The Development of Indigenous Substance Misuse Services in Australia: Beliefs, Conflicts and Change

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The aim of this paper is to overview earlier and recent issues in the field of Indigenous substance misuse intervention from its beginning to more recent developments. The overview will specifically analyse developments, advancements and change in the area of tertiary intervention or 'rehabilitation' as it is commonly referred to by Indigenous people. First, the paper will focus on Indigenous historical and theoretical constructs that have impacted on the development of Indigenous notions of 'rehabilitation' or intervention. Indigenous interpretations of the disease model of alcoholism, particularly the Alcoholics Anonymous philosophy, is analysed as well as the socio-cultural beliefs associated with those models. Second, conflicts with the mainstream management of substance misuse intervention are overviewed. Third, the paper highlights the complexity of more recent evolution of the services and discusses possible options for change. Attention is also devoted to Indigenous alternative interpretations of intervention and their relevance to the area of secondary intervention. Recent developments in the area of primary health care and their potential towards further improvement is also considered as well as obstacles to those changes.

Indigenous alcohol and drug problems in Australia have undergone consistent scrutiny in the last three decades. Ways of alleviating these problems have been focused on by Indigenous health professionals, policy makers and researchers, in attempts to devise appropriate strategies for intervention. In fact, the management of Indigenous substance misuse intervention services has been at the centre of debates, controversies and disputes (Alati, 1996; O'Connor, 1984; 1988; Wilson, 1986). However, the strength and poignancy of the debate invites questions about its lack of focus on contextual social and cultural factors.

Observers have analysed Indigenous alcohol and drug intervention services (Lyon, 1992; Wilson, 1986) and recognised theoretical archetypes and beliefs contributing to the current socio-historical construct of the Indigenous notion of intervention (Brady, Dawe, & Richmond 1998; Lyon, 1992; Wilson, 1986). However, there has been little investigation of subtle relationships between underlying socio-cultural beliefs and theoretical views such as the Alcoholics Anonymous' (AA) philosophy, the concept of disease and the notion of spirituality in treatment (Miller & Rowse, 1995). Nonetheless, these issues are of critical importance to the understanding of present Indigenous attitudes. They have also played an important role in the distinctive make-up of Indigenous substance misuse services (Alati, 1999).

Alternative models of substance misuse intervention have made important contributions to the general substance misuse field. They have influenced policies and mainstream services, and have brought forth changes in substance misuse policies for the Australian health care system (Heather & Tebbutt, 1989). However, the application of those policies to Indigenous programs might represent an important challenge for both the Indigenous intervention field, government agencies, funding bodies and policy makers (Alati, 1998a; Commonwealth of Australia, 1995), particularly in their efficacy in addressing some of the specific problems associated with Indigenous issues.

This paper has three aims. First, it constructs arguments around the development of models of drug and alcohol rehabilitation for Indigenous populations. Second, conflicts in the management of Indigenous drug and alcohol problems are examined. Finally, new approaches to dealing with drug and alcohol problems amongst Indigenous people are discussed, particularly in their appropriateness in addressing specific Indigenous social and cultural problems in perspective.

State and Commonwealth governments started to target alcohol and drug issues amongst Indigenous people in the early 1970s, when funding was made available for establishing community-based alcohol and drug 'rehabilitation centres' run by Indigenous co-operatives or communities. The initial programs were motivated by need for action by government and began a trend in government practice. This was characterised by little strategic planning and hurried allocation of funds. In 1977 an inquiry brought to parliamentary attention the magnitude of drinking and associated issues in Australian Indigenous communities and solicited further financial support for the running of treatment programs (Wilson, 1986).

A lack of strategic planning also characterised further government policy on Indigenous substance misuse programs. For example, in the mid-eighties, the first review of Indigenous alcohol and drug rehabilitation programs critically identified these shortcomings and labelled government efforts as being 'too little, too late' in their effectiveness (Wilson, 1986). Wilson also highlighted significant gaps in the provision of alcohol services to Indigenous people and called for government actions in those areas. Those gaps included the total lack of primary and secondary intervention programs and a one-sided commitment to the abstinence model in tertiary prevention. Other early reviews recommended more comprehensive approaches to alcohol problems and the introduction of prevention and education programs that specifically targeted Indigenous people (O'Connor, 1984, 1988).

In 1987, funding policies on Indigenous alcohol programs formally shifted away from in-patient care towards public health approaches to substance misuse. The then Department of Aboriginal Affairs (DAA) in the main directed funding toward prevention programs. Many Indigenous treatment programs discontinued operations and closed, but some of the better administered centres, such as Benelong's Haven and Ngwala Willumbong, still received limited funding and survived (Alexander, 1990; Lyon, 1992). When the DAA became ATSIC (Aboriginal and Torres Strait Islander Commission), regional councils played an instrumental role in the allocation of funding to treatment centres. In some cases, funding was increased and the programs extended (Brady et al., 1998). Since 1995, however, the health budget has returned to the responsibility of the Commonwealth Department of Health and Human Services and the substance misuse program is finally being reviewed.

Government attitudes and conflicts deriving from these changes need to be seen as strongly influenced by past policy and program interventions. The historical background and the beliefs that developed had a profound impact on the way services

and Indigenous health professionals operated and still operate today.

The 'Rehab' and the Abstinence Model

As with policy attitudes, early initiatives profoundly impacted on and produced some severe limitations to drug and alcohol intervention for Indigenous people and still influence current beliefs. The following section reconstructs that historical background and the grass-roots beliefs that developed from it.

Early programs for Indigenous problem drinkers have been mainly influenced by the disease model of alcoholism, that has long represented a prominent theory of problematic drinking in Australia and overseas (Levine, 1978). Based on the assumption that individual weakness caused incapacity of exercising control over alcohol, the model urged understanding of the 'individual-victim' suffering from such an illness and advocated a cure through lifelong abstinence. Since the eighteenth century this concept has gained prominence through American evangelical Protestantism of the nineteenth century (Valliant, 1983) and the Alcoholics Anonymous philosophy of post-prohibitionism (Alcoholics Anonymous, 1939). Contemporary revisions include the 'alcohol dependence syndrome', a perfected conceptualisation of the theory (Edwards & Gross, 1976), and the growth of an up-to-date terminology which conveys complex and multiple aspects of the concept with terms such as 'syndrome' and 'addiction' entering the domain of everyday speaking (Fingarette, 1988).

In short, those with alcoholic problems were seen as having a disease, and the cure was seen as total abstinence. Such a one-sided approach reflects a long-lasting ideological debate in mainstream practice between the metaphors of lifelong capitulation of the 'powerless' against notions of control of the 'empowered'. This reflects the dominant biomedical notion of control by the medical profession over the 'passive patient' in need of treatment.

Indigenous groups viewed Alcoholics Anonymous, the disease model of alcoholism and residential care as the solution to Aboriginal drinking problems (Wilson, 1986). Abstinence-based, in-patient treatment for Indigenous drinkers were advocated since the very first Indigenous initiative in the field (Wilson, 1986). This was at Benelong's Haven, started by a New South Wales Aboriginal woman, Val Bryant, who had stopped drinking by attending Alcoholics Anonymous (AA) meetings. Despite a long struggle for initial funding, Benelong's Haven received high standing and immediate popularity throughout Australia as a successful Indigenous initiative. So did the AA philosophy for Aboriginal people in treatment.

Other poorly funded 'rehabilitation centres', mostly run by Indigenous co-operatives, started in a number of States and developed their own initiatives. The Aboriginal 'alcohol and drug counsellors' employed by the centres were previous clients who had completed the AA-based treatment programs. Although not formally trained in counselling skills, they embarked on the first tenacious attempts to tackle alcohol problems in Indigenous communities (Wilson, 1986). In accordance with the founders of Benelong's Haven, they strongly supported the disease model of alcoholism and believed that Aboriginal people could neither control their alcohol intake, nor drink in moderation. The Alcoholics Anonymous (AA) philosophy was promoted as the most suitable treatment approach to solve the drinking problems affecting Aboriginal communities (Bryant & Carroll, 1978; Hunt, 1984). Other abstinence-based models, such as the Minnesota/Hazelden, also known as 'family disease' model and the 'Canadian Indian' model were later integrated into the AA philosophy (Brady, 1995a).

'Abstentionist' Views and Socio-cultural Motifs

The reasons for the appeal of the disease model are varied. A common theme of this

model is that substance misuse is an expression of profound psychological and physical illness. The extent of influence of this perspective on Indigenous interpretations of problematic drinking should not be underestimated. Perceptions of loss, dependence and socio-cultural deprivation have contributed to amalgamating the concept of disease to that of individual affliction (Alati, 1996; Brady et al., 1998). The belief that specific personality traits would make some people more likely to become 'alcoholics' than others or the hypothesis that alcoholism is a genetic or inherited disease (Murray & Gurling, 1982) have fitted comfortably with the construction of social and cultural sicknesses. Even the Alcoholics Anonymous' (1939) distinction between 'real alcoholics' and 'heavy drinkers', echoing Jellinek's progressive 'species' of alcoholism (Jellinek, 1952, 1960), reflects itself in the widespread belief that the 'Aboriginal person can't stop' (Brady et al., 1998, p. 72).

Deeply entrenched with the notion of individual weakness, is a strong conviction that alcoholic beverages were not 'part of culture' and therefore Indigenous people do not possess the basic tools of social and individual control to address problematic drinking (Alati, 1996). In reality, this belief is based on inaccurate evidence, as notes from early settlers documenting the use of intoxicating drinks and mood-altering drugs by Indigenous people in different parts of Australia has shown (Brady 1998). However, the popularity of the 'alcohol - not part of our culture' theme is widespread amongst Indigenous supporters of the abstinence goal and often shared by the general public as a simplistic construct of problematic drinking amongst Indigenous people.

Alcoholics Anonymous and Indigenous Treatment

The influence of the AA 12 steps on widespread beliefs about Indigenous powerlessness towards alcohol has been particularly strong. Although it is the most common treatment model adopted in Indigenous treatment centres, there has been little attempt to analyse the relationships between the conceptual framework of the AA philosophy and Indigenous applications (Alati, 1999; Brady et al., 1998). Since Benelong's Haven, Indigenous people working in the field found similarities between the powerlessness concept of AA and the lack of 'pride, dignity and self-respect' affecting Indigenous drinkers (Bryant & Carroll, 1978: Hunt, 1981, 1984). The pressure to conform to mainstream values, poverty and dysfunction in the family merged with the concept of 'dis-ease' and 'self-disruption' (Hunt, 1984) and found its final metaphor in the AA first step of recognising powerlessness in relation to alcohol. In the eighties, Indigenous purveyors of articles on male and female 'Aboriginal alcoholism and alcoholics' urged families and individuals to detect early signs of the 'disease' (Baird, 1985; Bryant, 1987; Hunt, 1984; Sington, 1984). Hunt (1981) even compared the need for intensive treatment of 'Aboriginal Alcoholism' to the need for the diabetic to take insulin on a regular basis. The work of many Aboriginal alcohol and drug workers has in fact reflected a belief about the etiology of Indigenous drug and alcohol problems that has grown in isolation from and non-alliance with mainstream policy directions.

Similarities have been drawn between key AA concepts and Indigenous culture. The closeness of Indigenous family and the degree of discomfort that heavy drinking has produced in the family has focussed emphasis on the treatment of the whole family. 'Alcoholism' was called 'family disease' (Hunt, 1981) long before the Minnesota/Hazelden Model of co-dependency was introduced in Indigenous rehabilitation centres as a treatment approach (d'Abbs, 1990).

The AA concept of achieving sobriety 'one day at a time' was compared to the nomadic lifestyle of traditional Aboriginal

societies (Miller, 1982). The ritual of the group and the 'story telling' entrenched in AA meetings have appealed to both Aboriginal counsellors and clients. The founders of Benelong's Haven treated their clients 'the Aboriginal way - in groups' as they found that 'Aborigines become alcoholics by drinking together in groups' (Bryant & Carroll, 1978). Several Indigenous clients who have found AA meetings useful to their recovery admit the importance of the ritual of sharing experiences:

> *It feels good to share all those stories, to hear that you're not alone* (Alati, 1996, p.21).

Spirituality and Healing Through Culture

The relationship between the spiritual dimension ascribed by AA to drinking problems and the appeal that spirituality in treatment has had on Indigenous people is also of considerable importance. Regarded as a 'silent dimension' of addiction research, the AA notion of recovery through the spiritual help of a 'Power greater than ourselves' will remain unique in the history of alcohol studies for securing 'spiritual healing' as a primary role in treatment (Brady, 1998).

Within the Indigenous substance misuse field, the concept of spirituality borrowed from AA has mingled with the concept of cultural healing. This has developed through the influence of Canadian Indian treatment models, which Indigenous people have attempted to adapt to Australian conditions (Brady, 1995b; Miller & Rowse, 1995). Indigenous people's advocacy of treatment through the recovery of culture has also been reinforced by the widespread belief that Indigenous substance misuse itself is a dramatic consequence of dispossession of the land, colonisation, racism and social disadvantage (Hunter et al., 1991; Vino, Berends, & Drysdale, 1996).

Treatment approaches based on reviving Indigenous spirituality and culture have been strongly supported by Indigenous groups throughout Australia. However, the issue has been poorly researched, possibly because non-Indigenous researchers are perfectly aware of the 'potential for misappropriation' (Alati, 1999) when dealing with Indigenous spiritual and cultural beliefs. A first analysis of the notion of spirituality amongst Indigenous workers and clients of substance misuse centres has identified problematic drinking as a hindrance to the path of inner balance:

> *Alcohol is a spiritual disease. It has drained us all of that inner energy. Like this man* [indicating a painting]. *His spirit is not strong enough to hear that plea for help, because our people have moved away from that contact with the spirit, that's the source of life within us* (Alati, 1996, p.23).

The words of this female counsellor echoed through clients' statements, which drew a clear relationship between spiritual loss and substance misuse. In the words of those clients:

> *Spiritual things can help a lot. It depends how strong your mind is. Alcohol damages your soul.*
>
> *Put it this way. If you had a soul, it* [the 'grog'] *takes it away from you.*
>
> *If I die from grog, I'll lose my soul. Do you believe in spirit? I do. If I die from drinking, I don't know where my spirit goes...I'll lose my spirit* (Alati, 1999, p.179)

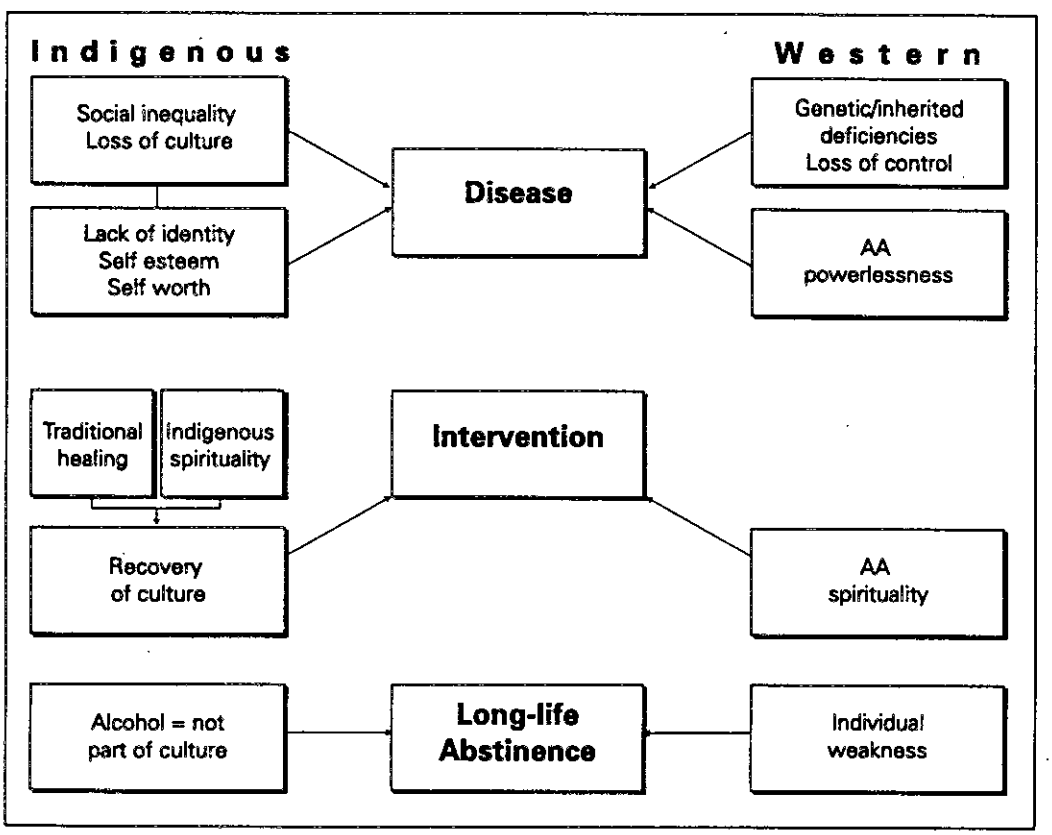
Due to the conceptual nature of the notions of spirituality, research and policy have not substantially sustained the development and implementation of these practices (Alati, 1996; Brady, 1995b; Miller & Rowse, 1995). One service attempting such an implementation has closed. Its culturally specific practices were controversial, and reservations were expressed of the effectiveness of these approaches to treat all Indigenous clients (Alati, 1996; Miller & Rowse, 1995). However, it has been suggested that healing and cultural practices should be identified

at a local level and such investigation should have a strong community development focus (Alati, 1996; Lyon, 1992). Such approach would inherently acknowledge Indigenous cultural practices in light of local belief systems, the setting of which can range from the urban to the more traditional aspects of extended family groupings.

More than two decades after the establishment of Benelong's Haven, Indigenous abstentionist views are still strongly subscribed to. This is despite reservations by health professionals, researchers and policy makers (Alati, 1996, 1999). This is the case not only for Australian Indigenous services but also for other Indigenous people overseas. Recent discussion on the appropriateness of harm reduction for Canadian Indians and subsequent international commentaries testifies to the level of theoretical debate amongst Indigenous populations worldwide (Brady, 1996; Hunter, 1996; Landau, 1996).

In Australia, a series of Indigenous socio-cultural constructs and Western theories have coalesced effectively towards comprehensive and quite unique notions of Indigenous 'disease' and intervention. Figure 1 shows a summarised model of the ways the theoretical constructs have interacted with each other. Social disadvantage, with its baggage of poverty, lack of employment and poor education, and 'loss' of Indigenous cultural values appear the most significant and pervasive themes in the etiology of alcohol misuse. These major Indigenous constructs have gradually blended with Western notions of inherited, genetic and individual weaknesses. In addition, more personalised forms of 'loss' such as lack of

Figure 1: An interactive model of Indigenous and Western constructs of alcohol intervention.



identity, self-esteem and self-worth have merged with the AA concept of 'powerlessness' theorised in the 'Big Book' (AA, 1939).

Consequently, Indigenous substance misuse intervention has aimed to 'rehabilitate' through addressing the core issues believed to be the problem in the first place. The services mostly targeted the cultural aspect, as readjusting social disadvantage requires long-term comprehensive approaches. Figure 1 suggests that visions for effective intervention lay in reviving the authenticity of Indigenous culture. That is where the AA construct of spirituality in treatment is amalgamated with the reclaiming of Indigenous spiritual values and treatment through traditional healing practices. Abstinence is the final outcome from the perspective of both Western and Indigenous constructs; whether the individual is incapable of controlling the substance (Western) or the substance is in fact alien to his/her culture (Indigenous).

The Impact of 'Social Learning' and 'Public Health' Approaches

In the time that Indigenous services were establishing intervention approaches around various applications of the abstinence model, revolutionary changes took place in mainstream directions and services for substance misuse intervention. The management of mainstream services was profoundly influenced and changed as a result. On the contrary, Indigenous agencies remained relatively unaffected by those beliefs.

The new approach was developed out of the cognitive behavioural paradigm and became known as the 'social-learning model' of alcohol and drug problems. A revolutionary theoretical breakthrough, this approach refuted the position that alcohol and drug misuse was a result of 'sicknesses' or 'deviance' derived from individual weakness or lack of will power (Heather & Robertson, 1985). The social-learning model in fact developed from the belief that substance misuse was learned socially and could be corrected. Based on behavioural theory, 'clients' ceased to be 'sick' and 'powerless' victims and became actively involved in the process of behavioural change: the theoretical focus shifted away from the idea of lifelong capitulation to the notion of control (Heather, 1990). The aim of intervention changed attention from promoting abstinence towards providing people with skills to cope with their alcohol or drug misuse (Heather & Tebbutt, 1989). Short-term counselling strategies at early stages of problematic drinking such as controlled drinking, relapse prevention and motivational interviewing were developed out of those notions.

Factors related to clinical and economic evidence reinforced the need for change. Inpatient treatment was found to be almost as effective as no treatment at all and expenses required to support patients in specialised clinics or homes lost justification. A radical move was advocated from the traditional ways the health care system targeted alcohol and other drugs related problems (Heather and Tebbutt, 1989). A practical outcome resulted in a shift in service provision, from inpatient to outpatient treatment, from 'tertiary' to 'secondary' and 'brief intervention' (Heather, 1990; Heather & Robertson, 1981, 1985).

The 'public health model' of alcohol-related problems developed out of concern over cultural and environmental factors in explaining drug and alcohol problems, and in the development of treatment programs appropriate to the context within which drug and alcohol problems arose. It emphasised 'minimal' or 'primary' intervention, moderate, 'sensible' drinking and the principle of 'harm minimisation'. Public health initiatives also strongly focus on the promotion of the harm minimisation

principle through media and educational campaigns. Hence, there is a stress on health promotion, prevention and education (Ali, Miller, & Cormack, 1992).

The increase of illicit drug and poly-substance misuse also contributed to changing policies on mainstream intervention for drug misuse. Findings from inpatient treatment programs challenged traditional approaches of medical detoxification and long-term treatment and affected policies on illicit drugs intervention accordingly (Ali et al., 1992). Therefore, current approaches to illicit drugs have moved on to the application of harm minimisation and cognitive-behavioural principles, such as relapse prevention and motivational interviewing (Heather and Tebbutt, 1989; Marlatt, 1985). Public health policies have increasingly targeted illicit drug use, as well as alcohol, and substance misuse related problems, such as domestic violence and criminal behaviour perpetrated as a result of alcohol or drug misuse (Ali et al., 1992).

Conflicts Between Mainstream Practices and Indigenous Services

Changes in mainstream practices eventually affected the running of Indigenous services. Programs were reviewed and shortcomings were identified (Lyon, 1992; O'Connor, 1988; Wilson, 1986). The generalised use of the AA model in treating all Indigenous problem drinkers was strongly criticised (O'Connor, 1988). O'Connor (1984) debated the concepts of individual disease and weakness as opposed to one of 'contingent drunkenness' of binge drinking in Central Australia. Lyon (1992) and d'Abbs (1990) advocated the use of more comprehensive approaches to face alcohol and drug issues in the Northern Territory. More recent studies have found that differences in the seriousness of Indigenous clients' drinking behaviours could allow for trialing of controlled drinking techniques on those clients who present with mild symptoms of dependence (Alati, 1999). The development of a 'drug' scene amongst Indigenous youth in urban and rural centres has also highlighted further inadequacies, with Narcotics Anonymous as the only intervention offered in many Indigenous agencies (Alati, 1998a, 1999; Gray, Morfitt, Williams, Ryan, & Coyne, 1997; Perkins et al., 1994).

Aware of mainstream directions and services, reviewers questioned effectiveness of Indigenous abstentionist approaches and the lack of appropriate reliable data. They advocated trials and implementation of the whole range of interventions available to the wider community and identified shortcomings in the area of evaluation.

Apparent Contradictions

In general, the gap between mainstream and culturally specific services seemed to have grown wider. The historical 'battle' for funding between the agencies and the government also represented an impediment to change, particularly when the condition for funding was seen as a forced embracement of mainstream ideological and philosophical approaches (Commonwealth of Australia, 1995).

A less visible process, however, has occurred as part of a more pragmatic approach to Indigenous alcohol and drug problems. Alcohol and drug workers were isolated from theoretical change, but not detached from the social issues affecting Indigenous drinkers and their families. While resisting alternative intervention techniques, such as controlled drinking and motivational interviewing, many organisations have rapidly initiated 'harm reduction' strategies in relation to substance related incarceration and violence (Alati, 1999). This occurred even before alcohol was identified as an underlying cause of Indigenous people's deaths in custody (Johnston, 1990). Similar issues in relation to illicit drug-related problems and drug-related criminal

behaviours have been promptly addressed. Continuous liaising with the criminal and legal system is now part of the day to day running of most services (Alati, 1999).

Additional initiatives have included the provision of outreach services, very well developed networks with sobering up centres, hostels and women's shelters. Networking with Indigenous prevention services and workers also takes place without the theoretical tension one might expect. It is not unusual to find community health workers, often supporters of the controlled drinking approach, on the boards of management of the centres. Similarly well established working linkages exist with community controlled organisations and Indigenous health services. The services have achieved a recognised role in communities as long-term providers of substance misuse services and have now the potential to act more harmoniously in the community scene (Alati, 1999).

The potential of these services for comprehensive intervention is still hindered by the same funding restrictions, which have also prevented earlier initiatives (Hunter, Brady, & Hall, 1998). This might be due in part to the agencies' official adherence to the abstinence model and their traditional role of providing in-patient care. Funding arrangements are based on the delivery of 'rehabilitation' programs and neither the services, nor their funding bodies recognise the provision of the secondary intervention services described above (Hunter et al., 1998). In the final analysis, the agencies' funding for programs and infrastructure remains scarce.

Mainstream directions in substance misuse intervention have changed considerably in the last few decades. New developments have favoured primary and secondary intervention, moving away from in-patient 'rehabilitation' and total abstinence. This has clashed strongly with the Indigenous theoretical constructs described in a previous section of this paper. In comparing the two sets of beliefs, it is not surprising that the strategy rejected the most by Indigenous substance misuse agencies has been the one of 'controlled drinking'. The same has not happened with some aspects of the public health model. Indigenous agencies now offer broader services. Some public health initiatives are in place and 'harm minimisation' is partly embraced to address certain substance misuse related problems. This hidden role has not, however, been appropriately acknowledged in relation to funding arrangements.

Recent Developments in Indigenous Substance Misuse Intervention

Since the late eighties Indigenous alcohol and drug primary intervention has evolved. Prevention programs for Indigenous communities have developed and have taken several forms. Educational and health promotion campaigns have been carried out in many Indigenous communities throughout Australia. At a national level, the National Drug Strategy (previously National Campaign Against Drug Abuse) has funded grand scale health promotion campaigns and educational programs. At a state level, comprehensive campaigns, such as the Living with Alcohol Program in the Northern Territory, have concentrated on promotion and prevention activities and taken into account the regional realities of different Indigenous communities (Brady, 1995a).

Initiatives developed through mainstream services have created a more comprehensive picture in the broad area of intervention. These have developed in an atmosphere of collaboration between communities and primary health care centres and have been regarded as examples of best practice. The key success factors for the positive outcome of these initiatives seem to have included a grass-roots community feeling of 'owning' the problem and partnership with the local medical clinic (Legge et al., 1996). For partnerships of this kind to appropriately develop and strengthen, a deep understanding from the medical profession

of the cultural issues surrounding alcohol and drug use in Indigenous communities is required. This specific need has prompted the development of clinical guidelines to manage alcohol-related problems in Indigenous primary health settings (Hunter, Brady, & Hall, 1999).

Another important addition to the substance misuse field is represented by the increasingly significant role that Indigenous Health Workers play in the provision of primary health care services to their communities. As this role becomes more recognised, their contact with substance misuse issues at community and individual level becomes greater. This is particularly true in remote and rural settings. However, health workers' training is at present hindered by a low level of degree education and a negligible participation in health workforce training (Sibthorpe, Baas Becking, & Humes, 1998). It is therefore uncertain whether such a background is comprehensive enough for Indigenous health professionals to act efficiently and provide brief and minimal intervention services.

Brady (1998) has recently published a comprehensive account of Indigenous initiatives in community-based settings. These initiatives differ from substance misuse projects targeting the broader community, but can be seen as Indigenous approaches to secondary intervention and harm minimisation. In remote areas, strategies have taken the form of limiting access to alcohol supplies, instituting sobering up shelters, dry camps, organising alcohol-free public events and maintaining night patrols. Also urban and rural communities have developed their programs. In Victoria, the Aboriginal Community Justice Panels represent an alternative means of 'keeping drinkers out of police cells' integrated with activities that promote Indigenous culture (Brady, 1998, p. 146). Some of these initiatives show how community involvement, harm minimisation approaches and a broad public health perspective have merged successfully.

In other cases, an apparent lack of logic transpires from the way aspects of the public health model are enthusiastically embraced in contrast with total rejection of other aspects of public health, namely harm minimisation or outpatient brief intervention practices (Alati, 1998a). This is particularly the case with the old Indigenous 'rehabilitation centre'. As discussed previously, these services have developed in a different historical atmosphere, often in total isolation from mainstream practices (Alati, 1999; Brady et al., 1998). In fact, it is questionable as to how much of the theoretical change, which has occurred in mainstream services, has reached Indigenous agencies. The AA tradition of employing ex-clients who had 'sobered up' as counsellors had created a pool of dedicated, poorly paid, 'lay' workers who lacked not only any type of formal training, but probably also confidence in their learning capacities (Alati, 1996). The key to acquire new knowledge often lies in either formal studies or other forms of professional development. The counsellors probably did not consider the first option, but professional development in the form of training, on the contrary, was actively pursued. Unfortunately, professional development for alcohol and drug workers has proved to be fraught with difficulties of various types (Alati, 1996). Training mainstream health professionals and Indigenous health workers together has been to the detriment of Indigenous health professionals' self-esteem and self worth (Alati, 1993). The last ten years have seen much culturally specific training but, for a number of reasons, information provided has been mostly abstinence-based, with little or no reference to more current strategies (Alati, 1996).

The development of partnerships and the feeling of owning problems with local clinics were important keys to success. What was needed was an understanding by clinicians of the cultural significance and meanings attached to the problems. Programs have been developed relatively recently which reinforce cultural beliefs, and which have targeted objectives such as reducing

imprisonment for alcohol related offences. However, what has been argued in the paper is that many of the changes in mainstream alcohol and drug services have not reached Indigenous services. In addition, the Indigenous health worker's role is becoming important.

Conclusion

The overall picture of intervention for the Indigenous health care system has become more sophisticated and comprehensive. Primary intervention for Indigenous people has been developed through health education and health promotion programs. Initiatives springing from community actions are now encouraged and supported. It is important that effective interventions based on new public health models, which foster community development and empowerment, are encouraged and promoted. It is through these models that successful initiatives offering opportunities for participation and self-determination in important health care issues are likely to be developed.

As far as residential services are concerned, the abstinence view is still strongly held. The historical and socio-cultural perspective discussed above suggests that there is more to consider than the mere adherence to individual 'illness' theories of the addiction field. The Indigenous conceptualisation has broadened the 'illness' metaphor from the 'individual' to the 'collective' sphere and shifted it to the realm of cultural 'loss' and social inequality. This has strengthened its resilience in the Indigenous intervention field and added cultural 'sense' to its preservation. In an attempt to provide a comprehensive picture, it is also worth noting that services have developed an atmosphere of scarce resources, limited funding and historical isolation. This has probably contributed to reinforce further the status quo.

By the same token, tertiary intervention services have slowly broadened. The 'centres' have developed comprehensive networks with other Indigenous organisations and their activities and practices now target substance misuse related problems. The abstinence approach has merged together with culturally specific practices whose risk reduction aim should not be underestimated by policy commentators (Alati, 1998a). These changes cohabit with abstinence oriented one-sided knowledge that is a little shaken by resources designed to meet workers' specific needs (Alati 1998b). This has resulted in a lack of recognition of the broadening of the agencies' intervention activities and in their resources and operational funding remaining limited. Funding bodies should devise mechanisms to monitor the extent of harm minimisation activities carried out by the services and readjust funding arrangements accordingly.

Successful partnerships within the primary health care setting in the development of community projects suggest there is potential for fruitful interactions and networks with Indigenous services. Such partnerships could carry implications for further improvements in service delivery. The primary health care setting and Indigenous substance misuse services occasionally interact, but these interactions are sporadic and are often generated by opportunistic needs. Improved collaboration with other primary health care professionals might be helpful in breaking through the intellectual isolation that has characterised most services in the past and could raise interest towards more varied intervention strategies.

Lastly, another category of health professionals is now emerging into the scene of substance misuse intervention. Aware of the cultural and historical issues that surround the misuse of alcohol and drugs in Indigenous communities, Indigenous primary health care workers are in a unique position to provide secondary intervention in the community setting. However, providing brief intervention advice is a trained skill with which not all health workers might be familiar.

It would be regrettable if, in ten-years' time, we were to conclude that today's workers went through the same obstacles experienced by their colleagues in the past. The challenge is still open to give this new

generation the same access to learning that is available to mainstream health professionals. However, if that challenge was to be met successfully, resources should be developed with the comparable and equal breadth of information available to non-Indigenous health professionals. Processes should be devised to develop appropriately, implement and effectively evaluate the resources. The evaluation should focus not only on the piloting stage of such resources, but also on their long term impact and usefulness to the community setting.

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