Presentation notes: Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander Communities at DASA Conference Room Monday 31 March 2014

Margo MacGregor, CEO, Drug and Alcohol Services Association (DASA).

I have worked in alcohol and other drugs for over 30 years in the Top-end and remote South Australia. I have working in Central Australia for the past 19 years, and been the CEO of DASA for two months.

Handouts: DASA Strategic Plan, DASA Annual report, DASA information Flyer.

Introduction

For over 30 years since it was established in 1984, the Drug and Alcohol Services Association (DASA) has been adapting and evolving services to meet the needs of the community.

DASA is a non-Government community based organisation that receives funding from the Northern Territory and Australian Governments.

As at today, DASA employs 36 full time staff. It operates from three sites within the town boundaries.

All of the programs of DASA are underpinned by the harm minimisation framework.

This means all of its activities are based on the ethos of self determination and choice. Clients have a right and are encouraged to fully participate in defining and managing their own care, and their own treatment goals.

DASA recognises that it is one component in an overall service system, and community. Society at large, has a responsibility to provide an environment where healthy personal development is valued and supported.

Services

DASA opened the first Sobering up Shelter in Australia to keep Aboriginal people safe as an alternative to police protective custody. This was a key recommendation from the 1987 – 1991 Royal Commission into Aboriginal Deaths in Custody.

From there it expanded to, for many years, provide community education. This was a particular focus of funding during the era of the Living with Alcohol Program. That program maintained policy focus on harm reduction though supply control, demand reduction and

harm reduction strategies. Community education was a key strategy complimentary activity along side targeted whole of community mass media campaigns aimed at shifting community attitudes and beliefs.

In the late 1990's DASA trailed a detox and treatment service for clients - many of who were also volatile substance users. This was against a background where there were limited harm reduction based residential services in town, or for people who also used inhalants. This led, in 2007 to DASA being funded to establish what is now the Aranda house residential treatment service.

In its attempts to improve early intervention and meet the needs of Aboriginal clients, DASA also trialled the first assertive Aboriginal outreach program. This was attached to the Sobering up service and trialled with funds from the Alcohol Education Rehabilitation Foundation and following a successful trial continues today with ongoing Australian government funding.

The outreach service is staffed by a team of four local Aboriginal people. They provide brief and early interventions to people at the Sobering-Up Service, provide case support for people in the community, in residential treatment and aftercare, and engage in a wide range of community information and education activities including prison in-reach, and whole of community health activities.

In the last three years, the Australian government has provided additional funds for DASA to establish seven Independent Living Units. These provide semi independent step down from either residential rehabilitation or some other form of therapy back into the community. There are also three Transitional Aftercare Units. These enable people to reside, with their families independently and with limited case management establish fully independent healthy living.

DASA works across the entire community and with a wide range of services from across sectors. These include alcohol and other drugs, mental health, primary health care, employment, housing, education, prison, corrections, police and many others.

Client profile

- 80% of DASA's treatment service clients are Aboriginal, of whom 2/3 are male
- All of its outreach clients and most of its Sobering Up Service clients are Aboriginal
- Ages range from over 17 to up to 65 years, the majority falling into the 30 – 45 year old age range
- They have complex needs – 70% with mental health issues, at least half with an underlying chronic and at times acute (trauma)health issue
- 1/3 of all residential clients are from remote communities– all over CA region.
- Mixture mandated and voluntary clients.

- By far the primary drug of concern is alcohol (95%), followed by cannabis and other drugs
- There are about 6000 admissions to the Sobering up Shelter each year

Issues

Policy

- Gap in early intervention. Targeting young people and those who are not yet considered dependent and those at risk during pregnancy (foetal alcohol). Re-fund DASA community educator. Community education at the population level as was the case with the LWAP.

- Policy needs to line up with harm minimisation framework to ensure the right policy is being applied for the right issues. Focusing on supply control to influence uptake by young people and reduce harms from moderate to risky users. Ensuring entrenched hazardous users have access to safety as well as supply control measures and look at unintended impacts (black market) and unsafe drinking camps.

- Need to be responsive to the growing needs of women with children, particularly younger women and pregnant women to develop alternatives to taking the children into care or family placement.

- Need to develop service models and facilities to accommodate family units where more than one partner may be using and or support partners in the treatment process. Also support strong family members such as grandmothers and grandfathers taking on carer roles.

- Need a longer term policy and funding view to build sustained change and have impact on Aboriginal families. Currently 1 year to 3 year funding cycles.

Models of care

- Holistic approach with services and programs working together – medical, homelessness, housing, family breakdown, incarceration, mental health issues. Alcohol is often a response to and a function of a wide range of other issues.

- Understand client pathways. Make sure for example there are systemic pathways for people leaving corrections, the prison and other health services to be properly prepared and linked into AOD services either residential or community outreach. And these programs need to be bolstered with additional staffing to meet the demand for immediate care and longer term aftercare.

- Need to revise the staffing profile and mix. For example to provide AOD counselling, services or individual support programs using validated therapies such as CBT and Narrative therapies because the needs of the clients are complex with roughly 70% have at the very least have some co-existing anxiety, trauma or depressive condition. And to

establish services with predefined resources / links to required supportive medical assessments and therapies (e.g. withdrawal)

Evidenced and equitable

- Programs and approaches need to be informed by the people affected so programs are culturally sound and meeting the needs of Aboriginal people in the community.

- Think through what success means. Judge programs on wether people use them, have a break, and time to think through their options. Also judge them on wether people come back and feel comfortable with the services – define treatment and outcomes.

- Judging services based on throughput and occupancy levels is unrealistic when we are working with highly transitory clients with complex needs suffering trauma and chaotic lifestyles. It is also contrary to the evidence.

- A logical funding model where there is a defined cost per service category / event across service types. So there is a minimum level of resource to client need, regardless of funder and service delivery agency.

Thank you for the opportunity to provide this perspective today.