>
<tbody>
<tr>
<td>May-Dec 1987</td>
<td>5</td>
<td>112</td>
<td>22.4</td>
</tr>
<tr>
<td>1988</td>
<td>7</td>
<td>162</td>
<td>23.1</td>
</tr>
<tr>
<td>1989</td>
<td>9</td>
<td>160</td>
<td>17.8</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>434</td>
<td>20.7</td>
</tr>
</tbody>
</table>

On average, as Table 3.1 indicates, each 4-week course at Daly River catered for an average of just over 20 people, although the mean number attending courses was lower in 1989 than in either of the two preceding years.

For most of the period under review, as stated above, the program offered only two courses, normally run in parallel: the Dependents' course for men and a Codependents' course for women. In 1989, as well as introducing a Children's Program and a course for Dependent Women, two special courses were also run for 'advanced' clients, i.e. those undertaking the 4th and 5th steps of AA's twelve steps. The overall distribution of admissions among courses is shown in Table 3.2.
Table 3.2: Admissions to Daly River Five Mile Family Program, 1987-1989, by type of course (excluding Children's Program)

<table>
<thead>
<tr>
<th>Course</th>
<th>No. of admissions</th>
<th>% of admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent men</td>
<td>172</td>
<td>39.6</td>
</tr>
<tr>
<td>Codependent women</td>
<td>204</td>
<td>47.0</td>
</tr>
<tr>
<td>Dependent women</td>
<td>24</td>
<td>5.5</td>
</tr>
<tr>
<td>Advanced course</td>
<td>29</td>
<td>6.7</td>
</tr>
<tr>
<td>Not known</td>
<td>5</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>434</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

More than half of all admissions to the program were drawn from two communities: Wadeye (Port Keats) and Nguiu (Bathurst Is.), while most of the remainder came from other communities linked historically with Catholic missionary activities, and still linked today by the presence of Family Workers employed by Catholic Missions. The distribution is shown in Table 3.3.

Table 3.3: Admissions to Daly River Five Mile Family Program, by source community

<table>
<thead>
<tr>
<th>Community</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pt Keats</td>
<td>119</td>
<td>27.4</td>
</tr>
<tr>
<td>Nguiu</td>
<td>112</td>
<td>25.8</td>
</tr>
<tr>
<td>Daly River</td>
<td>60</td>
<td>13.8</td>
</tr>
<tr>
<td>Santa Teresa</td>
<td>42</td>
<td>9.7</td>
</tr>
<tr>
<td>Turkey Ck, WA</td>
<td>20</td>
<td>4.6</td>
</tr>
<tr>
<td>Pularumpi</td>
<td>18</td>
<td>4.1</td>
</tr>
<tr>
<td>Kununurra area, WA</td>
<td>16</td>
<td>3.7</td>
</tr>
<tr>
<td>Millikapiti</td>
<td>12</td>
<td>2.8</td>
</tr>
<tr>
<td>Darwin</td>
<td>9</td>
<td>2.1</td>
</tr>
<tr>
<td>Other WA</td>
<td>6</td>
<td>1.4</td>
</tr>
<tr>
<td>Tiwi Is, unspec</td>
<td>5</td>
<td>1.2</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>2.8</td>
</tr>
<tr>
<td>Not stated</td>
<td>3</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>434</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Most admissions to the program appear to have been either self-referred or referred by Family Workers. However, the data here must be treated with caution, for two reasons: firstly, referral source was recorded for fewer than half of all admissions (206, or 47.5 per cent); secondly, given that practically all decisions to attend the course were voluntary decisions undertaken by the client in consultation with another person, such as a family worker or spouse, it becomes a somewhat arbitrary matter whether prime significance is attached to 'self' as opposed to the other
or others involved. However, the referral data available—summarised in Table 3.4—does establish one point of importance: namely, the very minor role played by government bodies such as health, welfare and judicial institutions in referring clients to the program. In only six out of the 206 admissions where referral source was recorded was one of these bodies named as the source; the same small number of admissions was accounted for by other drug and alcohol agencies. In other words, structurally speaking, the program is linked to and serves a Catholic Missions-based referral network, rather than forming an integral part of the government's own health and welfare system.

Table 3.4: Sources of referral for admissions to Daly River Five Mile Family Program

<table>
<thead>
<tr>
<th>Referral source</th>
<th>No</th>
<th>Per cent</th>
<th>Valid per cent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>80</td>
<td>18.4</td>
<td>38.8</td>
</tr>
<tr>
<td>Family worker</td>
<td>47</td>
<td>10.8</td>
<td>22.8</td>
</tr>
<tr>
<td>Friends, family</td>
<td>35</td>
<td>8.1</td>
<td>17.0</td>
</tr>
<tr>
<td>Other Catholic Mission staff</td>
<td>19</td>
<td>4.4</td>
<td>9.3</td>
</tr>
<tr>
<td>Drug/Alcohol agencies</td>
<td>6</td>
<td>1.4</td>
<td>2.9</td>
</tr>
<tr>
<td>Health, welfare workers</td>
<td>3</td>
<td>0.7</td>
<td>1.5</td>
</tr>
<tr>
<td>Probation/parole/courts</td>
<td>3</td>
<td>0.7</td>
<td>1.5</td>
</tr>
<tr>
<td>Uniting Church/Gordon Symons Centre</td>
<td>4</td>
<td>0.9</td>
<td>2.0</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>2.1</td>
<td>4.4</td>
</tr>
<tr>
<td>Not stated</td>
<td>228</td>
<td>52.6</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>434</td>
<td>100.1**</td>
<td>100.2**</td>
</tr>
</tbody>
</table>

* i.e. excluding 'not stated'
** errors due to rounding.

The 434 admissions to Daly River Five Mile were accounted for by 371 clients. The mean number of programs attended, therefore, was 1.17. The distribution of clients among the various programs is shown in Table 3.5.
Table 3.5: Distribution of clients among Daly River Family Program courses

<table>
<thead>
<tr>
<th>Course</th>
<th>No of Clients</th>
<th>No. of courses attended</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Dependent men</td>
<td>153</td>
<td>139</td>
</tr>
<tr>
<td>Codep. Women</td>
<td>187</td>
<td>170</td>
</tr>
<tr>
<td>Dependent Women</td>
<td>23</td>
<td>22</td>
</tr>
<tr>
<td>Advanced Course</td>
<td>27</td>
<td>26</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>390</strong></td>
<td></td>
</tr>
</tbody>
</table>

* This total exceeds the actual number of clients attending the Family Program (371) for two reasons: first, all of those attending the Advanced Course had previously attended one or more lower level courses; second, 2 women attended both Codependents' and Dependent Women courses.

A little over half of the clients were female (57.9 per cent). Additional demographic and other data were obtainable from program records for some clients only. In 219 cases (59.0 per cent), ages were recorded. These showed that female clients tended to be slightly older than male clients, having a mean age of 33.2 years compared to 32.4 for males. The modal age for all clients was 25, an indication that the age distribution was not spread evenly about the mean.

In the case of 215 clients, or 58.0 per cent, the intake data recorded whether or not the clients were drinkers. Interestingly, 22 out of 89 males were recorded as non-drinkers. Almost all of these (19 out of the 22) attended courses for Male Dependents, three of them twice and two of them on three separate occasions. Similarly, 34 women were recorded as drinkers, exactly half of whom attended courses as Codependents. The other 17 drinking women attended one or more of the Female Dependents course.

These findings lend weight to a suggestion made in the preceding chapter, namely that the categories "male dependent" and "female codependent", both of which are derived from the "family disease"/Minnesota model employed by CAAPS, have been imposed on Aboriginal client families with little regard to how closely they actually correspond to the patterns of alcohol misuse in Aboriginal families.

**PROGRAM OUTCOMES**

Clients come to Daly River with a variety of life-histories and hopes. For some, it is peace that seems to count. This course is good, I like it here, it's peaceful, wrote a woman upon completing the Codependents' course for the second time.
A man who had attended the Dependents' course for a second time wrote: *I will be attending AA when I go home. There are only two of us sober, but that is two more than last year.*

Family Program staff routinely record outcome observations of clients:

A attended the course with her husband and four children. A shy group member, she met all course requirements, however she seems afraid to 'rock the boat'. The fear of her husband's violence when he is drinking immobilizes her. *I don't know what I have learnt, but I feel better.*

These in-house evaluations also record less successful outcomes:

E was five days late in commencing the course. He was preoccupied by an impending court appearance. E looked and sounded depressed. He said: *It is all hopeless. I have tried many times to stop drinking. It is killing me. I see snakes and things. I am scared and hopeless.* E left the program to attend court in Darwin on ..../..../88 and did not return.

Any attempt to assess the impact of a treatment program is a perilous exercise, for several reasons. Firstly, there is the question of identifying appropriate outcome criteria. Secondly, even when outcomes are identified and methodologically valid indicator variables derived, problems will inevitably beset any attempt to establish causal links. If outcome X is not present, does this indicate that the program has failed, or rather that its impact has been negated by other subsequent events? Miller (1990), on the basis of a broad-ranging examination of alcohol treatment programs in the United States, concludes that outcomes following treatment are influenced more by experiences and conditions in the person's life following treatment than by the treatment itself. If outcome X is found, on the other hand, can we safely attribute its presence to the program; might not other causal factors have played a more important role?

For the purposes of this review, a more modest strategy has been adopted — one that eschews the goal of drawing firm causal conclusions, but that nonetheless compares ex-clients in a community with others in the community with respect to one outcome measure, namely, drinking behaviour.

This strategy, it is important to note, is not an experimental or quasi-experimental research design; the two groups itemised do not constitute 'experimental' and 'control' groups, and comparisons made between the two should not be used as a basis for drawing inferences that require an experimental or quasi-experimental design. In particular, we cannot assume either that all clients (or even all male clients) were heavy drinkers immediately prior to admission, or that the client population prior to admission was similar to the non-client population in terms of drinking behaviour.

The community selected in this case was Wadeye (Port Keats) from which, as shown above, some 27 per cent of admissions to the Daly River Family Program came, and in which a CAAPS field worker
(called a 'Co-ordinator') is employed. In comparison with other communities, Port Keats residents have been extensively served by CAAPS programs. Up to the end of 1989, 82 people from Port Keats had attended residential courses at Daly River; another 25 had attended courses at Gordon Symons Centre, while an additional 10 had attended courses at both centres.

The actual courses undergone by Port Keats residents are summarised in Table 3.6.

**Table 3.6: Programs attended by Port Keats residents**

<table>
<thead>
<tr>
<th>Place</th>
<th>Program</th>
<th>No. attending*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daly River</td>
<td>Dependent males</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Codependents</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>Advanced</td>
<td>12</td>
</tr>
<tr>
<td>Gordon Symons</td>
<td>Dependent males</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Codependents</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Dependent females</td>
<td>1</td>
</tr>
</tbody>
</table>

* Several people, as indicated in the text, had attended more than one type of program - e.g. some women had attended both Codependents' and Advanced programs at Daly River Five Mile at different times, while some, too, had attended Codependents' programs at both Daly River and Gordon Symons.

Among the 51 Daly River Five Mile clients for whom referral sources were recorded, most were either self-referrals, referred through a Family Worker, or referred by family and/or friends. (By contrast, all of the 13 Gordon Symons clients for whom source of referral was recorded were referred through the criminal justice system.)

**Data Collection**

The research procedure used in obtaining a sample of Port Keats residents is described in Appendix B. Briefly, it involved obtaining a random sample of 39 males and 40 females aged 15 years and over, who had not attended any CAAPS courses, from Health Centre files. These were added to the list of Port Keats residents who had attended one or more CAAPS courses. The total resulting sample thus numbered 196 people.

Two Aboriginal Health Workers at Port Keats were then asked, with respect to each individual in the sample, two questions:

- Is the person a non/moderate/heavy drinker?
- Is the person's spouse/partner (where applicable) a non/moderate/heavy drinker?.

(A "heavy drinker" was defined as someone who often drank to excess. While this might seem an imprecise yardstick, the Aboriginal Health Workers in this and other communities had no
difficulty in distinguishing in their own minds between moderate and heavy drinkers.)

Immediately afterwards, all names were erased from the sample, and from all computer files and other documents associated with generating the sample, in order to ensure that no individual could be identified.

Findings

The structure of the Port Keats sample is shown in Table 3.7.

Table 3.7: Port Keats outcome sample

<table>
<thead>
<tr>
<th>Treatment background</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>39</td>
<td>40</td>
<td>79</td>
</tr>
<tr>
<td>Daly River</td>
<td>39</td>
<td>43</td>
<td>82</td>
</tr>
<tr>
<td>Gordon Symons</td>
<td>15</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>Both (i.e. D.R. &amp; G.S)</td>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
</tbody>
</table>

The total 96 100 196

The mean age of the "non-treatment" subsample (33.6 years) was virtually the same as that of the former Daly River Family Program clients (33.9 years). Gordon Symons clients were younger (mean age 28.3 years), while those who had attended courses at both centres were appreciably older, with a mean age of 40.6 years.

Among the sample as a whole, as Table 3.8 shows, one third of the men and over 80 per cent of women were described by the Health Workers as non-drinkers - a figure that accords closely with the prevalence of Aboriginal drinking in non-urban Northern Territory communities as reported in (Watson, Fleming and Alexander, 1988). By the same token, 58.9 per cent of males were identified as heavy drinkers. By contrast, only 13.3 per cent of women were described as heavy drinkers. Few people of either sex were labelled by the Health Workers as moderate drinkers.

Table 3.8: Drinking Patterns, Port Keats

<table>
<thead>
<tr>
<th>Drinking Pattern</th>
<th>Male (%)</th>
<th>Female (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-drinkers</td>
<td>31 (32.6)</td>
<td>81 (82.7)</td>
<td>112 (58.0)</td>
</tr>
<tr>
<td>Moderate</td>
<td>8 (8.4)</td>
<td>4 (4.1)</td>
<td>12 (6.2)</td>
</tr>
<tr>
<td>Heavy</td>
<td>56 (58.9)</td>
<td>13 (13.3)</td>
<td>69 (35.8)</td>
</tr>
</tbody>
</table>

TOTAL 95 (99.9) 98 (100.1) 193 (100.0)*
*Data missing for 3 respondents

By combining data on respondents' drinking with data on the drinking levels of spouses or partners, a variable called here "household drinking status" was derived. Four categories of the variable were distinguished:

1. Non-drinking single person or couple.
2. Moderate drinking household, in which at least one person drinks, but neither respondent nor partner (where applicable) drinks heavily.
3. Household containing one heavy drinker.
4. Heavy drinking couple.

The distribution of the sample with respect to these categories is shown in Table 3.9.

**Table 3.9: Family Drinking Status, Port Keats Sample**

<table>
<thead>
<tr>
<th>Drinking Status</th>
<th>No.</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-drinking</td>
<td>64</td>
<td>33.2</td>
</tr>
<tr>
<td>Moderate</td>
<td>18</td>
<td>9.3</td>
</tr>
<tr>
<td>One heavy drinker</td>
<td>105</td>
<td>54.4</td>
</tr>
<tr>
<td>Two heavy drinkers</td>
<td>6</td>
<td>3.1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>193*</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Data missing for 3 respondents

One-third of the respondents were either single non-drinkers or were part of a couple in which neither person drank. In just under 10 per cent of cases, the respondent was either a single moderate drinker or belonged to a couple in which neither person drank heavily. A little over half of the respondents were either single or heavy drinkers or were part of a couple in which one person drank heavily, while a small minority (3.1 per cent) were members of a couple in which both partners drank heavily.

In order to gauge the impact of attendance at Daly River Family Program on drinking patterns, two comparisons were made. Firstly, the drinking status of males who had attended the Daly River Male Dependents Program was compared with that of "non-treatment" males. Secondly, the household drinking status of those who had attended Daly River Family Program courses was compared with that of those who had not attended any CAAPS Programs.

The results are set out in Tables 3.10 and 3.11. Table 3.10 shows that former clients of "dependent male" courses were more likely to be non-drinkers and less likely to be heavy drinkers than males who had not attended CAAPS Programs. The differences,
however, were not great and fell short of statistical significance: 61.5 per cent of non-treatment males were classed as heavy drinkers, but so too were 47.4 per cent of those who had attended the program on one or more occasions.
Table 3.10: Drinking status of ex-Daly River Family Program clients compared with that of non-treatment sample, Port Keats

<table>
<thead>
<tr>
<th>Sub-Sample</th>
<th>N=</th>
<th>Drinking Status (%)</th>
<th>Significance of Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Non</td>
<td>Mod.</td>
</tr>
<tr>
<td>Non-treatment males</td>
<td>39</td>
<td>30.8</td>
<td>7.7</td>
</tr>
<tr>
<td>&quot;Dep. male clients&quot;</td>
<td>38</td>
<td>39.5</td>
<td>13.2</td>
</tr>
<tr>
<td>Non-treatment fem.</td>
<td>40</td>
<td>80.0</td>
<td>5.0</td>
</tr>
<tr>
<td>&quot;Codep.&quot; females</td>
<td>43</td>
<td>87.8</td>
<td>2.4</td>
</tr>
</tbody>
</table>

For interest, Table 3.10 also compares women who had attended one or more "Codependent" courses at Daly River Family Program with 'non-treatment' women; this information, however, is not presented as an indicator of program impact, since women attending these courses were not seeking treatment for their own drinking. The Table shows that female ex-clients were a little more likely to be non-drinkers and less likely to be heavy drinkers than women who had not attended any CAAPS courses.

Table 3.11: Household drinking status, ex-Daly River Family Program clients compared with non-treatment sample, Port Keats

<table>
<thead>
<tr>
<th>Household drinking status</th>
<th>Sub-sample (%)</th>
<th>Non-treatment (N= 78)</th>
<th>ex-Daly River (N= 80)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Drinking</td>
<td>32.1</td>
<td>37.5</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>11.5</td>
<td>10.0</td>
<td></td>
</tr>
<tr>
<td>1 Heavy Drinker</td>
<td>51.3</td>
<td>52.5</td>
<td></td>
</tr>
<tr>
<td>2 Heavy Drinkers</td>
<td>5.1</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Chi-square 4.53756; d.f. = 3; p = .2090

When "non-treatment" households were compared with households of former Daly River Family Program clients (Table 3.11), some small differences emerged. For example, 32.1 per cent of "non-treatment" households were non-drinking households compared to 37.5 per cent of ex-Daly River households. In both cases, just over half of the households contained one heavy drinker. None of the ex-Daly River Family Program households, however, contained two heavy drinkers, unlike the "non-treatment" sample in which 5.1 per cent contained two heavy drinkers.
Discussion

What inferences can be drawn from these observations? Firstly, they provide some evidence that attendance at the Daly River Family Program is associated with a lower prevalence of heavy drinking, although the differences between ex-clients and others are modest. Drinking behaviour is only one of several possible relevant outcomes and, in the case of 'Codependents', not necessarily the most relevant. In order to incorporate the observations reported here into an overall assessment of program effectiveness, it would be necessary to consider additional indicators which gauged the quality of life not only of 'Codependents' but also of their children. This exercise has not been attempted here. For these reasons, the findings of this review are best seen as constituting a suggestion that attendance at Daly River Five Mile has a modest but real effect on drinking behaviour, such behaviour in turn constituting one of several relevant outcome criteria.

SUMMARY AND CONCLUSIONS

The chapter opened with an account of the structure and aims of the Daly River Family Program. Two observations warrant further emphasis. Firstly, it was noted that the aims attributed by Daly River Family Program to the courses specifically avoid any reference to altering clients' drinking behaviour, or to attaining any readily measurable outcomes. It was also suggested that this strategy may have been used by CAAPS spokespeople in the past as a basis for the assertion that CAAPS programs cannot be assessed in terms of measurable outcomes. Secondly, it was suggested that some of the day to day practices at Daly River Five Mile, such as the restrictions placed on clients using the telephone to ring their families in the communities, and the controls maintained over clients' spending at the nearby store, were hardly compatible with a program which professed to show people how to take greater responsibility for their own lives. The discrepancy, it was suggested, reflects a possible lack of congruence between the message being delivered and the backgrounds of the messengers, most of whose working lives have been largely involved with church missionary activity. (As noted above, however, the controls can also be viewed as a response to administrative difficulties encountered by program organisers.)

The next section of the chapter examined patterns of client contact. Between its commencement in May 1987 and the end of December 1989, the program had 434 admissions, most of them from communities linked historically and at present with the Catholic Church. Most admissions had occurred via an informal Catholic Missions network, rather than by government health/welfare or correctional agencies.

The admissions were accounted for by 371 clients, 58 per cent of whom were women. The mean age of clients were 33.2 years for women and 32.4 years for men. The modal age for all clients was 25 years.
In the case of 58 per cent of clients, intake data indicated whether or not the clients were drinkers at the time of entry into the Program. Some 22 out of 89 males were listed as non-drinkers, yet nearly all of them had been enrolled as male dependents. Similarly, 34 out of 126 women were listed as drinkers. Seventeen of these, however, had attended the female codependents' course. These findings lend weight to the suggestion, advanced in the preceding chapter, that the concepts of "dependent male" and "codependent female", both of which are integral elements of the treatment model espoused by CAAPS, are being imposed on Aboriginal client families with little regard to how adequately they represent the realities of alcohol misuse in Aboriginal family systems.

The remaining part of the chapter attempted to assess some aspects of program outcomes. In order to gauge the impact of attendance at Daly River Family Programs on drinking behaviour, the community of Wadeye (Port Keats) was selected. A random sample of 79 residents of Port Keats aged 15 and over, who had not attended any CAAPS courses, was selected and placed alongside the 82 residents who had attended one or more courses at Daly River (as well as 25 residents who had attended courses at Gordon Symons and another 10 who had attended courses at both Daly River and Gordon Symons.) The total sample thus created comprised 196 people.

Two Aboriginal Health Workers were then asked, with respect to each member of the sample, whether the person was a non-drinker, moderate or heavy drinker; where applicable, the same question was asked with respect to the person's spouse.

Analysis of responses indicated that male clients who had attended Dependent Male courses at Daly River were more likely to be non-drinkers, and less likely to be heavy drinkers, than males who had not attended any CAAPS Courses. Those who had attended Daly River Family Program courses were also a little more likely than those who had not attended any CAAPS courses to belong to households in which neither the respondent nor his/her partner (where applicable) drank. None of these results however, were statistically significant. They constituted, in sum, a suggestion that attendance at Daly River Five Mile has a modest but real effect on drinking behaviour, such behaviour in turn constituting one of several relevant outcome criteria.
CHAPTER FOUR

RESIDENTIAL RECOVERY PROGRAMS II: GORDON SYMONS CENTRE DEPENDENTS' EDUCATION-RECOVERY PROGRAM FOR MEN

From the time of its establishment in 1985 until March 1990, the only residential program offered by the Gordon Symons Centre was for 'dependents' (i.e. those deemed to be substance misusers). 'Codependents' (spouses and other significant others of the dependents) were offered a non-residential course. Since then, the Gordon Symons Centre has modified its program along lines similar to Daly River; it now also offers a family-based program for dependents and codependents.

This review is restricted to the period in which the Gordon Symons codependents' course was non-residential.

Like the Daly River Family Program, the Gordon Symons Centre (GSC) program was spread over four weeks; it also used much of the same course material as the Daly River program. In several respects, however, the program differed from the Daly River program. Firstly, as already mentioned, it did not form part of a larger suite of residential programs. Secondly, many clients stayed on for eight weeks, completing two consecutive programs. Thirdly, whereas Daly River accepts most of its referrals from family workers and deals in the main with clients having alcohol-related problems, most admissions to GSC prior to the restructuring of March 1990 were court-referrals, some 28.8 per cent of them arising out of offences related to petrol-sniffing rather than, or sometimes in addition to, alcohol misuse. These patterns are examined in more detail below.

The GSC Dependents' Program was also couched in terms of more outcome-oriented aims and objectives than the Daly River Family Program. According to the Centre's own description, it aimed to:

1. Provide an avenue for intervention in the substance abuse/misuse life-style of individuals;

2. Provide an effective counselling and education-recovery program for tribally oriented Aboriginal people whose substance abuse/misuse had led to serious personal and family dysfunction;

3. Help individuals and family groups recognise substance abuse/misuse as a family problem and demonstrate positive ways of arresting the deterioration in lifestyle;

4. Enable clients to re-establish themselves as meaningful members of society.

In addition to using videos, lectures, group discussions and one-to-one counselling methods similar to those used at Daly River, program staff conducted an assessment service for courts, legal services, hospitals and others, in which the role of substance misuses in individuals' problems was examined and reported on.
Prior to the March 1990 restructuring, the Dependents' Program was the responsibility of four full-time and one part-time staff, allocated as follows:

- Hostel Manager;
- Assistant Manager, Hostel;
- Senior Counsellor/Facilitator;
- Counsellor/Facilitator;
- Domestic Advisor (part-time).

In 1989, the two managerial positions were filled by non-Aboriginal staff, while the three remaining positions were filled by Aboriginal people. The natures of all but the fifth position listed above are self-explanatory; the role of the Domestic Advisor was (and remains, under restructuring) to help clients in household management matters, such as cleaning, cooking, buying food.

Clients are expected to follow a strict set of rules, namely:

1. No drinking alcohol, using drugs, or sniffing petrol.
2. Do not leave hostel without asking staff.
3. Do everything the staff ask you to do.
4. No visitors allowed without asking staff first.
5. All problems and broken rules to be shared in the group.
6. No making trouble for other people.
7. Look after your room and the areas you use, keep them clean.
8. Prepare your own food and clean up after.
9. Pay for food out of Sickness Benefit: $60 p.w. for each adult.
10. Pay rent/accommodation out of Sickness Benefit: $50 p.w. for each adult.
11. Do not go into other people's rooms

In addition, there are four 'Minor Rules' which stipulate: no smoking in groups or vehicles; emergency phone calls only by arrangement with staff; no clients in the office without a staff member; use of TV and video by arrangement with staff only.

PATTERNS OF CLIENT CONTACT

As in the case of Daly River, information about clients attending GSC was collated from the Centre's own records. The number of admissions to this course between 1985 and 1989 is shown in Table 4.1 - which also distinguishes admissions according to whether they were associated with alcohol abuse, petrol sniffing, or both.
Table 4.1: Admissions to Gordon Symons residential male dependents' programs 1985-1989

<table>
<thead>
<tr>
<th>Year</th>
<th>Alc.</th>
<th>Petrol</th>
<th>Both</th>
<th>Not stated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>1986</td>
<td>15</td>
<td>11</td>
<td>3</td>
<td>24</td>
<td>53</td>
</tr>
<tr>
<td>1987</td>
<td>72</td>
<td>31</td>
<td>8</td>
<td>17</td>
<td>128</td>
</tr>
<tr>
<td>1988</td>
<td>99</td>
<td>42</td>
<td>13</td>
<td>2</td>
<td>156</td>
</tr>
<tr>
<td>1989</td>
<td>97</td>
<td>20</td>
<td>5</td>
<td>2</td>
<td>124</td>
</tr>
<tr>
<td>Not stated</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>292</td>
<td>105</td>
<td>32</td>
<td>46</td>
<td>475</td>
</tr>
</tbody>
</table>

In all, the program catered for 475 admissions over this period, most of them between 1987 and 1989. The majority of admissions (292, or 68.1 per cent of those for whom the substance was recorded) were for alcohol abuse, although another 24.5 per cent were for petrol sniffing, with a small additional group referred for both alcohol and petrol abuse.

Admissions were drawn from a large number of communities in the NT, as well as from localities outside the NT. However, although the degree of concentration is less than in the case of Daly River, we again find a small number of communities - in this case, five - accounting for some 45 per cent of all admissions. Table 4.2 ranks contributing communities in descending order; where only one or two admissions were recorded from a community, the community is not shown separately, but included under 'other'.
Table 4.2: Admissions to Gordon Symons male dependents' residential program, 1985-1989, according to source communities

<table>
<thead>
<tr>
<th>Community</th>
<th>Number</th>
<th>Per cent of admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maningrida</td>
<td>65</td>
<td>14.9</td>
</tr>
<tr>
<td>Oenpelli</td>
<td>41</td>
<td>9.4</td>
</tr>
<tr>
<td>Angurugu</td>
<td>31</td>
<td>7.1</td>
</tr>
<tr>
<td>Port Keats</td>
<td>30</td>
<td>6.9</td>
</tr>
<tr>
<td>Bathurst Is.</td>
<td>29</td>
<td>6.7</td>
</tr>
<tr>
<td>Galiwinku</td>
<td>21</td>
<td>4.8</td>
</tr>
<tr>
<td>Yirrkala</td>
<td>17</td>
<td>3.9</td>
</tr>
<tr>
<td>Numbulwar</td>
<td>16</td>
<td>3.7</td>
</tr>
<tr>
<td>Katherine</td>
<td>15</td>
<td>3.4</td>
</tr>
<tr>
<td>Barunga</td>
<td>13</td>
<td>3.0</td>
</tr>
<tr>
<td>Daly River</td>
<td>12</td>
<td>2.8</td>
</tr>
<tr>
<td>Jabiru</td>
<td>12</td>
<td>2.8</td>
</tr>
<tr>
<td>Lajamanu</td>
<td>11</td>
<td>2.5</td>
</tr>
<tr>
<td>Umbakumba</td>
<td>8</td>
<td>1.8</td>
</tr>
<tr>
<td>Tennant Creek</td>
<td>8</td>
<td>1.8</td>
</tr>
<tr>
<td>Milikapiti</td>
<td>7</td>
<td>1.6</td>
</tr>
<tr>
<td>Santa Teresa</td>
<td>6</td>
<td>1.4</td>
</tr>
<tr>
<td>Imanpa</td>
<td>6</td>
<td>1.4</td>
</tr>
<tr>
<td>Darwin</td>
<td>6</td>
<td>1.4</td>
</tr>
<tr>
<td>Pularumpi</td>
<td>4</td>
<td>0.9</td>
</tr>
<tr>
<td>Beswick</td>
<td>4</td>
<td>0.9</td>
</tr>
<tr>
<td>Wave Hill</td>
<td>4</td>
<td>0.9</td>
</tr>
<tr>
<td>Goulburn Is</td>
<td>4</td>
<td>0.9</td>
</tr>
<tr>
<td>Ngukurr</td>
<td>4</td>
<td>0.9</td>
</tr>
<tr>
<td>Nhulunbuy</td>
<td>3</td>
<td>0.7</td>
</tr>
<tr>
<td>Milingimbi</td>
<td>3</td>
<td>0.7</td>
</tr>
<tr>
<td>Borroloola</td>
<td>3</td>
<td>0.7</td>
</tr>
<tr>
<td>Other NT</td>
<td>33</td>
<td>7.6</td>
</tr>
<tr>
<td>Queensland</td>
<td>20</td>
<td>4.6</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>436*</td>
<td>100.1</td>
</tr>
</tbody>
</table>

* Data on community missing for 39 admissions.

At first sight it might appear that the geographical pattern underlying admissions is a reflection of the distribution of family workers, since each of the five most heavily-contributing communities is serviced by a CAAPS family worker. However, examination of referral sources suggests that this is not so. Information on referral sources was available for 72.6 per cent of all admissions. Among these, some 80 per cent resulted from referrals by the court system - courts, probation and parole officers, Aboriginal legal aid organisations, and so on. Moreover, as Table 4.3 shows, this was true for alcohol and petrol related admissions alike.
Table 4.3 Admissions to Gordon Symons male dependents' residential program 1985-1989, by source of referral

<table>
<thead>
<tr>
<th>Referral source</th>
<th>Alcohol</th>
<th>Petrol</th>
<th>Both</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>17.6</td>
<td>6.3</td>
<td>9.5</td>
<td>14.5</td>
</tr>
<tr>
<td>Court system</td>
<td>80.0</td>
<td>75.9</td>
<td>90.5</td>
<td>79.7</td>
</tr>
<tr>
<td>Hospital</td>
<td>0.8</td>
<td>16.5</td>
<td>-</td>
<td>4.3</td>
</tr>
<tr>
<td>Other</td>
<td>1.6</td>
<td>1.3</td>
<td>-</td>
<td>1.5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Apart from the court system and self referrals, the only significant source of referrals revealed in Table 4.3 was provided by hospitals, which accounted for 13 of 75 referrals for petrol sniffing.

The referral system of which the Gordon Symons Dependents' Program is (or has been) a part is, then, fundamentally different from the system to which the Daly River Family Program belongs.

**PATTERNS OF CLIENT CONTACT.**

The 475 admissions were accounted for by 331 clients, who therefore attended a mean of 1.4 courses each. This represents a higher rate of repeated attendance than was found for the Daly River Family Program in the previous chapter. As Table 4.4 shows, some GSC clients attended up to five courses with 31 per cent attending more than one course.

Table 4.4: No of courses attended by clients of Gordon Symons Centre Male Dependents' course

<table>
<thead>
<tr>
<th>No. of Courses</th>
<th>No. of Clients</th>
<th>% Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>228</td>
<td>68.9</td>
</tr>
<tr>
<td>2</td>
<td>75</td>
<td>22.7</td>
</tr>
<tr>
<td>3</td>
<td>20</td>
<td>6.0</td>
</tr>
<tr>
<td>4</td>
<td>6</td>
<td>1.8</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>331</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The mean age of clients was 26.6 years with a mode of 22 years. The overall mean, however, conceals the existence of two distinct sub-groups. Those admitted for alcohol-related
problems had a mean age of 29.0 years, while those admitted in connection with petrol sniffing had a mean age of 20.5 years. (Those admitted for both alcohol and petrol sniffing lay, as might be expected, in between, with a mean age of 22.1 years.)

PROGRAM OUTCOMES

To assess the impact of the GSC Dependents' courses on substance misuse, a similar procedure to that described in the preceding chapter was adopted. In this case, however, two communities were chosen - Maningrida in Arnhem Land and Angurugu on Groote Eylandt. (Again, details concerning data collection are in Appendix B.)

As Table 4.2 above shows, 14.9 per cent of dependent male admissions between 1984 and 1989 came from Maningrida, and a further 7.1 per cent came from Angurugu. These admissions were accounted for by 42 males from Maningrida and 21 from Angurugu.

Maningrida

The outcome sample used for Maningrida comprised 35 of the 42 ex-clients (no information being available concerning the other seven), and a random sample of 36 male residents at Maningrida aged 15 and over who had not attended CAAPS courses. As in the case at Port Keats, two Aboriginal Health Workers from Maningrida were questioned about all individuals in the sample. On this occasion, however, as well as questions about drinking behaviour, two additional questions were posed about petrol sniffing, making four questions in all:

1. Is this person a non/moderate/heavy drinker?
2. Is the person's partner (if applicable) a non/moderate/heavy drinker?
3. Is this person a non/occasional/regular petrol sniffer?
4. Is the person's partner (if applicable) a non/occasional/regular sniffer?

As in the case at Port Keats, once the information had been entered into the computer, all references to names were deleted.

Of the 35 ex-GSC clients, most had been admitted on account of petrol sniffing (22, or 62.9 per cent), or petrol sniffing and alcohol (6, or 17.1 per cent). Only five had been admitted on account of alcohol alone, while in two cases, the substance concerned had not been recorded.

When the treatment and non-treatment groups were compared with respect to current drinking behaviour, ex-clients were found to be slightly less likely to be heavy drinkers, and more likely to be moderate drinkers, than the non-treatment group, as Table 4.5 shows. The difference, however, was not statistically significant.
Table 4.5: Drinking behaviour and petrol sniffing, ex Gordon Symons "male dependents" and non-treatment males, Maningrida

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>ex-GSC clients (%)</th>
<th>non-treatment group (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N=35)</td>
<td>(N=36)</td>
</tr>
<tr>
<td>Drinking Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non</td>
<td>8.6</td>
<td>11.1</td>
</tr>
<tr>
<td>Moderate</td>
<td>45.7</td>
<td>33.3</td>
</tr>
<tr>
<td>Heavy</td>
<td>42.9</td>
<td>55.6</td>
</tr>
<tr>
<td>Not stated</td>
<td>2.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Total</td>
<td>100.1</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Chi-square = 1.37255; d.f = 2; p = .5034

<table>
<thead>
<tr>
<th>Behaviour</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Petrol Sniffing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non</td>
<td>40.0</td>
<td>83.3</td>
</tr>
<tr>
<td>Occasional</td>
<td>42.9</td>
<td>13.9</td>
</tr>
<tr>
<td>Regular</td>
<td>17.1</td>
<td>2.8</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Chi-square = 14.37838; d.f = 2; p = .0008

When the two groups were compared with respect to petrol sniffing, former GSC clients were more likely to be current occasional or regular sniffers than non-treatment males - significantly so, in statistical terms. Sixty per cent of ex-clients were current sniffers compared with only 16.7 per cent of non-treatment males. The remaining 40 per cent of ex-clients were non-sniffers whose current abstinence may, of course, have been partly or largely a result of attendance at GSC.

Angurugu

The data collection procedure used at Angurugu followed that described above for Maningrida. In this case, the 'treatment' group of 21 males was compared with a 'non-treatment' group of 46 males.

Two-thirds of the ex-GSC clients had been referred on account of either petrol sniffing or sniffing and drinking; the remaining one-third, as Table 4.6 shows, were referred for alcohol.
Table 4.6: Male Dependent clients from Angurugu, by substance

<table>
<thead>
<tr>
<th>Substance</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>7</td>
<td>33.3</td>
</tr>
<tr>
<td>Petrol</td>
<td>11</td>
<td>52.4</td>
</tr>
<tr>
<td>Alcohol and petrol</td>
<td>3</td>
<td>14.3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>21</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Almost all referrals to the course - 16 out of the 18 for which this information is recorded - were referred through the criminal justice system. The remaining two cases involved hospital referrals of petrol sniffers.

Clients referred for petrol-sniffing or sniffing plus alcohol tended to be younger than those referred for alcohol problems alone. Petrol-sniffers had a mean age of 19.6 years, those admitted for petrol and alcohol 20.7 years, and those referred for alcohol problems, 30.3 years. Petrol-sniffing clients, unlike alcohol-related clients, also tended to be repeating clients. None of the clients referred for alcohol alone had attended more than one course, whereas seven of the eleven petrol-sniffing clients had attended more than one; one client had attended four courses, and another, five.

Table 4.7 compares ex-GSC clients with the non-treatment male group with respect to drinking and petrol-sniffing respectively. In the case of drinking status, the differences between the two groups are small and non-significant. Just over half of the ex-clients were described as non-drinkers, compared with 45.5 per cent of the non-treatment group. Among ex-clients, 17.6 per cent were heavy drinkers, compared with 20.5 per cent among the non-treatment group. (If ex-clients admitted for petrol-sniffing alone are excluded from the comparison, the proportion of ex-clients who were labelled as heavy drinkers is higher than in the non-treatment group (30.0 per cent, compared with 20.5 per cent among the non-treatment group); the difference, however, is still not significant.)
Table 4.7: Drinking behaviour and petrol sniffing, ex Gordon Symons "male dependents" and non-treatment males, Angurugu

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Ex-GSC clients (%)</th>
<th>Non-treatment group (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking Status</td>
<td>(N=17)*</td>
<td>(N=44)*</td>
</tr>
<tr>
<td>Non</td>
<td>52.9</td>
<td>45.5</td>
</tr>
<tr>
<td>Moderate</td>
<td>29.4</td>
<td>34.1</td>
</tr>
<tr>
<td>Heavy</td>
<td>17.6</td>
<td>20.5</td>
</tr>
<tr>
<td>Total</td>
<td>99.9</td>
<td>100.1</td>
</tr>
</tbody>
</table>

*Data missing for 4 ex-clients and 2 non-treatment males
Chi-square=0.27559; d.f.=2; p=.8713

<table>
<thead>
<tr>
<th>Petrol sniffing</th>
<th>(N=19)**</th>
<th>(N=43)**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non</td>
<td>68.4</td>
<td>93.0</td>
</tr>
<tr>
<td>Occasional</td>
<td>10.5</td>
<td>0.0</td>
</tr>
<tr>
<td>Regular</td>
<td>21.1</td>
<td>7.0</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

** Data missing for 2 ex-clients and 3 non-treatment males.
Chi-square= 7.77181; d.f. = 2; p=.0205

Amongst ex-clients, a little over two-thirds (68.4 per cent) were not petrol sniffers, compared with 93 per cent of non-treatment males. The remaining one-third of former clients continued to sniff.

As already noted, ex-clients who had been admitted for sniffing were drawn from a younger age range than alcohol-related clients and the population at large. All of the ex-petrol sniffing clients were aged (in 1989, the yardstick year) between 17 and 25, whereas ages in the non-treatment sample ranged up to 65 years. In order to remove a possible age-effect from the comparison, a second comparison was made, between ex-clients who had been admitted for petrol-sniffing or petrol-plus-alcohol on the one hand and, on the other, non-treatment males, with those aged 25 or over excluded. The results are shown in Table 4.8.
Table 4.8: Petrol sniffing status, Angurugu male sample, persons aged 16 to 24 years only

<table>
<thead>
<tr>
<th>Sniffing status</th>
<th>Dependents group (%)</th>
<th>Non-treatment group (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 12*</td>
<td>N = 14*</td>
</tr>
<tr>
<td>Non-sniffer</td>
<td>50.0</td>
<td>78.6</td>
</tr>
<tr>
<td>Occasional</td>
<td>16.7</td>
<td>0.0</td>
</tr>
<tr>
<td>Heavy</td>
<td>33.3</td>
<td>21.4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

* Data missing for 2 Dependents and 1 from non-treatment group

Chi square = 3.48019, df = 2, p = .1755

Half of the 12 ex-clients, compared with a little over three-quarters of the non-treatment group, were non-sniffers, while four ex-clients (33.3 per cent) were categorised as heavy sniffers. Three of these four young men were in fact either in Royal Darwin Hospital at the time this fieldwork was being conducted, or had been released immediately prior to it. They provide particularly sad testimony of the limitations of the GSC residential program as a response to chronic petrol-sniffing. All were in hospital in connection with serious, and possibly irreversible, petrol-sniffing induced injury. One of the three had attended four Dependents' courses over the previous two years, another had attended two, and the third had attended five.

Discussion

With respect to alcohol, the findings reported above involve numbers too small to warrant drawing conclusions. With respect to petrol-sniffing, I suggest, they give cause to doubt the adequacy of the Gordon Symons Residential Program for Dependent Males as a response to the problem of sniffing, although this should not imply outright condemnation or dismissal of the program. As in the preceding chapter, attention is drawn to Miller's (1990) observation that outcomes following treatment owe more to events and conditions in the person's life following treatment than to the treatment itself. Discussions with the Aboriginal Health Workers in the course of this research lend salience to this observation. In many cases, when I asked whether a particular person was a petrol sniffer, I was told "No, that person doesn't sniff now, but he used to", or words to that effect. When I enquired as to why the person had stopped sniffing, I was usually told that he or she had found a job, entered into a long term relationship, become pregnant or experienced some other life-event that evidently provided him or her with a subjectively valid reason to change their behaviour. Brady (1989a) found similar reasons to have played a major part in the decisions of petrol sniffers at Maningrida to quit sniffing.
The findings do, however, indicate that there is little justification for continuing to cling to this model of intervention as an article of faith. There is a need to ask why outcomes are not more apparently beneficial, to identify counter-productive elements in the approach and rectify them, and to build on strengths. Among questions warranting answers are the following:

- Is the program itself sufficiently attuned to the real needs and perceptions of the young men who form most of the clients?

- Is an intervention model which is based largely on the constructive exploitation of crisis in the lives of clients appropriate in the case of young men who may not regard a court appearance in a non-Aboriginal court for a petrol snifffing related offence as a significant crisis at all?

- Does the extension of an intervention model developed originally to deal with alcohol misuse amongst non-Aboriginal people provide an adequate basis for dealing with petrol sniffer among Aboriginal youths?

- Does the program, despite its apparent ineffectiveness as an antidote to petrol sniffing, offer other benefits: education, for instance, that might prove valuable as and when a person decides to try and change their way of using recreational drugs? Is it, if nothing else, a less unproductive response to a difficult problem than a jail sentence?

As of March 1990, as pointed out earlier, the GCS has abandoned the program structure which gave rise to the Male Dependents Program here examined. The changes that have taken place do not, however, invalidate the general tenor of these criticisms and questions, since the same Dependents Program has been retained in the new program structure.

**SUMMARY AND CONCLUSIONS**

Between 1987 and 1989, the GSC Dependent Male Program catered for 475 admissions, 68.1 per cent of which were for alcohol abuse, and most of the remainder for petrol sniffing. Some 80 per cent of admissions for which relevant data are available were a result of referrals through the court system, in marked contrast to the Catholic Missions-based referral system serving the Daly River Family Program. The 475 admissions were accounted for by 331 clients, a third of whom attended more than one course.

Treatment and non-treatment samples were obtained for both Maningrida and Angurugu. In the Maningrida sample, those who had attended GSC courses were slightly less likely to be heavy drinkers than those who had not attended courses. The difference however was not statistically significant. Former GSC clients were significantly more likely to be current petrol sniffers than males who had not attended any courses,
although 40 per cent of former clients were categorised as 'non-sniffers'.

In the Angurugu sample, little difference was recorded in drinking behaviour between ex-clients and the non-treatment sample. As at Maningrida, however, ex-clients were significantly more likely than non-clients to be petrol sniffers, although once again, a majority of ex-clients were non-sniffers.

It was suggested that the data cast doubts on the adequacy of the GSC Dependent Males Program as a response to petrol-sniffing by Aboriginal youths. This may be because the Program was not sufficiently attuned to client needs and perceptions, and/or because it drew on an intervention model based largely on crisis intervention, for another substance (alcohol) in a different cultural context. At the same time, attendance at the course may have other beneficial consequences, such as educational content which might be utilised at later stages of clients' lives.
CHAPTER FIVE

NON-RESIDENTIAL RECOVERY PROGRAMS: GORDON SYMONS CENTRE
EDUCATION-RECOVERY PROGRAMS FOR WOMEN

Female Codependents' Program

Between 1987 and 1989, Gordon Symons Centre offered a non-
residential Codependents' Program for women. Like the
residential program for Dependent Males, it ran for four weeks
and, like the Daly River Family Program, utilised a
Codependency model. The program's aims, as stated by CAAPS,
were:

1. To provide an effective counselling and education-
recovery program for tribally oriented Aboriginal people
suffering from the substance abuse/misuse of someone in
their family, in such a way that it had led to serious
personal, family and community dysfunction.

2. To help individuals and family groups come to recognise
substance abuse/misuse as a family problem and
demonstrate positive ways of arresting the deterioration
in lifestyle and re-establishing a quality of life.

3. To assist non-drinking and non-drug using family members
in gaining skills to intervene in the substance-
abuse/misuse life-style.

4. To enable clients to re-establish for themselves and
their children a quality of life, whether or not the
dependent person(s) concerned continued to drink or
relapse.

As with the residential programs, the course involved
lectures, video presentations, one-to-one counselling sessions
and group discussions, including Al Anon style meetings.

The Codependents' Program was the responsibility of two full-
time and two part-time staff, whose roles were as follows:

- Program co-ordinator;
- Assistant co-ordinator;
- Counsellor/Facilitator (part-time);
- Counsellor/Facilitator (part-time).

Both Counsellor/Facilitator positions were filled by
Aboriginal women.

(Although it lies outside the scope of the present review, it
may be useful to describe the changes in staff structure that
have occurred following introduction of the Family Program in
March 1990. The Codependents' Co-ordinator and Assistant-Co-
ordinator also perform the roles of Counsellor/Facilitators,
while the two part-time positions have been replaced by one
full-time Women's Dependents' Counsellor/Facilitator. The
positions of Hostel Manager, Assistant Manager and part-time
Domestic Advisor, which were formerly associated with the Male
Dependents' Program (as shown above) are now attached to the Family Program.

**PATTERNS OF CLIENT CONTACT**

Records kept by the centre contain little information about admissions to this program. No indicators are available, for example, of sources of referral, although it must be assumed that decisions to enter Dependents' courses are largely self-referrals. Nor were records kept to indicate the type of substance abuse which precipitated the decision to attend the program. Information is available concerning the numbers of admissions, and the communities from which they came.

The total number of admissions over the three year period was 227, with 59 in 1987, 80 in 1988 and 87 in 1989 (no year is recorded for one admission). The communities from which these admissions were drawn are shown in Table 5.1.

**Table 5.1: Admissions to Gordon Symons Female Dependents' program, 1987-1989, according to source communities**

<table>
<thead>
<tr>
<th>Community</th>
<th>Number</th>
<th>Per cent of admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maningrida</td>
<td>55</td>
<td>25.3</td>
</tr>
<tr>
<td>Darwin</td>
<td>25</td>
<td>11.5</td>
</tr>
<tr>
<td>Bathurst Is.</td>
<td>23</td>
<td>10.6</td>
</tr>
<tr>
<td>Alice Springs</td>
<td>18</td>
<td>8.3</td>
</tr>
<tr>
<td>Port Keats</td>
<td>17</td>
<td>7.8</td>
</tr>
<tr>
<td>Imanpa</td>
<td>10</td>
<td>4.6</td>
</tr>
<tr>
<td>Umbakumba</td>
<td>7</td>
<td>3.2</td>
</tr>
<tr>
<td>Goulburn Is.</td>
<td>7</td>
<td>3.2</td>
</tr>
<tr>
<td>Oenpelli</td>
<td>5</td>
<td>2.3</td>
</tr>
<tr>
<td>Milingimbi</td>
<td>5</td>
<td>2.3</td>
</tr>
<tr>
<td>Lajamanu</td>
<td>5</td>
<td>2.3</td>
</tr>
<tr>
<td>Wave Hill</td>
<td>4</td>
<td>1.8</td>
</tr>
<tr>
<td>Jabiru</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td>Pularumpi</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td>Queensland</td>
<td>15</td>
<td>6.9</td>
</tr>
<tr>
<td>Western Australia</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Other NT</td>
<td>14</td>
<td>6.5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>217*</td>
<td>99.9</td>
</tr>
</tbody>
</table>

* Data missing for 10 admissions.

These figures appear to indicate admissions rather than numbers completing courses. For example, GSC records indicate that the 55 admissions from Maningrida were accounted for by 32 clients. Records held by the Family Worker at Maningrida, however, list only 16 clients as having actually completed one or more courses. A report prepared by CAAPS for the financial year 1988/89 stated that the total number of admissions to the
GSC Codependents Program over that period was 57 — a number difficult to reconcile with GSC's own admissions data, referred to above.

According to GSC records, the 227 admissions were accounted for by 171 clients, 137 of whom (80.1 per cent) attended one course only. Another 21 attended two courses, 12 attended three courses, and one client took part in no fewer than six courses. Clients ranged in age from 16 to 62 years, with a mean age of 34.5 years and a median of 33 years.

OUTCOMES

Assessment of the effectiveness of the GSC Codependents' Program is even more difficult than it is in the case of other CAAPS programs, largely because GSC's own records, as already indicated, contain little information that could be used either as baseline data or as outcome indicators. Unlike the Daly River Family Program, GSC did not prepare in-house evaluations at the end of each course. Indeed, the failure of Gordon Symons Centre to establish a record keeping system which could be used to monitor outcomes warrants criticism in its own right, and should be rectified in future. (I should add that staff at GSC readily conceded that the current record-keeping system is inadequate.)

There is no reason to doubt the claim that the Codependents' course has made a significant difference in a number of people's lives, but the weight to be attributed to such claims cannot be determined in the absence of proper documentation.

At Maningrida I attended a discussion presided over by the non-Aboriginal Family Worker, the Aboriginal couple who will shortly replace him, and nine women, all of whom had taken part in the GSC Codependents course. The meeting at which the discussions took place followed the format of their regular meetings, with women being encouraged by the family worker to "share their stories", and the meeting closing with all those present joining hands and saying the AA Serenity Prayer, first in English and then in Bararda.

On this occasion, the stories were about their experiences of the Codependents course. Nearly all of them expressed similar views. They found much of the course difficult to follow, primarily because of language difficulties. Consequently, they had not found the course particularly helpful in their own lives. (One woman, however, identified another factor which, perhaps, highlights the need for more rigorous screening. She remarked wryly that her failure to derive significant benefits from the course may have had something to do with her real motives for being there in the first place: she had just wanted to get away to Darwin for a few weeks, so that she could do a little shopping.)

Gordon Symons non-residential Female Dependents' Program

Late in 1989, the Gordon Symons Centre conducted one non-residential program for dependent women. The program was attended by nine women from various communities (some of whom
had earlier attended one or more Codependents' Programs). Because the number of admissions is so small, no further attempt is made here to analyse the associated data.

SUMMARY AND CONCLUSION

According to GSC records, between 1987 and 1989 the GSC non-residential Codependents Program for women had some 227 admissions, which were accounted for by 171 clients. It is not clear how many people admitted to the courses actually completed them. Indeed, a striking feature of the program is the paucity of client records, in the absence of which it is difficult to see how either the program organisers at the time, or an external evaluator in the present, could reach an informed judgement about the effectiveness of the program. A discussion with one group of former clients at Maningrida revealed difficulties on the part of the women concerned in understanding the course content. To what extent this problem was shared by other clients, and to what extent it was offset by other, more beneficial outcomes, is not clear.

Taken together, these findings fail to provide a strong indication of either success or failure on the part of the Codependents Program.
CHAPTER SIX

CAAPS WORKERS IN THE COMMUNITY: THE ROLE OF FAMILY WORKERS, FIELD WORKERS, CO-ORDINATORS

Complementing CAAPS' residential 'awareness and recovery' programs are a number of community-based field workers, usually called family workers and sometimes, more recently, co-ordinators. In this chapter I shall use the term 'field worker' as a general label, but shall also use 'family worker' and 'co-ordinator' where specific positions are designated in one or other of these terms. All three affiliated Church organisations have appointed field workers. Unlike the residential programs, the activities of field workers are not governed by a ready-made model of intervention; in fact, it is probably fair to say that there are as many models of CAAPS field work as there are field workers. To some extent this is inevitable, as the people concerned bring their own personalities and skills to bear in unique settings, and attempt to devise effective intervention strategies in an area where maps and guidebooks are few.

Field workers do, however, share a few common characteristics: all have both a preventative as well as an after-care function; all are working in the field, rather than an institution, and all work to a greater or lesser degree with a 'family sickness' model of substance misuse. Beyond that, diversity prevails. Some are based in Darwin, others in communities; some focus on 'codependents', others on schools, others on petrol sniffing youths; some structure their activities around AA and Al Anon meetings, others do not.

In the course of this review, I visited and spent several days with field workers at Maningrida, Angurugu and Port Keats. I also interviewed the Darwin Family Worker. I did not have an opportunity to visit the field workers at Nguui (Bathurst Island) or Pularumpi (Garden Point). The observations and comments that follow are based, therefore, on an incomplete coverage; I hope, nonetheless, that they identify important points and include constructive suggestions.

Darwin Family Worker

The Darwin Family Worker position was created in 1985 and operates under the Uniting Church-affiliated Aboriginal Resource and Development Services Inc. (ARDS). Currently, it is filled by a non-Aboriginal woman who works mainly with women ('codependents') referred to her by various agencies in Darwin, including the police, hospital, Department of Correctional Services, and welfare workers. On the one hand, she attempts to assist the women in their dealings with these and other organisations; she also tries to persuade those women whom she thinks would benefit to seek treatment through the Codependents' Program. The present Family Worker does not see her role as that of a case-worker, providing regular counselling sessions, but rather as a support and linking role. This is not surprising, given that her background and qualifications lie in teaching (including teaching in Aboriginal communities) rather than in counselling.
According to a report prepared by CAAPS for the NT Drug and Alcohol Bureau, in 1988/89 the Darwin Family Worker recorded some 1,168 contacts with Aboriginal people with alcohol-related problems, plus another 62 contacts with petrol-sniffers. The contacts were made up as shown in Table 6.1.

Table 6.1: Client contacts reported for Darwin Family Worker, 1988/89.

<table>
<thead>
<tr>
<th>Subjects of Contact</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female codependents residing permanently or for extended period in Darwin/Palmerston area</td>
<td>597</td>
</tr>
<tr>
<td>Female codependents temporarily resident in Darwin</td>
<td>144</td>
</tr>
<tr>
<td>Female alcohol dependents in Darwin, temporarily or permanently</td>
<td>219</td>
</tr>
<tr>
<td>Male alcohol dependents in Darwin, temporarily or permanently</td>
<td>195</td>
</tr>
<tr>
<td>Male alcohol dependents in Darwin prisons</td>
<td>13</td>
</tr>
<tr>
<td>Male and female petrol sniffers in Darwin</td>
<td>62</td>
</tr>
<tr>
<td>Clients in communities outside Darwin:</td>
<td></td>
</tr>
<tr>
<td>codependents</td>
<td>17</td>
</tr>
<tr>
<td>female dependents</td>
<td>1</td>
</tr>
<tr>
<td>male dependents</td>
<td>5</td>
</tr>
<tr>
<td>Other professional persons (in social work, housing correctional services, etc.)</td>
<td>77</td>
</tr>
</tbody>
</table>

These figures tell us nothing about the numbers of clients involved in these contacts; how many of the 597 contacts recorded with codependents living in Darwin and Palmerston, for example, involved repeated contacts with the same persons? Moreover, the same report indicated that as a result of all these contacts, only 6 people were admitted to GSC programs, and 2 of these did not complete the programs. Finally, the Family Worker's contact sheets, which I examined, revealed only 75 contacts in the 1988/89 financial year.

To some extent, these discrepancies are a product of different modes of recording client-contact data, which in turn are generated by the demands of funding and other bodies. Some of the data above were recorded on contact-sheets, others in the Family Worker's diary. Nonetheless, the anomalies raise serious questions about the nature of data that should be collected in the course of program monitoring, and the appropriate ways of gathering and recording such data. Similar questions, it should be added, apply also to other CAAPS family worker positions.
Maningrida Family Worker

The position of Family Worker at Maningrida has been occupied from the outset in 1986 by a non-Aboriginal male who, like the Darwin Family Worker, has no formal training in counselling or in the addictions. For the first 12 to 18 months in the position, by his own account, he concentrated on providing follow-up (or 'aftercare') for young men who had attended the Gordon Symons Dependents' Course as petrol sniffer. He attempted to establish regular contact with the youths, taking them on weekly fishing outings and trying at the same time to encourage them to discuss and reflect on their problems.

Another task initially set for him was that of establishing AA meetings at Maningrida; however, he states that there was not enough interest for this to occur. At the same time, some Maningrida women travelled to Darwin to attend the non-residential Codependents' Course, as a result of which the Family Worker began to conduct weekly meetings at which he would discuss the course and reinforce the points made in it.

Towards the end of 1989, as the Gordon Symons Centre geared up for the change to a residential 'Family Program', the Maningrida Family Worker's role was also redefined to be more family-focused. Consequently, he now says, he has little contact with the petrol sniffer (most of whom are not only young, but single) and works most of the time with 'codependents'.

The Family Worker has one additional role: for some time now he has been helping to train an Aboriginal couple resident in Maningrida to take his place around the end of 1990.

Brady (1989a), in a study of petrol sniffing at Maningrida, assessed the Family Worker's efforts as "cumulative and long-term". She saw the program as valuable, in part because it existed alongside a recreation program - unconnected with CAAPS - designed to appeal to a broader spectrum of young people. Without such a program, Brady suggests, the Family Worker's activities might have had the inadvertent effect of focusing attention exclusively on petrol sniffers - which might even encourage the practice. In the Maningrida context, however, Brady described the Family Worker as serving "as a support to individuals who abstain from petrol and a caring reminder to those who are still using" (Brady, 1989a, p.50).

As was shown in Chapter Four, attendance by petrol sniffing youths at the GSC Residential Program did not appear to lead to a cessation of petrol sniffing. Sixty per cent of ex-GSC clients in the Maningrida sample described in Chapter Four were still sniffing, 17 per cent regularly. This compared with only 2.8 per cent of regular sniffers among the non-treatment "males" (see Table 4.6 in Chapter Four, above).

Does this indicate that the Residential Program, or the Family Worker or both, have failed? No, but it does indicate (a) that the outcomes of intervention at these two levels, even
when combined, are not impressive, and (b) that there is a need to explore more effective strategies.

Some of the Family Worker's own reflections on his experiences are relevant here. Although, he says, Aboriginal people recognise substance abuse as a family problem, he as a non-Aboriginal outsider describes himself as having had little success in establishing links with sniffers' families, as distinct with the sniffers themselves. Indeed, he says, some families were actively hostile to his having anything to do with the clients once they had come out of GSC, and even if they were not hostile, they did not regard their kinship links with the boys as constituting grounds for involvement in addressing the latters' sniffing problems.

In another major study, Brady (1989b) draws attention to the high value placed in Aboriginal culture upon personal autonomy, and the limits that this imposes on any one person's rights to tell another person what to do or not do. She also explores an important distinction in Aboriginal culture between public and private wrongs. Public wrongs - which are usually associated with customary law - involve the violation of binding norms; that is, they are issues of right and wrong which demand and often entail clearly defined sanctions. Petrol sniffing and many of the misdemeanours to which it gives rise, however, fall into the category of private wrongs - that is, they belong to the realm of disturbances and disputes. In this realm, a sniffer's kinsman is more likely to defend or deny the sniffer's wrongdoing than to collude with non-kinsmen in any intervention.

The presence of these and other cultural factors raises serious questions about the extent to which a "family work" model of intervention, designed and generally practised by non-Aboriginal people and based on European family norms, can be effectively utilised in Aboriginal communities. This is not to suggest that Aboriginal kinship systems do not constitute a potentially fruitful basis for intervention, but rather that a lot more thought needs to be given to how they might be used than appears to have been given to date within the CAAPS group of programs. This issue is explored further below.

Wadeye (Port Keats) Co-ordinator

The appointment of field workers by Catholic Missions' Alcohol Awareness and Family Recovery is of more recent origin, with appointments being made at Pularumpi and Wadeye in 1988, and at Bathurst Island in 1989.

In each case, their duties are defined as:

- fostering AA and Al-Anon groups;
- counselling and supporting ex-clients of the Daly River Family Program;
- guiding those who might wish to attend future courses at Daly River;
- maintaining links with local health centre staff regarding patients with alcohol-related problems;
being a resource-person on chemical dependency within the community;
if possible, arranging a drop-in centre.

As part of this review, I spent three days in Port Keats, some of the time with the field worker there, whose position is now designated as that of a 'Co-ordinator'. The Co-ordinator has organised his activities around a program of regular meetings on four evenings a week: Monday, Al Anon; Tuesday, AA; Wednesday, Women's Alcohol Awareness Group, and Thursday, Men's Alcohol Awareness Group. These constitute, in effect, a follow-up or aftercare program linked to the Daly River Family Program. The men's and women's Awareness Group sessions are attended by virtually the same people as attend the Al Anon and AA sessions; the main difference is that the Awareness Group meetings do not follow the procedures prescribed for AA and Al Anon meetings.

Normally, Awareness Group sessions begin with a 20 minute relaxation session, after which one of the CAAPS videos is shown, and a discussion is held. For AA and Al Anon meetings, the Twelve Steps have been translated into the Murinpatha language and also recorded on cassette. (The Port Keats Co-ordinator, alone of the non-Aboriginal staff employed by CAAPS whom I met in the course of the review, has made a serious effort to learn a local Aboriginal language.)

As well as providing an aftercare program, he arranges for referrals to Daly River and maintains contact with the local Health Centre.

Another important aspect of the Co-ordinator's work is that of identifying and helping to prepare local Aboriginal people to take over his own functions in future: in particular, chairing AA and Al Anon meetings, convening Awareness groups and liaising with agencies both in and beyond the community. To this end, he works closely with a network of women and with two men, all of whom have attended at least one course at Daly River Five Mile. The underlying shift in emphasis implied here, from one in which the field worker is the 'frontline' worker to one in which he or she is, rather, a resource person for local Aboriginal fieldworkers, is in part a product of the continuing assessment by CAAPS of the role of field workers, and in part a response to requirements imposed by the newly formed Aboriginal and Torres Strait Islanders Commission (ATSIC), which has made it clear that future funding will be contingent upon high levels of Aboriginal involvement in programs.

In contrast with the field worker at Maningrida, the Port Keats Co-ordinator works closely within an AA/Al Anon structure, although neither the AA nor Al Anon Groups at Port Keats are formally affiliated with the larger AA organisation. There seems little doubt that the Al Anon framework, and the concepts of codependency associated with it, have given strength to some women at Port Keats in their continuing efforts to cope with alcohol abuse in their families. At the same time, the style of work which I observed at Port Keats entails a number of difficulties. Firstly, as was the case in
Maningrida, there is no evidence of the field worker having been able to work with Aboriginal families, either in the form of nuclear households or extended kin groups. The Port Keats Co-ordinator, like his counterpart at Maningrida, works with a few individual women and a few individual men.

It is not at all clear that the AA/Al Anon framework in fact provides a basis for intervention with Aboriginal families, at least in the hands of non-Aboriginal people. It may be that, in the hands of Aboriginal people who obviously have a deep understanding of their own kinship systems, the AA/Al Anon framework can be fruitfully adapted; it is less easy to envisage non-Aboriginal people being able to do this.

Secondly, like the Maningrida Family Worker, the Port Keats Co-ordinator appears to have no conceptual or theoretical framework, or even a set of well thought out guidelines, for building links with other groups in the community. Earlier, in Chapter Two, I criticised the CAAPS model for its failure at a conceptual level to identify linkages between its chosen sphere of action - the family - and other institutions including community councils. The practical consequences of this shortcoming are nowhere more apparent than in some of the problems confronted by field workers.

Both the Port Keats and the Maningrida field workers have established some linkages with other groups in the community. The Port Keats Co-ordinator, for instance, receives referrals from the local health centre, but neither worker has established strong linkages at the community council level. This, together with their status as non-Aboriginal outsiders, leaves both of them to a considerable degree isolated from mainstream community life. In Port Keats especially, alcohol is a highly political issue, with polarisation about alcohol-related issues forming one of the main structural elements in local political life. Under these circumstances, it would be difficult enough for any person, particularly a non-Aboriginal person, to articulate an effective and acceptable model of community-based action with regard to substance abuse. The task is made even more difficult, however, by reliance upon an intervention model derived in a context of European systems, and having little to say about intervention beyond the level of the household.

The degree of isolation which, I believe, both the Maningrida and Port Keats field workers have experienced in their work has been compounded by isolation from the wider society. The CAAPS organisation, mainly through its Training Unit, attempts to provide regular in-service training for field workers, which entails the latter coming into Darwin periodically. It may be that this is all that CAAPS can be expected to achieve with its present limited resources. However, community based workers in Aboriginal communities - whether they be family workers or other community workers, government or non-government - must be supported by an adequate backup system which provides not only in-service training, but also regular recreational breaks from the "goldfish bowl" environment of many Aboriginal communities.
In short, my observations of the field workers at Maningrida and Port Keats suggest that, despite the differences in style and approach between the two workers, as well as differences between the communities themselves, the workers are hampered by a number of key deficiencies in the ways that the roles have been devised. These deficiencies have to do with the intervention model which provides the main set of "tools", a dearth of back-up support and possibly, lack of basic training in cross-cultural counselling and addictive behaviour.

**Anglicare's Family Worker in South West Arnhem Land**

Since 1984, the Anglican Diocese has maintained two field worker positions, one whose field of responsibility is labelled sometimes as South West Arnhem Land, and sometimes as Western Arnhem Land. The position covers Oenpelli, Jabiru and the offshore communities of Goulburn and Croker Islands. The other was associated, until recently, with South East Arnhem Land (i.e., Nhulunbuy, Umbakumba, Angurugu, Numbulwar and Ngukurr). Until 1989, both field workers were based in Darwin, from where they made regular visits to their respective groups of communities. In that year, the non-Aboriginal male field worker who had been servicing SE Arnhem Land resigned, and the position was subsequently modified along more genuinely community-based lines, which are described in a later section of this chapter.

The 'South West Arnhem Land' Family Worker position, however, continues to be filled by a non-Aboriginal man based in Darwin who travels each month to the communities listed above.

Both in his background and approach, the South West Arnhem Land Family Worker brings yet more variation to the field work theme. He does not have formal training in the addictions field, although a background and training in probation and youth work have given him extensive experience with substance-abuse problems in a variety of settings.

His approach takes three main forms. Firstly, in the communities he has formed links with schools, through which he offers preventative educational services. Secondly, he has endeavoured to make himself available to both individuals and groups in the communities, establishing links and providing counselling if appropriate, or just a foundation for later interventions. Finally, in Darwin he maintains contact with the Royal Darwin Hospital, Bagot Aboriginal Community, Malak House, prisons and other agencies and organisations. Through these he learns of Aboriginal people from the communities in his area who have encountered alcohol-related problems. He then attempts to contact these people, establish a relationship with them and, so far as he is able, help them attain a better lifestyle.

Some of these people, he says, are drinkers or sniffers, others members of drinkers' families ('codependents'). Some, he has referred to Gordon Symons residential or non-residential programs, but only if they wished to attend. Residential treatment for those not motivated he considers ineffective. The field worker has also established links with
other groups and organisations such as the Gagadju Association, community councils, police, health clinics, outstation resource centres and licensed clubs.

The drawbacks attendant upon working with people and families in communities, while being based in Darwin, are readily apparent. Nonetheless, the South West Arnhem Land Family Worker argues that his mode of operation offers an important compensatory advantage, in that it enables him to establish and/or maintain contact with people at times when they are particularly likely to need help—when they are in hospital or jail, for example—and also to maintain those same links once clients are back in their communities, or even if they gravitate to one of the town camps around Darwin.

The constant demands by funding agencies for statistical indicators of activity on the part of grant recipients has led, in the case of the South West Arnhem Land Family Worker, to the production of a bemusing pile of numbers, similar to those produced on behalf of the Darwin Family Worker. Thus, for example, a report prepared by CAAPS claims that in 1988/89 the South West Arnhem Land Family Worker chalked up 1,535 "individual contacts", 721 "individual counselling sessions" and 94 contacts with groups, total attendance at which numbered 429 people.

This sort of number gathering, of course, tells us little of value about the field worker's activities. Of more relevance, I suggest, is the field worker's own modest assessment of the outcome of the hours spent travelling to communities, arranging appointments with individuals, couples and groups—some of which took place while others, for a host of reasons ranging from unexpected deaths to "bad livers", did not eventuate. In a recent Quarterly Report, he states that, while the level of activity was higher than usual, the "ultimate measuring stick of success—figures of 'recovered' clients—is still very low and slow and relapse quite common". But, he adds, "good foundations (with young people) are being laid and if built on patiently, will yield a desired result".

This brings us to the heart of the issue. To what extent can a non-Aboriginal man, who is not a resident of any of the communities concerned, really help to lead young Aboriginal people toward a path not strewn with the consequences of substance abuse? I would not presume, on the basis of these limited observations, to answer that question. In any case, the policy of 'Aboriginalising' its services, to which Anglicare is committed, reduces the immediate relevance of the question. At Angurugu, on Groote Eylandt, a very different model is being pioneered.

**Family Work at Angurugu**

A non-Aboriginal couple who have been resident at Angurugu (Groote Eylandt) since 1970 now share the position formerly identified as the South East Arnhem Land Family Worker position, and use it to serve as resource and support persons for two Aboriginal men. One of the latter is a leader of one
of the main families in Angurugu, and combines traditional authority, a powerful personality, and a lifetime of abstinence from alcohol or other drugs.

It is these qualities which he is attempting to use in combatting petrol sniffing among youths in Angurugu. He talks of "starting in the middle of the disease", working in the first instance only with members of his own family over whom he can exercise authority according to his culture - his own children and grandchildren, and his sisters' children.

To date, his activities have taken two forms. The one which has attracted most attention was a venture early in 1990 involving the removal of 16 youths, all sniffers, to nearby Bickerton Island. The youths were drawn from two sources: about half were members of his own family, the remainder belonged to his extended kin group. The venture lasted about 8 weeks, although not all of the youths stayed for the duration. The main purpose of the camp was to re-introduce the youths to traditional skills, such as hunting and fishing, and to traditional values, including telling stories from the dreaming.

The other main activity is more ill-defined: it involves the Aboriginal worker demonstrating by example the family responsibilities of a senior clan member. He talks to members of his family, listens to them, and tries to help them become stronger 'inside' (as he puts it), so that they will be less susceptible to the appeals of grog and petrol-sniffing. In doing so, he hopes not only to help youths in his own family, but also to provide an example for senior members of other families, so that they too can start to provide the care and concern which he sees as being needed in answer to these problems. Revitalised family roles, he believes, hold the key to dealing with substance abuse in general, and petrol sniffing in particular.

The other Aboriginal family worker is the younger brother of the first and, interestingly, works quite differently, providing something akin to one-to-one counselling.

Crucial to this whole system of providing support are the roles of the non-Aboriginal couple; they have to be supportive, while not attempting to exercise control. This they endeavour to do (successfully, in my view) mainly by frequent informal meetings, usually in their own home, with the two Aboriginal workers and others who may be interested. Some of these meetings are instructional, with CAAPS videos being shown. At other times, they are informal discussion sessions, in which the Aboriginal workers may raise problems or simply explore ideas. The intention of the program is that the non-Aboriginal couple will continue in this capacity until - and only until - the two Aboriginal workers consider that they can carry on independently.

The non-Aboriginal couple draw and share a single salary, paid under a curious arrangement through the Church Missionary Society. Neither of the Aboriginal field workers receives a salary, but continue to draw unemployment benefits. Is this
discriminatory? The arguments for construing it as so are obvious. Against these, however, the following points must be weighed. Both workers have reportedly expressed a wish to work on this basis, partly because they avoid the accountability entailed in drawing a salary. In any case, Angurugu is about to enter a Community Development Employment Scheme (CDEP), under which their roles will be recognised. Finally, under this system, as many family workers can be engaged as are available and willing to carry out the role.

The Angurugu scheme only commenced towards the end of 1989; it is, therefore, too early to assess its effectiveness. The incidence of petrol sniffing at Angurugu did in fact drop sharply in the first half of 1990, possibly as a result of Murabuda's Bickerton Island venture. However, at about the same time, residents of Angurugu were also exposed to a TV documentary in which the son of the then Council President was shown in hospital in Darwin, where he was seriously ill - and plainly seen to be seriously ill - as a result of petrol sniffing. There is little doubt that both events contributed to the fall-off in sniffing and it would probably be impossible to disentangle the respective influence of each.

In my view, however, the model being employed at Angurugu warrants close attention. This must not take the form of a naive romanticism on the part of non-Aboriginal people; the fact that Murabuda is a a proud and passionately-caring older man does not mean that he will inevitably succeed where others have failed. At the same time, the combination of such a man's efforts with a supportive role being played by other, possibly non-Aboriginal people may well offer a potentially more productive model than most of the variants of "Family Worker" that have been tried to date.

SUMMARY AND CONCLUSIONS

As has been pointed out more than once in this review, the effectiveness of treatment for substance misuse usually owes more to what happens to clients after their attendance at the program than to the contents of the program itself. This is especially salient in the case of substance misuse in Aboriginal communities, since residential programs such as the Daly River Family Program and Gordon Symons Centre cannot address conditions in the communities where the problems arose. For these reasons, the role of community-based field workers or family workers is crucial. They constitute the sole means through which CAAPS can intervene in daily life in communities.

The observations reported in this chapter lead, I suggest, to a number of conclusions. Firstly, all of the field workers whom I met are conscientious, hard-working people who have almost certainly helped some Aboriginal people in their struggles against the affects of substance misuse. They also have extensive and varied experience in working with Aboriginal people. Without wishing to belittle the value of such experience, and still less to over-emphasise formal training, I believe that field workers should receive more training in cross-cultural intervention, and in basic
counselling and referral, than is available through CAAPS own in-service training.

This observation should not be construed as a criticism of the CAAPS Training Unit, firstly because that unit has neither the funding nor other resources to provide training other than short, essentially in-service courses, and secondly, because the lack of suitable training in these areas is by no means a peculiar characteristic of CAAPS programs, but rather a problem affecting Aboriginal alcohol services throughout the Northern Territory as a whole. It is therefore recommended that attention be directed to meeting current deficiencies in the training of field workers.

Secondly, I question the extent to which the non-Aboriginal field workers, not withstanding their titles, really work with Aboriginal families. Those that I observed almost invariably worked with individuals. It may be that they have no option, but if that is the case, the claim to be intervening at the level of the family in the name of a 'family disease' model needs to be re-examined, since it may serve to disguise rather than guide the true nature of intervention.

Finally, the non-Aboriginal field workers with whom I spoke were to some degree isolated from mainstream community life. As acknowledged early in this review, the degree to which local Aboriginal community politics is often structured around passionately held positions regarding "grog" may sometimes make this inevitable. At the same time, I would argue that the basis upon which field workers currently conduct their activities equips them poorly for working in the wider community context.

These shortcomings are undoubtedly in part a product of the ad hoc, inadequate funding arrangements governing the various field worker positions. Insofar as the full potential of residential programs can only be realised if these programs are complemented by appropriate community based services, the CAAPS Field Worker/Family Worker Program should be recognised by funding agencies as an integral component of prevention and treatment, and funded accordingly.

At the same time, my observations have, I believe, identified other problems besides funding deficiencies, which can best be outlined if we consider the basic functions of a field worker. These, I suggest, are: firstly, to help people in communities who might benefit from attendance at residential programs by referring them to these programs; secondly, to provide follow-up support for ex-clients of residential programs; and thirdly, to address some of the factors in community life which give rise to substance abuse problems. (The capacity of field workers to meet this last requirement is, of course, limited; field workers can not conjure up meaningful occupational roles, etc. At the same time, in any community there are resources that can potentially be mobilised.)

Each of these functions should serve the broader goal of promoting the capacity of people, individually and collectively, to control their own use of substances - whether
by abstaining altogether or adopting non-harmful consumption practices.

In order to fulfil these functions, I suggest, a field worker will need to meet three requirements. Firstly, he or she will need a broad understanding of Aboriginal kinship systems. Secondly, he or she will need basic counselling and referral skills, and thirdly, the field worker will require skills in community work, community development, or some other effective strategy for working with groups and organisations beyond the level of clients and their immediate families.

If, in the light of these requirements, we look at the "family disease" model of substance misuse which constitutes the main intervention tool for field workers, we see that it fails to meet adequately any of the three requirements. Even in the CAAPS-oriented form propounded in the 1988 paper by Murdock and Coster, and elsewhere in writings by Gluck and Sigston, it does not provide an adequate understanding of Aboriginal kinship systems. Neither does it offer counselling and referral skills, other than the fairly rigid prescriptive practices embodied in AA and Al Anon, and techniques focussing on denial. Finally, it fails to provide an adequate strategy for community work. Indeed, as pointed out in Chapter Two above, CAAPS has tended to reject the notion of working at the broader community level.

It may be that elements of the "family disease" model can be usefully incorporated into an intervention strategy that does meet the requirements identified, but in any such incorporation, the model would need to be located within a framework grounded in Aboriginal cultural realities, instead of the present situation, where bits of these realities are grafted onto what is essentially a non-Aboriginal intervention model.

I therefore recommend that the intervention model and practices utilised by CAAPS field workers be revised with a view to grounding the model and practices more thoroughly in Aboriginal culture and meanings, particularly in matters relating to kinship and substance misuse.

I also recommend that attention be directed to meeting current deficiencies in the training of field workers, especially in the three areas itemised above, namely: Aboriginal kinship systems, basic counselling and referral skills, and community development skills.

As well as addressing issues concerning the content of intervention strategies, such a revision would also need to address the role of Aboriginal and non-Aboriginal people respectively in community based field work. In my view it is not appropriate for me as a non-Aboriginal person to make precise recommendations on how these roles should be allocated. I am more concerned to recommend that an appropriate process be put in place whereby these roles could be identified. I therefore recommend also that a process of consultation with Aboriginal people be undertaken, aimed not only at revising the content of field work intervention
approaches in the directions indicated above, but also at examining the respective roles of Aboriginal and non-Aboriginal people in substance abuse field work.

It is, I believe, appropriate to advance some suggested principles concerning the roles of Aboriginal and non-Aboriginal people. These are as follows: firstly, the primary field work role should be undertaken by Aboriginal people, compared with whom most non-Aboriginal workers, with their limited cultural awareness and communication skills, can be little more than shadow-boxers. Secondly, in the immediate future, Aboriginal people may not be willing or able to work at the community level - especially in those communities that are deeply divided over issues of alcohol abuse - without close continuing support from non-Aboriginal people. Where this is the case the need for support should be recognised and built into the model employed. It is partly for these reasons that the model of field work currently being pioneered at Anurugu might well provide, not a blueprint, but rather a starting point for more culturally relevant, effective modes of field work.
CHAPTER SEVEN

CONCLUSIONS: LOOKING BACK...AND AHEAD

The CAAPS group of services represents a genuine attempt by concerned individuals to adapt an essentially western model of intervention and use it to provide services which will help non-urbanised Aborigines to overcome one of the greatest scourges of their contemporary life - misuse of alcohol and other substances.

The chosen model was discussed critically in Chapter Two. It was shown to be one of several competing explanations for substance misuse, which consequently offered one of several approaches to prevention and treatment. In a context in which no one of these approaches can legitimately claim to be clearly superior to all others, I argued that it was not appropriate for either myself as researcher or for governments through their funding agencies to insist on adherence to a particular model. CAAPS's use of its preferred model was criticised, however, on three grounds: firstly, CAAPS has in my view been resistant to alternative ideas; secondly, in using concepts such as "dependency" and "co-dependency", CAAPS has given insufficient consideration to the meanings of these concepts within Aboriginal frames of reference. Finally, I argued that the CAAPS model, while claiming to address the total context of substance misuse, has in fact failed to develop a framework for working at community levels other than that of the family.

The review then turned to the CAAPS residential programs at Daly River Five Mile and the Gordon Symons Centre respectively. I examined the structure of the programs, patterns of admissions and client contact and also attempted to gauge the impact of the programs by drawing samples from three communities - Port Keats, Maningrida and Angurugu - and comparing ex-clients of CAAPS residential programs with others who had not attended any residential programs. (The comparisons between ex-clients and others in the three communities were not intended as some sort of quasi-experimental examination of treatment effects, and should under no circumstances be interpreted as if they were. Rather, they were intended as 'broad-brush' indicators of effectiveness or the lack of it.)

The results of these comparisons are reported and summarised in Chapters Three and Four. At Port Keats, male clients who had attended Dependent Male courses at Daly River were more likely to be non-drinkers, and less likely to be heavy drinkers, than males who had not attended any CAAPS Courses. Those who had attended Daly River Family Program courses were also a little more likely than those who had not attended any CAAPS courses to belong to households in which neither the respondent nor his/her partner (where applicable) drank. None of these results however, were statistically significant. They constituted, in sum, a suggestion that attendance at Daly River Five Mile has a modest but real effect on drinking behaviour, such behaviour in turn constituting one of several relevant outcome criteria.
Findings from Maningrida and Angurugu were more complex. In the Maningrida sample, those who had attended GSC courses were slightly less likely to be heavy drinkers than those who had not attended courses. The difference however was not statistically significant. Former GSC clients were significantly more likely to be current petrol sniffers than males who had not attended any courses, although 40 per cent of former clients had become 'non-sniffers'.

In the Angurugu sample, little difference was recorded in drinking behaviour between ex-clients and the non-treatment sample. As at Maningrida, however, ex-clients were significantly more likely than non-clients to be petrol sniffers, although once again, a majority of ex-clients were non-sniffers.

These data, it was suggested, cast doubts on the adequacy of the GSC Dependent Males Program as a response to petrol-sniffing by Aboriginal youths. This may be because the Program was not sufficiently attuned to client needs and perceptions, and/or because it drew on an intervention model based largely on crisis intervention, for another substance (alcohol) in a different cultural context. At the same time, attendance at the course may have other beneficial consequences, such as educational content which might be utilised at later stages of clients' lives.

Other aspects of the residential programs also earned comment. Examination of intake data at Daly River Five Mile lent weight to the suggestion, which had already been advanced in Chapter Two, that the concepts of dependency and codependency were being imposed on client families - by the simple expedient of defining males as dependent and females as codependent - with little regard to the real dynamics of drinking in these Aboriginal families. In fact, quite a lot of male "dependents" were non-drinkers, and female "codependents" drinkers.

I also commented on an apparent contradiction between an intervention approach which professed to encourage assertiveness and the reclaiming of personal responsibility on the one hand and, and on the other, the day-to-day rules and practices at Daly River, which in fact embodied a high degree of control, almost invariably exercised by non-Aborigines. The issue of how much control should be exercised in an institutional setting, and how it should be exercised, is a vexed one that needs to be handled pragmatically rather than idealistically; nonetheless, in my view the degree of control at Daly River was excessive.

The complement in the CAAPS system of programs to the residential programs is provided by the field workers - or family workers, or co-ordinators, as they are also called. In Chapter Six, I reported on my observations of, and discussions with, several field workers. A number of conclusions were drawn. Firstly, while individual field workers have extensive and varied experience in working with Aboriginal people, the position itself is not at present supported by adequate training in cross-cultural intervention, and in basic
counselling and referral. This feature is not a peculiarity of CAAPS, but rather reflects the lack of suitable training available in the Northern Territory community at large for people working in the field of Aboriginal substance abuse. It is hardly reasonable to expect CAAPS' own Training Unit (at least in its present form), with only two staff members engaged in providing training, to meet this need in addition to the in-service and other training needs it is already attempting to meet. Nonetheless, the need is a very real one, and I hope that this review will help to underline the fact.

Secondly, I questioned the extent to which the non-Aboriginal field workers, notwithstanding their titles, really worked with Aboriginal families. Those that I observed almost invariably worked with individuals. If this was inevitable, as I suggested that it may have been, then the claim to be intervening at the level of the family in the name of a 'family disease' model needed to be re-examined, since it may serve to disguise rather than guide the true nature of intervention. I also suggested that all of the non-Aboriginal field workers whom I observed were to some degree isolated from mainstream community life. While this may also be, to some degree, inevitable given the local political factionalism generated by alcohol-related issues in many communities, I also argued that isolation was in part a result of field workers' reliance on a conceptual framework which provided few guidelines for interacting with social groups other than the family.

While the issue of funding does not form a focus for this review, it needs to be stated that the ad hoc funding arrangements which have, by and large, governed the funding of CAAPS Field Worker/Family Worker positions to date have hardly been conducive to maintaining the positions as an integral component of the CAAPS system.

**THE WAY AHEAD**

Several recommendations have already been made in the review. I should like to close, however, with some further recommendations, which I believe follow from the findings presented in the review. Most of these arise out of one basic proposition: the need, which I believe exists, for CAAPS systematically to explore alternatives in a number of key aspects of its programs. The need arises not out of a perceived failure on the part of CAAPS programs and services, but out of what I believe are indications of limited effectiveness, and out of a possibility that effectiveness could be improved.

With respect to the residential programs, I make the following recommendations:

1. CAAPS should consider, and trial, alternatives in terms both of the duration and content of courses. Is four weeks the optimum duration for all clients? Perhaps it is longer than necessary for some, and not long enough for others.
2. As recommended in Chapter Two, CAAPS should be urged to adopt, at appropriate organisational levels, a more open stance towards adopting differing treatment approaches (or incorporating ideas from different approaches). Greater consideration should be given to locating key treatment concepts within Aboriginal frames of meaning, through an extensive process of consultation with Aboriginal people.

3. Consideration be given to shifting the emphasis in funding, facilities and other aspects away from centralised residential treatment as exemplified by Daly River Five Mile and Gordon Symons Centre, towards smaller more localised facilities, attached to but geographically distinct from Aboriginal communities. In their staffing, administration and intervention practices, such facilities should have maximum Aboriginal involvement. The outcomes of any such shift in emphasis should be systematically monitored.

With respect to community-based field workers, as foreshadowed in Chapter 6, I make the following recommendations:

4. The present trend towards placing Aboriginal people into the primary community-based role, with support being provided by non-Aboriginal people, should be encouraged.

5. The ideas underpinning the field worker role should be re-examined with a view to (a) making more explicit the opportunities and limitations which apply to working with families, as distinct from working with individuals (which, of course, differ for Aboriginal and non-Aboriginal workers respectively), and (b) enabling the field worker to work with groups in the community other than families.

Two further recommendations apply to record-keeping and training respectively.

6. In their present and any future activities, administrators of CAAPS programs should maintain a record-keeping system adequate for both internal monitoring and external evaluation of both processes and outcomes. Such a system will not necessarily be the same as records required by funding bodies such as ATSIC, although some overlap would be expected. If requested, the NT Drug and Alcohol Bureau should provide assistance in setting up a system.

7. Because the CAAPS Training Unit has not been examined in this review, no recommendations concerning its activities are made here. However, the examination of residential and field worker programs did bring to light a situation which calls for comment, and that is the dearth of training facilities for people - both Aboriginal and non-Aboriginal - working in the area of Aboriginal substance misuse. This is not a need that CAAPS should be called upon to fill, unless it is provided with the necessary resources. Rather, organisations such as CAAPS should be
able to recruit staff from a pool of appropriately trained people (who would then require further in-service training from the Training Unit). The recommendation, therefore, that urgent attention be given to providing training for people working in the field of Aboriginal substance misuse, is one that is properly addressed to the NT Government.

The final recommendation refers to funding, and is addressed to funding bodies:

8 A period, which I would recommend as two years, should be designated as a "transition period" during which the recommended changes would be pursued. During this period, provided CAAPS undertakes to address the issues and is observed by a steering committee to be doing so, it should be assured by both Commonwealth and NT Government agencies of adequate and regular funding.
REFERENCES


APPENDIX A

TERMS OF REFERENCE

Stage 1 of the review, to be conducted by the Drug and Alcohol Bureau, will:

1. describe the nature, origins and objectives of programs and services provided under the CAAPS structure;

2. examine theories, models and other key concepts employed in CAAPS programs in:
   . the explanation of substance abuse in general;
   . the explanation of substance abuse among tribally-oriented Aboriginal people in particular; and
   . intervention strategies, both preventative and treatment oriented;

3. examine systems through which services, both residential and non-residential, are provided, including: selection and training of staff; facilities; models of service delivery; referral linkages; client eligibility criteria, and allocation of clients to programs;

4. examine funding arrangements and expenditure patterns relevant to CAAPS substance abuse programs;

5. examine patterns of client contact (both dependents and others) in individual programs covering, e.g.: numbers of clients; origins and referral sources of clients; duration and regularity of attendance at courses/programs, and other indicators of participation in programs;

6. examine intervention outcomes with respect to:
   . levels of substance abuse; and
   . prevalence of substance abuse-related problems among dependents and dependents' families (including codependents);

7. identify any unintended consequences of CAAPS interventions;

8. assess the contribution made by CAAPS programs and services to meeting needs associated with substance abuse in Top End Aboriginal communities; and

9. make recommendations aimed at improving the quality and availability of substance abuse programs and services for Aboriginal people and communities.
APPENDIX B

OBTAINING THE OUTCOME SAMPLES

Port Keats

From the list of Daly River clients, 97 were identified as having come from Port Keats. To these were added 42 names of clients who had attended a course at Gordon-Symons Centre. Eleven names appeared on both lists, giving a total of 128 made up as follows:

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients of Daly River Five Mile</td>
<td>39</td>
<td>46</td>
</tr>
<tr>
<td>Gordon Symons Centre</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>both</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>62</td>
<td>65</td>
</tr>
</tbody>
</table>

* 1, sex not stated

From the Community Health Centre data, it was estimated that the number of people in the community aged 15 and over was 333 males and 419 females. A random number program was then used to generate a sample of 46 males and 50 females from the files.

Where the same name appeared in both the Community Health Centre and treatment lists, the duplicate was eliminated. This occurred with 5 males and 9 females. Several more names were eliminated because, on further checking, it turned out that that had either deceased, moved to other communities or, in one case, appeared twice under different names.

The final sample comprised 196 persons, made up as follows:

<table>
<thead>
<tr>
<th>Treatment Agency</th>
<th>Male</th>
<th>Female</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>39</td>
<td>40</td>
<td>79</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>40.3</td>
</tr>
<tr>
<td>Daly River</td>
<td>39</td>
<td>43</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>41.8</td>
</tr>
<tr>
<td>Gordon Symons</td>
<td>15</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>12.8</td>
</tr>
<tr>
<td>Both</td>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5.1</td>
</tr>
<tr>
<td>Column</td>
<td>96</td>
<td>100</td>
<td>196</td>
</tr>
<tr>
<td>Total</td>
<td>49.0</td>
<td>51.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
The sample was then ordered alphabetically by first name and, with respect to each person whose name appeared on it, two Aboriginal Health Workers in the Community Health Centre were asked:

1. Is the person a non/moderate/heavy drinker?
2. Is the person's spouse/partner (if applicable) a non/moderate/heavy drinker?
3. Is the person a non/occasional/regular petrol sniffer?
4. Is the person's spouse/partner (if applicable) a non/occasional/regular petrol sniffer?

(The questions about petrol sniffing were included in view of the fact that, while all admissions to Daly River from Port Keats were related to alcohol, many of those to Gordon Symons were related to petrol sniffing.)

Immediately afterwards, all names were erased from the sample, and from all computer files and documents associated with generating the sample, in order to ensure that no individuals could be identified.

**Maningrida**

Similar procedures were followed at Maningrida and Angurugu. In the case of Maningrida, examination of Gordon Symons Centre records and records kept by the Family Worker at Maningrida yielded the names of 35 men who had attended Male Dependents' courses and 16 women who had completed non-residential Codependents' courses.

An initial random sample of 50 women and 48 men aged 15 and over was drawn from Community Health Centre files. When duplicates with the Gordon Symons lists were eliminated, along with names of those who had left the community or were underage, the 'non-treatment' sample comprised 43 women and 36 men.

The final sample was thus composed as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-GSC Male Dependents clients</td>
<td>35</td>
</tr>
<tr>
<td>Non-treatment males</td>
<td>36</td>
</tr>
<tr>
<td>Ex-GSC Codependents clients</td>
<td>16</td>
</tr>
<tr>
<td>Non-treatment females</td>
<td>43</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>130</strong></td>
</tr>
</tbody>
</table>

**Angurugu**

Gordon Symons Centre records indicated that 21 males from Angurugu had attended Depedents courses, 1 woman had attended a Codependents course and 1 a Female Dependents course. The two women were deleted from the list, partly because confidentiality could not be assured, and partly because they hardly provided a basis for drawing inferences.

A random sample of 50 males and 40 females aged 15 and over was drawn from Health Centre files; 4 males were subsequently
deleted for reasons outlined above with respect to Maningrida, leaving a sample composed as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-GSC Dependent males</td>
<td>21</td>
</tr>
<tr>
<td>Non-treatment males</td>
<td>46</td>
</tr>
<tr>
<td>Non-treatment females</td>
<td>40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>107</strong></td>
</tr>
</tbody>
</table>