Central Australian Aboriginal Congress Inc.
25 Gap Rd. PO Box 1604 Alice Springs NT 0871 PHONE (08) 8951-4400 FAX (08) 8953-0350

Submission to the

Legislative Assembly of the Northern Territory

Select Committee on Substance Abuse in the Community.

July 2002
Central Australian Aboriginal Congress Inc.

Introduction and background to Congress's history of involvement in dealing with substance misuse in our community. 3
Current trends in the use and abuse of licit and illicit substances in the NT. 4
Social & Economic consequences of current patterns of substance abuse, with special reference to the well being of individuals and communities and to the demands placed upon government and NGO services; 5
The services currently available in the NT by both the government and non-government agencies to deal with issues directly and indirectly related to substance abuse; 7
Factors that affect the level & nature of substance abuse in the Northern territory community or parts of that community, including without limiting the generality of the foregoing: 8
Accessibility/availability of licit and illicit substances within communities; 8
Correlation between socio economic conditions and substance abuse. 8
Appropriate policies and services for the prevention and treatment of substance abuse in the Northern Territory. 9
Attachments 10
References 11
Attachment 1 Submission to NT Ministerial Task Force on Illicit Drugs 12
Attachment 2 List of Congress papers on Issues related to this Inquiry 18
Attachment 3 Position paper: Substance Misuse in Central Australia 21
Attachment 4 Advertisement for Advocate edition of Tuesday 4.4.2000 31
Attachment 5 Appendix 7 of CARIHPC Central Australian Regional Substance Misuse Strategic Plan 34
Attachment 6 Letter Congress to Crundall re: development of Substance Misuse Action Plan 45

Introduction and background to Congress's history of involvement in dealing with substance misuse in our community.

The Central Australian Aboriginal Congress presents this submission to the Select Committee on Substance Abuse in the Community of the Legislative Assembly of the Northern Territory. This submission will concentrate on the licit drugs, alcohol and petrol sniffing and the illicit drug, cannabis, in line with the Committee's media release of the 3rd April, "Its initial focus is on alcohol abuse, petrol sniffing and the use of cannabis".

Our earlier submission to the NT Department of Health & Community Services Ministerial Task Force on Illicit Drugs is attached for your information (attachment 1).

Congress, as an organisation is involved in the development and delivery of Comprehensive Primary Health Care with the Aboriginal community of Central Australia has been dealing with the outcomes of the excessive use of alcohol, other drugs and substances for close to thirty years (see attachment 2).

Congress has a well established and clearly articulated position regarding Substance Misuse in our community, the harmful effects upon our community and the measures that must be adopted as part of a comprehensive programme designed to address Substance Misuse in Central Australia. We would wish to draw the Committee's attention to the following documents that state our position on the issue of Alcohol in the region (Central Australian Advocate advertisement 4.4.2000 and the Congress Position Paper Substance Misuse 1997 attachments 3 & 4).

In the late 1970's Congress commenced the alcohol rehabilitation programme at what was known as the Congress Farm, in Ragonesi Rd Alice Springs. This site is now the premise of the Central Australian Aboriginal Alcohol Programmes Unit, an organisation that Congress has helped support since its inception.

In 1990 Congress took direct action on the Alcohol issue by buying the license at 23 Gap Rd and publicly destroying the alcohol and attempting to get the government to acquire the license. When this wasn't taken up, Congress let the license lapse, an expensive and overt message to the community regarding our opposition to the number of licenses existing in the town.

Congress has been an active participant in community forums (Alcohol Issues Forum which then became the Alice Alcohol Representative Committee 1997-2000) and community groups (the People's Alcohol Action Coalitions 1995-1998 & 2000-) and the community forums held at The Red Centre Resort (1989) and Witcherty's Araluen Centre (2000).

As a core partner in the NT Framework Agreement on Indigenous Health, a partnership between ATSIC, Territory Health Services (now Department of Health & Community Services) and the Commonwealth Office of Aboriginal & Torres Strait Islander Health and our federation the Aboriginal Medical Services Alliance of the NT (AMSANT), we have endorsed the Central Australian Regional Indigenous Health Planning Committee [CARIHPC] Substance Misuse Strategic Plan that

supports a comprehensive range of measures designed to address the issues under consideration by the Select Committee. Our staff has also represented AMSANT on the Alice in 10 Quality of Life Substance Misuse Sub-Committee and the CARIHPC Substance Misuse Action Group.

Current trends in the use and abuse of licit and illicit substances in the NT.

Congress has long asserted that the problems of substance misuse amongst Aboriginal people in central Australia can be ranked in priority as:

Alcohol,
Petrol sniffing/inhalants/volatile solvents
Tobacco
Illicit drugs (including cannabis).

While alcohol is generally considered to be the overwhelming problem regionally, at a local community or family level petrol sniffing may at times be a more significant problem. By comparison the health implications of tobacco usage are less significant. Cannabis is currently implicated in around 10-15% of drug related cases presented at Congress. Although there is anecdotal evidences that its usage may be increasing in Central Australia.

On current trends, sniffing is primarily an activity undertaken by young people. The adult population is more likely to be involved in poly-substance misuse involving alcohol, tobacco and cannabis.

During the extensive consultations undertaken by the CARIHPC Substance Misuse Project Officer in the preparation of the CARIHPC Central Australian Regional Substance Misuse Strategic Plan the extent of various substance misuse was well documented. This appendix to the Strategic Plan is attached to this submission with additional notes (in bold) updating information based on current known information (attachment 5).

Social & Economic consequences of current patterns of substance abuse, with special reference to the well being of individuals and communities and to the demands placed upon government and NGO services;

The negative consequences of substance misuse upon the individual and community are extensive in both their destructiveness and reach. It can be dramatically illustrated by potential life years lost due to alcohol related causes of death.

Top five causes of years of potential life lost before age 65 among Aboriginal men and women aged 15 to 64 years in the Northern Territory, 1979-1991. (From Condon and Cunningham.1996 ***Relationship to alcohol and tobacco added*)**

Men	Total years of potential life lost<65	Percentage of total	Relation-ship to alcohol	Relation-ship to tobacco
1. Motor vehicle accidents	5 994	17%	Strong	-
2. Ischaemic heart disease	3 415	10%	?Moderate	?Strong
3. Homicide	2 594	8%	Strong	-
4. Pneumonia / Influenza	2 054	6%	Strong	Weak
5. Rheumatic Heart disease	1234	4%	?Weak	-

Women				
1. Homicide	2 140	11%	Strong	-
2. Rheumatic Heart disease	1 556	8%	?Moderate	-
3. Motor vehicle accidents	1 428	7%	Strong	-
4. Ischaemic heart disease	1 006	5%	?Moderate	?Strong
5. Chronic obstructive pulmonary disease (exc. asthma)	943	5%	?nil	Strong

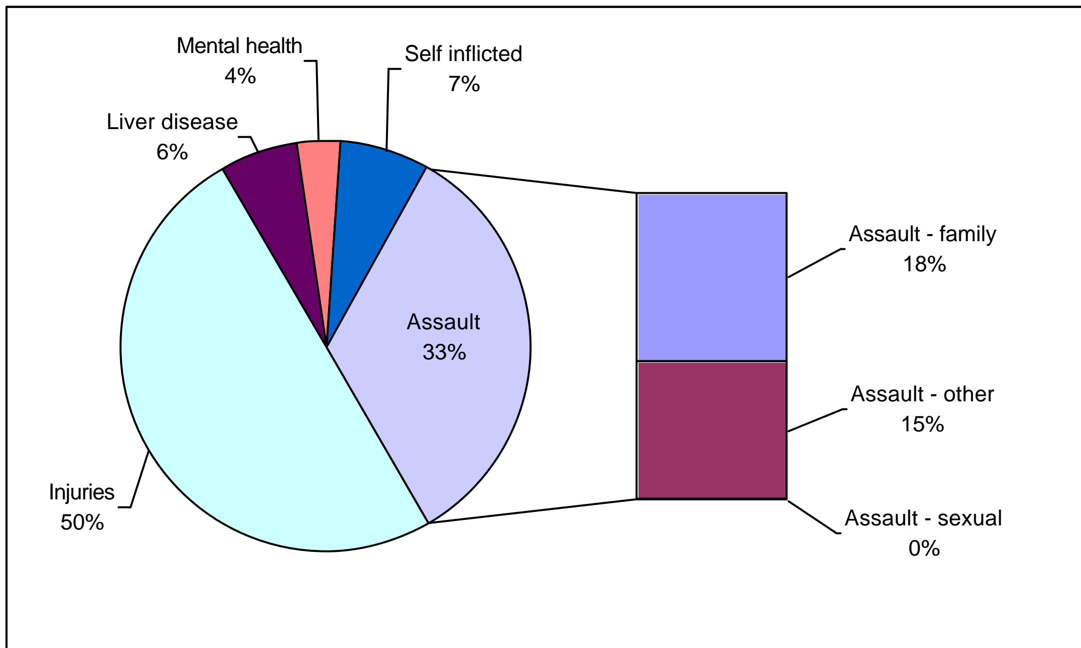
This analysis of premature death rates supports the experience of Aboriginal people: that too many of our people are dying too young from alcohol related causes. Unfortunately, this type of analysis has not been repeated and so we are not able to use premature deaths rates to assess progress over time. In addition to this there is still no clear way of recording deaths due to petrol sniffing.

At a population level per capita alcohol consumption in Alice Springs has been estimated to be 70% greater than the national average at 16.44 litres of pure alcohol per person [Gray & Chikritzhs 2000]. Per capita alcohol consumption is directly correlated with alcohol related harm in the community.

For individuals this may be represented by showing the number of presentations for alcohol related conditions at a clinical level.

Selected presentations to Central Australian Congress clinic, 1/1/1999 - 31/12/2001

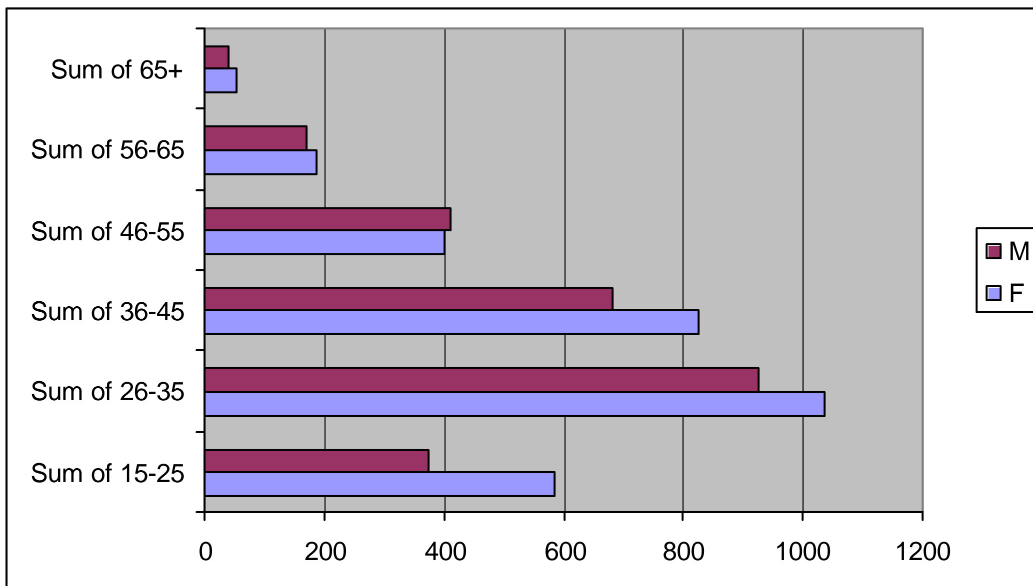
Summary characteristics by presentation category	count	% of total	% male	modal age group (%)
Assault - family	1043	18.3	19.9	26-35 (40.3%)
Assault - other	842	14.8	43.1	26-35 (41.3%)
Assault - sexual	4	0.1		
Injuries	2850	50.1	52.4	26-35 (32.4%)
Liver disease	335	5.9	46.3	36-45 (40.0%)
Mental health	221	3.9	73.8	36-45 (34.4%)
Self inflicted	395	6.9	56.7	26-35 (35.2%)
All	5690	100.0	45.8	26-35 (34.5%)



Selected presentations to Central Australian Congress clinic, 1/1/1999 - 31/12/2001

FOR ALL CONDITIONS

Age group	Gender		Total	
Data	F	M		% age
Sum of 15-25	586	375	961	16.9
Sum of 26-35	1035	927	1962	34.5
Sum of 36-45	824	682	1506	26.5
Sum of 46-55	400	410	810	14.2
Sum of 56-65	186	171	357	6.3
Sum of 65+	53	41	94	1.7
Total	3084	2606	5690	100.0
	% male	45.8		



Both these presentations illustrate the extent of the alcohol problem particularly for young adults. Given the relatively early age at which Aboriginal mothers in the NT have children [d'Espaignet et al 1998], young adults in the 26-35 years age group who are predominating in the alcohol related presentations at clinics like Congress are likely to have children on the threshold of teenage-hood. That these young people are being brought up in a family environment of excessive alcohol usage and its related harms, Congress believes, creates a cross-generational inter-relationship between adult alcohol misuse and child and teenage petrol sniffing.

> *Petrol sniffing in children and adolescents is associated with community and family crisis which is often closely linked to the misuse of alcohol. Parents who are binge-drinking are unable to properly bring up their children and are less able to deal with a problem like petrol sniffing should it arise in their family. Families that are caught up in the culture of binge-drinking, violence, sorry-business, and poverty tend to produce children whose fundamental social, psychological and cultural needs are not being met. It should surprise no one that many children in this position try to escape from this reality using whatever means are at hand: too young to drink and with nothing to do, petrol is the obvious way out, even for a few hours.*
>
> *Therefore, while it is clear that specific programs for young petrol-sniffers are essential, the problem is wider. Alcohol misuse forms a fundamental problem for the Aboriginal community, and until properly resourced, appropriate and effective programs are in place to deal with this, no substantial improvement in other areas of substance misuse can be expected. A key part of our strategy is to get the parents off the grog so they can exercise their responsibilities towards their children as well as providing services to the children themselves.[CAAC 1997]*

The services currently available in the NT by both the government and non-government agencies to deal with issues directly and indirectly related to substance abuse;

Congress provides an extensive range of services to Aboriginal people that either directly relate to substance misuse or provide supports for other people affected by those misusing substances, ie family members or individuals not able to receive the supports of their family due to their incapacitation.

Direct services include: Brief clinical interventions and clinical treatment. Counselling services (Social & Emotional Health Branch). Well men's checks (through the Male Health Programme) and well women's checks (Congress Alukura).

Support services: Women's ante-natal and post-natal programmes (Congress Alukura), Young Women's Community Health Education Programme (Congress Alukura), Youth Outreach Programme (SEHB), Under 2's programme of support for young mothers, Specialist Clinics (both Services Branch) Male Health Programme support for male roles in parenting and counselling referral

A summary of known additional services within the Central Australian region is attached from the CARIHPC Substance Misuse Plan with additional updated comments as supplied by the then Project Officer shown in bold (attachment 5)

Factors that affect the level & nature of substance abuse in the Northern Territory community or parts of that community, including without limiting the generality of the foregoing:

Accessibility/availability of licit and illicit substances within communities;

Alice Springs has a high ratio of alcohol outlets per head of population. While the total number of outlets is of concern the greater concern is probably their location That these outlets are concentrated around the central business district, some town camps and the Todd River environs allows determined drinkers the opportunity to shop around until they get served [Brady & Martin 1998].

There is overwhelming evidence both internationally and locally that supply reduction must be a major strategy to address alcohol misuse and related harms [d'Abbs, Gray et al 1999, Edwards, Anderson et al 1995, RCIADIC 1991]. The most significant supply factors outlined in these studies that impact on consumption and therefore harm appear to be the price of alcohol, the total number of take away trading hours and the type of alcoholic beverage ie cheap bulk grog, such as cask wine, is the most harmful. In towns that are already super saturated with alcohol outlets the number of outlets is probably less significant.

In the Alice Springs context an awareness of this research has led to the successfully lobbying by the community for restrictions on cheap bulk forms of alcohol, which effect the price per gram, and restricted hours of take-away trading. Although these limitations were not as extensive as some community based groups wanted (including Congress), preliminary evaluations of the trial show some positive effects may already be being drawn from the implementation of its provisions [Moon 2002].

The ready accessibility of petrol both through legitimate purchases from service stations and opportunistic theft from vehicles means that a different approach is required in controlling availability of this substance than those that can be put in place for alcohol. In some instances substitution is an option, such as the use of avgas/comgas.

Placing restrictions on accessibility and availability by itself will not address the problem however they are a necessary pre-requisite for other measures to be able to be effectively implemented. These measures as identified in the CARIHPC Central Australian Substance Misuse Action Plan need to occur in tandem with other measures that address the underlying causes of the behaviour in the social and physical environment of the users.

Correlation between socio economic conditions and substance abuse.

Congress supports the view that there is a strong correlation between the prevailing socio-economic conditions and the degree of substance misuse engaged in by individuals [CARIHPC 2001, DH&AC 1999, d'Abbs & MacLean 2000]. For Aboriginal people these causes have their genesis in the history of the colonisation of their country and the ongoing inequalities that this invasion produced. In the contemporary context individuals struggle in a setting of inter-generational poverty,

poor health, high unemployment and marginalisation from the job market, welfare dependency, family violence, trauma, low levels of education attainment, homelessness and overcrowding and a lack of access to a range of services and infrastructure both recreational and essential that the rest of society in the main takes for granted. That these conditions lead to despair and the spiral into substance misuse is widely recognised [DH&AC 1999, d'Abbs & MacLean 2000].

Appropriate policies and services for the prevention and treatment of substance abuse in the Northern Territory.

In the Congress Position Paper on Substance Misuse (attachment 3) and the Congress advertisement placed in the Centralian Advocate 4/4/2000 (attachment 4) we have consistently advocated a range of policies and services requirements to adequately address substance misuse in our community. Our tenacious pursuit of these issues has helped realise many of these priorities into practice, or their adoption by other agencies as their supported aims in the region.

However some key issues remain outstanding and others whilst adopted in name have not been satisfactorily adopted in spirit or application. Most notably in the former category are the unfinished business of the Stolen Generations and the adoption of the recommendations of the *Bringing Them Home* Report. Similarly the Commonwealth government's amendments to the Native Title Legislation have further weakened Aboriginal people's legal position in regard to land tenure and sovereignty. Economic development remains mired in a maze of racially based exclusion, welfarist policy proscriptions and under-funded limited projects.

At a policy level many of the initiatives in planning and service delivery in the health area have been adopted into government policy. However we are becoming increasingly disappointed in the inability of the Health department bureaucracy to adopt these initiatives of joint planning into their departmental practice. As part of the NT Aboriginal Health Framework Agreement, the Central Australian Regional Indigenous Health planning Committee was established in 1998. This Committee in turn established the Substance Misuse Working Group, engaged a project officer and produced the Central Australian Substance Misuse Strategic Plan (see below). Unfortunately since that time and the plans adoption little progress has been made due to the under-resourcing and subsequent poor support given to the Action Group charged with drafting the Strategic plan into an Action Plan (see attachment 6).

In addition the Department has shown a seeming inability to grasp the implication of signing off on the strategic policy framework for its own organisational business plan. This is best illustrated in considering that there has been no restructuring or re-prioritising of the Central Australian Alcohol and Other Drugs Service (CAAODS) in light of the Department's endorsement of the CARIHPC Strategic Plan for Substance Misuse. Recently this led the Department to go outside of its existing resource base to seek additional funding to meet some of its obligations under the Strategic Plan. These issues have led us to query what are the mechanisms by which Government, as distinct from the identified strategies within the plan, itself are to be evaluated, particularly around those factors that relate to meeting its core partner commitments. Such a lack of commitment on behalf of government has further led Congress and our peak body AMSANT to question the value of theses collaborative processes themselves. In this light we have welcomed the Ministerial review of the Department

of Health and Community services and will be placing our concerns before that review as well as with you the Select Committee.

Congress strongly endorses the Strategies as outlined in the CARIHPC Substance Misuse Action Plan to the Select Committee. And would draw your attention to the overview (pp9-14) which places the objectives and tasks within their strategic framework.

Congress has supported the liquor restrictions currently being trialled in Alice Springs, although we had some reservations that the restrictions are not as far reaching as they needed to be. This has been born out in the apparent substitution of fortified wines for the previously available 4lt cask wines. That this was predicted by Congress and others, with a proposed measure to avoid its occurrence, the holding of outlets to pre-trial levels of wholesale purchases on these items, and that this measure was not taken up by the Licensing Commission and was actively opposed by the alcohol retailers, gives us small comfort. We believe this measure would still be a valuable addition to the trial.

Congress supports consideration by legislators to facilitate the development of legal liability on individuals selling alcohol for the damage caused by or to their patrons- what is called alcohol related liability or provider liability [Solomon & Payne 1996]. This process recognises that legal responsibility for these actions goes beyond the intoxicated individual to include a shared legal responsibility for the purveyor of the alcohol where it is able to be established that they were aware that the person they were serving was already intoxicated or that as licensees they were involved in irresponsible hospitality practices.

Attachments

1. Task Force On Illicit Drugs submission
2. List of Congress papers on issue
3. 1997 Substance Misuse Position paper
4. 2000 Advocate Advert
5. Appendix 7 Service-generated Overview of Services Operating to prevent and/or Address Inhalant Abuse in central Australia.
6. Letter Ian Crundall: re SMAG Action Plan

References

Brady, M. & Martin, D. 1998 *Dealing with alcohol in Alice Springs: An assessment of policy options and recommendations for action*. Report to the Northern territory Liquor Commission form the Alcohol Reference Group and ATSIC Regional Office Alice Springs.

CAAC 1997 *Position Paper: Substance Misuse in Central Australia*. Alice Springs.

CARIHPC 2001 *Central Australian Regional Substance Misuse Strategic Plan* Alice Springs.

Cunningham, J. & Condon, J. 1996 *Premature mortality in Aboriginal adults in the Northern Territory, 1997-1991* The Medical journal of Australia 165 (6): 309-312.

Gray, D, Chikritzhs T. 2000 Regional variation in alcohol consumption in the Northern Territory. *Australian and New Zealand Journal of Public Health; 24(1): 35-38*

d'Abbs, P. Gray, D. et al 1999 *Alcohol Related problems in Katherine* Menzies School of Health research (unpublished) Darwin.

d'Abbs,P & MacLean, S. 2000 *Petrol Sniffing in Aboriginal Communities: A Review of Interventions* CRC-ATH Darwin.

d'Espaignet, ET. Kennedy, K. Paterson, BA. & Measey, ML. 1998 *From Infancy to Young Adulthood: Health status in the Northern Territory 1998* Territory Health Services, Darwin.

DH&AC 1999 *Review of the Commonwealth's Aboriginal & Torres Strait Islander Substance Misuse Program* Final Report Department of Health & Aged Care Canberra.

Edwards, G. Anderson, P et al. 1995 *Alcohol Policy and the Public Good*. WHO Europe & Oxford University Press Oxford

Moon, C. 2002 *Alice Springs liquor sales restrictions 1/4/02-31/3/02 Monitoring Report 1*. Report to the Licensing Commission (draft)

RCIADIC 1991 Vol 4 AGPS Canberra

Solomon, R. & Payne, J. 1996 *Alcohol Liability in Canada and Australia: Sell, Serve and be Sued* National centre for Research into the Prevention of Drug Abuse Curtin University of Technology Perth.

Attachment 1 Submission to NT Ministerial Task Force on Illicit Drugs

22 April 2002

Central Australian Aboriginal Congress

Submission: Taskforce on Illicit Drugs

Congress accepts the following definition:
DRUG: a substance that produces a psychoactive effect. Includes alcohol, nicotine, caffeine, medicinal substances, illicit drugs (eg heroin, ecstasy and cannabis) and substances such as petrol, some fluorocarbons (as found in products such as aerosol paint) and anabolic steroids.

1. Introduction

The following submission to the Taskforce on Illicit Drugs is from the Central Australian Aboriginal Congress, the major provider of Aboriginal primary health care in Central Australia. Congress has been in operation since 1973 and has a multidisciplinary team, which includes Doctors, Aboriginal Health Workers, Counsellors and other health care professionals.

Congress community health programs include FAAD (Frail Aged & Disabled), Bush Mobile, Male Health, Child Health, Specialist Clinic, Hearing Clinic, Dental, Transport and Pharmacy. Congress also includes Ampe Kenhe Apmere Child Care, Social & Emotional Well-Being, Alukura Women's Health and Birthing Centre, Aboriginal Health Worker Education and Policy and Research Development.

Congress provides services to Aboriginal people in Alice Springs and surrounding outstations with a medical clinic and programs, which saw 31,390 clients from 1 January to 31 December 2001. Consultations are often with, patients who have multiple chronic conditions particularly renal, diabetes, ischaemic heart disease, hypertension, hypercholesterolemia and cardiac failure.

Congress provides this submission recognising the impact and potential impact of drug misuse on the health outcomes of the Aboriginal population we serve. Our work is directly affected by drug misuse, predominately alcohol, tobacco and petrol sniffing. It has been anecdotally noted that amongst Congress clients there is little evidence of heroin use, there is cannabis use and some speed (amphetamines). In 1999 the Needle Syringe Program in Alice Springs noted that approximately 10% of clients were of Aboriginal background. The majority of drug misuse cases identified at Congress have involved alcohol and petrol, and only approximately 10 to 15% involved cannabis use.

We believe that the Aboriginal community taking responsibility for the issue and doing something about it is the most important way to effectively address the problem of Aboriginal drug misuse in the long term. Aboriginal community controlled organisations are the product of the Aboriginal community taking responsibility for tackling the health, welfare and justice problems that our people face. Drug misuse issues will most effectively be addressed through Governments supporting Aboriginal people to set up programs within the Aboriginal community.

Congress, through AMSANT, has contributed to the development of the *Central Australian Indigenous Substance Misuse Strategic Plan*. This Plan takes a wide view of the measures needed to address and prevent substance misuse in Aboriginal communities in Central Australia. It emphasises the need to insulate young people against substance misuse to the greatest extent possible by the provision of excellent health services, including home visits to young mothers, early childhood programs and good quality education. It also proposes as a key recommendation the creation of a community-controlled professional youth program throughout Central Australia. At present there are no trained youth workers working in Aboriginal communities, and virtually no case management of children and young people in remote areas. This program would undertake advocacy of youth needs, help communities to develop youth programs and projects, and take part in the case management of youth with special problems.

2. Trends in Illicit Drug Use

Reference: Trends in Illicit Drug Use in the Territory (Discussion Paper Pg 6)
Reference: About Illicit Drug Use (Discussion Paper Pg 5)

Congress recognises the importance of Central Australia being a part of the national agenda to address illicit drugs and the harms associated with illicit drug use. However making a hard distinction between illicit and legal drug use is problematic when experience shows that individuals with underlying problems will often engage in polydrug use (utilise a range of drugs). Alcohol is by far the most common drug causing harm and being used by Congress patients. However, Congress does not under estimate the impact of the use that the other drugs such as tobacco and cannabis are having, and can have on the population. Nor do we wish to ignore amphetamine and morphine use. Congress supports the adoption of an overall drug use strategy which seeks to address underlying causes of harmful drug use, reduce and regulate supply, provide effective treatment and rehabilitation services and accurately and effectively educate the population about drug use.

Illicit drug use has been an emotive national issue that is often based on myth and anecdotal information. The Northern Territory is in a unique position to be able to assess the lessons from other Australian States in regard to illicit drug use. It is particularly important that assumptions about illicit drug use within Central Australia are kept to a minimum and that valid research methods are employed to adequately gain a picture of the current activity and of the specific associated harms. Congress supports a strategic approach to identifying the particulars of the illicit drug use issue within Central Australia, which will then help us all to set achievable and measurable outcomes.

Congress supports the undertaking of appropriate and effective research into illicit drug use, provided the research is sensitive to cultural issues. The research should have a focus on the pattern of use, types of drugs being used and the associated health harms experienced within the Aboriginal community. Congress believes it would be useful to carry out research similar to the heroin use study undertaken by Curtin University (*The Harm Reduction Needs of Aboriginal People Who Inject Drugs* September 2001). The Curtin research provides an estimated level of the use, patterns of harmful illicit drug use and services and strategies to address the issues. The mechanisms to assist these studies exist through needle syringe programs and the

Illicit Drug Reporting System. There are also individuals in Central Australia with relevant expertise in the area of illicit drug use.

Before any changes are made to the laws regarding cannabis, it is essential that the impact on the northern Pitjantjatjara communities of the SA cannabis legislation changes be assessed. Information from the NPY Women's Council, Nganampa Health Council and the Marla police indicates that poly-drug use involving high strength cannabis, petrol sniffing and binge drinking of alcohol is increasing and having a detrimental impact on may young people in the region. Drug dealing under the protection of key community leaders is endemic in a number of these impoverished communities.

Illicit drug use must be considered holistically because it is usually symptomatic of other issues i.e. family breakdown, unemployment, poor socialisation, trauma, housing, and education. The circumstances of the drug use must also be considered; some people may be utilising substances as self-medication, to manage pain.

3. Illicit Drug Use Target Groups

Reference: About The Taskforce on Illicit Drugs (Discussion Paper Pg 3)
Reference: Illicit Drug Use among Young People (Discussion Paper Pg 7)

Congress acknowledges the importance of the focus on young people chosen by the Taskforce stated as:

- Young people. The Australian Institute of Health and Welfare define young people as those aged 12 –24 years.
- Drugs using parents of children up to 12 years of age.

Congress recognises the importance of a focus on young people:

- To try to prevent the uptake of illicit drug use; and
- To help guide young people who do experiment through the experimentation to prevent entrenched, problematic substance use.

However further investigation is required to find out the demographics of the group/s experiencing drug harm in Central Australia. In Victoria for example, the predominant age group found to be at risk of death from overdose was in the older 25 to 35 age group. The Taskforce indicates that there is a trend towards a growing younger using group. It should be investigated as to whether this is in fact the case in Central Australia and what are the associated health harms. There is also a need for further investigation into cannabis use in Central Australia, to consider the impact drugs can have when taken at a critical time in a young persons life. (Concern has been raised that cannabis mixed with low self-esteem can increase isolation and low motivation amongst young people and 'trap' an individual in a cycle of dependence).

The demographic groups experiencing harm associated with illicit drug use should be determined through investigating:

- Overdose statistics
- Ambulance and hospital data
- Coroners reports
- Police incident data
- Drug and alcohol services data etc.
- Primary health care service utilisation data.

There is a need to identify the group/s experiencing harm and the drugs being used so we can tailor service requirements appropriately. It was found in Victoria that traditional forms of drug and alcohol withdrawal and treatment services did not adequately meet the needs of the young age group and so a special Youth Substance Abuse Service was formed. Drug and alcohol services' models of withdrawal and treatment should be appropriate to the needs of gender and family groups and cater to the specific requirements of these groups.

4. Health Professionals and Carers

Reference The Role of Families (Discussion Paper Pg 7)
The Role of Other Professionals (Discussion Paper Pg 8)

The support of families (including parents, siblings, grandparents etc) is critical for the effective recovery of people addicted to drugs. Family members have an important role in supporting each other and the member who is addicted. The health professional has a role in promoting self-reliance of the family and supporting the family throughout the process towards recovery.

The people of Central Australia have only limited access to the range of interventions that are available to people in other parts of Australia. This includes an absence of medium to long-term withdrawal options. As a remote location Central Australia struggles to retain suitably qualified personnel. This highlights the importance of multi-skilling, training and retraining of all appropriate health and community professionals who deal with people who are addicted to opioid and other drugs. The alcohol and other drug service system in Central Australia need to be able to address polydrug use.

The role of the levels of Government in regard to illicit drug use also needs to be clearly defined to adequately address the issue. This includes clear policy direction and strategic outcomes that seek to address supply and demand. It also requires adequate and appropriate resourcing for services to achieve their aims.

5. Prevention

Reference: Preventing drug-related Harm (Discussion Paper Pg 9)
Reference: Early Intervention (Discussion Paper Pg 11)

Effective education is important and must also be applied strategically across Central Australia. The messages must be carefully targeted and developed by individuals with expertise in illicit drug use. Teaching about the nature of drugs and their effects should coincide with teaching about the nature of addiction. This should be taught within the school curriculum in a health context aiming to demystify illicit drug use and reduce the attached sensationism. The aim should be the skilling of young people to recognise their own limitations, the effects of drugs on their own bodies and the effect of their actions on others. Education campaigns should be relevant for the specific target group.

A key problem in trying to educate the community, especially young people, about drug use is the mixed messages that are sent out by the current legal status of some drugs. The most harmful drugs such as alcohol, tobacco and petrol, are legal while other drugs, such as heroin, cannabis and amphetamines, are illegal. There is a range of possible policy options concerning the legal status of drugs between free

availability and complete prohibition. Congress believes that the goal should be to regulate all mood-altering drugs and find the right balance between these two extremes. At a certain point on the regulatory scale the harm associated with drug use will be minimised. Different drugs may require different policies.

Congress believes that the legal status of a drug should be determined by how harm can best be minimised and not according to historical precedent or international pressure. Having stated this we also believe that drug policies should not encourage or appear to tolerate illicit drug use in any way.

6. Treatment and Service Options

Reference: Approaches to Recovery (Discussion Paper Pg 12)
Reference: Treatment as a Strategy (Discussion Paper Pg 11)
Reference: Pharmacotherapies (Discussion Paper Pg 12)

Congress recognises that there is no 'magic bullet' for recovery from addiction to opioids and recognises that individuals need an overall management plan that may include support, counselling and pharmacotherapies. Individuals from Central Australia are usually forced to undertake treatment and care away from family and support networks because of limited local service options and the absence of maintenance programs. This is also problematic when it has been shown that an individual can take a long time to recover from opioid addiction, which means they have long-term, intensive treatment and support needs. 'One size does not fit all' in terms of withdrawal and treatment needs. Individuals in Central Australia should have available to them the same treatment and care options as their counterparts in other parts of Australia.

Congress recognises that maintenance programs have a role in helping prevent withdrawal, as they reduce drug cravings and can block the euphoric effects of heroin and other opioids. Methadone maintenance is not a cure for heroin addiction. A maintenance program can take the pressure off maintaining an illegal habit. Further investigation at a national level needs to continue into heroin maintenance and decriminalisation.

Methadone maintenance treatment is one of a range of interventions to manage heroin dependence; other approaches include detoxification, therapeutic communities, self-help groups, day treatment and counselling. Congress is interested in providing the range of pharmaceutical options to our Aboriginal client group who are addicted to opioids including methadone, buprenorphine and naltrexone, in line with other general practices in other Australian states. Congress recognises that current alcohol and other drug services in Alice Springs could have the ability to deliver a range of treatments within the framework of a coordinated service system. Congress believes that current services i.e. CAAPU could have the capacity to expand to become a rehabilitation and treatment centre for clients who are addicted to different drugs.

Congress recognises the importance of involvement of both GPs and retail pharmacists in maintenance treatment to provide better access and equity and increased anonymity. The best model is a large number of GPs each with a small number of clients, rather than a small number of GPs with a large number of clients (strategies need to be adopted to ensure that individuals do not engage in 'doctor shopping'). Practitioners who are supported and have completed the accredited

training should provide maintenance programs. Maintenance programs should be well established and appropriately resourced within Central Australia and factor in remote and cultural issues.

7. Recommendations

1. The Northern Territory Government should ensure that people addicted to heroin who wish to enter a methadone maintenance program, can access one within days, with minimal entry criteria. These programs should be attractive and economical and have high retention rates.
2. The Northern Territory Government should ensure that newer drug treatment options such as buprenorphine and naltrexone are also readily available from within the primary health care and primary medical care sectors.
3. The Northern Territory Government should ensure that new needles and syringes are readily available at no or minimal cost at all times and places where there is a demand for their use.
4. The Northern Territory Government should investigate the provision of 'drug courts' as a means of diverting people from the criminal justice system into treatment and support services. There are various programs of this type operating or being trialled in different parts of Australia. These need to be evaluated to see what role they could have in the Northern Territory.
5. Funding for health and welfare assistance for people who use drugs should be increased.
6. The Northern Territory Government, in collaboration with all other Australian governments, should undertake a review of the current legal status of drugs, and institute a system of ongoing reviews of this nature.
7. Any changes in Northern Territory drug policy introduced as the result of this inquiry should be subject to rigorous evaluation.
8. Funding should be made available for research into the patterns of drug use especially amongst young people in the Northern Territory.
9. The Northern Territory Government wherever possible ensure that Aboriginal organisations are given funds to develop programs to specifically target Aboriginal people specifically.
10. Strategies need to be adopted to address the underlying socio-economic determinants of harmful substance use including the implementation of the 'Learning Lessons' review of education, the full implementation of the Primary Health Care Access Program, effective employment programs for Aboriginal people and Framework Agreements (modelled on the Aboriginal Health Framework Agreement) that allow Aboriginal people and communities to be involved in direct negotiation with governments about the policies and programs that are being developed to meet their needs.

Attachment 2 List of Congress papers on Issues related to this Inquiry

Papers and submissions

Title	Date	Summary
Submission to the House of representatives Committee on Aboriginal Affairs on Alcohol	July 1976	Paper by Dr Trevor Cutter argues that any discussion of alcohol and Aboriginal people must be viewed in the context history of (& current) racism. Describes Congress service on alcohol rehab 'the farm'.
Response to the NT Health (Alice Springs) Paper: Urgent Funding Proposals – Alcohol and Other Drugs, Area South Alice Springs Gaol Prisoner transport and repatriation Service	undated	Critique of the NT Government departments failure to adequately consult with Aboriginal community-controlled organisations on a proposal to divert Royal Commission money into an alcohol campaign.
Response to Sessional Committee on the use and abuse of alcohol bt the community: Measures for reducaing Alcohol Use and Abuse in the Northern territory.	undated	Congress response to the sessional committees findings.
A Critique of The Northern Territory Government Funding Submission For An "Alcohol Education Program And Consultation Process"	Mar 1991	Argues against the granting of Commonwealth funds to the NT Government's alcohol abuse proposal on the grounds of lack of Aboriginal involvement, inappropriateness of the HIV/AIDS model, and lack of local control.
Aboriginal Alcohol Abuse Programs and Health Service Delivery in Central Australia	Aug 1991	The response to the NT Government's 'response' to NT Alcohol Ed Prog. Critique 3-91 resp.doc. It broadens the debate, looking at who should control services to Aboriginal people, and the roles of the TPF, Government, and independent health services.
Position Paper on the National Aboriginal Health Strategy	Aug 1991	An extensive summary of the National Aboriginal Health Strategy, especially primary health care, community control, and intersectoral collaboration. Gives Congress definitions and positions on these and other points. See also the appendices (NAHSAPPS.DOC) Section on Alcohol & Substance misuse
A Summary of Recommendations in the Report of the National Aboriginal Health Strategy Working Party	Apr 1992	List of all the recommendations in the National Aboriginal Health Strategy, includes 2 pages on alcohol.
Congress Comments on the "Proposal for Health education Campaign to reduce Tobacco Smoking among the Aboriginal Population of the Northern territory".	Jul 1992	Critique of NT Health Department's and NT Anti-Cancer Foundations prioritizing of tobacco as a major focus campaign, when alcohol is clearly a much greater burden on the community also criticises the lack of consultation with Aboriginal organisations to develop the proposal.
Submission to the Sessional Committee on the Use and Abuse of Alcohol by the Community: Inquiry into the Disturbances at Nyirripi	Mar 1995	Gives a brief background to alcohol abuse problems in Central Australia, before looking in more detail at the success of CAAAPU. Points out the hypocrisy of closing down CAAAPU while bleating on about the need to do something about alcohol abuse.

Aboriginal Health: The Approach of the Northern Territory Government	Feb 1996	Critique of the NT Government approach to dealing with Aboriginal organisations and communities in the health sector, gives a series of concrete examples of the problems encountered.
Statement to the Special Meeting on "Anti-Social Behaviour"	Apr 1997	Brief paper outlining Congress's policy on alcohol misuse and strategies required to address the situation
Substance Misuse in Central Australia	Jul 1997	Comprehensive review of approaches to alcohol abuse and petrol sniffing: top down vs bottom up, health promotion vs PHC, controlled drinking vs abstinence. Updated for the CARPA newsletter of Oct 1998.
Response to the Draft Report on Petrol Sniffing in Central Australia	Aug 1997	Following the death of a petrol sniffer, THS commissioned a report into the problem. Congress' responses focuses on the gaps and inadequacies of their report, particularly their promotion of the "town-bush" split.
Submission to the House of Representatives Standing Committee on Family and Community Affairs Inquiry Into Aboriginal Health	Oct 1997	Important re-statement of the principles for addressing Aboriginal ill health. Defines regional, Territory and national responsibilities; and primary, secondary and tertiary care. Presents the important argument about shifting patterns of Aboriginal health
Briefing Notes on Aboriginal Health	Nov 1998	Collection of statistics on Aboriginal health. Argues the case for holistic health model , identifies comprehensive Primary Health Care as starting point for improvement.
Submission to the NT Aboriginal Family Violence Strategy Evaluation	May 2001	Submission argues that the levels of DV are rising in Abl Communities in the NT. Shows that in areas where there are Alcohol restrictions DV related hospital admissions are lower. Community Controlled Services such as NPY DV service have community mandate & are effective. NT Govt progs haven't been successful.
'Closing the Gap- Towards a Fairer Australia' Presentation to ACOSS/NTCOSS Election Forum Alice Springs 2001	August 2001	Presentation argues for Community Control of Abl health to be supported by ACOSS/NTCOSS. Includes brief description of PHCAP Issues in role out in NT & for social determinants, such as Alcohol, treaty education reform also to be supported.
'"Alcohol in the Alice" and the Central Australian Division of Primary Health Care' Spch Donna Ah Chee & John Boffa to National Divisions Conf Canberra	November 2001	Presentation on the transformation to the CA Div of Gen practice into the CA Div of PHC and its role as an agent for change within the Alice Springs alcohol debate.
Submission: Taskforce on Illicit Drugs	April 2002	Submission supports a prevention paradigm to be implemented in CA and that treatment services need to be tailored for specific target groups. Calls for methadone & other innovative programs to be available in the NT, including needle progs. to be where needed. A review of legal status of drug use/ers and through evaluations of progs and changes to legal system. Targeted progs for Abl people under Abl orgs and underlying causes of Drug prob the Social determinants to be addressed

Publications

Settle Down Country. *Pam Nathan & Dick Leichleitner Japanangka*	1983	Documentation of the story of the outstation movement.
Health Business. *Pam Nathan & Dick Leichleitner Japanangka*	1983	A community report commissioned by CAAC. Outlines the history of Aboriginal contact with European health care delivery. Provides an analysis of the then current health services in Central Australia.
The Adventures of Cuz Congress *Video*	undated 80's	Includes four health promotion advertisements: Good Food, AIDS in Pregnancy, AIDS and Blades, Ease Up On The Grog.
Health Promotion or Self-Promotion? A Central Australian Aboriginal Alcohol Media Strategy. *Charlie Maher & Edward Tilton*	1994	Critique of existing media campaigns on alcohol from an Aboriginal community perspective. Outlines how a media campaign on alcohol aimed at an Aboriginal audience should be produced- not its content, but how to develop one.
Health Promotion or Self-Promotion? A Central Australian Aboriginal Alcohol Media Strategy. ***Community Summary*** *Charlie Maher & Edward Tilton*	1994	A summary for community use of the full report.
Our Health in Our Hands.	1998	Report of the Central Australian Aboriginal Health Summit.
Living on Medicine: A Cultural Study of End-stage Renal Disease among Aboriginal People. *Jeannie Devitt & Anthony McMasters*	1998	Study initiated by Congress and MSHR into the situation of renal disease patients that goes beyond the stats to look at the social cost and difficulties-physical, cultural, geographical, faced by Aboriginal renal patients.
On the Machine *Jeannie Devitt & Anthony McMasters*	1998	A collection of selected and expanded interviews from the Living On Medicine Report
Central Australian Indigenous Youth Summit 2001 Ross River "Today's Youth Tomorrow's Leaders".	2001	Report of the Indigenous Youth Summit held at Ross River April 2001

Attachment 3 Position paper: Substance Misuse in Central Australia

Position Paper:

Substance Misuse in Central Australia

July 1997

Background

Central Australian Aboriginal Congress is an Aboriginal community controlled health service with over twenty years experience in Aboriginal health matters. Congress provides comprehensive primary health care to Aboriginal people from all over Central Australia; a significant proportion of our clinic clients are from communities outside of Alice Springs.

Congress has a long record of concern and action on what is currently termed "substance misuse." As a health organisation we are only too aware that substance misuse, especially alcohol and petrol sniffing, contribute greatly to premature death and disability amongst our people.

We believe that it is the health consequences of substance misuse that should be central to the debate. A focus, for example, on "anti-social behaviour" could be used instead as a mask for racist attacks on our people, attacks which do little more than "blame the victim" and offer no constructive, strategic responses to what is a vast and complex problem.

We believe that the problem of substance misuse can only be effectively addressed in the long term by the Aboriginal community taking responsibility for the issue and doing something about it. Aboriginal community controlled organisations are the product of the Aboriginal community taking responsibility for tackling the health, welfare and justice problems that our people face. We therefore hold that government have a duty to support our people and our organisations in setting up programs to address the problem. Unfortunately, as we shall see, this is duty that has often not been exercised.

The extent of the problem

We believe that the problems of substance misuse amongst our people in Central Australia can be ranked as priorities as follows:

1. Alcohol
2. Petrol-sniffing
3. Tobacco
4. Illegal drugs

Few people would disagree that the major focus of concern about substance misuse in Central Australia should be alcohol. The extent of the problem within both the Aboriginal and non-Aboriginal populations has been extensively documented over the years (see References). This is the area where most attention and most resources need to go although it needs to recognised that for some communities and families petrol sniffing is the number one problem: by comparison, the health problems caused by, for example, tobacco, are relatively minor.

The following tables show statistically what our people experience: it is alcohol and petrol that causes our people to die well before their time.

Top five causes of years of potential life lost before age 65 among Aboriginal men and women aged 15 to 64 years in the Northern Territory, 1979-1991. (From Condon and Cunningham. *Relationship to alcohol and tobacco added*)

Men	Total years of potential life lost<65	Percentage of total	Relation-ship to alcohol	Relation-ship to tobacco
1. Motor vehicle accidents	5 994	17%	Strong	-
2. Ischaemic heart disease	3 415	10%	?Moderate	?Strong
3. Homicide	2 594	8%	Strong	-
4. Pneumonia / Influenza	2 054	6%	Strong	Weak
5. Rheumatic Heart disease	1234	4%	?Weak	-

Women	Total years of potential life lost<65	Percentage of total	Relation-ship to alcohol	Relation-ship to tobacco
1. Homicide	2 140	11%	Strong	-
2. Rheumatic Heart disease	1 556	8%	?Moderate	-
3. Motor vehicle accidents	1 428	7%	Strong	-
4. Ischaemic heart disease	1 006	5%	?Moderate	?Strong
5. Chronic obstructive pulmonary disease (exc. asthma)	943	5%	?nil	Strong

What this table measures is not what the leading causes of death amongst our people are, but what causes the most years of life to be lost. It reflects what many of our people see as the central tragedy of contemporary life: that young-to-middle-aged adults are dying when they have potentially so many years ahead of them.

We have added our assessment of how each of these causes of death is related to alcohol and tobacco misuse. We can see that alcohol is very strongly linked to the premature death of our people; tobacco only much more weakly so. This is not to say that smoking is not a problem amongst our people; but it is not anywhere near alcohol. What the table above shows, put simply and crudely, is this: our people are likely to die of alcohol-related causes long before they have the chance to contract tobacco-related ones.

It is not possible to look at deaths and disability from petrol sniffing in the same way because statistically useful figures on mortality and morbidity from sniffing are not kept. However, because it mainly affects the very young, and because it's potential for permanent physical damage is high, we rate it as a very significant problem, and one which too little proper attention has been focused upon. Short-term, "one off" programs will not solve the problem.

Petrol sniffing in children and adolescents is associated with community and family crisis which is often closely linked to the misuse of alcohol. Parents who are binge-drinking are unable to properly bring up their children and are less able to deal with a problem like petrol sniffing should it arise in their family. Families that are caught up in the culture of binge-drinking, violence, sorry-business, and poverty tend to produce children whose fundamental social, psychological and cultural needs are not being met. It should surprise no one that many children in this position try to escape from this reality using whatever means are at hand: too young to drink and with nothing to do, petrol is the obvious way out, even for a few hours.

Therefore, while it is clear that specific programs for young petrol-sniffers are essential, the problem is wider. Alcohol misuse forms a fundamental problem for the Aboriginal community, and until properly resourced, appropriate and effective programs are in place to deal with this, no substantial improvement in other areas of substance misuse can be expected. A key part of our strategy is to g*et the parents off*

the grog so they can exercise their responsibilities towards their children as well as providing services to the children themselves.
Thus, when we talk about substance misuse in this paper we are concerned primarily with alcohol though much of what we say will be applicable to the other major problem in Central Australia, petrol sniffing. Tobacco and illegal drugs are not as immediate and as pressing a problem for Central Australian Aboriginal people.

Strategies
Substance misuse and its attendant problems result from the dispossession, disempowerment and alienation of our people since the colonisation of Central Australia. **There is no one simple solution to this problem amongst our people.** Instead, whatever assists our people to have greater responsibility for and control over our own lives, will be contributing to the struggle against substance misuse.

General Issues

Top Down versus bottom up strategies

Congress has always argued that "community-based" programs addressing the health of our people should be under the control of our communities, *to the maximum extent desired by those communities*. Of course, this approach has the support of modern public policy, in the form of the National Aboriginal Health Strategy and the Royal Commission Into Aboriginal Deaths In Custody.
It needs hardly be explained that this emphasis on Aboriginal community control of services –including substance misuse services – is not an ideological but a practical position. Non-Aboriginal bureaucracies, even where they employ Aboriginal staff, do not have a good record in dealing with the health and social problems of Aboriginal people, as even the briefest look at the history of health service delivery in Australia shows. Continuing statistics reporting Aboriginal health status comparable only to the poorest of Third World Countries tell the same story.
By maximising community control, those that live with the problems can work towards the solutions to them. It is for this reason that Congress believes that the supporting of *Aboriginal community-controlled initiatives to address alcohol and other substance misuse must be given priority over government or other non-Aboriginal organisations.*
This does not let government off the hook: they still have responsibility for ensuring the health and well-being of all citizens, and therefore the responsibility for delivering services where there are no Aboriginal community initiatives. Again, it should not need emphasising that in any such government programs, the input and control of the Aboriginal community over all aspects of the program must be maximised. A crucial part of this process (and one which the Northern Territory Government at least seems most reluctant to endorse) is using the expertise and experience of already existing Aboriginal community controlled organisations to advise on new programs and initiatives. Such an open and cooperative approach is, unfortunately, still a long way off in the Northern Territory as they are now the only jurisdiction in Australia which has not signed the Framework agreement on Aboriginal Health. They must work in collaboration with us if these problems are going to be solved.

Controlled drinking versus abstinence

Congress' position has always been to support a multi-faceted strategic approach to tackle alcohol problems. Central to this approach has been support for the Aboriginal community to tackle alcohol problems in whatever way that community sees fit. For this reason, Congress has (amongst many other things) supported the Tyeweretye Club project which teaches controlled drinking and provides a safe environment within which people can drink, and also CAAAPU's treatment centre based on sobriety. We have also bought one of the already existing licensed shops here in Alice Springs and poured alcohol down the drain. As part of this exercise we deliberately let our take-away license expire as a step towards the reduction in liquor outlets. We lobbied the Northern Territory Government extensively in an attempt to get them to buy back the license in accordance with their 1991 Living with Alcohol Policy. They refused. More recently we have submitted to the Living with Alcohol program to provide an alcohol counselling service which includes a controlled drinking approach.

The fact is that for some of our people, giving up drinking altogether is the best solution to their alcohol problem. For others, controlled drinking. Controlled drinking strategies are most likely to be effective amongst the educated middle-class – the very class from which the bureaucracy draws its staff and its experts. It seems unproblematic that a person's own habits and experience would inform their approach to alcohol misuse. Certainly, this was the case with CAAAPU –the key Aboriginal people behind CAAAPU were ex-drinkers and their families, people who experienced the chaos and violence of Aboriginal binge-drinking in the streets and creeks and town camps

Of course, controlled drinking strategies are appropriate for much of society, but CAAAPU's approach was based on an intimate knowledge of the social, political, cultural and economic situation of many Aboriginal drinkers. In short, CAAAPU knew what Living With Alcohol did not: that a controlled drinking strategy was simply inappropriate for many drinkers. For middle-aged binge-drinkers living in the creek beds or town camps of Alice Springs, 'responsible drinking' is not an effective option. Socially it is problematic as they live a world that revolves around drinking and drinking to enormous excess. Medically, many of these people already have severe chronic medical problems brought on by alcohol misuse, and the only responsible medical. There needs to be a range of different types of services for our people.

A Substance Misuse Strategy for Central Australia

General Strategies to address underlying issues

- **Improved Access to Primary Health Care Services**. Access for all our people to a well-resourced network of primary health care services is an essential basic requirement for our health to improve. This is especially true for our people who are misusing substances such as alcohol, petrol and tobacco for several reasons.

First, a basic level of health care must be available to protect the health (as far as is possible) of those who are drinking, sniffing, smoking, etc. This includes giving pneumococcal vaccine to prevent death in young drinkers from pneumonia. Second, there is now strong evidence that brief opportunistic interventions about substance misuse by doctors and other health professionals in the context of treatment for an associated clinical illness are as effective as less cost effective mass media and public education strategies. Substance misuse

education is an integral part of primary health care. Finally, primary health care services are *the gateway*, to a whole range of other health-related services (mental health, nutrition, hospitals etc). They play an important role in ensuring that our people are able to access other more specialised services.

- **Collaborative Health Policy Development**: **The NT Framework Agreement / Needs Based Regional Planning.** Collaborative health policy development as outlined in the proposed Framework Agreement on Aboriginal Health is critical for Aboriginal health advancement. The failure of the Northern Territory government to endorse Recommendation 286 of the RCIADIC on Petrol Sniffing**,** calling for a collaborative strategy to be developed, has led to *no strategy and no resources*. There is currently no collaborative regional plan on alcohol either. The Commonwealth government must act on its constitutional responsibilities and ensure that the Northern Territory Framework Agreement is signed so that health resources are allocated more efficiently and effectively. The proposed Regional Indigenous Health Planning Units need to be established. These units should establish a task force to develop a collaborative regional plan to address the problem of substance misuse as a matter of urgency. Part of this plan will need to include a commitment to evaluate all future strategies against agreed outcomes.

- **Education: the need for a Public Inquiry into the provision of education services to the Aboriginal community including the current education system and its funding arrangements and the possible provision of a specific literacy campaign delivered to the entire community.**

The fact that many of our children are not regularly attending school is a major issue in relation to substance misuse, especially petrol sniffing. Firstly, our children are walking around their communities during the day bored despite truancy laws. Even if school based education programs worked, and there is no evidence that they do, many of the children who most need to hear these messages are not at school. Secondly, in the last two years only one Aboriginal person has passed Year 12 in Alice Springs. Given the well established link between education levels and future employment what hope do many of our kids have to get work? This is a vicious cycle which we must break.

We recognise that Aboriginal parents have a crucial role to play in improving the education levels of their children. Unfortunately, however, the literacy level in the adult community is low and it is well known that you need to be literate in order to properly understand the need to be literate. Thus the most successful literacy campaigns across the world have been those that target the *whole community* so that adults and children become literate together. Once the adult community is literate they then more actively encourage their children to attend school and are able to actively engage in their children's education process We call for a public inquiry into the provision of education services to the Aboriginal community including the current education system and its funding arrangements and the possible provision of a specific literacy campaign delivered to the entire community.

- **Reconciliation and Native Title** Aboriginal people and our representative organisations have always argued the link between land and health.

Fundamental to improving the political, economic, cultural and spiritual base of our people is the negotiation of native title claims in our region. If the 10 point plan is implemented the resulting alienation and resistance will be inscribed into our peoples death statistics well into the next century. On the other hand, if native title rights of Aboriginal people are upheld more Aboriginal people will have the opportunity to develop an economic base from which to build a healthier future. Reconciliation is as necessary as immunisation for Aboriginal health advancement.

- **The Stolen Generation** The mental health consequences of the policy of removing Aboriginal children from their families have now been well documented in the Report of the Human Rights and Equal Opportunity Commission. The psychological trauma caused by this policy has made some of our people turn to alcohol. Implementation of the recommendations of the Report into the Stolen generation will help to address the problem of substance misuse.

Substance Specific Strategies

Alcohol

- The opportunistic use of *brief intervention programs* by all primary health care workers. Briefly, this involves bringing to a patients attention whenever possible that there is a link between the patients presenting problem and substance misuse and then giving the patient a clear message that the particular substance is damaging their health and offering them a referral to a specialist agency for further treatment. Common presentations include the link between recurrent episodes of acute bronchitis and smoking or the link between dyspepsia and alcohol misuse. Alcohol awareness is best delivered to individuals in the context of clinical treatment These types of interventions are simple and cost effective.

- The provision of *effective treatment and rehabilitation services*, including residential treatment, to Aboriginal people under Aboriginal community control. Although residential treatment services are no longer being recommended for mainstream Australia, where outpatient services are now preferred, these services are still necessary for people living in poverty because they need to be able to get away from their crisis driven home environment. The Menzies evaluation of CAAAPU showed that this service was achieving success rates better than the national average. Congress believes that CAAAPU has to be funded to deliver a residential treatment program for people who are misusing alcohol as well as petrol. This is an essential service that is currently not available to our people.
- The *restriction of alcohol availability* in Alice Springs. At the level of the population per capita alcohol consumption, alcohol availability and alcohol related harm are directly linked. As a result of this strategies that reduce alcohol availability either by, decreasing the number of outlets, decreasing the hours of trade, changing the type of outlet, increasing the price encouraging the consumption of low alcohol alternatives etc. will have an impact on alcohol related harm in the community. Congress has been a strong advocate over many years for the introduction of alcohol restrictions in Alice Springs. Congress is willing to work with other organisations to pursue this policy as a

matter of urgency.

- A commitment by government to continue *the levy on alcohol* beyond the year 2000 in order to both decrease alcohol availability and to be able to fund alcohol programs. This should occur in conjunction with an independent evaluation of the NT Living With Alcohol Program..

- An evaluation of the success or otherwise of Aboriginal social clubs in order to assess whether it is appropriate to develop more Aboriginal social clubs as part of a strategy to encourage controlled drinking. The recent debate about the potential benefits of " wet-canteens" on Aboriginal communities needs to be informed by proper research. It seems to us that this proposal fails to understand the nature of the problem and also assumes that the main reason that Aboriginal people come to town is to drink. Before any further social clubs or wet canteens are established this issue needs urgent research.

Petrol and other Solvents

- As argued above, petrol sniffing amongst children and teenagers is associated with their parents misusing alcohol. Therefore, getting the parents who are misusing alcohol off the grog so they can exercise their responsibilities towards their children is important..

- Immediate placement of children who are sniffing volatile substances into a safe environment, either with their family or in CAAAPU. If possible these children should be cared for by the immediate family with their parents taking responsibility for their rehabilitation. In each case there needs to be an urgent assessment of the family situation and if the family is too dysfunctional to take responsibility then it will be necessary to involve Welfare. In order for this assessment to occur, as mentioned earlier, primary health care services need to adequately resourced. Congress is well aware of the problems that Welfare Departments have created for our people in the past, however, this is a desperate situation and it is time for Welfare to act *in collaboration with* Aboriginal people and our organisations. It seems to us that there is a risk that concern about the legacy of previous Welfare action may become an excuse for inaction where it is now warranted.

Tobacco

- The opportunistic use of brief intervention programs by all primary health care workers

Illegal drugs

- The opportunistic use of brief intervention programs by all primary health care workers

- Provision of needle exchange programs including in prisons.

- Acceptance of a harm minimisation approach in the development of future policy

Alcohol strategies of little or no proven benefit
Recently (1995) the World Health Organisation (WHO) asked a team of leading experts on public health policy and alcohol issues to examine the whole area: the result was Alcohol policy and the public good (1995), probably the most up-to-date and comprehensive examination of the area current. On the subject of school-based education, public education, warning labels, and advertising restrictions, they conclude (page 208) that:

> *There is no present research evidence which can support their deployment as lead policy choices or justify expenditure of major resources on school-based education or mass media public education campaigns,* unless these are placed in the broader context of community action.(emphasis added)

Congress believes that continuing to place a strong emphasis on these types of strategies is wasting precious resources and failing to address the problem. Lastly, we call upon all people of good-will, both within and outside government, to back Aboriginal people in their continuing struggle for health and social justice. Alcohol abuse and the social disruption it causes will undoubtedly continue unless our efforts to take responsibility for the problem are supported.

References (Chronological order):

1. O'Conner, R. *A Report on the effects of the two kilometre law on the residents of Aboriginal town camps in Alice Springs*, 1983 (Unpublished report for the NT Drug and Alcohol Bureau.)
2. Smith, D. *Effectiveness of Restrictions on availability as a means of reducing the use and abuse of alcohol*, Australian Alcohol and Drug review, 1983, Vol 2: 84-90.
3. Noble, EP. *The Prevention of Alcohol related problems: a growing reality in the 1980's*. Australian Drug and Alcohol Review 1987:6:77-85.
4. Commonwealth Department of Community services and Health *Draft National Health Policy on Alcohol in Australia* 6 November 1987.
5. Simmons, L. *The Availability of Alcohol in Alice Springs: The Grog story*, Discussion paper for CAAC, Alice Springs, 1988
6. Ashley, MJ, Rankin, JG. *A Public Health approach to the prevention of alcohol related problems.* American Review of Public Health 1988:9:233-71.
7. Anyinginyi Congress Aboriginal Corporation. *Alcohol and Us: the Hard Facts.* Central Australian Rural Practitioners Association Newsletter 1989;10:14-20.
8. National Aboriginal Health Strategy Working Party. *A National Aboriginal Health Strategy*. Canberra, 1989.
9. Tangentyere Council and Central Australian Aboriginal Congress. *Grog Strategy, A Draft paper for discussion*, June 1990
10. Anyinginyi Congress Aboriginal Corporation. *Submission to the Sessional Committee on the Use and Abuse of Alcohol*. Tennant Creek, 11 July 1990.
11. Central Australian Rural Practitioners Association *Submission to the Sessional Committee on the Use and Abuse of Alcohol*. Tennant Creek, 11 July 1990.
12. Langton, m., AhMatt, L., Moss, B., Schaber, E., Thomas, M., Tilton, E., Spencer, L. 1990, *Too much sorry business: the report of the Aboriginal issues Unit of the Northern Territory to the Royal Commission into Aboriginal Deaths in Custody*, Volume 5 of the RCIADIC National Report, Australian Government Printing Service, Canberra.

13. Lyon, P. *What everybody knows about Alice: a report on the impact of alcohol abuse on the town of Alice Springs*, Tangentyere Council, Alice Springs, 1990
14. Central Australian Aboriginal Congress. *Response to the Sessional Committee on the Use and Abuse of Alcohol by the community: measures for reducing alcohol use and abuse in the northern* territory, Alice Springs, 1990.
15. Central Australian Aboriginal Congress. *A Critique of the Northern territory Government Funding Submission for An "Alcohol Education Program And Consultation Process*", Alice Springs, 1991.
16. Central Australian Aboriginal Congress. *Aboriginal Alcohol Abuse Programs and Health Service Delivery in Central Australia*, Alice Springs, 1991.
17. CAAAPU (Central Australian Aboriginal Alcohol Planning Unit) 1992, *Final Report* and Grog Action Plan of the Central Australian Aboriginal Alcohol Planning Unit, by P. Lyon, J. Hill & Wynter for CAAAPU
18. Boffa, J. George, C. Tsey, K. *Sex, alcohol and violence: community collaborative action against striptease shows in public bars*. Aust J Public Health 1994; 18: 359-66.
19. Maher, C. Tilton, E. *Health Promotion or Self Promotion? A Central Australian Alcohol Media Strategy*, Central Australian Aboriginal Congress, 1994
20. Boffa, J. *Fewer Grog Shops - The Answer?* Alice Springs News (Alice Springs), September 1 1994: 3.
21. Bartlett, B. Legge, D. *Beyond the Maze, Proposals for more effective administration of Aboriginal Health Programs.* National Centre fro Epidemiology and Population health. ANU, Canberra, 1994..
22. Central Australian Aboriginal Congress. *Aboriginal Health Issues Paper: Regional Health Planning in Central Australia*. Alice Springs, 1995.
23. Miller, K. Rowse, T. *CAAAPU: an Evaluation. Menzies School of Health Research, NT, Menzies Occasional Papers, Issue No 1/95*
24. Central Australian Aboriginal Congress, *Submission to the Sessional Committee on the Use and Abuse of Alcohol by the community, Inquiry into the disturbances at Nyirripi*, Alice Springs, 1995.
25. Aboriginal Medical Services Alliance of the Northern Territory. *The Way Forward, 1995*
26. Boffa, J. *Grog Crisis; Alcohol affects all.* Centralian Advocate (Alice Springs), 1995,
    December 15: 8
27. Benzeval, Judge, Whitehead (Ed.). *Tackling Inequalities in Health: An agenda for action*, Kings Fund, London, 1995, Summary xvii-xix.
28. Edwards, G. Anderson, P. Babor, T. et al. *Alcohol Policy and The Public Good*. World Health Organisation, Oxford University Press, 1995
29. Race Discrimination Commissioner. *Race discrimination, human rights and the distribution of alcohol.* Canberra: Australian Government Publishing Service, 1995.
30. Anderson, P. *Priorities in Aboriginal Health.* In Aboriginal Health: Social and Cultural Transitions, Robinson, G. (Editor), NTU Press, Darwin, 1996: 15-18
31. Bell. S. *Building Aboriginal Health from the Ground Upwards*. In Aboriginal Health: Social and Cultural Transitions, Robinson, G. (Editor), NTU Press, Darwin, 1996: 23-25
32. Saggers, S. Gray, D. *Supplying and Promoting 'Grog': The Political Economy of Alcohol in Indigenous Australia.* In Aboriginal Health: Social and Cultural Transitions, Robinson, G. (Editor), NTU Press, Darwin, 1996: 136-142

33. Hudson, P. Petrol-Sniffing in Aboriginal communities: a Remote Problem With Even Remoter Solutions in Aboriginal Health: Social and Cultural Transitions, Robinson, G. (Editor), NTU Press, Darwin, 1996: 156-166
34. Caldwell, J. Caldwell, P. *The Cultural, Social and behavioural Component of Health Improvement: The Evidence from Health Transition Studies*. In Aboriginal Health: Social and Cultural Transitions, Robinson, G. (Editor), NTU Press, Darwin, 1996: 167-173
35. Bartlett, B. *Aboriginal Community Control - Is It Just Rhetoric?* In Aboriginal Health: Social and Cultural Transitions, Robinson, G. (Editor), NTU Press, Darwin, 1996: 207-213.
36. D'Abbs, P. Togni, S. Crundall, I. The Tennant Creek Liquor Licensing Trial, August 1995 - February 1996: An Evaluation. *Menzies School of Health Research, NT, Menzies Occasional Papers, Issue No 2/96*
37. Scrimgeour, D. *Community control of indigenous health services.* Aust and New Zealand Journal of Public Health, Vol 20 (1), 1996: 17-18.
38. Boffa, J. *Freedom of the individual and alcohol*. *Centralian Advocate* (Alice Springs), 1996; June 7:10.
39. Cunningham, J and Condon, J *Premature mortality in Aboriginal adults in the Northern Territory, 1979-1991* The Medical Journal of Australia 1996, 165 (6): 309-312.
40. Boffa, J. *Alcohol group: extreme views, but no new ideas*. Centralian Advocate (Alice Springs), 1996; Nov 22: 10
41. Tsey, K. Aboriginal self-determination, education and health: towards a radical change in attitudes to education. Australian and new Zealand Journal of Public Health. 1997, Vol 21 (1): 77-83
42. Brady, M. *Aboriginal drug and alcohol use: recent developments and trends*. Aust and New Zealand Journal of Public Health, Vol 21 (1), 1997: 3-4.
43. Human Rights & Equal Opportunities Commission, *Report into the Stolen Generation*, Government Printing Service, Canberra, 1997

Attachment 4 Advertisement for Advocate edition of Tuesday 4.4.2000

Congress proposals for preventing alcohol-related harm in Alice Springs

The Central Australian Aboriginal Congress has been concerned about problems arising from excessive consumption of alcohol in Alice Springs for many years.

In 1990, Congress purchased a food outlet and an attached takeaway liquor licence, and allowed the licence to lapse immediately at considerable cost to itself.

Congress has developed the following package of proposals to help people think more clearly about what we as a community can do to prevent alcohol-related harm in Alice Springs.

Congress believes that there needs to be a broad range of measures taken to reduce the high level of alcohol problems. Therefore we are proposing reforms which go well beyond simply adjusting the regulations governing the sale of alcohol itself.

Congress asks Alice Springs residents to consider the package of proposals carefully.

If you have questions about the reasons behind these proposals, feel free to call Congress Public Health Medical Officer, Dr John Boffa, or Substance Misuse Project Officer, Bob Durnan, on 8951 4400.

Our proposals are:

1. Education

The recommendations of the **'Learning Lessons'** Report by Bob Collins et al should be implemented quickly and in partnership with Aboriginal parents, educators and community organisations.

2. Economic Development

Poverty* and underdevelopment are closely related to substance misuse and other public health problems.

Together with interested Aboriginal organisations & other community groups, the NT Government and ATSIC must develop a **comprehensive strategic plan for Aboriginal economic development in Central Australia**. The plan must be aimed at providing the maximum number of real work opportunities for Aboriginal people. This plan must be properly implemented, to provide competent advice and support to Aboriginal people involved in the development of work programs and businesses throughout Central Australia. Regionally based Small Business Advisory Services should be established to help provide reliable assistance as it is needed to Aboriginal community organisations and private businesses.

3. Alcohol Education

- At the same time that any changes are made to the regulations governing alcohol availability in Central Australia, the NT Government should implement a wide-ranging and culturally appropriate **alcohol education campaign**. This education campaign should include clear information about standard drinks, safe drinking levels and appropriate and inappropriate behaviour when drinking. Prominent role models, such as sporting personalities should be used in this campaign.
- The Liquor Commission should make it compulsory for places selling alcohol to display clear **information about safe drinking levels**.
- The Government and other institutions, such as Aboriginal organisations, should sponsor a wide range of **liquor-free events**, especially sporting events, in Alice Springs.

4. Health Service Delivery

All health service providers should ensure that their clients are asked about their levels of alcohol consumption, and offered brief interventions and referrals as needed.

5. Community Policing and Law Enforcement

- Police should stringently **enforce the existing laws** in relation to moving groups of drinkers waiting outside liquor outlets.
- The NT Government should consider matching the ATSIC grant for the **Tangentyere Night Patrol** so it can be expanded.
- The NT Government should double the funding for the **Tangentyere Warden & Return to Country** scheme, so it can increase its activities.
- There should be more regular activity by **Licensing Officers** (formerly known as Liquor Inspectors) in Alice Springs.
- The NT Government should substantially increase the **penalties for the illegal transporting and selling of alcohol**, and also direct the Police to increase their efforts at preventing the illegal on-selling of alcohol in Alice Springs and the illegal transportation and selling of alcohol in areas which have been declared dry by the Liquor Commission in our region.

6. Restrictions on Alcohol Promotion

Congress believes:

- There should be bans on all **advertising** that promotes consumption of alcohol
- The Liquor Commission should ban alcohol **promotions** in public bars & clubs

7. Promotion of Alcohol-free Events and Sports

- Government and community organisations should sponsor **liquor-free events**, especially sporting events
- Aboriginal organisations should do more to sponsor Aboriginal **sports** teams (eg softball, football, rugby, cricket)

8. Regulation of Alcohol Supply

Throughout the world, there is a significant body of scientific evidence showing that the health and wellbeing of populations is closely correlated with the availability of alcohol. Generally, the greater the availability, the greater are the problems associated with its consumption. These international studies in Europe and America have been confirmed by Australian experience in recent years. The consumption reduction strategies in Derby in WA and Tennant Creek and Curtin Springs in the NT have yielded very good results in terms of public health and social order benefits.

Congress recommends a 12 month evaluated trial of the following measures (to apply throughout Central Australia, not just in Alice Springs) to reduce alcohol consumption:

(a) Hours of trading:

- limiting **takeaway liquor trading hours** to a maximum of eight hours per day from Monday to Saturday for all outlets, including clubs
- banning all takeaway sales from all outlets, including clubs, on **Sundays** and **Thursdays**

(b) Types of liquor & containers:

- ban sales of **cask wine** above 2 litres
- impose **quotas on sale of fortified wine, sherry & spirits**, holding outlets roughly to current levels of wholesale purchases
- ban all sales of wine and sherry in **glass containers** larger than 1 litre

9. Tax changes

In order to maximise the incentive for drinkers to shift from heavier to lighter (and less harmful) types of alcoholic beverages, all parties should lobby the Commonwealth Government to reduce the tax on **light beer** & increase the tax on wine, to bring the cost of a standard drink of light beer below that of standard drinks of full strength beer & wine.

10. Welfare Reform

If the proposal for greater restrictions of takeaway alcohol on Thursdays is accepted, in order to enable families to budget and shop in relative peace on a day when there is less access to alcohol, all parties should lobby the Commonwealth Government to keep the issuing of **welfare** cheques in central Australia restricted to Thursdays as far as possible

* At present, the median weekly income of Aboriginal people in Alice Springs is $184, as against $468 for non-Indigenous locals. See p.88, **The Quality of Life in Alice Springs** by Janet McIntyre for the Alice Springs Town Council, February 2000. McIntyre points out that the generally accepted poverty line for a family with two children is now $464, and for an individual is $247 (p.89).

This is not an exhaustive list of the things that need to be done. However Congress believes they are all necessary prerequisites for getting the changes that we all want in our town and for our children.

For further information, phone Dr John Boffa or Bob Durnan at Central Australian Aboriginal Congress on 08 8951 4400, or e-mail us on <john.boffa@caac.mtx.net> or <bob.durnan@caac.mtx.net>

Attachment 5 Appendix 7 of CARIHPC Central Australian Regional Substance Misuse Strategic Plan

Appendix 7: Service-generated Overview of Services Operating to Prevent and/or Address Inhalant Abuse in Central Australia

Overview

Recent surveys (between early 1998 and July 2000) indicate that there are usually between 360 and 500 (mainly teenage) people involved in sniffing at any given period in Central Australia, i.e. in the land covered by the CLC in the Northern Territory, the Pitjantjatjara Lands in South Australia and the Ngaanyatjara Council in Western Australia. Up to 40 (mainly teenagers, with about 15 being regular sniffers) are sniffing petrol in the Balgo region, across the NT/WA border from Yuendumu. The average number of sniffers in the Northern Territory section of Central Australia seems to have risen from about 160 in early 1998 to around 260 in July 2000, while the numbers in the adjoining areas seems to have remained relatively stable. (**These figures would have to be updated through consultations with organisations operating on the ground in these areas).**

In the Northern Territory part of Central Australia, sniffing is heavily concentrated in the Northern Territory areas that adjoin Western Australia and South Australia, i.e. Planhealth's Zone 8 (Warlpiri – Yuendumu/Nyirrpi); Zone 9 (Luritja/Pintupi – Kintore/Papunya/Mt Liebig/Haasts Bluff); and Zone 12 (Pitjantjatjara/Luritja – Imanpa/Mutitjulu/Docker River/Aputula/Titjikala). There is also some sniffing in the adjacent Zone 10 (Western Arrernte) at Hermannsburg and Areyonga. In Zone 11 (Alice Springs/Amoonguna/ Santa Teresa) sniffing is normally restricted to groups of children and youths who are closely related or otherwise associated with sniffers in these other zones.

There are virtually no reports of constant sniffing in the other Central Australian health zones in the NT in the last couple of years, except at Willowra, which is now being incorporated into the Warlpiri Zone. Isolated cases (e.g. at Laramba in Zone 7) seem to have been dealt with rapidly and effectively, usually by promptly sending the ringleaders back to the communities they have come from in the 'problem zones'. There are recent reports of sniffing in Tennant Creek. This involves inhalants other than petrol, and measures are being taken by local health organisations to address this outbreak.

Even within the 'problem zones', in most cases the entrenched and sizeable levels of sniffing are mainly contained within one or two communities in each zone, with the notable exception of Zone 9. In Zone 9, which includes Walangurru (Kintore), Papunya, Mt Liebig and Haasts Bluff (Ikuntji), there are very serious problems with sniffing at all the communities except for Ikuntji (Haasts Bluff), which has a much lower level sniffing problem.

Seasonal factors, such as ceremonial gatherings, football carnivals and school holidays are often associated with upsurges in sniffer numbers. Numbers of chronic, long-term sniffers are probably somewhere between 25% and 40% of the total average number of sniffers at any given time.

Chronic sniffer totals as well as short/medium-term and opportunistic sniffing numbers are affected by the presence of preventative initiatives such as the Mt Theo and Intjartnama programs. The number of sniffers in each category is also affected by punitive interventions, the introduction of aviation gas (Comgas), and the general well-being and capacity of community institutions such as community councils,

clinics, schools, administrations, recreation centres (where they exist) and night patrols.

Upsurges in sniffing are usually the result of one or more inveterate sniffers being in an unsupervised situation for a period with other people of the same age group. Peer group pressure is a major factor influencing the likelihood of individuals starting to sniff, as are child abuse and neglect, poverty, alienation, absence of competent concerned adults and community institutions, and boredom. There are almost no effective programs in the bush communities to systematically address these causal or associated factors, and very few in Alice Springs.

Available Services: The Barkly Region – Zones 1, 2 and 3

These zones are generally serviced from Tennant Creek. There are no sniffers on record for the Barkly Region outside Tennant Creek in recent years. One identified sniffer who visited Tennant Creek (Zone 2) in 1998 was promptly dealt with by the Aboriginal community there and sent back to his home community. The recent outbreak in Tennant Creek itself has involved paint thinners and other solvents, and is apparently being contained.

Health services and clinics in the Barkly zones maintain a vigilant watch for any evidence of sniffing entering the region. There are no particular programs or services operating that would be able to address any inhalant abuse problems that might arise in the area outside Tennant Creek.

Anyinginyi Congress in Tennant Creek has an alcohol project **(interim residential programme 6 staff)**, a **Community Development Unit and a Youth Sport Recreation Programme focus which employs recreation and youth workers.**

An Alice Springs-based substance abuse educator (**may now be more than one**) from the THS agency CAAODS (Central Australian Alcohol and Other Drugs Services) is available to respond to invitations to visit communities.

Available Services: Zone 4 (Kaytetye/Warlpiri – Willowra and Tara)
Zone 5 (Alyawarre/Anmatyerre – Utopia, Ampilatwatja, Mulga Bore)
Zone 6 (Eastern Arrernte/Alyawarre – Harts Range, Mt Swan, Bonya, Atula, Lake Nash)
Zone 7 (Anmatyerre – Ti Tree, Laramba, Wilora, Aileron, Pmara Jutunta)

As with Zones 1, 2 and 3, petrol sniffing is not normally present in these four zones, although it has emerged in a major way in the Willowra community in the past year. Through most of this time Willowra has been without a functioning council, and there have been major crises in other community institutions. Willowra, on the far western tip of the area covered by this group of zones, is closely associated with Yuendumu, and is being moved into the Warlpiri Health Zone (Zone 8).

Together these four zones constitute a region (populated mainly by Kaytetye, Anmatyerre, Alyawarre and Eastern Arrernte speaking people, with some Eastern Warlpiri as well) that is adjoined on two sides by areas in which there are high to moderate levels of petrol sniffing occurring on a regular basis. There have been many intermarriages between families from these and the adjoining zones where sniffing is endemic, and there are frequent visits by large groups between zones and regions for social, ceremonial and sporting purposes. Thus there is the continual prospect of

‘carriers’ of the petrol sniffing habits entering the region, or of young people picking up the habit when visiting certain communities in the zones to their west and south.

On the western end of this region, the THS clinics have often been involved in helping to identify visiting sniffers and sending them back to their homes in Zones 8 or 9.

At the eastern end, the Alpurrurulam Community at Lake Nash (near the Queensland border) had problems with a group of visiting sniffers in 1998. The community council was able to remove them and send them back to their home community in Queensland. At the moment there doesn’t appear to be any legacy of problems from this experience.

An Alice Springs-based substance abuse educator (**now more than one**)from the THS agency CAAODS (Central Australian Alcohol and Other Drugs Services) is available to respond to invitations to visit communities in these zones to carry out basic education about the harm associated with a range of substances, including volatile inhalants such as petrol.

Available Services: Zone 8 (Warlpiri)

Petrol sniffing is a significant problem in this zone. The great majority of the sniffing occurs in the largest population centre, Yuendumu.

Of the other main population centres, Yuelamu, a small community on an old pastoral lease, is able to deal with visiting sniffers before they establish themselves. The THS clinic has been involved in assisting the council to identify and deport a small numbers of visiting sniffers to Zone 9 (Papunya) over the last two years.

Nyirrpi, the other main community, has had several outbreaks of problems with sniffing in the last couple of years, but it is currently dormant. This situation results from some extraordinary events involving payback, the killing of a sniffer by another sniffer, and subsequent efforts by many parties to contain the situation. The THS clinic and the council have both been heavily involved in the containment of these situations.

The Mt Theo Project is located off the road between Yuendumu and Nyirrpi, and is the one specific program operating to address inhalant abuse in the zone. Nearly all its clients are of Yuendumu origins. It is the most developed and effective project currently dealing specifically with sniffing in a discrete area in Central Australia. In its six years of operation, the project has reduced the average number of Yuendumu sniffers from over 70 to around twenty. It has dramatically reduced the amount of sniffing carried out by these chronic sniffers, as measured in ‘sniffing days per year’, to about 30% of what it used to be, with subsequent benefits for the individuals involved, the community and the taxpayer.

The Mt Theo Project, substantially funded by OATSIH, with some minor contributions from THS via the DASA brokerage fund, includes both preventative and harm minimisation elements in a sensible array of interrelated programs and procedures. It is a Warlpiri-language specific project, so access to its constituent parts is not generally available to individuals and communities from outside the zone. The project has been hampered at times by a lack of access to suitable expert health services. It needs a back-up counselling service that is sufficiently resourced to be relied upon to make weekly visits to Mt Theo and to be on call for emergencies to provide specialised counselling. This would bring the situation much closer to that recommended by the coronial report on the death of a petrol sniffer.

The Mt Theo staff often need to transport newly identified sniffers over long distances at very short notice, often late at night or on weekends, and would prefer to

be able to get thorough medical assessments carried out as soon as possible after the client has been transferred to the outstation. Speed is of the essence in these transfers to the outstation, as they need to be done while the sniffer's family or police or other authorities have the sniffer agreeing with the move. Experience has shown that waiting for the clinic to open the next day usually means the opportunity to make the intervention is lost.

Many particular aspects of the Mt Theo Project make it fairly 'Yuendumu specific'; therefore, no assumptions should be made about its possible general application as a model for use in other Western Desert communities afflicted by serious sniffing problems.

The Alice Springs-based substance abuse educator (**now more than one**) from the THS agency CAAODS (Central Australian Alcohol and Other Drugs Services) is available to respond to invitations to visit communities in this zone to carry out education about the harm associated with a range of substances, including volatile inhalants such as petrol, and has done so recently.

Available Services: Zone 9 (Luritja/Pintupi – Kintore, Papunya, Mt Liebig, Haasts Bluff)

Petrol sniffing is also a very significant problem in this zone. It has been particularly problematic over the last two summers at Walungurru (Kintore) and Papunya, and over the last eight months at Mt Liebig. None of these communities is funded to run a continuing program specifically designed to address sniffing problems. (**This should be checked with Waltja)**

Mt Liebig and Papunya have both received small grants from the THS-provided DASA Remote Area Aboriginal Alcohol and Substances Strategy brokerage fund this year to help seed projects to address sniffing problems. Both have received advice and assistance from the Intjartnama Program in the past, which is based in Zone 10 but had developed strong working relationships with most Zone 9 communities through shared family links and cultural activity. The Intjartnama Program provided some help until the death of its founder in early 2000, but wasn't set up on a scale sufficient to attempt to address all the petrol sniffing problems in Zone 9 in the same way that the Mt Theo Project does in one community in Zone 8.

A recent development has been the proposed re-establishment of a small specialised service at Winbarrku Outstation, south-west of Papunya and Mt Liebig, to take sniffers for 'respite' in much the same way that Mt Theo does for Warlpiri families. For safety reasons, it will be initially restricted to non-chronic female sniffers. (**This did not eventuate**)

The Winbarrku project proposal was developed with the help of a small seeding grant from the fund administered by the Waltja organisation in Alice Springs. (Waltja distributed a bucket of money, received from OATSIH in 1998, to help communities with small initiatives, up to $5000, to address sniffing problems. Most of this fund went to a range of communities for new one-off preventative activities, such as school holiday programs, and the fund was exhausted by mid-1999.) (**Commonwealth FACS has substantially increased its funding in the region for these preventative programmes).**

Papunya is negotiating with the NT Department of Sport and Recreation to upgrade its youth recreation services, which are presently funded through a small grant provided by World Vision. Lately Papunya has been using a small DASA brokerage grant to help set up a couple of respite outstations. **It has since got funding from NTDH&CS, FACS**

Walungurru Council at Kintore has had a series of major community problems on its hands, and a major, ongoing problem with sniffing has grown in the period of chaos. The council enlisted the help of the Intjartnama team several times in 1998/99, but the Intjartnama staff couldn't supply the constant presence, intensive support, daily strategising, nightly problem solving and assistance that the Mt Theo Project supplies at Yuendumu. For one thing, its workers are living 6 to 8 hours car travel time away from Kintore, and have commitments to several other communities as well as running their own residential service at Intjartnama. Since early 2000, Intjartnama has not even been able to continue providing the level of assistance that it had previously supplied.

Intjartnama's main input into the Walungurru community was in the form of interventions and support. It assisted and stimulated the council, families and community as a whole to recognise and own their problems in relation to sniffing, and to identify the available options for taking action to prevent or overcome the problems. Intjartnama staff held motivational meetings, information sessions, self-reflection discussions, analysis and emotional support at a full range of levels (whole of community, council, staff, health service, family group and individual) within the Walungurru community. They worked mostly with the council, night patrol, Aboriginal community police officer and particular family groups.

The Intjartnama team was able to bring a strong repertoire of experience, training and culturally appropriate education techniques and materials to the situation. It made prominent use of traditional painting, videos of congruent events and situations, traditional stories and storytelling methods. Overall, the Intjartnama approach encompasses intervention, information, education, support and provocation, in a mix which equates to a de facto strategic planning exercise with the community, or at least with families and the significant individuals and institutions who are prepared to take the sniffing issue seriously.

However, given that the Intjartnama team was only able to have an occasional presence at Kintore, it is up to permanent members of the Walungurru community to carry out the consistent actions that are required to apply the lessons and decisions which emerged from the discussion and planning process. That is, parents, extended family members, the elders council and the community council have to take responsibility for enacting the responses. Without permanent specialised on-site staff who have the primary responsibility of facilitating and co-ordinating and assisting these responses, this can become a fairly haphazard process, especially when key staff members are also overloaded by the numerous other responsibilities and problems that occur in this crisis-ridden community. Included in these problems is a set of institutionalised family conflicts. These conflicts mean that publicly agreed solutions often don't get carried out.

A core group of about half a dozen problematic Walungurru children and youth are practically homeless, in that they lack families who are able to provide them with most of the essential elements of practical family concern and care on a daily basis. Members of this group have been responsible for some of the more recent upsurges of sniffing at Mt Liebig, Papunya, Kiwirrkura and, to a lesser extent, in Alice Springs.

The THS CAAODS educator/support worker is available to, and does, visit communities in this zone when asked. A fair bit of his time has been spent in these communities over the last few months. **(Understand that there is now more time available).**

Available Services: Zone 10 (Western Arrernte – Areyonga, Hermannsburg, Wallace Rockhole, Intjartnama)

The Western Arrernte Zone is centred on Hermannsburg (Ntaria) and its many outstations, among which is Intjartnama. Some of these outstations are quite large. It also includes the established communities of Areyonga and Wallace Rockhole. The Intjartnama Program operates strongly in this zone, and was particularly active in 1998 and 1999 in helping to combat the endemic sniffing problems at Ntaria, mainly through a youth support program, counselling and community motivational work. It also provided a residential program for young sniffers, many of them referred by the courts from other zones. However, since early 2000, these activities have had to be discontinued because of the death of Intjartnama's co-founder.

Intjartnama has at times carried out an integration and information dispersal role among groups trying to deal with sniffing in the bush. Its outreach program, intervening at the request of communities in Zone 9, provided support, assistance and information, and helped with strategic analysis and planning (see previous section). This program is currently dormant, and its future is uncertain.

Intjartnama, along with the Mt Theo Program, has been the most consistent and competent of the bush-based services dealing with inhalant abuse over the last ten years, and has been the widest ranging in terms of its operations, techniques and experiments. It has gotten by with varying amounts of funding from THS, Commonwealth Health/OATSIH, ATSIC and other sources. It has normally had four strands of activities: residential; community interventions; community youth support; and dispersal of strategic analysis and information.

Intjartnama Strand 1: Provision of a residential service, as a respite and treatment option, at what was known as 'the young sniffers' camp' near Intjartnama. This was mainly for young people from Zone 9, plus some clients from Alice Springs, the Pitjantjatjara Lands in SA, and a sprinkling from other zones. Some of these were referred to Intjartnama by the Department of Correctional Services, but difficulties in dealing with a number of clients on community correction orders led to the service being wary of taking very many of these clients. This program was funded substantially by OATSIH in the 1998/99 year, and has not operated since late 1999, mainly because of the death referred to above. Intjartnama is planning to restore this component of its service as soon as possible. This will depend on being able to secure a reliable water supply for the camp, and the completion of some basic shelters.

Because the Intjartnama Program takes clients from a wide range of communities and language groups, it finds it more difficult than the Mt Theo Program (see above) to quantify its impacts on either individuals or communities. For this reason, and also because it is a more diffuse project and addresses a wider range of issues on a large number of sites, it cannot be compared directly with Mt Theo. Nonetheless, its impact on the Hermannsburg situation is apparent.

Intjartnama Strand 2: Provision of community interventions and support where requested by community councils and family groups in other areas. The best example of this has been the relationship with the Walungurru community that was established in recent years (see notes in section on Zone 9 above). This work at Kintore was somewhat handicapped by the need to construct a viable framework for action, in terms of enabling competing and feuding family groups to work out better ways of living and working together, so that the appropriate strategies could be implemented.

This strand has worked on a 'consultancy' basis. To be more effective, Intjartnama would need to be resourced to carry out this consultancy work on a

continuing basis. As it is still in the process of re-jigging its activities and refocusing following the death of its main worker in this field, it is yet to be seen whether Intjartnama will resume this type of activity.

Intjartnama Strand 3: Provision of community youth support services. This support has been given mainly to Hermannsburg youth, with these preventative activities centred mainly at Intjartnama and its satellite outstation (the 'young sniffers' camp). This strand is based on the provision of positive activities for youth. These activities consist predominantly of sports for groups of male and female Hermannsburg youth, including large numbers of sniffers. (A group of female sniffers, which ranges in size from 10 to 15 girls, has taken part on a regular basis.) The regularity of the program has been undermined at times by problems with transport, but these problems are usually overcome. The program has been assisted by the local Ntaria sports and recreation officer at those times when that position has been occupied. The program would benefit from the provision of more resources and more of the recreation officer's time.

The program includes the provision of food, checking on the well-being of participants, and provision of counselling as needed. Every second week on the Wednesday evening there is a special group counselling session.

Intjartnama Strand 4: Provision of analytical activity, on a sessional basis, using a part-time psychologist and small team who are able to carry out theoretical and strategic discussion, provide liaison and information, and generally act as a small-scale 'intelligence service' and 'think tank' in relation to petrol sniffing in Zones 9 and 10. This function is also suspended, pending further planning and decisions by the Intjartnama team about their future directions and focus, and the results of a planned review by OATSIH.

Community-based activities in Zone 10

Hermannsburg has had very high levels of sniffing and associated problems over the last few years. These have spread to Areyonga at times, although the sources of 'infection' have not always been from Hermannsburg, as Areyonga has close family ties with a number of places that continually experience sniffing problems.

Wallace Rockhole, a close knit and unusually disciplined community, rarely experiences sniffing problems.

Areyonga Council has been able to deal fairly effectively with sniffing outbreaks, including a large outbreak that occurred in the summer of 1998/99, and two smaller outbreaks since then. The departure of many families to ceremonies at Papunya during the summer school holidays gives the council some breathing space. It is able to use this opportunity to bring the situation under control.

The Hermannsburg THS clinic, in conjunction with Intjartnama, has been making great efforts to address the extremely serious sniffing epidemic among local youth. Between them, they seem to have brought the average number of sniffers down somewhat. The clinic staff have run special programs for sniffers, including a special night clinic, and have collaborated with others to provide some preventative activities in the evenings. Nonetheless, the number of recorded sniffers still ranges from about 35 to over fifty. (This is about half the number of chronic sniffers recorded a couple of years ago.) Hermannsburg also reports a growing problem with under-age drinking, and the transfer of some sniffers' preferences to alcohol and marijuana may explain some of the reduction in numbers.

The THS CAAODS educator/support worker is available to visit communities in this zone, and does so when asked. A fair bit of his time has been spent in these communities over the last few months. (**Uncertain if this is still the case**)

Available Services: Zone 11 (Alice Springs)

Alice Springs has a relatively small number of highly visible chronic sniffers. These are usually confined to three groups on Alice Springs town camp leases, one larger group (associated with Zone 10) at the Yarrenyty-Arltere Association in Larapinta Valley; another smaller group (Warlpiri, associated with Zone 8) at Ewyenper-Atwatye (Hidden Valley), Ilperle Tyathe (Warlpiri Camp) and Anthelk-Ewlpaye (Charles Creek); and the other (associated with Zone 12), usually consisting of only a couple of sniffers who occasionally become ringleaders, at Inarlenge Community, just south of Heavitree Gap in Alice Springs.

There are also sporadic outbreaks of sniffing among youth visiting Alice Springs from the 'problem zones', particularly Zones 8, 9, 10 and 12. The visitors from Zone 9, especially from Kintore, Papunya and Haasts Bluff, mainly stay at the camps on the western edge of the town in the Morris Soak/Trucking Yards area, at the Anhelke, Nyewente and Akngwertnarre town camps.

Outside Alice Springs itself, there are occasional outbreaks at Santa Teresa (which is not surprising given the high level of interactions with families from highly problematic places such as Hermannsburg and Imanpa). The council, community police officer, Spiritual Healing Centre and clinic are doing a good job of keeping the problems under control.

At Amoonguna there have long been serious problems of under-age drinking and cannabis smoking among a small group of youth; in recent months this has escalated into extensive sniffing behaviour.

In Alice Springs itself the CAISAN group has been acting as a co-ordination point for information and action to address not just the petrol sniffing on the town camps, but also the more widespread outbreaks of more generalised sniffing among the children of the town. Glue and all manner of volatile solvents are tried at times by large numbers of kids, particularly during the summer months.

The Territory Health Services' CAAODS is planning to expand its capacity to help with the counselling and detoxification of these sniffers. THS is also planning to resume its former practice of regularly consolidating sniffing-related data from its bush clinics, as a monitoring device to warn of new outbreaks and upsurges. (**This didn't eventuate).**

CAAODS' Alice Springs-based substance abuse educator is available to respond to invitations to visit communities in this zone to carry out education about the harm associated with a range of substances, including volatile inhalants such as petrol, and has done so recently. (**check if this is still the case**).

Territory Health Services contracted CAISAN member and researcher Blair McFarland to compile *A Project Report on Petrol Sniffing in Central Australia 1999*, which went to the Northern Territory Government and its Interdepartmental Committee on Petrol Sniffing. This committee was set up late in 1998 in response to Coroner Warren Donald's recommendations made as a part of his coronial inquiry into the death of a petrol sniffer. The McFarland report analyses causal factors, looks at the Coroner's recommendations, discusses best practice models, surveys the existing inhalant abuse services and related services, and makes recommendations for action in various spheres of activity, including changes to laws and procedures, improvements to existing services and the creation of some new services.

CAISAN is also calling for the establishment of a youth sobering up facility in the town, plus a special youth assistance and intervention service to support efforts like those at Intjartnama, Winbarrku, Ilpurla and Mt Theo. These proposals are discussed in the McFarland report.

The youth services at ASYASS and Aranda House (ACCA) make some effort to help and counsel sniffers who come in contact with these services, but they are not set up to supply particular services to inhalant abusers. These services, along with Congress and Tangentyere, are strongly of the opinion that Alice Springs needs an immediate expansion of appropriate facilities (beds and staff) to take care of many intoxicated youth while they sober up and/or find suitable long-term accommodation. This group includes fluctuating numbers of inhalant misusers. The size of this problem is a reflection of the widespread extent of serious family dysfunction within the very problematic Alice Springs social environment.

Central Australian Aboriginal Congress has received some NIDS funds to establish a specialist youth psychologist position, which has become the basis of a Youth Outreach Counselling Service. This service will be able to assist in sorting out a sensible teamwork approach to sniffing problems in Alice Springs. The NIDS funding has been complemented by some carry-over funds that OATSIH has agreed can be spent on the employment of three youth outreach workers.

Tangentyere Council is also running a Youth Recreation Program, which is making attempts to grapple with the sniffing problem in some ways, as does its Return to Country Program occasionally. Its Remote Night Patrol support program is also helpful in that it attempts to improve the quality and longevity of night patrol projects in a number of bush communities, and these in turn have some impact on the level of sniffing.

Various health facilities, including Congress and the Hospital, can provide help with medical aspects of detoxing from inhalants.

Available Services: Zone 12 (Pitjantjatjara/Luritja – Finke, Titjikala, Imanpa, Ukaka, Mutitjulu and Docker River)

This zone includes two communities (Aputula and Titjikala) where there are low numbers of isolated sniffers, and where the situation is basically under control, being managed by the councils and clinics. It also includes a sizeable community (Docker River) where there is a cohort of eight chronic adult sniffers, and sporadic outbreaks among young people. Again the situation is being managed on the whole, although it becomes very difficult at times, with upsurges of under-age drinking and cannabis use as well as sniffing, leading to the considerable problems associated with youth poly-substance misuse.

The major problem areas in this zone at the moment are at Imanpa, (**now much diminished**) which has long had high levels of problems, and Mutitjulu, which has only developed a chronic problem in the last couple of years, having previously been success in overcoming isolated outbreaks of sniffing.

The only service specifically addressing petrol sniffing problems in this area, at Ilpurla, near Illamurta, is currently operating at a very low level of activity. It is unclear whether it is likely to experience any recovery to its previous higher level (**it has since increased**). Some communities in the zone are still looking to it as the place where they want to send their chronic or problem sniffers for respite breaks. (The Adelaide-based Aboriginal Drug and Alcohol Council of South Australia [ADAC] has had some contact with Mutitjulu about delivering an aspect of its NIDS-funded program there**. Didn't eventuate**)

The CAAODS worker is also available to visit communities in this region, and has been to Imanpa recently.

The community-controlled health service at Mutitjulu has been liaising closely with the NPY Women's Council about its proposed project. This project may have some minor impact in the area, through the work of its project officer, but its main focus is likely to be at a small number of communities in the SA and WA Lands.

Available Services: Pitjantjatjara Homelands, SA

Although there are still more than 100 active sniffers on average across the Pitjantjatjara Lands (according to Nganampa Health), there has been a decline (**this was related to the introduction of avgas, it has increased a lot and is now more prevalent in a younger sniffer age group**) in overall numbers in recent years, as well as a shift in the average age of chronic sniffers: there has been a falling off in school-age sniffing, with a corresponding increase in the average age of continuing sniffers. The result is less sniffers in the 10 to 14 age group, with a higher proportion of current sniffers being aged over 15, and with a large number in their twenties.

This has been paralleled or assisted by general improvements in the schools and clinics, reflected in better attendance rates and improved health among school aged children. These improvements include a big decline in STD infection rates.

The main exceptions to this trend have been at Fregon and Amata, where there have been significant outbreaks of sniffing among school-age children. This has coincided with other serious problems in these communities, resulting in low morale and a temporary decline in the community's capacity for problem solving. Some of the new sniffers have since been persuaded to stop.

At present the Nganampa Health Council provides some services in relation to sniffing. Apart from taking an annual census of the sniffer numbers on the Lands, Nganampa also acts as an advocate for securing small amounts of funding for emergency support to people faced with crises resulting from sniffing. (**This function may have moved to NPY Women's Council)** These funds are spent on equipment and food in emergencies, on paying occasional respite carers, and small amounts on support for recreation and work-experience projects involving sniffers. For example, bits of this fund have paid for musical instruments, sports gear, camel mustering and a bit of fencing to keep the camels in. However, the time and resources that Nganampa can commit to addressing sniffing are quite limited.

The NPY Women's Council has established a NIDS-funded project which supports people in taking preventative measures, such as establishing youth projects. NPY is also trying to assist in building up one or two outstation respite services where there are highly motivated family groups who want to provide this assistance to neighbouring communities (**this wasn't successful**). NPY has employed a team of two workers at Fregon (**it closed**), and is trying to recruit a similar team for Amata (**currently operating**).

The SA Aboriginal Drug and Alcohol Council is also attempting to set up some aspects of its NIDS-funded program in this region (**didn't eventuate**)

Available Services: The Ngaanyatjarra Lands, WA

As with the Pitjantjatjara Lands, Ngaanyatjarra country does not have much happening. However, many of its community institutions are in a better condition for coping with the challenges presented by sniffing, and councils work in well in a number of cases with the WA Police and Correctional Services to keep things from spinning completely out of control. Still there are serious problem areas, such as

Kiwirrkura, across the border from Kintore, which urgently need addressing. A committee co-ordinates responses in the Warburton/Blackstone region, but this is a long way from problem spots like Kiwirrkura and Wingellina.

The NPY project may be of some assistance, through the Ngaanyatjarra Recreation Project, in fostering some preventative sporting and community/youth work activity, but this will probably have a small impact compared to the size of the problems.

Attachment 6 Letter Congress to Crundall re: development of Substance Misuse Action Plan

Ian Crundall
Convenor
SMAG
C/o DHCS
PO Box 721
Alice Springs NT

15th March 2002

RE: SMAG Draft Action Plan

Dear Ian,

The Central Australian Aboriginal Congress in submitting these comments to the draft Substance Misuse Action plan as developed by the Substance Misuse Action Group of CARIHPC, is continuing our long association with dealing with substance misuse issues within our community. Congress has always sought the highest levels of commitment to this issue from decision makers and service delivery agencies.

Congress played a major role in supporting the CARIHPC Central Australian Regional Substance Misuse Strategic Plan, from the lobbying for its inception through hosting the CARIHPC Substance Misuse Strategic Plan Project Officer and finally with the production of the Plan itself. It was with considerable satisfaction that Congress viewed the launch of the Strategic Plan on our premises in September 2001.

In light of the extensive resources, time and effort that Congress has put into the issue of Substance Misuse over many decades it was with a sense of growing dismay and disappointment that we worked our way through the current draft Substance Misuse Action Plan. Congress wishes to register our view that the current draft is not of a satisfactory standard expected from a CARIHPC Action Group and falls very short of the quality work embodied in the Strategic Plan that it is meant to implement and hence doesn't do that work justice.

We wish to note the following key problems with the draft SMAG Action Plan:

- The layout of the Action Plan is not consistent with the Strategic Plan, making cross referencing of the two documents very laborious:
    - This is particularly problematic where different terms are used to describe the same item Tasks in the Strategic Plan become Strategies in the draft Action Plan,

    - Task/strategies are not fully quoted or have been partially quoted often placing them out of context or substantially changing their meaning,
- Too often Actions are very weak, with major Task/Strategies being actioned merely with a letter and no follow-up action indicated,
- Some Actions bear little relation to the Strategy as stated,
- Core Partners to the agreement are not being asked to implement Strategies they signed off on in the Strategic Plan,
- Too often the SMAG Secretariat is left to be the responsible body, more stringent asks need to be made of other agencies.

Congress is very disappointed with the draft SMAG Action Plan as it currently stands. We have endeavoured to provide feedback to the Action Group to try and redeem the process, see attached. However unless there can be demonstrated a higher level of commitment to adequately and competently providing the standard of work expected from core partners in the regional planning process, Congress would find it difficult to support the current arrangements proceeding.

Congress strongly urged that a dedicated Project Officers position be funded to support the development of the Action Plan. Other partners to the process did not support this position. The standard of the current draft would seem to vindicate our original concerns that the Action Plan would not be effectively developed without such a position.

We will be raising with our federation, the Aboriginal Medical Services Alliance NT, these concerns and will be asking for AMSANT to pursue these matters through the Central Australian regional and Territory Aboriginal health planning forums.

Yours sincerely,

STEPHANIE BELL
Director Central Australian Aboriginal Congress Inc.

Cc: Brycen Brook CAAODS
Executive Secretary AMSANT