



HealingFoundation

Strong Spirit • Strong Culture • Strong People

**PROSPECTIVE
COST BENEFIT ANALYSIS
OF HEALING CENTRES**

22 July 2014

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Aboriginal and Torres Strait Healing Foundation. (2014). *Prospective cost benefit analysis of healing centres*. Canberra, ACT: Aboriginal and Torres Strait Islander Healing Foundation.



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Glossary

ABS	Australian Bureau of Statistics
AHF	Aboriginal Healing Foundation (Canada)
AIHW	Australian Institute of Health and Welfare
BCR	benefit to cost ratio
CBA	cost benefit analysis
CHCH	Community Holistic Circle Healing
CPI	Consumer Price Index
DV	domestic violence
HC	healing centre
NIDAC	National Indigenous Drug and Alcohol Committee
NPY	Ngaanyatjarra Pitjanjatjara Yankunytjara
SCRGSP	Steering Committee for the Review of Government Service Provision
TAU	treatment as usual
TC	therapeutic community
UK	United Kingdom
US	United States
VSU	volatile substance use



Executive summary

The Healing Foundation is currently supporting the establishment of 13 Indigenous healing centres and tasked Deloitte Access Economics with conducting a prospective cost-benefit analysis (CBA) of the centres.

Colonisation has had lasting detrimental impacts on Indigenous peoples, not just in Australia, but in other countries where white settlers overwhelmed native populations, such as New Zealand, Canada and the United States. The Aboriginal Healing Foundation of Canada explains the link between colonisation and poor economic and social outcomes for Indigenous people in all these countries:

“ Indigenous social and cultural devastation in the present is the result of unremitting personal and collective trauma due to demographic collapse, resulting from early influenza and smallpox epidemics and other infectious diseases, conquest, warfare, slavery, colonization, proselytization, famine and starvation” (Aboriginal Healing Foundation, 2006).

However, while the need may be obvious, it is not an easy undertaking to estimate the costs and benefits of Indigenous healing processes. The Aboriginal and Torres Strait Islander Healing Foundation Development Team (2009) states that “for Aboriginal and Torres Strait Islander people, healing is a spiritual process”. But, as the Cooperative Research Centre for Aboriginal Health (Grieves, 2009: 17 citing Smith, 1999) observes, it may not be possible for Westerners to understand this spirituality.

“ The arguments of Indigenous peoples based on spiritual relationships to the universe, landscape and to stones, rocks, insects and other things, seen and unseen, have been difficult for western systems of knowledge to deal with or accept...The values, attitudes, concepts and language embedded in beliefs about spirituality represent, in many cases, the clearest contract and mark of difference between Indigenous peoples and the West. It is one of the few parts of ourselves which the West cannot decipher, cannot understand and cannot control.”

An essential part of cost benefit analysis includes measuring the efficacy or outcomes of healing programs HC activities. This is problematic in that ‘healing’ is an ongoing process and does not possess an endpoint of ‘being cured’ as would exist in a biomedical approach. No one is ever completely healed and healing is understood as a journey along a pathway upon which one may suffer setbacks and deviate, then re-join years after the healing process has started (Aboriginal Healing Foundation, 2008).

Due to its poor comprehension and intangibility of measurement, spiritual healing is extremely difficult to value in dollar terms. The Canadian Government endowed its Aboriginal Healing Foundation with over half a billion dollars to fund ten years’ worth of Aboriginal healing projects. Yet, its evaluation report (Aboriginal Healing Foundation, 2006), which exceeded 1,000 pages, did not attempt to quantify the benefits. Coutre et al (2001: i), speaking of that experience notes:

“ the benefits of this process have not been acknowledged nor measured by the dominant society ... It is very difficult, if not impossible, to adequately place a dollar value on the depth, quality, commitment and sustainability of the substantial healing work achieved.”

However, some of the ‘collateral benefits’ of Indigenous healing produce results that can be measured and monetised. While there are very few studies which examine the measurable impacts of holistic healing in an Indigenous context, there are more which examine the related concept of therapeutic communities.¹ These studies demonstrate reduced rates of incarceration and mental illness, among both Indigenous and non-Indigenous peoples.

¹ Some Indigenous healing centres are therapeutic communities, for example at Mareeba, <http://ibaannualreport2012.com.au/healing-the-spirit-at-mareeba-therapeutic-community/>



The available cost benefit evidence from similar initiatives (section 4.1.2) indicates that healing centres and therapeutic communities typically return, on average, a benefit to cost ratio (BCR) of over 4 to 1, primarily from reduced rates of incarceration and recidivism.

Table i: BCRs for healing centres and related interventions

Study	Intervention	Sector	Nation	BCR
Dolan et al (1996)	Therapeutic community	Mainstream	United Kingdom	3.6
Davis et al (1999)	Therapeutic community	Mainstream	United Kingdom	1.8
Menzies et al (1993)	Therapeutic community	Mainstream	United Kingdom	1.9
Lo Sasso et al (2012)	Therapeutic community	Mainstream	United States	5.2
Buller (2001)	Healing centre	Indigenous	Canada	3.1
Buller (2001)	Healing centre	Indigenous	Canada	3.2
Deloitte Access Economics (2012a)	Various*	Indigenous	Australia	12.1
Average				4.4

*A range of residential rehabilitation programs including therapeutic communities and healing centres.

Adopting a breakeven analysis approach, the costs of the healing centres program is offset by only a number of diversions from incarceration per annum. It is estimated that in the first year, collectively the HC program would require an investment of up to \$7,007,509 or \$539,039 per Centre (includes establishment and ongoing costs). During subsequent years, collective program funding up to \$6,032,509 or \$464,039 per Centre would be required (in 2014 dollars). Deloitte Access Economics (2012b) estimated that the average case of Indigenous incarceration (including expected recidivism) has social costs of \$500,414. Thus, if the whole program were to divert just 14 cases of incarceration during its first year and 12 cases per year thereafter, it would more than break even. This equates to just 1.08 cases per Centre during the first year and less than one (0.93) case per year thereafter. The evidence shows that individual centres where actual re-incarcerations are calculable divert one or two participants from jail annually (section 4.1.4).

In addition to the quantitative evidence in relation to breakeven returns from reduced justice system costs, qualitative evidence indicates that Indigenous healing results in even greater benefits in areas such improved education, employment and family violence outcomes. While even more difficult to quantify, the benefits from reconnection to community, to country and to dreaming are the most substantial from an Indigenous perspective:

“ It needs to be recognized that cost-benefit analyses can only portray one part of the whole “benefit” to communities ... How can one put a dollar figure on the power of the Spiritual resonance that underlies those processes or the core philosophy around which both Community Holistic Circle Healing (CHCH) and Biidaaban (Canadian Indigenous healing programs) operate and bring healing to offenders and to the community? A suitable criterion has not been put into place, nor perhaps can it be, to quantify the threads of value or the parts that comprise the whole” Buller (2001: 2).

Deloitte Access Economics



1 Background

In February 2008, more than two centuries after colonisation, the Australian government gave a national Apology to the Stolen Generations and Aboriginal and Torres Strait Islander peoples². Subsequent funding and consultation with Aboriginal and Torres Strait Islander peoples established an Aboriginal and Torres Strait Islander Healing Foundation (the Healing Foundation). The Healing Foundation is an independent Aboriginal and Torres Strait Islander organisation with a focus on community healing.

Over time, Aboriginal and Torres Strait Islander people have developed culturally effective ways of healing trauma and loss. The Healing Foundation initiatives are reconnecting Indigenous people to these ways, where colonisation and subsequent policies created disconnection. This reconnecting offers healing from pain and the deep and broad benefits of experiencing harmony and balance from participating more fully in family and community life in healthy, safe and confident ways.

The Healing Foundation has spent \$4.8 million funding a range of activities and projects for catalysing healing by Aboriginal and Torres Strait Islander peoples, families and communities. The *Our Healing, Our Solutions* program showcases the critical role of traditional and cultural practices in healing in the Aboriginal and Torres Strait Islander context.

In 2011-12, the Healing Foundation funded 21 Healing Initiatives across Australia (see HI in Figure 1.1). These community based projects involve work in urban, regional and remote areas of Australia and support healing across the community for men, women, families, children and young people, and Stolen Generations members. The Healing Initiative activities included (Aboriginal and Torres Strait Islander Healing Foundation, 2012a):

- development of local healing centres (HCs);
- healing camps on country;
- cultural renewal and revitalisation activities including traditional dance, song, arts, crafts, rituals, ceremony, kinship structures and bush trips;
- utilising both western and traditional healing practices including Ngangkari treatments, bush medicine, wild flower essences, meditation, massage and bush tucker;
- men's and women's gatherings;
- leadership and mentoring projects focussing on trauma prevention;
- life skills programs focussing on prevention, resilience and recovery from trauma;
- development of resources to heal trauma, grief and loss; and
- increasing skills and knowledge sharing between organisations and individuals involved in providing healing services.

Many communities wanted to develop their own healing centres (HCs) to meet their community's healing needs. In recognition of this, the Healing Foundation commissioned a report to increase the understanding of the community's desire for HCs and provide an evidential basis, indicative program logic and common resources, principles and processes required for the establishment and operation of a HC (KPMG, 2012). The report found that Aboriginal and Torres Strait Islander people who participated in workshops considered healing to be their single most important priority:

“Healing should be number one priority. We have tried all of the techniques of what our service providers have wanted us to do, but where do you think this has ended up? There are so many of us in prison”
KPMG, (2012: 9).

² In this report, we refer to Indigenous people meaning Aboriginal and Torres Strait Islander people.

In 2013, the Healing Foundation called for expressions of interest from eligible organisations to support the establishment of HCs in communities across Australia.

FIGURE 1.1 : Healing Foundation funded programs, 2012



Source: Aboriginal and Torres Strait Islander Healing Foundation, 2012a

Funding of up to \$75,000 was made available to eligible communities to engage a consultant or fund a development team to support the design and initial development of a HC for their community. Funding provided was not designed to support the ongoing operational costs associated with the day-to-day running of a HC. Rather, funding sources for ongoing running of the HCs were to be identified during business planning. Examples of the activities of communities that have received funding for the development of a HC are contained in section 1.6.

Through consultations with Indigenous community members and staff from Aboriginal organisations, the Healing Foundation (2012b: 17) concluded that Government, business and the mining sector have a moral imperative to invest in Indigenous healing as a result of *‘taking away our land, mining it, destroying it, and building on it, etc. They need to put back in what they have taken out because they have destroyed so many things – our traditions, practices, ceremonies, food sources, dance stories, etc.’*



1.2 Study purpose and method

The 13 organisations funded by the Healing Foundation to design and develop a HC for their community are listed in Table 1.1.

Table 1.1: Foundation-assisted Healing Centres

	Organisation	Centre name	State
1	Gurehlgam Corporation Ltd	Clarence Valley Healing Centre	NSW
2	Kinchela Boys Home Aboriginal Corp	Healing Our Way	NSW
3	Sydney Region Aboriginal Corp	Healing Centre	NSW
4	Dhauwurd Wurrung Elderly and Community Health Services Inc	Healing Centre	VIC
5	Victorian Aboriginal Child Care Agency	Healing Centre	VIC
6	Bidjara Traditional Owners Ltd	Healing Centre	QLD
7	Gallang Place Aboriginal and Torres Strait Islander Corp	Healing Waters Aboriginal and Torres Strait Islander Counselling and Wellbeing Service Townsville	QLD
8	Gurriny Yealamucka Health Services Aboriginal Corp	Healing Centre	QLD
9	Helem Yumba Inc	Healing Centre	QLD
10	Derbarl Yerrigan Health Service Inc	Healing Centre	WA
11	Nyamba Buru Yawuru Ltd	Yawuru Holistic Healing Centre	WA
12	Northern Carers Network	Nattadlu Kanggandi Kurrurru Towilla Healing Centre	SA
13	Larrakia Nation Aboriginal Corp	Healing Centre	NT

Deloitte Access Economics was commissioned by the Healing Foundation to estimate the potential net social benefits of these HCs, in order to support a business case for further investment in ongoing operation of healing centres. The Healing Foundation desired a desktop analysis of existing studies which could give an outline of the economic costs of trauma and the cost and benefits of healing services “to the extent this is feasible”.

Extensive literature searches revealed no extant cost benefit studies conducted on Australian Indigenous healing centres. Three studies were found that investigated the impacts on justice system costs from using HCs as diversionary activities (one Australian, two Canadian)³. Even among the mainstream community, studies that investigated the costs and benefits of the related concept of therapeutic communities were almost as limited, with no Australian studies, but four identified from the United States (US) and United Kingdom (UK).⁴

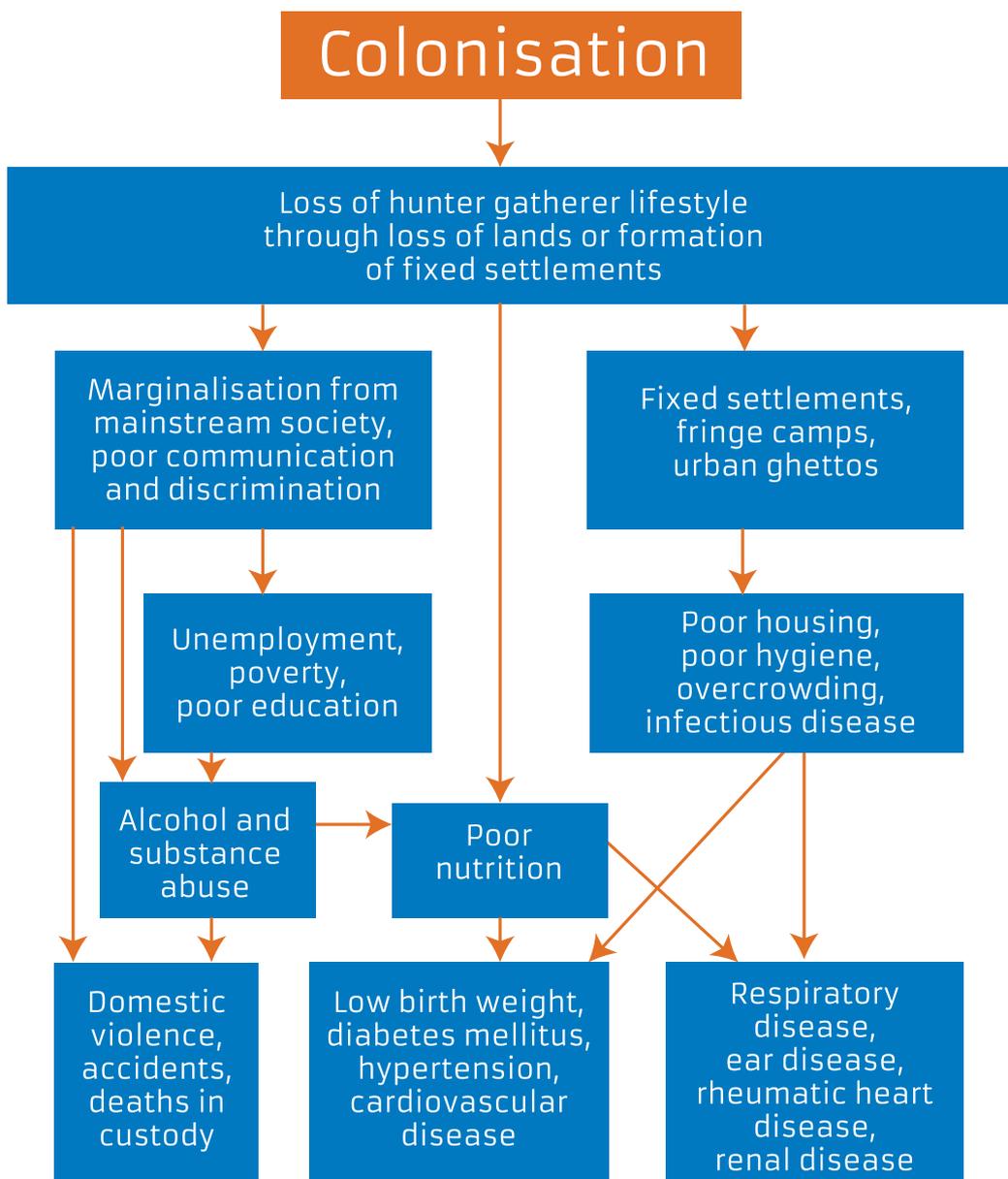
³ Deloitte Access Economics (2012a) and two by Buller (2001) respectively.

⁴ Dolan et al (1996), Davis et al (1999), Menzies et al (1993), Lo Sasso et al (2012)

1.3 Indigenous trauma

The trauma experienced by Indigenous people as a result of colonisation has had devastating consequences. The disruption to culture and the negative impacts on cultural identity has had lasting negative effects, which are being passed from generation to generation. The cumulative effect of this intergenerational trauma severely interferes with the capacity of Indigenous people to fully and positively participate in their lives and communities. This, in turn, has led to widespread disadvantage (Matthews, 1998).

FIGURE 1.2: Ongoing trauma impacts from colonisation



Source: Matthews (1998)



Coade et al (2008) report that the main forms of trauma affecting Indigenous people are:

- Historical/cultural trauma – Stolen Generations, racism, poverty;
- Community trauma – substance abuse, violence, multiple deaths;
- Family trauma – intergenerational trauma, domestic violence, loss of parenting skills;
- Individual trauma – child abuse and neglect affecting development, attachment to others and culture.

Assimilationist policies resulting in the removal of Aboriginal children from their families until the 1970s have had a devastating impact on the lives of Aboriginal people and the future generations. Their lasting legacy for Aboriginal people has included dispossession, destruction of traditional lifestyles, rapid cultural change, disruption of families and communities, discrimination, cultural exclusion, poverty, lack of educational opportunities and poor health (Healing Foundation 2012c).

Today, Aboriginal people are the most socioeconomically disadvantaged group in Australia and their health status is well below that of the general community, with an average life expectancy many years less than that of other Australians. Assimilationist policies such as the forced removal of Aboriginal children from their families have disrupted the fabric of Aboriginal family and community life. Aboriginal people are incarcerated up to 20 times more than the general Australian community, high school retention rates are many times lower and unemployment rates many times higher than for the general population. Chronic psychological distress has been shown to be associated with both longstanding environmental difficulties and intermittent acute stressors, such as physical illness in self and significant others, frequent bereavement, poverty and lack of educational opportunity (Mckendrick et al, 2013).

Purdie et al (2010) illustrates current significant health disadvantage associated with social determinants.

- Hospitalisation rates for cardiovascular disease in Aboriginal and Torres Strait Islander are two thirds higher than for other Australians.
- Rheumatic heart disease was nine times more common for Aboriginal and Torres Strait Islanders than for other Australians in the Top End of the Northern Territory and Central Australia.
- Three times as many Aboriginal and Torres Strait Islanders were reported to have diabetes or high sugar levels compared to other Australians.
- Hospitalisation rates for Aboriginal and Torres Strait Islander people with diabetes are almost six times higher than for other Australians
- Life expectancy for Aboriginal and Torres Strait Islander people is estimated to be 11.5 years for males and 9.7 years for females less than for other Australians.
- Overcrowding is common in remote areas where it is estimated that 48% of Aboriginal and Torres Strait Islanders live in such housing.
- Indigenous people are 13 times more likely to be in prison than other Australians.
- The retention rate for Aboriginal and Torres Strait Islander students from Year 7 to Year 12 was only 43% compared to 76% for other students.
- Aboriginal and Torres Strait Islander people aged over 18 are twice as likely to report being victims of violence or threatened violence than other Australians.
- The rate of substantiated child protection notifications per 1,000 was 32 for Aboriginal and Torres Strait Islander children compared with six for other children in 2006-07.

Kelly et al (2009) conducted a survey which found:

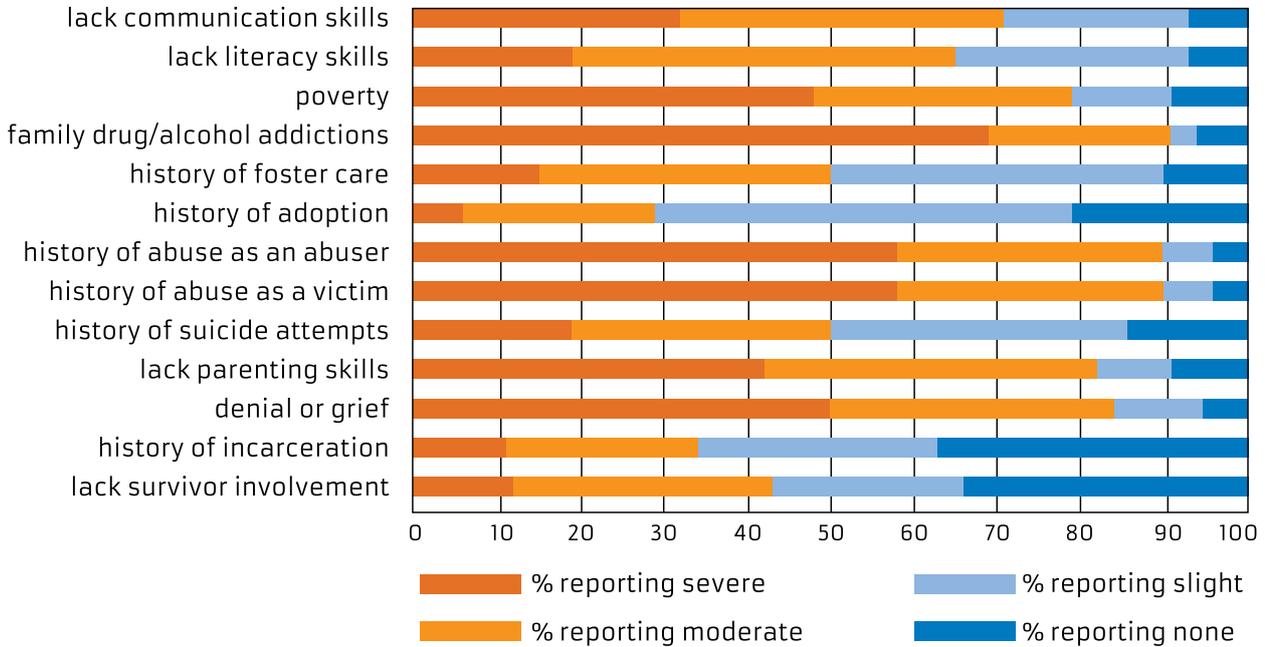
- Losing a family member or friend was reported by 58% of Indigenous people in remote areas. This was 2.4 times the rate for other Australians.
- Serious illness or disability affected 30% in major cities. This compared to 23% of other Australians who reported a serious illness and 7% a serious disability.
- Alcohol related problems impacted on 24.1% in remote areas, compared to 7% of other Australians.
- Indigenous Australians in remote areas were nine times as likely as others in remote areas to witness violence, and twice as likely when compared to Indigenous Australians in non-remote areas.
- Gambling problems were reported by 19% of respondents in remote areas. This was several times the rate reported by other Australians (3.2%).
- Trouble with police was reported by 16% of Indigenous adults, compared to 3% of other Australians.
- Being subject to abuse or being a victim of violent crime was reported by 10% of Indigenous adults, compared to 3% of other Australians.
- Being a victim of physical or threatened violence in the last 12 months was reported by 20% of Indigenous respondents, compared to 9% of other Australians.
- Having a serious accident was reported by 46% of respondents in remote areas. The rate for other Australians was 5.2%.
- Indigenous people were five times more likely than other Australians to live in crowded housing.



1.3.2 Canadian experience

Indigenous Healing Centres in Australia are modelled with consideration of Canadian counterparts. The effects of British colonisation on native peoples in North America have been similar to those in Australia.

FIGURE 1.3 : Evidence of trauma in Canadian aboriginal healing centre participants



Source: Aboriginal Healing Foundation (2001)

1.3.3 The impact of Indigenous trauma

Deloitte Access Economics (2012b) estimated the costs for some of the consequences of Indigenous trauma, including domestic violence, incarceration and volatile substance abuse:

- the total estimated financial cost from Indigenous family violence in 2011 was \$2.3 billion;
- the total estimated financial cost from Indigenous sentencing was \$1.17 billion in 2011; if burden of disease costs are included, this increased to \$11.8 billion; and
- the estimated national costs of petrol sniffing were around \$348 million per year in 2011 dollars.

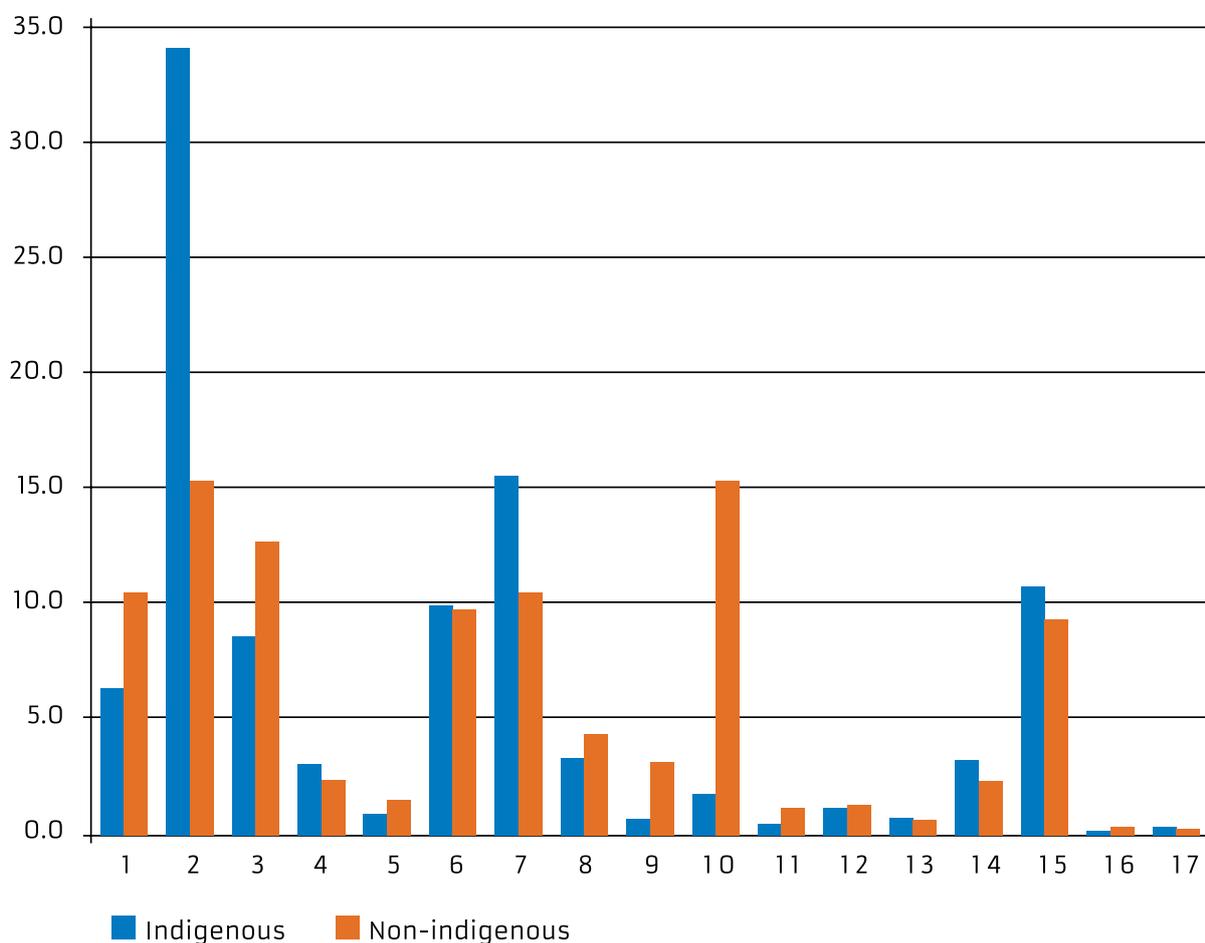
Sections 1.3.3.1 and 1.3.3.2 provide a brief description of some of the associated impacts of Indigenous trauma in Australia.

1.3.3.1 Incarceration of Indigenous people

An adult National Prisoner Census undertaken on 30 June 2013 (ABS 2013) found there were 30,775 prisoners held in the legal custody of adult corrective services in adult prisons, including periodic detainees in New South Wales and the Australian Capital Territory. The majority, 28,426 (92%) were males and 2,349 (8%) were females. Indigenous representation was high with 8,430 (27%) Indigenous prisoners counted in the Census, 7,657 (91%) males and 775 (9%) females.

As a proportion of all crimes committed by Indigenous prisoners, the percentage of offences which were ‘Acts intended to cause injury’ was almost twice that of non-Indigenous prisoners. ‘Unlawful entry with intent’ also had high representation among Indigenous prisoners compared to non-Indigenous prisoners. ‘Illicit drug offences’ had much higher representation among non-Indigenous prisoners compared to Indigenous prisoners, as did ‘homicide and related offences’.

CHART 1.2: Proportion (%) of Indigenous and non-Indigenous prisoners by type of offence, June 30, 2013



Source: ABS, 2013



1	Homicide and related offences
2	Acts intended to cause injury
3	Sexual assault and related offences
4	Dangerous or negligent acts endangering persons
5	Abduction, harassment and other offences against the person
6	Robbery, extortion and related offences
7	Unlawful entry with intent
8	Theft and related offences
9	Fraud, deception and related offences
10	Illicit drug offences
11	Prohibited and regulated weapons and explosives offences
12	Property damage and environmental pollution
13	Public order offences
14	Traffic and vehicle regulatory offences
15	Offences against justice procedures, government security and operations
16	Miscellaneous offences
17	Unknown

The national (crude⁵) imprisonment rate per 100,000 Indigenous adults in 2012-13 was 2,391.7 compared with a corresponding rate of 125.7 for non-Indigenous Prisoners – a ratio of 19.0:1, according to the Steering Committee for the Review of Government Service Provision (SCRGSP, 2014). Even taking into account the younger age structure of the Indigenous population, Indigenous people are more likely to be incarcerated than non-Indigenous people. Age standardised, the national imprisonment rate per 100,000 Indigenous adults in 2012-13 was 1,861.9 compared with a corresponding rate of 155.9 for non-Indigenous prisoners — a ratio of 11.9:1 (SCRGSP 2014).

Excluding prisoners with indeterminate, life with a minimum and periodic detention sentences, the median aggregate sentence length⁶ for sentenced Aboriginal and Torres Strait Islander prisoners was 2.0 years (24 months), while for sentenced non-Indigenous prisoners it was 3.5 years (42 months) (ABS 2013).

Excluding prisoners with sentences that are indeterminate, life (without a minimum), and periodic detention, the median expected time to serve⁷ for sentenced Aboriginal and Torres Strait Islander prisoners was 1.3 years (14.8 months). For the non-Indigenous prisoner population the median expected time to serve was 2 years (24 months) (ABS, 2013).

5 Not age standardised.

6 The aggregate sentence is the longest period that the convicted prisoner may be detained for the current sentenced offences in the current episode.

7 The expected time to serve is the period of imprisonment which a convicted prisoner is expected to serve taking into account the earliest date of release for sentenced prisoners.



Indigenous prisoners are more likely to have been convicted of a prior offence than are non-Indigenous prisoners. In 2013, 77% of Indigenous prisoners imprisoned had undergone a prior imprisonment versus 50.9% of non-Indigenous prisoners (ABS, 2013). As well as having higher prior offending rates, Indigenous prisoners have also been found to have higher re-offending rates than non-Indigenous prisoners (Thompson, 1995; Jones et al, 2006; Holland et al 2007). Holland et al (2007) found that Indigenous prisoners returned to prison at significantly higher rates than non-Indigenous prisoners, with 50% of Indigenous prisoners returning to prison within two years compared with 34% of non-Indigenous prisoners. However, this same study found that when age, gender, offence type, sentence length and imprisonment history were accounted for, Indigenous status was no longer significantly associated with recidivism. The authors suggest that the relationship between Indigenous status and recidivism might be driven by other factors such as age and number of prior terms of imprisonment, both of which are significant predictors of recidivism.

1.3.3.2 Substance abuse amongst Indigenous people

The use of alcohol, tobacco and illicit substances has significant negative impacts on Indigenous health and causes significant harm to families and communities through causing higher rates of injury, violence and interaction with the criminal justice system.

Alcohol

Economic marginalisation, discrimination, cultural dispossession and cultural assimilation difficulties, family conflict and/or violence and family history of alcohol misuse are all thought to contribute to risky alcohol use among Aboriginal and Torres Strait Islander people (Kelly and Kowalyszyn 2003; Saggars; Gray 1998 cited in AIHW, 2011). In 2008, the data shows that more Indigenous Australians (nearly three in ten or 29%) did not drink in the last 12 months which is almost double the rate of non-Indigenous Australians (15%). However, Indigenous Australians were twice as likely as non-Indigenous Australians to binge drink (17% and 8% respectively) in 2004-05. The proportion of Indigenous (15%) and non-Indigenous people (14%) who drank at long-term (chronic), risky or high-risk levels was similar in 2008 (AIHW, 2011).

Alcohol misuse is a contributing factor to a wide range of health and social problems, including: violence; social disorder; family breakdown; child neglect; loss of income or diversion of income to purchase alcohol and other substances; and, high levels of imprisonment (Wilson et al 2010). Vos et al (2007) estimated that the burden of disease associated with alcohol use by Indigenous Australians is almost double that of the general Australian population. In 2003, alcohol accounted for 6.2% of the overall burden of disease among Indigenous Australians, while preventing only 0.8% of this burden.

Indigenous Australians' deaths and hospitalisations due to alcohol abuse occur at a much higher rate than for other Australians (Wilson et al 2010). It is estimated that alcohol-related death rates were between five and 19 times higher for Indigenous Australians than for non-Indigenous Australians in Queensland, South Australia, Western Australia and the Northern Territory. Alcohol is also associated with 40% of male and 30% of female suicides within the Indigenous Australian population (Wilson et al 2010). Additionally, Indigenous people have higher rates of alcohol-related hospital admissions than non-Indigenous people. In 2005-06, the rates of alcohol-related injury from traffic accidents among Indigenous Australians were 20% and 30% higher - for males and females respectively - than those experienced by non-Indigenous Australians. In the case of assault, 50% were alcohol-related, with Indigenous Australian men and women experiencing assaults at 6.2 and 33 times, respectively, the rate of their non-Indigenous counterparts (Wilson et al 2010).

Tobacco

Tobacco smoking is the major cause of chronic disease among Indigenous people (Vos et al 2007). In 2008, the proportion of Indigenous Australians who smoked tobacco was more than twice the rate of non-Indigenous Australians. Just under half of Indigenous adults were current smokers (49.8%): 47.7% were current daily smokers while just over 2% smoked less frequently. Indigenous smoking rates were higher in remote areas than in non-remote areas. Smoking rates for Indigenous women during pregnancy are high. In 2008, more than half of Indigenous mothers (51%) reported that they smoked during pregnancy whereas the proportion of non-Indigenous pregnant women who smoked was around 14.4% (AIHW, 2011).

Illicit substances

Illicit substance use causes considerable harm within Indigenous communities. It is a contributing factor to illness and disease, accident and injury, and workplace problems. It is also a risk factor for ill health, such as HIV/AIDS, hepatitis C, malnutrition, low birth weight, poisoning, suicide, infective endocarditis (inflammation of the lining of the heart), self-inflicted injury and death by overdose (AIHW, 2011). The use of inhalants (for example, petrol sniffing or solvent abuse) can lead to serious health consequences, including brain damage, disability or even death (SCRGSP, 2007a cited in AIHW, 2011). Communities may also suffer family and social disruption due to domestic violence, crime and assaults related to illicit substance use. This disruption may be more apparent in smaller remote and rural Aboriginal and Torres Strait Islander communities (AIHW, 2011). In addition, illicit drug consumption has played a significant role in Aboriginal and Torres Strait Islander peoples' involvement in the criminal justice system (AIHW, 2011).

The 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) found that 43% of Indigenous Australians had tried at least one illicit substance in their lifetime and 23% had used an illicit substance in the last two weeks. The most common illicit substances used were marijuana, followed by amphetamines and pain-killers. Indigenous males had higher rates of illicit substance use than females. There were no comparative data available for non-Indigenous Australians. The Petrol Sniffing Prevention Program data collection provides estimates of the prevalence of petrol sniffing. During 2005–07, the subregions with the highest proportions of petrol sniffers were the South Central Australian subregion (16% of people within the Indigenous community) and the Ngaanyatjarra Lands in Western Australia (14%) (AIHW, 2011).



1.4 Indigenous healing

Indigenous healing involves the application of existing cultural knowledge and the development of new ways to practise this in a contemporary context, in order to address trauma stemming from colonisation and restore and sustain holistic wellbeing. According to Mackean (2009) cited in Arnott et al (2010:11):

“ Healing ... occurs throughout a person’s life journey as well as across generations. It can be experienced in many forms. Mostly, however, it is about renewal – leaving behind those things that have wounded us and caused us pain ... Healing gives us back to ourselves.”

Ultimately, healing restores and reaffirms a sense of pride in cultural identity, a connection to country and participation in and contribution to community. This is linked with spiritual, emotional, social health and wellbeing and is an important part of strengthening communities.

The Aboriginal Healing Foundation (AHF) (Canada) (2008: 7) describes healing as an ongoing journey of self-transformation with no end-point and being about the reparation of damaged and disordered social relations:

“ (Healing) does not deny historical processes or the legacy of the residential schools, which have created the conditions for social and psychological discontent; rather, it helps individuals understand why they have problems in a manner that allows them to simultaneously see that, while victims of oppression, they retain the necessary agency to change their lives for the better. Healing, then, is ultimately about hope for the individual, the family, the community, and the future”.

“ No one is ever completely healed. No one speaks of being cured in the same way biomedicine uses this concept. Even those who have been on the healing path for many years and who have become therapists themselves must struggle to remain on the path. Healing remains an ongoing process of self-transformation ... what (has) emerged is a common theme that healing is ultimately about the reparation of damaged and disordered social relations. The individual has become disconnected from family, friends, community, and even his or her heritage. Healing, then, is ultimately about hope for the individual, the family, the community, and the future” (AHF (Canada), 2008: 6).

1.4.1 Differences between Western and Indigenous healing

Different to traditional Western concepts of healing, Williams et al (2011) found that definitions related to Aboriginal healing practices tend to:

- have a more holistic approach to health than the approach taken in most Western medical models;
- mention spiritual and emotional issues in addition to mental and physical health;
- make frequent reference to ‘balance’ and/or ‘harmony’;
- place emphasis often on families and communities as well as on individuals;
- include references to nature or aspects of the environment;
- in many cases explicitly refer to healing from the trauma caused by aspects of colonisation, such as forced removals from family and incarceration in residential schools; and
- in contrast to western models, there are many examples which mention the healing required by those who have hurt others, as well as those who have been injured.

Williams et al (2011) conclude that traditional healing has only a very loose connection to health as it is understood in the mainstream, and is spiritual, holistic and often connected to expressions of identity such as land, family and culture.

Similarly, the AHF of Canada (2008) defines the key characteristics of healing as including:

- self-esteem;
- cultural reclamation or reinforcement;
- independence (emotional and financial);
- goal orientation;
- employability;
- leadership skills;
- movement beyond past trauma;
- seeking or continuing treatment and securing support;
- communication, relationship and parenting skills;
- healthy coping strategies;
- empowerment or assertiveness; and
- freedom from self-abuse (including addiction) and suicidal ideation.

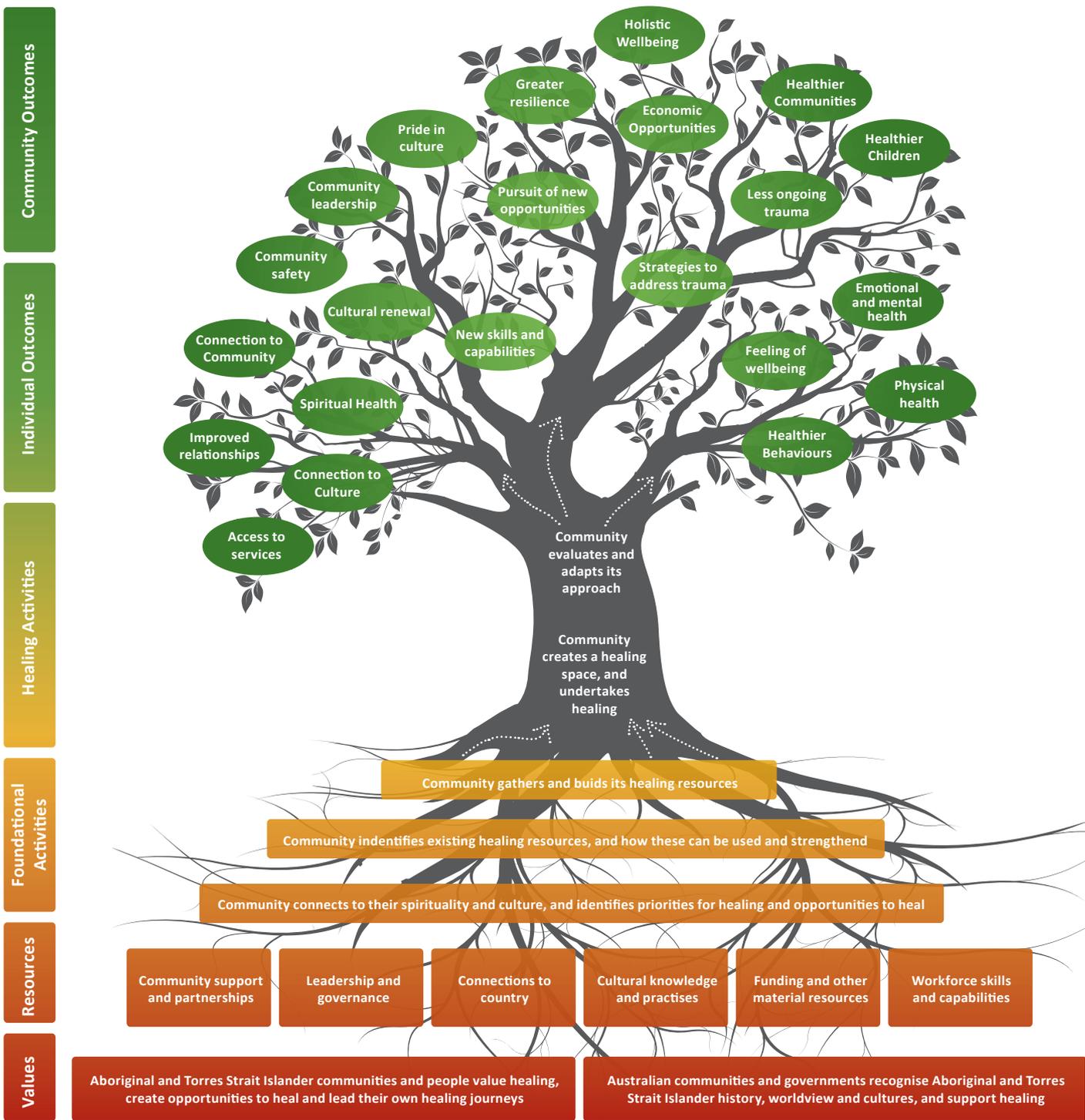
1.5 Indigenous Healing Centres

A HC is a space which supports the healing work for Aboriginal and Torres Strait Islander people. There is diversity in the way HCs are staffed, resourced and the activities in which they engage; however, there are consistent principles that apply to the design of all HCs across Australia. These common principles include (KPMG, 2012):

- HCs are physically socially and culturally safe and meaningful spaces for Aboriginal and Torres Strait Islander people and for the community which they serve in particular.
- HCs are founded from an Aboriginal and Torres Strait Islander world view, and strengthen connections between families, communities, land and culture.
- HCs are developed, led and primarily staffed by Aboriginal and Torres Strait Islander people, but also draw on complementary skills from mainstream partners and professions.
- HCs are operated with and for their own communities, identify and focus on meeting the community's healing needs, and work to empower individuals and communities to overcome the causes and symptoms of trauma.
- HCs facilitate healing through an experimental approach and emphasis on 'what works', drawing on both traditional and modern healing practices.

Healing programs encompass both traditional and western practices and cover a range of problems being experienced by individuals, groups of individuals, families and communities. Healing programs relate to the personal journey of individuals, families and communities dealing with the trauma (direct, indirect or trans-generational) caused by past policies and practices and current disadvantage, spanning areas of mental health, social and emotional well-being, family violence, child protection, addictive behaviour, sexual abuse, youth development, justice and corrections. The Healing Centres Final Report (KPMG, 2012) contains an indicative program logic for the establishment and operation of HCs as per Figure 1.4. Due to the diverse nature of HCs, this program is intended to illustrate the resources, foundational and healing activities, individual and community outcomes in a general sense. The activities carried out within HCs or healing programs are further described in section 1.6.

FIGURE 1.4: Indicative Healing Centre program logic



Source: KPMG (2012).

When describing the activities of a HC and what its desired outcomes are, it is important to acknowledge that there exist regions of Aboriginal experience and ways of seeing the world which remain incommensurable to white society. Simply put, non-Indigenous people *“cannot make sense of things from an Indigenous world view by simply extending our own brand of reason to cover the Indigenous world”* (Blagg, 2008: 50). Blagg (2008) notes that the notion of ‘program’ and the local ownership of such constructs presents a paradoxical if not contradictory problem in the context of remote Indigenous contexts. Programs are typically non-Indigenous constructs that are designed along the lines of mainstream world views, intent on achieving mainstream outcomes.

HCs provide the opportunity for Indigenous communities to develop what Blagg (2008) describes as ‘hybrid initiatives’ that sit between the ‘Aboriginal domain’ and the ‘non-Aboriginal domain’ in a kind of liminal space where syncretic processes are created at the points of intersection between these domains. While these are not traditional structures, they work within Aboriginal terms of reference and use Aboriginal notions of cultural authority to create a mechanism where *“Aboriginal people can manage problems in an Aboriginal way”*. Other than HCs, structures, practices and objects that sit in this liminal space include:

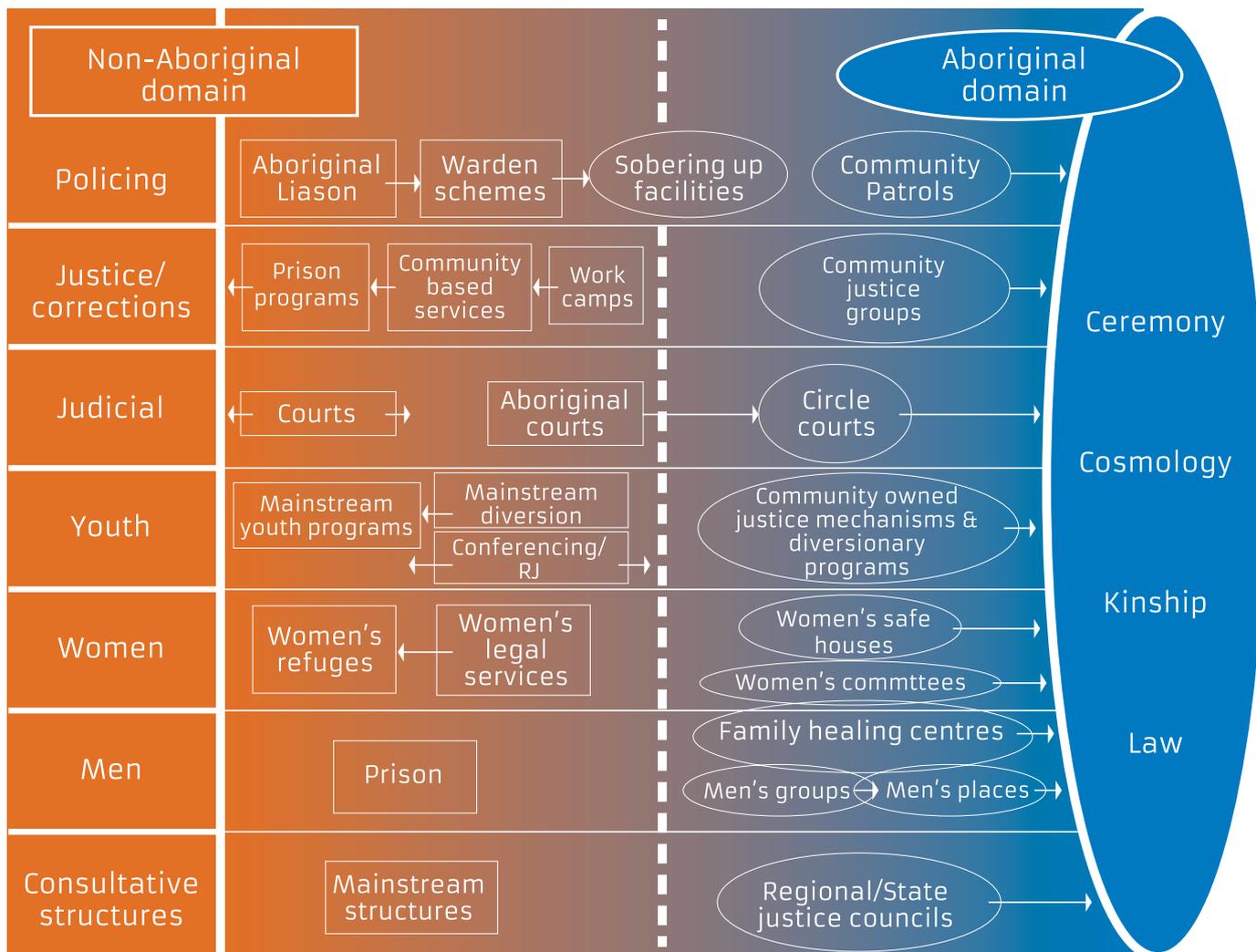
- Circle Sentencing Courts;
- Aboriginal Courts;
- Aboriginal policing;
- community justice groups;
- the ‘denied knowledge’ that is brought in to court by Aboriginal translators; and
- the cultural knowledge and authority of Aboriginal elders (Blagg, 2008).

Figure 1.5 provides examples of hybrid initiatives which sit in the liminal space between Indigenous and non-Indigenous structures.



FIGURE 1.5: Examples of hybrid Western-Indigenous structures in the justice realm

LIMINAL SPACE. HYBRID INITIATIVES



Source: Blagg (2008).

1.5.2 Healing resources required

The establishment of Healing Centres in Aboriginal and Torres Strait Islander communities requires a range of healing resources to be harnessed (KPMG, 2012). These are outlined in the following sections.

1.5.2.1 Cultural knowledge and practices

Cultural knowledge and practices are the source of healing for Aboriginal and Torres Strait Islander communities. These resources include knowledge and skills in bush medicine, bush tucker and traditional tools, knowledge of traditional languages, artwork, men's and women's business, lore and custom, kinship systems, song lines and dreamtime stories, and spiritual wisdom. The nature of cultural resources, and the extent to which communities have access to these resources, varies. This diversity of experience does not weaken the role of culture in healing but calls for a diversity of approaches in strengthening connection to culture.



1.5.2.2 Connection to country

Connection to country is an important resource for healing and can occur in multiple ways. Returning to custodial lands allows Aboriginal and Torres Strait Islander people to camp, spend time with other community members, yarn and practise culture. It can also be a time to collect materials used for healing such as food, medicine or tools. Returning to country is often seen as important for healers in understanding how to heal their people.

1.5.2.3 Community support and broader partnerships

Community support and broader partnerships play a central role in the development of healing centres. Community support is developed and maintained over time through purposeful effort to ensure that a healing centre both engages and meets the needs of the community. Trusted and respected community members can be ‘champions’ for healing who can help build consensus and mobilise the community to support the healing centre. Partnerships with organisations beyond the Aboriginal and Torres Strait Islander community can also be a significant resource.

1.5.2.4 Workforce development

The nature of a particular healing centre and the healing services it provides will determine the mix of workforce skills and capabilities required. Many communities will already have members with these skills and capabilities that can act as a resource in the development of their healing centre. A healing centre’s core staffing needs to reflect the community with which it works. As healing centres are relatively new in Australia, workforce development initiatives are essential.

1.5.2.5 Community leadership

Leadership within the community and good governance arrangements for a healing centre are another important resource. Community leaders play a crucial role in mobilising their community around the priority of healing and bringing people towards consensus and focused action. Community members, government representatives and relevant service providers can contribute to the governance of a healing centre provided that, on balance, the principle of self-determination for the community is enabled.

1.5.2.6 Sustainable funding

Attracting sustainable funding to support healing is an essential but challenging task. Healing is about empowering individuals and communities to generate holistic, sustainable and self-directed change and funders of healing work need to be comfortable with managing the uncertainty and long term commitment required of them.

In a healing forum held in Alice Springs, the main restorative activities identified by Aboriginal people were (Healing Foundation, 2012c):

- reconnection with country;
- building cultural strength;
- reconciliation;
- holistic programs;
- strengthening the role of men;
- providing good role models for children;
- genuine consultation; and
- taking care of those providing healing and support.

1.5.3 Design of Healing Centres

The Healing Foundation report (2012c) emphasises that the design and development of a healing centre is a significant piece of work. To support this emerging practice, dedicated time and resources are needed to document an effective program logic, business case and evaluation methodology. Many communities have not been able to move to a more comprehensive design and development phase due to a lack of dedicated resources.

The Healing Foundation (2013a) notes that the \$75,000 of initial funding is designed to overcome this barrier by providing communities with the necessary resources to fund the design and development stage of a healing centre. Activities outlined by the 13 organisations receiving funding include:

- community engagement and consultation regarding their needs with respect to a HC;
- governance establishment for the HC;
- evaluation of the evidence for HC service provided;
- identification of potential sites for a HC and the physical design;
- implementation plans/model for evidence based healing pathways;
- business case development;
- workforce identification and skills requirements;
- risk management framework;
- evaluation methodology;
- creation of partnerships with existing organisations that provide support services for Aboriginal people, government organisations and community based organisations; and
- identification of future funding sources.

The initial funding is not designed to be a source for ongoing operational costs associated with the day-to-day running of a healing centre. These funds enable consultation and comprehensive programmatic development and business planning, including sustainability planning, that otherwise would not be possible. A sample of activities from the April 2014 Progress reports of three HC development teams can be seen in Appendix A.

Business planning needs to ensure that funding sources are identified for any proposed healing centres from multiple funding options as future operational expenses will not be provided by the Healing Foundation.

1.6 Healing Centre activities

Aboriginal and Torres Strait Islander HCs offer a variety of activities reflecting the diversity of Aboriginal and Torres Strait Islander communities and their respective histories. Other activities that may complement Indigenous healing and HC activities but differ from HC activities are:

- not led by Aboriginal or Torres Strait Islander communities; and
- may address the symptoms and/or causes of trauma, alcohol problems or gambling addiction but do not align with the other principles of HCs.

As outlined in section 1.5, HCs operate in a variety of ways. Activities are often diverse, exploratory and informal, and evolve through the participation and input of community members. They cover a range of practices (traditional and western), cover a range of issues being experienced by individuals, groups, families and sometimes whole communities and operate with spirituality and culture at their core. Activities are developed by Aboriginal and Torres Strait Islander communities in response to a holistic understanding of their own healing needs. This requires an ongoing, iterative process of consultation and consensus making ('bringing the community with') when determining the future directions for a healing centre. Activities may focus on addressing a specific issue which is critically important to the community (such as the removal of children from families, or the maintenance of traditional healing practices), or a broader vision for the community's future. Therapeutic interventions are provided ranging across a broad spectrum of problems from mental health and emotional health to family violence, child protection, substance abuse, gambling, sexual abuse, youth development, justice and corrections.

HCs create appropriate spaces and arrangements for men, women, children, community gatherings, small groups, counselling and reflection. Traditional language/s, cultural norms, symbols and practices are often prominent within the space. They may be situated on custodial land, or on a site with significant meaning to the healing centre community. Activities that generate opportunities for cultural strengthening and renewal, learning and the practice of cultural and healing traditions may occur and may include visiting custodial land and meaningful sites, and the use of bush medicine, traditional tools, bush tucker and other produce. Activities also support individuals to develop and apply strategies to improve the quality of their life and relationships, often through a combination of mainstream and culturally specific therapeutic approaches (such as trauma informed counselling, restorative practices, yarning, advice and support from peers and elders, positive behaviour modelling, and opportunities for positive engagement, such as through meaningful work or creation of artwork). HCs tend to provide longer term, holistic and individualised support for individuals to heal. This support is not usually provided as a 'service' in the conventional sense, but is characterised by a creative and responsive partnership between the individual and the healing centre community.

There is also growing emphasis on preventative and restorative approaches. Caruana (2010) suggested a set of core characteristics for effective Indigenous healing programs:

- Indigenous ownership, design and evaluation of services – informed by an Indigenous, not a Western, worldview, and using culturally sensitive screening and assessment tools;
- holistic and multidisciplinary approach – addressing mental, physical, emotional and spiritual needs, with a focus on familial and community interconnectedness, as well as connectedness to the environment and spiritual realm;
- centrality of culture and spirituality – cultural renewal is seen by some as an essential precursor to healing;
- informed by history – being cognisant of the historical source of trauma, rather than focusing too strongly on the individual pathology;
- adopting a positive strength based approach – recognising and promoting the resilience of Indigenous people;
- preventative and therapeutic strategies – rather than reactive responses that merely seek to reduce symptoms;
- commitment to healing – as a process – a journey that takes time rather than a one off event;

- commitment to adaptability, flexibility and innovation – programs must be inclusive to ensure they reach people who may not have strong cultural ties and to incorporate localised practices;
- utilisation of particular approaches best suited to the Indigenous context – programs to include approaches such as narrative therapy, group processes and a combination of western and traditional practices, such as the use of traditional healers or ngangkari.

The evidence indicates that the most effective healing centres include a residential treatment component, and resemble a therapeutic community (TC) (Ryan et al, 2012). This involves a mutual support and self-help model where reciprocal relationships develop between staff and community members - staff and clients are simultaneously on their own healing journey and are able to use each other's experiences as a reflective tool for self-healing.

1.6.1 Real-life examples of HC activities/outputs

Specific activities of the 13 projects for which the Healing Foundation has provided establishment funds are still in the planning phase. A summary of planned HC activities for two communities is presented below.

Yarrabah activities planned

The Yarrabah community has identified the need for a new HC to provide holistic mental health treatment and other medical services in Yarrabah. This HC would integrate both medical and mental health/traditional healing practices into the same building to reduce the level of stigma attached to patients as a result of walking into the clinic. The design of the HC and the treatment techniques used must be tailored to the specific cultural practices and beliefs of the local community. Extensive consultation with local elders is crucial in the design phase of the HC. Quantifying and measuring the impact of healing will be challenging; however, on-going inclusion of elders into decision making and program implementation processes will help ensure that the services provided by the HC are appropriate to the needs of the community. Integrating volunteers from the community into the programs run by the HC will help to ensure that it is accepted as part of the community and not something being staffed and designed by outsiders.

Design elements that will be included in the Yarrabah Healing Centre include:

- a large open room with space for sitting down (group activities and meetings);
- an outdoor area for multipurpose use; and
- examination rooms for providing counselling and medical checks.

Design elements to be considered include:

- rooms for people to sleep or rest;
- a separate section of the building designated for women's health and healing and female doctors (this may improve uptake of services and lead to better results); and
- a kitchen service where patients, particularly women and children, can prepare and serve healthy food.

Mt Tabor activities planned

Bidjara community members have identified the need for healing as critical to the well-being of their community. In a workshop, they identified that a HC is needed because:

- young people have lost their way;
- there are displacement issues;
- there are drug and alcohol problems;
- there are general and mental health problems; and
- people lack self-esteem.

It is hoped that the HC will provide a legacy for future generations; rejuvenate culture and spirit; improve understanding of identity; reduce drug and alcohol problems; provide employment, training and education; and improve respect and recognition. The programs will be run for men, women, elders, youth, people with specific health issues (mental/general/drug and alcohol problems), non-Indigenous people, corporate groups, and provide coming of age ceremonies.

The programs will include: cultural/country awareness, spiritual awareness, return to country, ritual and ceremony, leadership, diet and nutrition advice, gardening/horticulture advice, exercise, meditation, mental health care, life skills, healthy lifestyle, drug and alcohol rehabilitation, appropriate natural healing modalities, fitness and wellness programs, hunting/fishing, bush food identification and use, bush medicine identification and use and training in art and craft. Additionally, the HC will conduct training in appropriate skills to equip people to engage with the workplace. A series of infrastructure needs for the HC have been identified as have two funding partners for future operations.

1.6.2 Evaluation of HC activities

CBA is largely a western concept and requires the measurement of benefits stemming from and costs of an intervention in quantifiable terms. Simply put:

The benefit of healing – cost of healing centres = net benefit

Both these benefits and costs are compared to the status-quo or 'usual-care' providing a quantification of the incremental change in costs and benefits of the interventions compared to an unchanged state. Measuring the benefits or outcomes of HC activities in quantifiable terms does not necessarily align with Aboriginal and Torres Strait Islander views of effective healing. Indigenous practitioners trained in Western methods warn against adopting only the methods of assessment and evaluation of Western biomedicine:

“ When it comes to testing the effectiveness of a new therapy or counselling intervention, it is crucial that the testing process include research methods and ways of knowing that characterize the diverse populations that will ultimately become the recipients of such helping services.” (Duran et al 2008,:293)

Measuring the efficacy or outcomes of healing programs HC activities is problematic in that 'healing' is an ongoing process and does not possess an endpoint of 'being cured' as would exist in a biomedical approach. No one is ever completely healed and healing is understood as a journey along a pathway upon which one may suffer setbacks and deviate then re-join years after the healing process has started (AHF, 2008)

Most healing programs use a combination of traditional healing methods and Western therapies; however, the focus is very much directed towards the spiritual which is ignored in most Western therapies (Mckendrick et al. 2013). To enable quantification of costs and benefits, CBA requires that the intervention and its attributable outcomes be viewed through a western lens with the requisite appropriate data collection. Although HC activities are widely reported in the literature, there is a lack of efficacy data reported according to a western word view. Section 2 further explores reasons why efficacy data has not been reported according to the literature.

Ryan et al (2012) offers the opportunity of conceptualising HCs through a western lens through highlighting the similarities between the TC approach and the Aboriginal and Torres Strait Islander concept of wellbeing. The Australasian Therapeutic Communities Association (2009) describes a TC as:

“ A treatment facility in which the community itself, through self-help and mutual support, is the principal means for promoting personal change ... Residents and staff participate in the management and operation of the community, contributing to a psychologically and physically safe learning environment where change can occur (and). There is a focus on social, psychological and behavioural dimensions of substance use, with the use of the community to heal individuals emotionally, and support the development of behaviours, attitudes and values of healthy living.”

According to Ryan et al (2012), elements of therapeutic communities similar to the Australian Aboriginal and Torres Strait Islander HCs are the:

- scope of treatment or healing process, individual, group, community and society;
- environment culture, learning knowledge, practising behaviours, supporting community members, sharing responsibility, transferring skills to greater community;
- flexible program structures with a focus on continual improvement based on community feedback and needs; and
- therapeutic or healing focus, seeing the presenting issue as an adaptive behaviour not as a faulty person.

The lack of outcomes data relating directly to Aboriginal and Torres Strait Islander HCs has meant that in developing this comparison of costs and benefits, the authors have conceptualised the HC as similar to a TC due to its similar elements and existence of reported tangible outcomes. This approach has limitations which must be acknowledged in the analysis:

- most studies are not Australian;
- most studies are not Indigenous
- studies chosen focus on dollar benefits to health and justice systems.

1.7 Report structure

The remainder of this report is structured as follows.

- Section 2 outlines the contribution of HCs to the well-being of Aboriginal and Torres Strait islander people. The construct and style of healing centres with respect to traditional and cultural models is considered.
- Section 3 outlines the benefit pathways across four domains of quality of life in terms of spiritual healing, standard quality of life measures, education and employment.
- Section 4 outlines the costs to the community and the Australian Government of administering the healing centre programs.
- Section 5 summarises the results of the CBA and conclusions are presented.

2 Potential benefits of Healing Centres

Although there is much documentation on what constitutes an effective Indigenous healing program, there is a lack of evidence regarding positive tangible outcomes/benefits from participation in healing centres in Australia and internationally. In a review of the literature, Mckendrick et al (2012) did not find any evaluation of Indigenous healing programs that used a clinical trial methodology (comparing the program with another evaluated program or placebo intervention). Barriers identified included the long period of time required to show changes in health and wellbeing, many Indigenous practitioners and communities do not accept that evaluation is necessary and the fact that programs need to be developed to suit local contexts and are not strictly comparable. The Healing Foundation (2012b) reports that there are a variety of challenges in gathering an evidential basis for the benefits of Indigenous healing programs. The challenges related to outcome measurement are because healing programs:

- are often small in nature;
- are short-term in nature and unable to track outcomes over a long period – such as employment, living conditions, family situation, recidivism, drug and alcohol abuse, etc;
- are not resourced to enable “evaluation” to be built-in;
- may not be staffed by workers who have the skills or interest in evaluation on top of their need to deliver a quality service;
- may be limited to evaluation measures which are qualitative in nature – such as levels of satisfaction with the program;
- changes in confidence, self-esteem, hope in the future (e.g. “I feel more connected to my community”, “I am more positive about my future” and/or the use of case studies;
- need to protect the cultural integrity and intellectual property of traditional healing practices and not open them up to the scrutiny of western evaluation techniques;
- are often not replicable in multiple locations/communities because they are designed specifically around local culture, community and target group needs; and
- would find it difficult to demonstrate cause and effect – participation in healing programs on their own is not sufficient without other issues being addressed simultaneously.

For example, Cripps and Mccade, (2008) report that the failure of mainstream programs to address family violence within Indigenous communities in Australia has led to grass-roots approaches which are largely undocumented. These approaches provide a holistic approach to the problem, based on partnerships with government and non-government organisations and are guided and supported by community autonomy, capacity and development. However, their outcomes are undocumented (Cripps and Mccade, 2008).

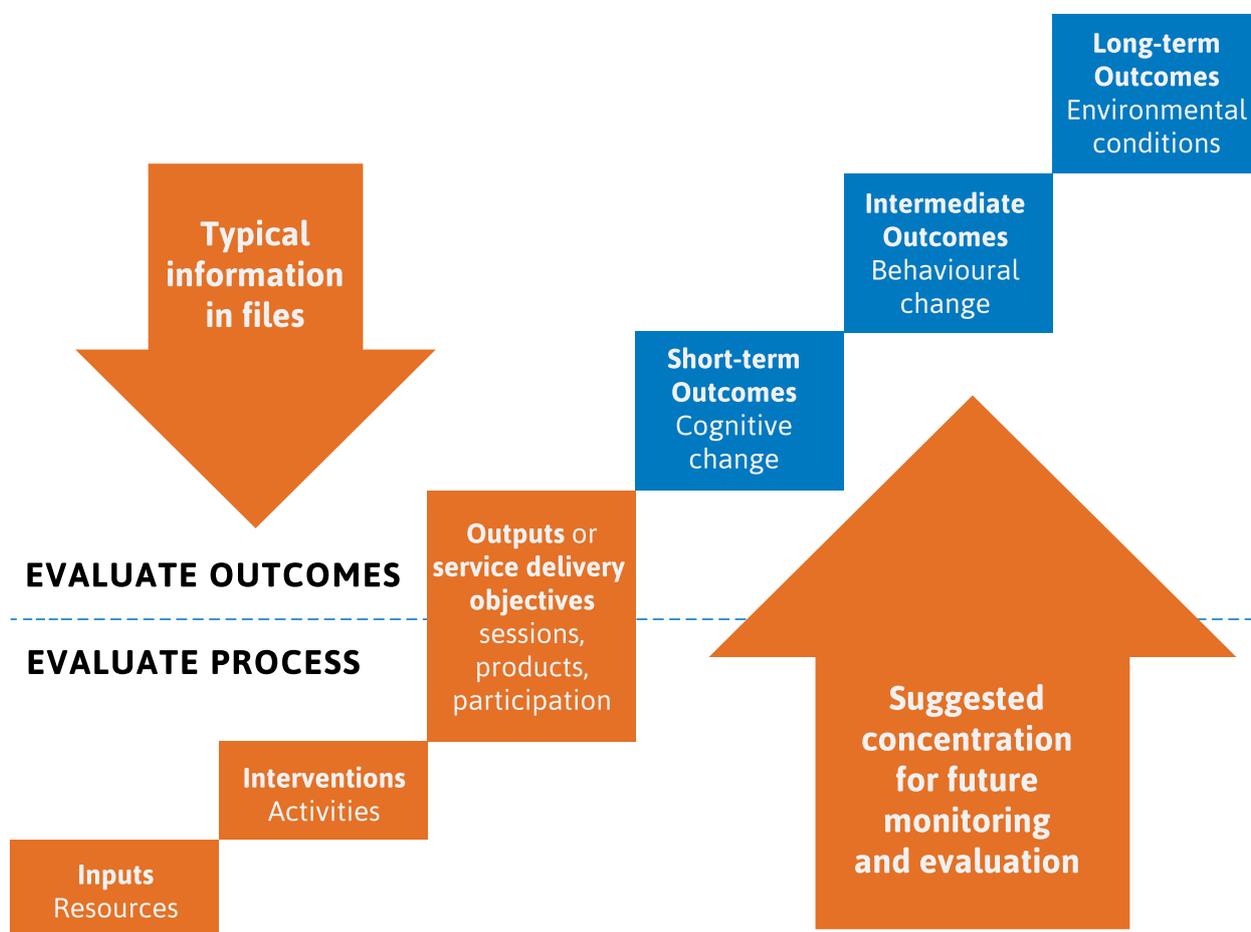
In a review of the Australian and international evidence regarding the benefits/outcomes from healing programs, Williams et al. (2010) found that Indigenous healing can:

- reduce the incidence of suicide;
- address mental health concerns;
- alleviate stresses on the health system;
- improve engagement with education;
- improve health promotion and awareness among Aboriginal participants;
- reduce domestic violence;
- overcome the impact of trauma and abuse;
- improve social inclusion;

- improve collaboration between mainstream and Aboriginal services;
- reduce recidivism rates among criminal offenders;
- enable reconciliation;
- enable intergenerational learning; and
- reduce rates of sexual and physical violence.

However, these outcomes are not quantified in the literature and hence do not easily lend themselves to CBA. In fact, the reported outcomes from healing programs are short-term and there are few examples of long term quantifiable outcomes. This problem is not limited to the Australian literature. Figure 2.1 demonstrates that the Canadian AHF suggests that concentration for future monitoring and evaluation should be on intermediate outcomes or behavioural change moving beyond cognitive change (AHF, 2006). Unfortunately no published evidence of this follow-up work could be found.

FIGURE 2.1: HC inputs, outputs and outcomes



Source: Aboriginal Healing Foundation (2006)



2.2 Intangible benefits

Coutre et al (2001: i) observe that it may not be possible to place a dollar value on the benefits of Community Holistic Circle Healing (CHCH) for First Nations in Canada:

“ Clearly, Aboriginal culture, value-system and process differ significantly from the dominant society ... The real value of CHCH work can only be identified by the community members impacted by the healing process; typically, however, the benefits of this process have not been acknowledged nor measured by the dominant society. Yet, the benefits of the CHCH activity have touched all aspects of life in Hollow Water, many of which cannot be given a specific dollar value. It is very difficult, if not impossible, to adequately place a dollar value on the depth, quality, commitment and sustainability of the substantial healing work achieved in Hollow Water, and the impressive track record CHCH holds.”

A consolidation of annual evaluation reports of 36 Canadian AHF’s funded projects from 2001 to 2003 assessed achievement of short-term outcomes. These included (AHF, 2006):

- increased understanding and awareness of the Legacy, as well as Survivors’ healing issues and needs;
- increased capacity of Aboriginal people to engage in the healing arts/professions;
- strengthened positive ties between those suffering from the Legacy and those in a position to heal;
- more strategic planning with a focus on healing;
- increased documentation and publication of the history, increased honour for those who have suffered; and
- enhanced healing, which is broadly defined as a reclamation of all that was lost caused by the effects of attending residential school.

These short-term outcomes in turn are believed to create conditions that will facilitate sustainable healing activities and end the intergenerational cycle of physical, sexual and other forms of abuse. In terms of quantifiable outcomes, the evaluation concluded that data on suicide, physical abuse, sexual abuse, children in care and incarceration rates remained high and there was no consensus among key informants that these problems were decreasing. This is further explored in section 2.3.2. However, there appeared to be individual case reports regarding the ways in which participant’s families and partners benefitted.

In an Australian context, the Healing Foundation’s 2012-2013 Annual Report (Healing Foundation, 2013b) reported success across the following outcomes from 14 healing projects:

- strengthened spirit, increased wellbeing, greater connection to and pride in cultural identity and improved social and emotional wellbeing;
- strengthened community and local leadership through culturally driven and managed activities;
- increased opportunities for participants to be paid for applying their cultural skills and knowledge in practice and in providing opportunities to engage with employment and participate in economic activity; and
- creation of a grieving space and healing time to enable participants to take care of hurt.

2.3 Tangible (but not measured) benefits

2.3.1 Australian programs with HC elements

There are a range of programs/initiatives implemented at the grass-root levels that have provided community benefits in Indigenous populations. This section provides examples of programs that i) appear to have HC elements, and ii) have demonstrated effectiveness according to the Steering Committee for the Review of Government Service Provision (SCRGSP 2011):

- Aboriginal Women Against Violence (NSW) is a safe space in which Aboriginal and Torres Strait Islander women in the Liverpool and Campbelltown areas learn to become trainers, mentors and advocates against violence in their communities.
- Through Young Black Eyes Workshop Kit (national) raises awareness of the effects of family violence and abuse and neglect of children, and has been used to run workshops nationally.
- Offenders appearing in a Murri Court (Queensland) had lower rates of absconding subject to warrant than the same Murri Court participants appearing in a mainstream Magistrates or Children's Court. However, appearing for sentence in the Murri Court had no impact on reoffending or the seriousness of offending.
- The Koori Youth Contact and Cautioning Program (Victoria) was developed in 2007 by the Victorian Aboriginal Legal Service in partnership with Victoria Police, with a pilot in the regional areas of Mildura and the Latrobe Valley. The program increases family and local community involvement in the diversion process, with Koori youth justice workers to provide advice. An evaluation of the program in 2007-08 found an increase in cautioning for first time Indigenous youth offenders in both pilot sites (a 45% increase in Mildura and a 32% increase in the Latrobe Valley). The success of the pilot has seen its expansion to other areas within Victoria.
- The Local Justice Worker and Koori Offender Mentoring and Support programs (Victoria) are designed to reduce the number of Indigenous offenders breaching community correctional orders. Local justice workers in 10 community organisations help establish culturally appropriate worksites for Indigenous offenders, and assist offenders to comply with their orders. More than 30 worksites have been established and assistance provided to over 1,000 clients since 2008. In addition, Koori Elders and Respected Persons provide support, mentoring, advice and cultural connection to Indigenous offenders to assist them to meet the requirements of their intensive community correctional orders. Since these programs began in 2007-08, there has been an increase in the number and proportion of community correctional orders successfully completed by Indigenous offenders, and by 2009-10, the successful completion rates for Indigenous and non-Indigenous Victorians were almost identical.

2.3.2 Canadian Indigenous Healing Programs

The residential schooling system in Canada began in the 1830s and was an initiative of Christian missionaries with the express intent to 'civilize' and the Canadian Aboriginal people through cultural extinction. From 1879, the residential schools were introduced as Canadian government policy and operated as a joint partnership between the government and church entities. Between the 1800s and the 1990s, over 130 church-run residences, industrial and boarding schools and northern hostels existed with the last federally run residential school closed in 1996. Within these schools, Aboriginal people were forbidden from using their language, interacting with opposite sex siblings and having warm familial connections to parents, denying them important cultural and psychological influences. The generations of children subject to these institutions received no nurturing, personal liberty, privacy or safety, leaving them ill equipped to raise their own families. They suffered physical and sexual abuse leading to low self-esteem, anger, depression, violence, addiction, unhealthy relationship and parenting skills, fear, shame, compulsiveness, bodily pain and anxiety. The intergenerational impacts of this trauma and the horrific stories of thousands of residential school Survivors (the Legacy) were not recognised until the 1980s (AHF, 2006).

In 1998 The AHF was created as a not-for-profit organisation. The AHF's role was to manage the distribution of a \$350 million one-time grant from the Government of Canada for community-based healing of the legacy of physical and sexual abuse at residential schools. It supported community-based healing initiatives that break the cycle of intergenerational abuse and create healthy Aboriginal communities where families are helped to learn and support their own well-being. Projects funded by the AHF focused around:

- healing services- either traditional or Western approaches;
- prevention/awareness activities;
- conference gatherings;
- honouring history;
- training- for potential healers and curriculum development;
- knowledge building
- community needs assessment; and
- project design and setup.

In 2000, a program evaluation of the AHF funded activities began with the random selection of 36 AHF-funded projects for file review, three national surveys sent to operational organisations in 2001, 2002 and 2004, telephone interviews with AHF board members, national focus groups with 'promising' projects, case studies and individual participant questionnaires. The evaluation found that a total of 1,686 communities were being serviced by the AHF, with a possible maximum of 59,224 participants engaged in AHF funded activities (Kishk Anaquot Health Research, 2001).

KPMG (2012) state that "The final report of the Canadian Indigenous Healing Foundation⁸ concluded that properly funded community-administered Indigenous Healing Centres have led to significant reductions in many of the most socially damaging problems (including suicide) in families and communities impacted by the residential schools system". Unfortunately, for the purposes of this cost-benefit analysis, the Final Report referred to does not demonstrate any "significant reduction" in socially damaging problems. Despite weighing in at over 1,100 pages, the final report (AHF, 2006) has very little analysis of outcomes almost none of which is quantitative and nothing whatsoever in the way of cost-benefit analysis.⁹

The initial interim evaluation report (Kishk Anaquot Health Research, 2001:11) states *that an impact evaluation would be conducted informed by thirteen case studies* representing each of the project types funded by AHF. Indicators were to include rates of physical and sexual abuse, suicide, incarceration and children in care.

A promising start was made by the AHF funded projects. The third interim report (Kishk Anaquot Health Research, 2003) reports that a vast majority (>85%) of participants rated projects' ability to provide respectful, welcoming and safe environments for healing very favourably. The majority also felt that their experience in the project helped them to handle difficult issues (71%), resolve past trauma (75%), prepare for and handle future trauma (78%) and secure support (64%). When asked about their ability to achieve personal goals in the context of AHF-funded projects, about a third indicated that they were able to do so completely or extremely well.

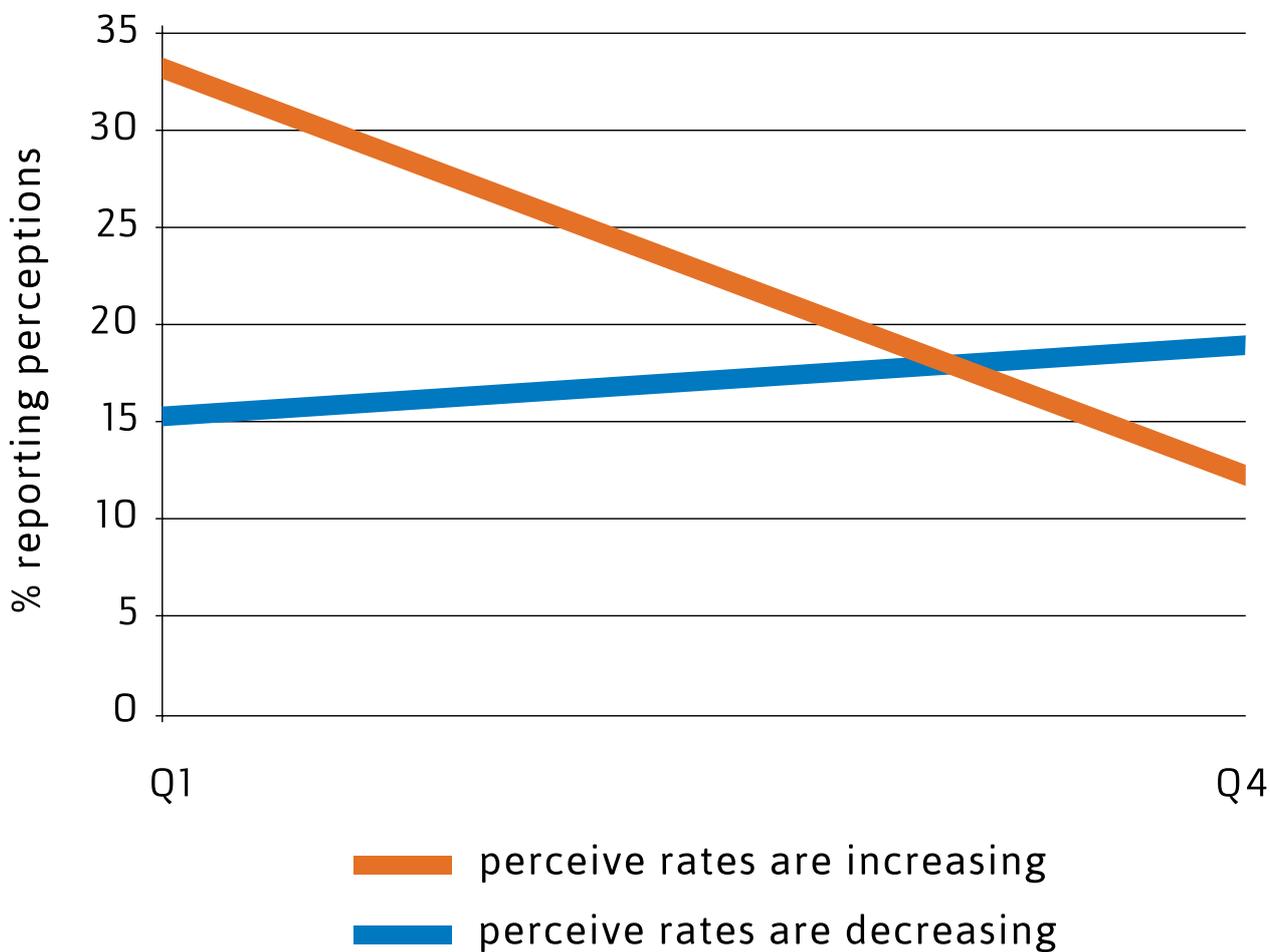
⁸ Technically, it is the Aboriginal Healing Foundation.

⁹ This is not a criticism. The Report contained many personal stories, which is probably a more effective way of evaluating results for the Canadian Indigenous target audience.

However, for reasons not specified other than as noted in the third interim report that *“it is still very early in the life of the initiative and impact evaluation is arguably premature...(and) it is clear that efforts have not yet reached peak activity”* (Kishk Anaquot Health Research, 2003, p. 40), the planned impact evaluation was not followed through. As a result, the 2006 Final Report of the AHF (AHF, 2006) which reports the results from the evaluation has very little numeric information.

- Volume 1 notes “For participants at the Pisimweyapiy Counselling Centre (Nelson House Medicine Lodge, Manitoba), evidence of change included some appearing better able to maintain sobriety, seek and secure employment, disclose past trauma, display physical affection, be outgoing, seek spiritual fulfilment and recruit others to participate”.
- Volume 2 (p.115) provides two pieces of graphic analysis of results from a national survey of participants conducted by the Aboriginal Healing Foundation. In both cases, only perceptions are reported, and those mostly for variables that would not be measured in a mainstream evaluation. The first is Figure 28 in the original.

FIGURE 2.2: Perceptions about children at risk by duration of healing program

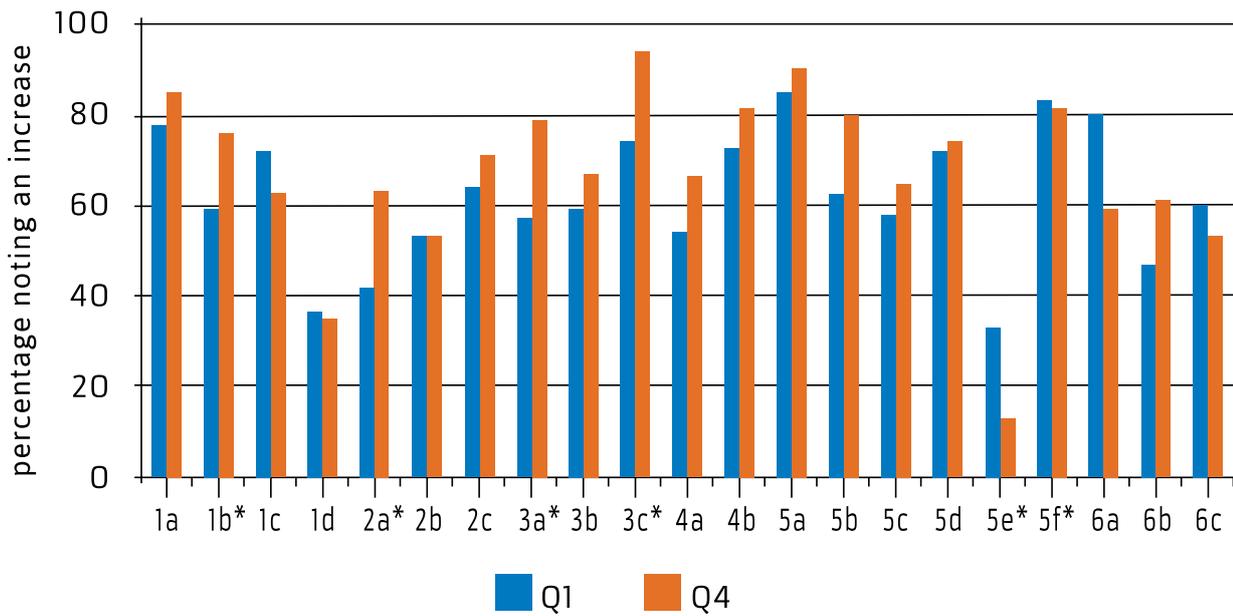


Note: Q1 = duration up to 15 months, Q2= duration over 42 months
 Source: Aboriginal Healing Foundation (Canada) 2006

- The second (Figure 29 in the original) is similar.



FIGURE 2.3: Perceptions of select impact variables over time



Notes: Q1 = duration up to 15 months, Q2= duration over 42 months

1a - Survivors want healing services

1b - Survivors meet to support each other or encourage other Survivors to heal

1c - Survivors are involved in decision-making about the project

1d - Survivors have decision-making authority in other service networks

2a - There are local healing services unique to the needs of Survivors and their families

2b - Local services for Survivors are used by Survivors and their families

2c - Survivors are using a range of social support services

3a - Community is using learning tools (e.g., archives, audiovisual materials, a curriculum package, visitor’s centre, commemorative site) to teach about residential schools

3b - Agencies outside of the community are aware of and understand the impact of residential schools on Aboriginal families and communities

3c - Survivors and their families understand how the history of residential schools has affected them /their parents/their grandparents, etc.

4a - Local access to training opportunities for healers/helpers 4b - Healing team or helpers have adequate knowledge and skills to effectively deal with physical and sexual abuse issues

5a - Participation in healing

5b - Disclosures of physical abuse

5c - Disclosures of sexual abuse

5d - Community is working together to support healing

5e - Number of children who are at risk in the community

5f - Healing activities are targeted at both Survivors and their families

6a - Community planning for long-term healing

6b - Community leaders are seeking resources to support long-term healing

6c - Organizations and service agencies (inside and outside the community) are trying to secure support for long-term healing for Survivors and their families

Source: Aboriginal Healing Foundation (Canada) 2006

However, there are some quantitative measures of the impact of colonisation trauma in Canada. Chandler and Lalonde (1998) assessed evidence of community trauma in Canada against First Nation adolescent suicide rates. They constructed a scale to test the theory, looking at First Nations communities to find:

- secure Aboriginal title to traditional lands;
- certain rights of self-government;
- community control over educational services, police and fire protection services and health delivery services; and
- officially recognised “cultural facilities” to help preserve and enrich tribal culture.

The results indicated that each of the six markers of cultural continuity employed here was found to be associated with a clinically important reduction in the rate of youth suicide. Similarly, an overall index created by summing across these different cultural factors proved to be strongly and significantly associated with reduced suicide rates (e.g. the observed five-year suicide rate fell to zero when all six of these protective factors were in place in any particular community).

2.4 Potential benefits per person

With one exception, the cost-benefit studies assessed in Chapter 4 as proxies for Indigenous HCs are either overseas and/or not Indigenous. Accordingly, an alternative option is to conduct a break even analysis in relation to the line of enquiry: for the indicative investment of \$539,039 in the first year (establishment cost of \$75,000 and operational costs of \$464,039) and \$464,039 per year thereafter (operational costs only)¹⁰ per HC, how many cases of trauma-related harm would need to be diverted before the investment paid for itself? (Section 4.1.4).

2.4.1 Costs of domestic and family violence

Domestic violence (DV) technically only includes violence by an intimate partner. COAG (2009) notes “The term, ‘family violence’ is the most widely used term to identify the experiences of Indigenous people, because it includes the broad range of marital and kinship relationships in which violence may occur”. Memmott et al (2001) note that in Indigenous contexts “the term ‘family’ means extended family, which more technically means a kinship network of discrete intermarried descent groups and, in many such cases, ‘family’ may constitute an entire community”. The issue of family violence within Indigenous communities has been described as a ‘national emergency’ with Indigenous people more likely to be victims of violence than any other section of Australian society (Kripps and Davis, 2012). The evidence suggests that a combination of interrelated factors contribute to the occurrence of family violence in Indigenous communities. Kripps and Davis (2012) summarised these factors as including:

- the disruption and distress caused by colonisation, dispossession and removal of Indigenous children from their families;
- socioeconomic disadvantage including unemployment, welfare dependency and overcrowding in households; and
- physical and mental health issues, low self-esteem and destructive coping behaviours such as substance abuse.

Deloitte Access Economics (2012b) estimated the total lifetime costs of domestic violence (DV) per adult victim were around \$302,462 per victim¹¹ in net present value (NPV) terms (2014 dollars). This is the amount of social and financial costs that can be avoided if a case of DV is prevented.

¹⁰ KPMG (2012) provides an indicative guideline for the cost of successfully operating a healing centre. Costing categories have been used in the estimation of a total cost of \$539,039 (establishment and ongoing cost) in the first year and \$464,039 per year thereafter specified in this report. Further details can be viewed in Appendix B

¹¹ The original report estimated the life time costs of DV per adult victim to be around \$282,253 in 2011 dollars. This figure has been inflated according to consumer price index to 2014 dollars. Consumer price index can be found at Australian Bureau of Statistics, 2014, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/6401.0Mar%202014?OpenDocument>, accessed 1 June 2014.

This provides an estimate of the cost of DV applied to the general population and may be below the cost for Indigenous victims.

- Costs may be higher for Indigenous women if the severity of domestic violence is higher in the Indigenous population than in the rest of the population. Nancarrow and Schmider (2007) report that Indigenous females are 35 times as likely to be hospitalised due to family violence as other Australian females, and the Australian Domestic and Family Violence Clearinghouse reports that Indigenous women are ten times more likely to die from family violence as non-Indigenous women.¹²
- It is possible that productivity losses per person may be lower in Indigenous communities; however, this is only one relatively small component of the total cost.

2.4.2 Costs of incarceration

As discussed in section 1.3.3.1, Indigenous representation in Australian adult corrective services is high. Indigenous people in adult corrective services are more likely to have been previously imprisoned and are more likely to reoffend. The main offences committed by Indigenous people incarcerated in adult corrective services on June 30 2013 were 'acts intended to cause injury' and 'unlawful entry with intent'.

In 2012, Deloitte Access Economics (2012b) estimated direct financial costs of \$358,915 per Indigenous incarceration. This estimation includes the likelihood of reoffending but does not including indirect financial costs such as lower employment. In addition to financial costs, there are also burden of disease costs. Deloitte Access Economics (2012a) calculated that the expected costs of Hepatitis C from incarceration of Indigenous Australians with drug and alcohol related problems are \$23,281 and the cost of Indigenous premature mortality is \$92,254 due to incarceration (relative to residential rehabilitation). Adding wellbeing costs yields a total cost of \$474,450 per case in 2012 dollars or \$500,414 in 2014 dollars when adjusted using the consumer price index (CPI).

2.4.3 Costs of drugs and substance abuse

A major national review in 2006 found that volatile substance use (VSU) is an issue in both Indigenous and non-Indigenous communities in Australia. It found that petrol sniffing is the most common form of Indigenous VSU in remote areas of Australia, whereas in urban and regional centres sniffing aerosol paints ('chroming') is more common. Estimates of the prevalence of petrol sniffing in remote Indigenous communities are varied. A 2006-07 survey of remote communities introducing non-sniffable Opal fuel estimated that 4.8% of the population between five and 40 years were current sniffers (Midford et al. 2011). Another estimate in 2008 across all sniffing areas in remote Indigenous communities and some urban areas produced a sniffing rate of 3% (South Australian Centre for Economic Studies, 2010 cited in Midford et al. 2011).

The estimated cost per case of petrol sniffing in remote Indigenous communities in 2011 prices is \$158,673 (Deloitte Access Economics 2012b). When adjusted using CPI, this equates to \$170,034 in 2014 dollars.

¹² <http://www.adfvc.unsw.edu.au/specialcollectionsIndigenouspeople.htm>



3 Costs of Indigenous Healing Centres

Deloitte Access Economics' literature review was not able to uncover any estimates for the cost of either establishing or running a HC. Hence, costs have been estimated from the small number of extant cost benefit evaluations conducted for similar activities (mainly First Nation healing centres in Canada, and mainstream therapeutic communities in the UK and US).

Quantitative evaluations for any form of community healing interventions are conspicuous by their absence. This is perhaps understandable for programs run by and for Indigenous peoples given that their culture is not dominated by analytics to the extent that mainstream culture is. But the dearth is surprising for mainstream therapeutic communities, especially given the emphasis on statistics in psychology.

3.1.1. Mainstream TCs

TCs are a participative, usually residential, group-based approach to long-term mental illnesses, including drug addiction. Two prominent centres for this approach, the Henderson and Cassel hospitals in the UK have featured in a number of evaluations published in psychiatric journals during the 1990s and 2000s. Suicidal behaviour, substance abuse and violent behaviour are common amongst patients. Most have criminal convictions.

Deloitte Access Economics' literature search was only able to uncover three studies that included sufficient financial data to undertake cost benefit analysis (Menzies et al 1993, Dolan et al 1996, and Davis et al 1999).

United Kingdom

- Menzies et al (1993) assessed 29 patients at Henderson Hospital. Cost of treatment for an average stay of seven months was £23,310 per patient. Average health system and justice system costs per patient in the year before admission to Henderson were £14,590. After three years of follow up, 41% of patients had not re-offended nor been readmitted to hospital. In comparison, over the same period, such 'success' was only attained by 21% of those who had been referred to Henderson but not admitted. This led to savings of £173,477 per year across the 29 subjects, or £5,982 per patient. Thus, one year of TC at Henderson would pay for itself (break even) in four years.
 - For compatibility with studies of Indigenous Healing Centres, which can cover up to ten years, it is assumed that the benefits from TCs are ongoing. However, to enable comparison in net present value terms, ongoing benefits are discounted at 7% p.a.
- Dolan et al (1996) measured the cost of treatment for 24 patients at Henderson (average stay 231 days) at £25,641. For patients in the study, average pre-admission health system (mainly psychological) costs and justice system (e.g. incarceration) costs were £13,966 per year. After being treated in therapeutic communities, these costs fell to an average of £1306 per person year, a reduction of £12,658. That is, under this study, the costs of Henderson TC would be recouped in two years from reduced justice and health system expenditure.
- Davis et al (1999) report on outcomes for 52 patients from the Francis Dixon Lodge TC in the UK. The cost of treatment (average stay 265 days) was £34,932. Patient records were assessed for the three years before admission and they were followed up for 12 months afterwards. Average pre-admission acute (psychiatric) costs were £9,499 per annum. After treatment, this fell to £928, a saving of £8,571. That is, as with Menzies et al (1993), TC took four years to break even, but in this the savings were measured from health system costs only.

United States

In the United States, there is a network of “Oxford Houses” which provide a community-based approach to addiction treatment, through an independent, supportive, and sober living residential environment. Following their stay at an Oxford house, patients’ rates of substance abuse and engaging in criminal activity halve on average, and their prospects of being gainfully employed almost double.

Again, despite their being over 1,400 such Houses, our literature search could only uncover one cost-benefit study (Lo Sasso, 2012).

- Lo Sasso et al (2012) conducted a randomised controlled trial (RCT) which followed a cohort of 68 participants through Oxford House residences for two years. Average total treatment costs for the cohort including an average stay of 8 months in an Oxford House was \$25,159¹³. Over the two year period, the intervention led to avoiding treatment as usual (TAU) costs of \$21,950. There were also net savings over the control arm of \$32,230 from increases in employment and reduction in crime and drug costs, compared to the control arm, for a total 2 year benefit of \$54,180.
 - As with the UK studies, the healing for Oxford House TC patients is assumed to be ongoing. Costs (crime and drug use) decreased over the two years patients were at an Oxford House. Accordingly, the last six months (rather than the average over the two years) is taken as representative of the ongoing state of Oxford House graduates. That is total ongoing treatment costs per quarter are 1,934 less for Oxford House graduates (\$4,850) than for TAU (\$6,784) (Table 3.1).¹⁴ Similarly, total ongoing net benefits per quarter are \$5,756 higher for Oxford House graduates (\$650) than for TAU (-\$5,106) (Table 3.2).¹⁵ That is, net societal benefits per quarter from Oxford House treatment are \$7,690 (treatment costs lower by \$1,934 and benefits higher by \$5,756) or, on an annual basis, \$15,380.

TABLE 3.1: Oxford House (OH) costs versus treatment as usual (TAU). \$US

Stream	Base	6 months	12 months	18 months	24 months	Total
OH Inpatient	31,781	5,479	3,836	2,740	3,836	15,890
TAU Inpatient	33,595	7,330	3,665	1,832	4,276	17,103
OH Outpatient	233	1,320	699	621	388	3,028
TAU Outpatient	433	1,645	346	346	346	2,683
OH 12 step	342	949	735	672	628	2,983
TAU 12 step	237	666	606	453	439	2,163
OH residential	-	1,817	2,021	2,074	1,692	7,604
TAU residential	-	-	-	-	-	-

Source: Lo Sasso et al (2012)

¹³ Figures for this study are in \$US.

¹⁴ Assumed no ongoing Oxford House residential costs. Last quarter incarceration costs assumed same as second quarter.

¹⁵ Higher Oxford House benefits are mostly from more employment, rather than less criminal costs.

TABLE 3.2: Oxford House (OH) benefits, by outcome, versus treatment as usual (TAU), \$US

Outcome		Base	6 months	12 months	18 months	24 months	Total
Employment	OH	1,134	4,243	4,847	4,630	5,594	19,314
	TAU	1,203	2,345	2,787	2,211	2,573	9,916
Crime	OH	-34,705	-533	-200	-3,797	-4,063	-8,593
	TAU	-26,064	-5,049	-5,198	-14,183	-4,975	-29,405
Drugs	OH	-804	-271	-289	-217	-210	-910
	TAU	-796	-339	-363	-392	-403	-1,313
Incarceration	OH	0		-688			-688
	TAU	0		-2,301			-2,301

Source: Lo Sasso et al (2012)

3.1.2 Indigenous Healing Centres

Fortunately, there are at least two good cost benefit studies conducted on Canadian Indigenous healing programs by Buller (2001).¹⁶ The purpose was to ascertain whether the financial investments made by governments to Biidaaban healing process for the Mnjikaning First Nation, and the Community Holistic Circle Healing (CHCH) for the Hollow Water First Nation, have resulted in net savings to the Canadian criminal justice system.

Importantly, Buller (2001: 2) noted that financial costs and benefits to mainstream society are only a small component of the impact of community healing programs.

“ It needs to be recognized that cost-benefit analyses can only portray one part of the whole “benefit” to communities ... How can one put a dollar figure on the power of the Spiritual resonance that underlies those processes or the core philosophy around which both CHCH and Biidaaban operate and bring healing to offenders and to the community? A suitable criteria has not been put into place, nor perhaps can it be, to quantify the threads of value or the parts that comprise the whole.”

In the Biidaaban healing process, a Community Gathering is a key element that begins with a ceremonial opening. The person who has harmed speaks about their wrongful behaviour and apologises to the person they have harmed, their family and community. The community then has a chance to speak about this behaviour. The community with everyone’s input develops a Treatment Plan. There is an educational component to the Gathering and there is a ceremonial closure. The Treatment Plan is reviewed every six months to monitor progress.

The Federal Government, contributed \$128,000 per year, over a five year period to Biidaaban. The Mnjikaning First Nation provides direct financial support in the amount of \$81,000 per year and in-kind support in the amount of

¹⁶ Interestingly, in the light of the above discussion on cultural aspects of evaluation, both these quantitative cost benefit evaluations of Canadian programs were conducted for an Australian organisation (the Australian Institute of Criminology).

\$25,000 per year, through the provision of space and administrative support. This allows Biidaaban to hire four staff and use the services of an Aboriginal psychologist, provide training to staff and hold community gatherings. Across the 27 participants, the average cost per person was \$14,222.

The marginal cost of adding one additional inmate into the federal system averaged \$13,720.¹⁷ The cost of supervising an offender on parole in his or her community was estimated at \$13,000 per year. Based on these estimates, it was determined that the total costs to governments for the care and custody of offenders diverted to the Biidaaban healing process over the four year period would have been \$829,782. This translates into an average saving of \$30,722 per participant. Against a cost of \$14,222 per patient, that is BCR of 2.16 to 1.

In assessing TC interventions, it was assumed that a one-off TC intervention would lead to lasting healing, which would pay for the intervention in two to four years through reduced future health and justice system costs. However, Buller does not take future costs or benefits into account. As length of incarceration avoided is not specified, it is assumed that participants either spend one year in jail, or one year in the healing centre. That is, there are no future year benefits to be discounted.

However, while Buller (2001) does not take recidivism benefits into account, it may be possible to incorporate such. Buller does note that only two participants had re-offended during the ten years of the CHCH study (a less than 2% recidivism rate), whereas “the recidivism rate for sex offenses is approximately 13% and for any form of recidivism the figure rises to approximately 36%”. Buller thus concludes that “it is appropriate to state that the value of the services to both the government and the community has been significantly understated. Buller does not specify whether the cited recidivism rates apply to First Nations or to the total population, nor over what timeframe the rates apply. In Australia, Holland et al (2007) estimate that 50% of Indigenous prisoners re-offend within two years.

Thus, it can be assumed that 36% of First Nation offenders not diverted to Biidaaban would re-offend in two years (and then two years later another 36% of that cohort, etc.) Netting out the 2% recidivism in the intervention group, this implies that for every 100 offenders not diverted, 34 would re-offend within two years – increasing (net) incarceration costs by 34%. Allowing for cumulative re-incarcerations, and converting to net present values, over ten years this would increase justice system costs by 48%. That is, the avoided incarceration benefits from Biidaaban increase to \$45,508, which yields a BCR of 3.2 to 1.¹⁸

The CHCH process conducted for the Hollow Water First Nation is also very different to Western psychological practices. The Director of Child and Family Services, Burma Bushie, describes it thus:

“The spirit piece is at the very core. It has to be in place to bring people back to balance. The whole field of psychology and psychiatry has developed its own language to determine who has a disorder, and how to get people well. We don’t have the same concepts or definitions. Ours is holistic. We don’t label people. We understand that the decisions that we make today will affect our people for several generations, and we use a traditional holistic approach to human living problems. We want our people in our community because it’s our heart and soul. Without the spiritual, balance will not be achieved, nor healing attained” (Buller, 2005: 4).

Buller (2001) estimates that the cost of CHCH over its first ten years was \$3.0 million, mainly for the provision of two full time counsellor positions.¹⁹ Assuming the 107 participants were evenly distributed over the duration of the program, and each spent up to a year actively engaged, this is equivalent to an annual cost of \$28,037 per person. On the same cost basis as used for the Biidaaban evaluation, the estimated savings to Federal and Provincial governments from avoided criminal justice system costs were \$6.2 million (or \$58,063 per participant). Adding in estimated recidivism (as per Biidaaban) benefits increases this to \$85,977. This yields a BCR of 3.1 to 1.²⁰

17 Canadian dollars.

18 Buller’s studies report nominal costs and benefits over up to 10 years retrospectively. Accordingly, unlike the other studies, benefits are not assessed against projected future savings.

19 There are also a considerable number of unpaid volunteers.

20 Benefits are not discounted in this case, as both costs and benefits were provided in nominal terms over the full ten years.

Australia

In 2012, Deloitte Access Economics (2012a) was appointed by the National Indigenous Drug and Alcohol Committee (NIDAC) to analyse the costs and benefits of addressing Indigenous problematic alcohol and drug use with residential rehabilitation, as an alternative to prison.²¹

Some of these facilities operate specifically as therapeutic communities, with the residents and staff jointly creating a community that sets the agenda for changes amongst the participants. Others, such as the Ngunnawal Bush Healing Farm or Bunjuilwarra are Indigenous healing centres. The personal nature of problematic drug and alcohol use means that there is no 'one size fits all' approach which makes it difficult to define a 'typical' residential facility offering drug and alcohol treatment for Indigenous people. Treatment approaches include: family and community support and involvement; abstinence; cultural support and involvement; harm reduction; controlled drinking; controlled use of other substances; and religious/spiritual support. In total, data for 2,816 Indigenous people across 30 service providers was analysed.

The results were impressive. Residential care (\$18,385 per person) was not only cheaper than incarceration (\$114,832); but produced better outcomes in terms of reduced recidivism and physical and mental health service costs (10 year NPV gain of \$15,012 per person). In addition there were gains in avoided mortality of \$92,759.²² Thus, an investment of \$18,385 returned benefits of \$222,603 in avoided health and justice system costs and reduced burden of disease – a BCR of 12.1 to 1.



21 If it is perhaps slightly ironic that the only cost benefit analysis of Canadian healing communities was published in Australia, it may be even more so that the only cost-benefit study of Australian healing communities uncovered in Deloitte Access Economics' literature search was conducted by Deloitte Access Economics.

22 As measured using the value of a statistical life year required for Commonwealth Government analysis, <http://www.dpmc.gov.au/deregulation/obpr/docs/ValuingStatisticalLife.pdf>

4 Summary of cost benefit analyses (CBAs)

Evidence from Canadian healing centre evaluation (Aboriginal Healing Foundation, 2006) suggests that Indigenous healing takes a long time, therefore, costs are compared to the net present value of benefits over ten years. As recommended by the Office of Best Practice Regulation, the discount rate used is 7%.

Extrapolating the one-off treatment costs from TC (Section 3.1.1) against discounted 10 year benefits, the average BCR for mainstream TCs is 3.13 to 1 (Table 4.1).

TABLE 4.1: Costs and benefits for therapeutic community interventions (£)

Study	Intervention	Cost	Benefit p.a.	Benefit 10 year NPV	BCR
Dolan et al (1996)	Henderson centre	25,641	12,658	93,311	3.64
Davis et al (1999)	Francis Dixon	34,932	8,571	63,183	1.81
Menzies et al (1993)	Henderson centre	23,310	5,982	44,097	1.89
Lo Sasso et al (2012)	Oxford House	25,159*	54,180*	130,641	5.19
Average					3.13

Notes: Discount rate is 7%. Figures are in £.

*For Lo Sasso et al, intervention cost and benefits reported for two year period, and currency is \$US. Values in then current values

TABLE 4.2: Per person costs and benefits for Indigenous healing communities

Study	Intervention	Cost	NPV benefits 10 years	BCR
Buller (2001)	Hollow Waters	\$28,037	\$85,977	3.07
Buller (2001)	Biidaaban	\$14,222	\$45,508	3.20
Deloitte Access Economics (2012a)	various	\$18,385	\$222,603	12.11
Average				6.12

Note: currency for Buller (2001) is \$CAN, for DAE (2012a) is \$AUD. Values in then current values.

4.1.2 Benefit-cost ratios

It could be argued that the Indigenous programs (Table 4.2) are more likely than the therapeutic communities (Table 4.1) to be a good proxy for the healing centres to be set up following Healing Foundation funding, even if they are mostly overseas examples. However, because of the small number of cases, the wide variance between them, and the unknown nature of the new Healing Centres, taking an average across all seven studies is an appropriately more conservative approach. On this basis, the most plausible estimate is that the **likely average BCR for the new Healing Centres would be in the order of 4.4 to 1** (albeit with a range between 1.8 to 1 and 12.1 to 1.)

4.1.3 Net benefits

The above analysis demonstrates that community healing initiatives have quite high BCRs. But simply having an estimated BCR is not that useful without first knowing the costs of a HC centre. The Healing Foundation is contributing \$75,000 to enable each centre to become sustainably established, but ongoing costs are not known.

The above estimates are presented in a large range of currencies and over many time periods. Accordingly, it is necessary to convert them into current Australian dollars. The Organisation for Economic Cooperation and Development supplies figures that enable conversion of one country’s currency into another’s in a given year at purchasing power parity²³ (for example, converting how much a UK pound would buy in Australian dollars in Australia in 1993). Once converted into Australian dollars, prices can be adjusted for inflation, using ABS CPI.²⁴

This reveals that such interventions are not cheap, with an average cost per participant of \$57,827 (Table 4.3), although HC interventions are considerably cheaper than the therapeutic community ones. On the other hand, the benefits are not small either, averaging \$187,385 per client, and comprising just the mainstream health and justice system costs. If appropriate health-related quality of life data were collected, the (currently) intangible benefits would be far higher.

TABLE 4.3: Per person costs and benefits of community healing programs, current \$AUD

Study	Intervention	Cost	(NPV) Projected Benefits	Net benefits
Menzies et al, 1993	TH	86,897	164,389	77,492
Dolan et al 1996	TH	85,310	310,455	225,144
Davis et al 1999	TH	108,888	196,950	88,061
Lo Sasso et al 2012	TH	39,118	203,126	164,008
Buller 2001 (CHCH)	HC	43,305	132,795	89,490
Buller 2001	HC	21,967	70,288	48,322
DAE 2012	HC	19,301	233,689	214,388
Average		57,827	187,385	129,558

This enables us to estimate costs and benefits per person, but we don’t know how many people will be treated by each centre. From the available studies, the numbers appear to be quite small, around 57 people per year for the average centre.²⁵ Even so, the average HC centre could yield annual benefits of \$8.3 million (Table 4.4).



23 <http://www.oecd.org/std/prices-ppp/purchasingpowerparitiespppsdata.htm>

24 <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/6401.0Mar%202014?OpenDocument>

25 Perforce, the only Indigenous subjects in this study are those for whom justice system costs can be collected. HC’s are designed to benefit whole communities, but most of the benefits are currently intangible.



TABLE 4.4: Annual estimated costs and benefits of community healing programs (\$m)

Study	Participants	Cost	(NPV) Projected Benefits	Net benefits
Menzies et al, 1993	24	2.09	3.95	1.86
Dolan et al 1996	52	4.44	16.14	11.71
Davis et al 1999	29	3.16	5.71	2.55
Lo Sasso et al 2012	68	2.66	13.81	11.15
Buller 2001 (CHCH)	107	4.63	14.21	9.58
Buller 2001	27	0.59	1.90	1.30
DAE 2012a	94	1.81	21.94	20.12
Average	57	2.77	11.09	8.33

4.1.4 Break even analysis

Given the studies used to estimate returns for the proposed HCs are mostly non-Indigenous or non-Australian (or both) it is useful to triangulate the estimates.

The Healing Foundation is contributing \$75,000 towards establishment to each of 13 HCs i.e. \$975,000 in total. Indicative ongoing costs per HC are estimated at \$539,039 in the first year (establishment cost of \$75,000 and operational costs of \$464,039) and \$464,039 per year thereafter (operational costs only). These costs are based on staffing and capital requirements outlined by KPMG (2012) and administrative costs provided by a HC six monthly Progress Report. Further details can be viewed in Appendix B.

Updating the cost per case estimates from Section 2.4 to 2014 values, the Centres *collectively* would need to avoid a certain number of adverse events to break even. If the program avoids 42 cases of volatile substance abuse or 23 cases of family violence, or just 14 cases of incarceration during their first year and 36 cases of volatile substance abuse, 20 cases of family violence and 12 cases of incarceration for each year thereafter, it has paid for itself (Table 4.5). Per HC, in the first year of establishment, this equates to 3.2 cases of volatile substance abuse or 1.8 cases of family violence or 1.1 cases of incarceration. During subsequent years, per HC it equates to avoiding 2.7 cases of volatile substance abuse or 1.5 cases of family violence or 0.9 cases of incarceration.

Given the substantial reductions in recidivism reported from similar programs (Buller (2001), Menzies et al (1993), Deloitte Access Economics (2012a)) such outcomes would appear to be achievable by the Foundation’s Healing Centres. For example, Menzies et al (1993) implies an average of 1.9 diversions per year from Henderson TC, and Buller (2001) implies an average of 3.6 per year from CHCH. Deloitte Access Economics (2012a) reported a 14% reduction in recidivism over ten years compared to TAU. According to the DAE (2012a) analysis, an average cohort of 94 Indigenous participants in 2009-10 were provided with drug and alcohol treatment per residential treatment facility, this would equate to 13 fewer re-incarcerations over the decade for that cohort, or 1.3 per year.

TABLE 4.5: Break-even analysis

Event	Cost per case 2014	Program funding in first year	Program funding in subsequent years	Cases avoided needed to break even in first year (and each year thereafter)
Incarceration	\$500,414	\$7,007,509	\$6,032,509	14.00 (12.06)
Family violence	\$302,462			23.17 (19.94)
Petrol sniffing	\$170,034			41.21 (35.48)

5 Next steps

As identified in Chapter 4, the likely average BCR for the new HCs based on historical estimates is 4.4 to 1. The benefits quantified in the literature which have been used to estimate this BCR mainly relate to reduced rates of incarceration and recidivism. The break even analysis provides further support for the establishment of HCs by demonstrating that it would take only two fewer cases of Indigenous incarceration for the whole HC program funding to be paid for across Australia.

There are likely to be many other quantifiable benefits resulting from HCs; however, these have not been captured in the literature due to the reasons described by the Healing Foundation (2012b). A particular barrier to measuring change and thus establishing an evidence base which is quantifiable for the HCs is that the benefits or outcomes may take too long to be realised. This was established in the evaluation of the Canadian AHF projects as discussed in 2.3.2 and hence the impact evaluation did not measure rates of physical and sexual abuse, suicide, incarceration and children in care as originally planned. This was despite the fact that four years had lapsed from the establishment of the AHF in 1998 and the writing of the Third Interim Evaluation report in 2002 (Kishk Anaquot Health Research, 2003).

However, despite a lack of quantifiable evidence regarding the benefits of Indigenous healing initiatives, as highlighted by the Healing Foundation (2012b), the public and private sectors have an obligation to support Indigenous healing, due to the inter-generational trauma and destruction bestowed historically on Indigenous peoples. This legacy continues to negatively impact the health and welfare of Indigenous communities today, causing widespread problems including socioeconomic disadvantage, high rates of family violence, poor mental and physical health and high rates of incarceration.

Part of that support should include the development of a culturally appropriate evaluation framework which can be adapted to the different environments in which Indigenous healing takes place. Ultimately, this framework would enable process and impact evaluations on healing initiatives, whilst being mindful that indicators of program efficacy from an Indigenous world view may be different from those with a Western world view. The process evaluation should help Indigenous communities refine their programs and determine what is and is not working well, and provide them with a resource for setting up similar programs in the future.

The impact evaluation should provide evidence of program effectiveness which speaks to Indigenous people and satisfies the Western need for outcome measurement across a number of domains. Indicators measured at a community level that may speak to a Western audience could include:

- employment rates;
- educational attainment;
- days of school attended;
- hospital admission rates;
- substance abuse rates;
- incarceration rates;
- suicide rates;
- child abuse rates;
- family violence attendances by law enforcement; and
- rates of children in out of home care.

Ideally an evaluation framework would be developed for a program at the time of program design and thus establish the data collection that would need to occur during the life of the program. In some cases this does not occur and evaluation is undertaken at the end of a program resulting in important baseline data not being collected. As such, these evaluations may be unable to determine how well the program has worked. By building evaluation into the early stages of program planning, it can examine the program throughout its life. This way, evaluation becomes part of the on-going program management and refinement.

An initial component of an evaluation framework is the development of a program logic model. The logic model should be informed by key stakeholders, various program characteristics and considerations, and evaluation timeframes. Developing a logic model will aid the conceptualisation of program, will clarify program activities and desired outcomes, and build consensus among program managers and stakeholders by connecting program activities with their intended short to long-term outcomes. The logic model typically contains six linked core components: program goals and objectives, environment factors, and assumptions; and evaluation inputs, outputs, and outcomes.

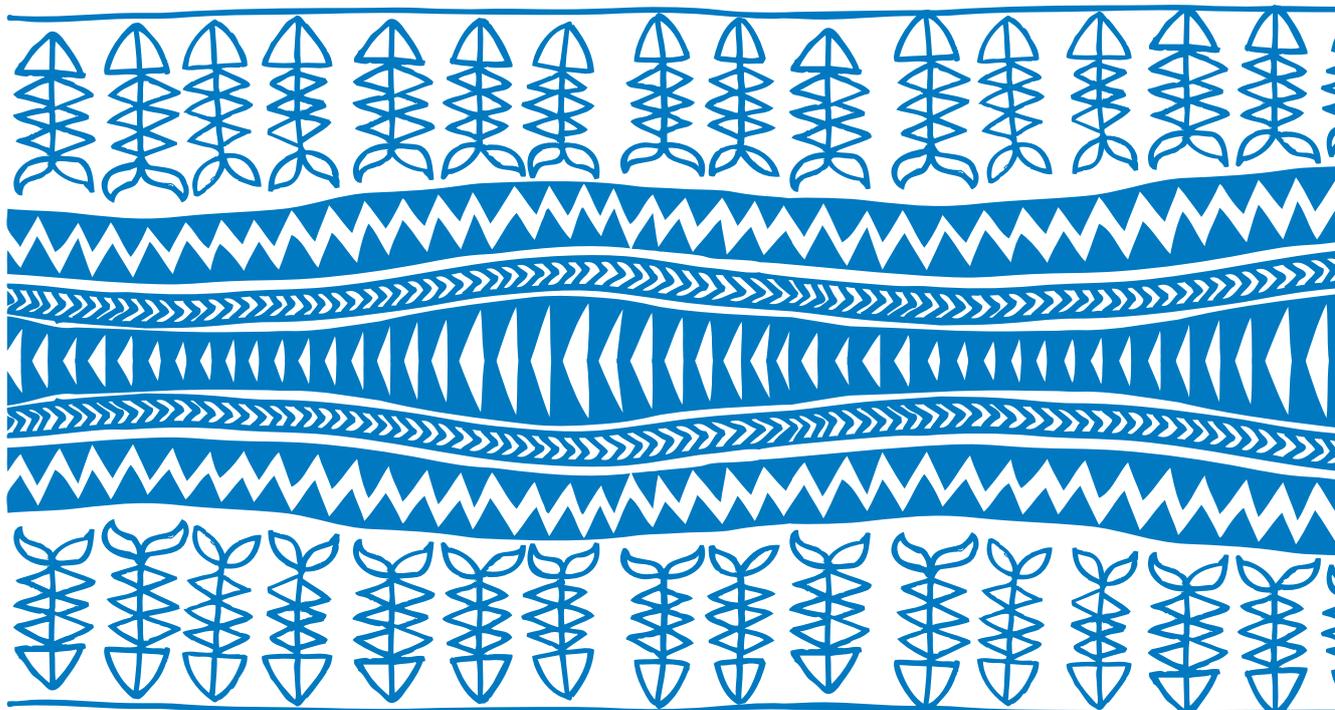
- A goal is a simple statement, which sets out the purpose of the program.
- Objectives are specific statements that are measurable and state exactly what we want to achieve – the desired outcome of a program.
- Program assumptions are the beliefs we have about the program, the participants, and the way we expect the program to operate. Assumptions influence program decisions that are made and need to be clarified as they may prevent the achievement of certain outcomes.
- Inputs are the resources, contributions and investments that are available for a program. The inputs used to produce the outputs may be financial, material or the amount of time that is committed.
- Outputs are the activities, services, events or products of the program services that reach those who participate or the targeted population.
- Outcomes are the overall result of applying the inputs to a program and achieving the outputs. These may include changes in knowledge, skill development, changes in behaviour, capacities or decision-making, and policy development for individuals, groups, communities, organisations or governments. Outcomes can be short, medium or long-term achievements. Short-term outcomes generally include changes to participants or the community. Medium-term outcomes may include changes to policies, plans and projects and long-term outcomes may include the ultimate impact that the initiative should achieve, which can include fundamental changes in the social, environmental, economic and governance priorities of the government. Longer-term outcomes are more likely to have been affected by factors external to the program that is being evaluated. Depending on the time available for the evaluation, it may only be possible to evaluate short to medium-term outcomes.

Evaluation questions are developed based on the type of evaluation e.g. process or impact, or both. Corresponding indicators which enable measurement or data collection and thus answers for the research questions or lines of enquiry need to be developed. As per the National Health Reform Performance Reporting Framework,²⁶ ideally, the indicators should be meaningful, avoid perverse incentives, be valid, reliable, attributable, comparable and able to measure progress over time. Additionally, they should be administratively simple, that is the data collection required and interpretation should not be overly burdensome and should use existing data collection sets where available.

Any information relating to the program that has been collected and can be shared with the evaluator and any other existing data sets of relevance would need to be assessed to establish whether data exists that can fill the indicators and any data gaps. Filling the data gaps may need to be done through research activities such as questionnaires, focus groups, interviews and forums. These research methods should be employed with cultural awareness and sensitivity and should be developed and implemented only after extensive consultation with key stakeholders within the community, key Indigenous organisations and relevant ethics processes.

²⁶ <http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/PAF>

A program logic has already been developed for the Healing Centres (recall Figure 1.4) which entails these elements, and the initial funding included the purpose of developing an evaluation methodology (recall Section 1.5.3). It is recommended that the evaluation for the HCs in the future embeds and measures both Indigenous and western outcomes to enable ongoing assessment of benefits and costs of Australian HCs, in addition to this limited and prospective analysis.



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Appendix A: Healing centre progress reports

This Appendix contains a summary of the April 2014 Progress Reports provided by three HC development teams. They provide an overview of the development activities conducted to date, future plans, challenges, solutions and financial activity.

Gurehlgam Corporation

Indicators

Employs one Indigenous staff member or consultant, with over 120 community members participating in the project. Services involved in this project include:

- initial project planning and installation;
- advisory/reference committee establishment;
- research;
- service mapping; and
- community consultants.

The project has not involved program logic/model development, business case development or stakeholder/partner relationship development, although these will be considered within the next six months.

Activity report

All activities were completed on time, as planned and within budget, although further community consultations are required, research of existing healing centres and identification of potential HC models is ongoing.

Response/reflections

Very good response, many community members and service providers stating that a healing centre is really needed for the Clarence Valley.

Key achievements and successes of project (over the past six months)

- Setting up the advisory committee and developing the memorandum of understanding between the community and the worker undertaking project.
- Consultations held with community to incorporate needs and wants of the community.
- Consultations held with service providers to consider what is needed, ensure no duplication of services and filling of gaps in service provided and partnership arrangements that could be considered.
- Identified room at Gurehlgam as the “healing centre”. This room is hired out free of charge so far, but will incur a fee in future – there are exemptions for community groups that aren’t funded.
- Development of Facebook page and a newsletter for the healing centre to ensure the community is aware of the healing centre development plan project and its progress.

Key challenges and solutions (over the past six months)

- Lack of community participation in development of plan

What does/does not work in design and development of a HC?

- Nothing significant found that does or does not work in the design of a HC.

Next steps

This project is running within the proposed timeframe and budget. Over the next six months they will continue to research various healing methods that may meet the community needs, continue to establish links with current service providers, continue community consultations, identify funding sources, and complete the development plan.

Financial report

Total income (from grant funding) is \$37,500.

Total expenditure is \$23,565. This is broken down by salaries, administration, meeting, printing, phone/internet, venue hire, catering, equipment, travel costs, vehicle costs, rent/utilities, sundries.

Net surplus is \$13,935.

Gurriny Yealamucka Health Services

Indicators

Employs three Indigenous staff or consultants, with 40-50 community members having direct contact via various briefings. Services involved in this project include:

- initial project planning and installation;
- advisory/reference committee establishment;
- research;
- service mapping;
- community consultants; and.
- stakeholder/partner relationship development.

On a scale of one to ten, participants indicated '5' as the level of satisfaction with services and activities delivered as part of the project.

Activity report

Some stages were delayed from the original proposed timeframe.

Response/reflections

Community members are supportive of the concept of a healing place. The community wants to promote the idea of wellness rather than healing and the place must be regarded as being safe (physically and culturally). The land for the healing centre is an emerging conversation. Architects from Indij Design stated that "the only site that can be confidently identified as being accessible is at the existing Workshop St occupied by Gurriny". This site would require a staged development. This site has positive attributes, such as being easily accessible, in an identifiable location and it is opposite public parkland. Redevelopment needs careful assessment of logistics for service continuity.

Key achievements and successes of project (over the past six months)

Establishment of a participative relationship with the traditional owner Native Title prescribed bodies corporates (PBCs). This has been underpinned by the provision within the project budget of an ex gratia payment for those groups to facilitate interaction amongst their membership.

Sufficient information now exists to develop design concepts for community validation.

Broader debate is required surrounding the types of services to be made available within the community HC. They should include social and emotional well-being, community justice support and cultural activities.

Key challenges and solutions (over the past six months)

Ensuring key community members are involved and that ideas are representative of the community requirements.

What does/does not work in design and development of a HC?

Descendants of 32 tribes live in the community; 80% of the population are descendants of people who were removed to Yarrabah as part of the Stolen Generation and as a result of other government policy interventions. Historical owners of the community seek to maintain cultural traditions due to affiliation with Yarrabah as “home”. These dynamics are important when considering trauma related healing. Project investigations will be respectful of the need to recognise overlapping interests – all cultural affiliations and social dynamics should be recognised.

The concept of a HC may have connotations related to sickness not wellness – it is open to different naming.

Next steps

This project is approximately two months behind approved schedule – and is expecting to catch up during the next six months. The project is on budget

Financial report

Total income (from grant funding) is \$37,500.

Total expenditure is \$4,756.50. This is broken down by salaries, consultants/contractors, administration, meeting, printing, phone/internet, venue hire, catering, equipment, travel costs, vehicle costs, rent/utilities, sundries. All \$4,756.50 has been spent on consultants/contractors.

Net surplus is \$32,743.50.

Healing waters

Indicators

Employs two Indigenous staff or consultants, servicing 131 community members that have participated in the project. The project delivered various services including: initial project planning and installation, advisory/reference committee establishment, research, service mapping, community consultations, program logic/ model development, business case development and stakeholder/partner relationship development.

The community reports ‘8’ as degree of satisfaction with services and activities delivered.

Activity report

The project planned to address all of the services listed above. The project is travelling well against the budget, and almost all the activities planned have been completed or near completion. Community consultations have been very positive and more are planned. Discussions with potential funders have been encouraging and are ongoing.

There has been uncertainty around future funding resulting from the change of Commonwealth Government. It has been difficult to develop a detailed business plan as the dimensions of future services are still unclear as a result of funding concerns.

There is a clearly identified potential need for the service.

Response/reflections

There is an overwhelmingly positive response to the concept of a locally based and Indigenous controlled HC. Responses have largely focussed on the need to identify a large number of potential service clients.

Individuals do not access current mainstream services as they are “not culturally appropriate”. Townsville Aboriginal and Torres Strait Islander Community Health have 500 clients on mental health care plans, developed by their GP’s, but only 2 counsellors to support these clients. The HC is an exciting prospect as it could meet the social and emotional well-being needs of these clients.

Key achievements and successes of project (over the past six months)

- Developed strong governance structure.
- Developed important community and funding linkages.
- Developed brand identity for Healing Waters (presentations/brochures/website) to promote vision and potential of healing centre. As a result – overwhelming appreciation of the need for a community based solution.
- Developed and written a community engagement strategic plan – feedback, mapping of services, stakeholder engagement for first stage of development.

Key challenges and solutions (over the past six months)

- Political funding uncertainty has made it difficult to move to ‘engagement and funding stages’. Frustration that they cannot deliver the services yet.

What does/does not work in design and development of a HC?

- There is a fine line between demonstrating the need and proving the benefits of a healing centre to the community and potential funders, and building expectations and demands that cannot be met in the short time.

Next steps

The project is within proposed timeframe and budget, as long as a funding body can be secured. Once secured, it can commence providing services after a short establishment period.

“We have successfully created an awareness of the demand for a HC that we are dedicated to the challenge of delivering. We could open our doors today and have ample referrals and a full case load, but that is not practical until we find funders.”

Financial report

Total income (from grant funding) is \$49,500.

Total expenditure is \$39,805.60. This is broken down by salaries, administration, meeting, printing, phone/internet, venue hire, catering, equipment, travel costs, vehicle costs, rent/utilities, sundries.

Net surplus is \$9,694.40.

Appendix B

The indicative cost of a HC was estimated based on the Guideline for Costing (the Guideline) for the operation of a successful HC outlined in the Healing Centres Final Report (KPMG, 2012). The Guideline details three major ongoing cost categories: staff; facilities; and running costs related to administration and utilities. The cost of staff as provided by KPMG (2012) has been outlined and updated using indicative 2013-14 salaries in Table B.1.

TABLE B.1: Cost of HC staff

Description	Suggested equivalent	Number of staff required	Salary range from 1/7/13 ¹	Salary mid-point	Salary plus on cost (23%)
Community Coordinator	As a guide, under the NSW Health Service Health Professionals (State) Award this role could be paid as a Level 4 Counsellor, Social Worker or Welfare Worker	1	\$93,923 - \$96,271	\$95,097	\$116,969
Women's Business Facilitator	As a guide, under the NSW Health Service Health Professionals (State) Award this role could be paid as a Level 3 Counsellor, Social Worker or Welfare Worker	1	\$86,554- \$89,451	\$88,003	\$108,243
Men's Business Facilitator	As a guide, under the NSW Health Service Health Professionals (State) Award this role could be paid as a Level 3 Counsellor, Social Worker or Welfare Worker	1	\$86,554- \$89,451	\$88,003	\$92,481
Social worker/ counsellor	As a guide, under the NSW Health Service Health Professionals (State) Award this role could be paid as a Level 2 Counsellor, Social Worker or Welfare Worker	1	\$69,903- \$80,472	\$75,188	
TOTAL annual cost of staff salaries					\$425,936

According to the Healing Centres Final Report (KPMG, 2012), the average HC requires 70m² of space. As per KPMG (2012), the average rental cost per m² per year is provided in Table B.2.

TABLE B.2: Annual HC facility rental cost

Location of facility	Cost range per m ²	Average cost per m ²	Average annual cost of facility in 2012
Metropolitan (e.g.Sydney)	\$450-\$550	\$500	\$35,000
Regional (e.g. Tamworth)	\$120-\$250	\$185	\$12,950
Average annual cost of renting a facility in 2012			\$23,975

When inflated to 2014 \$AUD, the average annual cost of renting a facility for use as a HC is **\$25,287**.

The Healing Centres Final Report (KPMG, 2012) describes the third category of ongoing HC costs as running costs related to administrative costs and utilities. However, no indicative costs are provided. Therefore, Deloitte Access Economics has estimated these costs from the six monthly Progress Reports provided by the HCs who were provided establishment funding by the Healing Foundation. Based on a six monthly Progress Report for the period 25 October 2013 to 25 April 2014, these costs have been estimated at **\$12,816** annually

Therefore, the total indicative annual cost in 2014 for the ongoing operation of a HC is **\$464,039**. Given that the Healing Foundation has provided each HC with a **\$75,000** establishment fund, the total cost of a HC in the first year has been estimated at **\$539,039**.



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