

# Indigenous-specific alcohol and other drug interventions - 13 April 2010

## Nationwide Review of Investment into Indigenous Drug and Alcohol Programs



**An important report identifying the areas of greatest need to address harmful Indigenous drug and alcohol use was released today by the National Indigenous Drug and Alcohol Committee (NIDAC) of the Australian National Council on Drugs (ANCD)**

The report, commissioned by NIDAC with funding from the Department of Health & Ageing, and to be launched by the Hon. Warren Snowdon, Federal Minister for Indigenous Health, Rural and Regional Health and Regional Services Delivery at the Aboriginal Medical Service in Redfern, has reviewed the actual level of expenditure on specific Indigenous specific drug and alcohol across the country.

The report takes a snapshot of expenditure in 2006/2007 to allow comparisons with a similar report commissioned by the ANCD in 1999/2000. These studies provide a great opportunity to identify service gaps as well as review any changes that have occurred.

A significant finding in the report released today finds that levels of one-off funding have increased and resulted in a great deal of turnover in both the programs available and the organizations delivering them.

Of the 213 organizations conducting projects in 1999/2000, only 52 per cent were doing so in 2006/2007.

Of the 277 projects conducted in 1999/2000, only 48 per cent were still being conducted in 2006/2007.

This reveals a 50% turnover in projects and organizations in this period and highlights the need for strategies to be put in place by governments to increase the proportion of recurrent funding for the provision of drug and alcohol services.

The report also highlights there are real disparities between the size of Indigenous populations and the levels of funding and services they receive. Indigenous populations in Sydney and Brisbane metropolitan regions are probably the largest in the nation yet they were receiving far less per capita than other regions.

Professor Ted Wilkes, NIDAC Chair says “the government’s focus on improving Indigenous health, particularly since 2007 has been welcomed. The focus on rural and remote Indigenous communities for many years now is also welcomed. However, we must recognize that the sizable majority of Indigenous people actually live in metropolitan and regional areas and they need and deserve similar levels of attention and investment to address drug and alcohol problems.”

Professor Wilkes added “money on its own won’t fix the problem. It’s how and where it is spent that is the key. Ensuring there is proper and respectful consultation with communities is also vital. Too often, consultation between different tiers of government or their departments is seen as consultation with communities. Or worse, consultation is cosmetic with decisions having already been determined before communities are engaged. Drug and alcohol misuse is having a devastating impact on some Indigenous communities but through consultation we can uncover some local solutions to these problems. Giving Indigenous people the

chances to review the evidence available to determine and deliver these solutions can also have some very wide and positive ramifications for Indigenous people”

Professor Dennis Gray of the National Drug Research Institute and an author of the report stated “what we saw when we looked at the service mix was that there were too few community-based or residential treatment projects addressing the special needs of women, families, young people, and those suffering from co-morbid mental health problems. Whilst nationally, there were only three projects funded specifically to provide on-going care for those completing treatment. To protect the investment made in treatment services, priority should be given to the provision of community-based on-going care services for those who have completed treatment”.

Professor Wilkes added “the report highlights what many people working in the Indigenous drug and alcohol sector have known for some time; money needs to be better targeted at what communities identify as needs. The lack of residential facilities being a case in point – they may be more expensive than other forms of treatment which is why investment in them is difficult to acquire at times but when compared to the cost of literally imprisoning thousands of Indigenous men, women and adolescents each year, many of whom have drug and alcohol problems, it is a difficult to argue against such investments.”

A particularly worrying finding from the report was the shift in funding from community controlled organisations to government services and non-Indigenous organisations and the lack of investment in staff, with only 2% of total funding expended on workforce development.

NIDAC believes that Indigenous targeted programs and services run by Indigenous communities provide a much better opportunity for real change. Understanding the cultural norms and views of a community makes the success of drug and alcohol interventions far more likely. Investing in Indigenous organizations and people must be an important component of any successful strategy in the future. The report’s finding that in the interest of providing more appropriate services, better client outcomes, and building capacity, all levels of government should re-commit themselves to the principle of Indigenous community-control of service provision was strongly endorsed by NIDAC.

Professor Ted Wilkes concluded “The findings of this report are a valuable guide for all governments. The strategic allocation of funding can effectively make a real difference in reducing harmful Indigenous drug and alcohol use and its associated harm. To ensure that gaps are filled with appropriate and evidence based services demands an agreement across all political divides”.

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## **FACT SHEET**

1. In the 2006–2007 financial year there were 340 Indigenous specific aod intervention projects being conducted by 224 organisations, of which 159 were Indigenous community-controlled organisations.
2. Between 1999–2000 and 2006–2007, there was 23% increase in the number of Indigenous specific projects and a 5% increase in the number of organisations providing them.
3. Between 1999–2000 and 2006–2007, in real terms (i.e. 2006–2007 dollars) operational expenditure on Indigenous specific aod projects increased from \$42.6 million to \$89.4 million – an increase of 110%. When

population growth is taken into account, on a *per capita* basis the increase was 34%.

4. In 2007–2008 and 2008–2009, the Australian Government increased its share of funding for Indigenous specific aod interventions by 32% and 42% over 2006–2007 levels.
5. Between 1999–2000 and 2006–2007 expenditure on preventive services increased from 11% to 28% of operational expenditure – thus addressing what had previously been identified as a significant imbalance in funding.
6. Between 1999–2000 and 2006–2007 non-recurrent funding increased from 5% to 17% of operational expenditure. This has resulted in a high turnover of both short-term projects and in the organisations conducting them.
7. Of the 213 organisations conducting projects in 1999–2000, only 52 per cent were doing so in 2006–2007. Of the 277 projects conducted in 1999–2000, only 48 per cent were still being conducted in 2006–2007.
8. Between 1999–2000 and 2006–2007, the number of Indigenous community-controlled organisations providing aod services decreased from 177 to 159 and the percentage of projects they conducted fell from 82% to 73% of the total. In the same period, the percentage of operational funding expended by Indigenous community-controlled organisations fell from 90% to 69% of the total.
9. Conversely, the number of non-Indigenous ngos providing Indigenous specific services increased from 16 to 44 and the percentage of projects they conducted increased from 6% to 17%. The percentage of operational funding expended by non-Indigenous ngos increased from 5% to 20% of the total.
10. The evidence suggests that about one fifth of ABS Indigenous Regions do not have adequate coverage of aod services.
11. There was no correlation between the size of regional populations and either levels of service provision or funding. There were regions with relatively large Indigenous populations, such as the Sydney and Brisbane metropolitan regions, that were under-served.
12. There were few community-based or residential treatment projects addressing the special needs of women, families, young people, and those suffering from co-morbid mental health problems.
13. Nationally, there were only three projects funded specifically to provide on-going care for those completing treatment.
14. Inadequate staff training was identified as a barrier to effective service provision.
15. Only 2% of total funding was expended on workforce development.

## **REPORT RECOMMENDATIONS**

1. All levels of government should enhance their efforts to develop more effective policies and strategies to address the inequalities that underlie such prevalence, as well as the specific needs for service provision identified.
2. The Ministerial Council on Drug Strategy should make a renewed commitment to the National Drug

Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan to address harmful levels of alcohol and other drug use.

### **Targeting gaps in service provision**

3. Given the disproportionate negative impact of tobacco smoking on the health of Indigenous Australians, far greater emphasis should be put on the provision of appropriate interventions to reduce its prevalence.
4. Given the paucity of community and residentially based treatment services for women, families, young people and those suffering from co-morbid mental illness, there should be a significant increase in the provision of such services.
5. To address the significant gap in the provision of ongoing care services, to minimise relapse among those who have undergone treatment and to protect the investment made in treatment services, priority should be given to the provision of community-based ongoing care services for those who have completed treatment.
6. Where a need is identified by Indigenous communities, and where justified by numbers of potential clients, there should be an expansion of detoxification services catering to the needs of Indigenous Australians.
7. There are several regions identified in Chapter 5 of this report which appear to be under-serviced. These regions should be targeted with regard to the provision of a wider range of Indigenous-specific alcohol and other drug services.

### **Capacity building**

8. In the interest of providing more appropriate services, better client outcomes, and building capacity, all levels of government should re-commit themselves to the principle of Indigenous community control of service provision.
9. To develop the capacity of Indigenous communities to address alcohol- and other drug-related harms, it should be a requirement of tendering conditions that non-Indigenous NGOs tendering for the provision of services to Indigenous Australians make all endeavours to tender in partnership with Indigenous community-controlled organisations and put in place strategies and timeframes for handover of services to those organisations.
10. Given the gaps in the capacity of some providers either to effectively deliver existing services or to meet other community needs, consideration of current capacity and any need to enhance it should be part of service contract negotiations and funding should be provided accordingly.

### **Workforce issues**

11. Given the shortages of skilled alcohol and other drug staff (and the constraints on service provision and expansion of capacity that such shortages impose) and the low levels of investment in staff development

and training, funding and other resourcing for skilled staff should be substantially increased.

12. Given the high turnover of staff within the community-controlled alcohol and other drugs sector (as a consequence of heavy workloads, poor remuneration vis-à-vis the government sector, and lack of career paths), staffing benchmarks — including remuneration and conditions of employment — should be negotiated between funding agencies and service provider representatives, and should be implemented.

13. Given that the demand for qualified Indigenous staff members cannot be adequately met within the alcohol and other drugs sector, the Australian Government Department of Health and Ageing (as the most important of the funding agencies) should enter into discussion with the Department of Education, Employment and Workplace Relations to explore ways of facilitating increased direct entry of Indigenous Australians into vocational and tertiary education programs of relevance within the sector.

## Funding

14. Given the evidence of significant gaps in the provision of alcohol and other drug services for Indigenous Australians, detailed costing of the services necessary to address those gaps should be developed in collaboration by the various funding agencies and service providers, and funding allocations should be increased accordingly.

15. Given the variation in need between regions and in community priorities, funding program guidelines and contractual arrangements for the provision of alcohol and other drug services to Indigenous Australians should be sufficiently broad to allow service providers to meet community needs within their particular regions.

16. Given the uncertainty of service delivery, the compromising of outcomes and the additional reporting requirements entailed in dependence upon non-recurrent funding, strategies should be put in place by governments to increase the proportion of funding allocated on a non-recurrent basis for the provision of alcohol and other drug services.

17. Benchmarks should be negotiated between funding agencies and service providers for the provision of treatment services — including provision for clients with special needs such as those with co-morbid mental health problems, polydrug users, and offenders — and services should be funded with regard to client needs and client mix.

18. Coordination of care within and between the government and non-government sectors should be part of treatment service benchmarking, and its provision should be appropriately funded.

19. Given the administrative burden of reporting requirements, steps should be taken by funding agencies to reduce such requirements — including the rationalisation of grant provision and the simplification and standardisation of reporting requirements — while at the same time upgrading the capacity of Indigenous organisations to meet them.

## Planning

20. Given the evidence of limited planning of service provision, regional alcohol and other drug planning committees, made up of a broad range of stakeholders and including all community-controlled AOD and

health services, should be established to facilitate provision of a 'range of holistic services from prevention through to treatment and continuing care', and to contribute to their evaluation and continuous improvement.

21. Agencies charged with collecting data on the prevalence of alcohol and other drug use and related harms should work together to provide such data at a regional level, and in a timely manner, to ensure that services are planned jointly by key stakeholders and funded in response to need.

22. Service provision at the regional level should be reviewed to ensure that a complete range of community-based services — and, where feasible, residential services — is available.

23. Where provision of services is not feasible at the local level, regional service providers should be resourced to provide reasonable region-wide access to their services.