Submission No 53

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

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Submission

to

NSW Legislative Council Standing Committee

Inquiry into Drug and Alcohol Treatment

Aboriginal Health & Medical Research Council of NSW

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Executive Summary

The Aboriginal Health and Medical Research Council of NSW (AH&MRC) appreciates for the opportunity to provide a submission to the NSW Legislative Council Inquiry on drug and alcohol treatment. The AH&MRC is the peak representative body and voice of Aboriginal communities on health in NSW, and represents its members, Aboriginal Community Controlled Health Services (ACCHSs), which deliver culturally appropriate comprehensive primary health care to their communities.

This submission provides background information, describes key principles relevant to considering programs and services for Aboriginal people, as well as responding to the specific terms of reference of the Inquiry, and identifying additional issues for Aboriginal communities relevant to the Inquiry's considerations.

Key principles for successful drug and alcohol programs that meet the needs of Aboriginal communities are:

- Involving Aboriginal people and their representative organisations, the AH&MRC and ACCHSs at all stages in the development and implementation of strategies to address harmful drug and alcohol use in their communities.
- Government and mainstream organisations working in partnership with Aboriginal communities through the ACCHSs and the AH&MRC. Meaningful (respectful, trusting and effective) partnerships are key to effecting positive change.
- Alcohol and other drug programs for Aboriginal people being holistic and encompassing the range of services including: prevention and early intervention services; harm minimisation services; non-residential treatment services; residential treatment services; services that provide support, referral and ongoing care; and workforce development services.
- Mainstream programs and Aboriginal specific programs run by mainstream organisations need to be accessible and inclusive of Aboriginal people.
- Service delivery needs to be reflective of need, and the different needs of individual clients necessitate program choices.
- Many Aboriginal communities have initiated activities aimed at improving the health and wellbeing of community members, and these initiatives should be supported.

In summary, the AH&MRC responses to the specific Terms of Reference of the Inquiry are:

- Naltrexone treatment (TOR 1): Research and evaluation of new interventions or treatments involving Aboriginal people should always be conducted in accordance with the AH&MRC Ethical Guidelines. In general terms new interventions or treatments should be proven effective and safe before being delivered to Aboriginal people.
- Adequacy of funding (TOR 2): Funding for the Aboriginal Community Controlled Health sector and other services to provide accessible drug and alcohol programs for Aboriginal people is currently insecure and inadequate to meet high levels of community need. Adequate and secure funding is required.
- Effectiveness of mandatory treatment (TOR 3): There is currently insufficient evidence to draw conclusions about the effectiveness of mandatory treatment initiatives for Aboriginal people. The AH&MRC supports the development of more voluntary diversionary programs for offenders with drug and alcohol problems

- Adequacy of integrated services (TOR 4): Lack of integration within the health system is a major challenge for drug and alcohol treatment in general, and for Aboriginal people in particular. There is a need for better integration between services generally, and in particular when people move between prison and the community
- Drug and alcohol education programs (TOR 5): There is a need for more Aboriginal specific strategies and programs with an education and prevention focus
- Models of service (TOR 6): More investment in the proven models used by ACCHSs to deliver alcohol and drug programs to local communities is required.

Additional issues and recommendations important to address needs, gaps and issues and improve the health and wellbeing of Aboriginal people in NSW with drug and alcohol problems are:

- Support for existing Aboriginal community initiatives
- More rural and regional services and for more services in metropolitan areas where there are high populations of Aboriginal people
- Prison services need to be improved, particularly better integration when people move between prison and community
- Aboriginal specific services for women with children are needed
- Mainstream services must more consistently provide appropriate and accessible care for Aboriginal people
- There is a need for greater investment in the Aboriginal drug and alcohol workforce. A skilled, well resourced and supported Aboriginal drug and alcohol workforce that has both clinical and cultural expertise and experience is required.

1. Introduction

The Aboriginal Health and Medical Research Council of NSW welcomes the NSW Legislative Council Inquiry into drug and alcohol treatment, and the opportunity to provide a submission. This submission aims to identify and provide information and advice to the Inquiry about issues for Aboriginal communities around drug and alcohol prevention, treatment and management broadly. While it is acknowledged that the scope of the submission is broader than the terms of reference for the Inquiry, the additional information is provided because there are a broad range of needs, gaps and issues specific to Aboriginal communities that need to be addressed. After providing some relevant background information, we have focused our comments in Section 3 under the headings "Key Principles" (3.3), "Response to the Terms of Reference" (3.4) and "Additional Issues for Aboriginal Communities" (3.5).

2. Background

2.1 Aboriginal People in NSW

More Aboriginal people live in NSW than in any other Australian state or territory. In 2011, an estimated 172,621 Aboriginal people were living in NSW, representing 2.5% of the total population and 31.5% of the total Aboriginal and Torres Strait Islander population across Australia (Australian Bureau of Statistics, 2011).

2.2 Aboriginal Health and Medical Research Council of NSW

The Aboriginal Health and Medical Research Council of New South Wales is the peak representative body and voice of Aboriginal communities on health in NSW. The AH&MRC represents its members, Aboriginal Community Controlled Health Services (ACCHSs), which deliver culturally appropriate comprehensive primary health care to their communities.

Aboriginal Community Control has its origins in Aboriginal people's right to self-determination. This is the right to be involved in health service delivery and decision making according to protocols or procedures determined by Aboriginal communities based on the Aboriginal definition of health:

> *"Aboriginal health means not just the physical well-being of an individual but . . the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life."* (National Aboriginal Health Strategy, 1989)

The AH&MRC represents Aboriginal communities and the Aboriginal Community Controlled Health Sector on alcohol and other drug issues at a state policy level. The AH&MRC also delivers

- state wide health promotion programs around drug and alcohol prevention;
- accredited training for Aboriginal drug and alcohol workers and other Aboriginal health workers through the Aboriginal Health College;
- workforce support for alcohol and other drug counselors through the workforce support unit; and
- business support for our member services, including the Aboriginal residential rehabilitation services, via the business development unit.

The AH&MRC is governed by a Board of Directors, which consists of Aboriginal people elected by our members on a regional basis. For further information please visit: www.ahmrc.org.au

2.3 Aboriginal Community Controlled Health Services

ACCHSs are based on the philosophy of self-determination and the principle of community control. ACCHSs are services initiated by and based in the Aboriginal community and governed by an Aboriginal body that is elected by the local Aboriginal community. They deliver a holistic and culturally appropriate health service to the communities that control them. Aboriginal people often feel more comfortable seeking health care in an Aboriginal community focused environment, and may feel disenfranchised from mainstream services. ACCHSs have had a positive impact on health outcomes (Dwyer, 2010; Peiris at al, 2009; Webster et al, 2009), and provide care to large numbers of Aboriginal people with complex needs, including people with drug and alcohol issues (Larkins, Geia and Panaretto, 2006, p2).

In NSW, the AH&MRC has 39 member ACCHSs and an additional eight members who are Aboriginal Community Controlled Health Related Services, including several residential rehabilitation services that are described more below. Details of the locations of AH&MRC member ACCHSs can be found at www.ahmrc.org.au .

2.4 The Aboriginal Drug and Alcohol Network

The Aboriginal Drug and Alcohol Network of NSW (ADAN) was established in 2003 and is hosted by the AH&MRC. The ADAN was established as it was recognised that Aboriginal drug and alcohol workers often work in isolation in a challenging field. The ADAN 's focus is to provide a mechanism for Aboriginal drug and alcohol workers to network, share ideas and resources, and obtain cultural and professional support. ADAN members and Leadership Group members include workers from Aboriginal Community Controlled Health Services, NSW Local Health Districts and non-government organisations.

The Network is guided by the ADAN Leadership Group, a biannually elected group of workers who meet quarterly to represent the membership. The Leadership Group offers government, NGOs and researchers the opportunity to consult with specialist workers on policy development and state-wide projects for the Aboriginal drug and alcohol sector. In the last 12 months, the ADAN Leadership Group have had input into the "Pathways to Healing – NSW Aboriginal Drug and Alcohol Prevention and Treatment Plan 2012 – 2016" (Ministry of Health, Mental Health and Drug and Alcohol Office), the "NSW Aboriginal Supervision Guidelines" (Ministry of Health, Mental Health and Drug and Alcohol Office) , and a number of state-wide health promotion activities aimed at Aboriginal communities.

3. Aboriginal Drug and Alcohol Issues

3.1 Drug and Alcohol Use in Aboriginal Communities

In NSW in 2008, Aboriginal people were less likely to drink alcohol, with 33% of Aboriginal people abstaining compared with 15% of non-Aboriginal people (NSW Health, 2012, p vi). There is evidence, however, that when Aboriginal people drink alcohol they are more likely to do so at harmful levels and their risk of experiencing adverse effects is greater than for the non

Aboriginal population. Aboriginal people also experience greater difficulties accessing appropriate care and currently do not access mental health and substance abuse services at a level that is consistent with their level of need, and this is largely due to inconsistent or insufficient culturally respectful services (Berry and Crowe, 2009, p 1).

Alcohol continues to be the primary drug of concern for Aboriginal people, used solely or in combination with other drugs. Cannabis is the most commonly used illicit drug, followed by amphetamines, analgesics, and then ecstasy (Catto and Thomson, 2010, p 2). Aboriginal people who inject drugs are a small but significant sub population (Kratzmann et al, 2011, p xi). Use of an illicit drug is often associated with other health-risk factors. In terms of treatment (as opposed to use), alcohol accounted for half (51%) of the treatment episodes for Aboriginal people in NSW drug and alcohol drug services in 2010-2011, followed by cannabis (20%), heroin (9%) and amphetamines (8%) (AIHW, 2013, p 3).

As with the wider population the misuse of alcohol and other drugs among Aboriginal peoples can have a devastating impact on the individuals, families and communities involved, with an associated increase in the incidence of ill health, violence and crime. The underlying range of causal, cultural and socio economic factors means that addressing Aboriginal alcohol and other drug misuse is complex and has deep historical, social, cultural and economic roots (NIDAC, Locally designed and operated indigenous community models, p 1).

For these reasons, it is critical that delivery of alcohol and other drug treatment and other services to Aboriginal people in NSW are accessible, wholistic and culturally appropriate and that the resourcing of such services is reflective of need.

3.2 Drug and Alcohol Programs for Aboriginal people

The delivery of drug and alcohol programs and services to Aboriginal people in NSW is achieved through various programs. These include those services provided by the Aboriginal Community Controlled Health sector, Aboriginal specific programs delivered by other organisations, as well as mainstream drug and alcohol services, which need to be accessible and acceptable to Aboriginal people.

Most Aboriginal Community Controlled Health Services deliver alcohol and other drugs programs in a variety of ways. Some ACCHSs have dedicated drug and alcohol programs which include early intervention, prevention and treatment. Other services have dedicated alcohol and other drug counsellors who provide early intervention, referral and counselling. ACCHSs without specialised programs provide drug and alcohol services through their primary health care. There are also six Aboriginal residential rehabilitation services in NSW with a range of models for single men, or families. However, there are no services specifically for women with children

Funding sources supporting ACCHSs to deliver drug and alcohol programs and services include the NSW Ministry of Health (Center for Aboriginal Health and the Mental Health and Drug and Alcohol Office), and the Department of Health and Aging (primarily the Office of Aboriginal and Torres Strait Islander Health (OATSIH)). The Aboriginal Residential Rehabilitation Services have piecemeal funding arrangements, including from the Department of Health and Aging,

NSW Ministry of Health, Corrective Services NSW, NSW Department of Attorney General and Justice and the NSW Aboriginal Housing Office.

Mainstream services for Aboriginal communities include both Aboriginal specific and those with a general population approach and are provided by NSW Local Health Districts, general practitioners and medical specialists, and non-government organisations. It is likely that Aboriginal people access or could be accessing the vast majority of drug and alcohol services and programs, meaning they should all have strategies in place to ensure their care and services are accessible and appropriate to meet the needs of Aboriginal people.

3.3 Key Principles

The AH&MRC believes that effective drug and alcohol services for Aboriginal people are underpinned by the following key principles:

1. Aboriginal people should be involved at all stages in the development and implementation of strategies to address harmful drug and alcohol use in their communities. Local planning is required for locally designed and operated services that can be tailored to community needs and in a cultural context that is owned and supported by the community.

2. No one treatment is ideal for everyone: the different needs of individual clients necessitate program choices. Research has shown, for example, that some Aboriginal clients will prefer to be treated away from family influences while others find family separation has a negative effect (Taylor et al, p S37).

3. Alcohol and other drug programs for Aboriginal communities should encompass the range of services including: prevention and early intervention services (e.g. targeted health promotion); harm minimisation services; non-residential treatment services; residential treatment services; services that provide support, referral and ongoing care; and workforce development services. Individuals will respond to different treatment regimes at different stages of their drug using.

4. Mainstream programs and Aboriginal specific programs run by mainstream organisations need to be accessible and inclusive of Aboriginal people. “Australia’s colonial legacy means that even when accessed, many Indigenous clients remain deeply suspicious of mainstream services” (Brady, 1993, quoted in Taylor et al, 2010, p S37).

5. It is of critical importance that government and mainstream organisations work in partnership with Aboriginal communities through the Aboriginal Community Controlled Health Services and the Aboriginal Health and Medical Research Council of NSW. Meaningful (respectful, trusting and effective) partnerships are key to effecting positive change. (For further information on partnerships, see NSW Ministry of Health, NSW Aboriginal Health Plan 2013 – 2023, available on line: http://www.health.nsw.gov.au/publications/Publications/NSW-Aboriginal-Health-Plan-2013-2023.pdf)

6. Service delivery needs to be reflective of need. More services should be provided in rural and regional centres as well as in metropolitan areas where there are high populations of Aboriginal people.

7. The capacity of Aboriginal communities to deliver intervention initiatives should include an expanded program of workforce development: Drug and alcohol services for Aboriginal people require a skilled, well resourced and supported Aboriginal drug and alcohol workforce which has both clinical and cultural expertise and experience.

8. Research affecting the health and well being of Aboriginal people in NSW requires review by the Aboriginal Health and Medical Research Council Ethics Committee[1].

3.4 Response to the Terms of Reference

In this section we address the first six Terms of Reference (ToR) of the Inquiry.

1. **Naltrexone Treatment (ToR 1):** The AH&MRC believes that a range of treatment options is required to meet the needs of Aboriginal people who are seeking drug and alcohol services. New interventions or treatments should be proven safe and efficacious for Aboriginal people in accordance with the AH&MRC Ethical Guidelines and the National Health and Medical Research Council recommendations. The AH&MRC notes that the NHMRC has concluded that:

   > "*Naltrexone implants are an experimental product and as such should only be used in the context of a well conducted [randomised controlled trial] RCT with sufficient sample size, appropriate duration of treatment and follow up, regular robust monitoring, provision of a comprehensive psychosocial treatment program, and with comparison to current best practice.*" (NHMRC, 2010)

2. **Adequacy of funding (ToR 2):** There is currently inadequate funding for ACCHSs and other services to provide accessible treatment programs for Aboriginal people to meet need. This, and the short term nature of funding (from one to three years), often impacts negatively on being able to recruit and retain appropriately qualified and experienced staff. The level of funding for Aboriginal Community Controlled AOD programs as a percentage of total operational funding has decreased. "There is evidence that there has been a movement away from commitment by governments to resourcing Indigenous community-controlled services and hence a limiting of the capacity ... to address harmful AOD use" (Gray et al, 2010, p x). The Australian National Council on Drugs (ANCD) has stated recently that there are many reports of funding cuts to AOD services and that these changes were adversely affecting the AOD sector's ability to meet the demand of communities to assist and treat people seeking help with drug and alcohol problems. Aboriginal AOD related services and the communities they serve were particularly raised as having borne the brunt of significant funding reductions (ANCD, 2013).

   Certainly, anecdotally there is the view among the Aboriginal drug and alcohol sector that AOD funding is not a priority at the moment. "Drug and Alcohol is the neglected area compared with funding for mental health and tobacco and even the need for specifically targeted CALD (culturally and linguistically diverse) services is better

[1] The AH&MRC Ethics Committee operates as a Human Research Ethics Committee (HREC) under the National Health and Medical Research Council (NH&MRC) legislation. The role of the AH&MRC Ethics Committee is to assess research proposals affecting the health and wellbeing of Aboriginal people and communities in NSW, and to monitor the collection of data on Aboriginal health to ensure these activities will be conducted ethically.

recognised and supported than those for Aboriginal people." (ADAN Leadership Group Meeting 3rd May 2013). The move to flexible contestable funding from OATSIH for Aboriginal drug and alcohol programs has added to the uncertainty around funding.

3. **Effectiveness of mandatory treatment (ToR 3):** Mandatory treatment is one of a number of strategies that may reduce harm from alcohol and other drugs. Diversion programs that provide the opportunity for adult offenders with substance abuse or alcohol problems to work on a voluntary basis towards rehabilitation as an alternative to prison are supported. Aboriginal people are over represented in NSW prisons and research has suggested that the outcomes of incarceration are worse for Indigenous Australians than for non Indigenous Australians and the evaluations of diversion treatment programs for offenders with drug and alcohol problems are favourable (NIDAC, 2013, pp vii, ix and x). Diversion is associated with financial savings as well as with improvements in health and a lowering of mortality and recidivism rates (Ibid, p xi). More investment is required into the NSW network of Aboriginal specific community residential rehabilitation services, as well as non residential and mainstream programs, to ensure treatment programs are available for Aboriginal people who wish to undertake treatment over a custodial sentence.

4. **Adequacy of integrated services (ToR 4):** The lack of integration between health services within the health system is a major challenge for AOD treatment in general, and for Aboriginal people in particular. There are difficulties with Aboriginal people seeking AOD care who have mental health issues and vice versa (substance misuse frequently accompanies mental health problems, and often these two disorders influence each other and this is particularly so for Aboriginal people due to the history of trauma and colonisation). There is also a lack of coordination across the social and health services: "A person might be homeless, drinking, doing drugs and needing treatment, housing and so on, but we can't get them into housing. Years ago we could, but not anymore. It's all patch work." (ADAN Leadership Group Meeting 3rd May 2013).

5. **Drug and alcohol education programs (ToR 5):** Education programs within schools and mass media campaigns are appealing because of their low cost but have limited effectiveness (Gray et al, 2009, cited in Conigrave et al, 2012, p 223) unless appropriately targeted. Education is only one of the range of activities that needs to occur for effective prevention. Mainstream education programs often assume that people don't know about the dangers of AOD misuse, whereas in fact generally they do. Lack of knowledge may not be a driver in misuse among Aboriginal people. The drivers are more likely to be boredom, lack of employment, lack of opportunities overall, unbearable stress, lack of entertainment options and other socioeconomic factors.

   There is a need therefore for more Aboriginal specific education and prevention programs and strategies aimed at young Aboriginal people. The AH&MRC, for example, is currently implementing two state wide community based campaigns aimed at young Aboriginal people. "It's your choice, have a voice" aims to empower young Aboriginal people to make informed choices around sexual and reproductive health in the context of alcohol and other drug use. This campaign uses the medium of hip hop dance and song writing to develop self esteem and to engage the target audience. The second

campaign, “Staying Strong: Act Connect Survive” aims to build on young Aboriginal people’s resilience around drug and alcohol use. This campaign uses song writing and production to empower and develop messages that resonate with young Aboriginal people.

In addition to education programs, prevention of drug and alcohol misuse requires increased investment into brief interventions that are culturally appropriate, as well resourced early intervention programs.

6. **Models of service (ToR 6):** Given the diversity of Aboriginal people and communities in NSW, a range of services and models are required. For example, there are currently 6 Aboriginal residential rehabilitation services for Aboriginal people, and only one of these services is funded to cater for families. There are no Aboriginal specific residential rehabilitation services for women and children, although this has been identified as a need.

   The AH&MRC recommends effective consultation with local communities, and ensuring that there is appropriate evaluation and monitoring of any new models of service delivery in NSW. Aboriginal Community Controlled Health Services are able to provide services that reflect the needs of local communities. It is also recognised that there is a need for culturally appropriate mainstream services for Aboriginal people who do not (or are unable to) access ACCHSs for drug and alcohol programs.

3.5 Additional Issues for Aboriginal Communities

In this section we raise a number of issues that are beyond the scope of the terms of reference of the Inquiry but which we believe will provide significant additional information for the Members of the Parliamentary Committee.

1. **Supporting community initiatives:** Many Aboriginal communities have initiated activities aimed at improving the health and well-being of community members without the assistance of dedicated AOD funding. Examples include men’s and women’s groups as early intervention strategies; coordinating sporting activities such as ‘midnight basketball’ to engage young Aboriginal people and to provide an alternative to less socially acceptable entertainment; and introducing programs that focus on culture and resilience of Aboriginal people. Some communities have advocated for and been successful in reducing the availability of alcohol in their community (e.g. Brewarrina has introduced an alcohol accord). Conigrave et al support the contention that “while grass roots engagement with community members was found to be labour intensive, such an approach may have the potential to support Aboriginal individuals and communities to reconsider drinking or other health risk factors” (Tsey et al, 2010, cited in Conigrave et al, 2012, p 223).

2. **Regional services:** There is a shortage of AOD services (including methadone prescribers, residential rehabilitation and detoxification or “detox” (withdrawal) services) and long waiting lists in regional areas and the impact of this is that Aboriginal people have to travel long distances for rehabilitation and detox. ACCHSs based on the south coast of NSW report driving clients as far as Cessnock and Orange to get clients

into residential rehabilitation services. The Lyndon Withdrawal Unit (detox) in Orange, has also reported seeing an increase in the number of Aboriginal clients traveling via public transport from Coffs Harbour to Orange (almost a 10 hour train trip) to attend the detox unit. There is also a well documented lack of general practitioners, medical specialists and allied health workers in regional, rural and remote areas.

3. **Prison services:** There is the need for better drug and alcohol services in prisons (and as already stated, Aboriginal people are over represented in NSW prisons). Prisoners loose their PBS (Pharmaceutical Benefits Scheme) status in jail and if they are not on, for example, an opiate program when they enter prison it is difficult for them to access one while incarcerated. There are also difficulties for Aboriginal people leaving prison with a lack of drug and alcohol community support services for ex-prisoners. There is a need for better integration of care between prison and the community.

4. **Services for women with children:** There are very limited culturally appropriate AOD services for women with children. There is also concern that some Aboriginal women are not seeking treatment services because they are afraid that their children will be taken from them. This is of particular concern for Aboriginal women given Australia's history of the Stolen Generations.

5. **Mainstream services:** Mainstream services often don't have an appreciation of Aboriginal culture, history, communities and families, particularly if they do not engage the local community or employ Aboriginal staff. The perception of cultural barriers may cause Aboriginal people to travel substantial distances in order to access health services that are delivered in a more appropriate manner. Teasdale et al report that individual health service case studies suggest that employment of Aboriginal staff and the provision of holistic and integrated health care help to ensure effective treatment provision for Aboriginal people (Teasdale, 2007, p 153).

6. **Aboriginal workforce:** There is a need for greater investment in the Aboriginal drug and alcohol workforce. Aboriginal drug and alcohol workers play a critical role in the delivery of AOD services in their communities but are thin on the ground and are often responsible for vast areas in regional and rural NSW. There is also the issue of culture and gender. There are more male than female Aboriginal AOD workers in NSW and it is not always appropriate for women to be treated by men. In NSW, the non-government sector (including ACCHSs) employs more Aboriginal drug and alcohol workers than does the government sector and these NGO sector workers are the lowest paid workers in the drug and alcohol field (Ella, 2013). The research by Ella (2013) found that the role and duties of the NSW Aboriginal drug and alcohol worker have not been clearly defined and that workers in NSW are employed under a variety of position titles with different conditions of employment. The findings of Harrison and Porter show that many Aboriginal workers at ACCHSs are 'poached' by mainstream organisations once they become trained and experienced because ACCHSs are unable to compete with remuneration packages offered by other sectors (Harrison and Porter, 2013, p 13).

4. Concluding Comments

The AH&MRC is well placed, as the peak organisation in NSW for our members (the Aboriginal Community Controlled Health Services), to provide further advice about drug and alcohol services for Aboriginal people and we are happy to expand on any of the information provided in this submission.

Sandra Bailey
Chief Executive Officer
23 May 2013

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