



**SANDAS submission on the Consultation for the National
Aboriginal and Torres Strait Islander Peoples Drug Strategy**

June 2013

Development of the National Aboriginal and Torres Strait Islander Peoples Drug Strategy

What is your name?

Andris Banders and Emily English

What is the name of your organisation?

South Australian Network of Drug and Alcohol Services (SANDAS)

What are the contact details for your organisation?

204 Wright Street Adelaide 5000
08 8231 8818 sandasinfo@sandas.org.au
www.sandas.org.au

What is the main focus of your organisation?

SANDAS is the South Australian Peak organisation representing NGOs and individuals working in the alcohol and other drugs (AOD) sector. SANDAS has a focus on people with AOD issues and other morbidities such as mental illness, gambling, and chronic disease. Our member organisations provide a range of services from front line engagement with intoxicated people, community based interventions, court diversion programs and residential rehabilitation.

Since its foundation in 2004, SANDAS has worked with Aboriginal and Torres Strait Islander (ATSI) service providers in the metropolitan and regional and remote areas of South Australia. This has included developing, providing or coordinating essential training and workforce development activities, as well as delivering training in communities where services are based.

SANDAS does not present itself as the AOD peak body for ATSI services, rather we collaborate with the Aboriginal Drug and Alcohol Council (ADAC) and the Aboriginal Health Council of SA (AHCSA), which both play a peak role. SANDAS also collaborates with the Australian National Council on Drugs (ANCD) and the Alcohol and Drug Council of Australia (ADCA) and with other state AOD peaks and ATSI services across the country. We join other peaks in advocating for AOD policy settings and initiatives that are sometimes taken in haste and out of frustration at the continuing media reporting of ATSI intoxication. Where it can, SANDAS reminds the sector and a wider audience that intoxication rates of the Indigenous population are lower than the non-Indigenous.

SANDAS also advocates for an improvement in the processes that create and implement a significant number of initiatives from central policy units and bureaucracies. Drawing on its

experience and networks, SANDAS has the view that appropriate community development processes are key, in getting initiatives beyond their project phase and into the longer term treatment mix.

SANDAS represented the SA AOD NGO sector on the national consultation to help inform the NDS 2010-2015, and argued strongly for ensuring appropriate service structures and service levels for Aboriginal people. We also stressed the need for the policy setting on NDS focussed services, to clearly include the recognition of family and community both in their need for support, and in their role in helping address the health and social impacts of AOD.

We are also a Chief Investigator in the Australian Research Council (ARC) Comorbidity Action In the North (CAN) project, in the northern suburbs of Adelaide, which has the highest concentration of residing Aboriginal people in South Australia. A main part of this research examines the barriers that prevent Aboriginal people from 12 years and older, in accessing appropriate help for mental health and substance misuse orders.

SANDAS also sits on the South Australian Justice Reinvestment Group, which has a focus on addressing the disproportionate number of ATSI people represented in the justice system.

What is your role in the organisation?

Andris Banders - Executive Officer
Emily English - Policy and Project Coordinator.

Both roles work directly with ATSI service provider organisation management and workers as part of the wider AOD sector in South Australia.

What is your email address?

andris@sandas.org.au

emily@sandas.org.au

A. Goal/s or objectives of the National Aboriginal and Torres Strait Islander Peoples Drug Strategy

1. What do you consider should be the main goal/s or objectives of the new Strategy?

The NATSIPDS should represent ATSI AOD issues in a way that does not fall into a "one size fits all" AOD policy. It should promote and reinforce the particular philosophies underpinning the needs and wants of ATSI individuals, families and communities in conjunction with the current and any future NDS, but not be harnessed by the main pillars of the NDS, its mainstream concepts and its initiatives.

The NATSIPDS should add a new dimension to the partnerships between the

Commonwealth, its states and territories, the National Public Health Partnership established in 1996, and the National Preventative Health Strategy launched in September 2009.

A NATSIPDS should inform, guide, engage and influence the Australian AOD policy community in a way that has not been done before.

In particular, it must facilitate the expression and actions in relation to the values underpinning the six main themes of that policy community and give appropriate accord to ATSI needs and wants.

This could be achieved namely through encouraging

- Independence
- A diversity of voices
- The good sense of bureaucracy
- Frank and fearless advice
- Checks and balances
- Leading the community

[Drug Policy, the Australian Approach. ANCD Research Paper 5, ANCD 2002]

It would appear that sometimes “good” policy has been overwritten by the somewhat loose setting of numerical and time based targets at various levels. These seem to become the drivers of policy rhetoric, and set initiatives that chase the targets more so than build long-term solutions and an integration of ATSI focussed approaches to the next generation of problems. The NATSIPDS can act as a balance to this trend by actively promoting proactivity and not reactivity, and strongly advocating for the central position of process in proposing or informing solutions. In particular, the NATSIPDS can provide a valuable launching point for the re-emphasis on community development as key principle and design feature of any AOD initiatives.

A NATSIPDS must be available to give advice without fear or undue restraint. In particular, in relation to the five recommendations made in the 2009 evaluation of the Complimentary Action Plan (CAP) and the four principles that underpin the strategy, namely:

- Holistic approaches
- Whole of government effort and partnerships
- Indigenous ownership of solutions
- Resourcing on the basis of need

The NATSIPDS must also be able to set directions for greater capacity and capability building in the ATSI AOD and comorbidity sector. The success of Indigenous ownership and longevity of that success, hinges almost entirely on ATSI workforce development in the widest meaning of that term. To date, the legacy of building and keeping that workforce in the AOD has been poor. The low retention rates in organisations and in the sector generally, have greatly restrained the growth of AOD based knowledge capital.

B. Principles

The overarching approach of harm minimisation guides the National Drug Strategy 2010-2015 and is based on the three pillars of:

1. **demand reduction** to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the harmful use of alcohol and the use of tobacco

and other drugs in the community; and support people to recover from dependence and reintegrate with the community;

- 2. supply reduction** to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs; and
- 3. harm reduction** to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs.

Acknowledging these broad principles and also recognising the diversity of populations and locations of Aboriginal and Torres Strait Islander populations, the Intergovernmental Committee on Drugs NATSIPDS Working Group who has responsibility for developing the NATSIPDS has identified four additional principles that could potentially underpin this Strategy:

- 1. Holistic Approaches** - Use of alcohol, tobacco and other drugs must be addressed as part of a comprehensive, holistic approach to health that includes physical, spiritual, cultural, emotional and social wellbeing, community development and capacity building.
- 2. Whole-of-government effort and partnerships** - Whole-of-government effort and commitment, in partnership with community controlled services and other nongovernment organisations, is needed to implement, evaluate and continuously improve comprehensive approaches to reduce drug-related harm among Aboriginal and Torres Strait Islander peoples.
- 3. Indigenous ownership of solutions** - Aboriginal and Torres Strait Islander people must be centrally involved in planning, development and implementation of strategies to address the use of alcohol, tobacco and other drugs in their communities, and should have control over their own health, alcohol and other drug, and related services.
- 4. Resourcing on the basis of need** - Resources to address the use of alcohol, tobacco and other drugs must be available on the basis of need, and at the level required to reduce the disproportionate levels of drug related harm experienced by Aboriginal and Torres Strait Islander peoples.

1. Are these principles appropriate? (please tick) Yes

2. Why / Why Not?

SANDAS supports the idea of the three pillars for the current iteration of the NDS 2010-2015.

However, given the expansion rate in volume, type and reach of drugs and alcohol across Australia, and in particular their penetration into the ATSI population, consideration must be given to open and vigorous debate on their relevance, as expressed currently, beyond 2015. A basic question must be whether the pillars have actually held up and delivered sufficient gains to, and for, the ATSI people.

Of particular concern, is the disproportionate impact of the NDS on the criminalisation of ATSI people with AOD misuse and comorbidity issues. In particular, the focus on policing and the Commonwealth and State interpretation around Supply Reduction strategies needs to be readdressed. The commonly held belief that policing and major supply interceptions will have a major impact is difficult to test. We do have announcements of record seizures, but we also have announcements of massive social, health and justice impacts each and every day with annual cost estimates in the multiple billions. We also know that our prisons are disproportionately full of ATSI people, who have low access and equity into the main

stream health system, or who have such a high levels of complexity associated with AOD misuse, that exclusion from the health system, offending and recidivism become a norm.

Also, the rapid rate of synthetic drugs, which are now available on the internet, from sites like Silk Road or Biochem Distribution, are consumed at a faster rate than they can be classed illegal. It has been reported in Europe, that one new synthetic drug enters the market every week. With such expanding drug types and selling mechanisms, the need for greater resources in demand and harm reduction seem apparent.

In light of the current Senate Inquiry into Justice Reinvestment and its growing evidence base in prevention of crime, including AOD related crime, serious thought should be given to either renaming the Supply Reduction Pillar, or adding Justice Reinvestment as a new, fourth pillar. JR initiatives seek to work on the basis that in one way or another, some form of supply will always reach communities and drive or respond to demand. To think otherwise is fraught. JR programs provide an intervention of engagement, preferably at an early age, to mitigate against demand and reduce the profit pool gained by supply.

SANDAS has attached its recent submission to the inquiry and that of the South Australian Justice Reinvestment Group.

The four principles cited above as underpinning this strategy are admirable, but problematic, and will always evoke debate and frustrate movement forward. The challenge is how they translate into action and initiatives that support or arise from the Strategy. For example, in providing AOD interventions the principle of holistic approaches has been understood and accepted for some time.

However, tenders for such services rarely fund "Holism" as the mainstream of procurement processes, and Government service acquisition are largely based on unit costs and not a wider reaching cost benefit approach that factors such matters as the impacts of and on death, pain, and suffering.

[Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis. DHHS Rockville USA, Centre for Substance Abuse Prevention, Substance Abuse and Mental Health Administration 2009]

In forums and networks attended by SANDAS, it is not unusual to hear that a clear framework guiding the formation of partnerships between levels of government, cross portfolios, government and non-government needs improving. This includes partnerships between the various ATSI groups and organisations. It appears that the development of such a capacity and capability is expected to occur organically and of its own right, largely because a strategy has been published. Such developments need focussed attention and the NAPSIPDS should make it clear what is expected of the policy community, and what new directions might be needed in the relevant funding streams.

The history of Indigenous ownership of solutions does not always read well. The transfer of genuine authority and responsibility has been, to an unacceptable extent, harnessed by a project paradigm of funding, and not a program development paradigm. For example, in 2002 the ANCD research report stated that in the 1999/2000 financial year of 277 alcohol and other drug intervention projects the majority (81.6 per cent) were conducted by 177 ATSI community controlled organisations.

It also found that such a trend resulted in non-recurrent funding decisions of many projects for various reasons. [ANCD Research Paper 4; Indigenous Drug and Alcohol Projects 1999 2000. ANCD 2002]. The real term loss to the ATSI sector is the inability to build a managerial and supervisory depth in the sector. In the Non-Indigenous sector, it is well known that staff retention and development is very difficult to sustain when there is little

prospect of funding beyond a 3 year cycle.

3. Are there other principles that should underpin this Strategy?

The strategy should more clearly and quickly establish a research and evaluation agenda to support evidence based approaches to ATSI AOD and comorbidity issues, and to capacity and capability building. Such an agenda would remove a certain ad-hoc approach to grant funding and grant allocation. One approach would be to establish a NATSIPDS expert panel on research and evaluation, which would also have resources to take an historic look at what intellectual and knowledge capital resides in past projects.

There may also be a case for such a panel to provide national guidelines on research and evaluation methodology, especially in investigations that involve community based data collection. The fostering of Indigenous researchers could also be enhanced. SANDAS' involvement in the ARC Linkage funded three year CAN Project (Comorbidity Action in the North) which focusses on Aboriginal comorbidity could not recruit one Aboriginal researcher for a PhD scholarship.

C. Broad Priorities for the Strategy

The NATSIPDS Working Group has also identified what it sees as some of the key priorities, issues and specific population groups that could be discussed in the Strategy. These include:

- Broad social and structural determinants related to harmful substance use including whole of government matters such as intergenerational social disadvantage; employment and welfare dependence and social and economic participation (including education, employment);
- Local service delivery issues, including workforce issues such as the ability to attract and retain staff across the range of disciplines necessary to provide effective and sustainable interventions, particularly in remote areas;
- Supporting children, youth and women – including children exposed to alcohol and other drugs during pregnancy and early childhood; and
- Transference and poly-addiction (not only between substances, but other issues such as gambling).

1. Are there any other key priorities, issues and/or populations that should be included?

The following three items are put forward as possible considerations to be included in the NATSIPDS. Their selection stems from the work of SANDAS in fields, networks and projects.

- Early childhood AOD education at primary school level with community based providers.
- The encouragement of peer support programs similar to the PHAMS (Peer Helpers and Mentors Support) programs in mental health.
- Capacity building in ATSI organisations focussing on policy development, Board and managerial governance, and manager and supervisor development.

D. Actions, including reviewing the Complimentary Action Plan

It is important that any actions identified in the Strategy provide detailed guidance to governments, communities and service providers; clearly articulate the overarching objective and link strongly with the underpinning principles. It is also important that they are concrete and assessable through national performance indicators and milestones.

The NATSIPDS Working Group has agreed that a small number of Key Result Areas or priorities are needed to focus action on achieving results.

The Complimentary Action Plan (the CAP) identified six key result areas for targeted action, which might be useful to review in looking to the new Strategy:

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

1. **Are the Key Result Areas of the CAP still the most important?**
(circle selected choice) **Yes** **No**

If not, what do you think the most important Key Result Areas should be?

SANDAS is of the opinion the CAP KRAs are still important. However there may be need for an examination of how well they have been able to “target action” in a comprehensive way, or how well they have informed funding decisions.

Given earlier comments regarding the non-recurrent funding of many projects, it is suggested that there be a focus on the most appropriate evaluation methodology for assessing the KRAs and for there to be clear and transparent understanding of the failure criteria for work aimed at achieving the KRAs. In an emerging sector, it may be more beneficial, to extend our learning from why things did not work. Also, there has in the past been some confusion about why some projects have not been refunded, the use of failure criteria may add to transparency.

E. Measuring Progress

Monitoring and reporting was identified as a weakness of the CAP, which can to an extent be addressed with effective performance measures and milestones.

As custodians of the National Drug Strategy, it is expected that IGCD will be responsible for the National Aboriginal and Torres Strait Islander Peoples' Drug Strategy and for providing updates to Ministers on progress against its actions. In order to gauge whether the Strategy is being effective and that progress towards the overall objectives is being made, it will be important to have clear indicators and milestones against the actions and priorities.

1. How often should progress be reported?

SANDAS suggests the frequency of reporting is less important than the "how" indicators and milestones that are reported. There should be equal consideration given to qualitative data and reporting.

2. Thinking about the actions and priorities that are identified above, or that you have identified, what sort of indicators and milestones could be used to demonstrate progress?

See 1 above.

F. Additional Comments

1. Are there any other issues you would like to raise that might be helpful in informing the development of the Strategy?

N/A

Written submissions should be received by NIDAC by no later than COB Friday 7 June 2013. These can be sent to either:

National Indigenous Drug and Alcohol Committee, PO Box 205, CIVIC SQUARE, ACT, 2608

Fax: 02 61622611

E-mail: nidac@ancd.org.au

Receipt of NIDAC receiving your submission will be sent to the email address provided.