

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES' SUBSTANCE USE POLICY

PREAMBLE:

In developing substance use policy and programs in relation to Aboriginal and Torres Strait Islander peoples, it is important to understand the context of substance use and its impact upon communities. The *National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2009: Background Paper* paints a grim picture:

“Inquiries into the health of Aboriginal and Torres Strait Islander people have consistently commented on the detrimental effects of dispossession and alienation on health and wellbeing. These issues must be recognised as a contributing factor to the lower health and socioeconomic status that Aboriginal and Torres Strait Islander peoples continue to experience today.

Substance misuse is both the cause and effect of much suffering in Aboriginal and Torres Strait Islander communities. Alienation, unemployment and despair arising from dispossession and dislocation all contribute to the use of substances. Substance misuse causes serious harm to physical health, and it can be argued, possibly even more harm to the social health of individuals and the fabric of communities. Acts of substance-related violence, over-representation of Aboriginal and Torres Strait Islander peoples in the criminal justice system and other forms of societal breakdown are manifestations of the pain, anger and grief experienced by Aboriginal people arising from the process of colonisation. This burden contributes to the unacceptable levels of harm currently caused by alcohol and other drug use by Aboriginal and Torres Strait Islander peoples.” (Ministerial Council on Drug Strategy, 2003, pg 2)

The results of the *2004 National Drug Strategy Household Survey* highlight the disproportionate rates of substance use and harm among Aboriginal and Torres Strait Islander peoples:

“One in four (22.7%) Indigenous people drank at levels that put them at high risk of alcohol-related harm in the long term; two in five (38.7%) drank at levels that put them at high risk of alcohol-related harm in the short term.” (Australian Institute of Health and Welfare, 2005, pg x)

“In terms of tobacco use, 52% of Aboriginal and Torres Strait Islander people aged 12 years and over had smoked 100 cigarettes (or equivalent amount of tobacco) in their lifetime, and 35% had smoked in the last 12 months. This contrasted with other Australians, 45% of whom had smoked at least 100 cigarettes (or equivalent amount of tobacco) in their lifetime, and 20% of whom had smoked in the last 12 months.

Illicit drug use among Aboriginal and Torres Strait Islander people was higher than for other Australians. For example, 19% of Aboriginal and Torres Strait Islander people had used marijuana/cannabis in the last 12 months compared with 11% of other Australians. Similarly, 10% of Aboriginal and Torres Strait Islander people used an illicit drug other than

marijuana/cannabis in the last 12 months compared with 8% of other Australians.”
(Australian Institute of Health and Welfare, 2005, pg 60)

In focusing on households, the *2004 National Drug Strategy Household Survey* excludes people who are homeless or institutionalised. Given the exclusion of these marginalised populations, it is likely that the survey underestimates real levels of substance use and related harm. Snapshot studies of Aboriginal and Torres Strait Islander health conducted in several jurisdictions have revealed shocking levels of substance use and harm in some sub-populations.

The combined evidence from the recent research appears to indicate that an emphasis on the social determinants of substance use (eg. the reasons why people use substances), rather than on particular substances, is most appropriate in the context of developing approaches that address substance use within communities. Given issues of comorbidity and the correlation between substance use and mental health issues, holistic approaches that address the reasons for substance use are more likely to achieve long term success and reduce risks associated with the so-called “substitution effect”. The substitution effect occurs when a person ceases problematic use of one substance but then commences problematic use of another substance because of an underlying lack of appropriate coping mechanisms.

GUIDING PRINCIPLES:

Relevant Policy Frameworks

National Drug Strategy Aboriginal and Torres Strait Islander Peoples’ Complementary Action Plan 2003-2009 (the Complementary Action Plan)

The *National Drug Strategy Aboriginal and Torres Strait Islander Peoples’ Complementary Action Plan 2003-2009* (the Complementary Action Plan) was developed through public consultation with Aboriginal and Torres Strait Islander peoples, under the direction of the National Drug Strategy Reference Group for Aboriginal and Torres Strait Islander Peoples, to complement the issues raised in national plans to address alcohol, tobacco and illicit drugs developed under the National Drug Strategic Framework.

The Complementary Action Plan was endorsed by the Ministerial Council on Drug Strategy (MCDS) on 1 August 2003 to help provide a nationally coordinated and integrated approach to reduce drug related harm amongst Aboriginal and Torres Strait Islander peoples.

The Complementary Action Plan sets out six key result areas (KRAs):

1. Enhanced capacity of 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 in collaboration with non-government organisations to implement, evaluate and improve comprehensive approaches to reduce drug-related harm;
3. Substantially improved access to the appropriate range of health and wellbeing services that play a role in addressing alcohol, tobacco and other drugs issues;
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 capacity of community-controlled and mainstream organisations to provide quality services;
6. Increased ownership and sustainable partnerships of research, monitoring, evaluation and dissemination of information.

(Ministerial Council on Drug Strategy, 2003, pg 1-8 of summary paper)

The MCDS endorsed the new *National Drug Strategy: Australia’s integrated framework 2004-2009*, on 20 May 2004. MCDS acknowledged that the development of the Complementary Action Plan was a significant outcome from the previous National Drug Strategy and identified the implementation of

the Complementary Action Plan as a specific priority area for action under the National Drug Strategy 2004-2009.

National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004-2009 (the Social and Emotional Well Being Framework)

The Social and Emotional Well Being Framework aims to respond to the high incidence of social and emotional well being problems and mental ill health, by providing a framework for national action. It was developed under the auspices of the National Mental Health Working Group and the National Aboriginal and Torres Strait Islander Health Council, by the Social Health Reference Group, which was specially appointed to undertake the task.

The Social and Emotional Well Being Framework is designed to complement the *National Mental Health Plan 2003-2008* and the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013*, and was endorsed by the Australian Health Ministers Advisory Council. (Australian Health Ministers' Advisory Council, 2004, pg 1)

The Social and Emotional Well Being Framework has five key strategic directions -

1. Focus on children, young people, families and communities:
Strengthening families to raise healthy, resilient infants, children and young people;
Recognising and promoting Aboriginal and Torres Strait Islander philosophies on holistic health and healing;
Responding to grief, loss, trauma and anger.
2. Strengthen Aboriginal Community Controlled Health Services:
Building a skilled and confident workforce able to provide mental health and social and emotional well being services within the Aboriginal Community Controlled Health Sector.
3. Improved access and responsiveness of mental health care:
Facilitating improved access and responsiveness of mainstream mental health care for Aboriginal and Torres Strait Islander people.
4. Coordination of resources, programs, initiatives and planning:
Providing optimal funding and coordination in order to improve Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing;
Improving coordination, planning and monitoring mechanisms.
5. Improve quality, data and research:
Developing and publishing culturally appropriate data and research that reflects Aboriginal and Torres Strait Islander mental health and social and emotional well being issues and that underpin improved service delivery.
(Australian Health Ministers' Advisory Council, 2004, pg iii-iv)

Common Themes Emerging

Both the key strategic framework documents promote some common themes. There is a common emphasis on building the capacity of both communities and workforces to enable access to holistic, evidence-based continuums of care in terms of the delivery of alcohol and other drug, mental health and related services. The provision of such holistic continuums of care and referral to appropriate treatment pathways is dependent upon the establishment of intersectoral linkages.

In other words, people will always have to access a number of different government and non-government services in order to have their needs met. If these services are all: adequately resourced; adhering to established standards of best practice within their respective areas of expertise; and able to work cooperatively together to meet the complex and multifaceted needs of individuals, then the journey of healing for these people will be a lot smoother.

Additionally there needs to be a focus on key "at-risk" or "target" groups that are experiencing disproportionate rates of harm that are impacting on the Australian Government's capacity to achieve

its strategic objectives. For instance, in relation to the spread of blood-borne viruses in sub-populations and implications for the broader community.

Established Best Practice

In 2004, the Australian National Council on Drugs (ANCD) released a report entitled *Indigenous drug and alcohol projects: elements of best practice*. The primary aim of the 2004 study was to identify and promote programs that could be suitable models for other communities to develop and implement.

The 2004 ANCD report identified best practice projects in five categories:

1. Acute interventions – primarily harm reduction strategies such as night patrols and sobering-up shelters;
2. Prevention projects – health promotion campaigns, provision of alternatives to alcohol and other drug use;
3. Non-residential treatment projects;
4. Residential treatment projects; and
5. “Multi-service” projects – projects that provided a range of services but in which those services were not administered as discrete projects.

The diverse categories reflect the range of intervention and treatment models required to ensure that service delivery reflects the differing needs of clients.

Of the fourteen projects short-listed for consideration as part of the ANCD’s best practice research, only one was a government delivered project. The other thirteen were all community-controlled projects.

The ANCD report went on to identify elements common to each of the five projects that received top ranking under the categories listed above, which were seen as contributing to best practice:

- Clearly defined and effective management structures and procedures;
- Trained staff and ongoing staff development programs;
- Good multi-strategy and collaborative approaches;
- Strong leadership; and
- Adequate and continuing funding.

Community Control and the Relationship with Mainstream Service Delivery

The fourth principle of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013: Framework for action by Governments* relates to “...supporting the Aboriginal community controlled health sector in recognition of its demonstrated effectiveness in providing appropriate and accessible health services to a range of Aboriginal communities and its role as a major provider within the comprehensive primary health care context.” (NATSIHC, 2003, pg 3)

This principle is supported by the results of the ANCD best practice study, in which thirteen of the fourteen projects short-listed for consideration were community-controlled projects.

Traditionally, community-controlled services have succeeded in attracting those people who are marginalised from mainstream services. Among this group of people are the “complex needs” clients, who have a range of needs that cross a number of categories of mainstream medicine (eg. coexisting mental health and alcohol and other drug problems). As many community-controlled services do not demand proof of Indigenous status, they often cater to the needs of some non-Indigenous people who have also had difficulty in engaging with mainstream services.

In terms of both making mainstream services more accessible to Aboriginal and Torres Strait Islander peoples and strengthening the capacity of community-controlled services, workforce development is critical.

By up-skilling more Aboriginal and Torres Strait Islander people to a level where they are qualified to work with alcohol and other drug use, there is a potential to impact on mainstream services in terms of the capacity to fill and support Indigenous-specific positions. The employment of Aboriginal and Torres Strait Islander staff within mainstream organisations is one of the key measures proven to make mainstream services more accessible to communities.

Similarly, the capacity of community-controlled agencies to respond to concerns around alcohol and other drug use issues is currently hampered by a constant lack of appropriately trained and qualified staff. This factor also contributes to burnout in existing staff. It must be noted that there needs to be sustainable funding to support appropriately qualified workers particularly in remote areas.

The holistic approach taken within the community-controlled sector acknowledges that there are reasons why people turn to alcohol and other drugs, and seeks to address the cause of substance use problems, as well as the symptoms. The establishment of Social Health Teams within some community controlled health services builds on the foundation of holistic care to deliver multidisciplinary care teams - enabling cooperative case management and care planning.

Implications of the New Arrangements in Indigenous Affairs

Office of Indigenous Policy Coordination (OIPC), Indigenous Coordination Centres (ICCs) and Shared Responsibility Agreements (SRAs)

The new arrangements in Indigenous affairs have created new opportunities to progress the national priority areas articulated in the Complementary Action Plan and the Social and Emotional Well Being Framework.

The SRA framework concept has created an opportunity for both government and non-government agencies to come together with communities to develop comprehensive approaches to local problems.

The establishment of ICCs has the potential to facilitate the establishment of whole-of-government approaches and projects as SRAs with communities. For instance, a project to maintain community housing could entail the provision of housing support officers, referrals to alcohol and other drug agencies and a commitment from the community to engage in the project by ensuring participants access relevant services.

The SRA funding model provides a tangible context for the development of holistic, whole-of-government approaches to addressing alcohol and other drug misuse and related health and social factors. Success rates of traditional programs and projects designed to address alcohol and other drug use problems (eg detoxification) could possibly be significantly enhanced through the addition of elements designed to address other factors impacting upon the person's use, such as homelessness and/or prior abuse. Such identified "risk factors" and/or "triggers" for people who misuse substances are not necessarily addressed in the context of traditional alcohol and other drug treatments and interventions. For instance, linking a client who has completed detoxification with safe and secure accommodation and/or subsequent vocational training options may reduce the likelihood of relapse by facilitating the transition to community life. The Social Health Teams emerging in some community controlled health services are already moving towards a multi-disciplinary model of care that could be built on through the new whole of government arrangements in Indigenous Affairs.

ACTIONS/RECOMMENDATIONS:

The Public Health Association of Australia advocates that government funding decisions in relation to substance use service provision should be guided by the following principles:

- A) Be evidence-based with reference to established best practice;
- B) Facilitate the provision of a multifaceted range of services within communities, and aim for equitable levels of service delivery across the nation; and
- C) Be in line with key national strategic priorities and timeframes for implementation set out in the Complementary Action Plan and the Social and Emotional Well Being Framework.

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