Response to the South Australian Alcohol and Other Drug Strategy 2024-2030

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For further information contact:

Michael White
Executive Officer
Ph 08 8231 8818
Mob 0416176611
michael@sandas.org.au
www.sandas.org.au

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SANDAS Context Statement

The South Australian Network of Drug and Alcohol Services (SANDAS) was established in 2004, to enhance community wellbeing and reduce the harms associated with alcohol and drug use. As the peak body, we provide independent, state-wide representation, advocacy and support for non-government organisations working in the alcohol and other drug sector, through networking and policy development. SANDAS is a not-for-profit association funded by membership contributions, the Commonwealth Department of Health, the SA Department for Health and Wellbeing and a range of other organisations on a project basis.

SANDAS undertook consultation with members, seeking feedback on drafts of this response. Significant input was provided by Board members. Members making submissions shared their drafts and SANDAS consolidated feedback into this response. SANDAS undertook consultations with a range of other non-member stakeholders.

Overarching comments:

This response is based on an exception model. That is comment is made on components that we believe could be improved. Where we have not made comment, we accept that the component reasonably represents a useful and clear component of the strategy.

This strategy is the first to cover a period of six years. Previous strategies have had a 3 year duration. The longer duration is welcomed in that it gives the sector clarity on the government's intention into the future and as such provides a platform for stability. However, the Strategy is very limited in terms of its intention to stretch or develop the sector. Much of the Strategy reflects the period in which it was developed (pre-Covid) and does not take into consideration significant social and sectoral changes that have occurred both as a function of the pandemic and after that time.

Of concern is that this means there are significant issues that are not addressed. The alcohol and other drug field is in a state of rapid change and the strategy is not explicit about its need to evolve. Some examples of the significant challenges and changes that will affect the sector that require consideration are:

- The international and national changes (particularly in the ACT, Queensland and NSW) to drug regulation which are responding to strong evidence based research into the value of removing legal sanctions for the personal use of drugs currently designated as illicit. Internationally for example, Canada, Germany, Portugal, Thailand, Mexico to name a few, and many states in the United States have either decriminalised or removed all legal constraints from the personal possession and consumption of some or all drugs (mainly cannabis). It is worth noting that a recent article in The Lancet noted that:

  > The Global Commission on Drug Policy's latest report… describes decriminalisation of drug use as an essential precursor to ending HIV and viral hepatitis as public health threats. Since its formation in 2011 by political, economic, and cultural leaders, the Commission has advocated for decriminalisation as part of a rights-based approach to drug policy, rooted in scientific evidence and principles of public health, to minimise the harms arising from drug use. The UN recognises criminalisation of drugs as "proven to have negative health outcomes" and to "counter established public health evidence"; yet a disconnection between discourse and policy action persists. National drug policies largely remain punitive; they are polarised, simplified, and based more on ideology than evidence[1].

- The Strategy was developed before the release of the 2023 United Nations System Chief Executives Board for Coordination (CEB), chaired by the Secretary-General which opens the door for re-regulation, stating "alternatives to punitive measures for personal consumption should be considered. Prevention, treatment, harm reduction, rehabilitation and other measures were [are] required to help to secure individual rights to health and avoid incarceration". These are to be prioritised over justice and carceral responses to drug use.
- The significant number of emerging drugs of concern coming into the drug market, including but not limited to high potency opioids and other pharmaceutical drugs (either diverted from the health system or manufactured by unregulated producers in Australia or overseas). The Strategy is silent on responses to these developments.

[1] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(23)02617-X/fulltext

- Research showing the long term effects of the use of alcohol, and the very clear indications that there is no safe level of use. This is in the context of very strong lobbying by the alcohol industry to remove controls on alcohol sales and marketing (for example, rapid delivery, the placement of zero alcohol products as promotional device for full alcohol beverages in supermarkets, high volume online advertising by passing current advertising guidelines, the use of influencers to increase alcohol sales, especially to minors and those who drink at risky levels. The use of terms related to 'risky levels of alcohol consumption' implies that there are safe levels of consumption. This should be addressed by rewording to clarify that there is no safe level for alcohol consumption[2].
- The existing and emergent research showing the strong relationship between alcohol use and family violence and child protection issues, suicidal ideation, attempt and completion and the continuing concerns about alcohol and high risk activities such as driving and working in high risk industries. The Strategy only mentions Liquor Licencing reform once at Priority Action 11. It is silent as to how the Strategy may address new models of licencing which could deal with home delivery, rapid delivery, online age verification, take away licencing of restaurants, social and sports clubs, and alcohol delivered by unlicenced persons (Uber, Door Dash and related models which are combining alcohol and food delivery).
- The Strategy is silent as to demand, either current or emergent demand for AOD interventions. It is difficult to assess the merits of the Strategy without understanding how it will respond to emerging needs of the community for treatment. This in in the context of a significant reduction in treatment availability in South Australia over the period between 2013 and 2021/22 as noted by the AIHW in their most recent report. Fewer clients are using [able to access] AOD services in 2021–22 than 2013–14, after adjusting for population growth (434 clients per 100,000 population compared with 624 per 100,000, respectively).[3]
- The Strategy document cites reductions in drink driving detections and alcohol related crimes. There are indications that some of these reductions may have been primarily or at least in part due to the impact of Covid-19 and its impact on social interaction in public places and reduced detections as police resources were directed to different Covid-19 related issues. This does not equate with how drink and drug driving may evolve into the late 2020s.
- The Strategy is silent as to the establishment of a state based model for governing the planning, commissioning, delivery and evaluation of the alcohol and drug system. Whilst government regularly requires the NGO sector to 'integrate' services and improve collaboration and partnerships, we have seen little or no movement towards integrated planning and commissioning at government level. We currently have funding flowing from SA Health, Corrections, Human Services, Child Protection, Housing and Homelessness, Disability, Attorney Generals and a range of other government sectors. Each pursues its own strategies often without consideration of the implications of disjointed planning and commissioning. Added to this are that services also receive funding from a range of federal government departments also dis-integrated into state based planning models (e.g., Department of Health and Aged Care (multiple subunits funding AOD and related interventions), National Indigenous Australians Agency).

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[2] https://www.who.int/azerbaijan/news/item/04-01-2023-no-level-of-alcohol-consumption-is-safe-for-our-health#:~:text=The%20World%20Health%20Organization%20has,that%20does%20not%20affect%20health.

[3] https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/contents/state-and-territory-summaries/south-australia

Comments on the Aim

SANDAS welcomes that expressed aim of the Strategy.

The focus on the implementation of harm minimisation strategies is welcomed. However, the overall concept of 'health in all' approach is not reflected strongly enough in the Strategy. The Strategy still drives a considerable engagement with and leadership from Police and the justice system. A health led approach should see entry into the health sector led by the health sector. Police and the courts, whilst they play an integral part in the implementation of alcohol and other drug management strategy should not be the gateway into treatment nor the first line of intervention for health service engagement. SANDAS believes that the primary function of alcohol and drug intervention at prevention, early intervention, education, treatment and support should be led by the department of Health and its divisions involved in alcohol and drug issues. A whole of government approach should of course engage Police, Courts, Corrections, Education, Attorney General and Industry and Trade departments as required and relevant.

Priority Areas

SANDAS welcomes the explicit recognition of the five priority areas as defined in the Strategy. However, we believe that the lack of an explicit priority to address the underlying legal and human rights issues that arise as a consequence of alcohol and other drug regulation is a significant gap.

Priority Populations

There are several concerns about the list of priority populations. The most concerning is that the list of Priority Populations is silent on the treatment needs of women. The 2024 Commission on Narcotic Drugs called specifically for an increased focus on the need of women for alcohol and other drug treatment. Whilst the list includes young people and parents it is does not highlight the needs of women. This is particularly important given the recent discussion cited previously from the United Nations CEB 2023 and related discussions at the 2024 Commission on Narcotic Drugs held in Vienna. In their most recent report, the AIHW indicated that 36.4% of South Australian clients were female[4].

The inclusion of men/young men as a priority population is possibly unnecessary as men make up over 60% of all people attending treatment (ibid).

The priority population list also fails to identify culturally and linguistically diverse communities as a key subgroup in the population requiring assistance with alcohol and other drug issues. Recent data from the AIHW indicates that over 98% of people accessing alcohol and drug treatment are English as a first language speakers and 91% were born in Australia. According to the Australian Bureau of Statistics over 30% of Australians were born overseas, 48% have a parent born overseas and whilst 22% spoke a language other than English at home.[5] CALD community members with AOD issues and their families face significant barriers to accessing information, help seeking, and receiving treatment. These barriers often result in complex and severe AOD and comorbidity issues within this population, underscoring the need to prioritise them. There is a significant gap in the collection of data on the CALD communities needs. This lack of data on the CALD community's access to treatment and support does not reflect their need for assistance. Additionally, in the realm of prevention and early intervention, it is crucial for government departments and AOD

[4] https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/contents/state-and-territory-summaries

[5] https://www.abs.gov.au/media-centre/media-releases/2021-census-highlights-increasing-cultural-diversity

service providers to work closely with local CALD communities. This collaboration should aim for meaningful and substantial improvements in people's lives rather than superficial or tokenistic efforts. The Strategy must ensure that our strategies and actions truly reflect the needs and experiences of the CALD community.

Social determinants of health

This section is a useful exploration of the social determinants of health. It however should commence with a more general statement as to why people use alcohol and other drugs. It is important to acknowledge that people ascribe alcohol and other drugs use with positive and life enhancing outcomes. That is, they drink or use drugs as they believe that using alcohol or drugs enhances their social interactions, is relaxing, is an important part of celebrations, and enhances their capacity to work, study or network. A more appropriate wording may be:

> *Although there is no definitive pathway into using alcohol and other drugs, evidence suggests there can be certain environmental, social, and contextual factors that may mean an individual is more likely to use or experience harms from their substance use. (p. 4)*

The impact of the criminalisation of substance use which drives significant engagement with the justice system is not mentioned. Whilst there is acknowledgement of the higher rates of Aboriginal and Torres Strait Islander engagement with the justice system, there is not specific recognition that alcohol and drug legislation has been significantly entangled in the enabling of discretionary policing, where poor, marginalised and homeless people are more often stopped, searched and detained in relation to intoxication or drug use. This often leads to individuals being charged not for any drug related issue bit for the way in which they engage with police or the justice system (a stop and search resulting in refusal to follow a lawful direction, threat to harm or breach of the peace). Current policy choices (criminalisation of personal use and possession, possession of implements to use etc) are inconsistent with the WHO proposed model outlined in Figure 1 (p. 4).

Priority populations

The identified priority populations cover a wide range of sub-groups in the population. There is significant research showing a considerable rise in the prevalence of female drinking which is not addressed in the Strategy. A recent study by NCETA found that daily alcohol consumption by women between 1950 to 1980 had increased by 203 per cent, compared to the 6 per cent rise in male during this period. The research highlights that women are more susceptible than men to experiencing severe health problems from excessive drinking, including liver issues, cardiovascular disease, cancers and mental health issues like depression and anxiety[6]. There are also significant issues arising from drinking during pregnancy and foetal alcohol syndrome prevention which could be more fully addressed.

The distinction between children and young people and parents who use drugs and alcohol does not appear well defined as the parental use seems significantly concerned with its impact on youth drinking. There are no specific interventions identified to address the impact of drug use on parental engagement with the justice or child protection systems. Engagement with child protection for young people can have lifelong consequences including increasing the likelihood of substance use in adulthood. A further omission is the link between childhood trauma, disability and neurodiversity. There are emerging evidentiary links between untreated or unsupported neurodiversity and engagement with substances[7]. There should also be a focus in the strategy on

[6] https://onlinelibrary.wiley.com/doi/10.1111/dar.13865
[7] https://onlinelibrary.wiley.com/doi/epdf/10.1111/dar.12249

the association between substance use and suicide, with a significant increased risk of suicide where people have substance use disorders[8].

How we got here – collaboration and partnerships

Whilst the NGO sector was involved in consultation prior to the drafting, there has been limited engagement for the last two years. Much has changed in this time (funding at federal level, emerging drugs, new research and evidence, changes in patterns of consumption, sales marketing to name a few). Until a full consultation, incorporating further NGO and other stakeholder feedback is complete this document should be considered a working draft.

There is a significant gap in the list of those who have or will have input into the strategy, most critically people who use alcohol and drugs in ways that bring them into the scope of the Strategy. There does not appear to be any consideration as to how to get their input. South Australia is one of the few jurisdictions in the country that does not have a representative body for people who use drugs, and the creation of a representative drug user body should be a significant outcome to be achieved in the next 3 years let alone by 2030.

The Strategy also cites consultations with the peer workforce. However, South Australia does not have a formalised alcohol and other drug peer support system. To date, despite the minimal resources to do so, state and federal governments and PHNs have failed to fund a comprehensive peer workforce support project. As such whilst individual peer workers may have been consulted it is not possible to describe an unfunded peer workforce as key partners. A component of the Strategy should reflect the need to establish and support a peer workforce project for the sector consistent with and drawing on models and the significant evidence developed in other Australian jurisdictions, and in parallel sectors such as mental health.

Priority area 1: Health promotion and prevention

Within the context of the Strategy, health promotion and prevention have been given a very narrow definition, focussed on providing support to individuals to make choices or change their behaviour.

A key aspect of prevention is creating the social and legislative context in which alcohol and other drug use occurs. This would include a focus on revising and updating existing legislation in relation to alcohol and drug use. For example, this may include changes to the current Liquor Licencing Act to curtail rapid home delivery, online advertising and ordering, the management of advertising and promotions, and the adoption of age verification tools to restrict underage access to alcohol. It may also be important to consider illicit drug regulation given the significant shifts in this area across Australia and around the world (de-criminalisation in ACT, regulation changes in Queensland, and the introduction of drug checking in Queensland, Victoria, ACT and NSW).

In relation to addressing stigma and stigmatising language, the government has a role in legislating and enforcing anti-discrimination legislation, where communications by the media and others clearly breach anti-discrimination legislation. *What we could see by 2030* could include a commitment to end the discriminatory content currently seen in the media. This may require education of both the media and civic leaders who regularly use discriminatory language in relation to substance use.

A focus on health literacy is important but health literacy is not sufficient to address alcohol and other drug use harms. Health literacy places the responsibility to manage risks on the individual over the social, legal and economic drivers of substance use. Addressing these drivers is critical to

[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9728854/

reducing the harms of alcohol and other drug use. Whilst the focus in the Strategy on Foetal Alcohol Syndrome is welcome, there is a significant need for all services in the health and human services to have the skills and knowledge necessary to undertake appropriate screening, assessment and referral for alcohol and other drug use. This includes developing skills in mental health, disability, housing, homelessness, justice, police, youth services and carceral settings.

PA 2 in this section should include leadership by Aboriginal Community Controlled Organisations. The word 'reduce' may be unclear in the context. Consider using the word 'address' in its place.

PA 4 should explicitly cite the internet as a 'point of sale outlet'.

PA 6 would be clearer is it was worded, "Increase community knowledge and awareness about the harms and consequences of drinking alcohol, including during pregnancy or when planning a pregnancy".

SA 8 could be strengthened by clarifying it as, 'Advocate for the Australian Government to restrict digital and physical advertising of alcohol where children may be targeted by or exposed to this marketing in any context'.

Priority area 2: Disruption and supply reduction

In relation to the government departments stated commitment in this section there should be an explicit statement about reducing the harms of alcohol through data monitoring of alcohol sales, licence compliance activities and the enforcement of legislative restrictions on the sale and advertising of alcohol.

What we could see by 2030 should acknowledge that the international restrictions on the personal use of currently illicit drugs will have shifted further from prohibition and criminalisation. By 2030 we should hope to see a regulatory system which balances the risks of harmful use of alcohol and other drugs with the social costs to individuals and the community of policing and carceral interventions.

It is especially important that the Strategy take into consideration the way in which current supply reduction strategies are weighted towards enforcement against Aboriginal and culturally and linguistically diverse communities, young people and people living in poverty otherwise marginalised).

It may also be of value to include a statement such as "A licencing system that meets the communities needs for appropriate controls on access to and promotion of alcohol and other drugs used in the community". This would enable the inclusion in any future licencing system of regulations relating to currently illicit drugs, the emerging regulation of nicotine related delivery systems and further developments in the regulation of the online sales and marketing of alcohol.

Priority Actions

PA 11: Clarify that the intent of this section covers all licencing not just high risk licences by rewording as 'Consider public health implications to inform policy and law reform of the Liquor Licensing Act 1997 including high-risk licence applications'.

PA 13: Whilst minimising access to illicit substances into prisons is welcomed, there needs to be a clearly articulated commitment to treating alcohol and drug dependence of those in the justice system (prison, parole, remand, community corrections). There also needs to be a clear intent to introduce harm minimisation strategies into prisons including needle and syringe programs, opioid substitution, and a broad range of other interventions. Currently the rates of opioid dependent

people leaving prison is equivalent to those entering prison[9]. By 2030 we should have an intent that no one should leave prison drug dependent.

SA 16: this could be reworded to be more explicit 'Maintain and enhance technology systems to minimise harms associated with online sales, home delivery and takeaway liquor and inform regulatory reform.'

SA17: Could be reworded to clarify the intent to address online sales and home delivery: 'Monitor and take action to modify online sales, delivery and takeaway alcohol sales at high-risk times and locations to reduce harms.' The inclusion of 'time' is critical given recent research as to the intersection of domestic and family violence in the context of televised sports events.

Priority Area 3: Early intervention and targeted intervention

Early and targeted intervention should include the use of harm reduction strategies such as drug checking/pill testing, outreach to alcohol and drug users who have engaged but not yet experienced harm and

Our commitment: All acronyms should be spelt out for ease of understanding. Aboriginal Health Councils should be capitalised.

What we could see by 2030: Consider rewording to identify location of improvement:

- Positive modelling of healthy practices to support disease prevention and health promotion in schools, workplaces, licenced premises, sporting and social clubs and in online environments

Include a statement of intent to transfer all service delivery for Aboriginal clients from mainstream to Aboriginal Community Controlled Organisations.

Include a statement of intent to see evidence based interventions in place in all schools and social clubs, and an expansion of workplace based interventions.

Include a statement of intent to fund early intervention and early prevention activities at a percentage of the level of need for such services. This would require a Priority Action related to defining and quantifying need and measuring outcomes arising from changes implemented.

The two existing statements of intent lack the capacity to be measured.

Priority Actions

This would be an appropriate point at which to indicate an intent to explore new models of early intervention (evidence based education in schools, the delivery of training to employers of apprentices and new entrants to the workforce on the need for good practices in relation to workplace drinking, the engagement with sports and social clubs in providing education and support to members in relation to safer use of alcohol and other drugs etc).

PA 24 seeks to address referral pathways; however, this is not achievable without sufficient services to accept referrals. The current issue in the sector is that at a national level the amount of treatment required is two to three times the current treatment on offer (New Horizons and other

[9] https://www.aihw.gov.au/reports/prisoners/the-health-of-people-in-australias-prisons-2022/contents/medication/opioid-substitution-therapy

work by Prof Alison Ritter, UNSW DPMP). SA has seen a significant decline in the number of people able to access treatment since 2014[10].

PA 24 and PA 25 Should specifically cite ACCHO/ACCOs as lead in this process.

PA 27 move to Priority Area 4 as this is a critical part of the treatment and support sector. It should be noted that meeting this Priority Action requires partnership with and leadership by the NGO sector.

Priority area 4: Treatment and support

Why is this important?: This section should be explicit that we are talking about a health condition where clients or patients are entitled to a full range of health interventions for their condition. This is essential if the Strategy is to take a 'health in all approach'. A key requirement would be that a whole of government response commences with a health approach.

The private sector in SA is an extremely small part of the care mix, currently more than 90% of government funding is directed to the NGO sector and this sector delivers nearly all intervention services. Consider:

> There is a need to support people who have an alcohol and other drug related health condition to receive high quality care through the coordination of treatment and care including care for multiple morbidities. The NGO sector plays a significant role in service delivery with a small private sector emerging. Shared professional development opportunities for those working across public, NGOs, and private services across health services are critical. The engagement of related sectors including justice, police, corrections, education, homeless/housing, disability etc sectors supports good health and wellbeing outcomes.

What could we see by 2030? This should be specific as to what type of health consumers – 'health consumers affected by alcohol and other drug use experience reduced discrimination within the health sector and the wider community resulting in improved health outcomes'.

Include commitments to meet the treatment needs of rural youth: 'Provide pathways for all regional young people to access youth-specific AOD services for brief interventions, treatment, and support. All rural youth having access to age-appropriate AOD services before they enter the juvenile justice arena, reducing youth criminal activities and improving health outcomes'.

Priority Actions

PA 28 This should include a commitment to increase service delivery across the board not just for residential care.

PA 29 was a government commitment at a previous election; however, it is looking like these beds will not be open until December 2025. There is also a need for similar small scale models in other locations, e.g., Ceduna, Pt Lincoln, Whyalla, Riverland. This could be effected by upskilling local hospitals in the existing rural hospital networks to incorporate alcohol withdrawal and

[10] https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/contents/state-and-territory-summaries/south-australia

detoxification services in every hospital and an NGO led, housing based or ambulatory model for these regions (consistent with SA 44).

PA 31 The extension of naloxone distribution is welcome. It could be mirrored by the establishment of a drug testing service either at a fixed site or mobile. Given changes in Queensland, ACT and Victoria and the increasing risk of drugs such as fentanyl and nitazenes further penetrating the Australian drug market this should be an intention by 2030 if not sooner.

PA 32 An increase to comorbidity or complexity services is welcome, there are already comorbidity nurses/workers located in some SA hospitals. It may be worth aiming to have an AOD trained team, including peer workers and other specialists alongside nursing staff with skills in comorbidity and complexity in every hospital by 2030.

PA 33 New and innovative models are useful on top of sufficient current evidence based treatment, harm reduction services and referral to NGO services with capacity to meet needs on release.

PA 34 PHNs could be encouraged to ensure all health service providers they work with are competent to undertake alcohol and other drug screening with an emphasis on identified groups such as women, LGBTIQA+ patients, Aboriginal clients, young people etc.

Supporting Activities

SA 35 This activity should specifically address the lack of integration across state and federal commissioning and identify the need to establish a comprehensive governance model to deliver integrated government needs assessment, planning, commissioning and evaluation of services.

SA 36 This activity is only achievable with sufficient funding to meet unmet demand.

SA 37 This activity is predicated on the assumption that the justice system remains the entry pathway into treatment. The treatment of people with substance use disorders including co/multimorbidity's should be in the first instance, through health services, irrespective of their engagement with the justice system. Substance use is the only health condition where access is mediated by the justice system. There should be an intention that this is addressed by 2030.

SA 38 It would be hoped that by 2030 best practice diversionary approaches had been implemented and evaluated. Change to 'identify, implement and evaluate'. This should include reviewing the current cap and reverting to the pre-cap model at the earliest possible time, whilst implementing intensive services for people who are diverted more than three times.

PA 40 Given the significant number of clients who attend NGO based services and never encounter DASSA services, this should include Hep C screening and treatment integrated into NGO practice by 2030.

PA 42 There have been significant developments in virtual care responses emerge during the Covid-19 epidemic (which occurred after the consultation on this Strategy). Consider rewording to 'evaluate the current and emerging models of virtual care and resource and implement models based on best practice evidence'.

PA 46 Given this is a six year strategy this should be reworded to 'Consult on, implement and evaluate…'

PA 47 There is a need to meet the basics in this respect. Recent reports by the Community Visitor make it clear that young people in the youth justice system are not getting any or insufficient interventions. Before we innovate, we need to meet the baseline need.

Priority Area 5: Engaging communities

Whilst the 'Why is this important?' and 'Our commitment" sections highlight the value and need for peer workers, the development of a peer or lived experience model is not identified as a key priority. There is no reference to developing planning models that engage people with lived or living experience in the development of the sector. There is not a priority action which deals with the establishment of an independent representative body for people who use drugs. A representative service exists in every other jurisdiction in Australia bar the NT. The WHO states:

> Harm reduction networks and community-based peer support groups have made significant contributions to the prevention of HIV and other infectious diseases among injecting drug users and other groups of people using drugs, as well as connecting people who use drugs with outreach health and social services.[11]

Add priority actions that address both the need for a peer workforce development strategy and the establishment of a statewide representative body for people who use drugs.

System enabler – Workforce development

Dot point 3 is missing key words, could be reframed as 'Implementation and collaboration activities that support workforce development across the alcohol and other drug sector are implemented'.

SA 53 The SA Workforce Development Framework has been developed, what is required now is the implementation of the Framework. This is especially critical as this is a six year strategy. This requires a commitment of funding by the State government. This work could be delivered by a number of industry based training organisations, including SANDAS as the peak body (in a coordinating role), sector based RTOs, TAFE SA and the higher education sector.

SA 54 Government must take responsibility to ensure that all alcohol and other drug services meet the requirements of the National Quality Framework for Drug and Alcohol Treatment Services and guiding principles. This Strategy should include a commitment requiring all services meet the Standards as a minimum by 2030. This should include developing legislation and compliance frameworks that address these requirements for public, NGO and private providers (who are currently exempt from meeting any standards).

SA 55 This activity is very specific, there are wider uses for models of communities of practice, and their establishment will require the investment of staff time and resources. Engagement in a community of practice may need to be identified as a KPI in commissioning processes underpinned by resourcing.

SA 57 This activity could go beyond promotion to evaluation and implementation of continuous improvement strategies that increase measured engagement with DACAS.

SA 58 Consider rewording to 'Work with national and state workforce development bodies to ensure that alcohol and other drug workforce needs are incorporated in national and state workforce development strategies and create pathways into and upskilling for the AOD workforce'.

SA59 Consider being more targeted 'Develop skills pathways that engage registrars and nursing students in alcohol and other drug and mental health services placements that enhance knowledge and skills development'.

[11] https://iris.who.int/bitstream/handle/10665/377960/9789240096745-eng.pdf?sequence=1, p. 125

System Enabler – Evidence and data systems

Our commitment could include a statement about the intention of sharing data, information and knowledge collected with or by the NGO sector with the sector and especially with subgroups such as Aboriginal Community Controlled services, LGBTIQA+ services and the wider NGO sector. This should be consistent with minimum data sovereignty standards as extant. This could be achieved by widening the scope of PA 62.

SA 64 By 2030 it would be hoped that in conjunction with drug checking we have a comprehensive public facing early warning system for emerging drugs of concern and issues relating to drug substitution and contamination. This is a fundamental harm minimisation strategy which enables alcohol and drug workers to engage with people who use drugs but are unlikely to ever present for drug treatment but who may be at significant risk from contaminated substances.

SA 65 There is an emerging body of research being undertaken by NGOs in conjunction with university research bodies and they should be included in the scope of this supporting activity.

SA 66 This activity should be extended to include recommendations for improvement, expansion or termination of services based on measurement and evaluation.

SA 67 Gap analysis should be extended to cover the whole population with sub activities to address the needs of specific groups.

Measuring success

It is a concern to the NGO sector that there is no NGO representation on the Alcohol and Other Drug Strategy Steering Group. Given the significant role the NGO sector undertakes this should be addressed. People who use drugs should be considered as key system informants should also be considered as essential participants on the Alcohol and Other Drug Strategy Steering Group.

Whilst annual monitoring is essential regular public reporting is also essential and should be undertaken and the findings shared regularly with the non-government sector and people who use the services.

It is notable that all the KPIs are related to reductions in harms and engagement with the justice system. There could scope to include KPIs related increasing the number of people receiving treatment and support and reporting positive outcomes from treatment (collated from NMDS and ATOP data).

Conclusion

While this submission highlights a number of concerns about the Strategy, SANDAS would like to acknowledge the significant work that has gone into preparing the draft. However, given the relatively short turn-around time for providing feedback on the document, particularly given its scope and complexity, we would suggest the Department provide further opportunities for the non-government health and community services sector and people who use or are affected by the use of alcohol and drugs in the community to contribute to the Strategy's further development.

This may include further face to face and written opportunities to provide feedback both from the non-government alcohol and other drug sector and the wider community services and health sector. This is particularly critical as this Strategy has been framed with a six year lifespan.

Thank you for the opportunity to provide feedback.