Council for Aboriginal Alcohol Program Services
Aboriginal Corporation

CAAPS

CAAPS Submission to the Select Committee on a Northern Territory Harm Reduction Strategy for Addictive Behaviours.

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Introduction and Background

The Council for Aboriginal Alcohol Program Services (CAAPS) welcomes the opportunity to provide input to the Legislative Assembly of the Northern Territory Government Select Committee enquiring into harm reduction strategies for addictive behaviours.

CAAPS is an Aboriginal Community Controlled organisation providing people and their families with residential and non-residential substance treatment services including:

- 12 Week Alcohol and Other Drugs (AOD) Treatment Program
- 16 Week Volatile Substance Use (VSU) Program
- Homeless Outreach Support
- AOD Counselling and Information

CAAPS clients come from across the Northern Territory, and a majority of clients originate from remote Aboriginal Communities in the NT. Over the last 33 years CAAPS have worked to support Individuals and their families in a culturally safe and effective way. Our time in this sector has allowed CAAPS to develop a solid understanding of the factors impacting the delivery of substance use treatment services in our local environment.

Scope of Submission

Terms of reference of the Committee that CAAPS will be responding to are:

- The current trends of illicit drug-use in the Territory and specifically the impacts on drug and alcohol activities.
- A review of best practice evidence related to;
    - culturally relevant health and education interventions
    - support for affected families and communities

  to support the development of a revised harm reduction framework for the Northern Territory.
- Effective strategies for coordination across treatment facilities to also provide for addictive behaviours more broadly.

Introduction

According to the recent National Drug Strategy Household Survey, the Northern Territory reported the highest (standardised) rates of recent use of illicit substances for people aged 14 years and older (Australian Institute of Health and Welfare, 2017).

Following national trends, Indigenous people continue to be over represented in this population when looking at data relating to accessing drug and alcohol treatment.

Recent reports show that over two thirds (66%) of AOD clients in the NT identify as Indigenous, compared to 15% of AOD clients nationally (Australian Institute of Health and Welfare, 2018).

Assessment, Counselling and Rehabilitation (respectively) were the most commonly accessed forms of AOD treatment in the Northern Territory (Australian Institute of Health and Welfare, 2018), with most services located within *Outer Regional* areas and provided by non-government agencies.

While the peak ages for people accessing services for their own substance use was 30 to 39 years of age, most people accessing treatment in relation to another person's substance use were aged 10 to 19 years of age (Australian Institute of Health and Welfare, 2018).

Demand for AOD treatment services continues to increase in the NT with closed episodes increasing by 111% from 2007 to 2016 (Australian Institute of Health and Welfare, 2018). These figures are significant when considering that the NT recorded 1,666 clients per 100,000 population compared to 600 per 100,000 population recorded nationally (Australian Institute of Health and Welfare, 2018).

Early Intervention and Prevention

As demand for AOD treatment services increase, a trend which can be seen over the last 10 years (Australian Institute of Health and Welfare, 2018), measures should be considered to reduce the burden of demand on treatment services into the future.

Effective prevention strategies to reduce tobacco use in Australia including intensive media campaigns, tighter social controls (e.g. smoking in public places, advertising and sponsorship, price of tobacco products) and education have resulted in a change of societal attitudes on smoking (Lubman et al., 2007). The outcome of these changes in attitude have resulted in a decrease in the uptake of smoking, which is likely to reduce the overall burden related to tobacco use (health, economic burden etc.).

Meanwhile, alcohol continues to be to be the leading drug of concern both nationally and in the Territory (Australian Institute of Health and Welfare, 2018). It has been suggested that changing societal values around alcohol with the same approach that has proven effective with tobacco should be strongly considered (Lubman et al, 2007). At present various strategies and policies are working towards tightening restriction of alcohol in the Northern Territory (e.g. BDR, pricing), however to improve outcomes a multifaceted approach should be considered.

Prevention and early intervention currently receive less attention than treatment. Preventing uptake, delaying onset of use and reducing use (of substances including alcohol) is a major priority of the current National Drug Strategy (Department of Health, 2017).

Key to the success of such an initiative rests on early intervention activities being conducted in collaboration with AOD specialist services and the education sector. To facilitate such collaborations, investment from government is essential. It comes as no surprise given the current funding climate in the AOD sector that many non-government organisations are stretched to capacity with delivering core business. However, given an opportunity to increase capacity to collaborate with key stakeholders around development of effective early intervention activities, would make such initiatives more feasible for many AOD specialist organisations.

Culturally Relevant Interventions

Research has found that Indigenous populations accessing AOD services are better serviced by organisations that are culturally safe and who have Indigenous staff (Gray et al, 2014).

As the data demonstrates, a significant proportion of persons accessing AOD treatment in the NT identify as Indigenous, therefore the importance of ensuring that there are enough effective and culturally safe programs and services to meet the demands of this population is high.

At present, there are several Aboriginal Community Controlled AOD service providers in the NT, however this is disproportionate to the number of Indigenous clients within the population seeking treatment. And while some government and non-government agencies attempt to implement strategies to be more inclusive to Indigenous clients, there are degrees to how well this works as well as how much genuine intention around cultural safety some organisations strive to achieve. Gray et al. (2014), noted this in a review of the AOD treatment service sector, drawing attention to the lack of genuine consultation that occurs in the sector with Indigenous communities that are being serviced. As a result, many programs and services that have been implemented without genuine consultations and are the wrong fit for Aboriginal people and do not deliver on intended outcomes.

To enhance AOD services provided to Indigenous populations in the NT there should be more emphasis placed on increasing the capacity of existing Aboriginal Community Controlled AOD organisations who have already demonstrated success in working with these populations. This will improve the likelihood that intended outcomes will be achieved, reduce unnecessary costs (e.g. utilise existing capacity in existing organisations) and reduce funding wastage (when poorly executed programs/services do not become viable) .

In situations where such arrangements may not be possible, then genuine consultation should be required in the development and implementation of AOD services to Indigenous populations. Relevant Aboriginal bodies should oversee development and implementation of services/programs to Aboriginal populations by non-Aboriginal organisations (e.g. Office of Aboriginal Health Policy and Engagement) to ensure more accountability around cultural safety and evaluations around cultural safety should be built into service agreements.

There is also a growing call from Aboriginal communities to assist them in addressing their own AOD issues. We have seen the benefits of this when looking at how VSU management plans were developed and implemented under the VSAP Act.

Another example of an effective community driven incentive is WYDAC in Central Australia. This is an example of an outstation program designed and operated by the communities that they service, which continue to assist young people with residential AOD services.

Such an approach whereby communities are empowered to develop their own solutions to community AOD issues through support should be considered. Support may include facilitating community members/elders/groups in planning, implementation and evaluation of incentives by a relevant professional organisation (government or non-government).

Support for Affected Families and Communities

As can be seen from NT data, most people accessing AOD treatment services as a result of impacts related to another person's substance use fall between the ages of 10 to 19 years of age (Australian Institute of Health and Welfare, 2018). Despite this there are a limited number of AOD services providing support to entire families as well at young people under the age of 18 years.

In looking at the services that are provided to this group, counselling opportunities seem to be the more predominant option available to this population, however even these types of AOD support options are limited.

Residential rehabilitation placements for family members are very limited in the NT, although research reports that family inclusion in AOD treatment has many positive impacts on treatment outcomes including early intervention and prevention, addressing parenting capacity and improving child safety (Battams et al., 2010).

Therefore, improving access to AOD services for concerned others including residential placements for family members (including children and youth) should be one of the key priorities of any recommendations related to AOD harm reduction.

Effective strategies for coordination across treatment facilities

The needs of someone entering AOD treatment are often such that cannot be met by a single agency or service provider. The service spectrum ranges from withdrawal through to treatment (e.g. counselling, residential rehabilitation) and on to aftercare. Therefore, seamless coordination of services along the spectrum is essential in promoting successful outcomes for clients.

Some of the issues impacting seamless delivery of services can include:

- Burden of multiple assessments (both for clients and agencies): Clients are required to undergo comprehensive assessment when accessing each separate agency involved in their care. Some of the information collected from each agency will be specialised and related to the specific intervention they are providing, while some of the information remains the same during the period that the person is accessing these agencies simultaneously (such as drug use history, social, legal and family histories). This can result in clients feeling fatigued and distressed at a process whereby they need to repeat their stories and information at each assessment. Agencies could also improve time management if better systems for information sharing (with client consent) were available (e.g. such as what is available to health professionals with access to electronic health records).
- Prolonged wait times for processing of Criminal History Check Applications (CHC): most residential rehabilitation centres require applicants to have a recent Criminal History Check as part of this agencies risk management policies. Return times after lodgement of the CHC application can be anywhere between 2 to 8 weeks. This can result in clients not receiving the services that they need at times of crisis (which is often when people are most likely to seek support) and can see people disengage from treatment options altogether. Having faster access to this information would improve the ability for services to reduce admission wait time. This would require better coordination between rehabilitations services and the Northern Territory Police. At present the Top End Health Service, Alcohol and other Drug Services have a system with PFES which allows them access to criminal history information at reduced waiting times. Information systems can be improved particularly where they relate to the safety and wellbeing of children and could provide less obstacles for entry to non-government services.

Summary

In summary, CAAPS thank the committee for the opportunity to have presented feedback around the inquiry into harm reduction strategies for addictive behaviours and look forward the improvements that may result from this process.

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